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Building reputation: the significance of pain talk in hospice  
and palliative care team meetings

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Thesis submitted for the Degree of Doctor of Philosophy  
January 2004

## Thesis abstract

The broad aim of my research is to understand from a sociological perspective how palliative care professionals talk about pain. I discuss the development of pain medicine and the concept of ‘total pain’ within the hospice and palliative care movement. I focus on two main areas within the thesis: pain talk and the negotiation of professional boundaries. I develop a theory of reputation, which links these two analytic ideas and enables one to understand how different types of reputation are constructed. I focus in particular on how specialist nurses in hospice and palliative care develop a reputation in the medical space through talk about pain. Through talk-in-action that focuses on pain, a space is opened up that enables the palliative care team to develop a unique identity around expertise related to pain and other symptoms, and in this way they build a reputation for themselves and for palliative care. Reputation is achieved through the use of rhetorical and linguistic resources. The rules of pain work are made visible in the talk and this enables both competent work and professional identity to be displayed and explored. By use of linguistic and rhetorical resources palliative care professionals’ construct their competence by comparison with those who do not have this expertise. Analysis of pain talk enables an understanding of how expertise and identity is negotiated. The expertise that is made visible in the talk is primarily biomedical expertise, but other forms of expertise are also made visible through psychosocial talk. The thesis therefore offers a linguistic analysis of how pain talk enables the members of the palliative care team to build a team reputation as experts in managing pain in the body. Talk about pain shapes the boundaries of professional work with patients in pain.

My findings suggest three substantive conclusions. Firstly that the palliative care team accomplish their reputation through pain talk, and that reputation is threatened when pain is difficult to relieve. Thus reputation is primarily achieved by a discourse that shapes pain and symptoms in the body as the primary mode of intervention. Secondly the palliative care team use rhetorical forms of speech to position themselves and their expertise in contrast to non-specialist practitioners and this establishes the collegial positioning of specialist nurses in such settings and achieves reputation for the specialist nurse as an expert in pain work. Thirdly specialist nurses in palliative care use specific linguistic strategies such as telling

mystery stories, asking questions and the use of footing to keep a neutralistic positioning to enter into medical discourse and to shape the agenda of talk. These strategies enable interprofessional work in the context of the team. In conclusion 'total pain' is linked with two types of reputation. Firstly the discourse of 'total pain' establishes the reputation of the palliative care movement within a holistic and humanistic framework. Secondly it enables the palliative care movement to construct its medical reputation as a successful speciality in relation to pain and symptom management. These two types of reputation are in tension.

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## Acknowledgements

I am very fortunate in having Professor Clive Seale as my supervisor. His sheer commitment to the task, his integrity, constructive criticism and support is remarkable and very much appreciated.

I am indebted to the practitioners and patients in the different hospice and palliative care settings. They took me on trust, made me welcome, and helped me in whatever way they could and for this I am extremely grateful.

When I started this thesis I received very generous support and sabbatical leave at Kingston University and St George's Hospital Medical School. In particular Tracey Murray supported me during my sabbatical leave and Chris Eberhardie could always be relied on for help and support.

I am now very grateful for the generous support and study leave provided by the University of Surrey. Professor Pam Smith has been very understanding and kind, which has helped me in completing the thesis.

I would like to acknowledge my good friends Ann Gallagher who organised a social life, and Sarah Li for her exuberance and friendship.

Finally this project would not have been possible without the generosity and tolerance of my husband and children. Mick has had everlasting patience and understanding. He has supported me, provided I.T. 'know how' and proof read some of the thesis. Ruth has taken a lively interest in my work and Ian has been good-humoured throughout. This level of support has enabled me to complete the thesis.

# **Chapter 1 An Outline of the Thesis and Brief Chapter Outline**

## 1.1 Introduction

I have chosen the topic of pain as I believe it is an important aspect of care for those patients with cancer and other chronic illnesses. The hospice movement has provided very effective techniques in the medical management of pain and these principles are now widely adopted and effective in the cancer care context (Twycross & Wilcock 2001, WHO 1996, Saunders & Sykes 1993). However managing pain is not just about medical techniques. Although pain may be relieved eventually it is not always possible immediately and sometimes not totally effective particularly with some types of non-malignant pain. Pain management techniques are also predicated on the possibility that the patient can tell you about the pain, to make this pain visible in some way to the health care professional either through words or through the body. This involves communication and not all patients are able to communicate particularly if they have cognitive impairment for example. I therefore became interested in how pain is talked about in the context of palliative care. I reasoned that in this specialist area pain work would be as good as you could get.

The topic of pain talk interests me for three reasons. Firstly, as a nurse I have had close contact with people in pain. This includes those suffering from acute pain such as occurring after accidents, following surgery and those with acute and chronic pain in the context of advanced cancer. I have had to struggle with how best to help people in pain. I have made it a priority to learn as much as I can about the experience of pain and to be knowledgeable and skilled in such work. Secondly, as a teacher of nurses I have become aware of the different beliefs and judgements made about people in pain. I have been disturbed by some of the stories I have heard about difficulties with people in pain, particularly in contexts other than cancer care. Thirdly, I was introduced to the concept of 'total pain' some years ago when visiting St Christopher's Hospice. A staff nurse talked about 'total pain' and applied the concept to a patient she was caring for. This I felt was a turning point in how I understood pain. What she was talking about was not something you find in medical and nursing textbooks. I wondered how the concept of 'total pain' can be demonstrated in practice and what would such practice look like. I believe that by researching practitioners in palliative care it may be possible to identify a new cultural performance in relation to pain that encompasses an expanded medical narrative.

In this thesis I explore how palliative care professionals talk about pain. My interest is in what such pain talk involves and how talk shapes and constructs patients' experience. The underlying interest for me is how the medical and the social influence and shape talk about pain. Two key themes emerge within the thesis: pain talk and negotiating professional boundaries. I am interested in how professional identities are constructed around talk about pain and how boundaries are made and unmade. My theoretical position is that reputation is a key construct in talk about pain. Therefore, in my analysis, I develop a theory of reputation and extrapolate this theory to the team performance as well as to the identity of the specialist palliative care nurse. I conclude by discussing the relationship and the tension between the concept of 'total pain' and the concept of reputation.

Although the thesis is organised in a traditional manner starting with a literature review (Chapters 2 and 3), I have regularly revisited all sections of the thesis in the light of my data analysis and findings as inductively generated concepts became more focused.

## **1.2 Outline of the chapters**

Chapters 2 and 3 of the thesis consist of two literature reviews. Chapter 2 reviews the literature related to the sociology of pain and the emergence of pain medicine and the hospice concept of 'total pain'. I discuss how both pain medicine and the hospice and palliative care movement prioritises the importance of the integrated experience of pain that results in the hospice concept of 'total pain' and the pain medicine concept of chronic pain syndrome. I evaluate empirical evidence that questions the adequacy of medical approaches to pain because they neglect the emotional and social aspects of pain. I argue that although the hospice and palliative care movement has done a great deal to humanise and open up the thinking around the meaning and interpretation of pain it is unclear how this thinking is enacted in medical and nursing practice. From the research evidence that I have studied I suggest that there may be differences, according to context, that structure and shape different performances in relation to pain. I am interested in the performance of pain work by specialist nurses in the context of hospice and palliative care; therefore I discuss some of the historical and contemporary developments occurring in nursing resulting in the emergence of specialist nurses in Chapter 3.

Chapter 3 provides a brief history of modern nursing, which locates nursing within the medical division of labour from a historical perspective. I use the work of Witz (1992) to structure this chapter. I apply her work to the development of specialist palliative care nurses and how such nurses are pursuing their 'professional project' in the medical space through a process of negotiation. I examine the contested nature of nursing both in relation to medicine and to issues related to caring. I discuss some of the tensions in the boundary between medical and nursing work and the dynamic nature of such a boundary. I re-formulate Witz's construction of nurses' professional project to include an inclusionary strategy as well as a usurpationary strategy.

In Chapter 4 I develop a theory of reputation that is applied within the context of the palliative care team. I explore how talk about pain is one area where specialist nurses seek to establish their reputation and this is an inclusionary strategy. I became aware of the concept of reputation during my initial period of data analysis and at this time I searched the research literature for studies related to reputation. I have therefore included this literature at this point in the thesis to construct the iterative nature of literature, data and theory construction. My research questions are formulated at the end of this chapter.

In chapter 5 the main principles of my methodological approach is outlined. This approach is set within the ethnomethodological tradition, which is concerned with how the everyday, the ordinary are achieved in practice. To this end I have collected naturally occurring data from palliative care team meetings on two sites. I am reflexive about my positioning in this field of study and what this means for the data collected. I discuss how my data analysis is influenced by ethnographic concerns but informed by the application of conversation analytic techniques and tools taken from linguistics. This microanalysis enables one to understand how interprofessional work is possible and how such work entails rhetorical and linguistic resources and positions expertise and competence. I discuss some of the limitations of my approach and what this means for validity.

I have two chapters related to presenting my findings, Chapter 6 and Chapter 7. In Chapter 6 I discuss how the palliative care team talk about pain. The themes that emerge are related to reputation. Reputation has three dimensions. Firstly pain talk is the means by which the palliative care team develop a reputation as an

effective medical discipline. Secondly pain talk enables the specialist palliative care nurse to have a collegial, inclusionary positioning within the medical division of labour in the context of palliative care. Thirdly patient complaints of unrelieved pain can disturb the equilibrium of the team and threaten reputation. This may result in the development of psychosocial talk, which constructs the patient reputation. Specialist nurses make explicit a tension in the boundary between themselves and non-specialist doctors through talk involving contrastive rhetoric. Thus non-specialist doctors can be a threat to the reputation of the specialist nurse and the palliative care team.

In chapter 7 I develop the theme of professional boundaries and how these boundaries are made visible in the talk. I have specifically focused on how talk may position expertise and how boundaries are made and unmade. I examine rhetorical and linguistic devices used by nurses to bring of a particular performance of expert practice related to pain work as well as claims made about expertise in other areas such as making referrals to specialist doctors. Thus using analytic tools taken from linguistics, such as conversation analysis, enables me to focus on the microstructure of talk in such settings. Specific rhetorical techniques used by specialist nurses are: telling a mystery story, making a pain story a psychosocial story, taking the floor, using questions to strategically manage a specific outcome and ‘information eliciting tellings’. Specialist nurses engage in interprofessional work by displaying their particular brand of professionalism by keeping a neutralistic footing, asking questions and making claims that disturb the medical and nursing boundary.

Chapter 8 draws together the main findings of the thesis. In this section I revisit my research questions and literature review. I discuss the link I have found between the concept of ‘total pain’ and that of reputation. As a concept ‘total pain’ enables palliative medicine to develop a particular type of reputation related to care of the whole person; ‘total care’ that is conceptualised in the image of pain. Credibility in palliative care is positioned on the basis of being effective in relation to the significant problem of pain as well as other symptoms. The ‘insider’ space of the palliative care team results in a particular performance of pain work vis-à-vis ‘outsiders’ such as non-specialist practitioners. This results in a reappraisal of the medical and nursing boundary because such specialist nurses appear to have an inclusionary positioning within the medical division of labour.

Thus I discuss what this inclusionary positioning means for the practice of 'total pain'.



**Chapter 2 Pain and Contemporary  
Health Care – A Literature  
Review**

## 2.1 Introduction

This literature review focuses on how pain and pain work is conceptualised, constructed and operationalised within contemporary health care settings. The dominant paradigm in relation to pain, within medicine, has been changing since the middle of the last century; evidence for this change will be discussed. The criticism that pain has become a medical problem, stripped of its social and cultural meaning is discussed as a partial representation of current medical practice. A new paradigm in relation to pain has developed from the gate control theory hypothesised by Melzack and Wall (1965). This theory has been widely accepted within medicine and has succeeded in integrating the physical and psychosocial elements of the pain experience. At the same time, the medical discourse has moved from a mechanistic approach to patients towards holism where the patient is encouraged to speak as an active subject (Arney and Bergen 1984). There remains, however, criticism both within medicine (Wall 1999) and from the social sciences (Bendelow and Williams 1995) that the experiential and emotional aspect of pain is neglected within mainstream medicine. This neglect has resulted in Bendelow and Williams' argument for a new and expanded model of pain. Research evidence from dental practice, pain medicine and palliative care suggests that the relationship between medicine and the patient in pain is located in new spaces where pain is re-defined. There is some ambiguity as to the nature of this pain practice in health care (Rogers & Todd 2000, Wakefield 1995). In addition, practitioners in pain medicine hold diverse ideologies in relation to their work. These ideologies have implications for how specialists practice (Vrancken 1989). Research suggests both a phased development of a paradigm over time, as well as different approaches in different contexts, based on individualistic, collective and professional ideologies (Clark 1999, Baszanger 1998, Hunt 1989).

The concept of 'total pain' will be discussed. 'Total pain' is a concept developed by the hospice and palliative care movement, in relation to patients with advanced cancer. The concept of 'total pain' is identified as a paradoxical and ambiguous concept. I will conclude by identifying how research in pain and palliative care may be advanced.

### 2.1.1 The aims of the chapter

- critically explore the medicalisation of pain
- discuss a sociology of pain that includes emotion and culture
- explore empirical work from the pain management field
- discuss critically the concept of ‘total pain’

## 2.2 Pain and medicalisation

In a radical critique of Western civilisation and contemporary health care, Illich (1976) describes Western culture as medicalised and says that as a society we value anaesthesia and have lost touch with the social meanings of pain. He argues that medical civilisation has turned pain into a technical matter that deprives suffering of its personal meaning. Frank (2001), although not speaking about pain directly but about his own experience as a social scientist and as someone who has experienced cancer, says that the biomedical discourse censors suffering:

*Suffering is the subversive voice in the biomedical discourse; it is central among all the things that do not fit. (Frank 2001:360)*

Thus the patient (Frank) felt his suffering was turned into something that did not fit because professionals sought ‘to explain me as an object of suffering, rather than remaining silent in the face of what they could not speak’. Frank says we should challenge the censoring of what does not fit. Cassel (1982) explains how suffering can include physical pain but is not limited to this and that the dual relief of suffering and the treatment of disease are both obligations of a medical profession dedicated to care of the sick. Cassel is in agreement with Frank that failure to understand the nature of suffering can result in medical intervention that not only fails to relieve suffering, but also becomes a source of suffering itself. Cassel, a doctor, describes how suffering is not addressed in medical education and medical students tended to be unsure of the relevance of the issue to their work. Sontag (2003) writes about how suffering is alien to modern sensibility. She argues that suffering is regarded as something needing to be fixed, because it makes one feel powerless.

The nervous stimulation causing the pain sensation, according to Illich results in an experience that differs, depending on personality, but also on culture. This experience, he argues, implies a human performance called suffering (Illich 1976). Illich believes that Western civilisation has lost the connection between pain, its

cultural meaning and suffering. By handing pain over to doctors, he argues, we have lost the strategies used in the past to cope with the pain. In addition, medicine appears to have lost concern for the experience of suffering that drove the patient to the doctor in the first place. Bendelow and Williams (1995) share Illich's concern with the medicalisation of pain. They argue that concern for the lived experience of pain through a phenomenology of pain is one way of bringing back the balance between pain, meaning and suffering. I will discuss Bendelow and Williams' proposal to develop a sociology of pain later in this review.

The situation described by Illich has developed as part of the dominant worldview of Western societies in relation to scientific progress. In the scientific worldview, doctors play a large role in the cultural construction of pain (Morris 1991). The scientific method emphasises the idea of the body as a machine. For Descartes in the seventeenth century pain was a signal that something was wrong in the body, a means to protect its mechanical integrity. Pain was thus reduced to a useful learning device and taught the soul how to avoid damage (Illich 1976). Wall (1999) refers to this as dualistic pain and describes it as the commonest notion of pain coming from our intuition, and expressed by the majority of philosophers. Benoliel (1995) argues that these early perspectives on pain continue to influence attitudes and beliefs about the causes of pain. The Cartesian split between mind and body is identified as a continuing major impediment to the adequate conceptualisation of pain (Wall 1999, Bendelow and Williams 1995, Morris 1991, Illich 1976).

### **2.2.1 The integrity of the mind and body: a new paradigm in pain**

Wall (1999), a neuroscientist, an eminent researcher on pain and eventually a sufferer of advanced cancer, argues that the experience of pain involves the mind, body and sensory systems as an integrated unity, serving the biological need of the individual. Arney and Bergen (1984) say that one of the far reaching changes taking place in medicine is the insertion of the experiencing person back into medical discourse. This, they argue, started to take place in the 1950s; the total person became the object of medical attention and discourse, hence holism has replaced mechanism as a central concept in medical discourse. Wall appears to agree with this by stating that the meaninglessness associated with the organic

model of pain is not a universal fact but belongs to a specific historical time and place.

A multidimensional approach to pain was enabled by the gate control theory developed by Melzack and Wall in 1965. This theory proposes that a gate-like mechanism exists in the spinal cord that modulates pain signals before they evoke perception and response (Melzack 1976). The gate can be opened or closed by variable amounts, depending on the activity of small and large nerve fibres, as well as psychological processes such as past experience and the attention given to pain. By proposing a gate control that could be turned up and down it was possible to alter the sensory inputs to the central nervous system and to the brain, where the unpleasant quality of pain is perceived. This theory provided the link between the cognitive processes and the impact of the lesion or injury on the experience of pain. The gate control theory allowed techniques such as massage, manipulation, as well as traction, local anaesthesia and psychological approaches to become accepted medical practices (Baszanger 1998). The gate control theory provided the theoretical basis for the integration of biological and psychological variables in pain work. However, I argue that the cultural and social determinants of pain are not fully explored in this theory. The gate control theory reflects Melzack's background as a psychologist, and Wall's as a neuroscientist.

### **2.2.2 The neglect of the experience of pain**

A number of different researchers have concluded that the person's experience of pain and suffering is a neglected issue within medicine. This neglect concerns the lack of an adequate framework or model that links pain with its social and cultural context (Bendelow and Williams 1995). The 'chronic pain career' is defined by Kotarba (1983) as both a clinical and an experiential career. He believes that health professionals favour a clinical definition of pain, which assumes pain to be routine and normative, but neglect the experiential aspect of pain. The private misery of pain is contrasted by Wall (1999) with the public expression of pain, with medicine having lost the link between clinical and experiential pain. These three points of view are discussed in the section that follows. I conclude by suggesting that despite the shift in the paradigm in relation to pain evidenced by the widespread acceptance in theory, of the gate control mechanism, the social and

experiential aspect of the pain experience are probably neglected in clinical practice.

## 2.3 A new model of pain

Bendelow and Williams (1995) propose to reclaim pain from the dominant scientific paradigm and transcend the mind body divide, by use of insights from emerging sociological interest in emotions and embodiment. They discuss how these insights would enable a more adequate phenomenological approach to the lived and embodied experience of pain. They are also concerned with the meaning and the cultural shaping of pain. In their view, traditional medical and psychological approaches to pain overlook subjectivity and neglect the voice of the patient or sufferer. They argue that this results in a neglect of the broader cultural and sociological components of pain. They continue:

*In other words, a far more sophisticated model of pain is needed; one which locates individuals within their social and cultural contexts and which allows for the inclusion of feelings and emotions. (Bendelow & Williams 1995: 146)*

Emotions, they argue, lie at the junction between mind, body, culture and biology. They draw on the work of Hochschild (1983), who emphasises how emotions take place within a social context, and the work of Denzin (1987), who discusses the study of emotionality that requires a conception of the human body as a structure of ongoing lived experience.

The theoretical position evident in the work of Bendelow and Williams is taken from the work of Merleau-Ponty (1962) who developed a conception of human embodiment that attempted to overcome the duality of mind and body. According to Merleau-Ponty our perception of everyday experience, is dependent upon a 'lived body'. Man in this conception moves back and forth between the corporeal form and personal acts. Wall (1999) in his book about pain and suffering, although critical of the classical academic approach to pain, does not give voice to his own lived and embodied experience of suffering and pain, associated with metastatic cancer. This is stated not in criticism of Wall, but in relation to what is allowed voice in the book. The voice of suffering is not explicit but is implicit throughout the book.

Bendelow and Williams also draw on the work of Leder (1984) who argues that pain re-organises our lived space and time relationships with others and with ourselves. This, Leder believed, could cause disruption to the sufferer's intentions, which consequently affects how we organise what we do. He also defines a spatiotemporal constriction, as pain can cause isolation and reflection. In addition, Bendelow and Williams discuss the search for meaning and explanation, by the person in pain, as involving a process of narrative reconstruction in the face of the biographically disruptive nature of pain and suffering.

Although there is acceptance that the pain paradigm has shifted with influences such as the hospice movement and the acceptance of Melzack and Wall's gate-control theory, Bendelow and Williams do not discuss this shift in any depth. Their argument is rather idealistic; they argue for change on a grand scale that overlooks the changes that have emerged within pain medicine and palliative medicine. However, they explore a very pertinent approach to the social meaning, and lived experiences of pain that is not developed in the gate control theory of pain. Pain, they argue, should be reclaimed from the jurisdiction of medicine. They are not explicit about who should reclaim pain.

### **2.3.1 The clinical and experiential chronic pain career**

Kotarba (1983) reconstructs the process of becoming a 'pain-afflicted person' through study of individual pain biographies. He defines the 'chronic pain career' as both clinical and experiential, and defines the tension that can exist between these two career themes. Pain-afflicted people, he argues, can reject the clinical definition of their pain as chronic and irreversible and may adhere to the hope that their pain will somehow be eliminated in the future. Pain professionals, he argues, consider pain to be routine and normative and may perceive the experiential level to be irrelevant and even disruptive. Kotarba provides interview evidence to support his argument:

*Dr. Stuart kept telling me that my backache would go away in time if I learned to take it easy and quit burning the candle at both ends. I had a feeling that the problem was more serious than that but, you know, the doctor knows best. I don't think he really realized how bad the pain was, but that's his job to find out. (Quoted in Kotarba 1983:64)*

Kotarba describes this as the stoic presentation of self by the patient, and that the professional may be perceived as too busy and too professional to want to hear of complaints.

Another patient describes how he felt unable to undertake painful exercises recommended by the physician to strengthen back muscles:

*I really didn't want to disobey the doctor, but I didn't have the heart to endure any more suffering. I just wanted to be comfortable for a change. (Quoted in Kotarba 1983:72)*

This patient felt that healing and rest made more sense than undertaking exercise that would cause more pain. Kotarba concludes that the patient's evasion, by not telling the doctor the truth, marks the beginning of a strained relationship between the physician and the patient.

As part of his research study of pain biographies Kotarba studied the experience of pain of athletes and manual workers. Kotarba provides evidence of how an athlete with job security may decide to reveal pain in order not to compromise his career. However, an athlete who has not yet proved himself may remain silent about his pain and play despite it. To make up his mind about which strategy to take to cope with pain the athlete has recourse to the 'athletic sub culture', which helps with the decision about whether to disclose or conceal his problem, by using drugs and other interactional strategies. Manual workers may appear to have fewer reasons for hiding their pain as occupational status, for example, is perceived as less of an issue than for the athlete. However, other factors such as the threat to one's self image and one's fitness for work may affect disclosure. Workers find the resources for handling such situations in the 'tavern culture'. According to Kotarba keeping quiet or talking about pain depends on who is addressed, the 'critical audience', as the social and emotional costs of revealing pain may outweigh the benefits. The rules of disclosure according to Kotarba follow the environment's explicit rules. For example, it is easier to talk about one's pain when the tavern is quiet, and the main activity is serious talk, than when it is busy such as during an important baseball match.



This study by Kotarba is important in demonstrating the differences between the patient's experiential world of living with pain and that of the medical clinician when treating the patient in pain. Kotarba establishes how medicine assigns importance to the normative signs and symptoms of pain, and the patient to the experience of his/her pain. This he argues may cause tension within the consultation. This research suggests that the patient experience of pain may not be considered important when pain is discussed within medical discourse. Wall further develops this point by highlighting the significant differences between public and private experience of pain.

### **2.3.2 Private pain and suffering**

Chronic pain is a truly private disorder, according to Wall (1999). Wall says that the public display of pain and the expression of private suffering are full of surprises. The amount of pain and the amount of injury are not tightly coupled. The public display of pain, he argues, has the purpose of informing others of the patient's needs while private suffering assesses the meaning and consequences of the patient's state. Wall is critical of the lost link between clinical pain and experiential pain in Western medicine, as it does not take into account the social, moral and psychological dimensions of pain.

This would suggest that 'the rules' implicit in medicine do not allow voice to the lived experience of pain and suffering. There is some support for this view in the research discussed in the next section.

## **2.4 Biomedical approaches to pain in clinical practice**

Various studies point to the predominantly biomedical approaches to pain criticised by Wall (1999) and Kotarba (1983) but evident in the practice of a variety of health care professionals. This includes oncologists (Rogers & Todd 2000), surgical nurses (Wakefield 1995), specialist symptom control nurses (Hunt 1989), and hospice nurses (Wright 1981). Furthermore, Fagerhaugh and Strauss (1977) contrasted the accountability for technical aspects of pain management with the non-accountability of psychosocial aspects of pain work. Sloan et al (1999) also argue that hospice nurses neglect the patient's pain biography when assessing pain. I argue that the practice of 'substitution' of specialist palliative

care nurses for doctors may account for the more medical approaches favoured in particular by specialist palliative care nurses (Hunt 1989).

In a study of consultations between oncologists and patients, which were audio-recorded, Rogers & Todd (2000) found talk about pain to be a prominent aspect of 39 out of 74 consultations. The researchers found that the doctors' exploration of the patients' experience of pain was brief and limited to physical aspects. The doctors used information-limiting strategies such as interruption, changing the topic or dismissing symptoms to avoid engaging in discussion about pain not within their field of expertise. The researchers termed the type of pain that interested the oncologists as the 'right kind' of pain. This 'right kind' of pain was amenable to specialist cancer treatment and seemed to be based on reading cues from the body in relation to biological indices related to disease.

In a small study of 5 nurses working in 3 surgical wards, using unstructured interviews Wakefield (1995) asked nurses about their ideas regarding postoperative pain. One of the features of their responses was the belief that pain 'can, and should, only be manifest in the presence of an identifiable cause' (Wakefield 1995:906). She argues that practitioners construct pain as solely dependent on surgical intervention, while understanding that pain can be aggravated or relieved in relation to the individual's psychological status. However, when pain interventions with medication did not work the nurses thought of the pain as 'imaginary' or 'psychological'. She also found that where patients exhibited public pain behaviour to secure additional doses of medication above that prescribed, nurses considered this behaviour to be 'immoral' and for this reason may be disregarded.

The above studies define how oncologists limit their consideration of the patient's pain to the possibility of successful intervention in relation to the pain with cancer treatment. Surgical nurses link pain with surgical intervention and regard some pain expression as inappropriate. For the nurses the 'right kind' of pain was related to the pain from surgical intervention and the response of this pain to medication. Both nurses and doctors in these studies seem to have very specific biomedical orientations to pain as something physical that can be treated in a specific medical way and should therefore respond to medical treatment, involving cancer therapy and medication. Where pain was not responsive to this type of

treatment there seems to be evidence that the pain is either disregarded or considered a psychological phenomenon, which may lead to questions of doubt about the presence of pain (Wakefield 1995).

Hunt (1989) studied 5 Symptom Control Team (SCT) nurses by audio recording conversations with patients and their family. The nurses were found to emphasise biomedical concerns particularly on first visits to patients. She discusses how nurses shifted from the biomedical role format as a means of coping with patients who were not responding to biomedical therapies, through use of psychosomatic explanations. This preserved the biomedical format as authentic and the primary method used. When attempts to solve problems by psychological means were unsuccessful nurses reverted to biomedical solutions by offering medications:

*Well, supposing I ring your doctor and perhaps we can get something to make you feel less depressed. (Quoted in Hunt 1989:244)*

Hunt discusses the professional ideology of terminal care in relation to the mind and the spirit. She argues that nurses adhered to this philosophy yet gave priority to physical symptoms. The nurses were confident in talking about the physical symptoms and tentative in emotional talk. Therefore the rhetoric and ideology of care was provided through physical ministrations and technical nursing tasks. Wright (1981) in his observation study within a hospice also found that despite nurses stating that they did not mind patients talking about their emotions, little such talk takes place in practice. This is a surprising finding considering the specific ideology of palliative care related to holistic care.

In an extensive study, involving two years of field research in 20 wards, and 8 hospitals in San Francisco and one in a small town in Northern California, Fagerhaugh & Strauss (1977) sought to ground a new perspective on pain. This new perspective concerned the organisational setting in which pain management and patient care takes place. The researchers used systematic observations and informal interviews with hospital personnel, patients and families. The researchers scrutinised the dominant medical ideology and looked for how this was operationalised within the ward structure and the work of staff. They argue that the political aspect of all institutional pain management results from health professionals reasoning that pain is a physiological phenomenon that can be relieved by the necessary procedures. The researchers found that staff may not be

aware of the different elements of the patient's biography and the 'social background' does not figure prominently in work concerns. They state:

*In general, the nursing and medical staff know little or nothing about a patient's pain trajectory other than the currently evolving portion of it. (Fagerhaugh & Strauss 1977: 23)*

The researchers say that even when a patient with a known history of pain is admitted the staff get bits and pieces of the psychosocial history but often do not share or put them together. They state:

*Personnel recognise the importance of that information, but their recognition is often more philosophical than operational. Indeed, it is safe to say that patients' psychosocial and pain histories are usually deemed unimportant. (Fagerhaugh & Strauss 1977: 73)*

These findings led the researchers to conclude that there is non-accountability for psychosocial aspects of pain management. They contrast the discrepancy between professionalised technical behaviour focusing on medical aspects and what they call 'lay behaviour' focusing on the social and psychological aspects.

There is some support for the findings of Fagerhaugh and Strauss (1977) in the study by Sloan et al (1999) of 27 hospice nurses of varied experience who were presented with the same standardised patient with cancer pain. They were asked to complete a pain assessment of the patient and also to make recommendations for pain management. An actor portrayed a patient with severe pain caused by unresectable, terminal rectal cancer. The researchers found that nurses completed items related to pain intensity, pain location and relieving factors very well. Items that were largely overlooked related to patients previous pain history, 77.8% of the nurses did not assess this, and 96.3% did not take a psychosocial history. The hospice nurses did well in relation to analgesic recommendations. Sloan et al conclude that hospice nurses performance in both cancer pain assessment and management recommendations exceeded that of resident housestaff 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 and junior medical staff. The researchers do not discuss why the majority of nurses omitted the pain biography and psychosocial history.

There is research evidence that SCT nurses are aware of their expertise in pain management and also compare their skills favourably with those of non-specialist

doctors. Hunt (1989) audio-recorded two of the weekly inter-disciplinary meetings attended by the SCT nurses, doctors and the social worker. She found that the 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 within the SCT meeting. This mainly concerned the prescribing habits of General Practitioners (GPs). Wright (1981) collected data using participant observation in a hospice setting. He discusses how nurses make decisions about medication, dosage and control of pain, rather than the doctors; doctors are consulted but often after a decision have been made. He continues:

*Certain nurses have expert knowledge of a limited area of pharmaceuticals relating to commonly confronted problems. They take pride in this area of expertise. (Wright 1981:147)*

Hunt also found that the SCT nurses seemed to take pride in their abilities to control the patients' distressing symptoms with medication and on occasion expressed this as constituting the satisfactions and rewards of the job. Hunt argues that by relieving patients of distressing symptoms so they could lead normal lives until a peaceful pain free death occurred, medical failure could become a medical success.

The studies discussed above from a variety of contexts lead one to conclude that health care practitioners share primarily biomedical orientations to pain work. Furthermore the specialist nursing practitioners appear to gain satisfaction from their specific expertise in relieving symptoms with medication. Hunt argues that with the SCT nurses 'substituting' for doctors it may be that these nurses are becoming more 'like doctors' in their working practices and are incorporating more medical approaches into their history taking than other nurses.

The situation so far discussed suggests that nurse's working in specialist areas such as palliative care may be a type of 'hybrid', a cross between a doctor and a nurse because of the need for 'substitution'. These nurses will also practice with their individual approach to those in pain. It seems likely that the dominant medical discourse, of pain as caused, something physical and treated appropriately, will be socialised further and substantiated into thinking and practice of these practitioners. 'Substitution' requires the nurse to have the knowledge and expertise to perform like a doctor when required. This is not a

promising scenario for the incorporation of the concept of ‘total pain’ within the practice of palliative care.

## 2.5 The embodied experience of chronic pain

Jackson (1994) has studied the lived and experienced aspect of chronic pain in the body. She carried out ethnographic research in a 21 bedded in-patient chronic pain centre in New England, taking an embodiment approach. The embodiment approach, she argues, requires the body as a methodological figure to be non-dualistic. In this conception pain is ‘lived and experienced in the body’. She explores chronic pain as simultaneously sensation and emotion, neither preceding the other. She is critical of current models of pain where pain is first caused and then experienced. She found that chronic pain patients resist the notion that pain is emotional and not produced by a physical cause. However she found that talk about pain confounded the ‘mind over matter’ and ‘matter over mind’ dualism by accounts of lived painful body experience by sufferers. She argues that the discourse related to pain as organic/mental/emotional versus that of psychogenic is concerned with causes rather than the experience itself.

Jackson discusses how patients sought relief from their pain by either moving towards increased subjectification and increased objectification. Those who move to increased subjectification, she argues, attempt to merge pain with their selves; if one accepts the pain, one better controls it. Those who move toward increased objectification speak in terms of ‘getting a grip on it’ not letting it dictate all that one does and separating it from the self. The programme in the rehabilitation centre encouraged patients to objectify their pain. Jackson argues that the subject object dualism’s seemed to break down in people’s actual accounts of lived painful body experience. People in pain speak of pain as an alien, an intruder as well as identification of the self with pain in the pain-full body. She continues:

*Knowing where a sufferer positions himself or herself on this continuum helps us understand how an individual experiences the body and how the pain-full body has determined the self these individuals have acquired.*  
(Jackson 1994: 209)

This, argues Jackson, is part of how patients construct a ‘new self’. Pain becomes a major component of the new self and the new identity. She continues that knowing the cause of the pain is important to how the sufferer experiences the

pain, but that the cause of pain is conceptually distinct from the embodied experience of that pain.

Jackson continues:

*Their tendency to stress the physical components of their pain derives in part from their struggle for legitimacy, and in part from difficulties finding an adequate language with which to talk about these issues. (Jackson 1994: 212)*

She identifies a barrier to communication when patients are led to believe that the physical causes constitute the meaning of the pain. This then makes it risky to talk about the emotional and cognitive aspects as this might threaten the legitimacy of the pain. Jackson draws attention to the importance of the inadequacy of language when speaking about the embodied experience of pain.

I believe that there is a neglect of the embodied experience of pain in favour of the clinical discourse of pain evident in much of the research discussed so far.

Practitioners by prioritising the importance of the biomedical indices such as diagnostic information, indices of disease progression, the cause of the pain, and the selection of the appropriate treatment, overlook the embodied, lived experience of pain in clinical practice. Pain as a medical entity and pain as an embodied experience appear to be two discourses that are separated by an inadequacy of language related to the different aspects of the pain experience.

This discussion leads one to conclude that despite the many changes in thinking about the multidimensional nature of pain, and the shift in the pain paradigm that has undoubtedly occurred in theoretical discussions, there is still a neglect of the wider social, emotional and cultural context of pain in clinical practice. I believe there is some evidence to support a new model of pain that incorporates the subjective and neglected voice of the sufferer and builds upon previous work. This would adjust the balance between the clinician and the patient by attention not only to the clinical reality but also to the experiential reality of the patient, in their encounter. The next part of the review will focus on research in clinical practice in dentistry, pain medicine and palliative medicine. This will help to illuminate the nature of different forms of specialist practice in relation to the patient and the experience of pain.

## 2.6 New perspectives on pain in clinical practice

Nettleton (1992) studied the issue of pain and fear among dentists and their patients. She presents data derived from journals, texts, ethnographic observations and interviews with dentists, mothers of young children and patients. She explores how pain and fear are present in dental discourse and defines how their meaning has changed over time. In addition, she is interested in the exercise of dental powers that involved a range of dental objects and subjects.

Pain, she argues, became constituted as a problem for the dental profession because it was a hindrance to dentists' professional status. However, through the elimination of painful dentistry, pain and fear have become objectified and a discourse produced about them. Nettleton argues that pain has been relocated from a biological space at the turn of the 20th century, which disregards the feelings of the patient to a psycho-physiological space during the 1950s. Practice in the psycho-physiological space acknowledged the importance of the mind as well as the mouth of the patient. She continues that in the latter half of this century, pain has been relocated within the socio-psychological space. Within this space pain and fear are located not in anatomy but in social relationships. In this conception the dentist's relationship with the patient and the patient's social context have now become the contemporary challenge in eliminating pain and fear. Nettleton provides evidence from an interview with a dentist who describes how pain and fear exists in the minds of patients and his satisfaction in building a trusting relationship with the patient:

*I think fear in dentistry is still paramount in people's minds, and I think in some children you get a fear of the needle, but when you can reassure them and you do a procedure that goes smoothly it's so nice to see them walk out and they trust you after that, and to me that is really one of the best and most satisfying things about the job. (Quoted in Nettleton 1992: 77)*

Nettleton also provides evidence from a conversation with a dental patient, who is critical of dental practice:

*I think a lot of them are not as understanding as they might be. I mean you go in and you sit in the chair and you could be absolutely petrified and it's 'open wide' like that. And they don't sit and talk to you nicely while they're treating you. (Quoted in Nettleton 1992:77)*

The evidence provided by Nettleton suggests differences between the dental discourse and the patient experience. The patient interview used by Nettleton



appears to suggest a dentist operating in a 'biological space'. Nettleton does not discuss this. She argues for a phased development of dental practice over time from the biological to the socio-psychological space. Her evidence presents ambiguities in the practice of dentistry and the theories found in the dental discourse.

In a study concerned with how pain specialists speak about pain and deal with patient's pain in eight academic pain centres in the Netherlands, Vrancken (1989) concludes that a number of different approaches exist. She used unstructured interviews conducted with physicians and psychologists from the eight pain centres. The interviews focused on the similarities and differences between patients, what is done for them and why, the outcomes of therapy and the termination of therapy. The interviews were analysed qualitatively by identifying connections between relevant classes of statement.

Vrancken identifies five major ways or 'ideal types' of conceptualising pain and chronic pain; she names these approaches as somato-technical, dualistic, behaviourist, phenomenological and consciousness approaches.

The somato-technical approach identifies pain as a symptom of disease. In this conception, pain is organic and is based on the neurophysical model of pain. The doctor can treat the patient by invasive procedures with a degree of success.

The dualistic, body-oriented approach defines pain as a psychobiologic phenomenon. In this conception, pain is organic and psychological with possible social factors playing a part. She designates this dualistic pain, not for its way of conceptualising, but because of its practice. In dualistic pain it is important to find the contribution of somatic and the psychic realms as this determines whether doctor or psychologist and or psychiatrist should treat the patient. She says that the many followers of this school consider the cancer patient as the ideal patient:

*They really have something, it is also recognised by everybody that they really have something. Their problems are also very real which makes it more easy for doctors as well as patients to face psychosocial factors too. Yes and...often they respond well to whatever kind of treatment. (Vrancken 1989:437)*

The behaviourist approach defines pain as learned behaviour. In this approach, the patient is characterised as someone whose coping strategies have failed.

Therapy minimises pain behaviour. The patient is recovered when pain behaviour is replaced by well behaviour. Treatment depends on the patient's position on the organic-psychic axis.

The fourth and fifth approaches are the phenomenological and consciousness approaches. Although Vrancken separates these two approaches they do not seem very different from each other. The phenomenological approach, she argues concerns the patient's experience of pain with pain the centre of life and everyday life becomes the background. The main features of the pain experience are the isolation of the body and the interruption of the intersubjective contact. The goal of therapy in the phenomenological approach is for the chronic pain sufferer to find a way back to the world. The therapist's concern is with the biography of the patient and his or her outlook on life. The consciousness approach considers pain to be a problem of the whole of consciousness filled with pain. The goal of therapy in the consciousness approach is not for pain to disappear; instead it becomes accepted and manageable. Like the phenomenological approach, Vrancken considers the goal of therapy is to establish an interpersonal relationship with the person and begin to understand their life and biography.

The last two 'ideal types' are described as anthropological and Vrancken describes them as quite different from the other approaches. She acknowledges that they have features in common but prefers to treat them separately. She appears to favour these approaches as the way to develop medicine and pain. She argues:

*That the person who suffers from pain and turns to a physician is appealing to the other for help to return to the world. (Vrancken 1989:442)*

Vrancken carried out her research on physicians and pain specialists. She does not provide evidence that she spoke to patients hence this statement is her interpretation of the person's need. Her data does not provide evidence for her conclusion but it does show that her sympathies lie with the anthropological approaches to pain. Vrancken's research suggests that these 'ideal types' co-exist in practice. This identifies the diversity in approaches to pain by clinicians in the Netherlands.

The theme of the disturbance to and alienation from the world developed by Vrancken also features in Scarry's (1985) conceptualisation of how pain 'unmakes' the world through its unsharability (it cannot be shared or denied) and

its resistance to language and destruction of language. Thus Scarry says that the person in pain has limited resources in terms of speech. According to Scarry those who are not in pain, but speak on behalf of those in pain, such as physicians bring the language of pain into being and create the medical context for such an experience. Likewise Hilbert (1984) discusses how chronic pain results in sufferers feeling socially isolated because of the inadequacy of cultural resources available to help them account for their experience. Thus, according to Hilbert, pain has an 'acultural dimension' which creates a problem of meaning. This acultural aspect of chronic pain results in a form of suffering which transcends physical pain (Hilbert 1984). In the next section I turn to how pain medicine and the hospice and palliative care movement address the problem of pain and contribute to the creation of a language and culture around pain.

### **2.6.1 The pain clinic**

The development of pain clinics, hospices and palliative medicine are described as radical new approaches to old problems (Melzack & Wall 1988). The gate-control theory of pain provides the conceptual background for these new approaches.

As a sociologist working in the field of medicine, Baszanger (1998) was concerned with the new conceptual and organisational forms for dealing with pain, resulting in the emergence of pain medicine. Her aim in studying the invention of pain medicine is to understand how an arrangement was made in medicine that would open a new space for a new problem: chronic pain or pain as illness. She also wanted to understand how new conceptions of pain medicine were applied in practice. She describes the creation of a world of pain as 'Bonica's project' and she traces it from 1944 to the present time. Bonica was an American anaesthesiologist who became convinced with his work with the casualties of World War II that there was a type of chronic pain poorly treated by medicine. He developed these ideas through extensive writing and expert practice (Bonica 1974). He established the first multidisciplinary pain clinic in Washington in 1960, with a neurosurgeon and a nurse (Bonica 1988). Baszanger describes this multidisciplinary approach as a radical change directing medical action to the pain itself and not only its cause.

Baszanger (1998) also studied how pain medicine took shape in France. She provides evidence as to how the evolving pain medicine movement led to two

standard arrangements or clinical frames, for dealing with pain. These different arrangements, in terms of organisational mode and the techniques used, are based on contrasting definitions of chronic pain and pain medicine. The first arrangement is formulated in terms of healing pain and the second in terms of management of pain. The first arrangement is described as one that reads pain in the body and belongs to the clinical model described by Foucault, and the second arrangement reads and listens to pain through the patient's experience and seems to relate to a new logic of intervention.

Baszanger rejects the thesis developed by Armstrong (1984) that there is uniform change in medical discourse at the theoretical level, which results in slow application into practice. Armstrong (1984) provides evidence for a development over time of a new theoretical context, a discourse that promotes a new perception of the patient's view. He describes what he calls the old and new regime. In the old regime, treatment success was evaluated by the disappearance of signs. In the new regime, the patient's attitudes were important. He cites medico-social research undertaken in the 1960s, which was concerned with new ways of constructing the patient. He traces how at each historical point medical analysis has an object and an effect: in contemporary health care, he argues the object is the patient's view and the effect is the 'person' who holds those views. In the past when the doctor searched for pathological lesions, the object was the symptom and the subject was the pathology afflicting the patient. The patient was viewed as an unreliable translator; patient words, which were not related to the lesion, were dismissed. Armstrong does acknowledge that most clinical practice, particularly in hospital, probably relies on the older scheme of interpretation. Baszanger is critical of the oversimplification in viewing medical activity as uniform from the cognitive standpoint of a given period, which she argues is evident in the work of Armstrong (1984) and Arney & Bergen (1984). She seeks to provide a different interpretation through her fieldwork data in the two clinics discussed.

Baszanger argues that in the creation of a world of pain, we are dealing with a central theory that in terms of practice results in two forms, each of which represents a new way of understanding chronic pain:

*The hypothesis that I shall advance here is that the existence of these two models are the result of the particular ways in which the concept of pain clinic, with its multidisciplinary framework and the technical possibilities offered by the gate control theory, were shaped in practice. In other words, the specific ways in which these techniques were developed and the specific organizational relations built around them led to different operative interpretations of chronic pain and pain medicine. (Baszanger 1998:121)*

The first approach, whose aim is curing pain, uses traditional tools of the clinic to distinguish physical and psychic pain. The second approach attempts to manage pain rather than cure it and transcends the physical and psychological and focuses on the patient's experience of pain and tries to modify it. This dual movement is described as having a common resource: the gate control theory. Baszanger describes this theory as being able to unite practitioners in relation to the outside world but also to separate them from within in relation to how they interpret this theory.

Baszanger uses literature, interviews with physicians at pain centres, and ethnographic observations of clinical procedures at two pain centres chosen for their representativeness of the two major conceptions of pain medicine. Baszanger studied medical work in action by observing as many consultations as possible, with different physicians at two centres over an eight month period. She used the method of constant comparison in her coding and analysis (Glaser and Strauss 1967). This method compares the first items generated by coding, then forms categories, then compares the items in each category, and finally compares the categories. She took fieldnotes and was able to audio tape some of the consultations and thus test the reliability of the note taking procedure. She coded 326 consultations.

The first clinic she studied was oriented toward technical intervention through analgesic blocks and surgical procedures. Staff there dealt with pain primarily in terms of specific diagnoses centring on pain and not on causal pathology. Pain that did not respond to these techniques was called hybrid and referred to other specialists. She referred to the approach of this clinic as 'hierarchical multidisciplinary'. She found that where pain is identified as physical neither the physician nor the patient brings up any issue not directly related to the pain. Cognitive and psychological processes take second place to somatic processes in terms of a particular pain and the object of work specific to the pain physician. In

most cases, the pain can be deciphered as a lesion or organic failure. In an interview with one of the physicians in the first centre the approach in this clinic is described:

*Herpetic pain (pain after shingles) after ophthalmic shingles, I saw one just last week...I've seen that patient six times...It's unusual, I hospitalized him, I did stellar ganglion blocking, he's had all the treatments including Laroxyl (antidepressant) that we were just talking about. It didn't work. Then he had external electric cutaneous stimulation, that didn't work either, we don't know what to do next, thalamic stimulation, but we hesitate to do that. So there you are. He's still in pain. (Quoted in Baszanger 1998:125)*

Baszanger describes few pain problems as requiring such complicated surgical procedures. However, when physicians have exhausted all possibilities in terms of drugs, physical treatments or infiltration they may consider referring to the psychiatrist. This Baszanger argues results in a redefinition of the patients pain situation within the organic/psychic dichotomy.

In the second centre Baszanger describes how pain requires deciphering that takes into account the physical, psychological, behavioural and social manifestations as part of a single framework, the chronic pain syndrome. This centre aimed at controlling pain rather than curing it. The conception of pain as a lesion was replaced by a conception of the person in pain. The approach practised in this clinic she called 'integrated multidisciplinary'. It included a neurologist, a psychiatrist-psychoanalyst, two general practitioners and a nurse and anaesthetist. In an interview with one of the physicians in the second centre the approach is defined:

*In the beginning...we used mostly explanations..., medication and techniques like acupuncture, stimulation, and it's true that we came to a bit of a standstill when they didn't work...But there was a kind of psychotherapeutic approach, nevertheless...People had begun to talk about things. (...) Then there was the introduction of behavioural therapies, relaxation, and so on, and then two years ago, the (patient) groups. This was the beginning, the start-up period...things have changed; now we tend to give people a whole package...In a sense, we gradually developed a more specific treatment for pain. (Quoted in Baszanger 1998:131)*

Baszanger argues that in this clinic pain is treated as poorly adapted behaviour and a diagnostic category of 'chronic pain syndrome' is defined. This new diagnostic category refers not only to the cause of the pain but also the person's reaction to the pain.

Within these two centres, Baszanger (1998) found the coexistence of heterogeneous modes of judgement and decision making in everyday practice. Both centres accepted the gate control theory as the scientific rationale for practice. The first centre used operational knowledge based on the 'something/nothing' alternative and the second centre was based on pain as illness, always something. In addition, she concludes, although there appears to be two ways of deciphering chronic pain, one that reads pain in the patient's body and another that listens to it from the patient's point of view, the two modes emerged simultaneously. They both constitute pain medicine as a new field but one appears more innovative than the other does. This leads me to conclude that there will be various orientations to pain in the body and pain as an experience even within specialist practice in pain medicine/palliative medicine. The latter approach appears more radical in terms of the changing paradigm of pain and the integrated mind/ body approach to pain. The former approach appears more in tune with the dualistic separation of the mind and body apparent in much practice in relation to pain discussed earlier.

### **2.6.2 The hospice and palliative care movement**

Clark (1999) is critical of recent writers on the sociological, cultural and historical aspects of pain for being silent about the work of Cicely Saunders. This may be because the work of Saunders is within the palliative care speciality and therefore not widely known about. He is also critical of how few empirical studies focus on how ideas and practices about pain are changing in modern health care. I believe that my study involving an ethnographic approach to how palliative care teams construct 'total pain' in practice would be a positive contribution to the research and literature so far discussed. This would begin to establish how pain work is re-defined, practised and shaped by practitioners in palliative care. This may assist in increasing knowledge and understanding of how medical practice is changing in the context of pain work and palliative care.

Cicely Saunders established the modern hospice movement in Britain. Her goal was to humanise the care of dying people and to reduce the suffering of terminally ill people with intractable pain due to cancer (Clark & Seymour 1999).

Saunders's concept of 'total pain' was central to her approach to dying people:

*It soon became clear that each death was as individual as the life that preceded it and that the whole experience of that life was reflected in a patient's dying. This led to the concept of 'total pain' which was presented as a complex of physical, emotional, social and spiritual elements. The whole experience for a patient includes anxiety, depression, and fear; and concern for the family who will become bereaved; and often a need to find some meaning in the situation, some deeper reality in which to trust. (Saunders 1996:275)*

Clark (1999) describes how much of Saunders' work was grounded in her practice with patients. For example, she often tape-recorded patients talking about their pain and its relief. He describes how by talking and listening to patients she turned them into active subjects. This suggests that the concept of 'total pain' reflects her intense and deep relationships with individual patients and their pain biography, as well as her own background and training as a nurse, social worker and doctor.

Clark (1999) seeks to uncover the archaeology of Saunders' thinking about 'total pain' through an analysis of her early writing up to the decade prior to the opening of St. Christopher's Hospice in 1967. He also seeks to explore the implications of 'total pain' in relation to social theory of the body, and finds within this some contradictory, paradoxical and conflicting tendencies. He read 56 of Saunders' publications and kept careful note of references to pain. He identifies the purpose that these publications served, at one level an unfolding of ideas which culminated in a strategic intention with two dimensions: wanting to understand terminal pain and pain management in order to transform it and secondly promoting the idea of a new modern hospice which combines clinical care, education, research and of raising financial support

Saunders' first publication was written while she is still a medical student (Saunders 1958). In it, she advocates regular analgesic drugs; hence the rule, Clark concludes, is to anticipate distress and pain so the patient does not continually do so himself. The paradoxical picture presented by Clark is that of constant control of the pain that is extended to constant control of the patient. This control could, on the one hand, relieve the patient of personal autonomy and on the other relieve them from dependence on the nurse and the doctor. The second aspect of the medical dimension he discusses is related to drugs, their levels of action and the levels of pain upon which they are effective. Hence the concept of



mild to severe pain emerged, with relevant analgesia and modes of administration, which apply to each level (WHO 1996).

Clark asks what conditions of possibility allowed the concept of 'total pain' to emerge in this way at this time. 'Total pain' is a paradox he argues, because it seems to humanise physical suffering and to acknowledge that pain is something including but greater than physical sensation. He describes pain as the key to unlocking other clinical possibilities by relieving pain the other problems of patients and carers can be accessed. This unlocking then can become an instrument of power; it involves a wider deeper searching for signs of trouble in the social network and even in the soul. He defines this as a disciplinary power rooted in knowledge of the patient and technologies of care. 'Total pain' in this conception becomes an extension of the clinical gaze, a new mode of surveillance and an extension of medical domination. Clark however, seeks to reassure the reader that this is not part of Cicely Saunders expressed vision or practice in relation to the 'total pain' experience.

Clark discusses the division which is forming in the social theory of the body. The division he argues is in relation to 'the body as lived' counterpoised to 'the body as inscribed'. The body as lived is drawn from the work of Merleau-Ponty (1962) and is phenomenological in character. This approach gives attention to narratives of suffering and the ways individuals make sense of suffering and their experience. The body as inscribed is how Foucault (1976) defines the body in relation to medicine. In this view the behaving body is subject to historical forms of conduct which mould the body but also force the bearer of these conducts to take responsibility for them. The medical techniques that support this are the clinical examination and the process of diagnosis. From a Foucauldian perspective Clark argues, 'total pain' would be a product of the gaze, a concept that moves medicine beyond the biological into the spiritual, psychological and social sphere. Paradoxically, he describes this as a strategy of power, one which in subjecting human suffering to the clinical gaze, objectifies it and prescribes strategies for its relief; 'total pain' then becomes a nomenclature of inscription.

Clark argues that the tradition of 'the body as lived' and the concept of 'total pain' enable a different logic of action. In this conception, a phenomenological connectedness exists between individual experiences of pain and suffering that are

part of our embodied attitude to the world. Clark states that it is the concept of 'the body as lived' and the nomenclature of facilitation that is evident in Saunders' reformist writings.

Crossley (1996) says that the tension between the concept of the lived body and the concept of the inscribed body is compatible and complementary at both the theoretical and political levels. He argues for a productive tension between the two concepts: the body as both active and acted upon (by other bodies). The body in this conception is both a social and a historical being. It is also both mastered and self-aware. He argues that one position can presuppose rather than negate another. Crossley concludes that we should 'resist the 'either/or' temptation and study body-subject and body-power as twin aspects of a single structure of action-upon-action' (Crossley 1996, Pg.115). I feel that there is a tendency to promote the nomenclature of facilitation as the more 'ideal' practice within Clark's article (Clark 1999). Crossley's theoretical and pragmatic analysis offers the bridge between these two perspectives, which is not fully discussed by Clark.

How the practice of 'total pain' facilitates and controls the patient and shapes treatment and care in palliative medicine is unclear. Evidence from a small amount of research on pain medicine and palliative care suggest that the claims of 'total pain' and the operationalisation of this claim might involve ambiguous, diverse practices in different settings and contexts. The nature of changes in clinical practice with patients in pain remains largely unknown. This I believe is a productive area for research.

## **2.7 Conclusion**

The literature and research discussed points to a revolution in thinking about pain, during the last fifty years. There appears to be many reasons for this revolution, including the rise of chronic illness and chronic pain experienced by people in Western societies and the change in medical discourse from the mechanistic model to the holistic model which creates the patient as a subject with a voice. The development of two specialised segments of health care: the hospice and palliative care movement, and pain medicine has been discussed. There is evidence that within these new spaces the work of defining pain in new ways is being carried out. It is still not clear from the research undertaken to what extent

the changes that are occurring in practice affect the status of the patient's experience of pain in medical work. There is some evidence, from within medicine and the social sciences that the experiential dimension of pain is still largely neglected (Jackson 1994, Sloan et al 1999). The proposal by Bendelow and Williams (1995) for a sociology of pain and a new model of pain is important in bridging the clinical and experiential career through a framework that includes the link between emotions, embodiment, culture, and the experience of pain. Although the gate control theory enabled pain to be viewed as a subjective, multidimensional experience, I believe that this theory does not capture the social, emotional and cultural components discussed by Bendelow and Williams.

Doubt has been cast on the medicalisation of pain thesis. The new segments of specialised practice in pain seek to place pain in its cultural, biological and social context. That a heterogeneity of thinking and practice exists is not disputed. There is sufficient evidence to conclude that the concept of 'total pain' and the integrated approaches to pain in the practice of pain medicine do a great deal to re-humanise and reverse the medicalisation of pain thesis explored by Illich. The pain medicine and hospice and palliative care movements acknowledge the patient's narrative and experience of pain and suffering that may have been corrupted in the mechanistic approaches of scientific medicine in earlier stages of medical development. There is insufficient research evidence to evaluate whether there is a phased development of a paradigm over time or different practices according to context resulting in ambiguity in clinical practice (Nettleton 1992). The issue of power and control exerted by surveillance of the whole person identified by Clark (1999) is insufficiently explored in the research literature. I suggest that the operationalisation of 'total pain' may be contextual, paradoxical, ambiguous and situated. This is an area worthy of further research.

In the next section (Chapter 3) I explore how modern nursing has developed. I discuss the development of specialist nursing roles in general and specifically within cancer and palliative care nursing. This provides a background as to how nurses are pursuing their professional project through specialisation and seeking collegiality with doctors in the medical space by a process of negotiation.

## **Chapter 3 Changing Boundaries: The Negotiation of Nursing and Medical Work**

## 3.1 Introduction

In this chapter I discuss how nursing as a discipline has developed since the inception of modern nursing in the late nineteenth century. Witz's conceptual framework and her analysis of nurses' professional project will be discussed. I explore and extrapolate the relevance of Witz's conceptual framework of a female professional project to contemporary specialist nursing practice. I suggest that the professional project of nurses may be achieved by those who are specialist because it is these nurses that have credibility in a medical context. This credibility enables them to have authority with doctors, other nurses and paramedical therapists. One of the dilemmas for nurses in developing a professional project is the nature of caring (Davis 1995). There is dismay among some nurses and social scientists about the perceived abrogation of caring in the dynamic high technology world of health care (Dingwall & Allen 2001). However, terms such as 'new nursing' and 'therapeutic nursing' prioritise caring relationships with patients. I discuss how there is a link between 'therapeutic nursing'; aspects of new professionalism and the construction of a caring practitioner model (Davis 1995). I present empirical evidence which explores how caring shapes up in specialist palliative care practice; the form that such caring takes; and how the nurse's identity and self-presentation is part of this practice. One of the means by which professional boundaries are reconfigured or blurred is through the process of negotiation (Strauss 1993). Empirical work points to the importance of a process of negotiation to get work accomplished in a variety of settings (Tjora 2000, Allen 1997, Svensson 1996). The process of negotiation enables professional boundaries to become more fluid and may be one of the means by which nurses enlarge their practice space and achieve some collegiality with doctors. I discuss the development of the clinical nurse specialist (CNS) role as colonising a niche between traditional nursing and medical work. The construction of expertise in the work of palliative care nurses will be discussed along with the resources used by these nurses to deliver palliative care (Li 2002, Lawton 1998, Corner 1996, Froggatt 1995, Hunt 1989). I also discuss some of the tensions that exist for specialist palliative care nurses (Seymour et al 2002). What is of interest to me, in my study, is how the specialist nurse will address the tension between medical work and caring in practice.

### 3.1.1 The aims of the chapter

- map the historical development of nursing in terms of a 'female professional project' (Witz 1992)
- analyse nursing rhetoric related to caring
- discuss the concept of negotiation and explore empirical work related to negotiation in practice (Strauss 1993)
- apply Witz's conceptual framework to contemporary specialist nursing practice

## 3.2 A historical perspective

Modern nursing emerged during the 19<sup>th</sup> century following the Nightingale reform of nursing, which was to turn nursing in the voluntary hospitals into a career for young middle-class women (Dingwall et al 1988, Abel-Smith 1960). Prior to the 1860s nursing was regarded as a superior form of domestic service and leadership was provided by 'distressed gentlewomen', who had no identity as nurses but needed to earn a living and sought to make use of their skills in domestic management (Dingwall et al 1988, Abel-Smith 1960). Nightingale's nursing work in the Crimea with the British Army made her into a heroine (Dingwall et al 1988, Abel-Smith 1960); and she is regarded as 'the greatest publicist the profession has ever had' (Abel-Smith 1960:20). Although much has been made of the Nightingale reforms, Maggs (1987) is sceptical about how much really was achieved by these reforms. Maggs says that at the Nightingale School at St Thomas's Hospital, the standards were much the same as before the reform, as nurses still did little formal training and seemed to be subject to greater discipline than before the reforms.

During the late 19<sup>th</sup> century the issues related to nurse registration, educational standards and the establishment of training schools set the political agenda (Witz 1992). Witz describes the long and bitter campaign for a system of nurse registration between 1888 and 1919, when the Nurses Registration Act was eventually passed. Mrs Bedford-Fenwick who was an ex-Matron and editor of a nursing journal led the campaign for nurses' registration. She was also an active campaigner for women's suffrage and was married to Dr Bedford-Fenwick a leading medical politician (Dingwall et al 1988). Florence Nightingale thought that the campaign for nurses' registration would subvert the high ideal of nursing

as a secularised calling and she actively led opposition to the registration campaign (Witz 1992, Dingwall et al 1988).

There were two discursive formulations of the nurse at the end of the nineteenth century the Nightingale philosophy and the professionalising discourse (Witz 1992). The Nightingale philosophy, according to Witz, constructed a discourse around the moral qualities of the character of the 'woman-as-nurse' and this meant that nurse training was largely concerned with character. The argument put forward by the anti-registrationists was that registration did not touch character. The pro-registrationists campaign was around a discourse of occupational professionalism, which constructed the nurse in terms of what she did, her technical expertise and skill and where expertise brought status and economic reward (Witz 1992). The problem that was being addressed in these two discourses was how modern nursing should go about the strategy of establishing itself as an autonomous female occupation in the emerging medical division of labour (Witz 1992, Dingwall et al 1988, Maggs 1987). This question continues to be part of the contemporary nursing agenda, which will be discussed later (Dingwall & Allen 2001). In the next section I will discuss some of the issues around what it is to be a profession and how nurses have sought to professionalise with reference to Witz's work on nurses' professional project.

### **3.2.1 Nursing a profession?**

Nursing is considered a 'semi-profession' by some sociologists because it is located in a bureaucratic organisational context, and therefore lacks autonomy and is dominated by women (Etzioni 1969). Witz (1992) is critical of the construction of nursing as a 'semi-profession'. She argues that the 'semi-profession' thesis as based on an androcentric model of profession, which is now largely displaced. Elston (1991) agrees with this and says that in the 1990s there is a change in attention paid to non-medical participants in the health division of labour. She argues that the depiction of nursing as a failed profession or a 'semi-profession' is a feature of 1970s and 1980s sociological writing.

The sociology of the professions provides insight into the high status, expertise, autonomy and exclusivity of the classical professions such as medicine. Abbott (1988:318) defines professions as 'somewhat exclusive groups of individuals applying somewhat abstract knowledge to particular cases'. Freidson (1994) says

that profession is synonymous with occupation and refers to work, which is specialised and by which one gains a living in an exchange economy. According to Freidson, profession involves a special kind of work, 'good work', and requires discretionary judgement, a commitment to a body of knowledge and skill, and to perform it well for the benefit of others. To Abbott, the most important aspect of profession is the control of work; the professional's jurisdiction. This jurisdiction, according to Abbott, is dependent on the profession's body of academic knowledge. However, Abbott does acknowledge that the public's belief in the abstract knowledge of the professional may be misguided. He argues that the public make an assumption that abstract professional knowledge will result in effective professional work. This link between abstract professional knowledge and professional work presumably is only possible if the profession or other interested parties make arrangements to ensure that professional clinical practice is the outcome.

Larson (1977) identifies a characteristic feature of the occupational structure in advanced industrialised countries as a tendency to professionalisation. Larson agrees with Freidson that the capability of professional advancement is the capacity to claim esoteric and identifiable skills. This is why perhaps the professionalisers in nursing emphasise particular educational preparation, credentials, expertise and skill (Gerrish et al 2003). I will now discuss how nurses have sought to achieve professionalisation using Witz's conceptual framework of a female project involving strategies of closure.

### **3.2.2 Nurses' professional project**

Witz (1992) says that we need a theory of professionalisation that can cope with the fact that women as well as men have engaged in professional projects. She proposes a framework of closure strategies of professionalisation following Parkin (1979), but in her analysis she distinguishes male and female professional projects. For Witz professional projects are gendered and located in the structures and history of patriarchal capitalism. Witz says there are four strategies of closure involving exclusionary, inclusionary, demarcationary and dual closure. Following Witz, exclusionary and demarcationary strategies are engaged in by dominant occupational groups such as male doctors, with inclusionary and dual closure



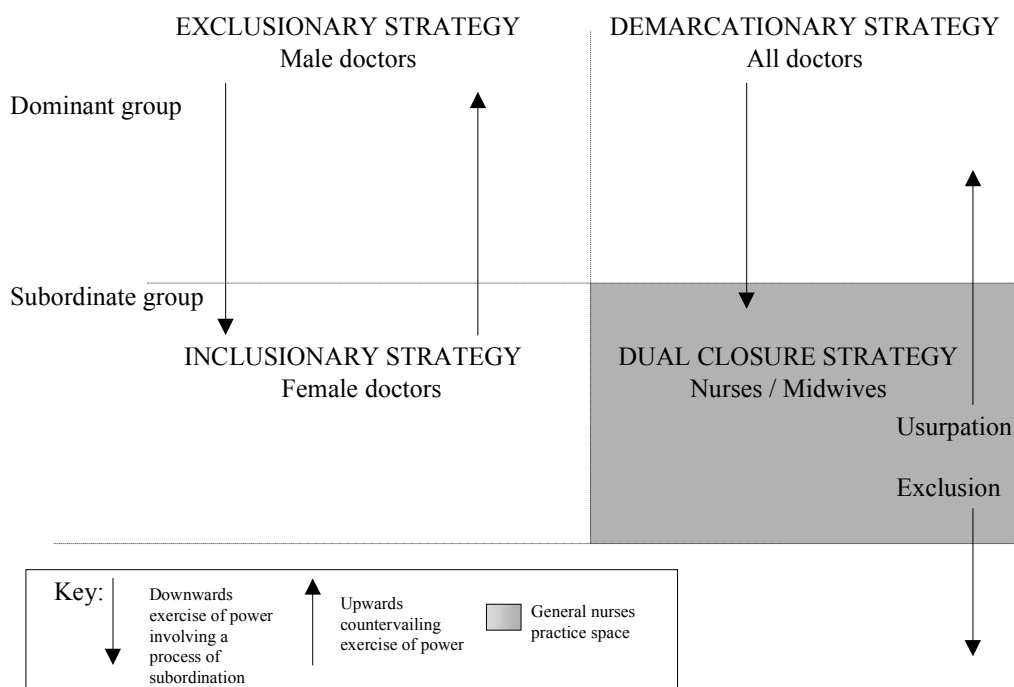
strategies the response of subordinate social or occupational groups such as female doctors and nurses for example.

According to Witz (1992) nurses' campaign for a state sponsored system of registration and the success of this campaign in 1919 when the Nurses Registration Act was passed, was part of a female professional project. She observes how the quest for professional status for nurses, by means of registration, was a project of social closure aiming to restructure the class base of nursing so that large numbers of educated women would be attracted to nursing. A group that is subjected to demarcation or exclusion utilises dual closure strategies or a strategy of exclusion. The professional project of nurses concerned a strategy of dual closure with usurpationary and exclusionary aims, employing legalistic and credentialist tactics as they were subject to a demarcationary strategy by doctors, according to Witz (Figure 1).

The campaign for registration along its usurpationary dimension posed three challenges. Firstly, it challenged employment relations between hospitals and nurses, which controlled standards and length of nurse training, pay and conditions (Maggs 1987). Secondly, it challenged inter-occupational relations between medical men, nurses and midwives; and could be viewed as competitive with medicine. Thirdly, it disturbed gender relations (Witz 1992, Dingwall et al 1988).

Nurses, according to Witz, attempted to usurp medical power by an upward exercise of power by fighting for control over pay and conditions by demanding a central body to control nursing. Nurses also used a strategy of exclusion, which involves a downward exercise of power that created an occupational monopoly and a 'one-portal entry' to nursing (Witz 1992). Exclusionary strategies therefore involve a process of subordination as the occupational group seeks reward and privilege in the labour market, and intra-occupational control over the internal affairs of an occupation, so for example male doctors have dominance over female doctors (Parkin 1979). Demarcationary strategies are used inter-occupationally and enable a dominant group such as doctors to control the work of a related but different group, such as nurses. My observation of Witz's conceptual framework is that nurses and midwives were restricted within the bottom right corner of the dual closure strategy (shaded area in Figure 1) with a glass ceiling above and a

glass wall on the left vertical axis, which denied nurses and midwives inclusionary status within medicine. In other words they were severely restricted in relation to their aims for an autonomous female occupation (Figure 1).



**Figure 1 Strategies of occupational closure: a conceptual model (adapted from Witz 1992)**

The dual closure strategy is applied to midwives struggles by Witz. Midwives like nurses used a dual closure strategy and campaigned for state-sponsored registration for midwives. Midwives in return for registration eventually accepted a restricted sphere of competence within midwifery practice (Witz 1992). Midwives' registration campaign was supported by pro-registrationist medical men for reasons of self-interest, according to Witz. The outcome for medical men was that the midwifery market could be segmented with midwives serving the poor and medical men the richer segments of society. This strategy to support registration saw off the potential threat from midwives to the scope of practice of medical men. Patriarchal power relations for nurses and midwives meant they had to be supported by powerful medical men (Witz 1992). The result of this for midwives and nurses was that medical men consolidated their control of the medical division of labour and to a great extent defined the scope of practice for nurses' and midwives' work.

Davis (1995:61) says that nursing is an activity that enables medicine to present itself 'as masculine/rational and to gain the power and privilege of so doing'. This privilege seems to have emerged during the late 19<sup>th</sup> century but perhaps Davis presents a rather polarised version of contemporary medical practice. The hospice and palliative care movement unashamedly markets itself on its holistic version of total care and teamwork, within a co-operative practice structure (Seymour et al 2002, Clark 2000, Clark & Seymour 1999). Furthermore Hibbert et al (2003) point out how some aspects of medicine are more orientated to holistic, psychosocial aspects such as general practice and palliative medicine while others, such as tertiary cardiac care is more focused on pathological concerns.

I will now show how the professionalising strategy of nurses was at the forefront of change in education and practice during the latter half of the twentieth century. I will introduce the notion of old and new professionalism and link this to the idea of 'new nursing'.

### **3.3 Changing nursing practice and education**

Up until the early 1970s nurses' work was organised around tasks to be completed (Menzies 1970). This worked well where there was a high ratio of untrained staff and student nurses; so a ward sister could allocate particular tasks according to the skill level of the student. The movement towards a more individualised form of care with nurses being given a group of patients to look after rather than particular tasks to perform probably reflected a more personal approach to work and seems to have taken shape during the early 1970s (DHSS 1972). This reconfiguration of nursing work, framed in the professional rhetoric of individualised care, has also resulted in altering how the patient is constructed by nurses (May 1990, 1992, 1995).

It seems that nurses not only construct the patient as a physical body but also now construct the patient as an active experiencing subject. May (1992) says there is a tension between the nurses' knowledge of, and work directed at the patients' body and the nurses' knowledge of the patient as a private subject, which opens up a different form of practice that is productive. Paradoxically by a shift in the nurses' gaze toward the social subjectivity of the patient, this enlarged gaze may increase the surveillance of the person as patient (May 1992, Armstrong 1983). This nurses'

gaze may be deeply problematic. For example it may take on the quality of the confessional (May 1992) and information extracted in this way may be reported in other spaces, written down and re-interpreted. The patient may not be aware of how his or her subjectivity may be animated and utilised and this may affect the care experience in subtle ways. Such surveillance by the nurses' gaze can be resisted and one of the means of resistance open to the patient and the family is to remain silent or to criticise attempts to impose open awareness (May 1992, Seale 1995).

Patient-centred approaches and holistic discourses provide nurses with a voice that distinguishes nursing care from purely biomedical approaches. This holistic, caring discourse was consolidated within nursing culture by the Project 2000 reforms of nursing education during the 1980s. Project 2000 was the United Kingdoms Central Council for Nursing, Midwifery and Health Visiting (UKCC 1987) plan for reform of nursing education, structure and practice. Project 2000 was widely regarded as a success for the professionalisers within nursing, as well as an effort to overcome some of the problems of low status, poor retention, and lack of a clearly defined area of expertise (Allen 2000, Beardshaw and Robinson 1990). The Project 2000 reforms removed nursing education from hospital-based schools into higher education and created a single portal of entry by abolishing the State Enrolled grade of nurse. The curriculum was developed in line with thinking about 'new nursing' and the creation of a patient-centred rather than a task-centred approach to care was emphasised. A new form of thinking about accountability and responsibility was also evident as patient care was reorganised around a named nurse<sup>1</sup>, team nursing<sup>2</sup> and the nursing process<sup>3</sup> (Fitzpatrick & Redfern 1999, Wright 1994). Recent developments in work organisation involve multidisciplinary working such as case management and patient-focused care systems (Fitzpatrick & Redfern 1999, Gournay 1995). Case management has been adopted by community and mental health services as well as in acute settings. The focus of this approach is managing the path of a patient by the case manager through a programme of care although this may be practised in different ways in

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<sup>1</sup> The Patient's Charter (DOH 1991) said that patients should have a named qualified nurse, midwife or health visitor responsible for nursing or midwifery care.

<sup>2</sup> Team nursing involves a number of trained and untrained nurses who care for a group of patients, accountability for care is less clear than with a named nurse system (Wright 1994)

<sup>3</sup> The nursing process is a tool whereby nurses assess the patient's needs, plan what needs to be done, implement the plan and evaluate the outcome (Yura and Walsh 1978)

different settings (Bergen 1992). Patient-focused care involves the decentralisation of all diagnostic, therapeutic and caring services to their point of delivery with services delivered by a multi-skilled workforce of co-ordinated care teams (Fitzpatrick & Redfern 1999).

The process of differentiation that was going on within nursing during the 1980s and 1990s was around establishing the nursing contribution to patient care. The patient-centredness of care approaches was prioritised and there was considerable interest in communication and interpersonal skills training, particularly in the field of cancer care (Wilkinson 1991, May 1990, Faulkner 1980). These approaches link with ideas about a new form of professionalism that prioritises the interpersonal performance of the carer. Thus old professionalism is rejected and a new form of professionalism emerges in written discourse about practice. These notions will be discussed next.

### **3.3.1 Old professionalism**

It seems to be generally accepted that the power and authority in the medical division of labour lies with the medical profession and this form of authority is accepted by the general public. Starr (1982) calls this cultural authority and it is a resource, which enables the ability to control. The cultural authority held by the medical profession enables two aspects of control, according to Starr (1982). Firstly, Starr argues, cultural authority enables the control over the action of others (through giving commands for example), and secondly the probability that medical definitions of reality will be accepted as valid and true. However, despite this form of power and control there are challenges being made to the cultural authority of medicine. These challenges come firstly from social scientists who are critical of medical self regulation and 'old professionalism', which they claim puts the profession before the patient and overlooks emotional aspects of care (Stacey 1992, Davis 1995). Secondly, articulate consumers of health care and those that urge service reform and modernisation (DOH 1999a, 2000b, 2001). Thirdly, leaders within nursing who argue for a 'new nursing' (McMahon & Pearson 1998).

Stacey (1992) in a study of the General Medical Council (GMC) identifies problems with self-regulation of the medical profession. She claims that institutionalised practice within the GMC results in the medical profession putting

its own interests before the public interest. She goes as far as to say that although there is a reluctance by the GMC to admit those doctors to the profession that will not be a credit to the medical profession:

*This has less to do with technical competence than with their social acceptability as members of this exclusive collectivity. (Stacey 1992: 207)*

This is a damaging portrayal of self-interest and lack of accountability and this could lead to problems in relation to the cultural authority identified by Starr, as this form of professional control via exclusivity and social acceptability does not fill one with confidence in expert practice. In contrast to the exclusive and expert model of medicine, nursing, has been identified as invisible, undervalued and a type of emotional labour<sup>4</sup> on the margins of high technology, medically defined work (Smith 1992). However, nurses are found within all areas of medical work including that of high technology settings. For example they work in intensive care units, high dependency units with specialised medical equipment and other technological innovations. Therefore nurses may be working within high technology medicine as well as using emotional labour to care for patients who are receiving high technology support as part of their medical treatment. These factors are not separate from the work that nurses do and the context in which work is carried out. Watson et al (1996) draws attention to the importance of setting in relation to role development. She identifies a lack of attention to the characteristics of the setting in which the role is performed. Jones (1994) agrees with this and discusses how it is difficult to generalise about nursing work as it takes place in so many different settings. Therefore, she argues, the character, style and pace of work will vary resulting in different work cultures and values in different settings. I will now discuss new professionalism and link this with issues related to caring.

### **3.3.2 New professionalism**

There is some concern that the new thinking about professionalism has not confronted the emotional aspects of nursing work and the caring that nurses do

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<sup>4</sup> Emotional labour according to Smith (1992, 2001) involves presenting a smiling face, listening and talking to patients and doing the 'little things' that help give patients comfort and demonstrating 'a little bit of love'. Thus emotional labour involves the processes of connection and involvement which promote an intimate and therapeutic relationship between nurses and patients (Smith 1987, 2001).

(Davis 1995). Davis argues that nurses face the difficult business of reconciling professionalism and caring as dilemmas of daily practice. She continues by pointing out how the caring practitioner model that is beginning to emerge goes beyond the gendered thinking associated with the concept of profession. She describes the new practitioner as neither distant nor involved but engaged, interdependent, accepting of an embodied use of the self as part of the therapeutic encounter, a creator of an active community in which solutions can be negotiated, and a reflective user of experience and expertise. This model of practice appears to blur the boundary between the different health care practitioner disciplines by using the caring practitioner model and avoids discipline-specific titles. This identifies caring as a central component of health care work irrespective of the core discipline or specialism. This re-interpretation of caring avoids the marginalisation of caring work as low status women's work. However it leaves nursing in a difficult position in relation to exclusive claims to caring and 'nursing as therapy'. However, nurses are very concerned about caring and this is reflected in nursing research, nursing practice and nursing theory (Cowley 1999). Thus perhaps the reputation of nursing cannot be separated from caring and this is reflected in the description of nursing as the 'ultimate caring profession' in the eyes of the public (Cowley 1999). Morrison & Cowley (1999) say that patients may only articulate their feelings about caring if it is perceived to be missing. This points to the taken-for-granted nature of caring and its intangible qualities.

Deverall & Sharma (2000) focus on the importance of interpersonal skills in the performance of a new professionalism. They argue that the new professionalism discourse challenges expert knowledge and recognises the importance of the self, interpersonal skills and intuition. Deverall & Sharma (2000) point out that in certain forms of work shared experience with the client group is more important than professional qualifications. This is evident, they argue, in the work of Human Immuno Deficiency Virus (HIV) prevention outreach workers who describe their gay identity as crucially important to the work that they do. Furthermore, Fournier (2000) discusses how new organisational discourses such as excellence, flexibility and the logic of the market are unfavourable to the professions. This is because the market dismantles the barriers to making the professions by dismantling the self-contained field of knowledge and this reduces

the barriers between the professions, the market and clients. This type of consumer-oriented discourse is evident in policy documents.

The NHS Cancer Plan (DOH 2000a) identifies the importance of the qualities of the health care professional and the expectation of the patient:

*Research evidence indicates that 'a willingness to listen and explain' is considered by patients to be one of the essential attributes of a health professional (along with sensitivity, approachability, respect, and honesty). (DOH 2000a:63)*

In a recent report by the Department of Health (DOH 2000b) 'A Health Service of all the Talents: Developing the NHS Workforce' a clear commitment to sensitive and appropriate health care is developed:

*A modern NHS is one which delivers care to patients in a way which is sensitive to their needs and expectations. (DOH 2000b: 9)*

This statement puts the needs of the service user at the centre of modernisation and service development. This approach uses the voice of the consumer to argue for changes in practice. The report reflects a changing view of how health care staff should work together by describing 'teams of people rather than as different professional tribes'. Within the report a promise is made to expand the numbers of doctors, nurses and other health professionals, in return for reform, which involves removal of professional and disciplinary barriers so that good care can be delivered within functioning teams. The report denounces demarcations between staff as holding services back and states that the skills of staff not their job title, is what counts.

In 'Making a Difference' (DOH 1999a) a commitment is made to maximise the nursing, midwifery and health visitor contribution to health by expanding and developing roles and developing satisfying and rewarding careers. The contribution of a well-informed public is acknowledged as central to this development. The report continues:

*People with chronic disease want to understand the course of their illness and to learn how best to manage it. Carers do not want to be the passive recipients of professional treatment but to work in partnership with nurses, midwives and health visitors. (DOH 1999a:9)*

The report also describes inaccurate, stereotypical images of nursing that prejudice and constrain the nursing contribution to decision-making, and need to be



countered and challenged. A clear commitment is made to supporting new nursing roles and new ways of working.

The theme of breaking down the barriers between health care professionals and the patient is further explored in 'The Expert Patient' (DOH 2001). This report sets out a commitment to help support those with a range of chronic disease in becoming experts. The patient is described, within this report, as having expertise in the experience of the illness, social circumstances, values and preferences and the clinician as having expertise in diagnosis, disease aetiology, prognosis, treatment and outcome probabilities. The report highlights the variability in the experience of service users, for example, they cite the case where there may be more attention given to the technical aspects of care with inadequate attention to the social or emotional consequences of the condition. The report describes two types of self-management programmes; those led by health professionals and concentrating on treatment regimes and those that are user-led and move beyond the medical view, using patient experience as the central focus.

The rhetoric of health care policy and service development constructs an appropriate performance for health care professionals. The exclusive knowledge of the professional is being deconstructed in relation to patients and inevitably other workers in the health division of labour. It is also important to consider how the boundaries between the practitioners and patients are being re-negotiated, particularly in the chronic illness context.

Next I turn to the discourse of 'new nursing' and how this notion concerns itself with aspects of new professionalism.

### **3.3.3 'New nursing'**

The 'new nursing' discourse, according to Salvage (1990), started in the UK in the early 1970s as new departments of nursing developed in higher education. This movement generated interest in nursing theory and drew heavily on work developed in the USA, which attempted to define the unique role of nursing (Henderson 1966, Peplau 1952). The knowledge base of this movement combined preparation for a more demanding role with a holistic approach and open and honest relationships with patients as well as a firm grounding in the biological and social sciences. The 'new nursing' discourse encourages a shift from practical

material labour focused on the body to what is called emotional labour (May 1995).

The idea of a partnership between patients and nurses and the belief that nursing was a therapy in its own right is a key aspect of 'new nursing' (Salvage 1990). At the Oxford Nursing Development Unit (ONDU) the nursing ethos sought to transform relationships with patients away from the biomedical model towards a holistic approach (Pearson et al 1992). The ONDU was established in 1985 with 16 nursing beds for patients who needed intensive nursing but who do not need frequent attention from doctors. However by the end of the 1980s this unit had been closed down despite its perceived effectiveness, although patients views of the unit were not researched directly (Salvage 1990, Pearson et al 1988).

Nursing makes distinct claims for caring as a central component of nursing work. However some leading nurses claim that caring has become marginalised and subordinated by the therapeutic interventions of doctors and paramedical therapists (Pearson 1991). Thus talk of 'nursing therapy' and caring can be used to make visible the tensions between doctors, paramedical therapists and nurses:

*Nursing as therapy is a powerful political stance that seeks to place nursing on an equal footing with all other health-care professionals. In this, it seeks to assert itself as a therapy in its own right and, further, as one that should not be subject to the invidious medical gatekeeping that so often dominates health-care access. (Northcott 1998:231)*

Salvage (1990) is critical of 'new nursing' claims on two counts. Firstly, she is unconvinced about whether 'new nursing' is a manifestation of 'old-style professionalism' or whether it contains the seeds of a more radical reorientation of nursing towards true partnership with patients. Secondly, she believes that there is a lack of evidence that patients want the kind of relationship advocated in therapeutic nursing.

Corner (1996) draws on the term nursing as therapy as used by McMahon & Pearson (1991) to describe a 'movement to reclaim nursing, for nurses'. She claims that there is evidence to describe cancer nursing as therapeutic and cites her own research in relation to the management of breathlessness in patient's with lung cancer. Her approach to breathlessness was to combine physical and emotion-focused interventions. She describes the result of nursing intervention as powerful:

*We found we could assist those with the symptom to redefine breathlessness as a problem that they could learn to manage for themselves, but that they needed help to work through the fears associated with the symptom, and the limitations their disease might impose over time. This model does not eliminate the use of powerful pharmacology, but adds other approaches to the care environment, and puts the sufferer in an empowered position for self-management. It also rejects the Cartesian notion of mind and emotion as separate from the body or the physical in the experience of a symptom such as breathlessness. (Corner 1996:13)*

Corner links medical approaches with emotion-focused approaches that enable an aspect of self-management for the sufferer. Corner believes that the way forward for therapeutic cancer nursing is to develop the evidence base for this approach. This is a less competitive stance to medicine and makes visible the other approaches in the care environment as well as the medical/pharmacological approaches. What is interesting about Corner's work is that she does not separate the problem experienced by the patient from the caring concerns of nurses and doctors. The practice of the nurse and the other members of the health care team, with the patient, are kept in focus and contextualised.

Nursing is not alone in claiming the therapeutic nature of its practice. Silverman & Bloor (1989) discuss how the emergence of 'patient-centred' medicine directs doctors toward the patient's utterances and demeanour as well as the body. They describe how medical intervention is directed towards that 'social space between doctor and patient' and how the doctor-patient relationship is conceived as a therapeutic relationship. So medicine also makes a claim to the same territory that nurses perceive to be their space. This draws attention to how medicine itself may want to increase the borders of its practice and in this sense share nurses concern with being 'patient-centred'.

An interesting image of the nurse as a 'skilled companion' is created by Campbell (1984). Campbell says that we can expand our understanding of nursing care through the discovery of fresh images of the nurse, which retains the humanity of the nurse and gives responsibility to the patient for involvement in care. Campbell offers the image of skilled companionship. The good companion, according to Campbell, is a bodily presence, which accompanies the other for a while and involves 'being with' as well as 'doing to'. This concept offers three advantages it is not gendered; implies change and mutuality; and requires commitment within defined limits (Campbell 1984: 49). Perhaps in the context of hospice and

palliative care one may begin to understand how such companionship may be possible and the resources used to engage in such a manner.

In the next section, I explore the changing nursing and medical boundary and how boundaries are being reformulated and negotiated.

### 3.4 Changing boundaries

A debate took place in May 1993 with the Chief Nursing Officers of England, Wales, Scotland and Northern Ireland and an invited group of nursing leaders and other professional colleagues to consider the future delivery of health and social care in the context of nursing (The Heathrow Debate DOH 1994). Within this debate the ‘ecological balance’ within the caring community was discussed as changing. There seemed to be an understanding that this process was an organic one as the ‘ecological’ metaphor suggests. The members of ‘The Heathrow Debate’ blurred the cure /care boundary by using the term caring community.

In a carefully worded and diplomatic statement from The Royal College of Physicians of London and The Royal College of Nursing (1996) the boundary issue between doctors and nurses is described as ‘skillsharing’. The colleges’ describe their concern with the welfare, safety, cost, quality and satisfaction of the patient with the care given. However, they also voice a general concern about the central element in the training of the particular profession:

*Transfer of skills should not be undertaken where there is a risk of losing a central element in the training of the particular profession. On the other hand a profession can, through training be introduced to new competencies. (Royal College of Physicians of London and the Royal College of Nursing 1996: 57)*

This statement appears to acknowledge the interrelationship between medicine and nursing by using the term ‘skillsharing’ rather than delegation for example. The statement voices the separateness of the core elements of different professions but also argues for flexibility and change. It uses the term ‘transfer of skill’ without defining what it means by skill and which way the transfer will occur. This statement does not define how radical the change will be, which skills are involved, and who decides what is to be shared. Alternatively this may also be an acknowledgement that change is inevitable but the extent of the boundary change has yet to be defined.

There is empirical evidence which points to the fluidity of professional boundaries particularly with junior medical staff and experienced nurses. Wicks (1998) carried out an interview study of 262 doctors and nurses which explored the nature of professional boundaries between these two groups. She found that the boundaries were least well defined when very junior doctors were seeing patients. Experienced nurses challenged the decisions of younger doctors in particular, but consultant authority was accepted by nursing staff in most situations. Her respondents described caring for patients and treating patients as distinctive processes. However, she argues that this distinction was difficult to sustain because of the numerous examples of nurses carrying out treatments, such as giving intravenous drugs, triaging patients and dealing with wounds. She concludes that caring and treatment are not sufficiently clear to carry the weight of differentiating between the two professions.

There is concern in the literature that nurses are being drawn into a biomedical role, which takes them away from understanding the patient's illness experience (Hunt 1994). Hunt is worried that role expansion may mean that nurses reframe their role in health care as a technological enterprise in which they are the new experts. However, role expansion may be framed for nurses. Reed (1995) reports that some nurse practitioners have expressed concern that they felt more like doctors' assistants than advanced nursing practitioners and they had little opportunity to exercise nursing knowledge or to make autonomous decisions. There is also some support for Reed and Hunt's concerns in relation to Tye's (2001) empirical study of the Emergency Nurse Practitioner (ENP) role. He found that this role was limited by a range of locally imposed protocols, which were medically driven and beyond the control of the practitioner. One aspect of control, identified by Tye, was the lack of prescribing powers, which resulted in blurring of roles through unauthorised practices related to prescribing medications. However, increasingly nurses do have prescribing powers particularly in the context of primary care (DOH 2001a, 1999b).

Allen (1997) in an ethnographic study on a medical and surgical ward also observed how ward nurses engaged in boundary blurring in order to maintain continuity of patient treatment and engaged in initiating tests and referrals, administered unprescribed drugs and requested the doctor to prescribe them later. The advantage for nurses in blurring the medical nursing boundary, according to

Allen, is that it gave them greater control of their work, improved patient care and avoided inter-personal tension. This suggests to me that it is not only specialist nurses and nurse practitioners that are involved in role expansion and supports Castledine's (1994) contention that the development of specialist nurses and nurse practitioners should be viewed as an expansion of the nursing role more generally, albeit informally. Watson et al (1996) say that there is no ideal and essential form for nurse practitioners as their existence and essence is historically contingent. This leads me to conclude that role development will accommodate a range of approaches involving medical and nursing skills. How these skills are utilised may be context dependent.

Macguire (1980) discusses the terminological confusion over whether the change in work pattern between doctors and nurses is an expansion of nursing or an extension of medicine. She suggests use of the term 'expanded' where nursing roles are drawn upon and 'extended' where nursing is not a pre requisite and where the tasks are essentially medical. This discussion of extended/expanded role, I believe, is predicated on the core values of medicine and those of nursing and also on the power differentials between the two professions. For example, the extended role argument would accomplish the essentially dominant position of medicine vis-à-vis nursing with medical discourse privileging the medical and doctors delegating medical tasks to nurses and nurses substituting for doctors. The expanded role argument would accomplish the core nursing value of caring within the nurse patient relationship with the goal of increased accountability for caring and enhancement of role rather than substitution.

Wright (1995) proposes that nurses should expand into activities that expand their caring function so they make care more personal, effective and holistic. It may be that this expanded caring function is made more visible in the practice of hospice and palliative care nurses and this will be discussed later.

I will now discuss how the 'doctor-nurse' game is being reformulated and how a negotiated order perspective is relevant to contemporary health care practice.

### **3.4.1 Re-negotiation of medicine and nursing**

I will now turn to the other important issue between medicine and nursing that of dominance and subordination, which may be undergoing change and

renegotiations. Mundinger (1994), a nurse in the United States of America, argues for a collaborative practice structure rather than 'turf wars'. There is some evidence that the relationship between doctors and nurses has undergone a transformation over a period of 35 years. Stein (1967) an American physician, describes how doctors and nurses relate in the 'doctor-nurse game'. In this game interactions were managed so as not to disrupt the doctors' superiority to nurses. The nurses handled this by making suggestion and recommendations to avoid disagreement among players. Stein et al (1990) updates his original thesis and states that nurses have now unilaterally decided to stop playing the game. He continues that the traditional 'doctor-nurse game' had a stultifying, anti-intellectual effect on nurses resulting in dissatisfaction with professional roles and interprofessional relationships. He continues:

*Physicians and nurses can both benefit if their relationship becomes more mutually interdependent. Subservient and dominant roles are both psychologically restricting. When a subordinate becomes liberated, there is the potential for the dominant one to become liberated too. (Stein et al 1990: 549)*

Although both Stein and Mundinger argue for a new orthodoxy there is evidence in the UK that this may be a difficult transition depending on the context of work. Tye (2001) undertook a postal questionnaire survey of Emergency Nurse Practitioner (ENP) services and a case study evaluation of the ENP role in one major Accident and Emergency Department. Tye (2001) describes how ENPs were denied referral powers to other health care workers and he concludes that this is an exclusionary strategy operated by some doctors, leading to a lack of professional recognition for ENPs. The problem for nursing in its current project of developing the profession, it may be seen to be competitive to that of medicine. This may be more pronounced in the acute setting of accident and emergency care for example.

I will now discuss how a negotiated order perspective can provide a perspective on how interprofessional relations may be accomplished in practice.

### **3.4.2 The negotiated order**

According to Strauss (1978) negotiation goes by many names including compromising, bargaining, making arrangements, trading off, wheeling and dealing. He says that negotiation is generic to human relationships and

arrangements and is a means of ‘getting things accomplished’ an individual wishes and to make things work. Individual action and organizational constraint can be understood by the nature and contexts of those negotiations (Strauss 1993: 249). Strauss describes the negotiated order concept in the following way:

*More generally the concept of negotiated order was designed to refer not merely to negotiation and negotiative processes. It also points to the lack of fixity of social order, its temporal, mobile and unstable character, and the flexibility of interactants faced with the need to act through interactional processes in specific localized situation where although rules and regulations exist nevertheless these are not necessarily precisely prescriptive or peremptorily constraining. (Strauss 1993: 249)*

Strauss says that negotiation always implies some tension between parties otherwise they would not need to be negotiated. Strauss describes how actors may make the nature of the social order visible by the context in which they choose to negotiate and what they believe is, for themselves and others, possible or impossible, problematic or probable.

I will discuss three studies that have used the concept of negotiated order to study the nurse-doctor boundary in a number of different settings (Allen 1997, Svensson 1996, Tjora 2000). Allen (1997) collected ethnographic data from a medical ward and surgical ward. She explores the differences between staff rhetoric in interview data and her field data. Although many staff recounted instances of contested boundaries in conversations and interviews her field observations revealed that nursing, medical and support staff carried out their work activities with minimal inter-occupational negotiation and little explicit conflict. She questions why uncertainty and disagreement in both the literature and in actors’ accounts were so little in evidence on the wards. Allen found that nurses stated that if they were busy they expected to negotiate the allocation of work with medical staff. However, in her fieldwork she found that nurses did undertake doctor-devolved work regardless of their other work pressures. Allen argues that that there was a non-negotiated blurring of the nursing and medical boundary and that this is a taken-for-granted feature of normal nursing practice. Allen overlooks the importance of the local culture between doctors and nurses. This arrangement could be a tacit agreement between the doctors and nurses as the smoothest way to get the work done in the circumstances and negotiated at an earlier stage in working life for example. This I would argue may not mean that the boundary blurring was non-negotiated but rather that this is the negotiated order at this



particular time as it enables the work to be accomplished. This boundary blurring may also enable nurses to have bargaining power with the doctors. Allen's data describes the extent of the interdependence and dependence between the less experienced doctors and the more experienced nurses. This type of boundary work seems to have led to good working relationships with a doctor:

*Diane on geriatrics is brill. She really sticks her neck out. She's really good. (Pre registration house officer Quoted in Allen 1997: 512)*

Doctors then may be grateful when nurses are prepared to employ their skills to ease their burden of work. The result of this arrangement is some kudos for the nurse; a 'really good' nurse as identified by the junior doctor above. Svensson (1996) supports this saying that nurses do a lot of service work for doctors and that if the nurse is good at the service work, such as arranging referrals and sorting out the paper work, the doctor is appreciative and they co-operate well in other situations too.

In an interview study with 45 staff nurses and ward sisters from 14 wards in 5 Swedish hospitals focusing on nurses' opportunities to influence decisions with doctors, the division of labour, exchange of knowledge and information, ethical attitudes and interaction with doctors (Svensson 1996); it was found that nurses were generally satisfied with their relationships with doctors, although there was some variation. Svensson says that new patterns of interaction have arisen because of the changed conditions for negotiations between doctors and nurses in particular having to deal with chronic illness; and also the concern of practitioners with the social aspects of the patient. According to Svensson this tips the balance towards doctors becoming more dependent on the nurses' knowledge in decisions about diagnosis, treatment and rehabilitation. This he argues is because nurses have knowledge about patient preferences, contact with relatives, observation of the patient and this knowledge can be important when a patient is to be discharged for example. Svensson says there are many methods open to the nurse in advancing the decisions s/he wants the doctor to take. For example s/he may exaggerate the pains felt by the patient by using rhetorical devices such as 'somewhat' or 'quite', hedges that suggest some clinical uncertainty. However the patient may spoil the picture by playing down troubles when they meet the doctor. Therefore, according to Svensson negotiations are often about the ability to argue and to create alliances. This I find a very interesting notion. It suggests that

negotiations are not just about doctors and nurses but patients are actively involved in this process also and they can create alliances to further their own ends. A limitation of Svensson's study is that the interview accounts are actors' accounts and in this sense a subjective representation of their practice.

There is little exploration within the selected literature about how the context within which work is carried out may structure interprofessional relationships and how roles develop. One exception to this is the work of Tjora (2000). Tjora (2000) in an empirical study involving observation in six Norwegian medical emergency (AMK) centres over a period of two years demonstrates how the use of radio-telephones impose changes in defining the boundary between doctors and nurses. Tjora describes how nurses staff AMK centres and take calls for ambulance services and access to doctors. The central task of the nurse is to screen patients to decide their level of urgency. To help the nurses prioritise cases effectively the Norwegian Medical Association developed a framework (called NI) for evaluative/diagnostic work in AMK centres. Tjora found that the NI was used selectively. He continues:

*Many of the nurses do not want to use it (NI) as a standard method because they feel more comfortable with the use of their own medical knowledge and experience than 'reading from a book'. Nevertheless, many nurses use the book as a post-decision quality control, a knowledge bank and reference, to check their own medical decisions and to learn more about concrete cases after they have passed callers on to the doctor. (Tjora 2000: 727)*

Tjora describes how nurses functioned as 'medical oracles' providing competent advice to callers not dissimilar to the advice a doctor might give. They also organised and prioritised work for doctors who are 'on the road'. He argues that this form of practice enabled nurses to develop their experiential knowledge and collective learning by social interaction with colleagues in the centre. He concludes, that in the case of the AMK, it is the advanced technology of the centres that creates the opportunity for autonomous work and alters the balance of influence and autonomy in the nurse's favour. Thus artefacts and technologies such as communication tools and their operation take part in the negotiation of the doctor nurse boundary. Nurses boundary-spanning actions are made possible by the communication technology that enables them to engage in medical decisions, and activities involving medical diagnosis in the AMK centres.

In the next section I will discuss the development of specialist nursing. There is research evidence to suggest that nurses working in a variety of specialist roles, are changing the nature of the professional /client relationship. The term specialist nurse may be reserved for particular kinds of work that accomplish both nursing and medical work.

### **3.5 Specialist nursing**

Castledine (1994) presents three forces affecting the changing context of professional nursing and midwifery practice: consumerism and public demands for better health care, the growth in medical science and technology and the efforts of nursing and midwifery to professionalise and identify the knowledge and skills that form the basis for practice. Castledine suggests that the development of clinical nurse specialist (CNS) roles and advanced nursing should be viewed within the expansion of the nursing role in general.

The development of CNS roles is part of a process by which nurses differentiate themselves and I would suggest enable nurses to claim expertise and enhanced professional status. However, Humphris (1994) like others, notably Elcock (1996) and Castledine (1995), is concerned with the construction of CNS posts as 'medical assistants' developing 'mini doctors' and 'super nurses'. This discourse was further complicated by the implementation of the Junior Doctors' Hours Initiative. The New Deal (NHSME 1991) set limits on junior doctors' contracted hours. Allen (2000) says that the response to The New Deal was mixed although many nurses supported role development they were unhappy with the link between nurses' role developments and junior doctors working conditions. However to keep the New Deal in perspective specialist nursing roles have been around since the mid 1970s (Webber 1997). Perhaps the New Deal has lead to acceleration in the development of such posts, but to establish a direct link with this initiative and nurse's role development is more complicated as role development was occurring before this initiative.

In response to the changing context of nursing practice 'The Scope of Professional Practice' was published (UKCC1992). This document shifted the onus for defining the boundaries of nursing to the individual practitioner. Scope enables individual nurses to take on more activities to benefit patient care, but they remain

accountable as individuals for their practice (Autar 1996). Allen believes that these developments have created jurisdictional ambiguity at the medical-nursing boundary and at the nurse-support worker boundary. However this could be viewed more positively as enabling an organic, negotiated order at service delivery level rather than an imposed order.

Waters (2000) concedes that despite attempts by professional organisations to define the parameters of the nurse specialist role, which include expert practitioner, educator, researcher and consultant, the roles tend to be shaped by the needs and pressures of the service rather than definitions formulated by the profession/s. Humphris (1994) thinks that CNS roles have largely developed in a medical culture with medically defined areas of practice rather than from patient needs. However, I believe that on closer inspection the development of these roles appears very diverse. McGee et al (1996) in a questionnaire survey exploring new roles in practice between 1996 and 1997 identified 603 nursing and 235 health care practitioner (HCP) posts in a 20% sample of English Trusts. Of the nursing roles, 33% had specialist in the title and 16% had practitioner, while 51% had other titles. McGee also found no standard job descriptions for specialist practitioner roles, even within the same organisation as well as little differentiation between specialist and advanced practitioner in terms of scope of practice.

Definitions of the CNS role stress the importance of advanced education. The International Council of Nursing (ICN) says:

*The nurse specialist is a nurse prepared beyond the level of a nurse generalist and authorised to practise as a specialist with advanced expertise in a branch of the nursing field. (ICN 1992:12)*

A credentialist tactic is evident in the ICN statement. There is no mention of the qualities or attributes of the practitioner. This definition relates to aspects of old professionalism stressing credentials and expert knowledge rather than to aspects of new professionalism, which stress the qualities of the caring practitioner. Nurse specialists according to Humphris (1994) are experts in an area, or about the needs of a particular client group, with an advanced education rooted in nursing.

A strategy of exclusion is evident in the following United Kingdom Central Council (UKCC) statement agreed in 1997 in response to changes occurring in service provision and the expansion in nursing roles:

*Following an extensive consultation process, that practitioners with the titles of nurse practitioner or clinical nurse specialist could record the qualification of specialist practitioner if they met the standards for specialist practice as currently laid down. (UKCC 2002:14)*

The UKCC have therefore set out standards to control the entry of nurses recognised by this body as specialist practitioners. This, therefore, excludes nurses who do not meet the council's standards. This continues the dual closure strategy identified by Witz (1992) and seems congruent with previous attempts to professionalise.

I will now discuss the emergence of hospice and palliative care nursing and how caring and specialist practice is framed within this specialist culture and discipline.

### **3.5.1 Specialist palliative care nursing**

Clark and Seymour (1999) ask the question: how can palliative care be distinguished from mainstream health care? Their answer to this question is that what is important is the alignment of palliative with the concept of care. They discuss how care is the organising principle by which the person in their totality is cared about and the disintegrative effect of life-threatening illness is removed by the promise of whole person care. This type of care is accomplished according to Clark and Seymour (1999) through the three principles of 'total care', 'teamwork' and 'trust'. They describe 'total care' as being concerned with the relief of suffering, 'teamwork' they argue is the model of interdisciplinary working effective in palliative care. Hugman (1991) also describes team meetings as a new way of structuring interprofessional relationships. Trust is about the nature of the relationship between those that care and those that are cared about, according to Clark and Seymour. They argue that it is these three principles that have resulted in the definition of palliative care set out by the World Health Organisation (1990):

*Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness, in conjunction with anti cancer treatment. Palliative care:*

- *affirms life and regards dying as a natural process*
- *neither hastens nor postpones death*
- *provides relief from pain and other distressing symptoms*
- *integrates the psychological and spiritual aspects of patient care*
- *offers a support system to help the family cope during the patient's illness and in their own bereavement (WHO 2002)*

The National Council for Hospice and Specialist Palliative Care Services (NCHSPCS 1994) have made a distinction between delivery of palliative care by those with specialist training and qualifications and the delivery of palliative care by non-specialist practitioners. The NCHSPCS (1994) distinguish three levels of provision. The first level they identify is concerned with what is called 'the palliative care approach' and is evident in the work of general practitioners, and those working within, for example long-term care institutions. The second level identified refers to those that are trained and accredited specialist practitioners who use their skills in a range of non-specialist settings. The third level identified is concerned with provision of a range of specialist expertise in which services are provided either at home or in a specialist setting such as a hospice.

Robbins (1997) questions whether the term specialist is justified in palliative care. She argues that the specialist needs to justify what they provide above the non-specialist. She continues:

*Is it up-to-date knowledge of pharmacological and non-pharmacological advances in pain and symptom control? Is it counselling skills in breaking bad news, and effective communication? Is it practical advice on benefits and financial matters? Equally possible, could it be a matter of resources, such as time for unhurried consultations and nursing sessions, or easily accessible beds for respite and terminal care, or effective multidisciplinary team working? (Robbins 1997: 18)*

Furthermore, Seale (1989) in a review of research evidence suggests that patient care practices in hospices and hospitals may not be so very different from each other.

There is some evidence that nurses working in hospice and palliative care make use of particular resources that may be context specific. The nature of these resources and expertise concerns the identity of the nurse (Hunt 1989), the nurse's use of time (Hunt 1989, Froggatt 1995) and the interpersonal performance of the nurse and patient together (Li 2001). There is also evidence that nurses and others, including volunteers in the hospice, work to break down the barriers between the health care worker, the volunteer and the patient (Lawton 1998). Hunt (1989) studied symptom control team (SCT) nurses in the community. She found that these nurses presented themselves to patients as 'friendly' and 'informal'. This performance of friendliness and informality was symbolised by nurses not wearing uniform, using their first names and by the nurses describing a friendly clinic, which patients and relatives could attend. Hunt concludes that these nurses were making efforts to highlight their individuality and change the nature of their professional client interactions. Hospice nurses have also been identified as being able to perform 'niceness' and that patients reciprocate this performance. This co-performance has been termed 'symbiotic niceness' and contributes to psychosocial care (Li 2002). Furthermore, these nurses use resources such as time and knowledge. Hunt found that the SCT nurses gave time and no visit appeared rushed. Froggatt (1995) in her ethnographic study within a hospice setting also identified a key resource of nurses, having time. She describes nurses working in the hospice movement as 'ritual specialists' who work to facilitate people's movement through the life-death transition. She argues that these nurses are specialists because they have knowledge of the patient and power to control the patients passage through illness and dying. According to Froggatt, knowledge and time enabled the delivery of care in a holistic manner.

Lawton (1998) in another ethnographic study within a hospice day care setting described how day care was a 'safe haven' for patients. She describes an informal mode of care having developed with the staff seemingly blurring the boundary between themselves, patients, and volunteers by making the centre very homely through the use of props, like plants, wall coverings and also by not wearing uniforms. Staff and volunteers also took their breaks and meals with the patients, Lawton concludes, that this enabled the status of day care patients as dependent people to be less apparent, and patients were able to hang on to a 'normal' identity

and sense of self in the present. Lawton argues that patients and staff together developed this informal mode of care.

I suggest that palliative care nursing has developed its reputation for an effective form of holistic care that is informal and approachable by being both nice and friendly and a safe haven where patients can maintain a normal identity. Resources that support this reputation include both knowledge and time. These nurses appear to be able to bring a personal touch to their practice and perhaps it is this personal touch that enables the patient to benefit from what is on offer (Smith 1992).

There are some tensions and contradictions identified in the research literature. In an evaluation study of hospital and community Macmillan Nurses<sup>5</sup>, commissioned by Macmillan Cancer Relief the researchers found that a wide variation in services existed. In particular the delivery of team work (Clark et al 2002), different expectations between Macmillan Nurses and their managers (Seymour et al 2002) and diversity in patient referrals (Skilbeck et al 2002).

Seymour et al (2002) using semi-structured interviews with the Macmillan Nurses (n=44) and their key colleagues (n=47) across 12 services found that there is a mismatch between the expectations of Macmillan Nurses and their managers about the appropriate focus of their work. All the nurses tended to derive satisfaction from face-to-face contact with patients. There seemed to be some confusion over what clinical nurse specialists were expected to do by Managers and what the Macmillan Nurses themselves wished to do:

*I came into nursing to do clinical work, to work directly with people who were very ill. And I'm not interested in administration, management, teaching apart from as part of this job or anything else really. (Community Macmillan Nurse Quoted in Seymour et al 2002:389)*

The hospital-based Macmillan nurses in the study highlighted the importance of maintaining their clinical credibility among consultants and ward staff. These nurses felt that clinical credibility was important in influencing the acute hospital setting toward a palliative model of care. Maintaining credibility was about working closely with patients:

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<sup>5</sup> The Macmillan Nurse is an example of a clinical nurse specialist (Clark et al 2002)



*I also think in terms of credibility...it's important to have that patient contact. (Hospital Macmillan Nurse quoted in Seymour et al 2002:389)*

A fundamental difference emerged between the wish of the nurses to maintain a direct clinical focus and the push for them to move toward a consultancy type role:

*Macmillan Nurses perceive almost insurmountable difficulties in reconciling their wish to continue to be closely clinically focused with the expectation that they reduce their clinical role and move towards a role that gives more prominence to consultation and education. (Seymour et al 2002:389)*

There was also a concern expressed that consultancy/educative role was the strategic push of Macmillan Cancer Relief:

*I think there's a conflict because Macmillan know that the way they generate monies is through generally our role the Macmillan Nurses being directly involved in families and in people's houses so on the one hand there is a big push to get us a bit more away from that but I think on the other hand they'll have, we'll always have to be there otherwise the generation of money won't, will probably start to dwindle. (Community Macmillan Nurse quoted in Seymour et al 2002:389)*

Credibility for the Hospital Macmillan Nurse also was around clinical skills and claims to expertise in pain control and breaking bad news over and above that of ward nurses:

*They can't move them, so they don't know how to deal with them, they don't know how to move them, they don't know how to use their pain control, or to see the effectiveness of that pain control. (Hospital Macmillan Nurse quoted in Seymour et al 2002:390)*

and of junior doctors;

*It was a good job I was there because it was left to a very junior doctor to break extremely bad news to her, so I was able to do it for him really, which I think was probably better in the long run. (Hospital Macmillan Nurse quoted in Seymour et al 2002:390)*

There is also some conflict identified between palliative medical staff and Macmillan Nurses about role boundaries:

*I think the medical policy should come from the doctors, you know, and go out from there, not necessarily – it's not a nursing decision about which drugs to use, whatever, that sort of thing. And I don't think they've necessarily fully appreciated that. (Palliative Medicine Consultant quoted in Seymour et al 2002:392)*

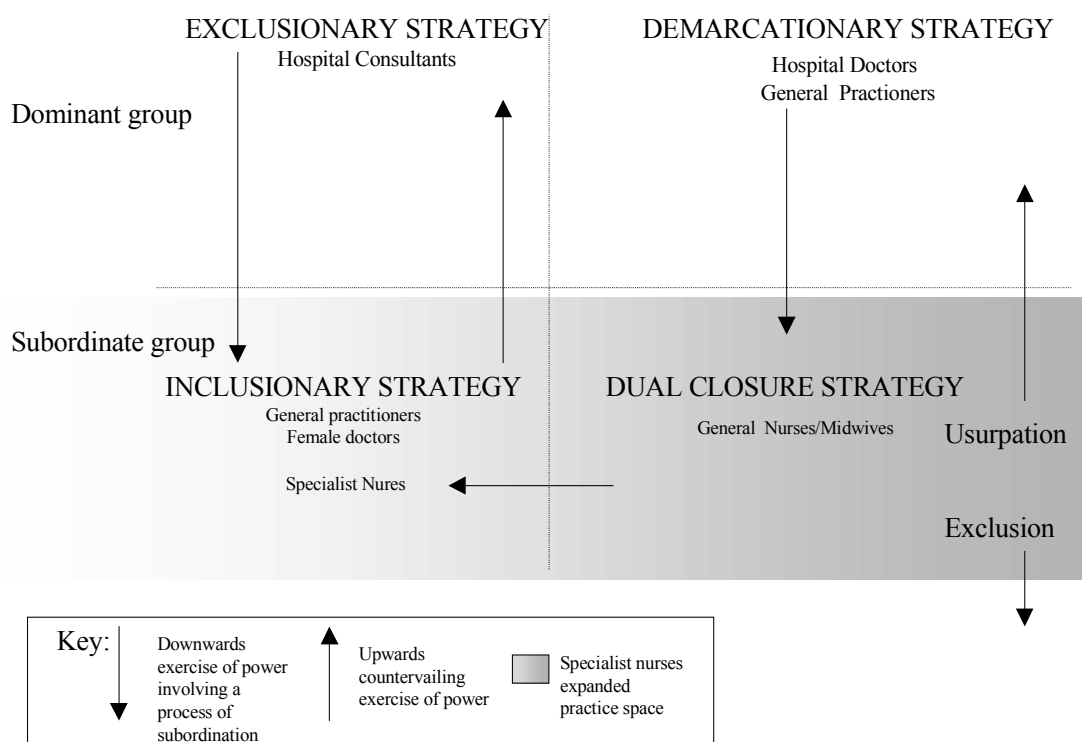
The above data extract defines the threat to medicine perceived by this doctor from nurses encroaching on medical territory. This is a traditional discourse about

the boundaries of expertise available to nurses and doctors and keeping those boundaries separate. However there is evidence that this traditional approach to professional boundaries is being re-negotiated. Seymour et al (2002) found that one multidisciplinary hospital team had good collaborative relationships over a period of 12 years and their working practices 'were highly conducive to shared medical and nursing care'.

Although there seems to be resistance at boundary points between doctors and nurses there is evidence that these are not insurmountable. I also suggest that Witz's (1992) framework does not depict any horizontal movement between a dual closure strategy, and an inclusionary strategy for example. I think that this needs to be re-framed in the light of some of the evidence discussed earlier.

### **3.5.2 Nurses' contemporary professional project**

I suggest that two things may be happening in nursing. Firstly general nurses may be moving backwards and forwards between nursing and medical work but they have not moved from a dual closure strategy (Figure 1). Some specialist nurses may have expanded their practice space and an inclusionary strategy is evident. Hence these nurses move across the glass wall into the inclusionary space (Figure 2). I suggest they may share this space with general practitioners and perhaps female doctors as well as junior doctors (Witz 1992).



**Figure 2 Strategies of occupation closure identifying specialist nurses' inclusionary strategy (adapted from Witz 1992)**

One of the means by which specialist nurses move into the medical space is through the process of negotiation. The negotiated order of work enables some flexibility around how work is accomplished and gives individual practitioners some scope to decide on what is to be negotiated. Negotiation is the process by which the glass wall is broken down and a space is opened up within medicine. Thus specialist nurses may have a bargaining position because of their clinical credibility in the medical context. What this clinical credibility consists of is an important area for research.

In my study I will be examining the multidisciplinary team (MDT) work of a hospital palliative care team, two hospice home care teams and an in-patient hospice team. I will hypothesise that there will be differences as well as similarities about what constitutes specialist work in these different contexts. In particular I am interested in how talk of pain takes on different characteristics and performances according to the context studied. I hope to demonstrate how nursing claims to expertise in pain work is enacted in the MDT setting. This will provide a snapshot of interprofessional relations and changing boundaries within one

particular field of care and in relation to the construction of a particular type of expertise in pain work. I will also explore the difference in performance between those working in a speciality for example a hospice and those working within a specialist role. This will begin to elucidate the traditional nursing role from the emergent specialist role in the niche between nursing and medicine within the discipline of palliative care.

### **3.6 Conclusion**

Specialist nurses, by colonising the niche between medicine and nursing, are positioned to accomplish interprofessional work and also perhaps their 'professional project'. Interprofessional work in a collegial space enables nurses to work closely with doctors and this form of work allows them to develop their medical knowledge experientially. Developing medical knowledge brings credibility and reputation in a medical context, I suggest. There is empirical evidence to suggest that specialist nurses in palliative care are renegotiating their identity and drawing on psychosocial skills as well as medical skills to accomplish palliative nursing. A new professionalism that brings the interpersonal and caring skills of the practitioner into focus avoids the marginalisation of caring as only the concern of nurses. There remains a tension however between the technical/medical aspects of the specialist role and the traditional caring role of the nurse. Although leaders in the nursing profession have attempted to develop 'new nursing' through the discourse of 'therapeutic nursing' other health care practitioners, such as doctors, have also defined therapeutic medicine.

Some of the tensions for nurses in general and for specialist nurses in particular have been explored. In conclusion I suggest that nurses have been successful in expanding their practice and some specialist nurses may have secured a collegial positioning with doctors within the medical space. Other more generalist nurses move into the medical space but have not got a secure positioning in a collegial context within this arrangement. The content and performance of specialist roles and new nursing work is of interest to social scientists, the public, to nurses, managers, national charities, the medical profession and researchers. All of these groups have a different stake in this development. The value of an expanded nursing contribution to practice and the blurring of care and treatment is of interest

to me. My research, related to how the tensions in such a performance may be constructed, negotiated and displayed in practice, therefore is timely.

I turn next to a theory of reputation because one of my premises is that talk about pain and pain work in hospice and palliative care enables the development of a reputation for the speciality. Pain talk also enables specialist nurses to develop a specialist identity within the medical space. The concept of reputation is one that emerged during the first phase of data analysis.

## **Chapter 4 A Theory of Reputation**

## 4.1 Introduction

In this section I explore a theory of reputation and discuss how this theory may be applicable to palliative care teams. I contrast the development of reputation with that of respectability. Reputation is a construct based on equality and personal worth as discussed in the work of Wilson (1973) on Caribbean men and Besson (1993) on Caribbean women. New organisational discourses developed by Kanter (1989) also stress the importance of reputation and its relationship to skills and knowledge. I discuss how reputation is developed through certain kinds of talk. In talk, through words, one may develop one's credibility and reputation as a particular type of person with particular skills and knowledge. I argue that specialist nurses develop their reputation by developing their medical knowledge and by being able to talk 'medically' within the palliative care team meetings. Talk may also be used to discredit those that lack skill and knowledge and who are not part of a social network (Wilson 1973, Besson 1993). Talk may defend one's good reputation by attention to the judgements of others and careful presentation of the self (Goffman 1959). Therefore, reputation is socially constructed through talk-in-action (Firth & Kitzinger 1998). Those who do not have access to the social settings where reputation is displayed may not be able to develop reputation and consequentially may lack power and authority (Wilson 1973). I argue that the palliative care team accomplishes their reputation in the team meetings. Team meetings are an important resource for health care professionals collectively and individually to display their knowledge and skill. Palliative care professionals construct reputation through talk related to illness, disease, symptoms and treatments (Chapter 4). The specialist palliative care nurse develops her/ his reputation by being a person who can talk about medical matters, in some circumstances prescribe like a doctor and build and display knowledge by asking particular types of questions within the team (Chapters 4/6). I conclude that the context in which palliative care teams construct their practice, with patients, leads to particular differentiation within the nursing and medical role. Within palliative care teams, specialist nurses have entered a space in which they can carve out a reputation for themselves that is visible and front stage. This may be in contrast to other types of nurses who remain less visible and back stage (Latimer 2000).

### 4.1.1 The aims of the chapter

- apply a theory of reputation to the work of the palliative care team
- discuss how the palliative care team work together as a social system to build their reputation
- identify the tension between team reputation and the positioning of the patient reputation

## 4.2 Reputation and respectability

Wilson (1973) developed a theory of reputation and respectability from anthropological fieldwork carried out on the island of Providencia in the Caribbean. This theory aims to provide an analysis of Caribbean societies as total social systems, and the underlying principles of thought and sentiment that articulate that social system. Wilson argues that within the society of Providencia there is a dialectic between the two opposed principles of respectability and reputation. Respectability, he argues is the concern of the ‘high class’ and it is socio-economic position that ultimately decides whether one has or lacks respectability. In contrast, Wilson proposes that reputation is an indigenous counter-culture based on equality and personal as opposed to social worth. He views reputation as a solution to the scarcity of respectability within indigenous Providencian society. However, by developing reputation, it may also be possible to increase respect in the eyes of others. Wilson continues:

*A man's reputation is the stimulus of other people's respect for him, and a concern for respect, for one's good name, is always smouldering. (Wilson 1973: 150)*

Wilson seems to suggest, in the above quotation, that reputation can also be fragile or damaged, by using the term, ‘smouldering’. Wilson discusses how reputation ‘must be earned and cannot be inherited’. This develops the egalitarian nature of reputation in that it can be worked at, is not coupled to inheritance and is potentially available to all. Reputation is a dynamic concept that reflects a process involving development, consolidation, disintegration and potential loss.

### 4.2.1 Reputation and ‘crab antics’

One way that reputation can be put at risk is through ‘crab antics’ (Wilson 1973). Crab antics behaviour, according to Wilson, involves ridicule and gossip in which reputation may be destroyed by words. Wilson describes this sort of behaviour as



purposeful and it is used as a levelling mechanism, to level claims to superior status. Crab antics are, therefore, a state of balance between reputation and respectability and prevent the establishment of any sense of superiority that could be linked with respectability, according to Wilson. Furthermore, crab antics behaviour identifies the importance of the peer group in evaluating, establishing and promoting reputation over respectability.

#### 4.2.2 Reputation and the peer group

Wilson develops the importance of the peer group by discussing how individual achievement is measured by and against the performance of one's peers on Providencia. The basis of a man's reputation may be fathering many children, musical ability, verbal skills such as the ability to argue and the ability to display knowledge and learning, according to Wilson. However, even those with prestigious occupations have to prove themselves according to the basic standards of reputation. Thus a schoolteacher will carry little authority until he has fathered children and can mix with the men in the rum shop and can compete with them when challenged. A mayor who fails to achieve a manly reputation has no credibility or authority:

*Respect comes to the man who secures his reputation and who carries out his role activities skilfully. (Wilson 1973:160)*

Skilful performance, judged by one's peers, is therefore essential to building reputation and respect within Providencian society. Curiously, Kanter (1989) a professor of business administration in the United States, develops a similar theme. She states that 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. She argues that opportunity in the professional form involves the chance to take on more challenging or rewarding assignments that require greater exercise of the skills that are the professional's stock in trade. Kanter continues:

*"Upward mobility" in the professional career rests on the reputation for greater skill. (Kanter 1989: 310)*

Therefore, to Kanter, the key variable of success in the professional career is reputation. She describes security in employment as developing from the accumulation of human capital in the form of skills and reputation. She describes

a shift going on within organisations to invest in reputation, which can produce more skilful and self-directed contributions. Kanter continues:

*In short, what people are increasingly working to acquire is the capital of their own individual reputation instead of the organisational capital that comes from learning one system well and meeting its idiosyncratic requirements. (Kanter 1989: 324)*

This discourse, related to skills is echoed in a study by Kinley et al (2001), which attempts to determine whether pre-operative assessment carried out by an appropriately trained nurse (ATN) is equivalent in quality to that carried out by a pre-registration house officer (PRHO). The researchers present data from an interview with a PRHO:

*Well, for everybody, the more skills you take on the more highly you're thought of. You need to get people maximising. I worked in America for a while and, where I worked, I didn't do bloods, ever, we didn't even put in cannulas – it was all done by nursing staff. (Quoted in Kinley et al 2001:29)*

Kanter goes on to discuss how the post entrepreneurial organisation is also more person-centred, with authority deriving from expertise and/or from relationships; in contrast to the hierarchical, status-driven corporation or bureaucracy. Wilson also discusses the importance of the person and his relationships as well as his skills. He describes how in each area a man may enjoy a degree of reputation for which there is no absolute standard, and as a whole person he is neither condemned nor elevated by any one status. There is no perfect singer or ideal father he points out. However, he concludes that such status scales are relative to a given time and the actual performances of people in that time and place. Thus, reputation and respect are social matters; they depend on the reciprocal evaluations of persons related to each other by commonly held standards within Providencian society. Power and authority in reputation arise, not from the imposition of external standards, but from the bestowal and withholding of social recognition in a matrix of relationships, according to Wilson.

### 4.3 Constructing reputation in a social space

Thus, I will argue that the palliative care team meeting is one of the social settings in which reputation arises. This is because reputation requires not only a means to be projected but also a social setting in which it may be constructed and displayed; the palliative care meeting is this site. Through the palliative care team meeting specialist nurses have a means to make visible their contribution to care. This space has risks as well as benefits to building reputation, as in Wilson's words; reputation is always 'smouldering'. In Wilson's study a man may boast about his virility in the public domain of the rum shop, for example; however, the social group can apply sanctions. Levelling constrains extreme claims to superior status, according to Wilson. Levelling, therefore is the socially constructed means by which someone is kept in their place

The Afro-Caribbean woman is overlooked in Wilson's analysis and Besson (1993) is critical of this, as it ignores the fact that women also compete for status among themselves and with men. Besson describes the community of Martha Brae in Jamaica, and how women participate in all the main dimensions of reputation discussed by Wilson. He argues that this includes entrepreneurial skills, procreation and verbal skills. Besson describes how women play a central role in a revival Zion cult based on Afro-Christian beliefs; two of the revival bands are led by women. One woman called Mrs K has a reputation as leader, prophetess and healer and has a network of alliances with other Zion bands throughout Jamaica. Besson describes how Mrs K's skill in testimony outshone her competitors. He writes about other ways that women also establish reputation; through entrepreneurial roles such as running a market stall, selling cooked food, running small grocery shops and a rum shop, all of which compete with similar establishments kept by men. Besson concludes, that women as well as men are concerned with the main dimensions of reputation. I conclude from this that palliative care nurses (on the whole women) will be very concerned with their reputation in the medical space. They will be concerned to develop, display and perform their reputation in the team setting and this enables one to study how such a reputation is constructed in this study through talk about pain, which I will argue is the main way they compete with non-specialist medical practitioners.

### 4.3.1 Managing one's reputation

In another study, Firth & Kitzinger (1998) discuss how women pay attention to, and manage their reputation, in this case through talk. Firth & Kitzinger (1998) collected data from 58 female school and university students who volunteered to participate in small group discussions about experiences of refusing sex. The data indicated that when talking about refusing sex, women worry about men's feelings. The researchers treat the data collected not as transparent evidence in support of emotion work theory but as a resource used by young women to account for their experiences, construct their identities, and to manage their reputations. What is of interest, they argue, is how women in interaction with other women talk about their own and their male partners' emotions and what such talk is doing in the context in which it is produced. Firth & Kitzinger discuss how these young women have specific investments in talking about the doing of emotion work, and that emotion work is used as a participant resource in self-presentation, and to achieve various interactional goals. Young women, according to Firth and Kitzinger are not just reporting on their own experience they are also attending to the expectations and responses of those to whom they are talking, managing their identities and accounting for their behaviour in socially acceptable ways. Therefore this talk is managed and negotiated to serve the interests of the participants. For example women can preserve their good reputation in relation to their sexual experiences through presenting men as emotionally vulnerable and damaged by refusal of sex. Goffman (1959) refers to this type of self-presentation as impression management. In a particular performance a person will be most concerned with the form of performance from which his/her reputation derives (Goffman 1959). By expressing their concern with men's emotional needs in relation to their reported refusal or acceptance of sex the young women avoid damage to their reputation in the context of the research situation. This demonstrates the socially constructed nature of reputation and the importance of face work to prevent damage to one's reputation in the public space of the interview. It also demonstrates the importance of reputation to these young women in this social context. Besson identifies the ability of women to develop reputation by developing similar skills to men in order to compete with them. Firth and Kitzinger demonstrate how women may also use their knowledge of men to position men as emotionally vulnerable and in so doing construct a reputation

for themselves as knowledgeable and in control. This latter aspect of reputation is important in relation to how talk constructs and positions those that are 'other' in a way that enhances one's reputation. This may mean that reputation talk within the palliative care team will position those that are 'other', such as non specialist practitioners and patients, in such a way as to enhance the palliative care teams reputation through talk-in-action.

There is some evidence in the context of chronic pain that patients may struggle to develop a reputation so that they may be viewed by doctors as credible and therefore be taken seriously by doctors (Werner & Malterud 2003). To be seen as credible, women with chronic muscular pain, work hard to make symptoms socially visible, real and physical in their consultations with doctors (Werner & Malterud 2003). This is an interesting study because the researchers attempt to understand the perspectives of the women when they present themselves in the medical encounter. These women perceived that to be taken seriously they needed to accomplish the physical nature of their pain. So the women in the study felt they had to fit with the normative, biomedical expectations of looking right in the face of medically unexplained pain. Thus patients also conform to an expectation that pain in the body is the key to medical attention and construct their presentation to fit in with this model and maintain a reputation as credible people in a biomedical context.

### 4.3.2 Reputation and social recognition

Wilson links reputation with power and authority. He describes how power and authority in reputation arise, not from the imposition of external standards, but from the bestowal and withholding of social recognition in a matrix of relationships. Wilson describes this power as arising from within and may provide one with an authoritative voice:

*A man lives to acquire a reputation, and having done so he can preach reform and improvement. In his personal life, with his reputation secure, a man seeks to establish his respectability – by marrying, by regularly attending church, by becoming a true believer, by giving up alcohol, and by living properly. (Wilson 1973: 185)*

However, the above may be a type of rhetoric related to alcohol use as Wilson also found that islanders who do not join in the rum shop culture find themselves socially ineffective. Therefore, if one is not part of the rum shop culture in

Providencia one cannot enjoy much authority. This appears to be because such people are marginalised. They do not have access to the means of building reputation and the social support necessary to this consequentially; they also lack power and authority. Kanter (1989) describes the importance of a team culture. She suggests that teams are one of the integrative vehicles that keep information, resources and support accessible. The resources of information and support involve power, according to Kanter. She also suggests that participation in teams, helps people have a broader outlook, more skills and ensures people have information beyond their limited purview. Therefore, working in teams may enable participants to enhance their reputation and their power by sharing knowledge. The sharing and distribution of knowledge may be an essential resource to a good team performance.

In the setting of the palliative care team meeting, members discuss their contribution to sorting out patient problems and symptoms such as pain. The team setting may also provide valuable rehearsal time for the future team performance with the patient and his/her family. This enhances the individual professional's reputation in the team but also serves to justify and maintain the team's reputation in the clinical setting as an effective clinical speciality with patients and other staff. The palliative care team meeting is also a space where specialist nurses present cases for discussion and is monitored by doctors and other health care professionals present. Prior (1998) discusses the work involved in health professional's construction of a case, which is discussed next.

#### **4.4 Constructing cases**

Prior (1998) draws attention to the ways in which the identification of cases involves more than simple matters of technical judgement and expertise vis-à-vis the autonomous human subject. Prior suggests that cases are produced in the day to day practices of health care professionals and 'caseness' is something imposed on subjects from outside according to practical and professional interests. Prior argues that the concept of case exists only in and through the mutual social relations and social practices of researchers, nurses and medical staff. White (2002) using an ethnographic approach to study social relations and case formulation in a child health service found that case formulations are highly contestable and require complex rhetorical work. White points out how case

formulations in child health are not just about clinical reasoning but also concern judgements on the adequacy of parental love. Clinicians' talk in the child health settings studied identifies three types of case formulation: the medical, the psychosocial and the 'not just medical'. This latter case formulation combines the purely medical with the psychosocial. White describes how a consultant produces a sophisticated and persuasive case formulation, which depended on his attention to detail in weighing up the evidence including measurement involving centile charts and scales of a child's weight and body measurements in a situation where his formulation could be contested. White describes how the consultant sets up a contrast between proper parental behaviour and a deviation from this:

*I don't personally believe that the maternal instinct, or whatever-. To have a child in the house of Sarah's age, not be able to feed her and not have any feelings of need to feed her. Most parents would not be able to tolerate that. They would be force-feeding the child, they would be beside themselves with worry about her not eating and there's none of that. She could go through a day and she would have 50mls which is less than two of feed in a whole day and she would not be anxious about her. (Consultant Quoted in White 2002:423)*

White discusses how the consultant's telling relies on strategies of argumentation and persuasion and behind the scenes forensic work. This is presented to an audience with a shared professional understanding along with the category entitlement of the doctor to bracket Sarah's medical problems. White concludes that attention to how clinicians tell cases tells us about science, professional 'know how' but also about how moral judgements exist as warrants for action. What is of interest to me in my study is how the palliative care team may construct cases. How cases may be constructed to build a certain type of reputation and the part played by specialist and hospice nurses in constructing a case and in so doing constructing a reputation for themselves and for the patient in the team setting.

There is some evidence that that nurse's conduct of care help initiate patients into the clinical domain, so those patients know how to conduct themselves as appropriate clinical material, and in doing so nurses occupy the same space as biomedicine (Latimer 2000). I think this work is interesting as it offers an alternative analysis to that suggested by the rhetoric of 'new nursing' and 'therapeutic nursing' discussed earlier. Latimer argues that the difference between nurses and doctors is that doctors do the frontstage work such as patient assessment and give the appearance that a medical decision is taken on a purely

clinical basis. Nurses, she argues, carry out the backstage work of observing, exploring and interpreting a patient's social situation and provide the context, which in turn affects the medical decisions. Thus together nurses and doctors configure a patients' identity. This alerts one to the importance of nurses in shaping the case and contributing to decisions in a manner that could be easily overlooked because of its backstage nature.

In contrast to Latimer, who describes the nurses working in the elderly care unit as doing the backstage work, I suggest that specialist palliative care nurses may be moving frontstage. This is because these nurses have a specialist identity and present the patient as a case in the palliative care team meeting (Chapter 6/7). Thus specialist nurses may capitalise on their biomedical knowledge and 'know how' but also on their knowledge of the patient and their psychosocial behaviour and demeanour. I am suggesting that the specialist palliative care nurse may be structurally positioned frontstage within the discipline of palliative medicine. Thus such nurses may be able to differentiate themselves as individuals, specialist nurses with particular skills and therefore build a particular identity and reputation in the biomedical space.

#### **4.4.1 Palliative care and reputation**

The United Kingdom Central Council (UKCC 1998) Health Care Futures Report identifies one of the likely characteristics of the future is both the demand for high technical competence and scientific rationality amongst nurses and a continuing need for human qualities and the time to express them. The report also identifies a demand for complementary approaches. Palliative care appears particularly well placed to address these concerns (Li 2001, Garnett 2000, Lawton 1998, Froggatt 1995, Hunt 1989). Clark (2000) is optimistic, but cautious of what the future for palliative care holds. He describes how the palliative care movement has become accepted and incorporated into mainstream health care and this he argues is a measure of the success of the palliative care movement, rather than a dilution of its original mission (James & Field 1992). However, he is cautious in relation to how palliative care will continue to achieve and resolve the balance between pain and symptom control as well as the spiritual and psychological issues concerning those with advanced disease. There is support for Clark's concern regarding the hierarchy of care identified within Australian palliative care that prioritises the



management of pain and physical discomfort (McNamara 2004). Hence medical problems with symptom control are prioritised within the setting studied by McNamara as there are effective means of achieving certainty and control with such symptoms. McNamara concludes that practitioners are less likely to act with such certainty in relation to psychological, social and spiritual distress and there may be inaction around these problems. These issues are of interest to me and it is important to understand how specialist and hospice nurses construct cases and the components of their reputation.

## 4.5 Conclusion

A theory of reputation, applied to the work of the palliative care team, enables one to understand how the palliative care team works together as a social system. The palliative care team meeting is a site where reputations are constructed by specialist nurses in relation to their medical knowledge and 'know how' in symptom management. Thus, how such nurses contribute to talk and present cases presumably may reflect the prioritisation of the physical over psychosocial and emotional concerns as biomedicine is the reference system of the team. Together, I argue, the team develop their reputation through talk-in-action. The team setting provides a social space for the construction of a team reputation, despite the different professional identities of the team members. 'Crab antics' is a potential tactic to discourage over zealous claims on reputation and may bring the balance between the team performance of reputation and the individual performance of reputation and overcome professional hierarchies associated with respectability and deference. Team talk-in-action enables the positioning of the palliative care team in relation to 'other' health care professionals. It is also useful, I think, to consider how potentially problematic patients with unresolved symptoms may also be positioned in relation to the team reputation. The team reputation and the patient reputation could be in tension I suggest particularly if pain and symptoms are difficult to control.

An analysis of reputation work enables one to explore how this group of diverse healthcare professionals, with different statuses and hierarchical positions within the health care system, work together to achieve their goals. For specialist nurses, the team setting and their role within it enable their contribution to palliative care to become visible. The palliative care professionals seem to get their work done by

monitoring each other in the team meeting and building their reputation as individuals and as members of a team with particular expertise and skills in palliative care, through talk. There is a degree of mutual dependence, within these teams that a first glance appears to cut across professional tribal allegiances to enable collaborative and collegial work. A key resource in the development of reputation is in the social construction of themselves and their patients through the cases presented and interpreted in the team. Within these teams nurses have colonised a space in which they can perform their reputation through the control of symptoms and this builds their reputation with medical staff. It remains to be seen how nurses continue to balance the human qualities and high technical competence identified for the future (UKCC 1998), and the priority given to each of these issues. In the next section I bring together my research questions resulting from the literature reviews.

## 4.6 The research questions

The aim of this research is to understand how palliative care teams (PCTs) talk about pain and the professional discourses used when talking about pain. I am also interested in how the patient is constructed in the talk of the team and how professional boundaries around such talk are made and unmade. I am particularly interested in the performance of the specialist palliative care nurse and the hospice nurse in terms of how they produce a 'new nursing' identity. My intention is to discover how the discourses about pain are produced, to try to unravel the status of the 'total pain' concept and to begin to understand how specialist nurses display their competence and credibility in the medical space of the team meeting.

Specifically, I would like to find out:

- What is talk about pain concerned with?
- How does the palliative care team construct the patients' experience of pain?
- How is pain talk a platform for specialist nurses to display their expertise and how are the boundaries of pain talk shaped?
- What is the significance of reputation to the talk of the team?
- How is the concept of 'total pain' orientated to in the talk of the team?

## **Chapter 5 Research Design and Methodological Choices**

## 5.1 Introduction

In this chapter I present a critical discussion of the rationale and justification for my research design. I explore the factors that influence my methodological choices. I reflect on how my thinking about the research sharpened and focused down on to talk about pain. I locate my research as influenced by an ethnographic perspective, but informed by ethnomethodology and techniques taken from linguistic analysis. I am reflexive about how I negotiated entry into the research sites; how my role as an observer may have influenced and shaped the data collected; and how I was positioned in this field of study as a type of ‘insider’. I discuss how I maintained good field relations by self-management techniques. Data collection and data analysis are discussed as proceeding together. The methods and tools used for analysis are described for each stage of the research. Issues regarding consent, confidentiality and validity are critically explored.

### 5.1.1 The aims of the chapter

- to justify methodological approaches in the light of other approaches open to me
- describe the study setting, how the data were collected and analysed using grounded theory, linguistic and conversation analytic techniques
- present a reflexive account of relations in the field
- discuss critically reliability and validity

## 5.2 Getting started

I am interested in the hospice and palliative care concept of ‘total pain’. I have therefore constructed a study within the medical speciality of palliative care with a focus on how the palliative care team talk about pain. In designing my research I was concerned with:

- Gathering data with minimum disruption to work routines
- Avoiding the situation where I was exposed to the rhetoric of palliative care rather than the practices which occur in these settings
- Avoiding the danger that my presence would interrupt the work of the staff
- Avoiding the danger that I would cause any undue distress to staff/patients by being an observer

The concerns and constraints identified above are what I perceived to be important in designing my research. I sought to take a critical and sceptical stance toward

texts and practices concerning pain in palliative care. My empirical approach concerns how palliative care professionals construct patients' pain through their talk and the resources they use to do this.

In the early days of my research I framed the study within the naturalistic<sup>6</sup> paradigm of an ethnographic study. My intention was to spend time in the research field observing as much as I could of the action in relation to the problem of pain. I began to explore palliative care in the hospital settings, to see how I would be best placed to research the phenomenon I was interested in. I spent time with hospital palliative care staff accompanying them on ward rounds, talking to them about their work and observing what they do. Gubrium & Holstein (1997) describe how attending to what informants tell you and beginning to understand what things mean to them is part of a naturalistic approach to research.

Mason (2002) says that in formulating one's research there are two issues to be answered. Firstly formulating a methodological approach while recognising that other approaches might have been possible and, secondly, knowing why you have rejected them. I therefore wish to address these two points in relation to my research. As I carried out initial explorations in palliative care settings I found it difficult to take detailed field notes of what was said, as often I had to write my field notes after I left the setting. I felt my field notes were impressionistic, lacking the detail of audio-recorded data for example. These notes depended on my recollections of events and memory of the words spoken. I gradually began to realise that if my focus was to be talk about pain, I would need to focus on settings where such talk takes place and to use an audio-recorder, so such talk is recorded and accurately represented. I was becoming interested in issues concerning the negotiation of palliative care work and professional identity. I was also interested in how team members negotiated decisions about patients' pain and how the division of labour was relevant to these decisions.

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<sup>6</sup> Naturalistic/Naturalism proposes that the social world should be studied in its 'natural' state so that one describes what happens in the setting and how people see their actions and those of others (Hammersley & Atkinson 1995).

One of the difficulties of the naturalistic approach is that of maintaining ‘distance’<sup>7</sup>, for example by getting up close to the action one might overlook the more interesting aspects of what is going on (Gubrium & Holstein 1997). The issue of distance is important. As a nurse I am familiar with the medical world, its specialised language and culture and I feel at home in this world. This familiarity, I reasoned, might blind me to certain aspects of the setting that I took for granted. Thus a method that would enable me to get ‘up close’ to the talk but also ‘step back’ so that a sociological eye is cast on how everyday realities are experienced and communicated was important (Gubrium & Holstein 1997). I wanted to get close to the action but not to overdo it. Thus my focus is the fine grained detail of how the palliative care team construct a world of experiences and give accounts to each other about these experiences, as an everyday accomplishment. I sought to research a slice of the social world of the palliative care team; a snapshot of how talk-in-action shapes this social world. The setting of the palliative care team meeting provides a slice of the action, a space where interprofessional talk related to pain work could be researched in microscopic detail through audio-recordings of talk-in-action. In constructing my research in this way I was moving away from researching the ‘natural’ world of participants’ actions and meanings, to one that tries to discover how such worlds are constructed (Gubrium & Holstein 1997).

### 5.2.1 Placing the study

The concern with the everyday, and the resources members use to construct the everyday is part of the approach called ethnomethodology. In an ethnomethodological approach to research there is a concern for the ordinary, everyday procedures and practices that society’s members use to make their social experiences sensible, understandable, accountable, and orderly (Garfinkel 1967). This approach moves the focus of research from the meaning of events, situations and experiences to focus on how the everyday, the ordinary, are accomplished in practice. Heritage (1984:2) says that the emphasis on the local, the moment-by-moment accomplishment of meaning in social contexts enables one to take the ‘actor’s definition of the situation’. This frees one from taken for granted

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<sup>7</sup> Gubrium & Holstein (1997) say that terms like “suspending” and “bracketing” describe ethnomethodology’s need to distance itself from the life world of subjects. This “bracketing” is especially necessary for objectivity when the researcher is studying one’s own tribe, according to Pollner (1987).

assumptions about what happens in these spaces, so one can focus on what members are accomplishing in and through their talk. This is a micro approach to social action rather than a macro approach.

Miller (1997) argues that we should construct a bridge between the theories of social life that concern macro and micro issues. He believes it is possible to respect the different contributions of each perspective but to link rather than blend them. Hence the metaphor of the bridge. Miller contends that ethnomethodology and discourse studies provide the interpretative resources for writing ethnographies of institutional discourse because they focus on the ways in which everyday life is organised through language (Miller 1994). As my interest is on how palliative care professionals talk to each other, in an institutional setting, about patients under their care, it is perhaps possible to place my study loosely within the remit of an ethnography of institutional discourse (Miller 1997).

Wolcott (2001) writes that a study that is influenced by an ethnographic approach<sup>8</sup>, is not the same as a study informed by these approaches. I therefore frame my study as influenced by ethnographic concerns to the extent that I have 'first-hand experience' of a setting, and make use of observational methods (Agar 1996). However I cannot say that I got 'right inside' the setting and in this sense I have been selective. For this reason then, I cannot claim to have undertaken ethnography in the sense that it is usually represented in academic texts (May 2002, Wolcott 2001, Hammersley & Atkinson 1995). I have researched a particular space for medical action and talk-in-action, namely the meetings of the palliative care team. I cannot make any claims for talk that occurs in other settings such as conversations in corridors between doctors and nurses, in backstage areas such as coffee bars and rest rooms and other conversations with patients such as those occurring in ward rounds and nurse to nurse handovers. I have not asked these practitioners to tell me about their work with patients. So the meanings they associate with such work are not a perspective that I can make claims about.

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<sup>8</sup> An ethnographic approach is a method, which characteristically involves the ethnographer participating in people's lives for an extended period of time (Hammersley & Atkinson 1995). However Hammersley & Atkinson acknowledge that the boundaries around ethnography are unclear so distinctions between ethnography and other sorts of qualitative inquiry can be difficult to sustain.

I use a grounded theory approach to the data (Glaser and Strauss 1967, Strauss and Corbin 1998). This is followed by further in-depth analysis using techniques taken from linguistic analysis.

### **5.2.2 Grounded theory perspective**

The grounded theory approach emphasises the inductive generation of theory from data (Glaser & Strauss 1967, Strauss & Corbin 1998). Seale (1999) says that the grounding of theory in data is important in achieving the aim of supporting claims with credible evidence. Thus according to Seale data and theory statements are interdependent and theory can be generated from close examination of the data, as well as the other way around. In this sense the process is iterative with data and theory informing each other. I use techniques taken from grounded theory to sensitise me to what my data is about. I also use the principle of data collection and analysis proceeding together, also a feature of grounded theory (Murphy et al 1998, Glaser & Strauss 1967). My approach is comparative as I have collected data in two settings and I identify deviant cases. Within this approach I have utilised some quantification such as word counts. Such a quasi-quantitative approach enables a sense of credibility and confidence in the findings and safeguards against criticisms of subjectivism and impressionism in the claims that I make (Seale 1999, Silverman 1993). The use of quantitative techniques also requires one to check the whole of the data set to provide a measure of the evidence for the claims made. The use of quantitative techniques enables a comprehensive approach to the whole data set. Following initial analysis of the data I used tools taken from linguistic analysis to break the data down further, which will be discussed next.

### **5.2.3 Linguistic analysis and conversation analysis**

Atkinson (1995) describes how he came to think of medical work in terms of rhetorical skills and narrative performance. He analyses how medical practitioners use rhetorical skills to situate their competence and credibility (Atkinson 1994). Wetherell (2001:17) writes that the notion of rhetoric is functional and persuasive 'to win hearts and minds'. She continues that the study of rhetoric is the study of persuasive work and the organisation of work to that end. I have drawn on the work of a number of researchers to enable me to analyse the rhetorical aspects of



talk and how such rhetoric has functional and organisational significance (Atkinson 1994,1995,1999, Prince et al 1982, Hargreaves 1981).

By analysing how accounts are constructed it is possible to understand how reality is constructed in the culture studied (Coffey & Atkinson 1996). For example accounts can be used to mitigate, such as use of excuses or to neutralise such as justifications for actions (Scott & Lyman 1968). Accounts need to be plausible and persuasive and accounting devices open up a level of potential analyses (Coffey & Atkinson 1996). By analysing accounting devices one can begin to understand how excuses and justifications are used when lapses in competence occur. These accounting devices enable the analysis of how social cohesion and collegiality is sustained. Thus I have focused on how accounts involving excuses and justifications enables the palliative care team to justify and attend to problematic practice and enables one to understand how tensions in professional practice and interactions are handled.

I have utilised conversation analytic techniques to explicate on a turn by turn basis how social action is possible and interprofessional work accomplished (Silverman 1998, Sacks 1984). Conversation analysis (CA) emerged during the 1960s with the work and collaboration of Harvey Sacks, Emanuel Schegloff and Gail Jefferson (Heritage 2001). Sacks (1984:413) was concerned with the fine details of 'naturally occurring conversation' and the development of a 'technology of conversation'. Thus CA is concerned with the study of recorded, naturally occurring talk-in-interaction and how participants both understand and respond in their turns at talk and how sequences of talk are generated (Hutchby & Wooffitt 1998). The goal of conversation analytic research is related to uncovering the competencies that ordinary speakers use and rely on in participating in interaction (Heritage and Atkinson 1984).

Talk-in-interaction (Schegloff 1987) is the major means by which people pursue practical goals in the work situation and conduct working activities (Drew & Heritage 1992). Drew & Heritage propose that interaction is institutional in respect of how institutional or professional identities are made relevant to the work activities in which people are engaged. I felt that research into talk-in-interaction would enable me to understand how the identities of nurse, doctor and social worker may be accomplished. I was interested in how such identities are

brought front stage<sup>9</sup> and kept back stage<sup>10</sup> to accomplish organisational goals. The study of the organisation of conversation is said to be central to understanding social interaction as well as for elucidating social structure as an everyday, practical accomplishment (Garfinkel and Sacks 1970). Thus I felt that the study of the micro aspect of talk-in-action may open up a theoretical perspective on how work is negotiated, and the consequences of this for the division of labour in palliative care practice and how the boundaries around such negotiations are shaped.

The advantages of using techniques taken from CA is that it produces reliable information and the method advances in an inductive fashion (Seale 1999, Alasuutari 1995). However, there are some disadvantages. For example everything has to be based on the material made available to the participants during the conversation and explicitly referred to by the conversationalists (Alasuutari 1995). Alasuutari makes a distinction between pure and applied CA. In pure CA one studies the rules of conversation, the procedures of talk-in-action (ten Have 1999). In contrast applied CA ‘involves CA-like practices which are carried out within a framework guided by different, let’s say ‘wider’, concerns’ (ten Have 1999:161). Thus according to ten Have one can make further observations from qualitative data, which may be used as clues in addressing social phenomena. This latter perspective is closer to the way I use CA.

One of the claims made for CA is that one can demonstrate that institutional contexts are ongoing accomplishments of co-participants rather than due to external constraints, which result in certain forms of conduct (Hutchby & Wooffitt 1998). This approach then offered the possibility of researching how the palliative care team as a social unit constructs talk about patients that blends medical, social, professional and cultural aspects and give clues to how such social action is possible. I will now discuss how I chose the research settings and negotiated entry to the research sites.

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<sup>9</sup> Front stage - a theatrical metaphor used by Goffman (1959) which situates individuals as similar to actors who perform ‘front’ stage to give their audience a good show and to convince the audience they are who they claim to be. This is part of what Goffman describes as ‘impression management’.

### 5.3 Choosing and negotiating the research settings.

Initially I looked for three sites for the research including a hospital, hospice and community palliative care team setting. Two of the settings I approached proved difficult to access. I arranged to meet with a hospital palliative care nurse at a local District General Hospital (DGH) to discuss the possibility of undertaking my research on this site. A colleague had recommended this site to me. There had been recent staff changes and the hospital palliative care nurse was new to the post. I felt he was not keen on research. I was not sure why. Perhaps he felt intimidated by the thought of research. I therefore decided not to pursue entry to this site. This experience made me realise that I should start with a ‘top down’ approach to entry rather than a ‘bottom up’ approach, through individual practitioners. I approached another hospice in London. Following two meetings with gatekeepers they verbally agreed to my using the hospice to undertake my research. When the time came for me to be able to undertake the research the hospice had undergone major change and my sponsors were now in different jobs. Although the hospice was still willing to consider my research I decided that that this was probably not a good time to be going into this setting.

All the names of people and places referred to in this thesis are fictitious. Through my work<sup>11</sup> I had contacts with a hospice on the outskirts of a large city. I had successfully negotiated to have student nurses gain clinical experience in this hospice setting. I made an appointment to meet Jenny the Hospice Matron at Rosebury Hospice to explain my research interest. Jenny was very helpful and sympathetic to my research. She set up a meeting for me, with the hospice Medical Director and his deputy. During this meeting I gave an account of my research and Jenny acted as an advocate for my project. Both of the doctors were prepared to help me. The Medical Director Matthew had a joint post as a consultant with a local DGH which I have called Oakwood. He agreed that I could attend the palliative care team meetings in this setting. This would enable me to have access to both the hospital palliative care team and the community

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<sup>10</sup> Back stage – this is the region where the impression fostered by the performance may be contradicted and front can be dropped (Goffman 1959).

<sup>11</sup> I was a Lecturer in Cancer Nursing at Kingston University, at this time.

palliative care team that served this locality. This was a small hospital palliative care team with a slightly larger community team (Table 1 & Table 2)<sup>12</sup>. The staff in this setting were very welcoming and friendly towards me. They seemed to have no problem with my presence as far as I could tell. This setting provided the data for the first phase of the study (Figure 3)<sup>13</sup>.

Later in the course of my research I became involved with another hospice which I have called Karamea Hospice, again negotiating for student nurses to have a clinical placements in the hospice. I had arranged to meet Fiona the Hospice Matron, for lunch at a local restaurant, to discuss the possibility of clinical placements. I decided I would take a risk and ask Fiona if I could undertake research in the hospice. I felt that this was potentially a risky situation as I was negotiating for not one, but two things, and clearly if my request was turned down my difficulties in finding another research site would continue. During the lunch I plucked up the courage to ask Fiona about the possibility of undertaking my research in the hospice. Fiona to my great relief was extremely encouraging and positive. Conveniently she was married to the Hospice Director Tom Jenkins and she gave me his home phone number. I rang Doctor Jenkins a couple of days later and he was very agreeable and positive. He arranged for me to sit in on one of the hospice multidisciplinary team meetings and gave me time to introduce my agenda. At this meeting he seemed to be smoothing my way introducing me to various members of staff. The numbers of people involved in the meetings on this site were much larger than on the first site (Table 3 & Table 4)<sup>14</sup>. There were many more people to meet on this site including social workers, receptionists and health care assistants. Doctor Jenkins arranged for me to speak to two members of staff the team leaders on their own.

I felt that the hospice team leaders were a type of gatekeeper and that I needed to gain their co-operation with the study. I found them to be more concerned with who I was than in what I wanted. I told them about my research and that I was a nurse. They quickly found out from me that I lived nearby, that I had children and

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<sup>12</sup> Table 1 & 2 is on page 94

<sup>13</sup> Figure 3 is on page 97

<sup>14</sup> Table 3 & 4 is on page 95/96

the children went to local schools. So I felt I was situated as someone a bit like them, a nurse and mother, and maybe this was important to reducing social distance and my acceptability to them. They were not going to put any obstacles in my way; they wanted to help me I felt. Doctor Jenkins also introduced me to the community team nurses who occupied a different part of the building. To my surprise one of the community team nurses Anna recognised me. She had taken a course at the university where I work and Doctor Jenkins said 'she speaks well of you one good turn deserves another'. Anna was very positive about the research. She was going to help me arrange and negotiate the practicalities of the situation, when to come in, the timing of meetings.

I seem to have got into these settings because of my professional contacts. I felt that I needed to be very careful about issues of consent. For example as I was going to be audio-recording team meetings this could be very worrying to some staff and their consent would need to be sought on each occasion.

### **5.3.1 Consent and confidentiality**

I prepared a short written proposal explaining my research that I presented to official gatekeepers in the institutions approached. I also applied for ethical clearance through the local Ethics Committee that served one of the research sites. I was not required to attend the meeting of the Ethics Committee and the research was given chair's approval (Appendix 1). On each of the research sites I made it known that I had gained ethical approval from the Ethics Committee and this seemed to satisfy gatekeepers. When I talked to the participants in the research settings I gave them a written account of the research (Appendix 2). I made promises that I would respect confidentiality, privacy and anonymity. I promised to disguise the identities of participants and the location of the research. Hence all locations and identities of staff have been anonymised and disguised. I said that if there was anything happening in the meeting that they did not want recorded to indicate to me and I would turn the tape recorder off. If somebody new was attending the meeting, I talked to them about the research and sought their permission for the audio-recording. So I did not take consent as a once and for all issue, but negotiated this on each occasion. No one ever refused to allow me to audio-record the meetings or their contribution to the meeting. On one occasion I

was asked to turn the tape recorder off when one item was discussed in the hospice.

I attended meetings on all the sites before I used the audio-recorder, to enable participants to become a little familiar with me so they would not feel overly anxious about being audio-recorded.

### **5.3.2 Maintaining access and acceptability**

I had two concerns about going into the palliative care settings to carry out research. Firstly, I could be attributed with an identity as some kind of expert. If this identity was going to be attributed to me I didn't think I could bring it off. Of course I am familiar with aspects of hospice and palliative care but my own nursing experience is with patients with cancer. I have not worked in a specialised palliative care culture or hospice. I therefore consider myself an outsider within this context. Secondly, it may be thought that I was in some sense overly inquisitive and/or attempting to evaluate the work going on in such settings. To combat the potential for these concerns surfacing I worked to appear relaxed and agreeable. My goal was to enable all levels of staff to feel comfortable when I was around. I also got to know the people on the hospice reception desk. I explained who I was and what I was doing so they got used to me coming and going and sometimes sitting in the reception area.

I decided to carry off the research role by working at a demeanour of approachability, and to push the help I needed from them to accomplish my research. Coffey & Atkinson (1996) say that one cannot control how others perceive your participation. I agree with this but I believe you can manage it. My impression management was an outward demeanour of being friendly, to watch and listen, greet people, and to use good eye contact. I decided not to ask too many questions, as this in itself might be perceived as threatening to some people. This self-management did shape the data and meant that I would concentrate on team talk and avoid asking too many questions unless invited to do so. I worked at my non-verbal behaviour and attempted to look engaged, animated, alert and interested in everything that was going on. This enabled me to have a degree of acceptability in such a setting I believe.

I was treated as a type of insider<sup>15</sup> in both the research settings. There were two occasions when my insider status was revealed to me and also my identity as a nurse, and one occasion when I was reminded that I was an outsider. I visited a patient with the community palliative care nurse Anna. When this visit was discussed in the team meeting Anna sought my opinion about the visit. I believe I was being addressed as a nurse. I felt totally wrong footed by this request. I could not frame a reply that I thought would be satisfactory, in effect I went blank. This was uncomfortable for me and I felt tense. I got over the incident by encouraging Anna to continue to tell the story herself. The story was told with some humour and there was laughter about the situation we had found ourselves in and my reported reaction to this situation. This incident made clear to me the tension of being in a marginal place balancing involvement with detachment and I think this is what caused the feeling of discomfort (Adler & Adler 1994). I did not think I could maintain objectivity if I started to take on a status as a type of insider. Coffey (1999) says a researcher who cannot stand back from the knowledge they have acquired may face analytic problems. I had not planned on being part of the action but clearly in this situation it was difficult to control. Kirk & Miller (1986:7) refer to participant observation as an 'oscillating situation'. The oscillating uncertainty on this occasion was around, which identity was going to be given, or withheld and the fact that I had to react in an appropriate manner.

On another occasion there was some sensitive talk around criticism of a hospital consultant and the community palliative care nurse indicated that she was aware of the audio-recorder. I leaned forward ready to turn the audio-recorder off. The nurse allowed the audio-recorder to continue to run. I felt I was trusted to record such sensitive talk and perhaps this reflected my acceptance as a type of insider. I was asked to turn the tape recorder off on one occasion. This was a 'delicate' situation concerning a family problem on the hospice site. I did not record anything in writing about this situation. On this occasion my outsider status was being managed and attended to by the hospice sister Beth.

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<sup>15</sup> Gerrish (2003) says that nurse researchers undertaking observation are in a privileged position because of their parallel status as researcher and nurse, which can assist them in gaining access but also in establishing rapport. The blurring of boundaries between the identities of researcher and nurse by participants may enable the researcher to be considered a type of insider.

## 5.4 The research settings

The setting for the first phase of data collection is the hospital palliative care team (HPCT) at Oakwood District General Hospital (DGH). Oakwood DGH is in an affluent area, on the outskirts of an urban area. The hospital has 350 beds and the HPCT cover all areas of the hospital, including outpatients, accident and emergency department and all the hospital wards. I was told that the HPCT visit approximately 15 to 20 patients a day and they see in the region of approximately 600 patients per year.

The HPCT team is based in a temporary building (a portakabin) in the grounds of the hospital. The team comprises two hospital palliative care nurses Liz and Amy, a part time secretary Sue, and Matthew the consultant, who spends half of his time at the DGH and the other half as a Medical Director of Rosebury Hospice, and a Hospital Chaplain Emma (Table 1). A social worker had been attached to the HPCT but due to financial constraints this post had been withdrawn. The hospital palliative care nurses meet with the consultant and chaplain once a week.

<b>Hospital Palliative care meeting</b>	<b>Meeting 1</b>	<b>Meeting 2</b>
Specialist Community Nurse	0	1
Consultant	1	1
Hospital palliative Care nurse	2	1
Chaplain	0	1
Number of patients discussed	11	16

**Table 1 Staff present at meetings and number of patients discussed HPCT Oakwood DGH**

Linked to Oakwood DGH is a community palliative care team (CPCT), which covers the locality around the DGH. The CPCT nurses are based at Rosebury Hospice, but they meet with the consultant and the hospital palliative care nurses once a week at Oakwood Hospital (Table 2). Each community palliative care nurse had a caseload of approximately 42-52 patients.

<b>Community palliative care team meeting</b>	<b>Meeting 1</b>	<b>Meeting 2</b>
Specialist Community Nurse	3	2
Consultant	1	1
Hospital palliative care nurse	2	2
Number of patients discussed	43	44

**Table 2 Staff present at meetings and number of patients discussed CPCT Oakwood DGH**



The HPCT meet in a fairly large office space with desks around the walls. The meeting with the CPCT is in another part of the portakabin, which is less like an office and has comfortable chairs and medical books on display. The first day I arrived at this setting I was warmly welcomed by the nurses and offered coffee. The consultant Matthew was writing a letter of complaint to the Chief Executive of the hospital. This complaint was about the withdrawal of the social worker from the team. Matthew told me that he was very annoyed and perplexed about the withdrawal of the social worker from the team. Table 1 and Table 2 identify the numbers of staff present at the meetings and the number of patients that were discussed at the meetings.

The setting for Phase 2 of the study was Karamea Hospice. This is a purpose built single story hospice with 15 beds. In reality there are 14 beds as bed number 13 does not exist due to superstition around the number 13. There is a warm and homely feel to this hospice. When I entered the hospice I could hear the sound of laughter and music from the day care centre, which was situated to the right of the entrance hall. In the entrance hall is a reception desk with a friendly receptionist and a small shop selling cards and other items. There is a comfortable armchair for visitors to sit in and magazines to read. The hospice has a Medical Director called Doctor Jenkins and a Matron called Fiona. There is a Senior Registrar called Michael and the ward team is headed by a Sister called Beth. There are two team leaders who co-ordinate the day-to-day running of the ward. The staff attending the hospice multidisciplinary team meetings are identified in Table 3.

<b>Hospice meeting</b>	<b>Meeting 1</b>	<b>Meeting 2</b>
Specialist Community Nurse	0	1
Consultant/Registrar	1	1
Hospice Nurse/sister	6	8
Social worker	1	1
Health care assistant	2	2
Volunteer nun	0	1
Number of patients discussed	14	14

**Table 3 Staff present at meetings and number of patients discussed Karamea Hospice**

There is a large community team based at Karamea Hospice headed by a Senior Nurse called Barbara (Table 4). Each specialist community nurse has a caseload of between 40-50 patients. I was told that occasionally individual nurses had over 50 patients on their books.

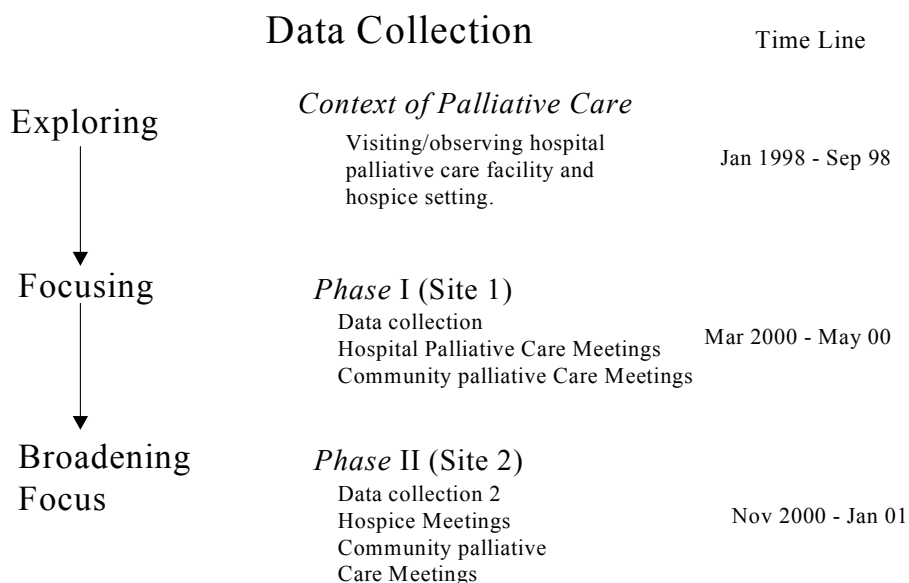
<b>Community team meeting</b>	<b>Meeting 1</b>	<b>Meeting 2</b>
Specialist Community Nurse	4	4
Consultant/Registrar	2	1
Social worker	1	0
Number of patients discussed	7	12

**Table 4 Staff present at meetings and number of patients discussed CPCT Karamea Hospice**

The meetings lasted between 60 minutes and 90 minutes. The meetings at Oakwood site did not have a social worker in attendance (Table 1 and Table 2).

### **5.4.1 Data Collection**

There are three stages to the research, which I have named exploratory, focusing down and broadening focus (Figure 3). The exploratory work within palliative care settings started in January 1998 (Figure 3). I carried out a number of observations in hospice, hospital and community palliative care settings. This amounted to approximately five visits/observations over a period of nine months. This gave me a feel for the different settings and a chance to talk to the practitioners involved, including palliative care doctors, specialist nurses, hospice nurses and social workers. I was able to make observations of how the work was structured and how they met together and went on visits and ward rounds. Purposive sampling concerns how one should think critically about the population one is interested in and chooses the sample and setting to suit that interest (Mason 2002). It is important therefore to choose a sample where the processes one is interested in are most likely to occur (Denzin & Lincoln 1994). I made a decision to focus down on palliative care and hospice multidisciplinary meetings. This would enable me to focus on pain talk as pain was a predominate concern at such meetings.



**Figure 3 Data Collection**

The process of focusing is described by Hammersley and Atkinson (1983) as a funnel structure where one develops the research problem but also begin to clarify the scope of the study. My study was developing at this time with the following design features:

- qualitative, using observation
- collecting naturally occurring data from palliative care team meetings
- comparative across two sites
- two phases of data collection

I audio-recorded<sup>16</sup> 8 team meetings of hospice and palliative care professionals between March 2000 and January 2001. I audio-recorded two meetings of the hospital palliative care team and two meetings of the community palliative care team in phase 1 of the study (Figure 3). I transcribed the tapes myself soon after the meetings. The first four audio-recordings were transcribed before phase 2 of the study commenced. I transcribed all the meetings verbatim. I borrowed a transcribing machine that enabled me to slow the tape down and this assisted with producing an accurate transcript of the talk. Silverman (2001) writes that there is no such thing as a perfect transcript and everything depends upon what you are trying to do in the analysis, as well as upon practical considerations involving time

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<sup>16</sup> I used a Sony cassette-corder TCM-459V with a microphone extension.

and resources. Heritage & Atkinson (1984) say that the production and use of tapes and transcripts are essentially ‘research activities’ they involve close repeated listening to recordings, which reveal previously unnoticed recurring features of the organisation of talk. Transcripts have an advantage because they are a public record, they can be replayed and transcripts improved, and they preserve sequences of talk (Silverman 2001). By listening to the tapes repeatedly, during the process of transcribing, I became very familiar with the content of the talk. My initial impression of the talk was how medical and technical it was. Certain patients had a lot of talk constructed around their troubles and others very little talk. The nurses in all the settings presented the patients within the meeting and seemed to do a great deal of the talking.

## 5.5 Methods of data analysis

Qualitative analysis according to Alasuutari (1995) is a means to explain or make sense of a phenomenon. He calls this ‘riddle-solving’. To begin to solve the riddle of my data or to begin to make sense of my data I used the following techniques:

- analytic induction using open coding to generate concepts and categories
- theoretical sampling
- constant comparative method
- deviant case analysis
- quantification by use of word counts

Seale (1999) says that methodological awareness contains a commitment to show as much as one can of the procedures and the evidence that leads to particular conclusions. I undertook a detailed line-by-line analysis of each transcript and made notes in the margin of the transcript. I analysed the HPCT meetings first followed by the CPCT meetings. My supervisor also read the transcripts and made notes in the margin of the transcript. I came up with a series of ‘noticings’<sup>17</sup>. By using analytic induction I was able to identify recurring patterns of talk involving criticism of non-specialist practitioners, for example. According to Murphy et al (1998) this inductive process avoids the imposition of theories and concepts and

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<sup>17</sup> ‘Noticings’ the unremarkable, unnoticed incidental details of daily life (Gumperz 1992)

enables one to develop analytic categories on the basis of observation and description of social phenomena.

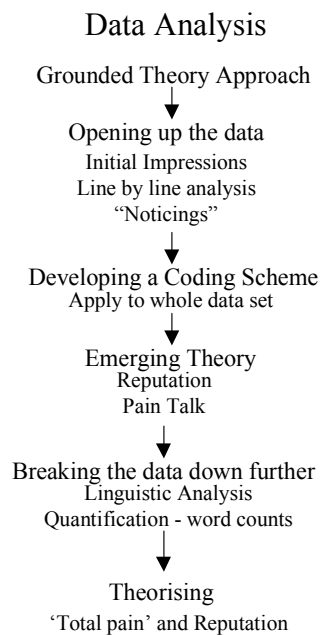
With the help of my supervisor the 'noticings' were entered into Word, printed out and cut up. We then went back to my research questions and established the categories of interest, which became 7 category headings or codes (Appendix 3). These codes were relevant to my research questions but also derived from the data. For example one of the codes was concerned with the concept of 'reputation' and this concept had been generated from the data. I subsequently applied the coding scheme to all eight meetings.

I entered all the data from the eight palliative care meetings into NVivo and applied the coding scheme to the whole data set. Seale (2000) says that one of the advantages of using computers to analyse data is the speed at which such programmes can carry out sorting procedures. Computer assisted qualitative data analysis (CAQDAS) enabled me to retrieve the data according to the code assigned. So I could retrieve all the talk about pain for example and as I also identified the professional group of the person I could also retrieve talk about pain according to professional group. This enabled me to carry out a comprehensive data analysis according to category across different research sites and professional group. I also used NVivo to carry out word searches and counts of phenomena such as instances of criticism and to search for particular words within the data.

Theoretical sampling is the process involving manipulation of data generation, analysis, theory and sampling activities during the course of the research (Mason 2002). Theoretical sampling guides one in to think about one's 'intellectual puzzle', and to shape that puzzle in different ways (Alasuutari 1995, Mason 1996). I decided, as discussed earlier, to enlarge my puzzle or broaden the scope of the study by including a hospice site in phase II of the study (Figure 3). This gave me access to hospice nurses and social workers and enlarged my sample significantly.

Mason (2002) cautions against selecting cases which are likely to support your argument. One way to avoid this is to search for negative instances, which challenge one's theory (Silverman 2000). By using the constant comparative method and deviant-case analysis I was able to test out provisional hypotheses

(Silverman 2001). A hypothesis that emerged from my data was that the ideal patient for palliative care was a patient with cancer and a symptom such as pain. I searched all the data set to see if this hypothesis could be contradicted. I did not find a negative case that could contradict this hypothesis. This search for deviant-cases enables one to have confidence in the emerging theory. Deviant-case analysis also provides confidence that the data has been looked at comprehensively (Seale 1999, Silverman 2000). Seale (1999) says that the search for negative instances reflects an ongoing scepticism about truth claims and contributes to claims made about the validity of findings.



**Figure 4 Data Analysis**

I began to read intensively around linguistic and conversation analytic techniques. I then began to apply these techniques to my data with interesting and analytically useful results (Figure 4). I used the following analytic tools to break the data down further:

- identify stories within the talk and their function and purpose (Sacks 1992, Silverman 1998, Atkinson 1995)
- use of contrastive rhetoric to exemplify arguments (Hargreaves 1981, Coffey & Atkinson 1996)
- accounts involving excuses and justifications (Scott & Lyman 1968, Coffey & Atkinson 1996)
- use of linguistic resources that mark credibility (Atkinson 1995, Prince et al 1982)
- conversation analytic techniques (ten Have 1999, Hutchby & Wooffitt 1998, Silverman 1998, Drew & Heritage 1992, Sacks 1984)

These techniques enabled me to carry out a microanalysis of talk and provided insights into how expertise, competence and professional identity are accomplished in and through talk about pain. These techniques also enabled me to identify how interprofessional work is possible in such settings.

### 5.5.1 Validity

My approach to CA is limited by the conventions I have used in the transcripts. I have not used counts of pauses, and overlapping speech is not identified in the transcripts. This is because I have taken a grounded theory approach to what the data is telling me and then applied some of the conventions of CA to break the data down further. Seale (1999:153) says that the rigour with which the conventions of CA are applied enable reliability. He concludes that the level of detail used when describing data remains a matter of judgement but are linked to the claims made within the study. I have not utilised some of the conventions of CA in the transcripts for two reasons. Firstly, I had limited resources in terms of the time required to prepare transcripts in this manner, and secondly I have not used pure CA but applied the tools of CA along with other forms of linguistic analyses.

Perakyla (1997) says that where research is based on tapes and transcripts the issues of reliability and validity concern how the researcher selects what he or she uses from the range of data recorded. Silverman (2001) writes that using appropriate tabulations avoids the criticism that one has been selective. Therefore simple-counting techniques enable one to survey the whole data set and avoid the criticism of anecdotalism (Seale 1999). I have used a number of word counts. This enables the frequencies of instances of talk to be displayed and gives an overall perspective on the data. Instance tables enable one to have an overview of

the relative weight and evidence to support the account and it can enhance the validity of an account (Seale 1999, Silverman 1993). Such counts gives confidence that the material is being used systematically, not merely as a search for text passages to support intuitive interpretations (Seale & Silverman 1997, Alasuutari 1995).

## **5.6 Conclusion**

In this chapter I have discussed how my research and my thinking about the research developed over the time. I have identified how decisions were made in relation to purposive sampling and theoretical and methodological interests. I discuss how my research became increasing focused on a particular medical space that was concerned with interprofesional talk. I describe how I broadened out my analysis from a grounded theory perspective to a particular method of working with audio-recorded data influenced by ethnomethodology. This enabled the application of conversation analytic techniques and tools from linguistics, so a microanalysis of data was possible. The use of these tools enabled a detailed analysis of the structure of talk about pain across professional boundaries. I have introduced some quantification within the study that strengthens the research design and avoids some of the limitations associated with reliability in such work.



## **Chapter 6 Pain Talk**

## 6.1 Introduction

In this chapter I discuss the importance of pain talk within the palliative care team meeting and how the rules of pain management are displayed in and through talk by illustrating where pain work has gone wrong. This talk seeks to position the palliative care teams' skill in pain work and the threat to the success of this work from the practices of non-specialists in palliative care. I analyse how talk constructs the PCT reputation by positioning their expertise against that of non-specialists by use of contrastive rhetoric (Hargreaves 1981). I argue that biomedical as well as psychosocial pain talk is central to the professional identity of the palliative care team (Hibbert et al 2003). When there is a threat to the reputation of the team, such as problems in controlling pain, the team resolve the threat by employing a discourse that results in a reputation being developed for the patient as well as for non-specialist medical and nursing staff (Fagerhaugh and Strauss 1977, Wilson 1973). I also will discuss how pain is negotiated and interpreted by both patients and health care professionals (Werner and Malterud 2003, Kugelmann 1999, Baszanger 1998, Jackson 1994)

I interpret the code pain talk as any talk where the word pain/painless/painful is used. Within the code pain talk I also identify analgesic drug talk. Talk about analgesic drugs is almost always linked with pain talk. I found one occasion where analgesic drugs are discussed and the word pain is not used, however, I include this data extract because pain and concern for comfort is implicit in the talk.

Transcription symbols and abbreviations are included in appendices 4 and 5.

### 6.1.1 The aims of the chapter:

- explore how competence in pain talk is produced by use of contrastive rhetoric
- identify how psychological pain is differentiated from physical pain and how this is negotiated by staff and patients
- develop and apply the relevance of 'reputation' to talk about pain

## 6.2 The importance of talk about pain

I have carried out a word count, which illustrates the importance of talk about pain to the palliative care team meetings (Table 5).

Symptom	Word Count
Pain/painful/painless	200
Vomiting	13
Breathless/breathlessness	8
Nausea	8
Weakness	8
Pressure sore	7
Incontinent	7
Constipated	6
Confused	6

**Table 5 Word count of symptoms discussed in PCT meetings**

Clearly, of all the symptoms discussed, pain is of considerable importance to the talk of the team, in terms of the number of times the word pain is used in comparison to talk about other symptoms (Table 5). It seems to be an obvious statement to make but relieving pain is central to the mission of the hospice and palliative care movement and this is evident in the teams studied. What may be more difficult to understand is how much less other symptoms are talked about. I conclude that pain is positioned in palliative care team discourse as the linchpin by which individual, professional and team reputation is developed and performed in and through talk. One way that a reputation is developed for the PCT is through talk which criticises the conduct of non-specialist practitioners, and this is discussed in the next section. By ‘non-specialist’ I mean any practitioner who is not a specialist in palliative medicine/care.

## 6.3 Criticism of non-specialist practitioners

I have analysed how members of the palliative care team criticise non-specialist practitioners by engaging in contrastive rhetoric. This type of talk enables the PCT to make contrasts between their expertise in controlling symptoms and those who lack this expertise, the non-specialists. Contrastive rhetoric according to Hargreaves (1981) is:

*that interactional strategy whereby the boundaries of normal and acceptable practice are defined by institutionally and/or interactionally dominant individuals or groups through the introduction into discussion of alternative practices and social forms in stylized, trivialized and generally pejorative terms which connote their unacceptability. (Hargreaves 1981:309)*

I argue that contrastive rhetoric enables the PCT to develop their unique occupational identity comparatively, by positioning their expertise against that of other occupational and professional segments, such as non-specialist nurses and doctors. Contrastive rhetoric enables the PCT to define and redefine the boundaries of acceptable practice against those that are unacceptable (Hargreaves 1981). This type of conversational rhetoric may also contribute to defining the in group and those on the outside of such a group as according to Erickson:

*It may well be that without this ongoing drama at the outer edges of group space, the community would have no inner sense of identity and cohesion, no sense of the contrasts which set it off as a special place in the larger world. (Erickson 1964:15)*

Thus use of contrastive rhetoric may set up the ‘ongoing drama’ that provides a platform for criticism resulting in group solidarity and the formation of a unique identity. Hargreaves concludes that contrastive rhetoric functions to exert a centripetal effect, drawing in the boundaries of existing practice and consolidating them. This centripetal effect is what makes the team a team. It helps co-ordinate their talk and actions within a context, a space where they define what is acceptable or unacceptable. In the following examples a number of criticisms are made about unacceptable practices in care homes. The most frequently occurring criticism, by specialist nurses, is the lack of knowledge and ability in pain and symptom management within care homes (Table 6).

Types of criticism	CPCN	HPCN
lack of knowledge of pain/ symptom assessment/management	2 (0.07)	1 (0.14)
poor quality of care	1 (0.04)	1 (0.14)
lack of support for daughter	1 (0.04)	
<b>Total</b>	<b>4 (0.14)</b>	<b>2 (0.27)</b>

**Table 6 Word count of criticisms of care homes (rate per 1000 words in brackets)**

Criticism of care homes by CPCNs and the HPCN concern the inability of care home staff to give morphine or to monitor symptoms following an analgesic dose reduction, illustrated in the following extracts:

*a) and she said that in the residential home, the daughter said you can't take morphine in the day because they can't give it, is that right? (18HPCN Liz)*

*b) 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. (19CPCN Marie)*

In extract b) a direct contrast is made between the bank nurses assessment of 'no better' and Marie's assessment of 'much better'. Thus Marie makes visible her expertise in contrast to the lack of this expertise made visible in her account of the bank nurses' conduct. In extract c) there is criticism of the perceived inability of care home staff to act appropriately in relation to the report, by the patient's daughter, of her mother's pain:

*c) she couldn't get the nursing home to do anything constructive about the pain. (CPCN Penny)*

There is also criticism of the quality of the care home and the perceived lack of knowledge of care home staff. A contrast is made between the fine qualities of the patient 'a darling', and the 'awful residential home' (extract d):

*d) She is a darling. She lives in that awful residential home and her daughter lives in Middlewich College. Her husband is a house master at Middlewich College it is a very nice little family. (HPCN Liz)*

In extract e) the care home staff are referred to in a negative manner:

*e) Thick as two planks over there (the nursing home). (CPCN Marie)*

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<sup>18</sup> HPCN – Hospital Palliative Care Nurse

<sup>19</sup> CPCN – Community Palliative Care Nurse

The other negative aspect of being in a care home, voiced by Penny, is the reduction, or loss of control experienced by those who have a close relative in a care home:

*f) You know she's a lot on her mind and you know she's lost all her control since the mother's at the nursing home. (CPCN Penny)*

The focus of specialist palliative care work in care homes has been identified by Froggatt et al (2001). In a survey of 610 Macmillan-funded CPCNs and 120 comparable posts funded from other sources, Froggatt et al say that the majority of work undertaken by these nurses was generally reactive. All the criticism of care homes is carried out by specialist nurses (Table 6).

The interface with the GP is also an area of tension in PCT talk in relation to drug prescribing, slowness in diagnosis and the perceived reluctance of the GP to visit patients (Table 7).

Criticisms of GPs	CPCN	Hospice Nurse	Consultant/ Registrar
drug prescribing	5 (0.18)	0	1 (0.06)
slow to diagnose disease/symptoms	3 (0.11)	1 (0.14)	0
doesn't visit/reluctant to visit	2 (0.7)	0	1 (0.06)
<b>Total</b>	<b>10 (0.36)</b>	<b>1 (0.14)</b>	<b>2 (0.13)</b>

**Table 7 Word count of criticisms of GPs (rate per 1000 words in brackets)**

In the following extracts the criticisms levelled concern too much analgesia being prescribed, resulting in opioid toxicity (extracts a - c) and a lack of coherence related to prescribing analgesic therapy (extract d):

*a) Doctor Jerome was the last one who went in and upped it. (CPCN Phillipa)*

*b) reduced the MST back down the GP put it up to 90. (CPCN Marie)*

*c) The GP shoved it up to 90 MST. Mm we've brought it back down to 60 and he still seems pain controlled. (CPCN Marie)*

Although extracts b) and c) refer to the same patient the criticisms are uttered at two separate meetings. In these extracts a direct contrast is made between the actions of the GP, too much medication, and Marie's reduction in the medication, which resulted in 'seems pain controlled'.

In the following data extract Penny (CPCN) does not understand the rationale for having the patient on sevredol and oramorph she 'couldn't make head nor tail of that one':

*d) 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 Martin hadn't changed him over to a slow release one. (CPCN Penny)*

In this extract the prescription for the opioids is contrasted with the reported comment from the patient '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 e) Matthew is critical of the GP who is giving the patient too much oramorph when she doesn't need it:

*e) but you need to speak to whichever GP it is who keeps on mistakenly poisoning her. (Consultant in Palliative Medicine (CPM) Matthew)*

Similarly in extract f) Anna is critical of a GP who has continuously treated a patient for pain even though she was not improving. This suggests a form of negligence on the part of the GP who does not seem to have investigated the cause of the pain:

*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 Anna)*

A contrast is made (extract g) between the actual serious situation of a patient having a rectal cancer and how the doctor (presumably the GP) thought it was a less serious condition, haemorrhoids, which is pointed out by the hospice nurse in the following extract:

*g) quite ahm a tumour growing through in the rectum and the doctor thought she had haemorrhoids. (Hospice Nurse Claire)*

Other criticisms of the GP concern the length of time to get him/her to act (extract h), and lack of knowledge about a patient (extract i):

*h) Doctor Raguci is her GP and he has dragged his heels over this lady and I have know him to do that. I've spoken to him about other people and he takes a long time to do anything. (CPCN Anna)*

*i) The GP didn't know she had a drink problem until I spoke to him two weeks ago. (CPCN Cathy)*

In the following three extracts of talk the GP is described as reluctant to visit and busy with other things including doing administrative work:

- j) He doesn't come and see her? (Hospice Registrar Michael)*
- k) 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 Anna)*
- l) And the daughter rang the nursing home this morning to see if the GP would come out today, and apparently it is Doctor Jordan and he was doing admin today and, according to the daughter, he wasn't keen to come out. (CPCN Penny)*

The result of this talk is the construction of a busy GP (extract l) who does not have time to visit (extract j,k,l), and the lack of support that the GP provides (extract k). This talk also positions the 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 through criticisms of some GPs draws attention to the problems GPs have in providing services within care homes and the community. GPs have been found to lack knowledge, skills or interest in how to meet the palliative care needs of residents in care homes (Seymour and Hanson 2001). 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). Thus, the community palliative care team and the hospital palliative care team seem to work in a similarly reactive way responding to other practitioners' referrals and requests for help. This is the context in which the criticisms are levelled and this may be why there seem to be fewer criticisms made by practitioners in the in-patient hospice setting for example (Table 7).

There is also criticism of hospital staff including nurses and doctors who send patients home without breakthrough medication (extract m) and who like the GPs (extracts a-c) also give large doses of opioid medication when they are not needed (extract n):

- m) They sent him home with no breakthrough medication. (CPCN Marie)*
- n) Someone had put her on big whopping irregular doses of oramorph. (CPM Matthew)*



By using criticism of non-specialist practitioners the PCT construct how they carry out their expertise as palliative care professionals. This talk enables the PCT to build their reputation by use of forms of speech such as contrastive rhetoric, which constructs their expertise against the backdrop of the mistakes and/or omissions of other practitioners. The use of criticism and blame, I suggest, is one means by which the identity of the 'team' is constructed. Thus a space is opened up where these practitioners can develop their reputation and promote their specialist agenda in a number of locations.

I suggest that the claims to expertise and knowledge that are produced in the discourse of the PCT generally privilege a focus on symptoms and pharmacological interventions as the specialist focus, rather than talk about psychosocial matters, for example. In a focus group study related to developing palliative care for patients with heart failure, medical participants also appeared to understand palliative medicine in relation to strategies for symptom relief rather than psychosocial issues (Hibbert et al 2003).

In the next section I will develop the focus on the in group identity marker 'we' in contrast to 'they' those who are not part of the in group, and the themes of competence and criticism is further developed.

### **6.3.1 Being competent in pain work 'I' and 'we' versus 'they' and 'someone'**

The practitioners positioned as 'other' are those who lack skill in the prescribing of analgesic drugs (such as GPs). Those positioned as 'they' in contrast to 'we' lack skill in the assessment, monitoring and prescribing for pain (such as GPs and ward nurses); spend inadequate time with the patient exploring their current experience of pain (ward nurses); and do not respond quickly to patients' complaints and do not visit (GPs).

In this first sequence of talk by the hospital palliative care team (HPCT) the importance of pain work is made explicit in relation to a patient called Mrs Grayston who is an elderly lady with peripheral vascular disease. She is recovering following a leg amputation in a general hospital. Liz the HPCN introduces talk about this patient.

- 1 HPCNLiz Mrs. Grayston is the lady with, who has had  
 2 the amputation, old lady with the peripheral vascular disease. We probably don't need  
 3 a lot of input now because the pain is solved since she had the amputation. So I almost  
 4 feel that we have done our bit probably.
- 5 CPMMatthew Actually she is quite drowsy now it is quite interesting. She was quite  
 6 sleepy yesterday morning but and she had been on regular, rather irregular oramorph  
 7 hadn't she?
- 8 HPCNLiz Big whopping doses.
- 9 CPMMatthew Someone had put her on big whopping irregular doses of oramorph  
 10 rather stupidly and they had given her 10 milligrams I think of oramorph and she  
 11 couldn't sleep because of the pain. She did sleep after that but she was very sort of  
 12 drowsy, still by half ten, eleven o'clock yesterday morning so we, well they'd got there  
 13 themselves, give her a small dose regularly but
- 14 HPCNLiz Yes. They'd actually worked that out.
- 15 CPMMatthew Yes. They hadn't actually started though. And the nursing staff were  
 16 saying that she had no pain at all whereas the fact that she said that she had  
 17 excruciating pain.
- 18 HPCNLiz Actually, it was quite interesting how she described that pain and  
 19 that's, what's such an interesting thing on the wards they don't go up and sit there and  
 20 say how is the pain today? They obviously can't do that because they don't pick up on  
 21 it. It's most interesting. I think they look at the patient, if the patient doesn't appear to  
 22 be complaining they go past.
- 23 ChEmma Mm. Mm.

### **Extract 1 Hospital palliative care team meeting Oakwood**

The team, through their talk, construct what 'I' and 'we' did (line 3/4) in relation to pain in contrast to 'they' (lines 10,12,14,15) and 'someone' (line 9). Therefore a series of contrasts are made between the actions of 'our bit', what 'we' did (line 4), and what 'they' and 'someone' did (lines 9,14,16). The emphasis on the over medication of the patient is accomplished by the repeated phrase 'big whopping doses' firstly by Liz and then taken up by Matthew 'big whopping irregular doses of oramorph' (line 9). This type of agreement to a prior speaker's assessment is termed an upgrade (Pomerantz 1984). Thus an upgraded agreement incorporates an upgraded evaluation in which Matthew adds 'irregular' to 'big whopping doses' (line 8/9). Pomerantz says that upgrades following assessments often occur as parts of clusters of agreements and this is the case in the above sequence of talk as both Liz and Matthew use 'yes' (lines 14/15) in response to each others' talk. Matthew constructs the 'someone' (line 10) who has put the patient on the 'big doses' as acting 'rather stupidly'. This has resulted in excessive drowsiness for the patient (lines 6, 9,12) and this is a sign of opioid toxicity (MacDonald 1998).

Matthew was going to say what 'we' did but carries out a repair 'so we, well they'd got there themselves, give her a small dose regularly' (lines 12/13). So 'they' in this context corrected themselves and 'got there'. Liz in what seems a patronising remark supports this 'They'd actually worked that out' (line 14). Liz

and Matthew in these utterances differentiate themselves as experts in prescribing opioid medication. This is a co-performance of expertise in contrast to those practitioners as yet unnamed. The use of ‘they’ seems to work to allow Liz and Matthew to criticise ‘they’ without being explicit about who ‘they’ are. Matthew then names ‘they’, ‘the nursing staff’ as ‘saying that she had no pain’ and makes a contrast with ‘whereas the fact that she said she had excruciating pain’ (lines 16/17). The use of the term ‘excruciating’ achieves just how negligent the nurses are. This is a type of atrocity story that achieves the high degree of ineptitude exhibited by the nursing staff. Matthew is contrasting his own skill at identifying ‘excruciating pain’ with the inability of the nursing staff who identified ‘no pain’ (line 16). In this account the professional identity of the nurse is topicalised by Matthew, which may suggest that Matthew considers the ability to identify such pain the responsibility of the nurses and therefore on this occasion they are negligent.

In her next turn Liz changes the topic of conversation to focus on the patient (line 18). However, Liz does not tell us what the patient has said but uses her own interpretation of the patient’s condition to illustrate the deficiencies in the ward practice. She does not refer to the nurses, but to ‘the wards’ (line 19). I conclude from this that Matthew feels at liberty to criticise the nurses’ practice, to name them and shame them. Although Liz seems to agree with Matthew she is more circumspect and does not use the term ‘nurses’ but the ‘wards’ (line 19). Therefore Liz is more careful and discreet in her approach. She almost sounds as if she is proselytising or preaching by referring to the inadequacies of the staff in assessing the patient’s pain. Liz says ‘they don’t pick up on it’ (line 20), ‘they don’t go up and sit there and say how is the pain today?’ (lines 19/20) and ‘they look at the patient, if the patient doesn’t appear to be complaining they go past’ (lines 21/22). This talk seems to place ‘they’, the staff as concerned with the physical presence and appearance of the patient, in other words the staff are orientating to the patient’s physical body, and because they only look and don’t spend time they cannot pick up on the patient’s pain. Therefore Liz is clever at describing what is nursing work without referring to nurses. I suggest that this is because Liz is accomplishing her own identity as a specialist nurse who has the time, knowledge and expertise to do all the things described in contrast to ‘they’ the unnamed without this expertise. This allows Liz to distance herself from these people and

perhaps that is why she does not name them. It may also enable her to construct the 'ward' as not only being staffed by nurses but by others such as students, junior doctors, senior doctors, and other paramedical staff and nursing assistants. This also implies that Liz does not feel sensitive to the criticism of nurses by Matthew as she is part of the 'we', the team that knows what to do and how to do competent work in all the areas discussed and agreed with in the talk. To be part of such a team one needs to have specific expertise and knowledge that goes beyond traditional professional boundaries. The boundaries are made relevant but are contained within a discourse of expertise around methods of pharmacological competence and the ability to assess a patient in pain that seem to be shared. Liz and Matthew demonstrate their expertise in both of these areas. So this enables them to understand each other and together to be concerned about deficiencies in medical work and nursing care albeit defined more explicitly by one rather than the other. Liz in contrast to Matthew is not explicit about who is to blame for the situation in her talk of 'the ward'.

There is also an element of dramatisation or lecturing during this talk. Liz uses the term 'it's quite interesting' (line 18), 'interesting thing' (line 19) and 'most interesting' (line 21) as though she is teaching or performing before an audience. Perhaps this account of 'interesting' things is performed for the benefit of the audience, Emma and myself, the onlookers to this performance. She seems to be teaching the audience how the team does expert practice in relation to pain. This is a co-performance of expertise in pain work by Matthew and Liz together and played out in front of the audience of two, Emma the chaplain, and myself. Liz and Matthew have a shared expertise that enables the team to function in an effective manner. Through their talk they convey that this expertise involves a performance of spending time uncovering pain and giving small amounts of opioid drugs regularly (not irregularly) and avoiding unwanted side effects such as excessive drowsiness. This competent performance is contrasted against the incompetence of the ward staff and the nurses and the effect of the excruciating pain and the drowsiness on the patient. Together, Liz and Matthew construct a team performance in front of an audience, which is recorded, taken out and documented by the researcher, in relation to how pain work should and can be done by those who know what they are doing.

### 6.3.2 'Mistakenly Poisoning'

In the next sequence of talk a similar theme is present in relation to competence in prescribing for and giving too much medication for pain resulting in accusations of 'poisoning'. The team is discussing a patient named Susan. This patient is in a cottage hospital. Like the care home setting GPs are responsible for patients in the cottage hospital. Although it is not made explicit in the talk the patient seems to have a cancer that has infiltrated the liver.

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

#### Extract 2 Community palliative care team meeting Oakwood

In this extract of talk Phillipa describes the status of the patient's pain three times. The patient is described as 'not having any pain' (line 6), 'not in particular in any pain' (line 8) and 'she wasn't in any pain at all' (lines 19/20). Therefore Phillipa has assessed that this patient is not in any pain but is having a 'lot of oramorph' (lines 6-8). The patient is having 10 milligrams of this drug four times a day even though she is not in pain (line 7/8). Furthermore the oramorph is making the patient drowsy and lethargic (line 5). This talk accomplishes the pain free status of the patient versus the inferred over medication for pain with the oramorph, by the GP identified by Phillipa at line 15.

Phillipa does not apportion blame for the situation, initially. She seems to be giving an account of the clinical facts of the case, describing the situation as it exists. She does not use the first person until line 10, which is in reply to Matthew's direct question 'who is giving it to her?' by this he means the oramorph (line 9). Phillipa is vague in her reply (line 10) and states 'the ward, which I think might' and she is interrupted by a specific request by Matthew in relation to the identity of the person who prescribed the drug 'but who prescribed it?' (line 11). Phillipa seems to generalise the responsibility for the situation to 'the ward' but Matthew seeks to pinpoint the person who prescribed the drug. Phillipa in her next turn says 'one of the doctor's going in just getting'. Matthew interrupts Phillipa in his next turn by a direct question 'who is?' (line 14). Phillipa is forced to name the doctor in her next turn, 'Doctor ( ) was the last one who went in and upped it' (line 16). Therefore Matthew wishes to establish the identity of the errant doctor. Phillipa uses veiled criticism by saying 'I don't think it's helping, because she is sleeping all the time' (line 23). The use of 'It's' leaves an ambiguity around what the nurse is critical of, is it the oramorph prescription, one of the doctors who 'upped it' or all of the doctors who went in. This indirect criticism is in contrast to Matthew's more open criticism of the GP 'talk to whichever GP it is who keeps on mistakenly poisoning her' (line 27). Matthew seems to direct attention away from a particular doctor at this point by his reference to 'whichever GP'. What is interesting about this is that nowhere in this extract are the 'nurses' referred to until Matthew raises them (line 25). This talk seems to mark the importance of the responsibility of the individual doctor in relation to the prescription, in contrast to the nurses in general (unnamed) who are not found as responsible in the same way that the named doctor is. Matthew is the person who can point out who is to blame for the situation described. He views the situation as emanating from the prescription written up by this GP. Phillipa is cautious and diplomatic in relation to the GP, which suggests the sensitivity of such interprofessional relations. She helps to create the scene where Matthew does the criticism. She does not directly criticise herself. Matthew does seem to be impatient with Phillipa's reluctance to name the GP. He interrupts her (lines 10 and 13) to demand an answer to who is responsible for the prescription. I conclude that this is a very sensitive boundary and that Phillipa is reluctant to actually name the GP.

Phillipa demonstrates her expertise by discussing how she has spoken with the patient's daughter and how this daughter 'didn't give her any' (line 19). This resulted in reversing the drowsiness (line 5), and 'she wasn't in any pain at all, and she did wake up' (line 20). The CPCN is successful, despite the prescription, because of her access to the patient's daughter and her advice not to give the oramorph (line 18). Although the CPCN does not say what she actually said to the patient's daughter, the outcome was that the daughter 'didn't give any' (line 19). It may be easier for the nurse to work with the patient's daughter to achieve a satisfactory solution to the problem than to talk with the GP directly. Phillipa effectively gets around the boundary issue and in this way maintains the status quo.

Matthew is performing as an expert in palliative medicine in criticising the practice of the GP in relation to practices related to prescribing for pain. Matthew appears to accept in its entirety the palliative care nurse's account of the situation. This suggests to me that the palliative medicine speciality is more important to Matthew, in terms of who is expert, than individual professional status such as GP or CPCN in this context. Also, although the nurse is less openly critical of other practitioners she still accomplishes her own expertise in resolving a difficult situation that indirectly reflects badly on 'the ward' and the link with nursing staff and the GP's opioid prescription for a patient who does not have pain. In this case the CPCN is also accomplishing her own competence as a specialist in contrast to the non-specialist whether they be nurse or GP. Therefore, the PCT meeting may also be a platform for the specialist nurse to accomplish a new identity as a specialist practitioner with expert pharmacological knowledge about pain. The tension for the nurse is in how this relationship with the GP is negotiated and resolved. Matthew recognises the CPCN expertise in pharmacological therapy for pain and the inadequacy of the GP prescription on this occasion. Consequently the CPCN and GP boundary is being blurred in the talk, but not in practice, I suggest, because of the implied resistance of such challenge, by Phillipa, in relation to the GP.

### 6.3.3 Too much MST in the nursing home

In the next sequence of talk a patient called Jack Reynolds is discussed. He is a retired headmaster, now residing in a nursing home and he has a diagnosis of colon cancer. He has also been given too much opioid medication by the GP.

- 1 CPCN Marie Um. Jack Reynolds has reduced the MST back down the GP had put it up to  
 2 90. Do you remember I said to you about the speech?  
 3 CPM Matthew Um.  
 4 CPCN Marie Jack Reynolds and I said I wondered if he had got cerebral secondaries.  
 5 CPM Matthew Yes.  
 6 CPCN Marie Well it's the nursing home. When I rang the nursing home they said  
 7 CPM Matthew Which one is Jack Reynolds is that the one in  
 8 CPCN Marie Jack Reynolds is the man with the colon but has been in on the ward. Um,  
 9 used to live in Stangate, in the flat in Stangate and has just gone into Firtree nursing home.  
 11 CPM Matthew Oh right.  
 12 CPCN Marie He is the retired headmaster. Know who I mean now?  
 13 CPM Matthew Mm.  
 14 CPCN Marie Mm. Well I rang the nursing home and they said no his speech was no  
 15 better, but it was a bank nurse on there, but when I went in there he was much better  
 16 with this 60 MST rather than this 90. He was still pain control. He put himself to bed  
 17 and he wasn't moving out of his room. He was staying in his bed but that is what he  
 18 did when he was in the hospice. I think we are not going to move on that one.

#### Extract 3 Community palliative care team meeting Oakwood

In this extract of talk the issue of expertise in pain work and prescribing is a continuing theme. Marie reports how the GP had put the Morphine Sulphate Tablets (MST) up to 90, which had affected the patient's speech (line 1/2). This made Marie think that the patient may have cerebral secondaries (line 4). The MST has been reduced to 60 presumably with a reduction instigated by Marie (lines 1 & 16). She does not use the first person but is ambiguous she says 'has reduced the MST back down the GP put it up to 90' so it is not entirely clear how the MST was reduced (lines 1-2). The patient was pain controlled on the 60 and didn't need 90 as prescribed by the GP (line 16). This GP like the GP in the previous sequence of talk and the staff on the hospital ward discussed earlier is over medicating the patient for pain. In Jack Reynolds's case this over medication was causing the patient to have speech problems. Also in this extract of talk one can identify Matthew's lack of knowledge of Jack Reynolds, he asks 'Which one is Jack Reynolds is that the one in' (line 7). Matthew is dependent on Marie's report on the patient in the care home. She contrasts the inadequacy of the bank nurse's report that Jack Reynold's speech was 'no better' with what she found when she visited him 'he was much better' (line 15). Marie uses the rule of going



in and seeing the patient for herself and not relying on reports of his condition by other nurses but checking things out for herself.

The expertise of the PCT concerns their knowledge of how to give opioid medication to control pain. They also make changes to the prescription to enable a more suitable dose of medication to be given that avoids side effects such as speech problems and drowsiness so they correct errors in prescribing for pain. Interestingly, they claim that there is a tendency for non-specialists such as GPs and hospital staff to give patients too much opioid medication rather than too little.

The interdependence of this team is a further feature of the talk. It is clear that Matthew has very little knowledge of this patient and is dependent on Marie's reports (line 7). He uses very minimal response tokens to Marie's report, 'yes', (line 5), 'oh right', (line 11), and 'mm', (line 13). Marie has a lot of discretion in relation to the management of this patient in the care home, as Matthew does not seem to visit this setting.

The following extract is also concerned with practices in the care home and again criticism of competence in relation to opioid analgesia is a feature of the talk.

## **6.4 Competent patient versus incompetent nursing home staff**

In this next sequence of talk the competence of the patient Mrs Beck is contrasted with the lack of competence of the residential home staff in giving opioid drugs. Mrs Beck has a diagnosis of leukaemia and a squamous tumour which has been removed from her leg and she is being treated with opioid drugs. What is interesting about this sequence of talk is that the word pain is not used, but seems to be implicit in the talk. The following data extract contains talk between Liz the HPCN and Marie the CPCN.

- 1 HPCN Liz Um. Mrs. Beck, she came in yesterday, did I tell you this?  
 2 CPCN Marie No. I've got a visit booked for her tomorrow.  
 3 HPCN Liz Yes that is wonderful. That's perfect. I think she thinks it's today actually.  
 4 CPCN Marie No it's tomorrow.  
 5 HPCN Liz She is a darling. She lives in that awful residential home and her daughter  
 6 lives in Middlewich College, her husband is a housemaster at Middlewich College, it is a very  
 7 nice little family. The old lady is on the ball. She's as bright as a button but she is quite  
 8 deaf and yesterday she had blood and platelets because you know she has got the  
 9 leukaemia and she has had this enormous squamous tumour lopped off so basically they  
 10 have not scooped it out. He has literally shaved it flat so it is going to come back but it  
 11 was literally like that hanging off the side of her leg in sort of pedicles, amazing thing  
 12 and they put kaltastat on. I have spoken to the district nurse this morning and I've  
 13 suggested, she said, at the moment she is on 5mg of oramorph at night which she  
 14 thinks is wonderful but she says that they can't give it to her during the day because  
 15 they are not allowed to give it. Andrea Jones says that's rubbish, so  
 16 CPCN Marie Thick as two planks over there.  
 17 HPCN Liz Yes. But what I thought might be easier, because she doesn't need 30 mg of  
 18 morphine equivalent, but I wondered if we try 10 bd of MST. So I have asked Andrea  
 19 to start MST morning and evening and see how she goes and bearing in mind she  
 20 might be a little bit fuzzy for a day or two because I think that will be the equivalent to  
 21 2.5 four-hourly which might be just enough. All she takes is paracetamol. Other than  
 22 that she says there is a lot wrong with her. She has got about three or four systemic  
 23 diseases you know, cardiac problems but she's totally with it and she can get about,  
 24 just about. So hopefully without this big tumour hanging on her leg she might be able  
 25 to put her tights on. She is such a sweet heart.

#### **Extract 4 Hospital palliative team meeting Oakwood**

Liz describes the residential home where the patient is resident as 'awful' (line 5) in contrast to the patient who 'is a darling'. The patient is reported to have told the district nurse (DN) that she cannot have oramorph in the day as 'they (the staff) are not allowed to give it' (line 15), although she has 5mg of oramorph at night. Although Andrea (DN) says 'that's rubbish' (line 15). Marie joins in with the criticism in her next turn 'Thick as two short planks over there' (line 16). Liz agrees with Marie as she replies 'Yes'. But then gets around the reported problem by describing how she give prescribing advice to Andrea 'to start MST morning and evening and see how she goes' (line 19). Therefore, she gets around the problem with the staff in the residential home by presumably Andrea going in twice a day, morning and evening, to give the MST. Liz in this instance performs her expertise by giving advice to the DN in relation to the prescription. This talk establishes how this prescribing advice is acceptable to Andrea. Liz also warns Andrea that the patient may be a little 'bit fuzzy for a day or two' when she starts the MST (line 20). The rule identified here is that when a patient starts MST they may be a little 'fuzzy' for a couple of days and this is to be expected. Within the PCT Liz can act like a doctor by being able to give prescribing advice to the DN. This demonstrates Liz's ability to move into Matthew's prescribing space. This is

presumably an informal practice, at the present time, within the context of the PCT but demonstrates the authority that is held by such nurses within hospital and community palliative care and the extension of palliative care into the residential home via advice to the DN from the HPCN.

Liz is positioning this patient as competent and credible. This is achieved by her reference to the patient's social status (lines 6/7) 'and her daughter lives in Middlewich College, her husband is a housemaster at Middlewich College, it is a very nice little family'. Liz establishes Mrs Beck as a credible patient by describing her as 'bright as a button' and 'on the ball' (line 7) and 'a sweet heart' (line 25). The social standing of the patient, her perceived credibility and brightness enables Liz to accept her account of the problems in the residential home in relation to giving drugs that help her or that she thinks are 'wonderful' (line 14). Presumably the oramorph helps Mrs Beck to sleep and keeps her comfortable. However, the existence and nature of pain is implicit, it seems accepted but not discussed. Perhaps Liz's positioning of the patient as of good standing (social status) intelligent (bright as a button) and having three of four systemic diseases (line 22) enable the team to act in relation to this patient's report in such a way that is not identified in other talk. Therefore, the rule identified is that the 'credible' patient one who is 'bright' and 'on the ball' is believed in relation to not being able to have oramorph in the day even when there is evidence of doubt about this (line 15). Werner & Malterud (2003) obtained interview data from 10 women patients with chronic muscular pain about how these women worked to appear credible in medical consultations. The women worked to look 'just right' such as not looking too healthy or too strong for example that might conflict with their disease status. 'Just right' for these women was constructed as being perceived as somatically ill whilst simultaneously avoiding appearing mentally unbalanced. Werner and Malterud say that by appearing 'just right' these women negotiate and achieve their goals for the consultation by establishing their credibility in body and in mind. I suggest that Mrs Beck is also a credible patient because she is 'just right'. She is able to construct herself as mentally alert, 'bright'. She uses interactional resources such as appearing a 'sweetheart' and a 'darling', good social status and importantly she is also positioned as a critic of the practices in the care home. Thus 'just right' in this context is also performed by

aligning oneself as a critic of the residential home practice in the same way that Marie, Andrea and Liz are.

The HPCN crosses between the hospital, community, and residential home boundaries as well as the specialist and non-specialist boundary when she communicates with the DN and the CPCN. Liz also crosses the nursing and medical boundary because of her ability to give prescribing advice to the DN. Although there is a number of criticisms of the prescribing practices of GPs throughout the data I have not found any criticism of the DN. This suggests to me that while there is a tension in the boundary between specialist palliative care nurses and GPs, in contrast there may be a good working relationship between specialist palliative care nurses and DNs. The specialist palliative care nurse is both positioning herself in her talk and being positioned by the DN as competent in prescribing analgesic medication. There is no tension with the DN in this talk as this practitioner accepts the expertise of the specialist nurse and shares the same professional background.

In the next sequence of talk there is criticism involving a patient's wife as well as implied criticism of a member of the PCT. Thus criticism is not only about those in the out-group even in-group members can be criticised.

#### **6.4.1 Incompetent family 'overdosing' him**

In this sequence of talk an accusation is made in relation to the patient's wife that she is overdosing her husband and that she is also obsessed with his analgesics. Again this extract demonstrates the consultant's dependence on the CPCN's account of the patient and his family, whom she has visited at home. There are a number of problems and accusations made about this patient, his wife and his care by Marie the CPCN.

1 CPCN Marie Richard Smith, I started him on his nifedipine Matthew, I'll be honest I  
2 haven't rung this morning to see the results of it. He hasn't got to come in anyway.  
3 CPM Matthew No. And you were saying to me that you reckon that his wife is sort of  
4 almost overdosing him, that is interesting because she was the one that was so  
5 obsessed with not giving him analgesics because of his bowels.  
6 CPCN Marie She is obsessed with not giving him analgesia but she wants a syringe  
7 driver back up but she can't see that there is diamorphine in the syringe driver that she  
8 had. There was wasn't there?  
9 CPM Matthew Yes there was. I'm not quite understand why they did it but they put 20 of  
10 diamorph in I think mm so that was sort of a 60s worth of oramorph and at that time, I  
11 think he had a  
12 CPCN Marie So that is what 10?  
13 CPM Matthew He had a 50 patch. Yes.  
14 CPCN Marie He had a 75.  
15 CPM Matthew Yes well we put it up when the mm syringe pump came down.  
16 CPCN Marie Well he has gone up again Matthew to a  
17 CPM Matthew He has gone up to 100 isn't it.  
18 CPCN Marie (hums)  
19 CPM Matthew He had some 50s  
20 CPCN Marie 100  
21 CPM Matthew Yes, he had some 50's on him when he went out they were keen to send  
22 him out so they said well look take some 25 patches with you if they were  
23 CPCN Marie Do you know when they did send him out Matthew his bowels hadn't been  
24 open for a week.  
25 CPM Matthew Well they sent him out I think on the Tuesday or the Wednesday and he said  
26 they hadn't been opened since the Thursday before  
27 CPCN Marie Yeah.  
28 CPM Matthew But during that time he had had a GA and so on and so forth and so we did  
29 say to the nurses look can you do a PR and try and sort him out and so on but um  
30 CPCN Marie Yeah. Mm we had night calls over night about the patient.  
31 CPM Matthew I think I did a PR and he had an empty rectum, I think he was actually so  
32 that it there wasn't anything to do for down below.  
33 CPCN Marie We had night calls that first night that he was at home. They sent him home  
34 with no breakthrough medication.  
35 CPM Matthew Well he had some oramorph.  
36 CPCN Marie It was very much of what comes home is what he's on and they had  
37 oramorph in the house. He wasn't sent home with any oramorph from here. That  
38 wasn't on their list.  
39 CPM Matthew No but I think I. This is mm Richard Smith.  
40 CPCN Marie Yes.  
41 CPM Matthew I think I was fairly explicit with them.  
42 CPCN Marie Right.  
43 CPM Matthew I told them exactly what to do exactly what fentanyl patch to go for. We  
44 suggested he went up from a 50 to a 75 and exactly what oramorph he should take.  
45 CPCN Marie Well he, he all I can say is that the night that she came home she was on to  
46 our (case) and she didn't know what to give him and all this.  
47 CPM Matthew But I think that is a measure of her anxiety  
48 CPCN Marie It is probably.  
49 CPM Matthew The nurses it's not necessarily a measure of the ward's incompetence.  
50 CPCN Marie No it is just a combination of that and the bowels and you know. You sort  
51 the bowels out in the middle of the night and the district nurse went in and gave him  
52 suppositories and he did have a very large result the next day, you know. So it was all  
53 sort of done as soon as she went.

### Extract 5 Community palliative care meeting Oakwood

In this sequence of talk the issue of competence is a key feature of the talk. This talk situates a number of people as incompetent. This includes the patient's wife who is described as 'overdosing him' (line 4). This description of the overdosing comes from Matthew and is attributed to Marie's previous report. However, Matthew does not entirely agree with this assessment as he has evidence that conflicts with Marie's account. Matthew says 'you reckon that his wife is sort of almost overdosing him, that is interesting because she was the one that was so obsessed with not giving him analgesics because of his bowels' (lines 3-5). It appears that the patient's wife has moved from giving too much analgesia to not giving it, because of her concern about the side effects of such analgesia, such as constipation. Marie confirms that the wife is 'obsessed with not giving him analgesia' (lines 5/6). Marie informs the meeting that the wife now wants the syringe driver back up, she (the wife) does not seem to link the contents of the syringe driver with the giving of opioid medication. Marie says 'she can't see that there is diamorphine in the syringe driver' (line 7). Presumably the wife wants the syringe driver back up, because her husband is now in pain. There seems to be some problem with the patient's drug regime and they discuss the medication the patient has been having since the syringe driver came down (line 15).

In a topic change Marie makes an accusation in relation to the ward sending the patient out without sorting out his bowels (line 23). Matthew does not agree with this as he has seen the patient on the ward. He responds 'we did say to the nurses look can you do a PR and try and sort him out and so on' (line 29). Marie makes another accusation in relation to sending the patient home without breakthrough medication 'we had night calls that first night that he was at home. They sent him home with no breakthrough medication' (lines 33/34). Matthew does not agree with this and says 'well he had some oramorph' (line 35). Schiffrin (1987) says that the use of 'well' is a response marker that places the user as not fully consonant with the prior utterance. She continues that it marks those points where agreement and coherence is not guaranteed. Therefore Matthew's use of 'well' marks his response as an upcoming disagreement with Marie's criticisms. Marie continues with her accusation of an inadequate supply of medication when the patient was sent home, 'it was very much of what comes home is what he's on and they had oramorph in the house. He wasn't sent home with any oramorph from here. That wasn't on their list' (lines 37/38). Marie's use of 'their' distances her

criticism from the PCT. However Matthew seems to respond to this as reflecting criticism of his actions when he says 'I think I was fairly explicit with them' (line 41). There is some hedging by his use of 'I think'. However, he becomes more explicit 'I told them exactly what to do exactly what fentanyl patch to go for' (line 43). Matthew is constructing his medical expertise in this statement and Marie does not respond to this but in her next turn changes topic by orientating to the problem with the patient's wife. She also uses the first person 'all I can say is that the night that she came home she was on to our (case) and she didn't know what to give him and all this' (line 46). 'Our' refers to Marie and the DN who were called out to this patient by his wife. Marie is using the DN to bolster her claim of incompetence, in relation to this situation.

Matthew refers to the wife's anxiety about her husband's condition 'but I think that is a measure of her anxiety' (line 47). He does not accept Marie's account. She agrees with him 'it is' but adds probably to make it less clear how far she agrees. Matthew then tries to get the ward and the nurses off the hook by stating 'it's not necessarily a measure of the ward's incompetence' (line 49). In this he does not discount that the ward has played a part. The turn is completed by Marie, she agrees but does not exonerate anyone by saying 'it is just a combination of the bowels and you know' (line 50). She finishes the turn by describing how the district nurse sorted out the patient's bowels in the middle of the night. 'You sort the bowels out in the middle of the night and the district nurse went in and gave him suppositories and he did have a very large result the next day, you know' (line 51/52).

Tannen (1987) discusses the discourse marker 'y'now'. She says that 'you know' can occur with general description of situations and events and speakers can use such descriptions to support their more specific claims. Thus according to Tannen 'you know' marks consensual truths which speakers expect their hearers to share, as well as being general descriptions upon which specific descriptions are expected to be included. She suggests that because these generalisations are not always endorsed by hearers both speaker and hearer may have to negotiate the status of the information as shared knowledge. Thus 'you know' at line 50 seems to refer to the lack of competence generally in the execution of the discharge, as already outlined by Marie. 'You know' at line 52 refers specifically, I believe, to the work that the district nurse had to do in the middle of the night in relation to

giving the patient suppositories. Perhaps this work carried out by the DN is embarrassing for Marie, as it reflects badly on the PCT who were involved, to some extent, in this discharge.

This is an atrocity story with implications for the conduct of both the hospital staff as well as the PCT. So even when one has carefully made plans, checking like Matthew has done, unforeseen problems can still arise. It also suggests the difficult state that the patient and his wife must have been in to call out the DN. Thus Marie's use of 'you know' enables her to push past Matthew's claims to have checked everything and to continue to press her complaints. We 'all know' that these type of problems should be avoided, but on this occasion the crux of the matter is that the DN had to sort out this problem in the middle of the night (line 51). This alerts us to how competence is done through talk. In this extract of talk the competent people are Marie and the DN and the incompetent people are the ward nurses who are negligent of bowel care, the wife who is not able to manage her husband at home and indirectly, Matthew and his team who were involved in this discharge and did not prescribe breakthrough medication. There is evidence of conflict, between and within the story told by Marie of problems with this patient and his wife and the story told by Matthew of how they prepared for this patient's discharge. Marie is critical of what she sees as three rules being broken. The first rule is that patients who are on analgesic drugs, which cause constipation, should have their bowels sorted out before discharge into the community. The second rule is that breakthrough medication should be prescribed. The third rule is that the patient's wife should have better understanding of what to give her husband for the pain. Marie through her many criticisms of the ward has led Matthew into having to justify his actions. He appears to justify his actions in relation to his prescription of the analgesic drugs, including oramorph, for breakthrough pain, rather than the problem of the constipation or the anxiety of the patient's wife. Accountability for pain medication may be prioritised above bowel problems and educating relatives. I would suggest that this might point to a division of labour within the organisation of the hospital. This enables Matthew to avoid some of the criticisms levelled about bowel care and education of the wife about pain medication. This may be considered the prerogative of the nursing staff who on this occasion are accused of negligence by Marie. This talk



also constructs Marie's concern with the analgesic drugs and the DN with sorting out the bowel problem.

This extract of talk illustrates the importance of accountability within the team for one's actions. Incompetence is not only about 'other' non-specialist practitioners but can be implicated in relation to PCT members. Competence and credibility appears to be something that has to be accomplished in talk. Marie seems to be using a form of 'crab antics' to challenge Matthew's account and draw attention to the inadequacy of the discharge (Wilson 1973). The team meeting is one of the spaces where practitioners prove their competence, through their talk, about their actions. Talk enables accusations and defences to be mounted and together the team evaluate their own competence and the competence of others. In this talk the interdependence of the team members is made visible. Criticisms are routinely used to define the speaker's own expertise as a matter of contrast. Unlike Liz and Phillipa, Marie has no hesitation in being critical of a number of people including Matthew. The problems discussed in the talk can tarnish one's reputation and this may be why Marie gets away with making such strong complaints. She is embarrassed to be associated with care that does not meet the standard required.

Pain and symptom occurrence and response to therapy is always discussed in the team, but when there are problems related to symptom control such as continuing pain this is the trigger for psychosocial, emotional type talk. When the reputation of the PCT is threatened by poor pain control the patient is constructed as troubled, troublesome and difficult. These troubled patients and families have their psychosocial and emotional reactions discussed. When these patients are talked about the momentum in the talk moves from objectively reported information such as disease status, pain assessment, pharmacological and other therapies to the construction of a subjective space where psychological and emotional reactions are discussed. This subjective space constructs the patient as an active actor in relation to their pain performance. The patient's performance of pain may lead palliative care staff to conclude that pain is psychological as well as organic. I will discuss how palliative care professionals develop strategies to deal with troubled and difficult patients.

## 6.5 Defining psychosocial talk

I have defined the code 'psychosocial' as any talk related to the psychosocial status of the patient and staff. This includes talk of emotions such as anxiety, sadness, anger, and aggression; talk of relationships such as those with health care professionals, family, friends; and talk of the social circumstances of the patient such as social support and location of care. I have linked psychosocial talk with talk about difficult patients as these two types of talk often occur together. I have defined difficult patients as those who do not respond to medical therapy or who do not respond to the health care professional. Difficult patients have problems with symptom control; they do not take their medications and they are inconsistent in the way they report their pain to health care practitioners. Difficult patients also have social problems such as excessive use of alcohol, a history of mental health problems and are critical of palliative care professionals. Some of these patients suffer with non-malignant pain such as peripheral neuropathy associated with circulatory disease, which is evident in the next extract of talk.

### 6.5.1 Aggressive when in pain – constructing the patient reputation

I have found one example where the patient's emotional reaction to pain is discussed and where this is introduced in an ambiguous way. This patient does not have cancer like the 'ideal type patient' but has pain and long standing problems with diabetic peripheral vascular disease resulting in an amputation. This type of disease trajectory may be more problematic for the HPCT than the cancer trajectory.

1	HPCN Liz	John Styles, there is not a lot to say really. He is
2		the chap who has had the amputation.
3	<sup>20</sup> Ch Emma	I had a lot to do with him.
4	HPCN Liz	Oh good. I'm pleased. He actually has a bit of
5		sepsis. Yes. I don't know how much, whether it is just a
6		bit wet or whether it is worse than that. I'll have to
7		check because I haven't seen anything.
8	Ch Emma	It seemed okay at the weekend.
9	HPCN Liz	Yes. That's good.
10	Ch Emma	He's much brighter and positive. He's doing all right
11		I think.
12	HPCN Liz	Yes, better than he was.
13	CPM Matthew	He was being rather aggressive when he was in pain.
14	HPCN Liz	I think he is better but it was a bit wet one side of
15		his knee.
16	Ch Emma	Yes. He was anxious about that.
17	CPM Matthew	He was writing complaining letters to the Chief
18		Executive because
19	Ch Emma	Was he?
20	CPM Matthew	Well talking about it wasn't he?
21	HPCN Liz	I think he was just fed up.
22	CPM Matthew	Demanding to see this that and the other surgeon,
23		and so on.
24	HPCN Liz	The trouble is they are just nibbling away as they do
25		with diabetic peripheral vascular disease. You know they
26		can't just chop a big bit off, they have to keep nibbling
27		at it.

#### Extract 6 Hospital palliative care team meeting, Oakwood

Liz starts this sequence of talk by stating that 'there is not a lot to say really' other than the fact that John has had an amputation (lines 1/2). However in her next turn Emma the chaplain indicates 'I had a lot to do with him' (line 3). Liz is pleased about this and in her next turn says 'Oh good' (line 4). The use of 'Oh' suggests however that this is news to Liz. Liz then comments on the 'sepsis' in relation to his wound (line 5). Emma seems to be constructing herself as someone in the know about this wound because in her next turn she says 'it (the wound) seemed okay at the weekend' (line 8). This demonstrates Emma's concern with the physical problem experienced by John and that she visits John at the weekend.

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<sup>20</sup> Ch - Chaplain

In her next turn Liz orientates to this and agrees with Emma's assessment when she replies 'Yes. That's good' (line 9). Emma makes a very positive statement she reports how John is much brighter, positive and 'He's doing all right I think' (line 10/11). This accomplishes John's character as someone, who is coping, with the right approach, namely positive and bright, in Emma's opinion. Liz agrees with this but states 'better than he was' (line 12). This suggests that John has not always been so positive and bright. In a topic change Matthew reports that John is, 'rather aggressive when he was in pain' (line 13). Matthew does not get a response to this statement (line 14). Pomerantz (1984) says that there are many ways in which speakers can pursue responses to their assertions. If a speaker expects a recipient's support or agreement and does not get it the speaker will try to work out what went wrong and to remedy it. One type of remedy pursuit is to check out the facts, according to Pomerantz. A speaker may then present to the recipient the relevant facts upon which he or she based the assertion. So Liz and Emma delay their response to Matthew's accusation of aggression. Matthew then seeks to provide further evidence for his assertion (line 17) when he references the 'writing complaining letters to the Chief Executive' (line 17). Emma in her next turn replies 'Was he?' as though this is news and challenges Matthew's report. Matthew in his next turn explains himself and adjusts his report to 'well talking about it wasn't he?' (line 20). Liz does not seem surprised by the report of John's complaints 'I think he was just fed up' (line 21). Matthew continues with his criticism of John when responding to Liz by stating 'Demanding to see this that and the other surgeon and so on' (line 22). Liz does not seem to agree she is aware of the limits of surgery for this type of condition 'The trouble is they are just nibbling away as they do with the diabetic peripheral vascular disease' (lines 24/25). She uses the term nibbling twice and contrasts it with the inability to chop a big bit off, so 'they have to keep nibbling at it' (line 26).

Liz through her talk shapes the limits of conventional surgical treatment for this type of disease. Matthew demonstrates his vulnerability to criticism, as a member of the medical profession, when patients are unhappy with their surgical treatment and demanding to see other doctors. Liz displays her difference, as a nurse and Emma's as a chaplain who is not vulnerable to John's criticism of the medical profession. Liz and Emma are able to silence Matthew's criticism and to repair John's presentation as just someone who is anxious, and fed up with the

limitations of treatment for his type of disease. This suggests to me that Liz and Emma in particular are concerned to present John as doing well and coping with his surgery and other problems. In this instance the team do not agree on their assessment and expectations about John's behaviour and his reaction to pain. Emma does not seem to agree with Matthew on this occasion and it is Liz who tries to reformulate the problem using a psychosocial construction of John as someone who is 'fed up' and then uses biomedical talk about the limitations of surgery. Emma and Liz try to portray John as anxious and worried rather than aggressive. Liz appears to take the middle position between Emma who says John is doing well and Matthew who is unhappy about John's complaints. Liz may be concerned to keep the lid on the emotional content of this interaction. Like Penny and the family mediators (Greatbatch & Dingwall 1999) she does not want to raise the emotional content of this talk<sup>21</sup>. She therefore avoids talk of blame and by doing so adopts a neutralistic footing. Matthew seems to be more sensitive to criticism because this criticism is targeted at doctors and not at the nurse or chaplain. Liz and Emma seem to play a role in identifying John's behaviour as 'normal' within the sequence of experiences he has undergone in the surgical trajectory, where disease can only be nibbled away. Liz uses both medical and psychosocial discourses to account for John's emotional reaction to pain. Emma also uses her knowledge of John, as well as knowledge of his wound to contribute to the team discourse. This suggests that Emma is constructing herself as someone with expertise both in relation to John and how he is getting on, and this is linked to her knowledge of his wound. However, this type of talk could begin to establish this patient's 'reputation'. Fagerhaugh and Strauss (1977) discuss how a 'reputation' can emerge when individuals are 'uncooperative' or 'manipulative' for example. The researchers found that this 'reputation' had a profound effect on patient-staff interaction. They claim that this can lead to problems in legitimating pain and staff co-operation in the control of pain.

In the next section I will develop the theme of reputation in relation to a patient called Patricia who has poorly controlled pain. Like John, Patricia has circulatory problems that are causing problems with pain and she is constructed as 'manipulative'.

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<sup>21</sup> See section 7.3.1 and extract 10

## 6.5.2 'She needs that pain'

Patricia is discussed in two meetings of the CPCT. This is a troubled and troublesome patient whose pain is poorly controlled. The trouble seems to be related to the fact that the prescribed analgesic drugs are not working and the CPCN Marie feels she is not getting anywhere with the patient's pain problem.

- |    |             |   |
|----|-------------|---|
| 1  | CPCN Marie  | A bit more discreet about it Matthew. Anyway, mm I must               |
| 2  |             | admit although I've taken Nicola's advice and put her on ( ), I       |
| 3  |             | actually feel it's almost we going to get her symptom controlled then |
| 4  |             | she's going to go   |
| 5  | CPM Matthew | Right.  |
| 6  | CPCN Marie  | Not completely symptom controlled but better controlled               |
| 7  |             | and then she'll go back home and she'll stop her drugs again the same |
| 8  |             | as last time. She was fine when she was in the ward and yet within    |
| 9  |             | thirty-six hours of going home she stopped.                           |
| 10 | HPCN Liz    | The trouble is she needs that pain.                                   |
| 11 | CPCN Marie  | Wha   |
| 12 | HPCN Liz    | She needs it in the sense that she needs to be able to have the       |
| 13 |             | attention which is part of it isn't it?                               |
| 14 | CPCN Marie  | I agree but then she's saying she's got pain. I can't sit back        |
| 15 |             | and say: 'you need your pain you get on with it' can I?               |
| 16 | HPCN Liz    | No, no, whatever you did however good it was                          |
| 17 | CPCN Marie  | Oh yeah, I know that and you know that but mm you've got              |
| 18 |             | to be seen  |
| 19 | CPM Matthew | Opioid switch or rotation might be                                    |
| 20 | CPCN Marie  | Well I've done that Matthew. I went from MST to fentanyl.             |
| 21 |             | When she thought the fentanyl was some hideous price per patch, I     |
| 22 |             | don't know how she got hold of it. It was working, but now its broken |
| 23 |             | through the fentanyl.   |
| 24 | CPM Matthew | Oxycodone might be just the thing.                                    |
| 25 | HPCN Liz    | (Laughs) Yes.   |
| 26 | CPCN Marie  | Yes, but we're only holding things while we                           |
| 27 | CPM Matthew | Remember Ross.  |
| 28 | CPCN Marie  | Yeah. I must admit we just going mm                                   |
| 29 | CPM Matthew | I think she sees James privately doesn't she?                         |
| 30 | CPCN Marie  | Yes she does, at Havering.  |
| 31 | HPCN Liz    | Has she ever had any acupuncture? That could be a good bit            |
| 32 |             | of attention for her.   |
| 33 | CPM Matthew | Will Tony do it?  |
| 34 | HPCN Liz    | Yeah.   |
| 35 | CPCN Marie  | I'll ask Tony but at the moment he's fully booked. He's got           |
| 36 |             | two every week. The alternative is to get Helen to do it here.        |
| 37 |             | Helen will do it.   |
| 38 | CPM Matthew | I'll talk to him he doesn't mind at the moment.                       |
| 39 | CPCN Marie  | Right. OK Matthew. We'll see how it goes.                             |

### Extract 7 Community palliative care team meeting Oakwood

This sequence of talk begins to establish the troublesome nature of Patricia's pain. It demonstrates how Marie is working to get Patricia's symptoms controlled. Marie uses the term controlled 3 times (lines 3-6). The problem with control of the symptoms is related to the patient's behaviour. Marie begins to refer to this 'I actually feel it's almost we going to get her symptom controlled and then she's going to go' (line 3/4); what Patricia is going to go and do becomes clear to 'stop her drugs again the same as last time' (lines 7/8). Furthermore, Patricia is described

as fine in the ward in contrast to how she is at home ‘and yet within thirty-six hours of going home she stopped’, presumably stopped taking her medication (line 9). Liz introduces a topic change ‘The trouble is she needs that pain’ (line 10). Therefore the pain is fulfilling a purpose for the patient. This brings into focus the person in pain and her need. Marie in her next turn orientates to this by some surprise by her vocalisation, ‘wha’ (line 11). Liz then justifies why she has said this. She continues to explain why Patricia needs her pain ‘She needs it in the sense that she needs to be able to have the attention, which is part of it isn’t it?’ (lines 12/13). Therefore, Liz constructs Patricia as someone who needs her pain to gain attention. This implies that Patricia is an active actor in her pain and this pain is not necessarily of an organic origin, because it serves a need to get attention. Marie agrees with Liz by saying ‘I agree’ but she has some reservations. She states that if the patient says she has got pain she can’t ignore this. Furthermore Marie argues, it would be inappropriate to say, ‘you need your pain you get on with it’ (line 15). This achieves Marie’s construction of her professional role as someone who is concerned about the patient’s pain in medical terms, trying to find the right analgesic drugs to give that would help this patient with control, and not telling her to get on with it because she needs it. I would suggest that Marie might view this sort of talk as unprofessional, even if she agrees with it. However this talk moves the responsibility for the pain away from the PCT and on to the patient. There is evidence for this in Liz’s talk ‘whatever you did however good it was’ the implication is that it would not be enough because of the patient’s actions (line 16).

Kleinman et al (1992) say that the patient may experience pain as an intrusive unwelcome force causing physical distress in contrast to others who may see the patient as producing the pain in relation to psychological and social conditions. He continues:

*This approach implies that pain is at least partially wilful, voluntary, and hence under the patient’s control. (Kleinman et al 1992:6)*

I suggest that the utterances produced by Liz and Marie lend support to the view that pain can be seen to be in some way under Patricia’s control. By interpreting the pain as a need suggests two things; firstly that Marie may not identify a role in relation to this implied need other than ‘get on with it’ and, secondly, that it would be inappropriate to suggest or discuss this need with the patient as it would not be

acceptable to her 'I can't sit back and say: 'you need your pain you get on with it' can I?' Perhaps this psychological talk is sensitive ground in the nurse patient relationship.

This talk establishes a reputation for the patient as a direct result of the failure to relieve the pain. This 'psychosocial' type talk seems to suggest that the PCT are eager to construct the patient as someone who needs that pain because all their interventions have not worked for reasons beyond their control. Patricia is not co-operating because she is not taking her drugs regularly. The logical extension of this is that she must need the pain, otherwise she would co-operate. In her next turn Marie agrees with Liz, 'Oh yeah, I know that and you know that but mm you've got to be seen' (lines 17/18). Marie feels she has 'got to be seen' to be doing something. This 'got to be seen', I suggest is part of her professional identity and the importance of being seen to be effective in relation to the patient's pain. The question of got to be seen by whom, is an interesting one. Possibly this could be, seen by the patient, the district nurse, the GP as well as the PCT. This is an interesting turn of phrase 'got to be seen' as it suggests that the person is most concerned with appearances and the audience for the performance.

Matthew in a topic change interrupts Marie and suggests a pharmacological strategy, an opioid switch or rotation (line 19). Marie responds that she has tried this. She then provides further evidence of suspicion about Patricia's pain experience. She reports that when Patricia thought the 'fentanyl was some hideous price per patch, I don't know how she got hold of it, it was working' (lines 21/22). This suggests that this drug did work initially especially as Patricia knew it was expensive. Matthew then suggests another drug 'oxycodone'. Liz agrees with this but this suggestion doesn't seem to lead anywhere. Also Matthew informs the meeting that she sees James privately (line 29). Clearly Marie is aware of this (line 30). Patricia is used to the private attention of her doctor. Liz in a topic change returns to the need for attention and suggests that acupuncture 'could be a good bit of attention for her' (line 31/32). This is interesting because it suggests that troublesome patients with troublesome pain may receive therapies such as acupuncture and this is linked with their need for attention. This suggests that acupuncture could both treat the need for attention and in doing so treat the need for the pain. I suggest that the resource and use of therapies such as acupuncture may be related to addressing the needs of troubled and troublesome patients with



difficult pain, and also to meet psychosocial and emotional needs, including the need for attention. It also suggests that the therapists carrying out this type of work may be very busy 'fully booked' (line 35). The use of complementary therapies in palliative care work may be a way of containing psychosocial distress by giving time and attention (Garnett 2000). In the next sequence of talk the term 'psychological' is used in relation to Patricia's pain.

### **6.5.3 A psychological aspect to pain**

In this next sequence of talk Patricia is discussed at another PCT meeting. It emerges that her pain is still troublesome. Patricia is reported, as not taking her medication and she has refused surgical treatment involving having her leg amputated. She is also complaining about her care, which, I suggest adds to her status as a troublesome patient. The result of this situation is that Patricia's pain is now constructed as in part psychological.

1 CPCN Marie And then there is Patricia. Nicola is off as you know.  
2 Nicola has been dealing with her quite a lot. Matthew we are in a  
3 circle. Nicola is saying that Patricia will probably need to come in to  
4 re-stabilise symptom control wise, for her pain, but she wants her to  
5 see Joe Stuart first.

6 CPM Matthew James Stuart.  
7 CPCN Marie James Stuart first. James Stuart, we should turn this  
8 thing off, but we actually think is avoiding her a little bit and normally  
9 he sees her quite quickly, he is saying he can't see her for five to six  
10 weeks. So we have got this period of five to six weeks.

11 CPM Matthew But why does Nicola want James to see her?  
12 CPCN Marie Well, because one of the things is the wound is breaking  
13 down a bit more but as I said to Nicola, he will only say amputation  
14 and she will say no.

15 CPM Matthew Yes exactly and I can see it from his point of view it is  
16 certainly a waste of time because he has been through it countless  
17 times before and a

18 CPCN Marie Yeah, and from our angle, the district nurse and I feel we  
19 will get her in, we'll stabilise her, she'll go home and within 24 hours  
20 whatever we have put her on she will feel awful on and she'll stop. I  
21 mean this is what has been the pattern before, drugs have worked for  
22 very short period. Mm she came in to day care last week and day  
23 care's comments, um, I read it to you, she was pain controlled. She  
24 said her leg was more comfortable, that's it, it was more comfortable,  
25 it wasn't pain controlled it was more comfortable. She is actually  
26 saying to the district nurse that it is excruciating pain and ringing up  
27 the GP, the GP rung Sheila at the end of the week could they restart  
28 the clonazepam? Well Sheila thought that was for the leg that we  
29 were virtually treating and in fact it wasn't it was for phantom pain on  
30 the amputated leg so yes he said we could restart it. Patricia we got up  
31 to day care because we thought if we saw her we could reassess her  
32 and see how much non-verbal signs of pain she was showing in day  
33 care. We sort of said come up, you know you will be assessed and all  
34 this sort of thing. Nicola was saying it's pointless me seeing her  
35 because we are just going around in circles she needs to come in after  
36 she's seen Stuart. So Patricia is saying – 'you get me up early to  
37 bring me in to day care, nobody is, the doctor doesn't see me, the  
38 nurse says well Marie is looking after your pain control and all they  
39 do', which is all they are supposed to do they are not supposed to take  
40 the dressing down, 'is re-pad the outer areas of the thing'. So this  
41 woman is asking a) not to come to day care or if she comes to come  
42 every other week for only an hour or something like this. We are just  
43 going around in circles. What do you want us to do? Do you want us  
44 to call her in?

45 CPM Matthew Has mm Stella Burrows seen her at home, the tissue viability  
46 sister?

47 CPCN Marie Not to my knowledge.

48 CPM Matthew No. Mm. (0.5) We can certainly bring her in. There is  
49 no need for James to see her before bringing her in.

50 CPCN Marie Only, I know you know that Patricia has pain but also there  
51 is a psychological aspect in it as well.

52 CPM Matthew Yeah, Yeah. She has been quite manipulative in the past she  
53 will kill herself if she thought she has to have an amputation and so  
54 forth.

55 CPCN Marie Exactly.

56 CPM Matthew Well she hasn't so far. She seems to struggle along quite  
57 satisfactorily if not happily.

58 CPCN Marie I mean as the district nurse said you know is it when she is  
59 in on the ward, she doesn't feel so awful because she is not drinking  
60 so heavily? The district nurse said she arrived at half-past nine  
61 yesterday morning and she had got the wine going at half past nine. I  
62 mean a combination of the wine and the drugs is that the thing that  
63 makes her feel awful. I mean she does drink on the ward.

64 CPM Matthew She does that on ( ) more (the infection).

65 CPCN Marie No she was on erythromycin and the actual swab came back  
66 nothing significant.

67 CPM Matthew Mm

68 CPCN Marie She had the swab done.

69 CPM Matthew Yeah. I mean I used to think she would feel much better if  
70 she had the leg lopped off.

- 71 CPCN Marie Yes.
- 72 CPM Matthew But I am beginning to wonder if to have a bi-lateral amputee  
73 up on the ward, who is dying, it has all gone wrong and its all and  
74 she's, Mrs Turner yeah she has got clostridium she's got MRSA, its  
75 very difficult and she's got fed up with it. She is slightly less  
76 enthusiastic. She was really quite good from a pain point of view once  
77 she had got rid of the dead leg.
- 78 CPCN Marie So I will put for her to come in Matthew.
- 79 CPM Matthew Yeah. We can always get James to come and see her at the  
80 hospice I'd of thought.
- 81 CPCN Marie I mean you know Michelle and I feel we are in the centre and  
82 that we are just going round from
- 83 CPM Matthew Michelle?
- 84 CPCN Marie Michelle the district nurse.
- 85 CPM Matthew Oh, right.
- 86 CPCN Marie We are just going round and round from one doctor to the  
87 other and not really getting to grips with it. Okay. Richard Smith, I  
88 started him on his nifedipine Matthew, I'll be honest I haven't rung  
89 this morning to see the results of it. He hasn't got to come in anyway.

### **Extract 8 Community palliative care team meeting Oakwood**

In this extract Marie introduces Patricia as continuing to have problems. Marie describes the situation thus, 'Matthew we are in a circle' (lines 2/3). This implies that they are going round and round with no end in sight. The suggestion, by Nicola another hospice consultant, is to bring Patricia in to the hospice to stabilise her symptom of pain. However, Nicola wants her to see the surgeon James Stuart first, according to Marie (lines 4-7). Marie indicates that she is going to say something sensitive 'we should turn this thing off', meaning the tape recorder (line 7/8). It emerges that James Stuart is avoiding seeing this patient and cannot see her for five to six weeks (lines 9/10). This is unusual because in the previous sequence of talk we were told that Patricia is a private patient of James and normally private patients do not wait for appointments. As the talk continues it emerges that Patricia's wound is breaking down and James Stuart has advised that her leg should be amputated. Patricia will refuse, according to Marie (line 14). Matthew understands the doctor's problem 'because he has been through it countless times before' (lines 16/17). This, it seems, is the reason why James does not want to see Patricia, she is refusing surgery. Therefore Patricia is not only troublesome to the PCT but also to James the orthopaedic surgeon, who seems to be avoiding her. Marie then describes the situation from 'our angle' (line 18). By 'our' she seems to mean the hospice team. She says 'we will get her in, we'll stabilise her, she'll go home and within 24 hours whatever we have put her on she will feel awful' (line 20). The implication is that Patricia will not cope at home as her medications may make her feel awful and she may stop taking them (line 20/21). For this patient the drugs seem to work for a short time, as Marie says 'I

mean this is what has been the pattern before, drugs have worked for very short period' (lines 21/22).

Marie then gives an account of how Patricia came into day care and she reads out the day care notes 'she was pain controlled. She said her leg was more comfortable' (lines 23/24). Marie contrasts how the patient said her leg was 'more comfortable' in day care but provides evidence of disagreement with this, as Patricia has told the district nurse that the pain is 'excruciating' (line 26). Patricia has also been ringing the GP, presumably about her pain (lines 26/27). The difficult situation for the patient becomes evident, as she has had one leg amputated already and is having a drug called clonazepam for phantom pain in the amputated limb, prescribed by the GP (line 30). Marie describes her reasons for bringing Patricia in to day care, 'we thought that if we could reassess her and see how much non-verbal signs of pain she was showing in day care' (line 32). In this statement Marie seems to be implying that she is looking for physical proof of the pain e.g. 'non-verbal signs'. This seems a contradiction as she has already described how Patricia has told the district nurse that her pain is excruciating.

Marie describes how Patricia has been critical of being brought in to day care. Marie uses Patricia's active voice, 'you get me up early to bring me in to day care, nobody is, the doctor doesn't see me, the nurse says well Marie is looking after your pain control' (lines 36/37). Patricia is reported as being frustrated and unhappy about her experience in day care. This experience has contributed to her suffering by getting her up early to attend and she describes, the lack of interest from the staff in day care and not being seen by a doctor, reported by Marie. Therefore Marie is making visible Patricia's complaints. Furthermore, Marie is meant to be 'looking after' her pain. Clearly Marie is not getting anywhere with the patient's pain and she asks Matthew, 'What do you want us to do?' (line 43). She uses 'us'; there is some ambiguity in the use of 'us' it is not clear who this refers to is it the palliative care team, Marie and the district nurse and GP or Marie and the day care team? I suggests 'us' may refer to the PCT and Patricia's complaints voiced by Marie maybe a threat to the PCT reputation in relation to pain and another approach is now required. Therefore Marie's use of the patient's active voice enables her to secure a decision to have the patient admitted to the hospice. Marie says, 'Do you want us to call her in?' (line 44). This is Marie's preferred option to get the patient admitted without her having to wait to see

James Stuart. In his next turn Matthew changes the topic to whether the patient has seen the tissue viability sister and Marie replies by saying she doesn't know. Matthew after a long pause of accedes to bringing her in without her having to see James (lines 48/49).

Marie has overturned Nicola's wish to have Patricia seen by James. It is then that Marie says a little more about Patricia's pain: 'Only, I know, you know that Patricia has pain but there is a psychological aspect in it as well' (line 51). Perhaps this is why Marie wanted to have Patricia assessed in the hospice, as she believed that some of the pain was 'psychological'. Matthew agrees with Marie and says 'she has been quite manipulative in the past she will kill herself if she thought she has to have an amputation and so forth' (line 52/53). Marie is in complete agreement as in her next turn she says 'Exactly' (line 55). Matthew in his next turn says, 'Well she hasn't so far. She seems to struggle along quite satisfactorily if not happily' (line 56/57). This patient has a 'reputation' because she is perceived to be manipulative in the way described by Fagerhaugh and Strauss (1977). However, this reputation may make the work of the team even harder because this patient is also able to criticise and some of her criticisms are directed at the PCT (lines 25-27 and 36-40). The result of this is that reputation may be mutually constructed (Wilson 1973). The reputation of one is dependent on the reputation of the other and furthermore the patient may be aware of this and exploiting it in her reported complaints to the GP and the DN (lines 22-28).

Marie achieves Patricia's responsibility for why she feels as she does, 'and she had got the wine going at half-past nine. I mean a combination of the wine and the drugs is that the thing that makes her feel awful' (lines 61-63). This link between drugs and alcohol achieves the discredited nature of Patricia's identity as someone who is mixing these two substances. Patricia is telling the district nurse how bad the pain is (line 26) in contrast she told the staff in the hospice day care facility that she was more comfortable (line 24). Marie is not explicit about what Patricia has shared with her, in relation to the pain. The labelling of Patricia's pain as in part 'psychological' seems to accomplish the reason for why the interventions to control the pain have not been successful she is not a credible patient. The implied moral character of the patient, her criticism of the efforts to help her, seems to suggest that her relationship with the community palliative care nurse is difficult. This patient is far from 'just right', she is not credible in this

context. She has a reputation that makes her a threat to the equilibrium of the team.

Marie's goal throughout this sequence of talk is to get Patricia admitted to the hospice. She says 'Do you want us to call her in?' (lines 43/44). At line 78 she has achieved this 'So I will put for her to come in Matthew'. Although she admits, that she has not been getting anywhere with this patient she does not use 'I' but 'we', 'We are just going round and round from one doctor to the other and not really getting to grips with it' (lines 86/87). The use of 'we' could refer to Marie and Patricia or the PCT and Patricia. Therefore the responsibility for the situation remains a team one. The only option left seems to be to admit Patricia to the hospice for symptom control. Perhaps, in the environment of the hospice this difficult situation can be turned around and Patricia may become 'just right'. However, Matthew has a story to tell that acknowledges the difficulties in helping some people. Matthew says 'I am beginning to wonder if to have a bi-lateral amputee up on the ward, who is dying, it has all gone wrong' (lines 72/73). This type of patient, following this type of surgery may be a liability in terms of the hospice 'good death'. He gives an example of another patient Mrs Turner who has also had both legs amputated and although she is 'quite good from a pain point of view once she had got rid of the dead leg' (lines 76/77). This patient is described as having problem with infections 'she has got clostridium she's got MRSA, its very difficult and she's got fed up with it' (lines 74/75). Therefore, this type of patient may not conform to the 'good death' that may be more of a possibility in relation to a patient with cancer.

Patients like John and Patricia seem to be a challenge to the PCT in terms of their resistant pain. Methods that work well with patients with cancer may not be so effective in the disease trajectory experienced by both John and Patricia. With palliative care broadening its remit to include the type of disease trajectory demonstrated in these cases there is a possibility that such cases could be a threat to the reputation of the team. There was criticism, by medical staff, of the contribution that palliative care specialists could make in relation to heart failure unless these specialists developed competence in the clinical management of the condition, as this illness trajectory does not have a clearly defined or straightforward boundary (Hibbert et al 2003). The researchers conclude that

palliative medicine has refined its technical expertise in cancer care and to move beyond this may threaten its legitimacy.

This talk constructs how the PCT move to a psychosocial moral discourse when biomedical interventions are not effective. Therefore psychosocial talk is deployed largely when difficulties in the biomedical format are experienced. I suggest that psychosocial/moral type talk may be used to imply a discredited identity or reputation when biomedical approaches to pain are unsuccessful. This type of talk is evident in relation to patients with diseases other than cancer but also in relation to patients with cancer who have other problems such as mental health problems.

In the next sequence of talk, which takes place in an in-patient hospice setting, there is talk about a patient called Elsie whose pain is difficult to assess. This patient has a history of mental health problems.

#### 6.5.4 Difficult pain

In this sequence of talk of the in-patient hospice team meeting, there is discussion about the difficulty in assessing Elsie's pain.

- |    |                             |  |
|----|-----------------------------|--|
| 1  | <sup>22</sup> HNurse Claire | Elsie, we've had an admission, an 80 year old                            |
| 2  |                             | lady with carcinoma of colon. She was admitted on, when was she          |
| 3  |                             | admitted, Friday.  |
| 4  | HNurse Tracy                | Friday, I think.   |
| 5  | HNurse Claire               | And she's also a lady who has a history of                               |
| 6  |                             | schizophrenia. She ah (Laughter)   |
| 7  |                             | This lady has a colostomy and it is quite prolapsed                      |
| 8  |                             | and mm she ah also has a very offensive discharge from the rectum        |
| 9  |                             | and she's very conscious of it and she's very private about it. (She     |
| 10 |                             | won't) always let you help her nor will she she a ( ) apparently she's   |
| 11 |                             | quite ahm a tumour growing through in the rectum and the doctor          |
| 12 |                             | thought she had haemorrhoids. She's on MST she was on oramorph           |
| 13 |                             | and she's now converted to MST 20 milligrams bd starting today           |
| 14 |                             | and I think she is fairly well pain controlled. She doesn't have the     |
| 15 |                             | need for breakthrough but yet she tells people that she feels            |
| 16 |                             | uncomfortable and she's sore and she's in pain, but she gives the        |
| 17 |                             | impression you know, when your talking to her, when you're in the        |
| 18 |                             | room, when your in and out all the time most of the time and when        |
| 19 |                             | she does, if you ask her is she in pain, has she any pain she'll say no. |
| 20 |                             | So, and she doesn't seem distressed. So I don't think she is in pain.    |
| 21 | HNurse Tracy                | She said that mm I don't know which doctor it was                        |
| 22 |                             | but she said that a doctor had told her, go away, that she had this      |
| 23 |                             | pain and she should put up with it.                                      |
| 24 | HNurse Joanne               | She told me that at lunchtime. That she has this in the                  |
| 25 |                             | rectal area and once she sits she has to work out how to sit and once    |
| 26 |                             | she sits in a particular any movement the pain comes back. So I'm        |
| 27 |                             | not sure that she is, I think she is very difficult to assess.           |
| 28 | HNurse Claire               | Very difficult.  |
| 29 | Dr Jenkins                  | We've started her on some voltarol today slow release                    |

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<sup>22</sup> HNurse – Hospice Nurse

30                                    voltarol as well as the mm MST. I spoke with Dr Piper yesterday and  
31                                    apparently mm what she told me wasn't true. She said that she  
32                                    hadn't had radiotherapy because her son wouldn't let her, her son  
33                                    said, 'it certainly wouldn't do any good'. Dr Piper said that he saw her  
34                                    in May and a a had a long talk with her and the son explaining that  
35                                    once a week radiation treatment might improve the discharge and  
36                                    also the pain. She was adamant that she, she wouldn't have it and  
37                                    the son tried to talk her into it. Ah he said that she's 80 and she's got  
38                                    very fixed ideas and a now she has put up with this pain and  
39                                    particularly the discharge has got worse and smelly now she's agreed  
40                                    to to go a week today.  
41    HNurse Claire                She's going on the 29th isn't she?  
42    Dr Jenkins                    A week tomorrow. Yeah that's right. But she's (slight  
43                                    laugh) using the son as an excuse for not having the treatment before,  
44                                    'he told me that it wouldn't do me any good and I shouldn't have it'.  
45    HNurse Claire                Right. Not too bad in the morning psychologically  
46                                    but a come a about 5 o'clock the vampire comes out and a she it's  
47                                    difficult (laughs). She's a different person and a your lucky if you get  
48                                    in the room door. You've just got to go but she a she there's a  
49                                    marked change come the evening (laughs). It is quite, quite  
50                                    remarkable.  
51    <sup>23</sup>SW Alice                    When dark comes you mean?  
52    HNurse Claire                It is like that. Yeah, yeah. She is almost  
53                                    incommunicado she's a you know gets she's really shirty and if you  
54                                    ask her a question well albeit on your head (laughs). She's not too  
55                                    bad in the morning.  
56    SW Alice                     Is he the main carer the son then?  
57    HNurse Claire                I think so yeah, yeah she told me ( ) she told me. I  
58                                    don't think he lives with her. I don't know.  
59    SW Alice                     Who's supporting him? Has he got family besides?  
60    HNurse Claire                Everything's in the notes. We never see him.  
61    <sup>24</sup>HCA Jane                    And all he did yesterday was apparently (she was telling off all  
62                                    the time).  
63    HNurse Claire                When he comes in she tells him off all the time so  
64    SW Alice                     We need to check out his support don't we really.  
65    HNurse Claire                Yeah.  
66    Dr Jenkins                    So as far as her discharge is concerned we will keep her  
67                                    until she's been to the specialist hospital.  
68    HNurse Claire                And make sure she goes. Yeah.  
69    Dr Jenkins                    and then we will see how she gets on we'll see what the er  
70                                    slow release voltarol does and if that doesn't work try her on a small  
71                                    dose of (amitriptyline).

### **Extract 9 Hospice team meeting Karamea Hospice**

Elsie is an elderly lady with cancer of the colon and she also has a history of schizophrenia (line 6). Claire, the hospice nurse, voices some criticism of her doctor who did not spot the tumour 'quite ahm a tumour growing through in the rectum and the doctor thought she had haemorrhoids' (lines 11/12). This is a complex case and Elsie has a number of problems including an offensive discharge (line 8). Elsie is described as 'very conscious' of the offensive discharge from the rectum (line 9). Elsie is also reluctant to let the nurses help her with the colostomy and is described as 'very private about it' (line 9). Claire says 'I think she is fairly well pain controlled' and her evidence for this is that Elsie

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<sup>23</sup> SW – Social Worker



has not needed 'breakthrough' medication (line 15). Claire subsequently provides evidence to contradict this statement, 'she tells people that she feels uncomfortable and she's sore and she's in pain' (lines 15/16). However Claire concludes, 'when you're in and out all the time most of the time and when she does, if you ask her is she in pain, has she any pain she'll say, no' (lines 18/19). Claire continues, 'So, and she doesn't seem distressed. So I don't think she is in pain' (line 20). By using the hedge 'I don't think' and 'seems' Claire reveals an element of uncertainty around this account. Bergman (1992) says that presenting knowledge as uncertain may be a method of inviting a recipient to deliver another version should he or she know better. He calls this 'information-eliciting tellings'. He also says that another way of showing the derivative character of one's knowledge is to describe this knowledge as derived from observation or impression and to mention the process of perception itself. Thus Claire describes the process by which she has assessed her 'impression' (line 17). She also uses 'when you're talking to her' (line 17) and her assessment of her outward appearance 'she doesn't seem distressed' (line 20). According to Bergman, 'information-eliciting tellings' may enable one to discover further information from a number of sources, which may cast doubt on the reported events. This seems to be the process at lines 21/22 when Tracy provides another account of how Elsie has blamed a doctor for telling her to put up with the pain and Joanne who agrees with Tracy and gives an account of how Elsie describes the pain coming back when she moves (lines 24-27). So Claire's 'I don't think she has pain' is reinterpreted by Joanne as 'difficult to assess' (line 27). Claire replies with an upgrade 'very difficult' (line 28). Thus the staff seem to take part in negotiating an account of Elsie's pain experience and behaviour, as experienced by them, by use of 'information-eliciting tellings', within the hospice team meeting. Jackson (1992) says that the nature of pain is constantly under negotiation, especially related to issues of responsibility. It has been found that the interpretation of pain both by the sufferer and by the medical staff is also not fixed (Jackson 1994, Baszanger 1998). I suggest the different versions or accounts of Elsie's pain point to a complex fluidity and tension concerning the individual cultural expression and beliefs in relation to pain and those of the culture within the hospice. There is some difficulty in pinning pain down that presents a dilemma for staff but this is

compensated for, to some extent, in the talk by the different accounts allowed expression.

Kugelmann (1999) conducted a study of 14 people attending a pain management programme. He says that respondents talked about ways in which a person can be active against pain by being strong minded and self-reliant and by using positive thinking. He found evidence that people put up with pain and deal with it because overt signs of emotion could be interpreted as a sign of weakness and may destroy them. Thus pain was not only a matter of sensing and feeling but also of thinking. Elsie like the participants in Kugelmann's study seems to believe that the experience of pain is her private responsibility but unlike the respondents in the study she is not overly concerned with proving its existence; she would rather not admit to her pain and seems to want to keep it private.

There is also some suggestion that Elsie's behaviour is to some extent odd, amusing or embarrassing as various staff laugh when they are talking about her, including Doctor Jenkins (line 43) and Claire (lines 6, 47,49,54). This may reflect the fact that she has a history of mental health problems. Dr Jenkins also provides some evidence to doubt Elsie's credibility. He reports how Elsie has refused radiotherapy, which may help the pain and the rectal discharge and that she is blaming her son for not allowing her to have treatment. The radiotherapist, Dr Piper has told Dr Jenkins that Elsie's son has tried to persuade his mother to have the therapy. Dr Jenkins concludes, 'what she told me wasn't true' (line 31). Elsie, according to Dr Jenkins, has now agreed to have the radiotherapy because the discharge has got worse (line 39). Once it is confirmed that Elsie is going to have radiotherapy the following week, Claire accomplishes a topic change. Claire now moves on to Elsie's psychological state, 'Not too bad in the morning psychologically but a come a about 5 o'clock the vampire comes out and a she it's difficult (laughs). She's a different person and a your lucky if you get in the room door' (line 45-48). The difficulty with Elsie is not only the pain problem and her refusal of therapy but also the troublesome nature of Elsie's mood as the day wears on. Claire's choice of language is rich in metaphor and slightly amusing. She is comparing Elsie to a vampire and her personality changes with the onset of the dark, a Jekyll and Hyde type character. The social worker Alice links the mood change with the dark: 'when the dark comes you mean?' (line 51). At this time of the day the patient is 'incommunicado' and 'shirty', according to Claire (line 53).

This constructs how difficult it must be, for Claire, when she tries to enter Elsie's room and ask her a question 'well albeit on your head' (line 54). The social worker establishes her concern is with Elsie's son (line 56) and she accomplishes a topic change to talk of his support (line 59). Furthermore, the health care assistant describes how Elsie 'she tells off' (line 61). So Elsie is difficult not only with Claire but also with her son. Claire reiterates the health care assistant's words and says 'she tells him off all the time' (line 63). Dr Jenkins changes the topic of talk to a decision about discharge 'we will keep her until she's been to the specialist hospital' (lines 66/67). Claire is concerned with compliance and replies, 'And make sure she goes. Yeah' (line 68). Dr Jenkins concludes by discussing her analgesic medication and the possibility of trying other medication if the current ones do not work (line 70). Dr Jenkins seems to accept that Elsie has got pain.

Elsie is difficult not only in relation to the pain problem but also in relation to her psychological mood. What is interesting about the discussion of her psychological state is that the other nurses remain silent during this talk. It is only the health care assistant and the social worker that joins in with Claire's talk about Elsie's mood. I suggest that this may be because this type of talk is sensitive. Claire is disclosing how difficult the patient is and how she reacts when she goes into her room. Elsie is reported as uncommunicative, sharp and shirty. Claire reports but does not give an opinion on this behaviour and nor do the other nurses, they remain silent. Perhaps this is something that cannot be said in this meeting, as staff in this setting do not openly criticise patients unlike the meetings in the other settings. Also a sense of professionalism is maintained by the neutral footing enabled by 'information-eliciting tellings' in presenting this case.

What is interesting about this sequence of talk is that although Elsie may wish to remain private about her pain and be reluctant to accept help, there is no attempt to directly link her poorly controlled pain with her mood. This may be because the personality change referred to, 'a different person' (line 47), is viewed as linked with her mental health history rather than with her experience of pain per se. There is some indication in the talk that Elsie believes that she should bear the pain. This is not a culturally congruent view in medical and nursing culture. The view that one should bear pain would be considered rather irrational and difficult to understand and may further question Elsie's credibility as a rational person.

Lawton (2000) observed how particular types of bodily deterioration and decay are contained within hospices. She describes how hospices contain bodies that leak from wounds and incontinence resulting in the disintegration of physical boundaries, which can also result in the loss of self. One way that staff maintained boundedness, according to Lawton, was in the successful control of symptoms and in this way self was also restored. Elsie I suggest is someone who has leaking body boundaries as she has a prolapsed colostomy (line 7) and she has an offensive discharge from the rectum (line 8) as well as the elusive pain. Elsie is resisting help perhaps because acknowledging such a need would increase her dependency, which may result in her becoming more vulnerable (Kugelmann 1999). This resistance may be one way that she can keep herself intact and private and in this way preserve her sense of self despite her disintegrating bodily boundaries.

Elsie, like Patricia and John, is perceived to be having poorly controlled symptoms and to be behaving inappropriately. The inappropriate behaviour concerns the non-co-operation with professional help, complaining about this help, denying the presence of pain and being emotional or aggressively emotional. Patients whose symptoms are poorly controlled despite the best efforts of the PCT are potentially a threat to the reputation of the palliative care team in all the settings discussed. The strategies used to contain them are the use of acupuncture, admitting the patient to the hospice, getting the reluctant patient's agreement to further therapy, providing support to relatives, and sharing one's concerns with the team and enlisting their help. There is evidence that other strategies and resources are available such as psychosocial therapies and these are used in one hospice in particular. This will be discussed later.

## 6.6 Conclusion

The PCT use rhetorical forms of speech, such as contrastive rhetoric, to position themselves and their expertise and knowledge in symptom control in contrast to those without this expertise. CPCNs, through talk involving criticism, position themselves as having more expertise in pharmacological management of pain than some GPs. The CPCT and HPCT portray themselves as working in a reactive manner to shore up the boundaries of inadequate symptom control, particularly problems such as over medication with opioids in the hospital and the community.

Rhetorical talk involving criticism also enables the PCT to develop their unique identity as a team around a discrete area of medical practice and in this way build a reputation for themselves in symptom control. Such talk blurs, to some extent, professional boundaries because PCTs share the same mission to alleviate troublesome symptoms that transcends professional boundaries.

The team reputation can be threatened and this occurs when symptoms are difficult to control. I suggest that there is a particular problem concerning patients with disease trajectories such as peripheral vascular disease and neuropathic type pain. This type of disease may be resistant to the current therapies and expertise available. Such illness trajectories include widespread surgical intervention that disturbs bodily integrity and functioning as well as severe pain, which may be resistant to analgesic drugs. These patients may threaten the reputation of the team and ultimately the success of the hospice in achieving a 'good death'.

Although the PCT talk about the patient's psychosocial and emotional state there is not necessarily a direct link made between that state and the pain in this talk. This link is side stepped, instead a psychosocial discourse is used that moves talk of pain into a subjective space that implicates the suffering patient in being in some sense, responsible for the pain, due to the inappropriate performance of a suffering body. However 'painmaking' is a cultural performance for staff as well as for patients as both staff and patients interpret, think about and negotiate pain in their talk. Hospice staff use conversational practices such as information-eliciting tellings and this enables them to keep a neutralistic footing. Thus a broad interpretation of what a cultural performance of pain may consist of is maintained I suggest. This enables some of the threats to reputation to be negotiated and a number of voices to be heard. Ultimately reputation is a mutually constructed category. The PCT seem to attend to this consistently in their talk. Primarily they do reputation through pain talk.

In the next chapter I turn to further linguistic analysis of how the boundaries of palliative care work are made and unmade and what this means for interprofessional work and work related to pain.

**Chapter 7 The Boundaries of Palliative  
Care Work and the  
Importance of Pain**

## 7.1 Introduction

In this section I analyse how palliative care nurses construct their competence and credibility as specialist nurses in and through their talk. This talk has similar features to those identified by a number of authors who have studied medical talk in action in a variety of contexts; for example the use of the pronouns ‘I and we’ to construct collegial talk (Atkinson 1999, Silverman 1987), and the use of ‘I’, reflecting a personal authority (Sacks 1992, Watson 1987). Also evident is the use of story telling and the asking of questions to take the floor (Silverman 1998, Sacks 1992); the use of rhetorical forms of speech and hedging (Atkinson 1995, 1994, Prince et al 1982), and the use of footing to construct a neutralistic standpoint (Greatbatch and Dingwall 1999, Clayman 1992). These linguistic devices enable specialist nurses to shape the agenda of talk and achieve their particular identity as competent professionals. I argue that the boundary between different types of medical and palliative care work is a space for negotiation, as well as evaluative and political action and this contributes to the fragility of professional boundaries (Beck & Beck-Gernsheim 2002, Svensson 1996, Dingwall 1977). Much of this talk both directly and indirectly involves the problem and troubles associated with the symptoms of advanced cancer and in particular pain.

### 7.1.1 The aims of the chapter:

- identify how accounts are constructed to demonstrate the specialist nurses’ competence
- specify linguistic and rhetorical devices that enable a competent performance by palliative care nurses
- discuss how the boundaries of palliative care are jointly constructed by use of questions, gate-keeping, challenges to non-specialist practitioners and explicit and implicit negotiations and agreements

## 7.2 Using ‘I’ in relation to the patient in pain

According to Sacks (1992) the pronoun ‘I’ is a referential standpoint and serves to present a personal position in an argument. Watson (1987) asserts that what ‘I did’ is distinctive to what ‘we did’, and thus the term ‘I’ is performative. The nurses in the following extracts of talk construct what ‘I’ did in relation to pain, namely ‘checking’ for pain with other practitioners and the ability to ‘see’ significant pain:

- a) *I'm just checking on pain whether or not he is still complaining of?  
(HPCN Liz)*
- b) *I just wanted to check with you was she still getting a fair bit of pain?  
(HPCN Liz)*
- c) *But I thought, well I would go and see if she has got significant pain.  
(CPCN Penny)*

This talk of 'checking' for and 'seeing' significant pain constructs the possibility of being able to visualise pain in the body. Therefore Liz and Penny construct pain as something tangible that can be checked for and visualised.

In the following extracts of talk pain is interpreted by the nurse and linked with mood, behaviour and experience:

- d) *I believe he becomes depressed very, very quickly. He is quite sensitive to pain and mm I think. (CPCN Marie)*
- e) *He's got a very low threshold, I think to pain as well and so a twinge.  
(CPCN Marie)*
- f) *He's still not really particularly comfortable. He's got this shoulder pain, arm pain and I'm not sure it's not bone they've eliminated that. I think quite a lot of this is psychological pain Matthew. (CPCN Marie)*

Marie makes three contrasts in this talk, firstly between being 'depressed very, very quickly' and 'quite sensitive to pain' (extract d); secondly between a low threshold to pain and a twinge (extract e); and thirdly between pain in the body such as shoulder and arm pain and psychological pain (extract f). This talk seems to achieve a differentiation between physical pain, and the particular circumstances of the patient response. The use of the word 'twinge' suggests pain is minimal and enables Marie to construct the patient as having a, 'low threshold' to pain (extract e). In other words a 'twinge' is not something someone with a 'high threshold' would experience as a pain. Morris (1998) says that pain always runs the risk of being thought of as unreal when it is unconfirmed by tests and biomedical indices. He also suggests that staff create expectations of patient's behaviour when the biomedical aspects of pain are not proven. The talk above achieves Marie's personal theory of pain as on each occasion she uses, 'I think' and 'I believe' to construct what she thinks and believes about pain. In her view pain is something that can be affected by mood, in particular depression and psychological pain can exist separately from pain in the body such as bone pain.



In the next extract of talk Liz and Matthew construct pain as a need and an emotional expression but do so in a factual manner and do not use the pronoun 'I'.

*g) The trouble is she needs that pain. (HPCN Liz)*

*h) He was being rather aggressive when he was in pain. (CPM Matthew)*

The statement 'she needs that pain' (extract g) is an unmarked statement and conveys that the speaker is committed to the proposition asserted (Prince et al 1982). Unmarked assertions are said by Prince et al to be 'unhedged' and they implicate that the speaker has knowledge via observation or logical reasoning that the proposition conveyed is true. In contrast the term 'I think' is called a plausibility shield by Prince et al (1982:86) who say that such shields are often used in everyday plausible reasoning. Therefore speakers may mark their outputs according to different types of reasoning involving logical and plausible reasoning. The link between pain and need introduced by Liz suggests that pain may be used to satisfy a need. These extracts of talk suggest that in the context defined by palliative care staff a link is developed between pain in the physical body and the body in pain. Good (1994) says that the divergence between the world of physical/physiological objects and mental states obscures our understanding in relation to chronic pain. Thus the integration of human experience into accounts of disease is a challenge for medicine according to Good. He continues:

*our medical practices are designed to localize suffering in a discrete site in the body, a site which can be made visible and subjected to therapeutic procedures. Chronic pain resists such objectification, defeats medical practices aimed at its localization time and time again. (Good 1994:132)*

Good says that when the objectification of pain fails it may be thought of as a disorder of the subjective self, which is held responsible for producing its own suffering. I suggest that the reference to the patient's aggression (extract h) and to need (extract g) introduces how Liz and Matthew interpret the patient's performance and objectify that performance. Hence pain will not be relieved because the patient needs it (extract g). The statement in extract h) suggests an emotionally charged situation that implies an inappropriate performance of aggression by the patient. Hunt (1989) observes that symptom control nurses use different role formats to cope with distressing and emotionally charged situations through talk. One of the role formats identified by Hunt is the bio-medical-psychological format. This format was found to be used by nurses in situations

involving uncertainty and emotion laden conditions such as the experience of pain. Nurses by shifting from the biomedical role format to the psychological format were able to cope with patients who were not responding to medical treatment. I suggest that extract g) and h) reflect the shift to the psychological format in relation to patients not responding within the biomedical format in relation to control of their pain.

I suggest that the use of 'I' in relation to pain enable one to understand the work of nurses in checking for and seeing pain. It also demonstrates that palliative care staff have their own theories about what is causing pain and use logical and plausible reasoning to interpret pain behaviour in a medical context.

### 7.2.1 Using 'I' in relation to support

There is some criticism that hospice staff privilege effective pain and symptom control over the psychosocial and spiritual needs of patients (Clark 2002, James 1986). I have found that palliative care and hospice staff focus on the psychosocial support needs of the patient and family, using the personal pronoun 'I'. In the following extract Penny interprets a family members expressed need for support:

*a) but I think you know she's actually asking for support. (CPCN Penny)*

In the next extract a hospice doctor assesses a patient's cognitive function and concludes that this patient will not benefit from cognitive therapy but that emotional support is suitable:

*b) and I think that previously her cognitive function is limited and I'm not quite sure how much she's able to partake of any sort of form of cognitive therapy. Emotional support fine. I don't think she could take part in any of Doctor Schwan's ahm cognitive or behaviour treatment. (Hospice Registrar Michael)*

In the following extracts nurses and social workers individually spend time talking to family members.:

*c) and it was really heart-wrenching ahm I spoke to the father in the evening and the way they want to deal with it is that they are not going to say anything to the younger son until she dies. (Hospice Nurse Anita)*

*d) I have met up with Nula and I was introduced to one of the daughters the week before last. (Social Worker Alice)*

In extract c) the nurse refers to the extreme distress involved in this situation by describing it as 'heart wrenching'. This metaphor of the heart implies the

emotional content of this conversation with a father. Extract d) implies the importance of the social worker being introduced to family members. Presumably this prepares the family for further social worker involvement.

In the next three extracts of talk the nurses report how patients want to 'chat' with them and how they also offer support and counselling when they are concerned about patients and young family members:

- e) *I mentioned things to him and he said, 'look you know it's pick the phone up all I can say is yes and I'll have to put the phone down', but when I was there, he was chatting away. It was very hard to understand him, what he was saying but he really wanted to have a chat. (CPCN Julie)*
- f) *I am very concerned really about him. I've suggested, would he like some extra support like counselling or whatever and he said, a very nice lad goes to Sladebrook school, he said he'd think about it and by the end of the visit he was asking where would it be and who would it be with? (CPCN Karen)*
- g) *So I asked her what her problems were with the counselling but she just didn't know what it was and I said to her its very much what you do now its talking about your fears, your worries all that sort of (thing). (Hospice Nurse Joanne)*

In extract e) a contrast is made between how the patient 'was chatting away' to Julie despite his difficulty making himself understood on the phone when talking to other people. This implies that the patient feels comfortable talking to the nurse despite his difficulties with communication. This achieves Julie's credentials as a caring nurse who spends time chatting to patients in difficult circumstances. In extract f) Karen displays her concern about a young family member who needs extra support and she has offered him counselling, which he seems to be interested in as she describes how he 'was asking 'where would it be and who would it be with?' In extract g) the nurse talks with the patient about her problems with counselling and her lack of knowledge about what it is and suggests it is a way that she can talk about her fears and worries and this is something that 'you do now'. In this talk the psychosocial support needs of patients and family members are constructed. Spending time talking and chatting seems to be important in identifying the support needs of patients and families and in giving support.

Through use of the personal pronoun 'I' members of the palliative care team orientates to the contemporary hospice philosophy of 'total care' and the search for total comfort of those who are dying or terminally ill through the discourse of psychosocial support (ten Have & Clark 2002). Saunders defines 'terminal

illness' as 'a claim for comfort rather than curative or even palliative' (Saunders 1966:225). Gracia (2002) says that the distinction between palliative care and palliative medicine became evident after 1987 when palliative medicine became a recognised medical speciality. Thus palliative care is about 'total comfort' and palliative medicine is a specific part of the whole strategy for achieving this level of comfort. However, Clark et al (2002) says that palliative care across Europe is developing with different practices and whilst the external goals of palliative care may be shared the internal goal has become blurred. My observation from the data presented is that the discourse of supportive care and psychosocial interventions appears more prominent in the data from Karamea Hospice. Staff at Karamea Hospice talk about specific psychosocial interventions such as cognitive behaviour therapy (CBT) in extract b), and counselling (extract e) and life review therapy in the next section (extract c) that is not mentioned on the Oakwood site. Talk on both sites includes talk of support and chat but it is only in Karamea Hospice team meetings that specific psychosocial interventions are named.

### **7.2.2 Constructing the team orientation to support using 'I' and 'we'**

Silverman (1987) refers to the clinical discourse of 'I' and 'we' in his work related to doctor/parent consultations. He refers to the 'I' voice being passive, reflective and authoritative, and that it is bolstered by the 'we' voice, which is active. The combination of these voices he argues, is the voice of persuasion, demonstrating its authority on rational sensible grounds. Thus together the use of 'I' and 'we' is a 'team-device' (Watson 1987). Silverman agrees with this and says that these voices of 'I' and 'we' get things done because they enable decisions to be made. Watson (1987) discusses the organisational use of 'we' when referring to oneself as a member of a unit or a member of an organisation.

In the following extract the use of 'I' and 'we' invokes the organisational identity of the palliative care team and continues the theme of support:

*a) I certainly think we did everything we could have done. They felt very well, very well supported. (Hospice Sister Beth)*

This reference to the team 'we' enables Beth to praise the work of the team by her use of the extreme case formulation 'very well supported'. In the next extract the use of we invokes the team of patient and nurse I suggest:

*b) Ah I talked to Seline on Sunday and she was asking all these questions about treatment and was she going to get better and I was very honest about what was happening and a and I was picking up from her her inability to cope with the mother going because the mother's been the central core in that family and there's this feeling that the ( ) family's going to collapse when the mother goes. The death of the brother came and all the rest of it and he was and we talked about counselling the mother's friend was there at the time you know the older lady that comes in and sits with her quite a bit. (Hospice Nurse Joanne)*

Nurse Joanne constructs a partnership with the patient through her use of 'and we talked about counselling'. Thus this nurse works in partnership with the patient and constructs a joint performance of raising and getting co-operation for counselling intervention. Similarly the social worker in the next extract of talk constructs herself and the patient as a team through the use of 'we':

*c) A lot of life review work we did. Yeah and ahm Julie's wanting to work with me in her bereavement. So that's a good sign. Mm whether that materialises or not we'll have to wait and see. (Social Worker Alice)*

Together this patient and the social worker have undertaken 'life review work'. This is a specific form of therapy offered by the social worker at this hospice. The second use of 'we'll have to wait and see' constructs the palliative care team interest in offering bereavement support.

The hospice team construct therapeutic work through their talk. They utilise emotional support, counselling, and offer specialist CBT and life review therapy. I suggest that such therapeutic discourse is a team concern at Karamea Hospice. In contrast to the psychosocial discourse at Karamea Hospice a CPCN from the community team at Oakwood suggests:

*d) Patricia, we never did anything for her but we did spend a lot of time chatting to her (CPCN Cathy)*

Thus extract d) contrasts the activity of 'a lot of time chatting' with, 'we never did anything for her'. This I suggest is an unusual contrast because it seems to suggest that the time spent chatting is not considered doing 'anything'. Perhaps 'anything' in this context refers to specific interventions for symptoms rather than chat or talk per se.

### 7.2.3 Using 'I' and 'we' to construct pain work

In the following extracts of talk the palliative care team through the use of 'I' and 'we' construct the team approach to problems around pain and pharmacological approaches to pain:

- a) *Yeah. She is on the carbamazepine for phantom pains and she is on 200. In fact we ought to review that at some stage just to make sure she doesn't have more phantom troubles. Mm and I cut it from 200 to 100 to see if it would make her less dopey and I suppose she has got significantly less body mass with no legs. (CPM Matthew)*
- b) *I think eventually we should stop the oramorph. (CPM Matthew)*
- c) *Came in for symptom control of pain ahm, which we haven't quite got under control yet. It's quite uncontrolled at the moment. She's on MST and that was increased and then she went on to oramorph and I think we're thinking of putting her on is it oxycodone. (Hospice Nurse Caroline)*
- d) *Devi hm ( ) this morning. Hm Yesterday that she was ( ). Unusual situation ( ) she was dying not really as a result of the cancer but as a result, we think, of the drugs that she had. (Hospice Sister Beth)*

In extracts a) and b) Matthew shapes how the team will work together. This talk constructs the nurses in a collegial relationship with Matthew. Together 'the team' will review the drug carbamazepine for the 'phantom troubles' (extract a) and 'eventually we should stop the oramorph' (extract b). Together Matthew and the nurses review the status of the pain and Matthew cuts the drug dose. Caroline uses the team device of 'we're' to name the drug that the patient may be put on (extract c). In extract d) Beth voices the team concern related to the unusual side effect of 'the drugs' rather than the cancer resulting in the patient dying. I conclude from this that pharmacological interventions are constructed as a concern of the team through use of the team device 'we'. This suggests that the collegial relationship that exists through the use of 'I' and 'we' is enabled because these nurses have specific knowledge of pharmacological therapies that enables doctors to treat them as a type of colleague. The team device is also used when referring to patients and family members. This conveys the importance of the patient working with the staff to reach clinical outcomes. The use of the collegial 'we' is part of the process of social alignment that enables doctors, nurses, social workers and patients to work together in relation to support on the one hand and pharmacological therapy on the other.

In the next section I will discuss the linguistic device of hedging and I will analyse how this device is used to convey elements of uncertainty and caution in the talk.

### 7.3 The use of hedging

Atkinson (1995) says that the discursive treatment of uncertainty includes the device known as hedging. Hedging refers to the use of words or phrases whose job it is to make things fuzzier (Lakoff 1972). Prince et al (1982) undertook a linguistic analysis of data collected by audio-recording morning rounds in a paediatric intensive care unit (ICU). They found between 150 and 450 hedges being used per hour. Prince et al say that hedges make things ‘fuzzy’ but do so in two distinct ways. One class of hedges they describe correlates with fuzziness in the relationship between the propositional content and the speaker and conveys the speakers’ commitment to the truth of the proposition. Prince et al give examples of the use of propositions such as ‘I think’ and ‘I guess’, which they call a shield. A second type of hedge is responsible for fuzziness within the propositional content proper, for example use of words such as ‘some’ or ‘somewhat’ and this is termed an approximator. According to Prince et al approximators are used to modify medical terms and descriptions in order to render them less precise and they name the two types of approximators as adaptors and rounders. Adaptors are used to indicate that there is a degree of mismatch or flexibility between a prototypical description and the observed or reported conditions and rounders are used to indicate a range of values, and are very common when measurements are being referred to. Prince et al reports that approximators occur in the ICU data most frequently in the description of symptoms.

In my data a number of approximators are used across all the sites in relation to the patients’ symptoms. Here are some examples of adaptors:

- a) *had put her on a fentanyl patch because she felt she had some some pain hmm. She has also got quite severe dementia’. (CPCN Penny)*
- b) *He has only a little bit of pain*. (CPM Matthew)
- c) *He had some mm sort of neuropathic symptoms did he, originally?* (HPCN Liz)
- d) *If you asked him he said it was just a bit uncomfortable down below.* (HPCN Amy)
- e) *There’s possibly an increase in some of the mets in the skull but there is nothing definite on scan.* (CPCN Cath)

Adaptors in the context of palliative care team talk construct a cautious approach to symptoms such as ‘some pain’, ‘little bit of pain’ and ‘bit uncomfortable’ (extracts a, b and d) and to diagnosis ‘possibly an increase in some of the mets’ (extract e). The use of adaptors implies the difficulty in being precise about symptoms and disease progression particularly when disease processes may not be made visible by techniques such as a scanning ( extract e).

Prince et al say that rounders are a shorthand device when exact figures are not available or not relevant. I have found a few examples of rounders in my data:

- f) Must be about sixty something. (CPM Matthew)*
- g) She is only on about two. That is the next thing to do tail that off. (CPM Matthew)*
- g) No she had a CA breast about twenty years ago and then I think. (HPCN Liz)*

I suggest that rounders may serve a function not discussed by Prince et al. For example they could be used to gloss over particular issues such as age or drug dosage particularly if a practitioner wanted to disguise such factors.

Shields mark the speaker’s degree of commitment to the report (Prince et al 1982). Two types are identified by Prince et al and they are termed ‘plausibility’ and ‘attribution’ shields. The authors argue that plausibility shields implicate various levels of lack of certainty and doubt and assertions marked by such shields implicate that the speaker is asserting a belief acquired via plausible reasoning. Prince et al says that plausibility shields are characteristic of utterances involving planning and diagnosing. Examples of plausibility shields in my data related to planning are identified below:

- h) I think Dr Jenkins has spoken to both the husband and the daughter about that and that she is poorly and that she is dying. (Hospice Sister Beth)*
- i) Well I think the best thing to do then is to leave the district nurse with, the GP. (CPCN Cath)*
- J) I think eventually we should stop the oramorph. (CPM Matthew)*



Plausibility shields related to diagnosis in my data are displayed below:

- k) *I think my feeling that this is organic brain disease this is an organic and I don't think it's just the medication. (Hospice Registrar Michael)*
- l) *I think that previously her cognitive function is limited and I'm not quite sure how much she's able to partake of any sort of form of cognitive therapy. (Hospice Registrar Michael)*

In contrast to plausibility shields, attribution shields are used to indicate that knowledge and beliefs have been derived from the report of others and they predominate in relation to background information, including the cause of hospitalization for example (Prince et al). Furthermore Prince et al say that in the case of a proposition accompanied by an attribution shield nothing is explicitly stated about the speaker's own level of commitment. They conclude that one can ascertain the speaker's level of commitment to the report by taking into account the attributee and how the attributee may be ranked by the co-participants. They give the example of how some physicians may rank higher than others may and nurses may rank higher than parents, but lower than physicians for example.

Examples of attribution shields from the data are displayed below:

- m) *Anyway ah in the message book, that the deputy had written, various phone calls, yesterday, from the daughter who has got herself quite distressed. (CPCN Penny)*
- n) *we got her pain under control and she went home and when she got home she looked in the mirror and this is according to her friend the doctor from Canada and said 'I'm not taking these steroids any more. (Medical Director (MD) Doctor Jenkins)*
- o) *Apparently Dr Benson er wants to do a OGD tomorrow because he thinks the tumour grown over the stent ( MD Doctor Jenkins)*

Atkinson (1995) says that the use of hedges enables one to display expressions of credibility, plausibility and competence. It also enables the person presenting the case to position himself or herself in relation to the material they are reporting. Therefore the members of the palliative care team position their expertise in relation to the actors involved in the cases discussed such as deputy matron in extract m), friend and doctor from Canada extract n) and hospital physician extract o). Thus the palliative care team construct an intricate web that codes the level of trust and reliability in the events reported. Atkinson (1995) says that hierarchies of trust and responsibility are displayed and degrees of certainty and uncertainty may be inscribed into the case history itself. Furthermore Atkinson highlights the

importance of analysing talk-in-action to build an understanding of collegial talk in the development of medical knowledge:

*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 1995:131)*

Atkinson says that various utterances are marked in various ways to suggest that the evidence that they report on is not certain or that interpretation is unsure, tentative or contested. This he calls ‘evidentiality’, he continues:

*The general analytic issue of evidentiality in discourse analysis or pragmatics concerns the linguistic coding of epistemology. In its broadest sense it is concerned with the ways in which speakers (or writers) display their attitude towards, their belief in, or claims concerning facts, knowledge, opinions, inferences and the like. (Atkinson 1995:121)*

Thus evidentiality enables a story to be created which brings the reported events under the heading of a case and it creates different domains of credibility and zones of competence (Atkinson 1995). I suggest that the use of hedging and evidentiality enable the palliative care team to position itself in relation to other practitioners and patients, to mark areas of uncertainty as well as areas of competency. In the next section I will discuss how practitioners also use the concept of footing to maintain a neutral or impartial stance and bring off a competent performance.

### **7.3.1 Footing and neutralism**

Goffman (1981:128) introduced the term footing as relevant to a participant’s alignment, set, stance, posture, or projected self. Furthermore, Goffman discusses how a change in footing involves, ‘a change in the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance’. (Goffman 1981:128). Therefore following Goffman when we shift from saying something ourselves to reporting what others have said we are changing our footing. Goffman says that by employing ‘production formats’ speakers may take up various footings in relation to their own remarks. He says one may use one of three ‘production formats’ where one may become the animator, which is an actor involved in the role of utterance production, the one that utters a sequence of words; the author the one

who originated the beliefs and selected the sentiments expressed; and the principal, the one whose viewpoint or position is currently being expressed and who is committed to the words spoken (Goffman 1981). I argue that palliative care professionals move between different production formats to achieve specific outcomes in relation to the cases presented.

Several analyses of legal contexts (Greatbatch & Dingwall 1999, Atkinson 1992) and news interviews (Clayman 1992, Greatbatch 1992) have identified the importance of neutralism in such contexts. Atkinson (1992) says that in the small claims court the arbitrator regularly marked his utterances by saying 'certainly' and in doing so acknowledged receipt of what the plaintiff said. He describes this technique as highly effective in avoiding displaying affiliation or disaffiliation with the prior speaker. This technique enabled a display of neutrality in the face of potentially controversial material and was a resource that reconciled two potentially conflicting legal roles namely questioning both parties to the dispute and then passing judgement (Atkinson 1992). Thus neutralism was the platform that defended the arbitrator against claims of acting unfairly or taking sides that may be grounds for future complaints. Similarly Greatbatch & Dingwall (1999) in a study of family mediation involving the audio-recording of ten mediation sessions, show how mediators advance a stance of neutralism while applying pressure in favour of some options over others. They conclude that the parameters of mediator neutralism are not fixed and there are variations in mediators and disputants' conduct. What is interesting about this piece of research is that the mediators and disputants seem to shape case presentations and negotiation in a manner that may affect the outcome of such sessions. This I believe is an important factor in palliative care team meetings where outcomes for particular patients may be directly related to the issue of neutralism also.

Greatbatch (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 Greatbatch 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. Clayman (1992) provides further insight into how news interviewers achieve a 'neutralistic posture' by explicitly linking Goffman's concept of footing. Hence, he says news interviewers shift footings at specific junctures as a way of adopting 'a locally neutralistic posture'. For example the interviewer distances himself from contentious assertions by prefacing them with an attributive verb in the passive voice such as, 'it is said' and 'some people'. He continues, 'the footing shift thus achieves more than neutralism for its speaker; it simultaneously endows the attributed item with qualities that would otherwise threaten that posture'. Thus particular items are selected for special treatment and handling so that it is made clear that the views reported originated elsewhere (Clayman 1992: 170). The use of footing is a resource that is defensive and it protects and shields the interviewer in hostile environments by deflecting ownership away from him or her. Therefore, this resource is useful when those involved in interaction need to be cautious and careful in how they attribute actions to themselves and to others. This is a feature in the palliative care meetings particularly when difficult situations involving criticism or blame are involved. The data extracts below involve difficult situations involving pain, analgesia and interactions with family members:

*But with the daughter yesterday she wasn't doing that she was just, according to the daughter, in a lot of pain and she couldn't get the nursing home to do anything constructive about the pain. (CPCN Penny)*

*And she said that in the residential home, the daughter said 'you can't take morphine in the day because they can't give it. (HPCN Liz)*

In these data extracts Liz and Penny animate the voice of family members in relation expressions of criticism of the nursing and residential home staff. Atkinson (1995) argues that the narrative itself is not a mere chronicle of events but struck through with threads of responsibility, culpability and judgement. Hence the extracts above imply judgements made about the inability of care staff to control pain voiced by the CPCN and HPCN but attributed to the family member. In the next section I apply the concepts of footing and hedging which enable me to analyse how accounts are constructed to meet certain outcomes.

## **7.4 Constructing pain and psychosocial talk by taking the floor**

In this next extract of talk Penny the CPCN reports on her visit to a patient who is in pain and who is resident in a nursing home. Penny displays her ability to cross a number of boundaries to sort out the troubles in the nursing home. Penny through her talk displays her zone of competence as that related to finding and prescribing for pain, as well as in assessing and intervening in the support needs of a patient's daughter. In displaying her competence in these areas, Penny crosses two zones of credibility: that of the physician and that of the social worker.

1 CPCN Penny We're doing psychological yeah psychosocial.  
2 I've been to sort out one of Estelle's patient's at lunchtime  
3 that's why I'm late. Do you remember, Dr Jenkins a little lady  
4 called Lydia White who is now 88? Ah who is in a ( )  
5 nursing home one of Estelle Barnett's and she's she was  
6 referred to us I think by St Paul's and she's hmm got  
7 metastatic squamous carcinoma of the skin and possibly bone  
8 and hmm  
9 Dr Jenkins Yeah  
10 CPCN Penny And hmm when she was referred, Louise from  
11 St Paul's, had put her on a fentanyl patch because she felt  
12 she had some some pain hmm. She has also got quite severe  
13 dementia. She's the ex-ballet dancer does anyone (ring any  
14 bells ) her?  
15 Dr Jenkins Did she come in?  
16 CPCN Penny No. Estelle's just done, I think, either one or two  
17 visits.  
18 Dr Jenkins I seem to remember Estelle talking about it, about her  
19 being a ballet dancer.  
20 CPCN Penny Estelle went on the 24th and had various phone  
21 calls and was planning to meet the daughter on the 4th so  
22 that's where it is up to. Anyway ah in the message book, that  
23 the deputy had written, various phone calls, yesterday, from the  
24 daughter who has got herself quite distressed, because she  
25 gone to see her mother in the nursing home and her mother  
26 was very distressed and agitated and she felt she had  
27 significant pain and she didn't think the fentanyl 25  
28 micrograms was touching her. This lady does get distressed  
29 when she's not in pain apparently ah because of her dementia  
30 and then she can be, you know, very agitated and striking out  
31 at people and things like that. But with the daughter yesterday  
32 she wasn't doing that she was just, according to the daughter,  
33 in a lot of pain and she couldn't get the nursing home to do  
34 anything constructive about the pain, and so the daughter was  
35 sort of looking through the notes and trying to ring the GP,  
36 and all that, which of course upset the nursing home as well.  
37 You can imagine. So hmm  
38 Dr Jenkins She hadn't got anything for breakthrough?  
39 CPCN Penny No. The reason, one of the reasons, why she  
40 was put on the fentanyl patch was because she doesn't take  
41 hmm tablets very well. So hmm I went, I rang the daughter  
42 this morning and hmm she said that she'd spoken to the nurse  
43 in charge this morning and hmm they'd rung the GP because  
44 when the GP essentially agreed to come last night, it would  
45 have been very late and the daughter had felt it you know was  
46 one in the morning. The daughter was there from 12  
47 midnight and hmm the daughter thought that that would be  
48 too late anyway and her mother was getting more and more  
49 tired. And the daughter rang the nursing home this morning  
50 to see if the GP would come out today, and apparently it is Dr  
51 Jordan and he was doing admin today and, according to the  
52 daughter, he wasn't keen to come out. But I thought, well I  
53 would go and see if she has got significant pain. So I rang the  
54 matron and they said she was quite comfortable this morning  
55 and said they would be very grateful if I did call. So I went  
56 round to see her and hmm had a long chat with the hmm the  
57 nurse in charge and this lady apparently has been in the  
58 nursing home some years. I thought it was fairly recent  
59 admission. So they do know her quite well and she said she  
60 does get agitated from time to time and it is difficult to tell  
61 whether it is due to pain or due to ahm. So I went up to see  
62 the patient and hmm her daughter was with her and hmm she  
63 was very comfortable and looked very exhausted and was just  
64 resting really. So I didn't feel, just on the few minutes I was  
65 with them both, that hmm that there was an indication to  
66 increase the patch. Although really I don't have any  
67 objections to increasing the patch because she's had it since  
68 the 21st of the 10th and she could have got some tolerance to  
69 it by now if she has got pain but what I thought might be of  
70 benefit was to have some oramorph hmm

71 Dr Jenkins Liquid. Absolutely.  
72 CPCN Penny Because the daughter thought she would take a  
73 liquid. She thought she would take a teaspoon if it had been  
74 available to give her. So I rang Dr Jordan regarding that but  
75 also what I did do was hmm I talked a long time to the  
76 daughter about if she thinks she could benefit from some  
77 support because this daughter is travelling to and from  
78 America and you know she's got a lot on her mind and you  
79 know she's lost all her control since the mother's at the  
80 nursing home and she's I think could do with psychological  
81 support. When she said, 'yes please'. So hmm I was going to  
82 do a referral to you, but I don't know if your inundated? I'm  
83 quite happy to take her on because I've got some space so I'll  
84 do a referral and hmm hmm you can  
85 SW Gill Well, we are both quite busy at the moment we  
86 had quite a lot of referrals.  
87 CPCN Penny Okay.  
88 SW Gill Ahm.  
89 CPCN Penny I don't mind whichever way you want to play it,  
90 but I really think, you know, that she would you know, she's  
91 beginning to see, difficult to see the wood from the trees,  
92 really but I think you know she's actually asking for support,  
93 and I think from the commotion that happened yesterday.  
94 You know, the fact that she rang here and was saying, 'what is  
95 the hospice about', you know, because it didn't come out. So,  
96 you know, I think she's reached sort of fever pitch and I think  
97 she really needs  
98 SWGill And yeah, you've obviously have met the daughter.  
99 CPCN Penny And because Estelle will be coming back to work  
100 with the mother, I'm quite happy to take her on because I  
101 won't probably be involved with her again. Well shall I just do  
102 it then?  
103 SW Gill If you don't mind. Thank you very much.  
104 CPCN Penny Okay.  
105 SW Gill Thank you.  
106 CPCN Penny That's hm that was her.  
107 Dr Jenkins Hmm ().

### **Extract 10 Community palliative care meeting Karamea Hospice**

Penny gives an accomplished performance by telling a story about a patient in a nursing home, who needs to be sorted out. Telling a story is one way of getting the floor according to Silverman (1998). Penny announces that, 'we're doing psychological yeah psychosocial' (line 1). This works as a 'story preface', which is a specific activity designed to hold the floor (Silverman 1997). According to Atkinson (1995) stories told in medical settings have different genres such as puzzle, mystery or atrocity story. The genre of story constructed by Penny, I suggest, is that of a mystery story. The mystery story is a common format in accounts involving problems that defy definitive explanation and resolution (Atkinson 1992). The mystery story concerns a patient called Lydia who has dementia and is in pain. Furthermore, Lydia has a biography as a former ballet dancer and she has a daughter. Penny uses a variety of rhetorical devices such as hedging (Atkinson 1995, Prince et al 1982,) and footing to enable her to remain neutral in relation to the circumstances she is reporting (Clayman 1992, Goffman

1981). This type of positioning enables Penny to present herself as a competent and credible professional (Atkinson 1994, Greatbatch & Dingwall 1999).

Penny informs the meeting that she ‘has been to sort out one of Estelle’s patient’s at lunchtime’ and that is why she is late (line 2/3). Lydia, the patient, is described as ‘one of Estelle Barnett’s’ (line 5). I conclude from this that Estelle (a community palliative care nurse) is a named nurse with specific responsibility for Lydia. Like doctors in the hospital setting, these nurses have responsibility for specific patients. A crisis seems to have emerged that means Penny needs to intervene on behalf of Estelle. What Penny has to say about Estelle’s patient is timely, current and potentially interesting, as there is an air of urgency in her language, with her reference to being late and sorting her (the patient) out at lunchtime (line 13). Penny elicits what may be known about the patient by firstly addressing Doctor Jenkins (line 3) and secondly, the others at the meeting, ‘She’s the ex-ballet dancer, does anyone (ring any bells) her’ (line 13/14). Silverman (1997, 1998) observes how an information check can serve as a method for retaining the floor when one is in information delivery and ‘newsworthiness’ is an important consideration. Penny is also bringing into play information about the patient’s biography, ‘the ex ballet dancer’. This talk conveys Lydia’s reputation as someone with artistic skill and high culture, therefore an interesting and impressive biography. Furthermore, this is what is memorable to Doctor Jenkins as he recalls how Estelle talked about, ‘her being a ballet dancer’ (line 19). This talk works to align the recipients of the story to be active in hearing this story as about Lydia, an ex ballet dancer, who is in a nursing home and has cancer and dementia (lines 7 and 13).

#### **7.4.1 Solving a mystery**

Penny describes how Lydia has ‘metastatic squamous carcinoma of the skin and possibly bone’ (line 7). Therefore this cancer has spread beyond the original site and is ‘metastatic’. She continues that Louise (the hospital palliative care nurse) put Lydia on a fentanyl patch because ‘she felt she had some some pain hmm’ (line 10/11). The use of ‘some some pain’ is discussed by Prince et al (1982) as a type of shield, an approximator that makes symptoms less precise. Thus the hedge ‘some’ casts ambiguity around how much pain this patient has (Prince et al 1982). However in the next turn it becomes clear why there may be an element of



uncertainty around Lydia's pain. Penny makes a contrast between 'some pain' (line 12) followed by the news that Lydia has 'quite severe dementia' (line 12/13). This latter statement marks the dementia as severe although some hedging is present in the use of 'quite'. I would suggest the use of the word 'some pain' works as a rhetorical device to cast ambiguity around the status of the patient's pain, when such a patient also has 'quite' severe dementia. The connection between pain and having dementia is important as to how Penny accomplishes the telling of this story, as not only about pain, but a psychosocial story.

According to Penny, Estelle had visited the nursing home on the 24<sup>th</sup> and had various phone calls with Lydia's daughter and was going to meet with Lydia's daughter on the 4<sup>th</sup> but circumstances have now changed (line 20/21). Penny reports, 'Anyway ah in the message book, that the deputy had written, various phone calls, yesterday, from the daughter who has got herself quite distressed' (lines 22-24). By using the term 'quite', this seems to temper just how distressed the daughter is. Penny does not say what the deputy matron wrote down in the message book about the daughter's phone calls. Perhaps this is purposeful and works to minimise the tension caused by the various phone calls and the implication of a 'quite distressed' daughter. Penny describes how the daughter has gone to see her mother in the nursing home and found that 'her mother was very distressed and agitated' (line 26). The use of an extreme case formulation 'very', attributed to the daughter, communicates the extreme degree of distress experienced by the mother (Pomerantz 1987). Throughout this talk the daughter is not given a name. Her identity is repeatedly constructed as that of daughter rather than as a named person. Sacks (1992) describes a device called 'relational pairs' that enables two persons to be treated as a pair. Sacks also says that even though we may hardly know someone, when we have got such a pair the identification is complete. Therefore using the term daughter rather than named person enables Penny to develop her story as that of a distressed daughter due to her mother's distressed condition in the nursing home. I conclude that this talk seeks to attribute the daughter's distress to the mother's distress and this is why the daughter is unnamed. It enables them to be treated as a pair, rather than as two distinct people.

Penny continues by describing how the daughter thought that her mother had 'significant pain and she didn't think the fentanyl 25 micrograms was touching

her' (line 27/28). This attributes a degree of knowledge about the amount of pain, drugs and their dosages, to the daughter. Penny repeats the daughter's insistence that her mother has pain 'she was just, according to the daughter, in a lot of pain and she couldn't get the nursing home to do anything constructive about the pain' (lines 32-34). The contrastive rhetoric here is that the 'some pain' attributed to the hospital palliative care nurse, Louise (line 12) is now contrasted with the daughter's reported description of 'significant pain' (line 27), 'in a lot of pain' (line 33). Furthermore, Penny describes how the daughter, 'couldn't get the nursing home staff to do anything constructive about the pain' (line 33/34). Thus Penny is reporting criticism, by the daughter, of the lack of the ability in the nursing home to do anything about the pain. Although the contrast is not made explicit here, there is an expectation by the daughter, in her telephone call to the hospice that the hospice staff will have the expertise that the nursing home staff does not have. What form this expertise may take remains part of the mystery, yet to be revealed. Penny appears to be weighing up the evidence presented to her by various people when she says 'this lady does get distressed when she's not in pain, apparently' (line 28/29). The use of 'apparently' is an attribution shield and indicates that this knowledge has been derived from the report of others so this information is second hand, presumably from the nursing home staff and/or the daughter. Atkinson (1995,1999) describes the weighing up of evidence engaged in by clinical staff as 'evidentiality'. The use of evidentiality establishes the many ways in which the credibility of a reported event, or statement is conveyed in language according to Atkinson. Penny by weighing up the evidence from the different accounts given to her, her use of hedging and contrastive rhetoric such as 'some pain', 'significant pain', 'quite severe dementia', 'upset when not in pain', plays one account off against the other in the talk. Atkinson (1999) refers to this type of talk as the rhetoric of case presentation, which is evaluative in its goal and it encodes the division of labour and sets up the credibility of action.

Penny now informs the meeting about how the daughter's behaviour has upset the nursing home, 'and so the daughter was sort of looking through the notes and trying to ring the GP and all that, which of course upset the nursing home as well. You can imagine. So hmm' (lines 34-37). Her 'of course' suggests she understands the nursing home sensitivity around this situation. The 'you can imagine' does conjure up the extent of disturbance and tension in the nursing

home. Tannen (1989) says that the use of 'imagine' creates images in the mind, which are more convincing and memorable than abstract propositions and that this is one way of creating involvement and mutual participation in sensemaking by creating an image in words. The creation of the image enables hearers to draw a conclusion favoured by the speaker according to Tannen. There is also a reference to the fact that the daughter's behaviour may have upset someone else 'upset the nursing home as well'. This reference suggests that the GP may also be upset. This story is now becoming a dramatic incident with a breakdown in the sentimental order within the nursing home, and with the GP (Goffman 1959, Strauss et al 1982). Strauss et al (1982) in a study of the social organisation of medical work describes sentimental work as acts involved with caring. One of these acts he describes is the building of trust. According to Strauss, trust involves the expectation that staff will interact with patients in a way that encourages the belief that the work will be done quickly and competently. Therefore, I argue there is a threat to the sentimental order within the nursing home, by the criticisms of the daughter, about the inability of the staff to act appropriately and relieve her mother's distress, reported by Penny.

The circumstances described above have a consequence for the 'face' of all the actors involved in the story. Penny, I suggest orientates to face work by being very cautious in her talk. A number of authors in legal and broadcasting contexts discuss how speakers may use varying degrees of interactional caution, which enable the minimisation of interpersonal disagreement while maximising agreement (Clayman 1992, Greatbatch 1992, Greatbatch & Dingwall 1999). Penny uses the production formats identified by Goffman (1981) she primarily acts as an author and a principal, and in doing so she deflects and distances herself from the talk that she is reporting. These shifts in footing enable Penny to avoid giving an opinion and in doing so she avoids attributing blame or responsibility to any of the actors involved. In a study of professional neutralism in family mediation it was found that mediators respond to disputants' accounts of emotional and psychological problems in neutralistic and disengaged ways (Greatbatch and Dingwall 1999). The researchers argue that neutralism allows two things to happen; firstly, it enables the mediators to constitute their relationship in professional terms, and, secondly, it discourages disputants from heightening the emotional intensity implicit in their interactions. Like the family mediators,

Penny's neutralistic positioning is the platform for her to position herself as a professional, a specialist nurse who can defuse the difficult situation in the nursing home. Her resource in sorting things out is her neutralistic position. In effect she is mediating on behalf of those in dispute in the nursing home.

#### **7.4.2 Defining what is to be sorted out**

In a topic change Doctor Jenkins makes an accusation, 'She hadn't got anything for breakthrough?' (line 38). Doctor Jenkins by wording his question in this way defines a lapse in competence because, if she hasn't 'got anything for breakthrough', it presumably hasn't been prescribed. Penny gives an account about this situation (line 39-41). Scott & Lyman (1968) describe an account as a linguistic device, which is employed when an unanticipated action or behaviour is explained, and a justification works to accept the responsibility for the act as bad but to deny the pejorative quality associated with it. One of the justifications given in Penny's account is that, 'she doesn't take hmn tablets very well' (line 40/41). With this accounting she addresses the lapse in competence, which could be attributed to Louise who had put the patient on the patch. Although the account does not justify why she is not on breakthrough medication, this is glossed over perhaps to save face for Louise, a fellow palliative care nurse. This account seems acceptable to Doctor Jenkins, as he remains silent.

Penny continues to display her area of competence. She uses the pronoun 'I' to report how she has acted, 'So hmn I went, I rang the daughter this morning' (line 41/42). She then changes footing to describe how, although the GP had agreed to come out in the night, it was considered too late by the daughter as it was past midnight (line 45/46). Penny describes how the patient's daughter has requested from the nursing home a GP visit this morning. The GP who is named as Doctor Jordan is reluctant to come out, 'and apparently it is Doctor Jordan and he was doing admin today and, according to the daughter, he wasn't keen to come out' (line 51/52). Penny again keeps a neutral footing by reporting what the daughter has said about the GP. However Penny sets up a contrast between the GP's reluctance to visit and her own willingness, 'But I thought, well I would go and see if she has got significant pain' (line 52/53). Atkinson (1992) says that narrative contrasts may compare 'us' and 'them'. I suggest that Penny is contrasting 'I' and 'him'. Penny is defining her expertise as being able to find 'significant pain' in

contrast to the GP who is concerned about other matters. Penny negotiates her visit with the nursing home matron who would be ‘very grateful if I did call’ (line 55). She spends time with the nurse in charge ‘had a long chat’ (line 56). She describes how she discovered that Lydia has been in the home for some time ‘and she said she does get agitated from time to time and it is difficult to tell whether it is due to pain or due to ahm’ (line 60/61). Penny is attributing the distress to either pain or something else, which has not yet been named. She then describes how she went, ‘to see the patient and hmm her daughter was with her and hmm she was very comfortable and looked very exhausted and was just resting really’ (lines 61-64). Penny, like Liz has the ability to look and see pain on the patient’s body. Penny interprets what she sees on the patient’s body as ‘very comfortable’ and ‘very exhausted’ and ‘just resting’. The use of ‘very’ is an extreme case formulation therefore exemplifies the extreme of the case described. She continues, ‘So I didn’t feel, just on the few minutes I was with them both, that hmm that there was an indication to increase the patch. Although really I don’t have any objections to increasing the patch’ (lines 64-66). However Penny believes that Lydia could benefit from some oramorph (line 70) to which Doctor Jenkins replies, ‘Liquid. Absolutely’ (line 71). Also the daughter believes her mother is able to take a liquid on a teaspoon (line 73). So this action is absolutely agreeable to Doctor Jenkins, it is also agreeable to the daughter and Penny has spoken to Doctor Jordan, who presumably also agrees with this. This prescription also addresses the accusation about no ‘breakthrough’ medication made by Doctor Jenkins earlier (line 38).

Penny’s expertise about pain and medication is made more explicit ‘she could have some tolerance to it (fentanyl) by now if she has got pain’ (line 68/69). Therefore Penny understands how patients become tolerant to drugs such as fentanyl and this is a reason to increase the drug dose (Twycross & Wilcock 2001). There seems to be doubt in Penny’s mind about the existence of pain by her choice of words, ‘if she has got pain’ (line 69). This statement launches Penny into what I have called the ‘psychosocial reading’ of the case. She says ‘but also what I did do was hmm I talked a long time to the daughter about if she thinks she could benefit from some support because this daughter is travelling to and from America and you know she’s got a lot on her mind and you know she’s lost all her control since the mother’s at the nursing home and she’s I think could do with

psychological support' (lines 75-81). By using her resource of spending time talking with the daughter, Penny discovers the daughter's difficult circumstances. Penny interprets the mystery of the present troubles as those involving a lack of psychosocial support for the daughter. The accuracy of this reading is emphasised by Lydia's daughter being reported as eager to accept such support and Penny animates the daughter's active voice when she describes this, 'yes please' (line 81). In this footing shift Penny accomplishes what the cause of the troubles is, namely a lack of support for the patient's daughter. Penny is now acting as an intermediary for Lydia's daughter and her reading of the daughter's need for support.

Penny by interpreting and acting on the problems in the nursing home undertakes 'rectification work'. Strauss et al (1982) defines 'rectification work', as a type of sentimental work that is needed if a member of staff has failed to perform their caring work adequately. Penny, I suggest, by spending time talking with various people begins to stabilise the disruption caused by the daughter's criticism of the competence of caring staff. Penny by maintaining a neutral footing defuses the tension caused by the daughter's criticism of the nursing home staff. By these actions Penny accomplishes face for those involved in this situation (Goffman 1959). If Penny had chosen to tell this story as an 'atrocious story', the incompetence of various actors would be part of the telling. Telling the story in the way she does enables Penny to display her particular form of competence in solving the troubles and commotion in the nursing home and establishes her particular professional credentials. According to Erickson (1999) competent clinicians organise their reports in such a way as to make themselves look professionally competent. Having the skills demonstrated by Penny enables the credibility and reputation of palliative care to ride high in the nursing home and the team share in the success by participating in the meeting.

In the next section I discuss how Penny achieves 'definitional privilege' and negotiates support for the daughter.

### **7.4.3 Achieving 'definitional privilege'**

In a study of clinicians' talk in a child health setting, White (2002) describes three types of case formulation, 'medical', 'psychosocial' and 'not just medical'. The 'not just medical' is a mixture of medical and psychosocial formulations (White

2002:413). White argues that these formulations are highly contestable and require extensive practical and rhetorical work to accomplish. White found that the paediatrician in her study has ‘powerful definitional privilege’ to adjudicate whether a problem is biological or psychosocial or a combination of both. She discusses how case formulations such as the ‘not just medical’ require particularly complex story-telling since the presence of a biological disorder requires the psychosocial component to be worked up in the talk. Furthermore she argues that the artful and persuasive telling of the ‘not just medical’ requires rigorous questioning of witnesses, cross checking of accounts and attention to detail. I would argue that Penny through her meticulous attention to the details of Lydia’s case, by weighing up what she has been told, by whom, and keeping a neutralistic position achieves ‘definitional privilege’. She does this by defining this case as ‘not just about pain’. She persuades the team that this story has a psychosocial interpretation. This supports White’s contention that the case is in part constituted through the telling and in telling cases clinicians are not only engaged in using knowledge but are also making knowledge. Penny has managed to make this case the business of the team by telling the case in the manner described. Doctor Jenkins and Doctor Michael remain silent throughout the talk about psychosocial support. They do not seem to have expertise in this area, or at least they leave this talk to the nurse and to the social worker. On this occasion Penny pulls off this story as not just about pain, but a psychosocial story about a distressed daughter and in doing so, I suggest, she has achieved ‘definitional privilege’.

In the next section Penny makes a claim to give psychosocial support.

#### **7.4.4 ‘Whichever way you want to play it’, getting agreement**

Penny makes a claim to provide psychosocial support for Lydia’s daughter, ‘So hmm I was going to do a referral to you, but I don’t know if you’re inundated?’ (line 81/82). The use of the pro-term ‘you’ refers to Gill the social worker. Penny’s use of the past tense, ‘I was going to do a referral’ indicates a change in orientation to her next move. She continues, ‘I’m quite happy to take her on because I’ve got some space’ (line 83). Goody (1978) describes request-deference questions that leave the initiative and power to decide with the respondent and in doing so achieves the importance of the respondents’ agreement to what is being asked. Therefore Penny presents her request in a way that defers to Gill’s

judgement, 'so I'll do a referral and hmm hmm you can' (line 83/84). This suggests to me that Penny is being cautious and avoids overstepping the mark in relation to the nurse and social worker boundary. Gill interrupts Penny and refers to being busy, 'Well, we are both quite busy at the moment we had quite a lot of referrals' (line 85/86). Gill references 'we', and this marks her insider status as a member of the team of social workers. Penny then continues with her claim by again emphasising Gill's right to choose, 'I don't mind whichever way you want to play it' (line 89). This is an interesting metaphor of 'play' that suggests this is part of a game and Penny makes her move and plays her hand, 'but I really think, you know, that she would you know, she's beginning to see, difficult to see the wood from the trees, really but I think you know she's actually asking for support, and I think from the commotion that happened yesterday' (line 90/93). Penny is giving her opinion that the 'commotion' in the nursing home is due to the lack of support for Lydia's daughter. Furthermore she believes that there is more to 'come out' and continues, 'the fact that she rang here and was saying, 'what is the hospice about', you know, because it didn't come out. So, you know, I think she's reached sort of fever pitch and I think she really needs' (line 94-97). Gill interrupts by acknowledging the work Penny has already done with the daughter 'And yeah, you've obviously have met the daughter' (line 98). I would suggest that Penny has accomplished her competence in sorting out the commotion in the nursing home by persuading Gill that she can give the daughter the support needed. Finally Penny says 'Well shall I just do it then?' (line 101/102) and Gill replies, 'If you don't mind. Thank you very much' (line 103). This seems to imply that Gill considers this a favour. Presumably for Penny it enables her to use her psychosocial support skills as she states, 'Estelle will be coming back to work with the mother' (line 99/100). Therefore Estelle will presumably continue with the pain work and Penny with the psychosocial support work. Penny has accomplished her performance as someone who is competent in both pain work and psychosocial support.

Penny's metaphor of 'whichever way you want to play it', encapsulates the dynamic nature of the division of labour between herself and the social worker. The context of practice in the palliative care team enables Penny to present her credentials as a competent person to deliver the type of support normally given by the social worker. On this occasion she has successfully negotiated the claim to



deliver support to Lydia's daughter. Svensson (1996) in a study of the negotiated order in medical and surgical wards in Sweden argues that what is considered under the categories of medicine and nursing are concepts created and modified by practice. He concludes that one of the factors that has transformed the negotiation contexts in health care settings is the new arenas for co-operation such as face-to-face meetings with doctors and other staff. However, my data suggests that what is up for negotiation is contextual and dependent on the portfolio of competencies that the individual practitioner brings to his or her work. These are not just clinical and psychosocial skills but involve the ability to use linguistic devices to give a credible account of one's work and persuade others as to the accurate reading of one's account.

In the next sequence of talk the boundary between medicine and specialist palliative care nursing becomes an issue in negotiating a referral to a specialist doctor. In this talk the identity of doctor and nurse becomes significant in the talk.

## **7.5 Managing the identity of doctor and nurse**

The following sequence of talk takes place in one of the daily meetings of the community palliative care team. A patient, called Eileen, is referred to the hospice community team because she has a problem with pain. It is the patient's daughter who asked for the referral and she works as a receptionist in the hospital attached to the hospice. I accompanied Anna, the community palliative care nurse, on her first visit to Eileen. During the visit it became clear that pain was not such a problem as, according to Eileen, it was well controlled with analgesic drugs, but her poor vision was very problematic to her. Anna told me that sometimes patients were referred to the community palliative care team with 'pain' because the person doing the referral believed that having a problem with pain would achieve a quicker referral. During the meeting it became clear that Eileen's GP, Doctor Katz, was slow to identify her recurrence of cancer and he has been treating her for arthritic pain. Eileen subsequently collapsed at home and was admitted to hospital. Following investigation she was told that her breast cancer, first diagnosed and treated 25 years ago, had recurred. Anna in the next extract of talk is negotiating with Doctor Jenkins for a referral for Eileen to a specialist consultant in the PCT meeting.

- 1 CPCN Anna I mean is it worth me trying to get an  
 2 appointment at Birchwood? I mean do you think Mr Sharife or  
 3 somebody would be able to see anything on ahm  
 4 Dr Jenkins Well they could certainly, one has seen, I've seen  
 5 bilateral choroidal metastases.  
 6 CPCN Anna Can they pick it up with their special  
 7 equipment up there. Do you think they will?  
 8 Dr Jenkins They will see. They will see they will look in the eye  
 9 CPCN Anna Because that will give us some clout with Dr  
 10 Jasper  
 11 Dr Jenkins If there is some choroidal metastases he will see  
 12 them straight away.  
 13 CPCN Anna Can I ring up Birchwood or do I have to wait for Dr  
 14 Katz to do a referral? because that's going to delay things  
 15 quite considerably unfortunately.  
 16 Dr Jenkins If Dr Katz agrees.  
 17 CPCN Anna Well I give him a ring but yeah  
 18 Dr Jenkins If he agrees then you go ahead.  
 19 CPCN Anna 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 Dr Jenkins Before her sight goes completely.  
 23 CPCN Anna 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 Dr Jenkins They want some science.

### **Extract 11 Community palliative care meeting Karamea Hospice**

The question and answer format evident in this sequence of talk is a feature of CPCN and HPCN talk (See extracts 4/5/6/7). Such 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). Therefore adjacency pairs provide a way in which one person can compel another to speak to him or her on a topic of his own choosing and in this sense it is a social device (Goody 1978, Schegloff & Sacks 1973). Anna initiates the chain of questions that positions Doctor Jenkins as the recipient of the questions. This turn taking procedure of question and answer, I suggest, operates to manage a key task in interprofessional relations namely the identities of doctor and nurse. By Anna interrogating Doctor Jenkins's medical 'know how' she treats him as a medical oracle. This achieves Doctor Jenkins's expertise in relation to medicine and enables Anna to enter into medical discourse while maintaining Doctor Jenkins's footing as a medical expert. This system enables them to do interprofessional work in a manner that is mutually constructed. Therefore Anna casts herself as the sort of person who can ask the right type of questions to solve and shape the riddle of what to do next. Her resource in doing questions in this way is her knowledge of the patient, as Doctor

Jenkins has not visited this patient. Anna, by asking the questions, shapes the agenda for talk and demonstrates her concern about Eileen's sight. She negotiates with Doctor Jenkins to get Eileen seen by an ophthalmic consultant at Birchwood Hospital (lines 1-8). Anna asks a question, 'I mean is it worth me trying to get an appointment at Birchwood?' (line 2). Anna asks Doctor Jenkins about what the specialist whom she names, as 'Doctor Sharife' 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 Doctor Jenkins's authority to make a decision about whom to refer to. Doctor Jenkins marks a difference in his view when he uses 'well' at (line 4) and says, 'they could certainly', 'one has seen' and culminating in, 'I've seen'. Doctor Jenkins like 'they' and 'one' has the same expertise to look in the body and see, 'I've seen bilateral choroidal metastases' (line 4/5). He is making visible his own expertise as a physician, like other physicians so 'they', 'one' and 'I' share a similar biography as medical practitioners. By referencing this shared biography, Doctor Jenkins constructs his own reputation as a member of the medical profession, an insider, someone who can see inside the body and diagnose 'choroidal metastases', like other doctors. Anna in this context is an outsider. She does not have this type of expertise to see inside the body, and she does not share this biography. Anna in her strategic use of questions attempts to achieve a pragmatic compromise between the problems experienced by the patient and a selective evaluation of what can be offered by medical expertise and science. Anna continues, 'Can they pick it up with their special equipment up there. Do you think they will?' (line 6/7). Doctor Jenkins 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). Anna believes that this type of 'seeing' using specialist equipment will give 'some clout with Dr Jasper' (the oncologist) (line 9/10). The problem in the patient's eye can only be seen by the specialist consultant, according to Doctor Jenkins, 'choroidal metastases he will see them straight away' (line 11/12). At this point Anna seems to have achieved the referral.

Anna by asking questions and Doctor Jenkins by supplying answers is jointly accomplishing the referral up until line 15. Asking questions may enable the nurse to have some influence on the course of events even though these events are of a medical nature. Goody (1978) discusses 'masking' questions as equivocal, in the sense they are really masking commands. They work to mask the questioner's

ability to control the recipient and they work to make the recipient responsible for the consequences of the reply and thus make them a partner, according to Goody. Clearly Anna wants to have Eileen seen by an ophthalmic consultant. Her questions are a masking tactic to enable Doctor Jenkins 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. Anna is masking her intention to get the referral, by gaining Doctor Jenkins's co-operation by the use of questions.

### **7.5.1 Pushing at the boundary of doctor and nurse**

According to Silverman (1997) sequences of questions and answers are collaboratively produced and at any stage the questioner can stop asking questions and the answerer can add components to his or her answers. Therefore shifts occur in conversational roles. I suggest that these shifts in conversational roles enable the boundaries of work roles to be made visible. Anna changes the topic of talk and brings another agenda to the talk by making a claim. She asks Doctor Jenkins, 'Can I ring up Birchwood or do I have to wait for Doctor Katz to do a referral?' (line 13/14). This question aligns Doctor Jenkins as authoritative not only in relation to his medical expertise but in giving her the permission to bypass the GP by going ahead with the referral herself. Anna believes having 'to wait' for the GP to do the referral 'that's going to delay things quite considerably unfortunately' (line 14/15). However, Doctor Jenkins in his next turn changes footing out of the role of answerer, he replies, 'If Doctor Katz agrees' (line 16). Doctor Jenkins maintains the GP/CPCN boundary by asserting that Anna must ask Dr Katz to do the referral. Anna's footing is now as recipient and she replies, 'Well I give him a ring but yeah' (line 17). Anna marks her different view by her use of 'well' and 'but yeah' (Heritage and Sefi 1992). At this point Anna gives the floor back to Dr Jenkins and in his next turn he reiterates, 'If he agrees then you go ahead' (line 18). Perhaps one of the reasons behind Doctor Jenkins's insistence on Doctor Katz'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. The problem that Anna is concerned about is the delay in getting the referral from a GP who she considers is going 'to delay things quite considerably' (line 14/15). In her next turn Anna 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). Anna

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 Anna revises her earlier utterance to one that is more acceptable and therefore exhibits a preference for agreement and this enables the smoothing out of the interactional troubles displayed in her request. Anna is projecting that she is going to ask the GP for the referral and in the meantime ring Birchwood Hospital herself. In this way Anna is attempting to save face, I suggest. Anna's claim could be a strategy to usurp the GP based on her evaluation of his competence and his propensity to delay. Doctor Jenkins has acted to stabilise the slippery slope of a nurse carrying out a direct referral to a specialist hospital doctor and potentially causing trouble with the GP.

Anna and Doctor Jenkins collaborate to contain and smooth over their disagreement between lines 21-23, when they identify the need for Eileen to be seen quickly. In doing so both parties respect the preference for agreement (Heritage & Sefi 1992). At line 21 Anna says 'I think this lady needs to be ahm' and Doctor Jenkins finishes her sentence for her, 'Before her sight goes completely' (line 22). Anna aligns herself as a recipient by saying 'Yeah' (line 23). Anna accomplishes the active cancer/ palliative boundary in her following statement and rhetorical question, 'It's probably more prudent to do that then to getting her up here to see yourself cause even if you think agree and think there's cerebral they're still not going to do anything at the Royal on that are they? They need to have some more proof' (line 23-27). In this statement Anna is explicit about the limitations of Doctor Jenkins being able to provide the type of proof needed to get the Royal to offer treatment. This talk establishes Anna'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. She answers her own question and finishes by referring to 'more proof'. Dr Jenkins seems to agree with this summary and retorts, 'They want some science' (line 28). This illustrates the importance they both attach to science and proof and being able to visualise and read what is going on in Eileen's body, by the use of specialist technology in order to know if anything by way of cancer treatment can be offered. This talk invokes the active treatment/palliative boundary. Both practitioners appear to understand

that this case requires both speed, to prevent further deterioration, prudence in approach to the dilemma of Eileen's loss of vision, and more knowledge of what is going on to evaluate what type of treatment, if any, that can be offered.

The fact that Anna has attempted to renegotiate the specialist nurse and GP boundary suggest to me that under some circumstance she may be able to make the referral without necessarily having the referral letter from the GP, otherwise why would she suggest such a move? However, there may be an issue around this particular GP. In data extract 10 Penny's negotiations with the GP are not topicalised. This suggests to me that there may be better co-operation between some GPs and specialist nurses than others. Anna is eager to pursue the referral quickly and is unconcerned about professional sensitivities and etiquette. On this occasion Doctor Jenkins's frame of reference may be keeping on good terms with the GP and keeping a front of professional niceness (Li 2002). Anna is unconcerned with professional niceties as she is critical of the competence of the GP. She, I would argue, is more concerned with her own competence and credibility as an effective professional that can get things moving quickly.

The tension that exists in the boundary between community palliative care nurses and some general practitioners is evident throughout my data set. Beck & Beck-Gernsheim (2002) in an analysis of couples and their conflict over private labour questions why the division of labour is so important. He suggests the reason for conflicts occur at two levels. One concerns the content of mundane activities such as domestic chores in the home. The other concerns the deeper dimension, which is how the division of tasks is bound up with self-image and the life projects of men and women. Beck & Beck-Gernsheim concludes that negotiations over the household division of labour are part of 'identity choice' but also part of an identity struggle, which breaks out when external barriers become more fragile. Therefore, Beck & Beck-Gernsheim argue, 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 a particular type of practitioner with specific expertise in palliative care that some medical practitioners do not have. Thus the type of claim that Anna is making is causing this boundary to become more fragile. The fragility around such boundaries becomes evident in the talk through accusations about competence, attributions of blame and claims on

territory and work. The development of specialist nurses with expertise in palliative care is disturbing the professional equilibrium between the GP, the specialist nurse and the palliative care consultant. The discussion and decision about the referral is, I argue, a type of ritual that maintains the fragile boundary with the GP, but it is also a boundary marker that is being called into question by the specialist nurse.

Anna's use of questions and her aligning of Doctor Jenkins to be the recipient of the questions enables Anna to accomplish her goal to have Eileen referred, without delay, for a specialist ophthalmic opinion. The use of questions also allows her to push at the boundary between herself and the GP and to criticise the GP for delaying tactics. Asking questions is not only the prerogative of Anna; Doctor Jenkins can change footing by becoming the questioner and Anna the recipient. By taking on the role of questioner and/or answerer one can begin to formulate the boundaries that exist around this type of work. This data provides further evidence for Svensson's (1996) assertion that concepts about boundaries are created and modified by practice and resolved through negotiations about the division of work. Therefore boundaries are a social construction in nurses, doctors and other members' talk. The discourses that contribute to making and unmaking the boundary are related to discourses of expertise and tradition (Giddens 1994). The discourse of tradition is related to professional status and etiquette and this is the discourse evident in Doctor Jenkins's talk. The discourse of expertise emphasises the importance of competence and credibility and this is the discourse that Anna accesses and this I suggest is the basis for her reputation as an effective specialist nurse.

In the next section I discuss how the discourse of expertise is also a concern of the palliative care consultant Matthew who, in a similar way to Anna, is unhappy with a GP's ability to prescribe opioid medication in an appropriate manner. Therefore, the discourse of expertise crosses the boundary of professional identity and blurs the expertise boundary between nurse and doctor.

### **7.5.2 Tradition and expertise**

Matthew in the next extract of talk positions himself as concerned with expertise rather than professional status and tradition. He displays his disapproval of a GP who does not know how to prescribe opioid medication. Therefore Matthew

contributes to the fragility of the boundary with a GP who lacks expertise in the proper prescription of analgesic drugs. He, like Anna, questions the competence of the GP.

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

### **Extract 12 Community palliative care meeting Oakwood**

This patient is being given too much oramorph, an opioid drug given for pain with side effects such as drowsiness reported by Phillipa (line 7/8). Phillipa is cautious and does not criticise the GP directly but makes a contrast between the 10 milligrams of oramorph four times at day (line 7/8) and the fact that the patient is 'Not in particular in any pain' (line 8). Matthew asks Phillipa about the identity of the GP who prescribed the oramorph three times (lines 9,11,13) before he gets an answer from Phillipa that satisfies him at line 14. Matthew uses strong language to make an accusation that the GP, 'keeps on mistakenly poisoning her' (line 25/26). This I suggest is an outrageous statement, a type of atrocity story (Webb & Stimpson 1976). A GP who should be alleviating pain, is, through ignorance poisoning the patient. Matthew wishes Phillipa to speak to the nurses but he is most concerned that she will 'talk to whichever GP it is' about the prescription (line 25). Phillipa offers an excuse for the GP, by suggesting she is concentrating on problems other than the pain (line 28). Scott & Lyman (1968) describe how accounts are concerned with untoward action and are offered when activity falls



outside of expectations. One type of account is an excuse for doing something inept. Therefore in this talk Phillipa is offering an excuse for the GP suggesting she is more concerned with the spread of the disease than the problem of pain medication (line 27/28). According to Scott & Lyman, excuses are socially approved vocabularies for mitigating responsibility. I believe that the mitigation provided by Phillipa displays her reluctance to challenge the GP and her cautious approach to reporting which GP was responsible (lines 9-14). Phillipa, unlike Anna is unhappy about challenging the GP therefore Phillipa like Doctor Jenkins attempts to maintain the shaky doctor nurse boundary on this occasion and therefore avoids upsetting the status quo.

Phillipa is being urged to correct the GP about her mistaken prescription, on the authority of the consultant. However in extract 11, Anna is unsuccessful in her claim to make a referral and bypass the GP. I suggest that Phillipa has not claimed the right to check the GP's prescription; Matthew has given her the authority to do this. Anna, unlike Phillipa, makes a claim to bypass the GP and do the referral. The difference in the two settings is that having expertise in pharmacological aspects of pain management may be the recognised expertise in one team, which enables Phillipa to have the delegated authority to check the GP. Making referrals to other doctors remains a medical matter and is not up for negotiation. The consultant on both sites has the authority to make or dismiss the boundary as relevant in both meetings. Matthew, unlike Doctor Jenkins is unconcerned with professional etiquette on this occasion. His concern is with the level of expertise in prescribing for pain that the GP does not display. On this occasion Matthew aligns himself as a critic, like Anna. However, there is a difference between the two contexts in that one is about pain and the other is not. Therefore, I suggest that pain work may be the recognised expertise of the CPCN that enables challenges to the doctor nurse boundary, unlike the referral procedure to other medical practitioners.

In this next extract of talk Liz, like Anna, uses questions to control the agenda of talk to focus on pain. However the identities of nurse and doctor are also significant in the talk in relation to who has authority to name the type of pain experienced by the patient.

## 7.6 Controlling the agenda of talk by using questions

1	HPCN Liz	What about pain?
2	CPM Matthew	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 Liz	Mm now just going back to the pain a minute. He had
6		some mm sort of neuropathic symptoms did he, originally?
7	CPCM Matthew	No, not particularly.
8	HPCN Amy	He said he had these sort of pricking,
9	HPCN Liz	Yeah.
10	HPCN Amy	down his sides.
11	CPM Matthew	Yes.
12	HPCN Amy	He was taking dihydrocodeine at night.

### Extract 13 Hospital Palliative Care Team Oakwood

Liz asks an open question ‘What about pain?’ Matthew responds by saying, ‘He has only a little bit of pain’ (line 3). In this reply Matthew seems to be ameliorating the pain by making it small through use of ‘little’. Matthew says ‘It doesn’t seem too bad pain’ (line 2). Therefore Matthew has visited this patient in Oakwood Hospital and has knowledge about his pain. This is unlike the situation in the community palliative care team where the consultant relies on the nurses to visit the patient at home. Liz then proposes that the pain may be linked with ‘sort of neuropathic symptoms did he, originally?’ (line 6). By using ‘sort of’ Liz is hedging, casting some uncertainty around her naming the pain as ‘neuropathic symptoms’. Matthew in his next turn constructs his response as dispreferred by answering no but ameliorates it by using ‘not particularly’ (line 7). Therefore Liz’s attempt to attribute the pain to neuropathic symptoms is dismissed by Matthew. Liz’s voice is silenced by this response. Amy reports, ‘He said he had these sort of pricking, down his sides’ (lines 8 and 10). Liz agrees with this, ‘Yeah’ (line 9). Amy supports Liz by describing symptoms consistent with neuropathic type symptoms namely a ‘pricking’ type sensation. Matthew accepts Amy’s account of the patient’s symptom as he answers ‘Yes’ (line 11). Liz’s question about neuropathic symptoms demonstrates that she has some knowledge of the possible causes of pain. However, Matthew, the doctor, does not confirm the suggested link. The link between pain and neuropathic type symptoms, in this context, remains the doctor’s area of jurisdiction. Matthew therefore shapes his expertise related to the probable cause of the pain, by discounting Liz’s suggestion of neuropathic type symptoms. Liz’s area of expertise, in this context, lies in checking for the presence of pain and shaping talk, by use of questions. Liz displays her specialist nurse expertise in relation to her ability to introduce and discuss biomedical issues related to the patient. However, classifying pain as part

of ‘neuropathic symptoms’, on this occasion is the jurisdiction of the doctor. I suggest that classifying pain as ‘neuropathic’ comes too close to the doctor’s role in diagnosis. This talk allows Matthew to display his specific expertise in naming the cause of the pain. I conclude that doctors gate keep their specific expertise related to the classification of pain and other parameters related to disease. Therefore nurses seem to have limited success when they attempt to move into this sphere of expertise. This may be why nurses focus on specific symptoms such as pain. The next section identifies how the division of labour related to classifying pain and prescribing works in practice.

## 7.7 Classifying pain and prescribing Matthew’s expertise

The following sequence of talk identifies Matthew’s particular role in classifying pain and prescribing medication for pain. In this sequence of talk Liz introduces ‘analgesic talk’ and Matthew names the patient’s pain as ‘phantom pains’.

1	HPCN Liz	Did you see Kim yesterday? No. There is
2		nothing really more to say about her at the moment. Is
3		she still on her MXL?
4	CPM Matthew	No, no, no. She's on
5	HPCN Amy	Tiny oramorph.
6	CPM Matthew	She's on tiny, tiny bit of oramorph and she was
7		getting a little bit mm sleepy wasn't she? That was the
8	HPCN Amy	Cut the carbamazepine ( ).
9	CPM Matthew	Yeah. She is on the carbamazepine for phantom pains
10		and she is on 200. In fact we ought to review that at some
11		stage just to make sure she doesn't have more phantom
12		troubles. Mm and I cut it from 200 to 100 to see if it
13		would make her less dopey and I suppose she has got
14		significantly less body mass with no legs. She has had her
15		legs chopped off. She has got terrible peripheral vascular
16		trouble. Mm and see if she is less sleepy. The thing is
17		she can't do that much physio to get her arms stronger
18		because she is so sleepy.
19	HPCN Liz	Oh. I see. Right. Do you think she's lost any
20		brain cells?
21	HPCN Amy	Mm.
22	HPCN Liz	(laughter) No I mean since her surgery since she had
23		her trachy.
24	CPM Matthew	No. No. I don't think so she seems pretty her usual
25		self but er
26	HPCN Liz	Okay.
27	HPCN Amy	Okay.
28	CPM Matthew	I think eventually we should stop the oramorph.
29	HPCN Liz	Yes.
30	CPM Matthew	She is only on about two. That is the next thing to
31		do tail that off.
32	HPCN Liz	Right.

### Extract 14 Hospital Palliative Care Team Oakwood

Liz starts this sequence of talk by asking Matthew if he has seen Kim (line 1). Liz by use of questions seems to be keeping track of what is happening to the patient. Therefore, there is some suggestion that Matthew and Liz deputise for each other by providing an account of their last meeting with the patient. Liz introduces 'analgesic drug talk' in this sequence by asking, 'Is she still on her MXL?' (line 3). Matthew appears more up-to-date with Kim's medication when he answers, 'No, no, no' (line 4). When talking about Kim's medication Matthew uses the collegial 'we', 'In fact we ought to review that at some stage just to make sure she doesn't have more phantom troubles' (line 10/11). Matthew uses the authoritative 'I' when discussing how he has changed the drug dosage, 'I cut it from 200 to 100 to see if it would make her less dopey' (line 12/13). He continues, 'I think eventually we should stop the oramorph' (line 28). By use of the 'clinical discourse' of 'I' and 'we' Matthew shapes how the team will work together. This talk aligns the two nurses in a collegial relationship with Matthew. Therefore, the team will review the status of the 'phantom troubles' and reduce the oramorph, but Matthew reduces the dose of carbamazepine. Therefore the nurses review the status of the patient's pain and Matthew on this occasion reduces the drug dose. This is Matthew's prescribing boundary. Amy appears to have knowledge about the need to cut carbamazepine but is unable to hold the floor (line 8). The team appear to agree on the 'balancing act' related to the prescription of oramorph balanced by the unwanted side effect of being 'dopey' (line 13) that would prevent the patient carrying out physiotherapy. Liz and Amy take on the role of 'chorus' to this talk by responding, 'Okay' (line 26), 'Okay' (line 27), 'Yes' (line 29) and 'Right' (line 32). Liz and Amy help Matthew shape his prescribing role in the team by their chorus of responses indicating agreement.

The team together shape pain as a biomedical problem. Therefore the team orientates to biomedical decision making related to the correct drugs and dosage for this type of pain. The knowledge and expertise that supports this type of decision making is that held by Matthew as the consultant with expertise related to prescribing medication. This lends support to the view of the 'medicalised' notion of pain discussed in the literature review, which shapes pain as a technical matter to be solved (Illich 1976). When pain is shaped in this way the nurses defer to the consultant and are in complete agreement with his prescribing decision. The other aspect of this talk is the work it does in relation to the status of the nurses.

Matthew, in discussing his rationale for prescribing, treats the nurses as a type of colleague 'a collegial relationship'. This type of collegial teamwork may be one way that these nurses enhance their professional standing and develop an identity as specialist nurses and in this way differentiate themselves from the body of nurses in general.

The next section demonstrates how Liz is concerned about a patient's experience of pain and his response to surgical intervention and proposed further treatment with radiotherapy.

### **7.7.1 Differing accounts of pain**

In the next sequence of talk different members of the team give different accounts of the patient's pain. This example further highlights Liz's concern with the problem of pain and Matthew's concern with further local treatment.

Furthermore, there is some ambiguity around the nature of Mr B's pain that is difficult for the team to resolve.

- 1 HPCN Liz So all the pain that he had has all gone now, since  
2 he had his surgery?
- 3 CPM Matthew Yeah.
- 4 HPCN Liz Good. It was mainly colic. Wasn't it? Oh no. He  
5 had the perineal pain. He couldn't sit on his bottom.
- 6 CPCMMatthew Did he tell us he had pain?
- 7 HPCN Amy If you asked him he said it was just a bit  
8 uncomfortable down below.
- 9 HPCN Liz But not, because when I saw him he couldn't sit at  
10 all. He was lying flat. But nothing will have changed will  
11 it?
- 12 CPM Matthew Well.
- 13 HPCN Liz Except that there won't be an obstruction.
- 14 CPM Matthew Yes, but I mean, they need, they have done a  
15 defunctioning colostomy so that he will now be referred for  
16 palliative radiotherapy to that rectal tumour.
- 17 HPCN Liz Yes, but do they think it's a prostate?
- 18 CPM Matthew No.
- 19 HPCN Liz They think that it's a separate rectal tumour?
- 20 CPM Matthew Yeah.
- 21 HPCN Liz No, because they were querying whether it had grown  
22 from the prostate, and was causing (pressure).
- 23 CPM Matthew No. I don't think so. I think they have biopsied.  
24 His PSA is low, I think. Isn't it?
- 25 HPCN Liz Mm.
- 26 CPM Matthew Well either way mm he needs to go to have local  
27 radiotherapy because it is a local problem.
- 28 HPCN Liz I think you've got him. It's just that if he  
29 couldn't sit down on his bottom. I wondered why anything  
30 has changed?
- 31 HPCN Amy ( ).
- 32 HPCN Liz T3 carcinoma poorly differentiated but that was from  
33 the prostate. As far as I am aware nobody has ever proved  
34 that there is a separate primary.
- 35 CPM Matthew Okay.
- 36 HPCN Liz Mm. Anyway, all I'm querying is that the main problem  
37 with him apart from the fact he is obstructing and had a  
38 distended abdomen was the fact that he had perineal pain so  
39 bad he couldn't sit on it. So is that taking the pressure  
40 off the colon made a difference to that?
- 41 CPM Matthew No.
- 42 HPCN Liz So why?
- 43 CPM Matthew It needs to be irradiated.
- 44 HPCN Liz Yes I know it needs to be irradiated. I'm just  
45 checking on pain whether or not he is still complaining of?
- 46 CPM Matthew I think some of the pain was
- 47 HPCN Amy Or lying flat seems to be the main advantage.
- 48 HPCN Liz Yes. He can lie flat.
- 49 HPCN Amy Found a coping strategy.
- 50 HPCN Liz Yeah.
- 51 CPM Matthew He was a cheerful bunny yesterday wasn't he?
- 52 HPCN Amy He had actually been up walking.
- 53 CPM Matthew Yeah.
- 54 HPCN Liz That's good.

### **Extract 15 Hospital Palliative Care Team Oakwood**

In this sequence of talk Liz uses questions to establish whether this patient has still got pain following surgery (line 1/2). Matthew responds, 'Yeah', indicating agreement that the pain has gone (line 3). On this occasion Liz seems to know more about the patient's pain than Matthew or Amy. Liz states that the pain was due to colic and seems to remind herself as she talks that he also had 'perineal pain' that prevented him from sitting down (line 5). In Matthew's next turn he is

unclear about the pain ‘Did he tell us he had pain?’ (line 6). Amy does not use the word pain but describes, ‘just a bit uncomfortable down below’ (line 7/8). Amy seems to be downplaying the pain by using the words ‘a bit uncomfortable’. Liz marks her disagreement by ‘but’ (line 9). She describes how when she saw him ‘he couldn’t sit at all’ (line 9/10). These different accounts about the patient’s pain seem to be trying to establish whether or not he has got pain. Liz and Matthew between lines 10-27 discuss the surgery to relieve the patient’s obstruction (line 13), and the fact that he has a defunctioning colostomy and is now to be referred for palliative radiotherapy to the rectal tumour (line 15/16). At line 17, Liz asks a question, ‘they think it’s a prostate?’ In his next turn Matthew replies ‘No’ and Liz then states ‘They think that it’s a separate rectal tumour?’ to which Matthew replies ‘Yeah’ (line 20). Liz disagrees with this because she states ‘they were querying whether it had grown from the prostate, and was causing (pressure)’ (line 21/22). Matthew disagrees with this saying, ‘No. I don’t think so. I think they have biopsied. His PSA is low, I think. Isn’t it?’ (line 23/24). Matthew is referencing his own view with that of the biopsy result and the fact that his PSA is low, but asking for confirmation. Liz replies with the response token ‘Mm’ (line 25). Matthew then states that ‘either way mm he needs to have local radiotherapy’ (line 26/27). This questioning and answer sequence achieves Liz’s interest in all aspects of the patient’s disease. She like Anna enters medical discourse by interrogating Matthew and asking for confirmation and proof for his medical opinion.

Liz now goes back to the problem the man has in sitting down and asks, ‘I wondered why anything has changed?’ (line 29/30). Liz now reads from the patient’s notes ‘T3 carcinoma poorly differentiated but that was from the prostate. As far as I am aware nobody has ever proved that there is a separate primary’ (line 32-34). Liz like Anna is concerned with medical proof. Liz by accessing the notes has provided definitive proof that the problem with the patient is the prostate tumour and there is no evidence that there is a rectal tumour. Matthew now accepts this evidence when he replies, ‘Okay’ (line 35). Liz now summarises the main problem with the patient, ‘all I’m querying is that the main problem with him apart from the fact he is obstructing and had a distended abdomen was the fact that he had perineal pain so bad he couldn’t sit on it. So is that taking the pressure of the colon made a difference to that?’ (line 36-40). Thus Liz keeps her

alignment to Matthew as an elicitor, a questioner and this maintains Matthew's footing as a medical expert just like Anna did with Doctor Jenkins in extract 11. The upshot of this is that Liz does not overstep the mark and upset interprofessional relations.

The notable feature of this sequence of talk is the different reports of the patient's pain from each member of the team. Matthew is unsure about whether the patient has said he had pain (line 6). Matthew discusses the need for further treatment with radiotherapy three times (lines 16/27/43). He describes the need for 'local radiotherapy as it is a local problem' demonstrating his concern with further treatment for the cancer presumably (line 27). Liz introduces talk about whether the patient has one cancer or two separate sites of cancer (lines 17/19/21/22). This demonstrates her interest in the progression of his disease. Liz seems to be questioning the benefit of surgery when she says, 'It's just that if he couldn't sit down on his bottom. I wondered why anything has changed?' (lines 29/30). Matthew returns to the need for treatment with radiotherapy 'It needs to be irradiated' (line 43). Liz replies 'Yes I know it needs to be irradiated. I'm just checking on pain whether or not he is still complaining of?' (line 45). The patient's complaints about pain reported by Liz appear to be countered by talk of further medical treatment with radiotherapy by Matthew.

Liz orientates to pain and Matthew orientates to further treatment. This is how work is divided up in the team, I suggest. However, I also suggest that the team orientate to bodily signs of pain, as there is a continuing theme of being able to see pain through movement. Liz is differentiating her specialist expertise as concerned with pain, but she also monitors the patient's current disease status carefully so she is in a position to ask the right type of questions, like Anna. Matthew is about to give an opinion on this man's pain, 'I think some of the pain was' but Amy interrupts (line 46). Matthew now acknowledges the patient's pain. There is uncertainty about what Matthew was going to attribute the pain to. The interruption works to prevent Matthew from naming the pain and casts further ambiguity around how the team legitimates the presence of pain. This type of talk seems to demonstrate the difficulties for the team when pain remains unrelieved or uncertain. I suggest that Matthew is interrupted to prevent him naming what he believes to be the cause of the pain. The interruption enables Amy to resolve the problem of the pain by suggesting that the patient is coping he has, 'Found a



coping strategy' (line 49). This seems to address Liz's concern; she answers 'Yeah' (line 50). The different accounts of the patient's pain is now resolved. A satisfactory answer has been found. This patient is brave and stoical and he is coping. Matthew and Amy together present an image of a patient who is 'a cheerful bunny' (line 51) and who is 'up walking' (line 52). Liz accepts the new account that the patient is coping when she says 'That's good' (line 54). Matthew and Amy together present a patient who is functional and cheerful and Liz accepts this despite her earlier concerns. This talk I suggest, enables a team performance and minimises disagreement. However, I believe there is still uncertainty about the status of the pain. The team preserves their front of togetherness even when there is evidence of continuing troubles.

This talk is generally medical and technical in character concerning the type of pathology the patient has, the stage of the disease, treatment by surgery and in the future with radiotherapy, is discussed, as well as the location and intensity of the pain. There is some talk of psychosocial issues such as the patient's emotional state (i.e. cheerful, and his ability to cope). Also Liz introduces talk about the effect of pain on his functional status. There is no talk about analgesic drugs. There is an underlying ambiguity about the legitimacy of this patient's pain and also the legitimacy of Liz's account of the patient's intense pain, which remains unresolved. I would suggest that the effect of the pain on the patient experience such as his ability to sit developed by Liz is downplayed in favour of talk of further treatment, his ability to cope and his cheerful demeanour. This leaves some uncertainty as to the nature of the patient's current experience of pain, for example the pain may still be present but the patient is presenting as stoical and coping. It may also be that the patient presents himself differently to the different practitioners in terms of his pain experience. Kotarba (1983) discusses the importance of the 'critical audience', those to who pain is addressed. This 'critical audience' may be addressed differently according to the context of their meeting, for example how rushed and busy key personnel are. There may also be a gender issue with the patient wishing to appear stoical and able to cope in front of Matthew or alternatively the patient may wish to appear to be improving hence he does not complain of pain in the presence of the doctor. He may not feel so constrained with the female nurse. Liz enters into medical discourse in a similar way to Anna, by asking questions. Liz not only monitors the medical and surgical

trajectory of the patient's experience but also keeps in mind the effect of this on the patient's functional status and his level of pain. In contrast, Matthew is less concerned with the pain and more concerned with the need for further local treatment. This division of work enables a number of areas concerning pain and treatment to be reviewed and brought up for discussion.

In the next extract of talk Liz extends her role into prescribing behaviour when talking with the district nurse. I suggest that Liz has more space to extend her role in the medical space when talking to non-specialist practitioners such as district nurses. Therefore the positioning of expertise is relative to the status of specialist and non-specialist practitioner as well as the identities of doctor and nurse. The collegial positioning of Liz within the palliative care team enables her to develop her specific expertise and authority when talking with non-specialist staff about pain and furthermore in the context of her talk with the district nurse this expertise seems to be accepted and utilised.

### **7.7.2 Liz's prescribing boundary**

I will contrast Matthew's prescribing behaviour in the HPCT meeting with Liz's prescribing behaviour when talking to the district nurse. What is significant in the next sequence of talk is that Liz can extend her prescribing behaviour when talking to the district nurse. Liz is positioning herself and being positioned by the district nurse as an expert in palliative care when talking about the prescription. Therefore Liz can extend and display her expertise when talking with non-specialist practitioners. Liz in this sequence of talk moves between 'checking for pain' and 'prescribing behaviour. Liz when talking on the phone to the district nurse uses 'I' eleven times and she does not use the term 'we' at all. Therefore, I conclude that the district nurse is not a colleague in the sense of Matthew and Amy, she is not a member of the palliative care team. Liz, when talking with Andrea the district nurse, positions herself as a specialist palliative care nurse who can give prescribing advice.

1 HPCN Liz (on the telephone to Andrea the district nurse) But  
 2 the thing that I just wanted to check with you was she  
 3 still getting a fair bit of pain? And she said that in the  
 4 residential home, the daughter said 'you can't take  
 5 morphine in the day because they can't give it'. Is that  
 6 right? Well I just wondered Andrea whether it would be  
 7 worth trying her on MST 10 milligrams bd, 10. I mean it's  
 8 a weenie dose, but you see if she has 20 milligrams in the  
 9 day, 10 bd, it will be equivalent to 2.5 milligrams of  
 10 oramorph four hourly. So I reckon, see what I don't want  
 11 to do is the easy thing would be to give her MXL at night  
 12 but I am not sure that she needs as much as 30 milligrams,  
 13 it might actually make her. Yeah this is the trouble and  
 14 30 milligrams of MXL is equivalent to 5 milligrams four  
 15 hourly, now that might be a bit a bit too much for her  
 16 during the day. So what I thought was if you gave her 10  
 17 in the morning and 10 at night. I suspect that won't be  
 18 too much. Well what she said was she's getting, she said  
 19 the night times are wonderful with her 5 milligrams of  
 20 oramorph but the trouble is she gets quite a bit of  
 21 shooting pain in the daytime. Now that thing is smaller  
 22 it might make a difference. But the only thing to watch  
 23 out for is if you start the MST, just make sure she doesn't  
 24 get too muddled with it. I don't think she will, it's so  
 25 small. It's not like she is morphine naive now. She'd  
 26 been used to having it at night. So why don't you try 10  
 27 in the morning and 10 in the evening. Yes. I told her to  
 28 take it twice a day particularly to try with the morphine,  
 29 but warn her that she might feel light headed for the first  
 30 couple of days or so on the MST and if there is any signs  
 31 after the first few days that she has gone off a bit then  
 32 you may have to stop it. You'll have to go back to the  
 33 oramorph, I suppose.

#### **Extract 16 Hospital Palliative Care Team Oakwood**

This telephone conversation with Andrea the district nurse provides Liz with a platform to use her expertise about pain and analgesic drugs. Liz uses the personal pronoun 'I' to present her role in checking for pain, 'I just wanted to check with you was she still getting a fair bit of pain?' (line 2/3). In this sequence of talk Liz, like Anna in extract 11 uses a series of questions to align the district nurse as a recipient or answerer of the questions. By using 'fair bit of pain' Liz hedges and is cautious about attributing how much pain the patient has. She is also checking with Andrea about whether what the daughter has said is correct, 'the daughter said "you can't take morphine in the day because they can't give it". Is that right?' (line 4/5). So Liz is checking out the credibility of the report she has received. She is thus checking the evidentiality of the account given and eliciting Andrea's opinion. Liz is also using prescribing behaviour, just as Matthew did in the palliative care team meeting. Prescribing behaviour I would argue, is a platform for Liz to accomplish her specialist role as a palliative care nurse when talking with the district nurse. Liz continues, 'I just wondered Andrea whether it would be worth trying her on MST 10 milligrams bd' (line 6/7). Liz by being explicit about what dose of MST to give, reassuring Liz that this is 'a weenie

dose', and discussing expected side effects of the drug, undertakes 'medical work' by moving into the doctor's prescribing boundary. The boundaries of Liz's role are extended beyond checking for pain into prescribing analgesic drugs when she talks about the patient's pain with the district nurse.

Liz, Amy and Matthew use minimising talk such as 'weenie' (extract 16, line 8); 'tiny oramorph' (extract 6, line 5) and 'tiny, tiny bit of oramorph' (extract 6, line 6). Doctor Jenkins also uses the term tiny:

*she may have had a tiny little something in the past...with sensitive thing like the central nervous system ah if they're in certain places those tiny little unmeasurable mets can cause an enormous amount of problem. (MD Doctor Jenkins)*

Rollnick et al (2001), in a study of how GPs manage upper respiratory tract infections (URTI) in children, collected audio-recorded data of such consultations. The researchers found that a standard strategy employed by the GPs was to minimise the concerns reported by the parents about the symptoms experienced by the children. The minimising strategy used by the GPs included use of words such as 'little bit swollen' and 'probably just a viral infection' and countered the extremely abnormal events reported by the parent about their child. This minimising talk functioned in two ways, it enabled parents to feel reassured that what their child had was absolutely normal, but also enabled the GP 'a pre-emptive' move in which a decision not to prescribe for the URTI was being worked up. The minimising talk in the palliative care team meeting refers to morphine type drugs and organic disease. It achieves the palliative care team expertise in knowing the tiny type of doses that achieve pain control in contrast to other practitioners. It also achieves Doctor Jenkins's expertise vis-à-vis the palliative care team in relation to his medical knowledge of cerebral metastases and their characteristic behaviour. This talk positions the nurses as knowledgeable about doses of drugs but Doctor Jenkins has specific expertise that in this context remains expert medical knowledge about the metastatic disease process.

Liz, by using the authoritative 'I' takes responsibility for her prescription advice. Liz through her use of 'I' displays her expertise as a specialist nurse who can make prescribing decisions in her own right when talking with the district nurse. Liz makes her claim to specialist expertise in two areas; one is in checking for pain and the other is in relation to prescribing medications. These claims are

enacted differently in different situations. Within the HPCT she uses the checking for pain expertise by controlling the agenda of the team meeting by use of questions that orientates to the symptom of pain. The checking for pain and prescribing expertise is used outside of the team with the district nurse as discussed above. These findings are consistent with Hunt's (1989) study where she also found SCT nurses had specialist and technical knowledge of drugs and prescribing. Hunt argues that by claiming expertise in drug-prescribing specialist nurses' sense of professional self esteem and team membership was increased. Thus prescribing may be one way for these nurses to increase their professional standing and status both within the profession of nursing, within the medical profession and with patients. However, the situation that enables this practice to develop is the lack of expertise in palliative care in the community. There is a knowledge deficit that enables the specialist palliative care nurses to extend into medical territory within the community setting. So although nurses may be appropriating more medical approaches in their practice and this may inadvertently contribute further to medicalisation this seems to arise, in part, because of deficits in knowledge and competency within primary care teams.

What is interesting about this talk is that Liz extends into Matthew's prescribing space in her dialogue with the district nurse. She can extend her performance in the 'I' mode when giving advice to the district nurse when Matthew is not present. I conclude from this that nurses may have more space for developing their expertise in the medical space when they do not have to compete with specialist doctors directly. Corner and Dunlop (1997) assert that the early success of the hospice movement was based on the management of cancer pain using powerful pharmacological drugs. This they argue has led to a construction of care placing a great deal of emphasis on a biomedical model. The collegial positioning of specialist nurses within the palliative care team provides them with the resource, in terms of knowledge acquisition, to extend their expertise in the medical space.

I have found that nurses play a key role in relation to acting as a gatekeeper about the type of patient suitable for the team. I contrast the construction of the 'ideal patient' for palliative care with the less than ideal patient. The presence of pain features prominently in the staff talk of the preferred or 'ideal type' patient. I examine the nurse's role in gatekeeping the boundaries of palliative care. I use examples that concern the symptom of pain as well as problems related to

advanced disease and psychosocial troubles. I conclude that the presence of pain and other symptoms are very important to the joint action of the team unlike problems such as psychosocial troubles.

## 7.8 The ideal patient ‘definitely one of ours’

The HPCT construct the ‘ideal type’ patient, which is a patient with cancer and, or symptoms, including pain. The team members therefore, act as ‘gate keepers’ so that suitable patients are identified and patients no longer in need of their help are discharged. In the extract below Eric Barker has got two cancers and is experiencing a number of symptoms including pain. He is defined as ‘one of ours’.

1	HPCN Liz	Eric Barker is interesting. He has got two
2		primaries. He has got a prostate and a rectal tumour and
3		he came in with bleeding, diarrhoea and pain.
4	CPM Matthew	He is someone you will get at some stage.
5	HPCN Liz	Yes, definitely. I am not sure where he is actually.
6	CPM Matthew	He is going for radiotherapy isn't he? He had a
7		defunctioning colostomy, and he looked, as though he was
8		obstructed and he was partly obstructed when we first came
9		across him wasn't he?
10	HPCN Liz	I mean that's really when we were introduced to him.
11		He had a colostomy because they thought he was ( ). He
12		lives up in Roundwood so ( ). The thing about him is he has
13		got a wife actually. We will probably go up and see him
14		today. His main symptom was he had a dry mouth and we used
15		this new stuff on him and it worked like a dream.

### Extract 17 Hospital Palliative Care Team Oakwood

Matthew and Liz together define Eric as ‘one of ours’. Matthew states, ‘He is someone you will get at some stage’ (line 4). In this statement Matthew seems to be acknowledging Liz as a colleague, someone who takes on patients. This is accomplished in his use of the democratic ‘you’. There is no doubt about Eric’s ‘ideal’ status and Liz replies ‘Yes, definitely’ (line 5). Liz further defines Eric’s ‘ideal’ status. He is interesting. He has got two primaries (cancers) and is symptomatic with pain, bleeding and diarrhoea. (lines 1/2/3). I have searched my data set to look at how the term ‘interesting’ may be used in palliative care talk.

### 7.8.1 ‘Interesting cases and crocks’

Liz and Matthew use the term ‘interesting’ on a number of occasions (Table 8). Becker et al (1961) says that medical students use simple typologies such as ‘interesting cases’ and ‘crocks’ to describe patients. An interesting case for example has a wide range of meanings including having a disease that one has not

seen before. Becker et al says that what is interesting about such typologies is the interpretative value implied by use of such a term and the kind of problems to which it may refer. The terms ‘interesting’ and ‘crock’ do not automatically apply according to Becker et al and the particular circumstances of the situation are always important and influence the student’s view of that patient.

This term interesting seems to have some significance in relation to how the hospital palliative care team talk as this team use this term most often. Liz and Matthew use the term ‘interesting’ in a number of ways to refer to the patient and his/her disease, medical interventions, and to orientate to the hospice philosophy of spiritual care:

- a) *It was very interesting yesterday. Um. She is such a sweetheart isn't she, she really is. Yes. Well what he's done, he's done a wonderful job I think. He's, they gave her blood and platelets and he has taken the whole thing off. (HPCN Liz)*
- b) *Oh that's interesting they haven't biopsied it or anything? (HPCN Liz)*
- c) *You've got some interesting patients. (HPCN Liz)*
- d) *He is an interesting character. He's the guy that presented with cord compression. (HPCN Liz)*
- e) ( ) *Myers now she's an interesting she's got a dead foot or two. (CPM Matthew)*

Liz’s use of interesting reflects a clinical and personal context because she uses the terms ‘interesting patients’ and ‘interesting character’ (extract c,d). However the reference to ‘interesting character’ occurs alongside her referencing of the serious condition of ‘cord compression’. This type of condition is considered an oncologic emergency and this seems to enhance this patient’s ‘interest’ in a medical setting I suggest. The use of the term interesting also enables her to praise the doctor’s skill in doing a ‘wonderful job’ by taking ‘the whole thing off’ (extract a). Therefore Liz uses the term interesting in a fairly eclectic way to combine medical/clinical and personal forms of interest. Matthew’s use of interesting concerns the patient’s ‘dead foot or two’ a clinical context referred to in a humorous fashion.

The only occasion that Doctor Jenkins uses the term interesting is when he reports the words of a hospital doctor in relation to the patient’s disease status and prognosis:

- o) And the the liver function was marginally better in some areas wasn't it but the bilirubin was doubled. I saw Frank Walton on Saturday. He said 'very interesting but I still don't think she'll make it. (MD Doctor Jenkins)*

Doctor Jenkins quotes the hospital specialist Frank Walton and his interest in the improvement in the disease status of the patient in terms of liver function and bilirubin measures. I conclude that the term interesting is one that is located in a specific clinical context relevant to the concerns of hospital work and hospital palliative care rather than to hospice or community palliative care work.

The term 'interesting' is also used to convey veiled and not so veiled criticism in the following extracts of talk from Liz and Matthew:

- f) Actually it was quite interesting how she described that pain and that's what's such an interesting thing on the wards they don't go up and sit there and say how is the pain today? (HPCN Liz)*
- g) Yes and she's got power of attorney which is even more interesting because there are children from the marriage and she has now refused to let him go to St. Anthony's because it is too expensive. (HPCN Liz)*
- h) Actually she is quite drowsy now it is quite interesting. She was quite sleepy yesterday morning but and she had been on regular, rather irregular oramorph hadn't she? (CPM Matthew)*
- i) and you were saying to me that you reckon that his wife is sort of almost overdosing him, that is interesting because she was the one that was so obsessed with not giving him analgesics because of his bowels. (CPM Matthew)*
- j) It is quite interesting because this man plagues us with phone calls. (HPCN Liz)*

In these extracts a professional and clinical context is projected and the use of 'interesting' enables Liz and Matthew to maintain a footing of impersonality, which enables veiled criticism. Thus interesting is used as a device to identify inappropriate behaviour in all the above extracts. Interesting is a veiled way of saying non-specialist staff and relatives are of interest because of their ineptitude.

The term interesting also seems to be used to discuss impressions and patient responses:

- k) Well, I mean, but it's interesting because his, his impression is that she'll go down and live in a nursing home. (HPCN Liz)*
- l) It will be very interesting to see how, what response you get. (HPCN Liz)*



This use of interesting implies talk concerning family members and how they may have different impressions about future plans (extract k). In the extract l) Liz is suggesting that the interesting response will be the patient's reaction to a visit from the chaplain Katie. The term is also used in relation to how the team responds to certain patients:

*m) I think that was interesting what she said, she said she feels so guilty for you all because you have all worked so hard for me and it was always like she was trying to keep going for us and not for her. (HPCN Liz)*

*n) Although I get a great sense of, we were talking at the hospice the other day about what does spirituality mean and it was quite interesting. (HPCN Liz)*

The use of interesting in extract m) fits the notion of 'give and take' developed by James (1986) who observed how reciprocal relationships develop between hospice nurses and patients. The patient in extract m) by her concern for staff achieves the 'magnificent even though they are suffering' because of her concern 'to keep going for us' (James 1986:169). In extract n) Liz voices how the team orientates to the hospice philosophy of spiritual care. Liz seems to operate as a mouthpiece for this team to talk up the dimensions of palliative care concerning spiritual needs and to cross the boundary between the clinical context of 'interesting', and the context of hospice philosophy and its concern with spiritual matters. Therefore the talk manages to introduce a wider connection between interesting pathologies, interesting characters, interesting and inept and the spiritual concerns of the hospice movement (Table 8).

Word count of Interesting	Liz	Matthew	Dr Jenkins	Hospice nurse
Case/character	6 (0.84)	2 (0.22)	1 (0.23)	0
veiled criticism	5 (0.70)	2 (0.22)	0	0
to hospice	3 (0.42)	0	0	1 (0.15)
Total	14 (1.95)	4 (0.45)	1 (0.23)	1 (0.15)

**Table 8 Word count of the use of the term 'interesting' (rate per 1000 words in brackets)**

### 7.8.2 Not one of ours

The 'ideal' status of Eric in extract 17 is in contrast to the next patient Mrs Grant who was 'one of ours' but is no longer because the symptom of pain is solved. Liz makes the link between the HPCT and the symptom of pain:

- 1 HPCN Liz Mrs Grant is the lady with, who has had the  
 2 amputation, old lady with peripheral vascular disease. We  
 3 probably don't need a lot of input now because the pain is  
 4 solved since she has had the amputation. So I almost feel  
 5 that we have done our bit probably.

### **Extract 18 Hospital Palliative Care Team Oakwood**

Liz defines the limits of palliative care, once pain has been solved by surgery (line 3/4). The absence of pain means 'we have done our bit' (line 5). This statement works to identify Liz's particular expertise and that of the team in pain problems. This is done through Liz's use of the clinical discourse of 'I' and 'we', 'So I almost feel that we have done our bit probably' (line 4/5). Liz is able to shape the discourse of the HPCT to work with particular types of patients who can benefit from palliative care. The work of palliative care therefore is constructed around those with the disease of cancer and the symptom of pain, where pain, which may often be a feature of cancer is controlled by the titration of pharmacological interventions. Thus what is potentially a 'bad' situation is turned into a success when pain is successfully managed. This may be the *raison d'être* for the speciality of palliative care and its main resource in achieving satisfactory outcomes.

The next extract of talk demonstrates how patients who have advanced cancer but do not have any symptoms such as pain may be classified as 'not one of ours'. The achievement of 'not one of ours' in the extract discussed below is a pragmatic decision when the palliative care nurse and the palliative care team conclude that they are unable to help this patient. Therefore I conclude that having a diagnosis of advanced cancer is insufficient for sustaining specialist palliative care resources. Other factors come into play and these factors to some extent reflect the skills and competencies of both patients and staff to sustain meaningful relationships.

### **7.8.3 Telling an atrocity story and achieving 'not one of ours'**

The next two extracts of talk illustrate how a patient with advanced cancer can be classified as 'not one of ours'. This patient is a difficult patient management problem as she has a problem with alcohol. In the next two extracts of talk Cath develops an atrocity story about this patient. The story that she tells enables Cath to achieve 'definitional privilege' similar to Penny in extract 10 but on this occasion definitional privilege enables Cath to have this patient re-categorised

within the team as ‘not one of ours’. Atkinson (1995) describes how clinical narratives can take on the genre of ‘atrocious story’, which may attribute blame and responsibility and a moral may be drawn about the mistakes of the narrator and others. Webb and Stimpson (1976) suggest that an atrocious story works as a means of accounting for and explaining the social world and in this sense they enable the integrity of the teller to be maintained. Therefore such stories constitute roles and moral identities for medical staff and patients, according to Webb and Stimpson. In this atrocious story, Cath is very concerned about the risky behaviour of a patient who has advanced cancer.

- 1 CPCN Cath You're not going to stop her drinking, she's got  
2 too much stress.  
3 It's how I'm going to try and support her through?  
4 Dr Jenkins Well what's the situation as far as the breast cancer  
5 concerned.  
6 CPCN Cath Very stable. I rang and spoke to Dr Forster. The  
7 last letter is only two weeks ago. She's had multiple bone  
8 secondaries that are well controlled and she has just had a pin  
9 put into her right arm as prophylactic. She's had one  
10 fraction of DXT for that. There's possibly an increase in some  
11 of the mets in the skull but there is nothing definite on scan  
12 and everything else seems to be stable. They've taken her off  
13 the phosphadex hormone trial that she was on, because she  
14 wasn't getting any better and she certainly wasn't  
15 deteriorating and they decided to stop it. There was no point  
16 keeping her on it. And they have just kept her on the  
17 tamoxifen. But she is actually very stable you know. She is  
18 very very good at the moment. Functionally, she's very good  
19 in the house better than I've ever known her to be.  
20 Dr Jenkins So really it's purely an alcohol and social problem.  
21 CPCN Cath Purely a social problem.  
22 Dr Jenkins It's not us.  
23 CPCN Cath And if she, you know, if she's not going into  
24 care, Janet I think, is just a small part.  
25 SW Gill She comes to our day centre?  
26 CPCN Cath No.  
27 SW Gill She comes to our day centre?  
28 CPCN Cath No she won't come to the day centre. It was  
29 offered while she was in here. It is not her type of thing,  
30 because she can't have a drink. (laughter)

### **Extract 19 Community palliative care team Karamea Hospice**

In this extract of talk Cath constructs an atrocious story about a woman who has an alcohol problem (line 1). Cath has difficulty constructing a role in how to, ‘support her through’ (line 3). She states the patient ‘has too much stress’ (line 2). In his next turn Doctor Jenkins in a topic change asks a question about the status of her breast cancer (line 4/5). This positions Doctor Jenkins as concerned with the symptoms of breast cancer rather than issues of support. Cath has spoken to the oncologist, Doctor Forster (line 6) and she reports that the, ‘multiple bone secondaries that are well controlled’ (line 8) and she ‘seems to be stable’ (line 12).

At line 17 Cath says ‘very stable you know’. This talk constructs the stable and well-controlled disease status of the patient. Doctor Jenkins and Cath are bringing into play factors relevant to the performance of palliative care, namely the disease status and symptoms associated with breast cancer. This is doing the ‘clinical mentality’ where disease, tissues, and organs are entities in their own right (Anspach 1988, Foucault 1976). This clinical mentality may result in the presentation of a patient as, ‘a passive receptacle for the disease rather than as a suffering subject’ (Anspach 1988:372). Anspach found that in case presentations within neonatology and obstetrics that there was a separation of the biological process from the person, which she calls depersonalisation.

Cath uses a number of approximators between lines 8-12. She reports how ‘she just had a pin put into her right arm as prophylactic’ (lines 8/9). She continues ‘There’s possibly an increase in some of the mets in the skull but there is nothing definite on scan and everything else seems to be stable’. These hedges work to downplay and create ambiguity around the seriousness of the patient’s disease status. However, this woman has advanced metastatic cancer that has infiltrated her bones and she has been treated with a number of different treatment modalities. A pin has been put in her arm (line 8) and she had radiotherapy, ‘DXT for that’ (line 10). She has recently been taken off a hormone trial (line 13) and she is on tamoxifen (line 17). I conclude that this is a patient who is at an advanced stage in her disease trajectory. In contrast Cath describes just how ‘good’ this patient is functionally. She uses the extreme case formulation, ‘very stable, you know’ (line 17). She continues, ‘she is very, very good at the moment. Functionally she is very good’ (line 18), ‘better than I’ve ever known her to be’ (line 19). This enables Doctor Jenkins in his next turn to re-classify the problem, ‘purely an alcohol and social problem’ (line 20). In her next turn Cath drops the alcohol and echoes, ‘Purely a social problem’ (line 21). So together Doctor Jenkins and Cath collaborate to cast this woman as a non-palliative care patient and Doctor Jenkins in his next turn says, ‘It’s not us’ (line 22). Cath by stressing the patient’s good functional ability in the home, enables the team to re-categorise this patient as ‘not one of ours’. This alcohol and social problem is a backstage issue in specialist palliative care it is not the concern of the palliative care team.

Becker et al (1961) says that patients categorised as ‘crocks’ by medical students are those without any disease, they probably cannot be cured and they are likely to create scenes. I suggest that Cath’s patient may be a ‘crock’ in the sense that she has a problem with alcoholism that probably cannot be cured and she potentially can create scenes by non co-operation with advice and indulging in risky behaviour. Becker et al points out the label ‘crock’ is not automatically applied when characteristics of the type are spotted. The circumstances and the student’s previous clinical experience influence the view he or she takes of any patient. Cath does not feel competent in continuing with the challenging circumstances surrounding this patient I suggest. Doctor Jenkins’s use of clinical data related to the disease process enables Cath to collaborate with Doctor Jenkins to mutually construct the patient as ‘not one of ours’. Her telling of the case as an ‘atrocious story’ is her resource in enabling this classification to be made and in this way this patient is a type that meets the criteria of ‘crock’ in this context.

Dingwall (1977) argues that the telling of atrocity stories is a device to resolve conflict and does boundary work by enabling social groups to work together and in the context of that work group enables them to voice their complaints at a distance. In my data the telling of an atrocity story also enables Cath to define her area of expertise and that of the team as not in the area of troublesome ‘social problems’ and deviance concerned with alcohol abuse, or working with people who have ‘too much stress’. She also makes clear her lack of confidence in being able to support a patient with these types of troubles (line 3). Also this woman has refused to go into care, ‘and you know if she’s not going to go into care’ (line 23). So she is not co-operating because she is not going to stop drinking, and she refuses to go into care. She is therefore a liability to the palliative care team and to Cath who is worried about her falling and injuring herself, which is discussed in the next extract of talk.

1 CPCN Cath Well I think the best thing to do then is to leave  
 2 the district nurse with, the GP didn't know she had a drink  
 3 problem until I spoke to him two weeks ago. So ah and just let  
 4 them all know that you know, currently, we are going to have  
 5 a trial period at home and if she falls  
 6 SW Gill Well if anyone falls you know it's the same  
 7 situation isn't it?  
 8 CPCN Cath Well I suppose it is really cause she has got all  
 9 the anxieties of the family over her really but we can't solve  
 10 all of those problems really.  
 11 SW Gill Mind you if she drinks heavily she could still fall  
 12 even if she has a member of the family there. Couldn't she?  
 13 Dr Michael Hmm. Hmm.  
 14 SW Gill Really.  
 15 CPCN Cath I was looking at that.  
 16 Dr Jenkins You're absolved.  
 17 CPCN Cath I'm absolved.  
 18 SW Gill Well I think you have to sort of remember what  
 19 your brief is Cath don't you?

### **Extract 20 Community palliative care meeting Karamea Hospice**

Cath uses the pronoun 'I' to suggest the following decision, 'Well I think the best thing to do then is to leave the district nurse with, the GP didn't know she had a drink problem' (lines 1-3). Therefore patients considered to have problems like this are positioned as problems relevant to the district nurse and the GP. However, the GP does not seem to know that this patient has a drink problem (line 2). So there is some doubt about how long this patient has had an alcohol problem or perhaps the patient has hidden this from the GP. I suggest that this patient's biography remains a mystery. For example she could be drinking alcohol due to her inability to cope or because she has unrelieved pain (Ferrell et al 1993). The team seems very concerned to whittle out what is a symptom control problem and separate it from a 'social problem'. Cath is worried about the patient falling at home (line 5). This accomplishes Cath's identity as a nurse who is concerned about her responsibility, if the patient falls and injures herself. Gill the social worker in her next turn generalises the problem of falling to a problem that could happen to anyone (line 6). Cath also emphasises the limits of what can be offered, 'she has got all the anxieties of the family over her really, but we can't solve all of those problems really' (line 9/10). Table 9 demonstrates the proportion of talk involving symptoms, emotions and drugs in relation to professional identity.

	Doctors	Hospice nurses	Social workers	Specialist nurses
Symptom words	74 (4.99)	50 (7.17)	2 (0.93)	163 (4.76)
Emotion words	22 (1.48)	20 (2.87)	16 (7.46)	59 (1.72)
Drug names	75 (5.05)	23 (3.30)	0	140 (4.09)
Total	171	93	18	362

**Table 9 Word count of symptoms, emotions and drugs (rate per 1000 words in brackets)**

Specialist nurses like Cath use words related to symptoms and drugs on many more occasions than words related to emotions. Thus one conclusion that may be drawn from this is that expertise and knowledge is drawn from the biomedical base of symptoms and drugs rather than the psychosocial domain of emotion talk in specialist nurses' talk.

Cath in her use of the collective 'we', speaks for the team, as being unable to solve the patient's many problems. In her next turn the social worker states that the patient, 'she could still fall even if she has got a member of the family there. Couldn't she?' (line 12). The social worker is also achieving the classification of this patient as 'not one of ours'. Doctor Jenkins in a topic change says 'You're absolved' (line 16). This implies that Cath is absolved of responsibility for the patient if she does have an accident. Doctor Jenkins has the authority to absolve Cath of responsibility. Cath echoes Doctor Jenkins's words, 'I'm absolved' (line 17). This team has collaborated to absolve themselves of their commitment to this patient who is indulging in 'risky' behaviour, which could result in a calamity if she falls and damages her fragile bones. Cath by using an atrocity story persuades the team to dispose of this patient back to the GP and the district nurse. The social worker reminds Cath of her brief (line 19). Her brief is not concerned with patients who put themselves at risk because of their behaviour.

There are no symptom control needs identified with this patient. However, what seems to be evident in this talk is the lack of attention to the psychosocial needs of the patient. She is identified as having 'stress' but this is not explored. There is no talk of her dying, or her distress about her advanced disease. What is explored is the difficulty in managing a patient who doesn't follow the advice to stop drinking in the home setting. Unlike Penny's neutralistic approach, Cath works this story as one of blame and responsibility. The blame lies with a patient who is drinking alcohol and in so doing is putting herself at risk. This is a difficult patient management problem and the team together decides this is 'not us'. It is a more

general problem related to daily living and the risky actions of the patient. Table 9 identifies the social worker's much higher use of words related to emotions. I suggest that once the patient has been identified as 'one of ours' because of specific symptom control needs the social worker can contribute to psychosocial support needs but psychosocial support needs per se are insufficient for access to specialist palliative care despite having a diagnosis of advanced cancer. This may be one way that hospice and palliative care teams avoid being dumped on by taking patients that are a liability and impossible to help in the way envisaged and idealised by the hospice movement.

Murcott (1981) argues that a wide range of criteria is used for the moral evaluation of clientele including patients who make the work of the staff more difficult. Such patients, she argues, are troublesome and pose difficulties for medical staff trying to do their job properly, as they see it. She suggests that staff may use sanctions such as sarcasm, sedation or transfer elsewhere. In the case of Cath's patient she has been disposed of by her transfer to the GP and district nurse care. This suggests that difficult psychosocial problems have a low priority when allocating specialist palliative care. There is evidence for this in a study of hospice admissions meetings on three sites, where requests for admission for symptom control and terminal care were identified as high priority in contrast to the low priority given for psychosocial requests on all three sites (Eagle 2002).

I conclude that for a patient to be considered 'one of ours' they need to have a specific symptom control need such as pain. Without this type of need, even if they have specific psychosocial need associated with their advanced disease, they may not be successful in securing specialist palliative care. This, I suggest, adds support to the argument that there is an increasing medicalisation of hospice and palliative care with less emphasis on terminal care per se (McNamara 2001, Corner & Dunlop 1997, Field 1994, Biswas 1993). The palliative care team in categorising a patient as 'not one of ours' is situating their expertise and reputation in being able to palliate the symptoms associated with advanced disease. Ideally these types of problems are grounded in the bodily experience of the patient.



## 7.9 Conclusion

In this chapter I have provided a linguistic analysis of talk that explores how the palliative care team construct the boundaries of palliative care work. Nurses use similar linguistic devices to clinicians in medical settings and professionals in other work contexts and this enables them to display their competence and credibility as specialist nurses (Greatbatch & Dingwall 1999, Anspach 1987, Atkinson 1995, Clayman 1992). Strategies such as asking questions and the use of footing to keep a neutralistic position enable nurses to enter into medical discourse and do interprofessional work. Asking questions avoids making challenges to medical experts, but also allows nurses to shape the agenda of talk. Nurses also construct stories in different genres such as the mystery story and the atrocity story and this enables them to take the floor and establish their particular area of competence. All members of the team construct the presence of bodily problems and symptoms associated with advanced disease as a priority for access to palliative care. It is these symptoms that differentiate specialist palliative care from other forms of care. I conclude that nurses are able to achieve definitional privilege by defining patients as suitable for palliative care and in doing so establish their area of competence and identity as a specialist nurse. The area where nurses are differentiating their expertise is in relation to finding and prescribing for symptoms, such as pain. This is a central part of specialist palliative care.

## **Chapter 8 Discussion and Conclusion**

## 8.1 Introduction

The broad aim of my research is concerned with understanding from a sociological perspective how palliative care professionals talk about pain. I have explored how individuals display their professional and occupational identity within the boundaries of team talk about pain. For this purpose the analysis has focused on two main areas, which are ‘pain talk’ Chapter 6 and ‘shaping professional boundaries’ Chapter 7. The theme, which links these two chapters, is the theme of reputation. Through talk-in-action that focuses on pain a space is opened up that enables the palliative care team to develop a unique identity around expertise related to pain and in this way they build a reputation for themselves and for the team. Reputation is achieved through the use of rhetorical and linguistic resources that enables the rules of ‘pain work’ and ‘boundary making’ to be made visible through talk-in-action. By use of linguistic and rhetorical resources palliative care professionals construct their competence. Analysis of talk enables one to understand how expertise and identity is negotiated across professional boundaries and with patients. The expertise that is made visible in the talk about pain is primarily biomedical expertise but other forms of expertise are also made visible, through psychosocial talk. Such talk enables professional credentials to be displayed and professional boundaries are made and unmade and the implications for the concept of ‘total pain’ are revealed.

### 8.1.1 The aims of the chapter:

- discuss my research questions in the context of my findings
- to draw together the results of the study and to place the findings in the context of the literature review and the concept of ‘total pain’
- to make suggestions for sociological study and health care practice
- to address limitations and the new questions raised by my findings

## 8.2 Research questions

### 8.2.1 What is talk about pain concerned with?

Analysis of talk about pain enables one to understand how an expert performance in managing pain is constructed. Pain talk often involves biomedical talk that defines the rules of pain work as well as talk about the patient in pain (Chapter 6). The ‘right kind of pain’ (Rogers and Todd 2000) for the palliative care team is that

which is sensitive to pharmacological interventions. The palliative care team also engages in psychosocial talk. There is a link between biomedical talk about pain and psychosocial talk. The team for example may construct the patient as experiencing emotions that are to be expected as part of a difficult disease trajectory involving the experience of pain, or to be behaving and performing inappropriately by non-adherence with pharmacological therapy or resisting advice (Chapter 6). Specialist nurses are important in positioning the patient on the biomedical and psychosocial axis in all the settings studied. Vrancken (1989) says that the separation that occurs in relation to the body and mind of the patient in pain results in a dualistic approach. In this approach it is important to distinguish the contribution of the somatic and the psychic realms when assessing pain, according to Vrancken. Talk about pain in the team approximates to a dualistic construction because the patient is talked about as having pain in the body and sometimes also having pain located in the mind (Chapter 6). The positioning of the patient, by the team, on the somatic and psychosocial axis is important when decisions about pain interventions are discussed (Chapter 6) but also in relation to access to specialist palliative care services (Chapter 7).

Threats to effective pain work arise from a number of locations. Of importance is the non-specialist practitioners' expertise in pharmacological therapy for pain. Talk, which involves criticism of non-specialists, enables the rules of pain work to be made explicit (Table 6 and Table 7). Talk opens up a space for specialist nurses to develop their unique identity and expertise in pharmacological therapy for pain by defining their expertise in contrast to those without this expertise such as GPs (Table 7). Thus talk-in-action involving criticism is a 'usurpatory' tactic utilised by specialist nurses in relation to GPs. Witz (1992) uses the term 'usurpatory' to define the collective action of a subordinate group, which assumes a form of resistance or opposition in response to the experience of exclusion. Criticism, involving contrastive rhetoric, is a type of verbal resistance utilised by specialist nurses to push at the boundary between medicine and nursing (Chapter 6). Such talk enables the nurses to reveal their individual, specialist expertise as a certain type of nurse, one who has more knowledge of pain and symptom management than some GPs. Parkin (1979) says that usurpatory actions aim to bite into the resources and benefits accruing to dominant groups ranging from marginal redistribution to complete expropriation. Thus the

subordinate group (the specialist nurses) mobilise verbal and rhetorical power against the dominant medical group (the GPs) to bite into medical territory where they believe they are the experts in symptom management (Chapter 6/7). Witz says that a strategy of 'inclusionary usurpation' is a means by which women challenge a male monopoly over competence. She continues that it is an inclusionary strategy because the goal is to be included in structural positions rather than excluded. Thus specialist nurses are seeking to be included within the medical space, because they claim they have specialist medical knowledge of symptom management that GPs and other non-specialist medical and nursing staff do not have (Chapter 3 and 6).

Hospice nurses have been found to use usurpationary strategies to increase their autonomy in relation to the application of complementary therapies (CTs) (Garnett 2000). The basis of the usurpationary tactic reported in Garnett's study is that hospice nurses present themselves as having the tools consisting of 'specialist knowledge and skills to carry out CTs and to gain autonomy in their use' (Garnett 2000:173). Thus specialist palliative care and hospice nurses may be achieving their professional project by a range of medical and psychosocial strategies. These strategies share the common goal of increasing nurses' autonomy (Garnett 2000, Witz 1992). Strategies to increase autonomy seem to depend on the structural position of the nurses within the palliative care division of labour. Hence specialist community and hospital palliative care nurses seek more autonomy in the medical space, through expert knowledge of pharmacological approaches to symptom control, while hospice nurses may seek to increase autonomy in the psychosocial space through the use of CTs (Garnett 2000). Hospice and specialist palliative care nurses are developing their professional project on two fronts; both in the medical and psychosocial space but both projects are concerned with the issue of increasing nurses' autonomy.

I have found that if pain is not responding to pharmacological interventions, strategies such as psychosocial talk are utilised, which move talk from pain in the body to talk about the patient in pain and the patient's ability to cope with pain (Chapter 6). Vrancken (1989) says that the behaviourist approach to pain emphasises the failure of coping strategies and the objectives of this approach are to minimise pain behaviour so that the patient and the family cope with pain more effectively. In this approach pain behaviour is discouraged. Therefore I suggest

that the behaviourist approach to pain exists along with the dualistic approach (Chapter 6). Patients with non-malignant disease such as peripheral vascular disease may have pain that is difficult to control and exhibit behaviour that is also difficult to control, such as being emotionally aggressive or being critical of pharmacological interventions and palliative care staff (Chapter 6). Fagerhaugh and Strauss (1977) say that the result of failure in relation to biomedical approaches to pain may result in the construction of the patient reputation. Such patients were talked about as uncooperative and manipulative according to Fagerhaugh and Strauss. I have found that patients whose pain may be resistant to pharmacological therapy also have a reputation developed for them in team talk that involves a psychosocial construction of a performing patient (Chapter 6).

In the hospice team meeting there is a range of voices heard in relation to the patient and their pain (Chapter 6). Hospice staff negotiate an account of pain by use of conversational practices such as ‘information-eliciting tellings’ and this enables them to keep a neutralistic footing in relation to what they are reporting. The technique of a neutralistic footing enables palliative care staff to avoid criticising patients’ demeanour and behaviour particularly when it is difficult to find a rational explanation for patients’ actions and behaviour (Chapter 6). This finding for the hospice setting is supported by Li (2002) who found that ‘nice’ palliative care professionals do not do criticism of patients. Good et al (1992:199) say that chronic pain comes to meaning in the context of conflicted social relations and contested interpretations. They continue that the “politics of interpretation” is always important. Good et al are critical of those that are disaffirming of the persons’ pain experience, and argue for a reconfiguration of such ideologies. There is evidence for an interpretative framework using ‘information-eliciting tellings’ in the hospice setting that provides some evidence of an approach that takes into account the intersubjective experiences of patients and carers, around the problem of interpreting pain.

In my analysis of pain talk I have found a variety of ideas and beliefs about pain given voice both by professional staff and by patients. However, there is a consistent link between talk concerning problems with pharmacological strategies for pain and psychosocial talk. This is why I conclude that pain talk tends to be dualistic in construction because it is problems in biomedical strategies that result in psychosocial talk about patients in pain.

### 8.2.2 How does the PCT construct the patients' experience of pain?

The patients' behaviour, bodily expression and pain complaints are discussed within the team. Palliative care professionals make visible their observations of pain in the body and give an account of the patients' pain (Chapter 6). Beliefs about the patient experience of pain are very diverse (Chapter 6/7). In the context of advanced disease pain may be viewed as related not only to one's medical condition, but to psychological and social conditions also. The result of this is that pain may be thought to be at least partially under the patients' control as discussed by Kleinman et al (1992). This further results in a dualistic construction of pain, as either in the patient's body or to some extent in the patient's mind (Chapter 6).

Staff may hold similar or conflicting beliefs about pain to those of patients. Patients may believe they should bear pain, not complain about it and cope with it. Staff may also believe that patients should be able to cope with pain and not complain too much or display unwelcome emotion (Chapter 6). Some patients appear to be constructed as more credible than others. Credible patients are 'just right' because they are credible in a medical context; they are troubled in the body but not in the mind (Werner & Malterud 2003). Thus credible patients troubled in the body are easily managed with pharmacological solutions and in this sense they are 'just right'. Patients with non-malignant pain may not be constructed as 'just right'. They seem to experience a degree of unrelieved pain (Chapter 6). Patients considered 'not right' express their pain in a way that is difficult for palliative care staff to understand, such as being emotionally aggressive, denying they have pain, being inconsistent in taking medications, refusing to take advice or indulging in risky behaviour (Chapter 6/7). Perakyla (1989) says that when problems occur in the medical frame, such as not responding to medical treatment this may result in a shift by staff to the psychological frame. The psychological frame, according to Perakyla, restores the identity disturbances that may be faced in other frames. Hunt (1989) also observed that symptom control nurses primarily use the biomedical role format but may use it in conjunction with the psychological format to cope with uncertainty and emotion laden conditions. A shift from the biomedical to the psychosocial format was a means to cope with patients who are not responding to medical treatment or non-compliance, according to Hunt. In my data also a shift from the biomedical to the psychosocial frame enables disturbances in the biomedical frame to be addressed (Chapter 6). There is

evidence in my data that patients with diseases other than cancer, who have difficult pain management problems, are constructed in the psychosocial frame by the PCT. This leads me to conclude that the legitimacy gained through the experience of cancer pain within the palliative care and hospice movement may not be directly applicable in the context of other disease trajectories such as peripheral vascular disease (Hibbert et al 2003, Clark 1999). This may be why the psychosocial frame is used to neutralise such a threat within the biomedical frame and why patients with non-cancer pain in particular may be framed in this way.

### **8.2.3 How is pain talk a platform for specialist nurses to display their expertise?**

Specialist nurses are positioned within the PCT in a collegial type relationship with medical staff. The basis of this positioning is the nurses' knowledge and expertise about pain management. They also have authority in other areas such as contributing to decisions about which patients are appropriate for palliative care and to decisions about discharge from palliative care (Chapter 6). Therefore these nurses act as a type of gatekeeper for the palliative care discipline. This is important in relation to the effectiveness of the team. Thus patients need to be selected that complement the skills of the PCT and this has consequences for the effectiveness of palliative care. Patients that fit the criteria for specialist palliative care are those who have pain and/or other symptoms preferably associated with the diagnosis of cancer (Chapter 6).

The collegial positioning of specialist nurses in the PCT meeting suggests a strategy of inclusion (Witz 1992). Witz describes the difference between exclusionary strategies which aim for intra-occupational control over internal affairs and access to the profession and demarcationary strategies which aim for inter-occupational control over other occupations in the division of labour (Chapter 3). I am suggesting that these nurses have a collegial positioning in the team that enables an inclusionary strategy within the medical division of labour, which displaces the exclusionary strategy available to the dominant medical group, in this context (Figure 2). I have come to this conclusion because the dual closure strategy of usurpation and exclusion does not explain the collegial positioning of specialist nurses in the PCT. Consultants in palliative medicine through talk involving criticism of non-specialist nurses and doctors support the



strategy of inclusion (Chapter 6). However an exclusionary strategy is used by medical staff when boundary negotiations go one step too far such as specialist nurses seeking to make referrals to specialist doctors (Chapter 7). Collegiality has its limits and the boundaries of inclusion and exclusion are made explicit in the talk by the consultant. Thus such consultants are in control of the medical-nursing boundary in this context (Chapter 7).

It is the structure of the working relationships and the interface with the non-specialist practitioners that gives the specialist nurses the platform to develop their 'professional project' within the medical space. Specialist nurses not only demonstrate their authority and professional competencies in work related to pain and symptom management. They also carry out rectification work in the care home setting, keep the lid on emotional matters by adopting a neutralistic positioning that enables professional relationships, act as an advocate for the patient and for close relatives, and support medical staff (Chapter 6/7). Therefore a range of medical and other matters are addressed using a number of skills over and above medical skills. There is evidence that nurses can take the floor when it comes to talking about psychosocial issues and when this occurs the medical voice may remain silent (Chapter 7). However doctors also orientate to a psychosocial discourse when seeking explanations for the behaviour of patients and close family members (Chapter 6). So doctors as well as nurses shift to the psychosocial frame.

Although specialist nurses are critical of non-specialists doctors and nurses, they are careful not to challenge the medical knowledge and expertise of the consultant. They enter into medical discourse in such a manner that enables the consultant to be consulted (Chapter 6/7). Linguistic strategies used by specialist nurses consist of narrative reconstruction to tell mystery and atrocity stories and to give accounts of patient problems (Chapter 7). How the nurse chooses to reconstruct the patients' story has implications for how palliative care services can be accessed and delivered. For example telling an atrocity story may result in a decision that excludes the patient from specialist palliative care services and telling a mystery story may result in a pain problem being re-interpreted as a psychosocial problem (Chapter 7). Another linguistic resource used by specialist nurses is to adopt a neutralistic position in relation to what they report, which enables interprofessional work as it avoids accusations of blame or criticism and enables

such nurses to portray a particular form of impartiality and professionalism (Chapter 7).

Specialist nurses also shape interprofessional work with medical staff by use of questions. Questions enable the palliative care consultant to keep his/her footing as a 'medical oracle'. They also enable the nurse to shape the agenda of talk and to accomplish certain goals in relation to patient referral to specialist doctors and admitting the patient to the hospice for symptom control (Chapter 7). Thus specialist nurses interact with senior medical staff by use of linguistic strategies that maintain the doctors' footing as a medical expert (Chapter 7). Some problems are entirely dealt with by specialist nurses and they report on their interventions and achievements in the team meeting and in this way they develop their particular brand of competence and reputation (Chapter 6/7).

Specialist nurses have a range of skills that can place them on the somatic and psychosocial axis in terms of their competencies and expertise. By this I mean that some specialist nurses demonstrate their competence toward bodily symptoms and have a more medical approach whilst others seem to cross the medical and social work boundary and demonstrate skill in pain work and psychosocial support work (Chapter 7). I have argued that the competence displayed by the individual specialist nurse is important in relation to access to palliative care services. I suggest this is because these nurses have 'definitional privilege' involving the power to adjudicate on whether a problem is psychosocial or a combination of medical and psychosocial (White 2002). This has consequences for patients and families in relation to access to palliative care services. These nurses present the patient as a case to the PCT and their interpretation of the case is important in relation to subsequent interventions. Hence patients presented as having advanced disease, symptoms such as pain and other troubles, gain access to specialist palliative care services but those with advanced disease and psychosocial problems may not be able to access such services (Chapter 7).

One area that seems to be a problem for specialist nurses in the community is in relation to non-specialist doctors' prescriptions for analgesic therapy that results in over medication with opioids (Chapter 6). This over medication causes tension in the boundary with the GP because nurses may be expected by the palliative care consultant to correct such problems and chastise the GP. Some specialist nurses

although engaging in veiled criticism of the GP (Table 7), seem to be hesitant in confronting the issue of expertise in practice. Therefore the tension in the boundary is achieved by talk involving contrastive rhetoric and veiled criticism in the team meeting. The PCT meeting offers a collegial setting, a safe place to criticise such practices at a distance. But caution is evident in relation to the practicalities of a subordinate group displaying expertise that challenges a dominant group. Hence specialist nurses may be hesitant to disrupt the traditional medical and nursing boundary. Palliative medical staff seems to accept that such nurses have expertise in symptom control, but of course this expertise does not threaten their own expertise. One begins to become aware of the ordering of expertise in a medical hierarchy; with a disruption in the boundary caused by a new player positioned between medicine and nursing that threatens the position of the GP within a palliative care context.

#### **8.2.4 What is the significance of reputation to talk of the team?**

The PCT build their reputation largely through talk about pain in a collegial space that enables teamwork. Thus reputation is mutually constructed as a system for developing an effective medical discipline. Wilson (1973) says that reputation is a social construct and arises from the bestowal and withholding of social recognition in a network of relationships. Thus power and authority in reputation arises not from external standards but from the social networks available to the group, according to Wilson (Chapter 4). Following Wilson, to be able to build reputation one needs to have the social support necessary to share knowledge. Thus I argue the PCT is the social space for the construction and sharing of knowledge about the patient and constructing one's expertise. This is possible because in this setting a collegial approach is adopted and standards are internally orientated to and monitored in talk (Chapter 6/7). Non-specialist staff pose a problem for the PCT, but also enable them to use linguistic and rhetorical resources that construct the reputation of the PCT in contrast to those who do not have such expertise. Thus a social space is constructed that enables specialist palliative care practitioners to construct their reputation through talk-in-action (Chapter 6/7).

Reputation for specialist nurses is about building a professional identity with expertise and competence in pain work as the main platform for such a reputation

(Chapter 6). Pain work takes place in a number of different locations including care homes and the patients' homes. The work of the community PCT in relation to care homes suggests that the palliative care movement is continuing its entrepreneurial mission of finding new spaces to improve practices with those with advanced disease and those that are dying. Specialist nurses are important to the extension of such care into cottage hospitals and care homes, as they seem to be the members of the PCT that visit and have contact with patients and family members in these locations (Chapter 6/7). Furthermore the staff, patients and relatives in these locations acknowledge their expertise and seek their services. I therefore suggest that those who seek and make use of palliative care services also construct reputation for the PCT.

The ideal patient for the PCT to develop their reputation seems to be someone with cancer and/or symptom/s such as pain (Chapter 6). A patient who has advanced cancer and psychosocial type problems may not gain access to specialist palliative care, as symptom experience seems to be the key to accessing services (Chapter 7). Certain types of patients may threaten the reputation of the PCT. These patients may resemble a type of 'crock' and have a great deal of psychosocial talk generated about them (Chapter 7). In fact the longest piece of talk by a specialist nurse was in relation to a patient eventually categorised as 'not one of ours' (extract 19/20). This patient was constructed by the PCT as a 'social problem' because she has an alcohol problem as well as advanced metastatic breast cancer. Therefore it may be easier to sustain one's reputation with those with a diagnosis of cancer but also with a bodily symptom. Reputation is mutually constructed with patients. If this mutuality is not available such patients may meet the criteria of a 'crock' (Chapter 7).

Strategies used by palliative care practitioners to contain threats to reputation are; admitting the patient to the hospice, offering CTs, and employing the psychosocial format. Therefore these strategies may be considered as adjuncts to biomedical therapies, and to limit damage resulting from failure of biomedical approaches. They enable the patient and staff to engage with re-building reputation.

Specialist palliative care practitioners are positioned in a biomedical framework that gives priority to biomedical problems and approaches and other problems and interventions are secondary to such a framework. Once constructed as a suitable

patient to access specialist palliative care services one's physical and psychosocial troubles will be the concern of staff, but to gain entry one will need to have a symptom for staff to address. This is because these practitioners can be most effective in relation to bodily symptoms and problems. Taking on problems that are constructed primarily in a psychosocial space will potentially damage their reputation, as these are areas that are difficult to control and manage (McNamara 2004, Lawton 2000). In the context of the PCT reputation is primarily achieved by a discourse that shapes pain (or symptoms) in the body as the primary mode of intervention.

### **8.2.5 How is the concept of 'total pain' orientated to in the talk of the team?**

I have found that the PCT talk extensively about psychosocial issues. They are concerned with patients' support needs, social interaction and specialist psychosocial services (Chapter 7). I therefore do not wish to downplay the extent to which these needs are orientated to in the talk. My interest however is in the integrated concept of 'total pain' and how such a notion of pain may be given voice or spoken about in such settings (Chapter 6). My findings suggest that when pain in the body is uncontrolled by pharmacological means then psychosocial discourse about the patient in pain is used (Chapter 6). I propose that in the practice of the team Cicely Saunders' concept of 'total pain' is transformed into a discourse shaped around bodily pain and a discourse around psychosocial support needs that is not necessarily linked within a discourse of pain (Chapter 6/7).

Illich (1976) says that there is a medicalisation of pain, which has resulted in loss of its link with suffering through its transformation into a technical problem (Chapter 2). Many authors agree with Illich that the question of suffering is neglected within the medical literature (Cassel 1982); that suffering may not be confined to physical symptoms (Charmaz 1983) and that the nature of suffering has become contested territory within palliative care (Clark et al 2002). Clearly the medical treatment of pain is essential to patient comfort and management and the hospice movement has had an enormous influence in relation to such work. The PCT talk about the rules of pain work and demonstrate how such work can be tailored to meet specific patient needs for pain relief (Chapter 6). I believe, however, that Illich may have a point and I am interested that Cicely Saunders

developed ‘total pain’ with suffering implicit rather than explicit in this concept. In fact the term ‘suffer/ing’ is not used in my data set at all other than once in relation to a medical diagnosis (Table 10). In contrast the terms death/dying are frequently referred to, which suggests that it is not death and dying that may be denied (McNamara 2001) but suffering. The word suffer/ing may no longer be used because medical science and palliative care believes it has the means to control the symptoms associated with suffering.

	<b>HPCN/CPCN</b>	<b>Doctor</b>	<b>Hospice Nurse</b>	<b>Total</b>
death/dying	11 (0.31)	5(0.32)	6(0.82)	22
suffer/ing	0	0	1(0.14)	1
Total	11(0.31)	5(0.32)	7(0.95)	23

**Table 10 Word count of death/dying and suffer/ing (rate per 1000 words in brackets)**

Lawton (2000) says that the hospice movement may have cultivated the image of suffering as pain because this is a more palatable image and allows such experience to be hidden away in cultural discourses that elide suffering into pain. Or another interpretation is that the contribution that palliative care can make to a complex picture is a medical approach utilising pharmacological therapy to manage difficult pain problems (Chapter 6). Insiders in palliative care agree that the success of the hospice movement is located in the management of cancer pain using pharmacological therapy and the application of research to practice is concerned with such pharmacological developments (Corner and Dunlop 1997). However, there are patients in my data set whose pain is resistant to pharmacological methods of pain management and who deny they have pain (Chapter 6).

There is empirical evidence of two clinical frames for dealing with chronic pain in France (Baszanger 1998) (Chapter 2). The first clinical frame concerns pain in the body and distinguishes physical from psychic pain and the second reads and listens to pain through the patient’s experience of pain and tries to modify it. Baszanger says that an integrated multidisciplinary approach is reflected in the second clinical frame. She continues that in this second clinical frame practitioners do not separate the mind and body because the person’s experience of pain is at the centre of professional concern. My data reflects the first clinical frame because of the dualistic nature of the talk (Chapter 6).

'Total pain' is closely linked with two types of reputation. Firstly, the rhetoric of 'total pain' establishes the reputation of the palliative care movement within a holistic and humanistic framework that is the concern of those that provide such care as well as those that receive such care, which emphasises the many facets of pain (ten Have & Clark 2002). Secondly, it enables the palliative care movement to construct its reputation as a successful medical speciality in relation to pain and symptom management (Hibbert et al 2003). These two types of reputation are in tension. In practice the latter type of reputation is the platform for reputation in the medical space and the former holistic reputation is the wider discourse of particular approaches to 'total care' shaped within the palliative care movement (Gracia 2002). In my data professional staff do construct both approaches to reputation in their talk (Chapter 6/7).

The concept of 'total pain' may be less facilitative than is suggested by Clark (1999). There is evidence in my data that 'total pain' may indeed be a product of the medical gaze, a disciplinary power rooted in knowledge and the technologies of care, which may objectify human suffering by psychosocial talk that emanates from failure of medical therapy (Chapter 6). Specialist nurses contribute to the medical gaze by employing strategies to manage pain in a similar space to medical staff and in this way they achieve their reputation as expert specialist nurses. Paradoxically the facilitative discourse, the phenomenological connectedness between individual experiences of pain, distress and suffering become lost between the dualistic construction of pain in the body and psychosocial talk (Frank 2001, Clark 1999, Bendelow and Williams 1995).

### **8.3 Limitations of the study**

I have studied two settings; both located in the South East of England. Therefore the size of my sample and the location of the study limit my research. A broader perspective could be achieved by enlarging the sample to a number of hospices and palliative care units throughout the UK. The inclusion of palliative care units within a DGH not linked with a hospice would provide further insights and comparisons beyond the settings discussed. These factors limit the generalisability of my findings.

An exploration of participants' reactions to the data by showing them the transcripts of talk would enable a more participative and collaborative approach to the research. This approach may yield further ethnographic insights about the context of such talk. This idea was suggested to me when talking about my work at a conference (Arber 2003). Unfortunately I have not had the resources in terms of time and organisation to be able to do this. However, I do intend to offer to talk about my work in both of the research settings in the near future, as promised in the early stages of the research.

## 8.4 Developing further research

There are three main areas for further research. Firstly, I believe it is important to map the changing nature of specialist nursing practice within the medical division of labour. Collaborative practice across disciplinary and professional boundaries is identified as a priority in relation to developing cancer and palliative care services (Guidance on Cancer Services 2004, Cowley et al 2002, The NHS Cancer Plan DOH 2000a). Using techniques taken from linguistic analysis and CA it may be possible to build a model of how collaborative team work is accomplished through talk-in-action and what this means for the division of labour and the interface with non-specialist practitioners in palliative care.

Secondly, it may be possible to generate insight into other aspects of reputation by extending the research focus into areas such as observation studies of specialist nurses' interaction and talk with patients during the cancer and palliative care journey. This would enable a broader picture of what specialist nurse expertise consists of and the platform for such expertise and reputation across different contexts and disease trajectories.

Thirdly, it may be useful to consider the use of video recording of team meetings. Visual data would enable analysis of how social interaction is accomplished through the body and physical artefacts (Heath 1997). Heath argues that ethnomethodology and CA have provided the resources where it is possible to exploit video for sociological purposes. Visual data may provide an expanded picture of the social action in the medical space of the team that is not captured with audio-recorded data alone.



### **8.4.1 Methodological contributions**

By using research tools taken from linguistics and CA it is possible to study specialist nurses' talk-in-action and to make such talk and action visible. One can then begin to explore the changing shape of the professional project of specialist nurses and the resources used such as pain talk to develop expertise, credibility and competence in the medical space. The use of methodological tools taken from linguistics enables one to understand how one segment within nursing is developing expertise and competence in a medical space and one can interrogate what this particular expertise consists of in microscopic detail. Therefore nurses' talk can be compared and contrasted with doctors' talk and social workers' talk in context and provide empirical evidence about collaborative practice including practice with patients. Thus the dynamic and negotiated nature of professional boundaries can be made visible and ultimately the changing nature of nursing practice. Such research enables one to stay close to the realities of nursing and medical practice.

## **8.5 Implications for clinical practice and policy**

Palliative care nurses working in the hospital, community and hospice setting have a collegial positioning in the team that enables them to shape patient identity and troubles when they present patients as cases in the team meetings. They therefore have considerable influence on how the biomedical and psychosocial aspects of the pain experience are framed. I suggest that nurses need to be more proactive in framing the patients' pain problem within the holistic model presented in the palliative care literature. There is considerable evidence to support such a model (Wall 1999, Baszanger 1998, Vrancken 1989, Kotarba 1983). An integrated approach to pain does not separate the mind from the body and there is evidence of this integrated approach within the discipline of pain medicine (Baszanger 1998). There is some evidence for an integrated approach at Karamea Hospice where the specialist nurse takes the floor to sort out the pain problem and the psychosocial support for the patient's daughter and the medical voice remains silent (Chapter 7 extract 10).

Physical pain, it has been suggested often has no voice but when it finds a voice it tells a story (Scarry 1985). The ability to listen and attend to patients' stories

involves a type of emotional labour that may be difficult for hard-pressed staff with large caseloads. I suggest that nurses pain assessment should attend to what Schumacher et al (2002) describe as 'pain management autobiographies'. Thus an autobiographical approach may enable insights into patients' personal thoughts, feelings and preferences about pain and its management. The use of pain autobiographies may enable an integrated mind body approach to pain management by integrating the patients pain history and psychosocial assessment (Schumacher et al 2002, Sloan et al 1999, Fagerhaugh & Strauss 1977).

My findings have implications for the education of doctors, nurses, social workers and other therapists in relation to pain. Education initiatives should allow the patients' voice to be heard and that of close relatives so that medical, nursing and other staff stay close to the patients' 'lived experience' and begin to understand that experience from a social, emotional and cultural perspective as well as from a biomedical standpoint. It is also important that education about pain is interdisciplinary so the different professional groups understand each other's perspective. For palliative care staff it is important that they explore non-malignant pain and the different pains associated with peripheral vascular disease. This is important as the palliative care movement moves beyond the cancer care context.

It may be that nurses and medical staff feel more comfortable and effective in dealing with pain in the physical body and this may require further education for specialist nurses and doctors so that the idea of pain as linked with but different to suffering is developed. Perhaps the distancing of talk away from suffering is a protective strategy for staff and distances them from the emotional aspects of patients' experiences with pain. This is an area that requires further research. Frank (2001) a social scientist, speaking from a personal perspective of being diagnosed with cancer and eventually fearing recurrence of cancer says that the biomedical voice silences suffering. One way to enable practitioners to be sensitive to the suffering of their patients is to use educational material taken from the humanities such as the use of literature and art. This would further develop the wider link between pain and suffering that seems to be lost or invisible in talk about the technologies of pain. Appropriate support for staff working in such a manner, particularly in the context of the community and hospital palliative care team, is a key issue for policy makers and managers.

If health care staff are changing their practice to adopt more integrated approaches to pain there may need to be more public education about pain. I very much doubt if patients have heard of the concept of ‘total pain’ and may be surprised that health care professionals understand pain in this way. Hence it is important to involve patients by talking to them about ‘total pain’. This would enable patients as well as staff to develop shared understandings about pain.

## 8.6 Conclusion

My thesis explores how the palliative care team talks about pain. By analysing pain talk one can establish the social and cultural resources used to conceptualise pain and what this means for the discourse of ‘total pain’. ‘Total pain’ is a cultural resource that is drawn on within the hospice and palliative care movement to produce a particular performance of humanistic and patient-centred practice. In my research I have disturbed the taken-for-granted aspect of the concept of ‘total pain’. This concept I suggest is useful in building a certain type of reputation around humanistic and holistic caring approaches.

Practitioners in hospice and palliative care are very effective in finding, interpreting and managing pain in the body in the collegial context of the team. The rules of pain work are made explicit in the talk and these rules contrast effective and ineffective pain work. The rules of pain work are specific and usually, but not always effective in managing pain in terminal illness and life-limiting disease. Close scrutiny of the patients’ body and what the patient says about his/her pain enables the medical origin of pain to be defined and viable therapies selected. There is criticism from some quarters that there is a ‘creeping medicalisation’ within palliative care where medical attention tends to ‘focus on pain and symptom management as a bounded set of problems within the relief of suffering’ (Clark 2002:906). Medicalisation in the contexts I have studied is a very necessary part of meeting the needs of patients in pain. However it is not the only story going on I suggest. According to Silverman (2000) how we label phenomena defines their character. Hence how one labels pain results in a particular performance of pain work and this is the beauty of the ‘total pain’ construct: it broadens up the thinking about pain to take a more holistic view. How pain in team talk is socially constructed has implications for how the patient as a suffering subject is talked about and interacted with. Morgan (2002) urges for widening our

perspective to go beyond the biomedical to consider how minds, cultures, emotions and beliefs shape the meaning and experience of pain. Thus this widening perspective needs to take in not only health care professionals but also patients themselves. This is because patients, like the staff, have beliefs about pain that may or may not fit with holistic interpretations.

Reputation and symptom control are uniquely linked within palliative medicine. Saunders was very shrewd when she conceptualised 'total pain' and broadened the medical concern to the wider aspects of the experience of pain. However, I believe from my findings that this concept has only partial development within the settings studied, as essentially talk about pain is dualistic.

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## **Appendices 1 - 5**

# Appendix 1 Ethical Committee Approval



12 June 2000

Anne Arber



Dear Anne

re: **Research Proposal ER292: How do palliative care teams construct pain and talk about pain in practice?**

Thank you for your letter dated 12th June 2000 addressing the issues raised by the Nursing Research Ethics Committee

I am therefore happy to take Chairs action and grant full approval.

May I wish you the best of luck with your study and I look forward to receiving a copy of the abstract in due course

Yours sincerely



**Director of Nurse Education & Professional Development**

## Appendix 2: Written account of the research for participants

I am writing to you to seek your help with my research. I would like to be able to examine how the patient's pain is discussed in palliative care team meetings. My interest in this is to begin to establish how the area of pain and work associated with pain has developed within the speciality of palliative care. There has been very little research on how members of the palliative care team talk to each other about the patient in pain.

### **Research Topic:**

**How do palliative care teams construct pain and talk about pain in practice? An exploration of how work related to pain is defined, shaped and practised by practitioners in palliative care in the multidisciplinary setting.**

For the purposes of the research I hope to:

1. Attend meetings where the palliative care team are present and if possible tape record the meeting. I will not intrude on the meeting. If you feel it not appropriate for me to be present at any part of the meeting I will leave on request. I anticipate that I would need to attend approximately 15 meetings, if that is possible.
2. I hope to attend the ward round when members of the palliative care team are present and if possible take notes.
3. I hope to be able to examine patients nursing and medical notes to enable me to understand how discussions and decisions about pain are documented.

Anonymity and confidentiality will be strictly observed.

All names associated with the research will be changed and tapes will be destroyed after completion of my PhD project. The only other person with access to my data will be my supervisor Dr Clive Seale.

I appreciate that you may not want to participate in the research. This is for you to decide. If you are willing to help me with my research, all your answers and comments will be completely confidential. I will also agree to give you feedback on the research when I complete my PhD.

Thank you very much,

Yours sincerely,

Anne Arber ..... (details deleted)

**Staff consent form:**

I.....of

.....

Agree to participate in the research described overleaf. The nature, purpose and possible consequences of the research has been summarised overleaf, and have been explained to me by..... and are acceptable to me.

I understand that I am entering this project of my own free will and am free to withdraw at any time, without necessarily giving any reasons.

Signed.....

## Appendix 3: Coding Scheme

- Code name: **Pain talk**  
 Definition: Any talk where the word pain is used  
*Drug talk*  
 Talk about analgesic drugs, drug dosages, side effects of drugs such as sleepiness, confusion, and sensitivity to opioids  
*Type of pain*  
 Pain attributed to colic, neuropathic pain, pain from bony secondaries and pain called ‘breakthrough’ where pain breaks through the medication given  
*Pain assessment*  
 Moves by health care staff to evaluate the patient’s pain experience. This includes level of comfort/ discomfort observed by the health care professional and volunteered by the patient. The reported effect of the pain on the patient such as mood, bodily movements and function, relationships and the patients verbal report of the presence or absence of pain.
- Code name: **People**  
 Definition: Type of health care professional
- Code name: **Difficult patient**  
 Definition: A patient that does not respond to medical therapy or that does not respond to health care professional  
*Non-compliant*  
 Patient does not take advice or take medication  
*Social problem*  
 Abuses alcohol and/or living in inappropriate accommodation or perceived as unable to cope at home  
*Ineffective therapy*  
 Medical therapy does not work, pain remains uncontrolled
- Code name: **Relatives**  
 Definition: Talk in which relatives are discussed or spoken to  
*Criticism*  
 Where staff are critical of relatives
- Code name: **Team Reputation**  
 Definition: The team talk about pain and use their specialist expertise to control pain. They make changes to their care by discussing each patient and making decisions about care and interventions  
*Criticism of GPs*  
 Specialist staff criticise the skill of GP in managing pain.  
*Criticism of non-specialist staff*  
 Specialist staff are critical of non-specialist’s skill in palliative care e.g. nursing home staff, ward staff, inexperienced doctor  
*Praise for professionals/patient*  
 Praise for specialists in cancer and palliative care including self, colleagues, patients, and relatives

- Code name: **Treatment for pain**  
 Definition: Any medical treatment given for pain  
*Pharmacological*  
 Definition: Drugs prescribed for pain and non-prescribed drugs taken by the patient  
*Non-pharmacological*  
 Where non-drug measures to relieve pain are used including, complimentary therapy, radiotherapy, surgery, also patient related e.g. patient coping
- Code name: **Causes of pain**  
 Definition: Anything that is attributed to the cause of pain  
*Physical and medical causes of pain*  
 This is where a physical cause such as a disease process or disease progression can be attributed to the cause of pain.  
*Unknown*  
 Where there is no identifiable physical cause for the pain
- Code name: **Psychosocial talk**  
 Where anything related to the psychosocial status of patient and staff is talked about  
*Emotions*  
 This is where emotions are discussed in relation to patients and staff such as anxiety, sadness, hope, anger, and aggression  
*Relationships*  
 Any reference to the patient's relationship with the health care professional, family and friends  
*Psychosocial Interventions*  
 This is any psychological therapy discussed such as support, life review, counselling
- Code name: **Uncomplaining patients**  
 This is where patients are nice to staff, compliant and uncomplaining. Pain is controlled or the patient does not complain of pain

**Bold: code name**

*Italics: refer to child node*



## Appendix 4: TRANSCRIPTION CONVENTIONS

( ) Empty parentheses indicate the transcriber's inability to hear what was said

(word) Parenthesized words are possible hearings

(.) A dot in parentheses indicates a tiny gap of no more than one-tenth of a second

(0.5) Numbers in parentheses indicate elapsed time in silence in tenths of a second

All names of places and people are pseudonyms

All tape-recorded materials are verbatim transcriptions

## Appendix 5: ABBREVIATIONS

bd	Twice daily
Ch	Chaplain
CPCN	Community Palliative Care Nurse
CPM	Consultant in Palliative Medicine
DGH	District General Hospital
DXT	Radiotherapy
GP	General Practitioner
HCA	Health Care Assistant
HPCN	Hospital Palliative Care Nurse
MD	Medical Director
MRSA	Methicillin-Resistant Staphylococcus Aureus
MST	Morphine Sulphate Tablets given 12 hourly
MXL	24 hourly morphine
PR	Per Rectum
PCT	Palliative Care Team
PSA	Prostate Specific Antigen
SW	Social Worker
T3	Tumour (stage 3)