**Investigating nurses' professional identity construction in
two health settings in New Zealand**

by

Mariana Virginia Lazzaro-Salazar

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Abstract

The increasing nursing shortage experienced in healthcare institutions alongside the communicative issues related to multicultural nursing teams have placed nurses at the centre of the stage in a growing body of healthcare-related research. In this context, the values, beliefs and conceptualizations which characterize a nurse's professional identity play a significant role in organizational life since they guide nurses' decisions on the kind of clinical practices they adopt and influence their work performance. However, there is little empirical evidence on how nurses *discursively* construct their professional identity. To date most sociolinguistic research on professional identity in healthcare environments has focused on the power asymmetries characterising doctor-patient, doctor-nurse and nurse-patient discourse, largely disregarding nurse-nurse interaction. Thus, moving away from the traditional approach taken to this area of enquiry, this thesis considers how nurses from an array of ethnic backgrounds construct their professional identity through discursive practices as they interact with other nurses in workplace meetings.

The data for this study involve nurses and nurse managers in a ward of a public healthcare institution and at a private healthcare institution in New Zealand. The data consist of audio and video recordings of four roster and five handover meetings from the hospital and four clinical and four staff meetings from the clinic, collected by employing Interactional Sociolinguistics as a methodological approach which provides an ethnographic lens and a focus on context and culture. To investigate professional identity construction, the analysis takes a theoretical stance which draws on social constructionism and social identity theory and explores professional identity as it emerges within the boundaries of local interaction and practices.

Nurses' professional identity formation is considered in three interactional contexts, namely, voicing and responding to complaints, displaying professional expertise, and negotiating professional values. Findings demonstrate that nurses index multiple group membership alignments as a way to 'indirectly' voice direct complaints and to respond to them in community-appropriate ways as they build in-group solidarity and rapport, and observe interactants' face needs. In addition, considerations of the use of question-answer

adjacency pairs, medical jargon and rationality of case presentation show how expertise construction belongs in a dynamic continuum which is actively transited by nurses as they construct themselves and others as more or less expert on different aspects of professional practice. Considering nurses' expert claims as temporary, nurses are shown to construct multiple self and other subject positions at the local and wider community levels in order to achieve different interactional goals. This thesis also shows how, when evaluating professional practice, nurses negotiate their professional values at both local and wider community levels by indexing multiple group alignments and displaying expertise that positively construct their professional stance, and by using persuasion techniques that ascribe preferred professional images with the aim of standardising professional practices.

Overall, the research highlights the partial nature of identity construction as other-initiated claims cause nurses to re-consider their stance in order to orient towards a preferred professional image of themselves, making situationally motivated selections of their discursive resources to craft their identity claims.

Chapter 1

Introduction

Today's workplaces are characterised by a very culturally diverse workforce. Over the last two decades this has attracted considerable attention from scholars from a number of disciplines who have explored an array of communicative scenarios in order to address various aspects of workplace interaction (Koester and Lustig, 2012; Scollon et al., 2011; Spencer-Oatey and Franklin, 2009). In this regard, healthcare settings in New Zealand clearly reflect this global environment, especially in regards to its nursing workforce. According to a report issued by the New Zealand Nurses' Organization (2009), New Zealand health care providers have succeeded in recruiting international nurses in an effort to tackle the existing shortages of nursing staff around New Zealand. To date, it is estimated that 23 percent of the registered nurse (RN) workforce comes from overseas and that this number will continue to rise due to an increasing demand for health services as a result of population growth. The fact that a large proportion of the RN workforce comes from abroad and that these nurses represent 95 different ethnicities has placed nurses at the center of the stage in a growing body of healthcare-related research. This phenomenon has placed nurses at the centre of research enquiry, making nurses' interaction a popular site for the investigation of workplace phenomena. Thus, scholars from a number of disciplines have explored the nursing workforce from multiple perspectives in different interactional contexts (e.g. Davidson et al., 1997; Roxburgh, 2006; Webb and Kevern, 2001; Nyamathi and Shuler, 1990; Retsas, 2000; Spilsbury et al., 2008; see overview of studies in chapter 2). This research has raised awareness of the need to deepen our understanding of the interactional phenomena that surround nurses in order to enhance the positive aspects of their cross-cultural communication. This is exactly the focus of this study.

To that end, this research takes up an appreciative approach to the study of nurses' interaction, investigating the ways in which nurses discursively build their professional identities in appropriate ways according to the interactional norms of their local and wider

communities. In particular, this study demonstrates that professional identity claims constitute a dominant aspect of nurses' discourse and the discursive practices explored are a vital aspect of these nurses' professional practice, of how they 'do being nurses' by displaying and negotiating group affiliations, expertise and professional values while they discuss issues of professional practice.

1.1 Why undertake research about language in health care settings?

Sociolinguists have long established the connection between language and the workplace on the basis that the former influences and is influenced by the social norms and practices of an institution and/or profession (see Candlin, 2006; e.g. Holmes et al., 2011a and b; Bargiela-Chiappini and Harris, 1997; Holmes and Stubbe, 2003). This view emphasizes the significance of language as a social practice, as a way of performing social action (Roberts and Sarangi, 2005). As Sarangi and Roberts (1999: 1) note, "workplaces are social institutions where resources are produced and regulated, problems are solved, identities are played out and professional knowledge is constituted" through the use of language. Discourse analysis allows us explore discursive patterns as embedded within socially and culturally defined contexts of interaction (Paltridge, 2007). In this light, Cheek (2004) explains that discourse analysis is an approach and not a fixed method, which, by drawing on several other research areas, provides a multiperspective approach that enriches the investigation of interactional issues. Thus, drawing on several research areas, such as anthropology, sociology, and social psychology, for example, discourse analysis can take different theoretical stances according to the research focus (see Kvarnström and Cedersund, 2006).

In particular, the contributions of a discursive analytic approach to the study of communication in health care settings have also been widely acknowledged and discussed in the literature (e.g. Tannen and Wallat, 1986; Candlin and Candlin, 2002; Drew, 2010; Lingard et al., 2004; Kvarnström and Cedersund, 2006; Jones 2003; see review of studies in Stevenson et al., 2004). Studies of this nature have made an exceptional effort to demonstrate the relevance of adopting a discourse analytic approach to the study of professional talk in understanding organizational phenomena in health care settings. For instance, Hodges et al. (2008) review studies on health care communication that base their analysis on one of the

three approaches to discourse analysis they broadly identify: formal linguistic discourse analysis, empirical discourse analysis (which includes genre and conversational analysis) and critical discourse analysis. This review emphasizes the contributions this approach can make to the understanding of communication at a micro (or meta) level, that is to say, which linguistic resources are used by interactants and how, and, at a more macro level, that is to say, how those linguistic resources are used to reproduce social structures.

What the existing research on healthcare communication has in common is the researchers' view of interactional phenomena and their use of naturally occurring data for analysis. Thus, whatever their research focus is or whether they follow an ethnographic approach (e.g. Lingard et al., 2004) or a conversation analytic approach (e.g. Drew, 2010; Drew et al., 2001), they all view conversation as an interactional accomplishment, a collaborative endeavor in which the outcome is, to a great extent, discursively negotiated as the interaction unfolds. They also highlight the role of interactants' discursive practices as a means through which they interpret and communicate meaning, and perform meaningful social action (see Drew et al., 2001). In terms of my study, discourse is viewed as a means through which nurses *enact* their professional identity as they negotiate their stance.

To a great extent, this earlier research mainly represents doctor-nurse, nurse-patient, or doctor-patient interactions, placing the strongest emphasis on either the doctor or the patient (see Candlin and Candlin, 2003; e.g. Jones, 2003). It is irrelevant at this point to reflect on the reasons that have traditionally led the research on health care communication to focus on this interactional aspect (as an example consider Drew et al., 2001). What is clear, however, is that interactions among nurses have been under-studied from a discursive point of view (see Candlin and Candlin, 2003).

Moreover, several efforts have been made to study nurses' professional identity outside of communication research (e.g. Fagerberg and Kihlgren, 2001). This research, however, has almost exclusively focused on the development of professional identity in the transition from being a nursing student to becoming a novice (e.g. MacIntosh, 2003), exploring the development, negotiation and/or maintenance of professional identity mainly through participants' perceptions (see exception in Apker and Eggly, 2004). Thus, basing

their methodological approaches on the use of self-reporting techniques (see Ballinger et al., 2004; Kasper, 2004), such as open-ended questionnaires and surveys (Carpenter and Platt, 1997; Allsop and Mulcahy, 1998; Fagermoen, 1997), and identity status interviews (Fagerberg, 2004; Niemi, 1997; Fagerberg and Kihlgren, 2001; Lingard et al. 2003; Allsop and Mulcahy, 1998; MacIntosh, 2003; Öhlén and Segesten, 1998; Fagermoen, 1997), to name a few, insights on nurses' professional identity rely on what nurses 'think' and report they are like professionally. Unfortunately, this research has almost completely disregarded the role of naturally-occurring talk in the construction of social meaning. Regarding language as the tool through which daily workplace routines are managed and displayed (see Fasulo and Zuccheromaglio, 2002) and its use as a form of social practice, this study explores those discursive practices that enable nurses to index and negotiate their professional identity in salient ways.

To that end, following this research tradition adopted by scholars such as Roberts and Sarangi (2005) and Holmes et al. (2011a) discussed above, this study uses audio and video recordings of nurses' interactions with the aim of investigating "language as it occurs in everyday interaction" (Tannen and Wallat, 1986: 295). This allows me to investigate how nurses discursively enact their professional identity in local interaction (see "situated meaning" in Gumperz, 1982). As Fairclough and Wodak (1997) note, the use of naturally-occurring interaction is central to the understanding of organizational phenomena as language constitutes and is constituted by social practice.

1.2 Why nurses?

Having worked in several projects involving the discursive analysis of written texts in health as a research assistant in the School of Nursing, Midwifery and Health at Victoria University of Wellington, New Zealand, I became aware of how under-researched nurses' discursive practices have been in relation to other medical practitioners, especially doctors. This is even more striking when we consider the role played by the nursing workforce in the health care sector today.

The nursing workforce constitutes the group with the largest representation in the health care sector in most countries around the world (see Candlin and Candlin, 2003; Buerhaus et al., 2000; Zurn and Dumont, 2008; Sundin, 2001). Paradoxically, the shortage of nurses experienced in most healthcare institutions worldwide has attracted considerable scholarly attention towards the nursing profession over the last few years (North, 2007). Several factors have been found to contribute to this shortage; some of these are overseas training (North, 2007), nurse ‘burn out’ and poor nursing’s image (Murray, 2002), long training programmes and the ageing of the nursing workforce (see possible reasons for the latter in the US context in Buerhaus et al., 2000; see also Palumbo et al., 2009).

Very importantly, this shortage has led to a high rate of international mobility that is very characteristic of this professional sector today as nurses are trained to be ‘exported’ to foreign countries (Aiken et al., 2004). In this regard, although New Zealand has an average nurse workforce for a country that belongs to the Organisation for Economic Co-operation and Development (OECD) (9.5 nurses per 1000 people), its large emigration rate prompts New Zealand’s health institutions to recruit nurses from around the world (for a history on the development of the nursing workforce in New Zealand see Gage and Hornblow, 2007; see ‘brain drain’ effect in North, 2007). This increases their immigration rate significantly and positions New Zealand as one of the countries with the highest rates of migrant nurses (Zurn and Dumont, 2008; see nurse flows in New Zealand in North, 2007).

The projections for years to come are not encouraging. US estimates on the future numbers of registered nurses (RN) are similar to those predicted in New Zealand and other OECD countries (Aiken et al., 2004): “by the year 2020, the RN workforce is forecast to be roughly the same size as it is today, declining nearly 20% below projected RN workforce requirement” (Buerhaus et al., 2000: 2948; see also Palumbo et al., 2009). With this in mind, it is expected that New Zealand will heavily depend (even more than today) on the immigration of nurses as a short-term solution to meet their shortages in the near future (Zurn and Dumont, 2008; North, 2007).

The ramifications of these projections extend beyond the boundaries of legal matters related to this global market in which nurses participate (see Buerhaus et al., 2005, 2009).

One of the consequences that is directly related to issues in healthcare communication is the interculturality of the nursing workforce resulting from immigration waves. As pointed out in the introductory section of this chapter, it is estimated that 23 percent of the RN workforce in New Zealand comes from overseas and that these nurses represent 95 different ethnicities (see details on countries of origin in North, 2007 and Aiken et al., 2004). The challenges this environment poses to the management as they face the coordination of intercultural teams have brought intercultural issues to the fore. On an anecdotal note, this concern was raised to me by the managers of the two workplaces where the data for this study was collected. Upon first meeting them to discuss the details of my study, both managers described their nursing teams as ‘highly intercultural’ and reflected upon the (very often negative) effects this has on nurses’ communication skills.

These perceptions are certainly reflected in the literature on healthcare communication since the cultural diversity presents sociolinguists with the challenge of exploring an array of communicative scenarios in order to address culturally-sensitive issues of workplace interaction. In particular, this research field has attracted the attention of discourse analysts who have explored shared understanding, and communicative and interpretive processes when presenting illnesses and discussing diagnoses (e.g. Roberts and Sarangi, 2005; for a comprehensive review of studies focusing on nursing in intercultural health care settings see Candlin and Candlin, 2003). Almost exclusively, however, these studies have explored the linguistic and discursive aspects that lead to misunderstandings and communication breakdowns (see Roberts, 2007) and their focus has been, as discussed in section 1.1, doctors and patients, including nurses only occasionally, and analyzing their discursive practices in relation to those of doctors or patients (see Candlin and Candlin, 2003). In marked contrast to the rather negative picture painted by these earlier studies, communication among participants of different ethnic backgrounds can indeed be successful when, for instance, they have developed a repertoire of shared practices as a result of having worked together for a number of years.

Thus, the growing interculturality of nursing teams and its associated communicational issues, in addition to the fact that nurses’ discursive practices have been considerably under-explored when considering other groups of health professionals, make

nurses an interesting sector of the healthcare workforce worth investigating in greater detail. Moving away from the research tradition described above, this thesis adopts an appreciative inquiry approach to the study of nursing communication (see Holmes and Stubbe, 2003) with the aim of advancing our understanding of those discursive practices that allow nurses to successfully communicate their professional identity in workplace interaction.

1.3 Why professional identity?

Professional identity has become a major focus of sociolinguistic study in recent years due to the role it plays in team performance and interpersonal interaction (Richards, 2006). Thus, for instance, a flourishing number of studies in healthcare settings are concerned with the role of care givers' professional identity in the management of social relations with patients (see Roberts, 2007 for overview of studies) and in the communicative impact it has on providing health care (Leonard et al., 2004; Gerrish, 2001). As will be demonstrated through the analysis, the values, beliefs and conceptualizations which characterize a nurse's professional identity, guide and shape their decisions on the kind of clinical practices they adopt (Killeen and Saewert, 2007). In addition, conceptions of what it means to be a good nurse also influence interpersonal dimensions of workplace interaction as, for instance, nurses promote solidarity and collegiality based on the values they hold (e.g. Ely, 1994). Professional identity does then play a significant role in organizational life as it can influence nurses' work performance at different levels (see rich discussion in Pratt et al., 2006). Investigating nurses' professional identity in intercultural settings can then shed light on some of those communicative aspects managers are often concerned about (see section 1.2) with the hope that the findings will help improve communication among nurses and nursing practice (see Gregg and Magilvy, 2001).

1.3.1 Defining 'profession'

Before reviewing literature on professional identity to find a definition and theoretical approach to identity that is appropriate to the scope and views of this study, I will define nursing as a profession since this status has been much contested in the literature of medical practice (Messer, 1914; Liaschenko and Peter, 2004).

As early as in 1934 Carr-Saunders and Wilson defined professions as follows:

Professions were organized bodies of experts who applied esoteric knowledge to particular cases. They had elaborate systems of instruction and [formal] training [...]. They normally possessed and enforced a code of ethics or behavior (in Abbott, 1988: 4).

This definition, Abbott explains, became the core of later definitions of profession. Abbott (1988: 8) makes an effort to refine this definition by saying that “professions are exclusive occupational groups applying somewhat abstract knowledge to particular cases.” He explains that the practical skills of professions grow from an abstract system of knowledge. This knowledge, Killeen and Saewert (2007) explain, is based on theory and research, and it empowers professionals by making them autonomous in their decision-making and accountable for their actions.

In social sciences, profession(al) and occupation(al) have been used interchangeably (see Killeen and Saewert, 2007; Apker and Eggly, 2004; Cohen-Scali, 2003) and frequently as part of the same definition. However, some scholars have drawn important distinctions between the two. Thus, an occupation differs from a profession in that, for instance, training usually takes place on the job; work is mainly manual; and decisions are largely guided by experience (Chitty, 2011). For a profession, on the other hand, training takes place in an educational institution; work can be both manual and intellectual; and decisions are largely evidence-based, that is to say, they are based on “science or theoretical constructs” (Chitty, 2011: 64). Though these are important distinguishing characteristics, it is equally important to mention that professions “evolved from occupations that originally consisted of tasks but developed more specialized status” (Chitty, 2011: 62) through, for instance, formal education, public recognition and legal status. The two then are at opposite ends of the same continuum. The process of transition from being an occupation to becoming a profession is called professionalization (see Chitty, 2011; Killeen and Saewert, 2007). In this complex process its members seek to attain professional status through a series of steps such as, but not exclusively, developing its occupational tasks, determining work standards and the group’s mission, establishing educational programs, finding legal protection for the professionals of the discipline, and establishing a code of ethics (Chitty, 2011). At the same time, professionalization involves the acquisition of values, skills, behaviours and

professional norms (see Killeen and Saewert, 2007). In this regard, Carpenter and Platt (1997: 339) place special emphasis on, according to them, one of the most important distinctions between occupation and profession as they explain that “for an occupation to be a profession the members must identify with it and its mission.” They explain that professionalism involves “a shared purpose, mission, goal, value system, and code of ethics, plus a sense of unity and association” (1997: 339). An occupation, according to this view, is stripped of these characteristics.

Nursing has seen a transition in terminology in the way it has been conceived, from being regarded as an occupation to attaining higher status and being regarded as a profession. Though it is not within the scope of this thesis to discuss this transition in the nursing profession, it is worth clarifying that, while some claim that nursing still does not fall under the professional label (see Brown and Gobbi, 2007), there is broad consensus in support of the professional status of nursing (see American Nurses Association, 2010). Because nursing fulfills all the requirements of a profession described above (see Chitty, 2011), nurses in this thesis are considered professional practitioners.

1.3.2 Defining professional identity

Unsurprisingly, this definitional controversy of concepts between profession and occupation has also been reflected the conceptualisations of professional identity. Defining professional identity has not been an easy task for researchers from various fields focusing on this aspect of workplace interaction. Very often discussions of professional identity are vague, as operational definitions are not offered or reviewed, possibly relying on our shared understanding of what professional identity is (see Chiles, 2007; Richards, 2006; Schnurr, 2009). Such studies seem to be based on the assumption that professional identity is the type of identity constructed and enacted in workplace contexts. In this regard, Blin (1997, in Cohen-Scali, 2003) advocates that the context of interaction is paramount in the ‘mobilization’ of professional identity. Blin (1997, in Cohen-Scali, 2003: 238) explains that “the context activates in order of preference identities which are relevant to the given situation.” It has been generally believed that the workplace, as an interactional context, is very likely to mobilize first and foremost participants’ professional identity for its expected

relevance in work activities. But Schegloff (1987: 218) warns that those “notions [place, participants and activity] collected under the rubric of ‘context’” may not be sufficiently relevant to the interaction, participants’ choice of identity and the way identities are displayed. As Richards (2006: 6) explains, Schegloff explores “the dangers inherent in the assumption that ‘being a doctor’ necessarily involves consistently ‘actively being a doctor’.” Simply put, not every conversation that a nurse, for instance, has in a hospital is constructing and/or displaying their professional identity. Logically then, assuming that every bit of conversation that takes place in the workplace is potentially and/or necessarily enacting professional identity solely because it occurs in the workplace may be far from the interactional reality in which participants are immersed. In this regard, while Bucholtz (2003: 408) strongly supports the claim that identity is “closely tailored by the context” in her model of tactics of intersubjectivities, she agrees with Schegloff when she explains that “identities emerge from temporary and mutable interactional conditions” (see also Blommaert, 2005). Thus, because the features of the interactional context are dynamic rather than stable, assuming that ‘context’ is only exclusively identified as the physical environment of the ‘workplace’ is erroneous. So for instance, a doctor may display their professional identity while talking to their son on their way to swimming classes as long as that context is relevant to them for the enactment and construction of his professional identity.

But what is professional identity? As pointed out earlier, while a working definition of professional identity is absent in a number of studies of workplace communication, other scholars have made fruitful attempts to address this issue. Broadly speaking, definitions of professional identity provided in these studies can be grouped into two deep-rooted traditions, namely, those focusing on stable or fixed ideas of identity and those focusing on a more dynamic conceptualisation of identity.

In the case of the former, identity has often been described as “a person's essential, continuous self, the internal subjective concept of oneself as an individual” (Reber, 1995: 355), involving “an outward manifestation of the ‘reflexive project of the self’” (Giddens, 1991 in Dyer and Keller-Cohen, 2000: 285). Professional identity is then the reflection of a person’s professional self-conceptualizations (Pratt, 2006; also see Levinson, 1992). More specifically, identity is “an organized representation of our theories, attitudes, and beliefs

about ourselves” (Beijaard et al., 2004: 108) and the process by which a person integrates their various statuses, roles and experience “into a coherent image of the self” (Epstein 1978: 101 in Sachs, 2001: 154). These views on professional identity heavily rely on professional values, which are seen as instrumental in clinical decision making since they guide nurses’ professional practice and ways in which they think about themselves (Killeen and Saewert, 2007). In this light, scholars have explained that professional identity is “the subjectively perceived sense of fit between professional and personal values” (Carpenter and Platt, 1997: 346), that is to say, how personal desires to be a good professional and to provide a good service, for instance, can be translated into professional values such as altruism and empowerment. Such conceptualisations of professional identity usually originate in views of the ‘ideal professional’ as the self-considerations usually reflect values and beliefs stated in the professional code of ethics, mission statements and so on (Killeen and Saewert, 2007).

Most of the definitions that fall into this ‘essentialist’ category support Erikson’s conception of identity as an intrapsychic element that is acquired, ‘continuous’, as Reber (1995) explains, and that evolves within the self, independently from the forces of social interactions (in Baker 2008). In the workplace context, the underlying understanding behind these conceptualisations is that the person identifies with a set of values and attitudes which, according to Sundin (2001), are inherent to each profession (see section 1.3.1 above), and are shared by professionals in each area of expertise. This is not to mean that every professional will passively adopt these inherent professional values and attitudes in their entirety. On the contrary, Sundin (2001) reports that professionals adopt these values and attitudes to various degrees according to their self-identification with their profession, highlighting those aspects of professional identity that are concerned with people’s perceptions of themselves as professionals (see also Gregg and Magilvy, 2001). However, although inner conceptualisations of the self and their professional values are indeed vital aspects of someone’s professional identity, rather stable or fixed conceptualisations of identity ignore the larger social constructs which come into play when a person participates in meaningful social activity (see Mendoza-Denton, 2002).

Coincident with developments of social constructionism in anthropology and social theory, a growing number of sociolinguists have advanced our understanding of identity

construction by adopting social constructionist views that challenge those of fixed attributes of the self in favour of dynamically and socially achieved features of identity (de Finna et al., 2006). In this regard, professional identity is usually defined as one of our various social identities (Sundin, 2001; Hall, 2002; cf. Cohen-Scali, 2003), which, in Tajfel's words, is "the individual's knowledge that he (sic) belongs to certain social groups together with some emotional and value significance to him of this group membership" (1972: 292). As this indicates, professional identity then is no longer seen as "a property or a stable category of individuals or groups" (Blommaert, 2005: 207) but rather as the "the social positioning of self and other" (Buchlotz and Hall, 2010: 18) that is negotiated and reworked at every step of someone's professional life (Kosmala and Herrbach, 2006). Thus, identity is considered a form of socially meaningful practice, something people do and use in interaction "that is embedded in some other social activity, and not something they [passively] 'are'" (Widdicombe, 1998: 191; Blommaert, 2005). As a social practice, it is a relational phenomenon that develops in social settings through social communication as social actors index and negotiate their stances as they interact with relevant others (Beijaard et al., 2004).

Furthermore, identity is the result of multi-faceted expressions of positioning (Long, et.al, 2008). As Sachs (2001: 154) reflects, interactional contexts change continuously and as social actors rework their stances to fit within the context of interaction, identities become "negotiated, open, shifting, ambiguous." In this light, identity is "the situated outcome of a rhetorical and interpretive process in which interactants make situationally motivated selections from socially constituted repertoires of identificational and affiliational resources and craft these semiotic resources into identity claims for presentation to others" (Bauman, 2000: 1, in Hall, 2002: 34; see also Antrim, 2007 and Beijaard et al., 2004). According to this claim, which is strongly supported throughout this thesis, identity is naturally multifaceted, that is to say, there are a number of subidentities that may conflict or align with each other (Cooper and Olson, 1996; in Beijaard et al., 2004). This will depend on the social setting, or context, in which one or more identities are enacted.

Inevitably, this shift in approaches to identity (from more essentialist to more social constructionist ones) has brought about a strong focus on the *process* of professional identity *construction* rather than on the nature of it (e.g. Holmes, 2005; Holmes and Riddiford, 2010).

As a consequence, current research on professional identity then investigates “how people *practically* identify themselves and others” through their discursive practices (Blommaert, 2005: 210). Following this trend, this study investigates not only how nurses’ professional identity is displayed but also how identity claims are rejected, reworked and negotiated in the context of discussions of professional practice.

1.3.3 Professional identity in this thesis

In this study, the traditional and socio-constructionist views on identity explored above are seen as complementary rather than exclusive as, combined, they seem to provide a comprehensive conceptualization of what professional identity is (see Angouri and Marra, 2012; Bucholtz and Hall, 2006). In this light, I consider professional identity to have both, rather ‘stable’ and some more dynamic aspects to it. While through the former we can describe the nature of it, social constructionist views of identity allow us to describe its collaborative process of construction. Thus, professional identity is an amalgam of attributes and values that, based on their group identifications and affiliations (see Gregg and Magilvy, 2001), are enacted in meaningful social practice and negotiated at the same time social actors negotiate their relationship within their social networks or communities (Mendoza-Denton, 2002; Antrim, 2007). Consistent with the view of language discussed in section 1.1, this second aspect emphasizes the social constructionist approach to identity adopted in this study as nurses discursively construct and interactionally negotiate their professional identity as it is reinterpreted in emerging social experiences.

Fagermoen’s (1997) definition of nurses’ professional identity best captures this relationship between these two aspects of identity, and, thus, it is used in this study as its operational definition. In her study of the values embedded in meaningful nursing practice, Fagermoen (1997) defines professional identity as “the nurse’s conception of what it means to be [stance] and *act* as a nurse; that is, it [professional identity] represents her/his philosophy of nursing” (1997: 435, emphasis added). By philosophy of nursing Fagermoen (1997) refers to the values and beliefs that inform and guide a nurse’s thinking, actions and interactions with patients as well as with other professionals in the healthcare context (see also Beijaard et al., 2004). In this view, professional identity is mediated by the interactants’

understanding and knowledge of the local conventions for performing certain acts and displaying certain stances.

It is worth noting that, though, for instance, values may be a more ‘stable’ aspect of identity when compared to professional practices (see Northrup, 1989), it would be erroneous to say that values remain constant throughout someone’s professional career. Professional values, attitudes and beliefs are also constantly negotiated and reworked through professional experience and relevant interactions as professional views are challenged, contested and reevaluated.

In nursing research, professional identity has not been discussed as such but in terms of its related concepts or some of its components, such as professionalism, values, nurses’ attributes and role perceptions, dealing with professional identity implicitly (see Fagermoen, 1997 for an overview of studies). To the best of my knowledge, studies investigating nurses’ professional identity rely almost exclusively on nurses’ perceptions of their professional identity through the use of questionnaires and interviews (e.g. Fagermoen, 1997; Fabergerg, 2004; Öhlén and Segesten, 1998; Gregg and Magilvy, 2001). Certainly, these studies make a significant contribution to the exploration and understanding of professional identity. However, studies that focus on the discursive evidence of fully practicing nurses’ enactment, construction and maintenance of professional identity are scarce (Candlin and Candlin, 2003; also see Deppoliti, 2008; Apesoa-Varano, 2007; Price, 2009). As Gregg and Magilvy (2001: 48) reflect, “virtually no information exists about how individual nurses establish their own professional identity.” Thus, by adopting a socio-constructionist approach, this study proposes to advance our understanding of how nurses ‘do being nurses’ through their discursive practices in spontaneous interaction. Moreover, in order to avoid operating on the assumption that any identity-related activity in the workplace constitutes nurses’ professional identity claims, this research focuses on nurses’ discussions of professional practice, which, as will be explored throughout the thesis, provide a rich environment for the display and negotiation of nurses’ professional identity.

1.4 Why workplace meetings?

Workplace meetings were chosen as the interactional context of this study for three main reasons. First, meetings constitute one of the most common socializing activities in which nurses get involved, sometimes on a daily basis. The social constructionist views of professional identity construction discussed earlier contend that professional socialization provides opportunities to “maintain and develop a critical understanding of [a professional] role” and, thus, to construct their professional identity (Bathmaker and Avis, 2005: 48). Meetings then provide a suitable context in which nurses have an opportunity to actively engage in professional identity construction and negotiation as they come together to discuss issues of their professional practices. Second, most research on professional identity in healthcare settings explores what Goffman (1959) refers to as frontstage work, for example, when nurses interact with patients, ignoring the importance of backstage work, for instance, when nurses interact with other nurses in tea rooms, in identity construction (e.g. Heritage and Sorjonen, 1994; Haskard et al., 2009). This study then aims to advance our knowledge of how nurses discursively construct their professional identity in an under-explored context of backstage work. Finally, building on the view that language is seen as the “site for the construction and contestation of social meanings” (Weedon, 1997: 21 in Baker, 2008: 14), an obvious reason for choosing meetings as the interactional context of this study lies in the fact that communication in meetings is primarily discursive, which makes them a rich source of data for discourse analysts.

Specifically, this study is based on the analysis of nurse-nurse interaction in workplace meetings through the audio and video recordings of four kinds of meetings at two health care workplaces, the clinic and the hospital. The meetings at the clinic have been labeled as clinical and staff meetings, and the ones at the hospital as roster and handover meetings.

1.5 Aims of this thesis

This research contributes to the existing body of research on the construction of professional identity and nurses’ interaction by exploring it in a backstage context, which has

not, to my knowledge, been explored before, through the lens of discourse analysis. It also aims to contribute to the rapidly growing body of research in and intercultural communication in the workplace, and more particularly in nursing, with the ultimate goal of deepening our understanding of the interactional phenomena that surround nurses in order to provide useful insights that help to avoid conflict and dysfunctions in the workplace and to enhance, strengthen and promote harmonious work relations (Johnston and Mohide, 2009; see Gregg and Magilvy, 2001).

Many of the studies outlined in section 1.1 highlight the need to provide a more comprehensive understanding of the contributions that a discursive analytic approach can make to the study of health care communication (Cheek, 2004; Hodges et al., 2008). Responding to this, my study also aims to raise awareness of the kind of contribution a discursive analytic approach to professional identity can offer in terms of how complaints should be voiced and responded to in order to comply with the norms of a particular group (chapter 4), how expertise is displayed and negotiated in appropriate ways in a given community (chapter 5), how values that inform professional decision-making are interactionally negotiated (chapter 6), and how this impacts organizational life (chapter 7).

1.6 Thesis overview

Following this introductory chapter, Chapter 2 offers a review of the literature and places this research within the field of sociolinguistics, particularly focusing on workplace and discursive practices research. I examine existing literature on the contextual and relational factors influencing identity construction and establish the relationship between identity construction and discourse, the healthcare settings and meetings. This chapter also presents the research questions to be addressed in this study. Chapter 3 describes the methodology used to address the research questions, focusing on the different phases of the study and supporting my methodological decisions by exploring the framework of Interactional Sociolinguistics. It also provides detailed information regarding the two workplaces involved in this study, the meetings recorded and the participants. Finally, the chapter discusses how decisions were taken regarding the selection and the analysis of the data. Three analytical chapters follow. Chapter 4 explores how multiple group memberships

are a salient discursive tool employed by nurses as a way to ‘indirectly’ voice direct complaints and to respond to them in community-appropriate ways. Chapter 5 addresses the question of how nurses construct their professional identity through the discourse of expertise in workplace meetings as they engage in discussions of clinical cases and ACC cases. This chapter also demonstrates how expertise is learned in the context of local interaction and how expert claims are temporary and dynamic as nurses construct themselves and others as more or less expert on different aspects of professional practice. Chapter 6 pulls together and builds on the constructs of group membership and expertise explored in chapters 4 and 5 respectively to investigate the display and negotiation of professional values embedded in discussions of professional nursing practice in high stakes situations. Finally, chapter 7 summarises the conclusions that can be drawn from this study, discusses some of the theoretical and methodological implications of this research, and places a special emphasis on the implications of this study for healthcare organizations.

1.7 Summary

This chapter has outlined the motivation for this research, placing special emphasis on the suitability of nurses as participants in this study and the relevance of employing a discursive analytic approach to the investigation of nurses’ professional identity as enacted in meetings. In sum, this thesis explores some of the dominant discursive strategies that enable nurses to enact and negotiate their professional identity in relevant ways according to the interactional norms of the local and wider communities with which they index alignment. To this end it focuses on three interactional activities within the context of meetings: voicing and responding to complaints, displaying and negotiating expertise and displaying and negotiating values.

The next chapter describes the theoretical frameworks that inform this study, further situating and establishing how this research contributes to existing knowledge in the fields of workplace, discourse analysis and nursing research.

Chapter 2

Theoretical background

During the past few decades, sociologists, sociolinguists, anthropologists and social psychologists have directed significant attention towards the study of interpersonal and (inter)group social identity. The workplace as a contextual setting for identity enactment has attracted interest as researchers, for example, consider the internal structures of groups and their relation with the complex network of intergroups in organizations (Boden, 1994; Saks and Ashforth, 1997; Hogg and Terry, 2000; Puusa, 2006). Healthcare in particular has seen a growing number of studies concerned with the role of care givers' identities in the management of social relations with patients (see Roberts, 2007 for overview of studies) and in the communicative impact they have on providing health care (Leonard et al., 2004; Gerrish, 2001). In order to explore nurses' construction of professional identity in workplace meetings, this chapter reviews relevant literature¹ and outlines the theoretical stance this study takes on professional identity enactment and construction.

At this point, it is worth mentioning that the aspects of identity formation that will be explored in this review have been traditionally associated with a number of, sometimes, competing theories in the field of sociolinguistics and very often scholars cannot explore those aspects without making reference to those theories. Independently of the theories which have appropriated these concepts, the researcher acknowledges the importance of some of the concepts underlying these theories for their salient role in the processes of identity construction as they are valuable resources for the discursive enactment and negotiation of professional identity. This study adopts a social constructionist stance on identity construction, and I draw on these tools as they integrate different facets of identity formation.

The chapter starts with a review of workplace research in the area of professional

¹ Conceptualisations of expertise are explored in chapter 5.

identity, followed by a detailed consideration of those aspects of identity formation that guide the research questions. Links between professional identity and discourse, and professional identity and workplace meetings are explored in order to establish the relevance of a discursive study of professional identity in workplace meetings in healthcare settings. The chapter finishes with a review of professional identity research carried out in healthcare settings and the research questions that guide this study.

2.1 Professional identity and workplace research

Workplace research has been both enriching and productive when it comes to investigating professional identity, particularly since the 1990s. Different linguistic resources and interactional aspects involved in the negotiation of professional identity have become the focus (e.g. Marra and Angouri, 2011). For instance, in their early work, Drew and Heritage (1992) consider how institutional roles shape conversational moves, such as turn-taking, sequence organization and lexical choice (see Heritage, 2005; also see Hamilton, 2003 for a short review of such studies), and how certain communicative activities and practices can be directly associated with the display of (professional) identity (e.g. Gotti, 2002). Scholars have also been interested in looking at the role of in-groups and out-groups in the display and construction of professional identity formation (see Sarangi, 2002; Gallois, et al. 2005; Benwell and Stokoe, 2006) as well as how relational talk (including humour as one of the most well researched aspects) contributes to the negotiation of professional identity (Koester, 2010; Holmes, 2006; also see Marra and Holmes, 2007 for multicultural workplaces). Another area of inquiry that has attracted considerable attention has been the role of power asymmetries in the construction of professional identity, especially in interactions between professionals and laypersons (see Hamilton, 2003 for an overview of studies).

These aspects of professional identity have been investigated in a range of workplace contexts. In particular, sociolinguists have greatly advanced knowledge on the construction of professional identity within organizations. In this regard, a growing body of literature has approached the study of professional identity by investigating narratives as a linguistic resource to position oneself professionally. As an example, Holmes (2005) distinguishes between ‘socially-oriented workplace anecdotes’ and ‘transactionally-oriented working

stories' and explores their role in the construction of different aspects of personal, professional and social identities of the participants in her study (also see Holmes, 2006; Holmes and Marra, 2005). Dyer and Keller-Cohen (2000) investigated the institutional discourse of lecturers and the contribution made by their narratives in the construction of their professional identities as lecturers who distance themselves from non-expert others. Other researchers have focused on small talk or non-work related talk and have explored how this type of talk is employed to construct professional identity (see the construction of mentors' professional identity in Chiles, 2006, 2007; also see Holmes, 2000).

Language teaching has also made a significant contribution to the current understanding of professional identity.² The classroom is an important site for the construction of professional identity of both teachers and students who will become professionals in their chosen field. Very often a major research focus is how students gain knowledge of their professions and learn to be professional, how courses of different kinds promote specific socialization processes with the aim of defining students' professional identity, and how classroom discourse and practice construct and shape students' professional identity (Dannels, 2000). A general concern has been to examine the extent to which academic communicative practices shape students' professional identity. Focusing on lecturers, Bathmaker and Avis (2005) investigate the construction of professional identity of a group of trainee lecturers using Lave and Wenger's work on apprenticeship to communities of practice. They provide evidence that communities of practice help to shape new lecturers' professional identity and describe how they feel when they become actively involved in existing communities of practice. Other research focuses on professional identity construction and the moral stance of novice teachers by exploring reflective and relational workplace narratives (Vásquez, 2007). Scholars have similarly explored how different aspects of

² Although it is not within the scope of this thesis to develop this issue in detail, it needs to be acknowledged that the status of the language classroom as a workplace has very often been controversial and neglected in the workplace literature. Nevertheless, I follow Alexandra Georgakopoulou's views (2011: 151) in that "workplace research has tended [...] to equate the workplace with office type of environments" and the language classroom falls within the boundaries of what workplace research has traditionally called institutional setting (also see Hamilton, 2003). For that reason, I believe that the language classroom does constitute a valid environment for workplace research and that the studies outlined above make a highly valuable contribution to the study of professional identity in workplace research.

expertise contribute to the shift in the perceptions of secondary school teachers from when they started teaching to the current stage in their careers (Beijaard, et al., 2000). Other research in this area includes the study of professional identity in view of the significant changes in government policies and educational restructuring in, for instance, Australia. Sachs (2001) explores how teachers' discourses, characterized by 'democratic professionalism', compete with those of the government, characterized by 'managerialist professionalism', both creating different, competing types of professional identity.

The studies outlined above, whether in educational or organizational settings, share the view that doing professional identity constitutes a form of social practice in which social actors become involved in relevant and meaningful interaction. Workplace interactions provide a site in which workers can define and rework their professional identity. Most workplace research in this area (as the studies above illustrate) has focused on *construction* and the way that it sheds light on the intricacies and complexities of the socio-linguistic processes involved in the interactional negotiation of professional identity. Following this line of enquiry, this study hopes to make a valuable contribution to the analysis of the construction of professional identity by nurses/clinicians in the context of workplace meetings.

2.2 Theoretical discussion of professional identity construction

Prevailing social constructionist conceptualizations of (professional) identity highlight the need to investigate the discursive processes of identity formation specifically in local practice in the workplace. As discussed in the introductory chapter, though professional identity has some relatively stable elements such as some professional values that are passed on from generation to generation in a code of ethics, professional identity is not seen here as merely a static or stable entity but rather a dynamic one which is reworked in interaction with relevant others (Doane, 2002; Bucholtz and Hall, 2005; Apker and Eggly, 2004; Buchlotz and Hall, 2010). Professional identity is not a "fixed attribute of a person, but a relational phenomenon" (Beijaard et al., 2004: 108; Kosmala and Herrbach, 2006). As Sacks explains in the light of the rapid changes faced by societies, identities cannot be fixed; rather, they are "negotiated, open, shifting, ambiguous, the result of culturally available meanings and the

open-ended power-laden enactment of those meanings in everyday situations” (2001: 154). The aspects of identity formation outlined here are explored in more detail in the upcoming sections in order to provide the theoretical framework that lead to the research questions of this study.

2.2.1 The contextual aspect of identity construction

When they interact, social actors have a choice of a range of, usually intersecting, identities (such as gender, cultural, personal, and professional) that are available to them at any given point in the interaction. In this regard, identity can be said to be naturally multifaceted, that is to say, there are a number of subidentities that may conflict or align with each other as they serve different purposes in an interaction (Cooper and Olson, 1996; in Beijgaard et al., 2004). Social constructionist processes of identity construction are situated, that is to say, identities emerge from, and are displayed and negotiated in local contexts of interaction (see Pennycock, 2010; Renkema, 2004). Consequently, the choice of identity or identities and their interactional relevance are dynamic as they are “responsive to [also dynamic] contextual conditions” (Hall, 2012: 33). This attests the current views “toward increasingly more interactive and dialogically conceived notions of contextually situated talk” of social constructionism (Duranti and Goodwin, 1992: 1). As Dannels (2000) explains, the negotiation of identities within situated contexts of interaction will result in one particular identity or facet of an identity being more salient at any given moment than others. So what kind of identity is enacted and negotiated at a certain point in the interaction will depend on the social setting, or context, in which the identity is embedded. Furthermore, the choice of identity will shift as it is adapted and adjusted to fit the changing conditions of the context that surrounds it. No two interactional contexts will be the same; the contextual features, including interactional needs, will be different from interaction to interaction and even within the same interaction. Consequently, each interactional event will call for constant reconsideration of participants’ choice of identity orientation and the ways of displaying it.

Context, in this study, is viewed as a conjunction of interactional features such as speech situation, audience and interactants, physical place of interaction, cultural setting, linguistic and discursive choices available to participants, shared background assumptions,

topic of the conversation, (institutional) roles of the participants and interactional activities within which an interactional event is embedded (see Goodwin and Duranti, 1992 for a discussion on the evolution of the term ‘context’ and ‘contextualization cues’; also see van Dijk, 2006). In addition to these features, the choice of identity also lies in the relational goals of the interaction, for instance, maintaining harmonious relations with co-workers, or transactional goals, for instance, eliciting information for a work project (see Holmes 2005; Lazzaro-Salazar, 2009). Thus, the interactional activity in which the social actors participate, together with the identities of other social actors involved, and the goal(s) of the communicative event(s) will shape the identity or identities that become relevant and appropriate for display in that context. The discursive practices involved in the enactment and negotiation of identity are also context-sensitive as they need to adapt to aspects of the context in order for them to be appropriate and relevant to the interaction (see Fairclough, 1995 and McKenna, 2004). As van Dijk explains, the interactional context “constrains discourse production, structuration, and understanding” (1999: 110). Thus, interactants’ subjective interpretations of the contextual needs of the interaction will guide their discursive choices. Furthermore, as Renkema (2004) notes, discourse may not only need to be adapted to certain contextual features to satisfy interactional needs but also create the context of interaction. Lexical choices, for instance, may both need to be adapted to contextual characteristics, such as to the role of the participants involved in the conversation, and also create the context by providing the tone of the conversation.

In conclusion, identity formation is a contextually mediated process because the context of interaction plays a significant role on which identity or identities are made more salient and how they are discursively enacted. The context will have an impact on how identities shift through the course of interaction, and how they are interpreted, negotiated, reworked and reinterpreted among participants according to their perceptions, their interactional needs and the interactional development of the conversation. As a result, the enactment of identities conveys meanings that are contextually relevant to participants. Contextual features of interaction such as those discussed in this section will be embedded in the analysis of the data explored in this study in order to provide illuminating insights into their role in identity construction and display.

2.2.2 The relational aspect of identity construction

Applying a relational-constructionist view certainly promises to provide a comprehensive picture of professional identity formation in organizational practice, such as in meetings. In this regard, identity formation is said to operate at, at least, two broad levels: intrapersonal and interpersonal. At the intrapersonal level, a person attempts to claim a certain social identity by performing certain acts³ and displaying certain stances (Ochs, 1993). In line with this, Pennycook (2004: 8) explains that “identities are a product of our ongoing performances of acts.” Following Foucault’s views on identity (1988), the fundamental assumption behind Ochs’ claim is that identity formation is not an external process that ‘happens’ to the social actor but rather an internal one in which creation the social actor takes ownership. In this regard, it is not uncommon to see in the literature of identity work phrases such as ‘performing identity’, ‘an act of identity’ and ‘doing identity’, all of which embody the vital assumption Ochs and social constructionists in general make.

With this in mind, then, social actors become ‘agents’ of their own identity construction (see Korsgaard, 2009; Bucholtz and Hall, 2010). This concept has been extensively developed as one of the pillars of sociolinguistic theories such as performativity theory in gender studies (see Butler, 1990; King, 2011; see Pennycook, 2004 for a comprehensive review of performativity theory). Post-structuralist and post-modernist conceptions of intra-personal construction of identity conceptualise the social actor as an agent who manages the construction of their own professional identity by making decisions on, for instance, the linguistic choices (see ‘language use as an act of identity’ in Pennycook, 2004). This self-regulated process helps social actors accomplish a preferred orientation of the self by displaying certain stances or positionings (see Kosmala and Herrbach, 2006; see ‘positionality principle’ in Bucholtz and Hall, 2010). Moreover, Giddens states that agency is “something that has to be routinely created and sustained in the reflexive activities of the individual” (Giddens, 1991: 52, in Hall, 2002: 35). Thus, social actors engage in acts of

3 It is worth mentioning that while there are other ways of communicating social identity (such as by the way people dress), in this study I restrict my focus to the discursive construction of social identity in line with the data I have available.

identity as a routine activity and the way they exercise their agency should reflect the internal processes or reflections of identity construction of social actors. However, these acts of identity, that is to say, in Ochs' words, the performance of certain acts and the display of certain stances, do not happen in a vacuum. Social actors participate in workplace activities regularly and social interactions with co-workers typically rank at the top of these activities.

This interpersonal level adds a most interesting dimension to the sociolinguistic study of identity construction. In this light, Hall (2002) explains that identity is a relational phenomenon that emerges in local interaction (see Beijaard et al., 2000; see relational theory in Fletcher, 1999; cf. Holmes and Marra, 2004). It is in social interaction that social actors face the need to position themselves in regards to certain stances in order to reproduce certain identities. In this process, identities are interpreted by all social actors involved, and negotiated and reworked to fit the interactional goals at hand. Thus identity is an interactional accomplishment and partly the outcome of interactional negotiation. In Cerulo's words, an identity is "continually renegotiated via linguistic exchange and social performance" (1997: 387), "an ongoing series of social and cultural performances [...] a self-reproducing activity" (Pennycock, 2004: 8).

In daily life, the intra and interpersonal aspects of identity formation are complementary. They overlap each other as while a social actor is interacting with other social actors and engaging in identity negotiation activities, the social actor also goes through internal processes of identity re-definition in view of the negotiation. Prevailing social constructionist views on identity in workplace research also hold the view that identities are achieved by individuals as they interact with significant others (see Benwell and Stokoe, 2006). As Doane (2002: 633) explains "inherent in this process [the ongoing, relational process of identity construction] is the tension between the interpersonal and the intrapersonal" in the case of competing professional values, for instance (see chapter 6). Not surprisingly, a definition that includes considerations of act, stance and agency, for example, would emphasise this interrelation between the two levels of identity formation, intrapersonal and interpersonal. An *act* is understood as "*socially* recognized, goal-directed behaviour", for example asking for permission, and *stance* is "*a socially* recognised point of view or attitude" (Ochs, 1993: 288). In addition, Ahearn (2001: 112) defines agency as the "*socioculturally*

mediated capacity to act” (see Ahearn, 2001 for a review of definitions of agency) [emphasis added]. While act, stance and agency form the backbones of definitions of the self-constructed aspect of identity, the social component is also included as a vital part of the process of identity formation (see Giddens, 1999). All rest on the principle that the agentive attribute of the social actor in their identity formation is put into practice when they interact with other social actors in relevant contexts.

Identity ascription is also an integral aspect of the negotiation process. At the same time that social actors create their own professional identity, relevant others create, or ascribe, certain identities or aspects of an identity for them as well (see examples in analysis chapters). Coldron and Smith (1999 in Beijaard et al., 2004: 113) contend that professional identity entails a certain level of inherent tension between “agency [the personal dimension of identity construction] and structure (the socially ‘given’).” This, they explain, means that in order to be a nurse, for example, one needs to see oneself as a nurse as well as to be perceived as one by others. These perceptions grow out of the interpretations of speakers’ stances and play a salient role in the interactional negotiation of identity. Going back to the meaning of stance in this context, Haddington (2006: 77) contends that “stance *taking* [...] is [...] a sequential and dynamic *activity* in which interlocutors evaluate and assess, and position themselves in relation to their co-participants, objects of talk and the surrounding world” (also see Wilson, 2011). In situated social interactions, these stances are evaluated by interlocutors in relation to the social expectations they hold of the identity embodied by those stances (see Cooks, 2010). In other words, as social actors orient towards a preferred image of themselves, the other interlocutors are involved in interpretative and evaluative processes of this identity enactment. As a result, the performance of certain acts of identity is compared against what interlocutors consider to be morally and socially appropriate or acceptable for their context of interaction, and an evaluation of this will be displayed through interlocutors’ discursive and linguistic choices (see Cooks, 2010; Beijaard et al., 2000; cf. theory of stance in Haddington, 2006). This may result in social actors reorienting their identities in response to self and other interpretations and evaluations of their stances and acts of identity.

Finally, social actors’ interpretations of stances and acts of identity are mediated by interpretations of previous social experiences. The way social actors position themselves in

interaction and how they interpret other social actors' positions in conversation is guided by their previous experiences of social interaction (Apker and Eggly, 2004). Beijaard et al. (2000: 750) note that the ongoing process of identity construction involves "the interpretation and reinterpretation of experiences as one lives through them", which constitutes and refines social actors' conceptions of identity. Consequently, professional identity is also partly the result of negotiations of experiences in the workplace (see Beijaard et al., 2000; Gergen and Davis, 1985).

2.2.2.1 Professional Socialization

An often mentioned inter-group process of identity construction in the workplace, which is relational in nature, is commonly referred to by anthropologists, social psychologists, sociologists and sociolinguists as (professional) socialization. Instances of socialization are at the heart of workplace activities where professionals interact with other professionals, or with relevant others, on a daily basis. Simply put, professional socialization is an interactional phenomenon which serves to integrate professionals into their professional life (Cohen-Scali, 2003). According to MacIntosh (2003: 725; see also du Toit, 1995 for a review of definitions; Mortimer and Simmons, 1978) professional socialization entails:

the process whereby individuals acquire and integrate into their lives the expected knowledge, behaviours, skills, attitudes, values, roles, and norms deemed appropriate and acceptable to their chosen profession.

The combination of each of these components makes up an individual's professional identity. Socialization is then a core aspect of the building process of professional identity. Implicit, and sometimes explicit, constructions of interactants' professional identity are embedded in instances of professional socialization, such as casual encounters with colleagues in tearooms or more formal encounters in meetings. In the case of this thesis in particular, socialization is seen to take place in meetings involving feedback sessions, discussions of professional practice and discussions of patients' cases. Through professional socialization, interactants "endeavour to experiment with new definitions of [their professional selves]" by engaging in social interaction (Cohen-Scali, 2003: 243) in order to

become competent members of a professional group or community (Kulick and Schieffelin, 2006; Austin, 2002). It is when professionals interact with other peers or co-workers that they have a chance to measure the status and appropriateness of their professional identity against that of relevant others in specific institutional contexts (see comparative processes of in-groups and out-groups formation in section 2.2.2.2). As part of the socialization process, workplace discussions on topics related to the ideology of the profession, professional values and ways of acting (or professional culture) (see Apker and Eggly, 2004), all play a role in making sense of workplace experiences which in turn contribute to negotiating and shaping one's professional identity and professional reputation (Austin, 2002; also see MacIntosh, 2003). When professionals engage in conversations of this kind, they share their opinions and views on, for instance, professional practice and values, as they orient and are oriented towards the preferred norms of professional conduct. In view of these opinions and of individual and others' interpretation and evaluation of one's professional identity, interactants may problematize and reshape their attitudes and identities as they see fit. As Kulick and Schieffelin explain (2006: 350) "co-workers socialize one another as coworkers" creating and re-creating each other's professional identities in socializing interaction. It is also as part of this professional integration process that social actors actively negotiate their rights and responsibilities as professionals of an institution or organization. Thus, socialization opens the doors for the renegotiation and re-establishment of a person's professional identity by becoming actively involved in socializing activities with other workplace colleagues.

For the last two decades, organizational theorists have argued that socialization processes take place when a person is becoming a fully practising professional (e.g. Kulick and Schieffelin, 2006; Ochs, 1993). For these scholars, professional socialization starts at the training level, when students are attending medical school, for instance (see MacIntosh, 2003). Thus, traditionally, the literature on socialization has as its focus the development of professional identity of novices (see organizational socialization in Saks and Ashforth, 1997) and students entering the workforce (see Apker and Eggly, 2004 for medical students and medical residents; also see Cohen-Scali, 2003). However, Schieffelin (1990: 19) contends that "interactions are all potentially socializing contexts" (in Kulick and Schieffelin, 2006: 350). This view acquires a special meaning in the dynamic nature of today's workplace contexts (see Finkelstein et al., 2003 for a list of common current workplace changes), where

there is a need to recognise that socialization processes can also be an on-going process of identity formation which allows people to socialise themselves into not only new jobs but also the new emergent realities of their workplaces (see Corcoran and Clark, 1984). In today's social environment, new and already established, but all the same changing, professional statuses and roles are socialized into being in both new and already established professional groups. Thus, the assumption that socialization only affects novices seems to be deemed irrelevant. This conceptualization of professional socialization is in line with current socio-constructionist views of identity (see 'process of apprenticeship' in Lave and Wenger, 1991 and Kempster, 2006). Both status and construction processes are dynamic as they are influenced by the always-changing social, contextual and personal realities of interactants. The processes involved in its formation can also be seen as dynamic and should not be tied to a particular point in time in one's professional career. In fact, socialization at its foundation points towards a life-long process of learning, interpreting, evaluating, and reworking one's professional identity in the changing environment of workplace interaction. In the case of nurses in particular, fluctuations in staff are very common in hospitals where nurses very frequently change shifts, change wards and new nurses join teams daily (see report of UK Department of Health, 2006; Morgan and Tobin, 2004 for US report; see report on the Australian and New Zealand case, 2012). In this working reality, socialization processes then are likely to be constantly at play. As a consequence, socializing instances here are understood to transcend the period in which a person first becomes a professional to also encompass interactional processes in which members of a professional group negotiate and rework their membership and identity claims as they 'socialize' with other professionals.

2.2.2.2 In-groups and out-groups

So far several factors that contribute to a social actor's construction of their professional identity have been reviewed, which include, the role of context in identity formation, the role of the social actor as an agent in the formation of their own identity, and the role of interpersonal relations and socialization in interpreting, evaluating, negotiating and assigning identity. But a review of interpersonal aspects of identity formation would be far from complete if we were not to consider the development of social identification in the interactional negotiation of identity that, more often than not, takes place in instances of

socialization (see Ashforth and Mael, 1989).

The idea of group membership is not new to discussions of identity as it is often referenced when exploring definitions of identity. Social psychologists and sociolinguists have extensively studied group membership, also commonly known as the formation of in-groups and out-groups, as an integral part of the interpersonal process of identity formation (e.g. Abrams and Hogg, 2004). Drawing on social identity theory (SIT), some of the early and most important contributions to the understanding of identity construction have been made by Tajfel (1972, 1974) and Turner (1975) who explored in-groups and out-groups within what became known as the theoretical frameworks of social categorization and membership categorization (see Hogg and Terry, 2000). Having been widely recognised in the literature of identity construction to date, social categorization is one of SIT's theoretical pillars which rests on the process by which a person claims, maintains or rejects membership to social group(s). Making an invaluable contribution to the understanding of identity construction, Tajfel (1974: 69) explains that “social categorization can be understood as the ordering of social environment in terms of social categories, that is, of groupings of persons [objects and events] in a manner which is meaningful [or relevant] to the subject”. It is important to stress Tajfel’s idea that the groupings of persons into in-groups and out-groups has necessarily to be meaningful to the social actors. Here lies the connection between the formation of in-groups/out-groups with identity formation relevant to this study. In this regard, Tajfel (1974:69) explains that social categorization of people, social objects or events into groups is meaningful to social actors because these groupings reflect “individual’s actions, intentions, attitudes and system of beliefs.”

Turner (1975: 7) best discusses this connection when explaining that “an individual defines himself as well as others in terms of his location within a system of social categories – specifically social group memberships - and social identity may be understood as his definition of his own position within such a system.” An individual’s social identity, such as, for instance, their professional identity, is then partly defined by the social actor’s positioning in the relevant social groups in which the individual interacts. For this reason, social actors will claim and maintain membership of certain social groups only if they identify in some way or another with those social groups and if those groups help them construct a positive

self image of a targeted type of social identity (Tajfel, 1974).

In this light, social identity is seen as “deriving in a comparative and ‘relational’ manner [see discussion above] from an individual’s group memberships” (Tajfel, 1974: 77). This draws attention to an important aspect of the identity construction process which is the comparative nature inherent in the process (see Abrams and Hogg, 2001). As Tajfel highlights “a group becomes a group in the sense of being perceived as having common characteristics or a common fate only because other groups are present in the environment” (1974: 72). Tajfel claims that the contribution an in-group can make to an interactant’s construction of identity “acquire[s] meaning in relation to, or in comparisons with, other groups [the out-groups]” (1974: 70). In the identity negotiation process, members of a group accentuate their in-group similarities, for instance, the professional values they share, while they emphasize differences between their in-group and an out-group to maximize intergroup distinctiveness (Gallois et al., 2005; Hogg and Terry, 2000). By establishing positively valued distinctiveness, the in-group becomes meaningful to social actors’ identity. Social groups and their memberships are maintained as they are reworked through the members’ reinterpretations of the group’s attributes and their engagement in social action (Turner, 1975). In addition, the characteristics of the group need to be ‘consensually valued’ to have a positive impact on members’ social identity, for the characteristics of a group will reflect a given image of its members in relevant social contexts (see Tajfel, 1974). By building intergroup distinctiveness members of a group draw the boundaries of who they are (in-group) as opposed to who they are not (out-group) through the discursive performance of acts and display of stances (see Ochs, 1993; Hall 2012; Turner, 1975).

Intergroup distinctiveness is possibly more evident in the norms of behaviour that guide groups’ social conduct. Turner (1975) contends that belonging to social groups gives sense to members’ way of behaving because social groups shape and control acceptable behaviour. As part of the socialization processes, understood in this context as an interactional process through which a social actor claims membership to a group, social actors build aspects of their professional self as part of a group. They build, for instance, mutually held expectations of their roles within, for example, a professional or a workplace group. They also build attitudes and perceptions of how members should behave and what

group members can or cannot do as part of that group. In order for this to be achieved, high social consensus is necessary. This works to maintain, enhance or change the group attitudes, beliefs, and values that shape their social conduct. The group's way of behaving is described in Tajfel et al. (1971) as 'generic groupness norms' and they reflect discriminatory intergroup behaviour as each group strives to behave differently from other groups. Social behaviour only becomes meaningful when it is compared to other groups. Consequently, 'groupness norms' lead to the division of groups into 'us' and 'them' (Tajfel et al., 1971; see 'groupy behaviour' in Hogg and Terry, 2000). Usually, members align their behaviour with the norms and expectations which have been ratified as appropriate by members of their in-group in order to claim and/or maintain legitimate group membership (see Hall, 2012). In this way, our "perceptions and evaluations of our own and other's identities are tied to the groups and communities of which we are members" (2012: 34).

A final aspect of the formation of in-group and out-group to be mentioned, but nevertheless important, is its situational, or context-dependent, aspect. The interactional context in which a social actor is involved will influence one of two choices that this person has: to behave exclusively as an individual or to behave as a member of a group (see Tajfel, 1974). In this regard, Turner (1975) supports Tajfel's claim that social categorization is meaningful only "at a particular point in time" (1974: 69) by explaining that group memberships are evoked in interaction according to the interactional goals that call for their use in order to appropriately display a positive social identity of its members. Interactants' choices of group memberships at any given point of the interaction need to be contextually relevant or appropriate. Those features of group identifications which become salient in conversation are negotiated and reoriented as the interaction evolves. And while some group memberships may be well established for instance, institutional groups, others emerge in the context of interaction as, for instance, a conflict arises in conversation and interactants need to take sides. In addition to the locality of in-group affiliation, and retaining the idea that "we are a bundle of identities which are brought into play through social action" (Giddens, 1991 in Allsop and Mulcahy, 1998: 809), it is logical to assume that social actors may claim more than one group membership, even within the same interaction, in order to adjust to the changing interactional goals of a conversation (see Abrams and Hogg, 2001). By engaging in this type of affiliative activity, interactants ensure that they claim membership of those

groups that will satisfactorily display a positive social identity of themselves. As Tajfel (1974: 69) explains, a person is “a member of numerous social groups” and, in this regard, interactants have ‘social mobility’, that is to say, “if a group does not contribute adequately to an individual’s social identity, [they will move] to another group” (1974: 78) that better satisfies their interactional needs. These various group memberships often serve interrelated purposes tailored by the interactional context for which they become complementary to each other rather than exclusive.

This section has discussed a key concept of identity formation: the self as defined by an individual’s group memberships. It has been postulated that professional identity is the result of not only negotiations of experiences in the workplace (see previous section) but also social memberships (see Beijgaard et al., 2000; Apker and Eggly, 2004; Gergen and Davis, 1985). It is then logical to assume that the formation of in-groups and out-groups in the workplace can be expected to be influenced by professional affiliations and preferences such as standards of professional performance. Thus, individuals’ identifications and memberships with certain professional groups can shed light on interactants’ professional identity. For that reason, concepts associated with group memberships and group identification will be explored in more detail in chapter 4.

2.3 Identity and community of practice

First proposed by Lave and Wenger (1991) and later developed by Wenger (1998), the framework of CofP has been widely applied in organizational research as a system of knowledge management (see Coakes and Clarke, 2006 for a collection of studies and reviews in the field; Wenger, 1998b). Evolving from a social constructionist theoretical framework, the notion of CofP has also been a useful tool for sociolinguists as it captures the dynamic process(es) by which a group of people, in this case in the workplace, are mutually engaged in a jointly negotiated enterprise (Eckert and McConnell-Ginet, 2003; Corder and Meyerhoff, 2007; Marra and Holmes, 2007). Thus, sociolinguists have often employed the framework in order to investigate the relationship between discourse and workplace phenomena as social actors construct their identity around their community membership (e.g. Holmes and Marra, 2002). The past decade in particular has seen a growing number of theoretical and empirical

studies concerned with the role of a CofP in identity formation (e.g. Bucholtz, 1999 and Tsui, 2007). It is this last focus which makes a significant contribution to this study as it becomes of great value to the understanding of professional identity construction for two reasons.

First, encapsulated within the notion that doing identity is a social activity the CofP framework reflects social constructionist views on identity formation that are in line with the views adopted in this study. In establishing the link between CofP and identity, Wenger highlights their “profound connection” (1998: 149) as identity is inextricably related to practice. In this regard, Wenger contends that in order to develop [professional] practice social actors need to become involved in the activities carried out by relevant groups or communities. Practice then requires the formation of a community with which an individual feels identified and which acknowledges them as a participant. To do this, social actors also need to develop ways of being and behaving in the context of those communities; thus, “the formation of a community of practice is also the [development and] negotiation of [the appropriate] identities” which grant social actors a place in their communities (1998: 149). Framing identity as the self resulting from negotiations within social contexts of interaction mirrors principles of social constructionist adhered to in this study.

Furthermore, looking at the definition of identity within the CofP framework leads us to the second point of discussion. Similarly to the definition posed above, Wenger (1998: 145) explains that “building an identity consists of negotiating meanings of our experience of membership in social communities.” If we look at this definition more closely, the CofP framework integrates all the concepts that I have discussed as core to the process of identity formation in the previous sections:

“building an identity [INDIVIDUAL AGENCY] consists of negotiating meanings of our experience [SOCIALIZATION] of membership in social communities [INGROUPS]”

These aspects of identity formation constitute the backbones of some of Wenger's five dimensions of identity, the first of which is *identity as negotiated experiences*. In line with my previous discussions, this dimension considers identity as the result of social actors' participation in a community and the negotiated experiences that result from actively

engaging in the practice of a community or communities. Core to the operation of a community of practice is sustained engagement in meaningful activities, which often leads to the development and negotiation of shared (relevant) meanings (Sachs, 2001).

Strongly connected to the first dimension and to the ideas of in-groups and out-groups discussed above, the second dimension is *identity as community membership*. A community of practice, Wenger (1998b: 6) maintains, provides home for its members' identities; we define who we are by "what we participate in" ingroups, "and what we stay away from" outgroups. As pointed out earlier, "identity is formed through participation [...], [consequently] our membership constitutes our identity" (Wenger, 1998: 152). This dimension is concerned with how social actors learn to be part of a community by abiding by its rules of conduct, by coming together in interaction to draw the boundaries of their community (Wenger, 1998b), and by sharing repertoires to appropriately participate in its social activities. Particularly focusing on professional identity, Hall contends that "we appropriate [...] group memberships developed through our involvement in the various activities of the social institutions that comprise our communities" (2002: 31). To be part of a community then, members come together in a joint enterprise as they have common goals or purposes (see previous dimension); they also interact with each other, what Wenger calls 'mutual engagement', in social activities relevant to that community; and, finally, they develop a shared repertoire, a shared understanding of what they do in their community, what values they hold and how they should carry out community activities in appropriate ways. An important link between the social constructionist ideas discussed earlier in this chapter with these views of CofP can be provided by Ochs' ideas (1993); she emphasises that the construction of a social identity, such as in this case professional identity, is mediated by the interactants' understanding and knowledge of the local conventions for performing certain acts and displaying certain stances. As Fagermoen (1997: 434) explains "fundamental to the socialization process is the internalization of values, norms and ethical standards of the professional culture [or group to which they claim membership]." In other words, interactants need to share the knowledge of what acts and stances are associated with a particular professional identity and of the appropriate resources at hand to construct that identity within a given community and context of interaction. In this regard, this dimension of identity within a CofP captures the importance of the contextual sensitivity involved in the construction of

professional identity that Ochs (1993) makes reference to. This rests on the ideas of social constructionism by which a person's social identities are socially and jointly negotiated and constructed in local interaction (Ochs, 1993; Park, 2007; Agnihotri, 2007; Spreckels and Kotthoff, 2007). Moreover, communities evolve as members come together to "exchange information, knowledge and experiences, and thereby, learn and generate new knowledge and common practices" (Zboralski and Gemünden, 2006: 218). By interacting together and creating this web of knowledge and practices, members very often develop a common sense of identity that ties them together as a social group (Wenger et al., 2002). This aspect of a CofP is what, as Wenger believes, differentiates a community of practice from other work groups (see Wenger, 1998b for differences between networks, teams and communities of practice; and Holmes and Meyerhoff, 1999 for CofP vs. social network and speech community).

Introducing a crucial aspect, the third dimension is *identity as learning trajectory*. As community members come together into shared social spaces, they interact with each other in light of their shared goals and purposes, and they learn ways of being part of that community from each other (Blunt, 2003). Learning to be part of a CofP takes place in opportunities to practice. Rephrasing Wenger and Lave, being part of a CofP involves knowing "how experienced members talk, walk, work, conduct their lives, how outsiders interact with it, how and when" (Bathmaker and Avis, 2005: 50). In the context of institutional reality, social actors' identity formation is in a constant state of flux, that is to say, social actors are constantly adjusting to the changing conditions of the social environments characterising workplaces (see Wenger et al., 2002; see section on 'context' in section 2.2.1). We constantly learn new ways of being as we renegotiate our identities when faced with, for instance, new social actors, new roles, new workplace rules and regulations, new social contexts, and as new forms of participation also emerge. Professional practices, for instance, change through time; thus social actors are constantly learning new ways of belonging and of enacting memberships (see Lave and Wenger, 1991). In other words, this learning is mediated by the social context in which the social actors are embedded, as the context shapes the structures and meanings of an interaction and, consequently, social actors' identity. The workplace becomes a valuable social space where learning certainly occurs (see Illeris, 2011). As Wenger (1998b: 4) concludes "a community of practice exists because it produces a shared

practice as members engage in a collective process of learning.”

The fourth dimension is *identity as nexus of multi membership*. This refers to the relationship between a social actor’s multiple identities and their various group memberships. As explored in the in-group section above, social actors may belong to more than one social in-group or community at once. In this regard, Lave and Wenger (2002: 115, cited in Bathmaker and Avis, 2005) define CofP as “a set of relations among persons, activity and world, over time and in relation with other tangential and overlapping communities of practice.” Identity construction is seen then as a multilayered and dynamic process in which a person participates in different communities at once. The reasons underlying these memberships vary and are personal. However, as mentioned earlier in this review, each of the social actors’ affiliations to different communities needs to add a positive value to their identity. The negotiation of their identities within situated contexts of interaction will result in one identity and community membership being more salient at any given moment than others (see Dannels, 2000). This negotiation will be influenced by aspects of the context of interaction, such as its transactional and affective goals, the social actors involved, and the kind of activity in which they are involved, etc. It is important to remember, however, that a person’s various community memberships and the identities that arise from them may all (or some) be enacted within the same instance of interaction, as the display of identities is a dynamic one and shifts of identities may be observed (Doane, 2002).

Finally, the fifth dimension is *identity as a relation between the local and the global*. In this regard, Wenger claims that “we define who we are by negotiating local ways of belonging to broader constellations [of contexts and discourses]” (1998: 149). This dimension then establishes the connection between the situated practices of a community within the broader context of that community. In order to belong, members need to not only actively participate in its activities but also share understandings of these activities and what they mean for them personally and for the wider community in which this CofP is socially embedded. Wenger contends that in a social theory of learning, the individual needs to understand his role within the immediate CofP in which he is participating and the role of this CofP in a wider context of interaction with other, sometimes overlapping, CofPs. To give an example, the immediate CofP of clinicians may be the group with whom they share shifts. At

the same time, clinicians may be members of other communities such as all the people working on their ward (as opposed to people working on other wards), people working in that particular institution (as opposed to other institutions), all people who share the same profession (regardless of the institution), and so on. When interacting, clinicians may display more than one group membership depending on what aspect of identity they are enacting. It is, according to Wenger, essential that social actors are aware of the relationship of one community membership with the other community memberships and the role these memberships have in the wider context of their social environments.

In the context of this study, nurses come together as co-workers who engage in daily social interaction (mutual engagement), including work tasks, weekly and sometimes monthly meetings and casual gatherings in kitchens and corridors. They work together towards the achievement of shared institutional objectives and thus, they, as will be shown in chapters 4-6, often have a shared understanding of their professional roles and values, of their routines, and the norms guiding their professional practice. Using the framework of CofP as the contextual environment in which professional identity is constructed in the workplace provides a rich opportunity to integrate all the aspects of identity construction that have been discussed in this literature review as salient in the identity formation process. In addition, as will also be demonstrated in the analysis chapters, no evidence was found in nurses' discourse to soundly support the premise that there exists some intercultural difference in the way they discursively construct their professional identity. In this regard, the CofP framework allows me to account for the similarities in the use of linguistic strategies observed in the data in spite of the ethnically diverse backgrounds of the participants, investigating professional identity as it emerges within the boundaries of local interaction in the context of a jointly negotiated enterprise. The framework of CofP, then, serves as a complementary framework to social constructionist views on professional identity in that it enriches the exploration of the discursive construction of professional identities as part of the jointly constructed social norms of the groups of nurses involved in this study (see Gallois et al., 2005; Baker, 2008).

2.4 Professional identity and discourse

The common denominator among all of the aspects of identity formation outlined above is the use of language. Though the role of discourse⁴ (see characterisation of discourse as big D/little d in Gee, 2008) in the construction of a social actor's professional identity has been implicitly conveyed throughout this literature review, it deserves closer attention in order to establish its relevance within this study.

Social constructionist views of discourse and identity formation build on the view that language is the “site for the construction and contestation of social meanings” (Weedon, 1997: 21 in Baker, 2008: 14). Eggins and Slade (1997) explain that language should be seen as social practice since talk is a way of doing social life. Coming from a written discourse tradition but nonetheless relevant to spoken discourses, Bhatia (2004) claims that discourse is both a social and a professional practice, the tool through which we enact and present our social selves and one of the ways in which we perform professionally. Increasingly, organizational scholars from different fields and traditions have come to acknowledge the importance of discourse in the daily routines of an institution as “the internal structure of organizations is [...] managed and displayed through talk” (Fasulo and Zuccheromaglio, 2002: 1121). But possibly the most devoted followers of such views have been sociolinguists, who have taken up this view of discourse in context and have, during the last two decades, made valuable contributions to the investigation of the linguistic resources and context-related patterns employed when expressing a given stance and performing certain acts of identity (Cashman, 2005; Ochs, 1992; see Marra and Angouri, 2011; Eggins and Slade, 1997). In this light, identity is “embodied by a series of discursive practices” (Kosmala and Herrbach, 2006: 1394) that serve to index a myriad of identities as social actors adopt certain stances in the course of interaction (see Marra and Angouri, 2011; Ochs, 1993; Boden, 1994). In other words, language is a tool that, at a microlevel, enables social actors to position themselves in social situations [stance] where identities are claimed, contested and re-constructed [act] through discourse (Bucholtz and Hall, 2005, 2010; see Sarangi and Roberts, 1999; Norris,

⁴ Discourse in this thesis is conceptualized as a unit of language, for example, a sound, a word, a phrase or a sentence, which communicates meaning in context (Cameron, 1998).

2007, in Hall, 2002: 35; Ochs, 1992b). As the interaction evolves, stances, or subject positionings, are constantly negotiated, reinvented and reconstructed (Haddington, 2006). As social actors engage in interactions their choices of linguistic resources, such as the use of pronouns and intonation, become a vehicle to index “situational meanings” such as a given aspect of their professional identity, and affective and epistemic stances (Hall, 2012: 53; Eggins and Slade, 1997). The context in which an identity is enacted will influence these linguistic choices. And because the linguistic choices will depend on features of the context of the actual interaction, the construction of professional identity can be said to be locally and discursively negotiated among interactants (cf. Doane, 2002; Drew and Heritage, 1998; Hall, 2012). Moreover, the secret of indexicality, or contextualization cues (see section 3.2.1, chapter 3), lies in the fact that, in order for those indexicalities to be properly understood and displayed, the meanings embodied by those indexicalities must be shared by all parties involved in an interaction. This links to postulates of the CofP, to which we turn to now.

Supporting the view that language is a vehicle to enact social identities, the CofP framework also highlights the fundamental role of discourse in the process of identity formation. Wenger (1998) maintains that while the members of a community are actively involved in ‘social enterprises’, shared social norms of linguistic and non-linguistic behaviour will emerge as a result. As Coakes and Clarke (2006: 92) explain “communities are governed by internal informal and unspoken rules dominated by specialised language development.” While social actor socialise, they work towards becoming group members and draw social boundaries among groups. In this regard, quoting Fishman’s work (1968), Tajfel (1974) explains that group (or community) distinctiveness is frequently created through the use of language, where in-groups and out-groups are distinguished through various forms of ‘us’ and ‘them’ (e.g. Grice et al., 2006 and Fasulo and Zuccheromaglio, 2002). It is then through these indexicalities that social actors display their community memberships. These norms of community membership categories, such as language use and practices, are shared by all members of an in-group or community (Carlin, 2003) and form the ‘social matrix’ of the group, or community, and their social meaning (indexicality) is established, renegotiated and adjusted as social actors actively engage in interaction (see Corder and Meyerhoff, 2007).

Discourse then not only claims a salient role in the enactment, maintenance and

negotiation of professional identity but also in the formation and maintenance of a community of practice. As Lave and Wenger (1991) explain, to claim membership of a given group or community, its members need to learn to talk appropriately in that community. Our group memberships play an important role in the linguistic choices available to actors; the group has historically developed their own linguistic resources for fulfilling their relevant activities (see Hall, 2012; Lingard et al., 2003). Talk then involves the language that is used by a given CofP, that is to say, how participants learn to talk as legitimate members of a CofP.

In conclusion, both social constructionist and CofP views of discourse and identity formation maintain that language is an essential tool used to index socially relevant meanings, which, in turn, embody a certain type of professional identity (see Ochs, 1992). In this way, the relevance of language use in instances of spoken socialization within a community has been established as a fundamental aspect in the display of affiliations. Thus, a linguistic exploration of the discursive resources employed by clinicians/nurses to index certain stances and display certain acts can advance our understanding of the dimensions involved in the construction and enactment of professional identity.

2.5 Professional identity in healthcare settings

As has been explored in the previous sections of this chapter, for the past two decades researchers of workplace interaction have been interested in exploring various dynamic components of professional identity. While some have focused on its formation, others have paid more attention to how it is maintained, or negotiated, or ascribed, sometimes considering more than one aspect at a time. Professional identity has also been seen through the lens of a variety of professional, and workplace contexts (spoken and written, casual and formal, etc.). Such plurality of views on professional identity has also been present in healthcare research, which, during the last decades, has contributed an extensive body of research.

Most research places a strong emphasis on the study of doctors' professional identity. For example, exploring the discursive analysis of professional identity, Apker and Eggly (2004) investigate how medical ideology and physician professional identity are socially

constructed during morning report. Allsop and Mulcahy (1998) investigated the way doctors respond to patients' written complaints regarding their professional practice. Looking at a range of negative emotions these complaints elicited from the doctors as these are perceived as challenges to their professional competence, the study focuses on how doctors maintain and reinforce their professional identity in their replies to patients. In order to explore aspects of professional identity development such as whether the medical student is committed to the professional values and personal goals deemed needed to practice the profession, Niemi (1997) shows how students' personal experiences during the preclinical years help to gradually develop their professional identity. The professional identity of doctors has also been widely studied where the relationship between the doctor and the patient is the focus of attention. As such, doctors' professional identity has been investigated in exchanges where a diagnostic is given (see Heritage and Maynard, 2006), where patients present their cases (see Barone, 2012). Very often studies where both doctors and nurses, doctors and students, students and nurses are the subjects of study, comparisons between the dyads are offered.

Other research has been concerned with investigating the impact that social, economic and/or political changes have had on health professionals' professional identity. As an example, Carpenter and Platt (1997) focused on the development of professional identity by evaluating the impact that changes in the U.S. healthcare delivery systems has had on the professional identity of social workers. Similarly, Drew (2011) investigated the importance of nurses' handover meetings and the impact on professional identity caused by changes in the health and social care system in the UK from 2006 to 2010. In the New Zealand context, a recent reform of the healthcare sector "involved the corporatization of public hospitals, and the contractualization of social relations between and within institutions" (Doolin, 2002: 369). Doolin (2002) explores, for instance, the way clinicians are held accountable for the resources used at a hospital and how the discourses of management and enterprise are accepted, resisted or compromised as clinicians reinterpret their professional identity.

Many studies concerning nurses in particular are longitudinal in nature and aim to trace the development of participants' professional identity over a period of years. Most research of this kind focuses on the development of professional identity during the transitional period from being a medical student to becoming a fully practicing doctor or

nurse (see Apker and Eggly, 2004 for an overview of studies). Emphasis is placed on how professional identity is initially constructed through learning experiences in the pre-graduate/novice environment and how professional identity is constructed through professional socialization (see MacIntosh, 2003). As an example, Fagerberg and Kihlgren (2001) conducted one such study with the aim of understanding “how [Swedish registered] nurses experience the meaning of their identity as nurses, when they are students and nurses 2 years after graduation” (2001: 137). A follow-up study was carried out by Fagerberg (2004) in which registered nurses’ professional identity status was explored in their narratives of work experience five years after graduation. Other reflective studies looking at nurse identity include that of Ölhén and Segesten (1998) in which they carried out semi-structured interviews with the goal of eliciting the state of a group of nurses’ professional identity.

With a few exceptions (e.g. Fagermoen, 1997), then the participant focus of studies in this area of research is limited as scholars have largely disregarded professional identity construction in fully practicing nurses. Thus, in the light of the evidence discussed in this section, this study has a number of goals in order to address research gaps in the field. First, research concerning the discursive study of professional identity involves studies concerning doctors or medical practitioners other than nurses. The studies concerned with nurses’ professional identity outlined above rely on nurses’ perceptions of their professional identity, as data was collected through interviews, logs, participant observation and questionnaires and surveys (e.g. Fagermoen, 1997)⁵. Though these make a significant contribution to this field of research, studies that focus on the discursive evidence of clinicians’/nurses’ enactment, construction and maintenance of professional identity are scarce (see Gregg and Magilvy, 2001). As a consequence, this study aims to shed light on the *discursive* enactment and construction of nurses’ and clinicians’ professional identity.

The sociolinguistic literature on professional identities in healthcare settings has traditionally focused its efforts on describing the construction of social inequalities, of medical discourse and of asymmetrical power relations between doctors and nurses, nurses and patients, and doctors and patients (Gallois et al., 2005; Roberts, 2007). For example,

⁵ This point will be explored more fully in the methods chapter.

Roberts (2007) explains that issues concerning intercultural communication in healthcare settings have revolved around miscommunication problems that bring about social inequalities but that little attention has been paid to the interactional dimension such as “how [any given] social identity leaks out into interaction through talk” (2007: 249). In fact, no published literature on how nurses from different ethnic backgrounds construct their professional identities and interact among themselves has been found in the course of this PhD research.

In addition, none of the studies reviewed above investigates the professional identity of nurses in backstage interaction (consider discussion in introductory chapter). Apker and Eggly go as far as to claim that “scholars still lack a complete understanding of how the in situ discourse of medical socialization [...] develops professional identity” (2004: 412). Thus my research aims to contribute to the understanding of how nurses negotiate their professional identity in backstage instances. This study also hopes to expand this field of research by looking at the discursive enactment and construction of nurses’ professional identity when they interact with other nurses, as opposed to comparing them with other health professionals.

Taking note of the gaps in the field of healthcare settings as discussed in this section, the next section explores the interactional site chosen for the study of professional identity in two healthcare settings: staff meetings.

2.6 Professional identity and meetings

Meetings constitute one of the most common workplace activities in which workers get involved, sometimes on a daily basis. For that reason, the study of business meetings has received increasing attention from sociolinguists interested in organizational talk (see Marra, 2008; Huttunen, 2010; Bargiela-Chiappini and Harris, 1997; Bargiela-Chiappini and Nickerson, 2002; Bargiela-Chiappini et al., 2007; Asmuß and Svennevig, 2009; Holmes et al., 2011; Angouri and Marra, 2010). This research has been concerned with a great variety of aspects of meeting organization, such as floor-taking strategies, topic choice, turn-taking sequences and power relations (see Huttunen, 2010; Asmuß and Svennevig, 2009 and Marra,

2008 for comprehensive reviews of studies). However, the fast growing amount of research in this area has very often equated to the kind of workplace meetings which take place in (multinational) corporations. As a result, meetings in other workplace contexts have been comparatively under researched, which applies, in particular, to staff meetings in the healthcare setting. For the purposes of this study, it should be made clear that staff meetings in healthcare settings fall within the descriptive boundaries of business meetings. In this context then, meetings are generally understood as institutional (discursive) events that take place at a “customized and designated space with a very clear [and agreed] agenda and speaking rights” (Holmes, et. al, 2011: 60; see Asmuß and Svennevig, 2009 for a brief review of definitions; Rogerson-Revell, 2007; Huttunen, 2010). In what follows I explore the theoretical considerations for including meetings as the interactional context of the present study.

Meetings provide possibly one of the most vital contexts for socialization processes to occur in the busy environment of healthcare workplaces. The social constructionist views of professional identity construction discussed earlier contend that professional socialization provides opportunities to “maintain and develop a critical understanding of [a professional] role” which leads to the formation and reformation of professional identity (Bathmaker and Avis, 2005: 48). In order for socialization processes to take place, nurses need to share social spaces that allow for their stories to be told as these instances serve as the context in which their professional practice, their professional role and thus, their professional identity, can be evaluated, considered, enacted, judged, shaped, constructed and sustained. In this light, meetings are interactional sites where nurses have a quiet time from the hectic activity ‘on the floor’ and come together to make sense of their professional and institutional roles, or as Asmuß and Svennevig (2009: 10) put it, “act in their institutional roles”, as they engage in professional practice and in conversations about their current and future professional performance. Seen as an “interactional joint achievement” (Asmuß and Svennevig, 2009: 3), meetings then are sites where nurses/clinicians work together to accomplish not only transactional goals, for instance, reporting, reviewing protocols, making arrangements, briefing or joint problem solving, but also relational goals, for instance, building positive relationships through small talk (Coupland, 2000) and negotiating their professional identities (Holmes et al., 2011). Furthermore, as social actors engage in processes of professional

socialization, they can simultaneously develop and participate in their community (or communities) of practice, which, as explored above, also provides a rich context for the formation and re-formation of professional identity. In this regard, Fagerberg (2004: 284) describes the work context, in this case meetings, as “a learning context where nurses share, learn and support each other.” Meetings are also sites where situated learning, in the sense of a CofP, takes place (cf. Dannels, 2000; Huttunen, 2010). Thus, meetings provide a relevant and meaningful organizational context for the discursive exploration of how nurses’ professional identity can be contested, challenged, negotiated, maintained and reinforced.

Most research of professional identity in healthcare settings explores what is referred to as frontstage work ignoring the importance of backstage work in identity construction (e.g. Heritage and Sorjonen, 1994; cf. Huttunen, 2010). Frontstage instances of workplace interaction involve those in which institutional representatives and clients participate whereas backstage instances refer to those in which only institutional members are involved (Bardovi-Harlig and Hartford, 2005; cf. Wilson, 2011). Current literature of workplace studies draw on Goffman’s postulates to distinguish between frontstage and backstage work contexts in workplaces. Two aspects differentiate frontstage from backstage instances of workplace interaction. The first aspect is the type of activities social actors perform. As an example of healthcare settings, frontstage activities may include interviewing the patients and having handovers sessions next to a patient’s bed; while backstage activities may include staff meetings and casual meetings in tearooms. The second differentiating aspect refers to how social actors adopt a different set of behavioral standards when they are confronted with ‘the public’ (frontstage), such as in this case patients, to when they are confronted with only other coworkers and away from the public eye (backstage) (Goffman, 1959; see as examples, Koester, 2004; Rogerson-Revell, 2008; Holmes et al., 2011). As a simple example, a nurse may address patients more formally than when she addresses other nurses when sharing their tea break (see Sarangi and Roberts, 1999). The link between backstage work and professional identity rests on the idea that professional knowledge and professional identity are, in great part, constructed in backstage work as professionals interact among themselves on a daily basis. Unfortunately, “it is this everydayness that takes place backstage which often tends to be ignored by workplace researchers” (1999: 22). Consequently, although professional identity is a role that professionals play either in public or as ‘backstage behaviour’ (Kosmala

and Herrbach, 2006), “most studies (both within discourse analysis and workplace sociology) [...] have been concerned with the frontstage and have assumed, unproblematically, that, for example, being a [nurse] means dealing with patients and clients” (Sarangi and Roberts, 1999: 20; also see Roberts, 2007; Vaughan, 2007; Richards, 2006). As demonstrated in the previous section, this applies to most research in the area of healthcare, which has investigated the construction of professional identity in frontstage instances of interaction when, for example, doctors and nurses interact with patients during appointments (Bardovi-Harlig and Hartford, 2005). Thus this study aims to advance knowledge on the construction of professional identity at the micro level of organizational life through nurses’ backstage work for which meetings provide a rich environment of exploration. Moreover, it needs to be acknowledged that there is much debate about the dynamic nature of frontstage and backstage work as social actors move from one to the other within the same work space. The staff meetings recorded for this study, however, are held in meeting rooms with restricted access (cf. Wilson, 2011; see Sarangi and Roberts, 1999). For this reason, the characteristics of the activities performed in the meetings of this study correspond to those often described under the category of backstage work.

Finally, an obvious reason for choosing meetings as the interactional context of this study lies in the fact that communication in meetings is primarily discursive, which makes them a rich source of data for discourse analysts. In this regard, there is general agreement in the institutional literature that organizational activities are largely based on discursive practices (see Fasulo and Zuccheromaglio, 2002). For this and the other reasons posed above, I believe meetings are a meaningful site for the exploration of the enactment and negotiation of professional identity of nurses/clinicians.

Building on those resources of professional identity construction, such as contextual and relational aspects, and the operational frameworks for the study of professional identity, such as social constructionism and CofP, presented in this literature review, the next section outlines the research questions that guide the exploration of the data of this study.

2.7 Research questions

As discussed at the outset of this thesis, the research questions posed are guided by the more general question: how do nurses/clinicians discursively construct and display their professional identity when they interact with other nurses/clinicians in formal, semi-formal workplace meetings? As demonstrated in this chapter, a number of contextual features and relational aspects constitute an integral part of the processes of professional identity formation. For that reason, they are explored in more detail in the analysis of nurses' professional identity in the following chapters. Those concepts are articulated in the following research questions:

- 1) *How does the formation of in-groups and out-groups contribute to nurses' discursive construction of professional identity in workplace meetings?*
- 2) *How is professional identity constructed through the discourse of expertise in workplace meetings?*
- 3) *What are the values that characterize nurses' professional identity and how are these presented through discourse? What professional stakes do these values represent for nurses?*

Question one explores how nurses/clinicians construct their professional identity in workplace meetings at a hospital, focusing on the formation of in-groups and out-groups as a resource to achieve this. The second question addresses nurses'/clinicians' construction of their professional identity in workplace meetings at a clinic, particularly exploring the discourse of expertise. Question three explores how nurses construct their professional identity through the negotiation of professional values and the high stakes these represent for nurses' and the institution's images in discussions of professional practice. The chapter addressing this question integrates the constructs explored in chapters 4 and 5 and adds consideration on identity ascription as a form of organizational control, combining the data from the hospital and the clinic.

2.8 Summary

The concepts contributing to the academic understanding of professional identity construction in workplace meetings discussed in this chapter are highly interrelated. Social actors naturally use them dynamically to construct their identities and those of others. Thus, while a nurse's discourse may be constructing a sense of community in-group, they may, at the same time, be doing it by ascribing an identity to the other nurses present in the room. Consequently, the purpose of the research questions posed above is to provide the reader with the analytic lens that guides each chapter. It should be pointed out, however, that considerations of the different resources discussed above are not restricted to any one chapter in particular; rather they will be brought up at several points in the analysis for the purposes of explaining processes of professional identity construction.

In order to explore these research questions, chapter 3 will discuss the characteristics of the workplaces that participated in this study, the methodological design of the study and the analytic tools used to explore the data.

Chapter 3

Methodological Design and Analysis

As discussed in the previous chapter, this study adopts a social constructionist perspective to the discursive enquiry of how nurses construct their professional identity in workplace meetings. From this standpoint, knowing how nurses ‘do being’ nurses through local practice is prioritised over what they report they think they do in reflective practice (see section 2.5 in chapter 2). This study then places a strong emphasis on the importance of collecting authentic data. In line with the principles of social constructionism, this chapter identifies the relevance of using Interactional Sociolinguistics as a methodological framework for collecting naturally-occurring data, as well as the relevance of the research design, and analytical considerations that stem from employing SIT and the CofP framework, which made the study of nurses’ professional identity construction possible.

3.1 Investigating identity in the workplace

With few exceptions (see Apker and Eggly, 2004), research concerning nurses’ professional identity (section 2.5 of chapter 2) has explored the development, negotiation and/or maintenance of professional identity through participants’ perceptions of their identity status. This research has almost completely disregarded the role of naturally-occurring talk in its construction. Largely stemming from traditional approaches, this frequent choice of methodological design is to elicit participants’ perceptions, that is to say, self-reporting (see Ballinger et al., 2004; Kasper, 2004). To that end, some of the major sources of data collection have been open-ended questionnaires and surveys (Carpenter and Platt, 1997; Allsop and Mulcahy, 1998; Fagermoen, 1997), identity status interviews (Fagerberg, 2004; Niemi, 1997; Fagerberg and Kihlgren, 2001; Lingard et al. 2003; Allsop and Mulcahy, 1998; MacIntosh, 2003; Öhlén and Segesten, 1998; Fagermoen, 1997), diaries (Fagerberg, 2004), learning logs (Niemi, 1997), and non-participant observations (Öhlén and Segesten, 1998; Drew, 2011). In many cases, researchers combined two or more of these methods of data

collection as a way of increasing the reliability of their findings (see Allsop and Mulcahy, 1998, for instance).

Drawing on verbal protocols of experimental psychology, the strengths of introspective methods for collecting perceptions have been widely acknowledged in the literature of healthcare for providing researchers with participants' insights into their inner thoughts and beliefs. The validity of the findings, however, has been widely contested. For instance, Del Boca and Noll (2000) explain how the data collected through self-reports vary according to how they were elicited (for example through emailed questionnaires or through face-to-face interviews). In this regard, it should be noted that "because experience is not directly observable, data about it depend on the participants' ability to reflectively discern aspects of their own experience and to effectively communicate what they discern through the symbols of language" (Polkighorne, 2005: 138). Needless to say, not all participants may have such a reflective and communicative ability to provide accurate accounts of their professional identity status.

Though the research makes insightful contributions to the understanding of nurses' (perceived) professional identity, it does not address the issue of how professional identity is constructed in interaction. Thus, this study proposes to go beyond participants' perceptions of their professional identity and to explore nurses' professional identity as a social category that emerges and is negotiated in their *discursive* practices in actual instances of interaction. Consequently, in order to study how nurses do their professional identity through a number of discursive and interactional realizations, much is to be gained from collecting and analyzing authentic, commonly referred to as naturally occurring, data from workplace sites. In this regard, for the past two decades sociolinguists have stressed and acted upon the need to use authentic data in workplace research for the reliability and insights that this kind of data provides to the study of interactional aspects of communication through actual language use (e.g. Tannen, 1994; Bilbow, 1997; Holmes and Marra, 2002; Takano, 2005; Holmes, 2006; Habib, 2008; Ladegaard, 2011; Schnurr et al., 2007; Schnurr and Chan, 2011; Vine, 2009; Lazzaro-Salazar, 2010). Heritage and Atkinson (1984: 3) explain that the current empirical emphasis of the sociolinguistic research moves away from the theoretical traditions of verbal

reports, which more often than not provided ‘idealized or invented examples’, resulting in a more “adequate basis for making and debating analytic claims.”

A sound argument for employing authentic data in workplace research is based on the premise that it affords “examination of a wide range of discursive features” and this “sheds light on participants’ production of communicative action” (Kasper, 2000: 317; see also Spencer-Oatey, 2008; and Bargiela-Chiappini and Nickerson, 2003). A growing body of research which explores identity in the workplace has used naturally occurring data (for instance, Chiles, 2007; Schnurr, 2009; Holmes, 2005). When considering the study of professional identity in healthcare settings in particular, it needs to be acknowledged that some scholars have used authentic data as their analytic source (see Rees and Monrouxe; 2010; Heritage and Maynard, 2006; see studies in Drew and Heritage, 1992; Heritage and Clayman, 2011; Major et al., 2008). However, whether professional identity is dealt with implicitly or explicitly, their research has not focused on the discursive construction of professional identity of nurses as they interact with other nurses in their community (or communities) of practice in backstage work (see chapter 2 for an exploration of backstage work).

Thus, guided by the research aims outlined in the previous chapter, a discursive analysis of nurses’ professional identity entails exploring instances of actual language use, which can be achieved by collecting naturally occurring data. Using a qualitative approach to the study of nurses’ professional identity, naturally occurring discourse can offer insights into the sociolinguistic behaviour in which nurses engage to socially construct their professional identity in interaction, as opposed to how they ‘think’ they do it (see Koester, 2002).

The following section shows how the principles behind Interactional Sociolinguistics make it a suitable methodological framework for the study of the discursive construction of nurses’ professional identity in workplace meetings.

3.2 Interactional Sociolinguistics as a methodological framework

Interactional Sociolinguistics (henceforth, IS) has developed from disciplines such as anthropology, sociology and linguistics, and emerged from Gumperz' work on the ethnography of communication (Gumperz and Hymes, 1972). As a qualitative and interpretative approach to the study of social interaction, IS is rooted on the idea "that language as it is used in social interaction is constitutive of social relationships" (Trudgill, 2003:65) and as such is interested in how language is used to achieve relational goals, such as the management of rules of cooperation and turn-taking. Thus, an IS approach to the study of conversation investigates how a language is used to maintain, develop, change and/or contest social relationships among interactants. This conception of the role of language in interaction makes IS a suitable methodological framework for the study of nurses' professional identity construction through actual language use.

Moreover, the relevance of using IS as an approach that guides the methodological decisions made in this study also lies in its compatibility with the analytic stance adopted. Both IS and SC share the philosophical view that language is a social practice that constructs and contests social meanings (see section 2.4 in chapter 2). Then IS, as the methodological approach, and SC and CofP (see chapter 2), as interpretative approaches, serve as complementary frameworks for the study of how nurses enact and negotiate their professional identity in workplace meetings. In addition, they allow me to collect relevant data and to look at social interaction from a discursive point of view that stresses the negotiation and social construction of meaning as social actors collaboratively construct talk in locally situated interaction (see section 2.2.1 in chapter 2).

3.2.1 Interactional Sociolinguistics: Focus on context and culture

IS, as originally proposed by Gumperz and Hymes (1972), is mainly concerned with investigating language use in relation to the culturally-specific norms of linguistic behaviour that guide social actors in their interactional activities. Attesting to its anthropological tradition, IS highlights the role of two salient aspects of communication, the situational context of interactants' culture, as crucial for interpreting social interaction: "language usage

[...] is governed by culture and context-specific norms that constrain both the choice of communicative options and the interpretation of what is said” (Gumperz and Gumperz, 2006: 57). Thus, on the one hand, the interactional context constrains the choice of linguistic resources that social actors can employ in a given situation to index a desired stance (see chapter 2). To this end, social actors use contextualization cues, such as intonation and prosody, that help them decide which linguistic resources and norms of behaviour are appropriate for a particular communicative moment, guiding social actors towards the appropriate way of developing a conversation (Wetherell, 2001). Thus, IS investigates those indexicalities available to social actors and how these are used to enact their stance. IS is a highly contextualised approach to discourse analysis as it draws on the analyst’s knowledge and understanding of the pragmatic norms of behaviour that govern the community being explored for the interpretation of the data. On the other hand, culture also plays a fundamental role in the construction of any social identity since it constitutes an integral part of who social actors are. Our social identities are forged by our social realities which are in turn characteristically cultural, that is to say, the content of the social categories that constitute our social identities are generated within our cultural reality (Howarth, 2002). Because of the central role culture plays within any theory of identity and within the IS framework in particular, it is important to define ‘culture’ as it is conceptualised in this study in order to be able to consider the culturally-specific norms of linguistic behaviour that inform social interaction in the data collected.

The early discussions of Gumperz about what counts as culture are open to interpretation (see examples in Schiffrin, 1996; Gumperz, 1999). Thus, the operationalization of the term ‘culture’ as defined within the boundaries of IS has proved to be a problematic one in recent workplace literature. Sociolinguistic views of the concept of ‘culture’ have evolved from being a ‘given’, a static attribute of a people in the 70’s and 80’s (see Gumperz and Hymes, 1972), to being a socially constructed category that is made available through discursive practices. As a ‘given’, culture has usually been used as a synonym of race, ethnicity or nationality (for instance, Irish, Arab, Chinese; see ‘national culture’ in Young and Sercombe, 2010), and its conceptualization is “outside the locally constructed meanings of those interacting” (Yates, 2001: 88), that is to say, ‘extrinsic’ to social actors (Fitch, 2001). In that way, cultural norms of (linguistic) behaviour are imposed on social actors who do not act

upon them but according to them. Though this view of culture still receives the greatest focus in the literature of intercultural workplace research (Blommaert, 1991) for its contribution as a “well-defined analytic framework [that enables the researcher to] provide generalizations, typologies and subsequently solutions to alleged communication problems in the workplace” (Angouri, 2010: 209), it has also been challenged as an oversimplification of the discursive work of social actors in interaction (Kotthoff & Spencer-Oatey, 2007).

Thus, some discourse analysts, encouraged by the predominance of interactional approaches to the study of discourse, have recently reworked what they mean by culture to widen the scope of its conceptualization to also include other interactional components (see Angouri, 2010 for a review of the limitations of equating culture with national culture). Within the realm of social constructionism, culture has then been defined as “a fuzzy set of attitudes, beliefs, behavioural conventions and basic assumptions and values” a person has, which operates within a social system (Spencer-Oatey, 2000: 4), or as Park (2005: 12) concludes it is “a relational demarcator whose usage is an inscription of differential positions and hierarchical identities.” Thus, one’s culture is also partly manifested through interaction in our self categorizations and group alignments. These views of culture move away from the traditional views that associate it solely to ethnicity or nationality characteristics and see culture as an interactional achievement of a group of people who come together because they share the same beliefs, values, etc. In this light, culture is understood to be constructed rather than acquired.

Several scholars have taken up the view that small groups (independently of ethnic background) can create their own ‘culture’ (see Eliasoph and Lichterman, 2003). In this regard, Fine (1979) assigns the term group culture or ‘idioculture’ to those social groups that create their own cultural forms by frequently interacting with each other and using these forms in an array of interactional situations in which the group is involved. These cultural forms, Fine (1979: 733) contends, are “*functional* in supporting the group’s goals and individual needs” and they are interpreted in similar ways as they are co-created by the group’s members (also see Spencer-Oatey, 2000). Thus, as social actors affiliate to different social groups, communities or networks, they are said to participate in different ‘cultures’ (Young and Sercombe, 2010; Bargiela-Chiappini and Nickerson, 2003). This

conceptualization of culture has been responsible for countless classifications of different contextually-bound types of ‘cultures’, such as youth culture (Pujolar, 2001; Bucholtz, 1999, 2002, 2006), the culture of different speech communities (Barley et al., 1988; see Eckert and McConnell-Ginet, 2006), and the culture of learning in SLA research (Brown et al., 1988), to give a few examples. In workplace research in particular, discussions on the role of organizational, institutional, workplace and/or corporate culture in the discursive practices and the identity enactment of workers also inform the field (see Alvesson, 1996, 2004; Swales and Rogers, 1995; Hardy et al., 2005; Meek, 1988; Holmes, 2002). In the healthcare setting in particular, the nursing ‘culture’ has been greatly explored over the last two decades (Suominen et al., 1997; here see chapter 6).

In line with the social constructionist ideas that guide this study, it is important to emphasise that this view of culture stresses the dynamic and interactional construction of identity (see Bargiela-Chiappini and Nickerson, 2003; here see chapter 2). Furthermore, this conceptualization of culture informing IS captures the three main dimensions of the CofP framework: *joint enterprise* and *mutual engagement* as group members claim membership to participate in group activities, and *shared repertoire* as members create their own set of routines, norms of (linguistic) behaviour, and stylistic resources, all of which may contribute to the construction of their own group or community culture (see Gumperz and Gumperz, 2006; Angouri, 2010). Consequently, IS, SC and the CofP serve as complementary frameworks for the study of how nurses, independently of their ethnic backgrounds (see introductory chapter), enact and negotiate their professional identity in workplace meetings.

3.2.2 IS and the methodological design

In practical terms, the framework of IS proposes to provide an analysis of the on-going process of face-to-face interaction focusing on the richness provided by naturally occurring conversations (Schiffrin, 1996). IS methodology usually involves an ethnographic component that provides insights into the interactional reality of the participants in order to offer richer interpretations of the data. As described in section 3.3.2 and 3.3.4 of this chapter, I observed a number of meetings as a starting phase of the study with the aim of becoming familiar with the workplace contexts, the participants and their work culture, and the

interactional routines of the meetings (see Holmes and Stubbe, 2003). IS methodology typically involves audio and/or video-recordings as data (see section 3.3.4 this chapter) and detailed linguistic transcriptions. As Gordon (2011: 67) points out, this is followed by a careful micro-analysis of “the conversational features in the context of the information gained through ethnography” (see section 3.5).

The aim of this analysis is to show how social actors use contextualization cues to index certain social meanings (for instance, professional identity) and how, using their past experience of similar events, this is recognised and interpreted by other social actors through culturally-sensitive mediated processes of sense-making (what Gumperz calls ‘conversational inference’). IS methodology and the type of analysis it advocates has proved fruitful in the study of workplace interaction. An increasing body of workplace literature has productively employed IS as ‘an approach to discourse’ (Schiffrin, 1994). Thus, research concerned with the microanalysis of discursive resources in relation to the societal context surrounding the interaction have used IS as a methodological tool to, for instance, identify common meeting norms for developing course materials (Marra, 2008), investigate the co-construction of leadership through collective talk in the workplace (Vine et al., 2008), and explore verbal humour in routine workplace interactions and its relationship to power enactments and politeness (Holmes, 2000; see also Holmes, 2003). IS has also been used to explore the role of small talk in the workplace (Holmes, 2005), workplace narratives (Holmes, 2006; Marra and Holmes, 2004), and identity enactment (Rampton, 2007; for other workplace studies also see Roberts, 2007; Stubbe et al., 2003; Gunnarsson et al., 1997; Habib, 2008; Gunnarsson, 2009; Boxer, 2002; see Hinkel, 2005 for overviews of studies).

The interactional foci of the present study call for a methodological approach that focuses on the micro-analytical study of naturally occurring data. Thus, the methodological framework proposed by IS makes a relevant contribution to the discursive enquiry undertaken in this study in that it enables the researcher to look at the interactive construction and organization of discourse, and the organization of discourse as social relationships emerge and are maintained in naturally-occurring interaction (Nevalainen and Raumolin-Brunberg, 2012). In this process, the analysis will shed light on the construction and enactment of professional identity as shaped by contextual factors, such as the content of the meetings, by

the interactional dynamics involved in those meetings and cultural aspects of participants' CofPs. In sum, IS is a suitable methodological framework for the study of how nurses maintain, negotiate, develop, construct and co-construct their professional identities through discursive practices since it supports the interactionally dynamic views of social constructionism on identity construction discussed in chapter 2.

3.3 Research design

3.3.1 Choosing and approaching the two workplaces

From 2007 to 2010, I worked as a research assistant in the School of Nursing, Midwifery and Health at Victoria University of Wellington, New Zealand. I was involved in a number of projects focusing on the discursive analysis of written texts in health (such as Implementing the New Zealand Health Strategy, 2002) and the evaluation of New Zealand's Nursing Entry to Practice Programme (NETP⁶). During this period I had the opportunity to meet a number of professionals in the health area who became interested in the projects with which I was involved. In particular, managers at the two workplaces where the data for the present study was collected had expressed their interest in becoming involved in future studies. I seized this opportunity as it is usually not an easy task to obtain access to research sites in healthcare settings and "we have to capitalise on those [sites] that are available to us [researchers]" (Holliday, 2007). Thus, my choice of research sites was in part based on the opportunistic availability of these (see Duff, 2006, 2008) and I approached the two managers at the start of my PhD project. This choice of workplaces was also strategic as it opened an avenue of investigation in which I could compare and contrast a public institution, referred to here as 'the hospital', and a private-like institution, 'the clinic'⁷. In light of the evidence discussed in chapter 2, the operationalization and construction of the communities of practice in each workplace was expected to be characteristically different (see concluding considerations in section 2.3 of chapter 2). In the case of the hospital, a number of scholars

⁶ For more information on this programme see <http://www.healthworkforce.govt.nz/sites/all/files/growing-our-own-NETP-final-report-Jan2010.pdf>

⁷ See a description of both workplaces in section 3.4.

describe the dynamic atmosphere enhanced by the always-changing staff, who frequently change shifts, wards or even jobs. In the case of the clinic, my first meeting with the manager revealed that the permanence of staff members in that workplace was more stable than in the case of the hospital. Consequently, the construction of a community in the clinic was expected to be a more stable phenomenon. This distinction was expected to provide rich insights into how nurses belonging to two communities, which were presumably different in nature, construct their professional identities.

From the very first meeting in which I outlined the overall aims and the research design of the project (cf. Holmes and Stubbe, 2003), the two managers were enthusiastic about participating in this study. In this first meeting, both managers, and in the case of the clinic, also the CEO, discussed with me details of how each institution works (including how shifts work, characteristics of the staff members, etc.), the kind of meetings they hold, and their interest in participating in my study. We also discussed some concerns raised by the managers in terms of obtaining ethics approval from the Health Ethics Committee for video-recording the meetings (see section 3.2.2 this chapter). In the case of the hospital, my first meeting with them was presided over by the head of the nursing department and was also attended by the charge nurse managers of four wards. Incorporating participatory research methods (Cameron et al., 1992), we jointly assessed the suitability of each ward, in terms of willingness of the staff to participate in a study of this nature and ethical considerations regarding patient information for the purposes of my study. Towards the end of the meeting, we jointly made a decision to include only Ward A in this study, mainly due to ethical concerns of the healthcare teams about the other wards. In the case of the clinic, they only had one team of professionals working at that institution. I then approached these two teams with the hope they would agree to participate in my study (see section 3.3.3 this chapter).

3.3.2 Choosing the meetings to be observed

Guided by the aim of doing research *with* participants, rather than *on* them (Cameron et al. 1992), I decided that this study should follow the most important paradigms of participatory research (Cahill et al., 2007; Sarangi and Candlin 2001). Involving participants in the research process can potentially create supportive links with the researcher as engaging

in it calls for some degree of commitment with the research project and the researcher (see Cameron et al., 1992). This kind of dialogic research opens an avenue of dialogue between the participants and the researcher, in which the researcher can potentially help improve institutional practices and the participants can help the researcher in ‘coordinating strategic action’ such as solving methodological issues, or even influencing the direction of the study (Flecha and Gómez, 2004; also see Bowl, 2008). This also proved fruitful in providing me with the views of the participants about my research and their views of ‘the real issues’ of the workplace (see Asmuss and Svennevig, 2009).

Considering this was a new workplace context for me, it was vital to listen to and to follow, as I had been doing (see section 3.3.1), the suggestions made by the managers of the workplaces for two main reasons. First, following their advice maximises the chances of obtaining consent from participants. Second, I benefited from their experience and knowledge of the institution in order to make informed methodological and analytic decisions that would lead to the successful completion of this research study. This also posed another advantage for this study: taking decisions collaboratively with the participants helped to ensure that the study was only minimally invasive in such a sensitive work environment.

In order to make an informed decision about which meetings I would include in my study, I asked the managers of the hospital and the clinic for permission to observe different kinds of meetings in order to become familiar with the workplace and their activities (see Llamas, 2007; see description of this in phase one of the study). In this regard, ethnographic approaches, such as IS, seek to explore meanings and behaviour that are embedded in the social norms, values and actions of communicative routines of its participants (Titscher et al., 2000). A core aspect of ethnographic methodologies, observation gives the researcher access to a considerable amount of contextual knowledge concerning the pragmatic aspects of interaction that affords richer interpretations of the data (see section 3.3.4 phase one).

In both workplaces, the managers explained they had a range of meetings and they suggested shortlisting the wards and the number of meetings I would be observing. Thus, the meetings I held with the managers of the two workplaces served as decision-making instances in which, based on my explanation of the purposes of the study (see appendix C),

we jointly assessed the suitability of the meetings and selected the ones I needed to observe. For instance, one of the daily meetings on the ward were multidisciplinary and were attended by representatives of all the disciplines in the ward, that is to say, nurses, doctors, physiotherapists, and social workers. The purpose of these meetings was to present a number of patients' cases and to debate the next treatment steps. Although I thought the interactional context of these meetings seemed suitable for the purposes of this study, the managers present at the meeting discouraged me from using them for two reasons. First, they were adamant that trying to get the doctors on board would be a long process and a daunting task, even if I was focusing my analysis on nurses' interactions. Second, these meetings contained highly confidential information about the patients that could not be disclosed. As a result, we decided that multidisciplinary meetings were not viable for this study and we opted for two other kinds of meetings: roster meetings and handover meetings at the hospital (see their description in section 3.4), and clinical meetings and staff meetings at the clinic (see their description 3.4.2). In both cases, before any data collection took place, however, I needed to obtain appropriate ethics clearance.

3.3.3 Ethics

In order to observe, and to audio and video record meetings in the two workplaces selected for this study, I followed the guidelines dictated by Victoria University's Human Ethics Committee (HEC). In accordance with these guidelines, in order to carry out data collection in the health environment, I first obtained the approval of the School's Research Committee. Following this, an application requiring approval from the Central Regional Ethics Committee (CREC) was sent to the Secretary of the HEC who forwarded it to the relevant regional committee (CREC). Once the relevant CREC made their favourable decision, Victoria's Human Ethics Committee was notified. The HEC was satisfied with this approval and waived their obligation to grant their own approval on the grounds that they considered it had been granted by a more stringent institution (CREC). Following this, the letter granting permission to conduct the study under the rubric of an 'observational study' was forwarded to the managers of both workplaces so that the relevant internal procedures needed for the start of the data collection process could be observed. In the case of the hospital, I completed an additional form providing the details of the data collection process

which was sent to both the nursing director and the Human Resources manager. As for the clinic, I signed an additional confidentiality agreement so that the manager could share it with all members of staff involved in this study (see Appendix B).

Following this and before data was collected, participants were given an information sheet outlining the nature and purpose of the study, and the procedures involving their participation (see Appendix C). Participants also completed and signed participants' background information sheets (see Appendix D) and consent forms (see Appendix E). Two participants opted out of participating in this project. In these two cases, participants sat behind the cameras and the instances in which they participated were not used in the data analysis. The interactional dynamics of the handover meetings at the hospital allowed for professionals who were not participating in the meeting to enter the meeting room sporadically for different purposes. This posed some ethical challenges as the recording devices captured conversations of professionals who had not signed the consent forms to participate in this study. This issue was tackled either by collecting consent forms retrospectively, that is to say, asking for their consent immediately after recording the meeting, or by excluding the instances in which they participated. Participation in this project was voluntary and participants could withdraw from the project at any point during the study. Throughout the study and dissemination of the findings, all names are pseudonyms so that participants' identities remain confidential.

Furthermore, during my initial meetings with both the nursing manager at the hospital and the manager of the clinic, and my first meetings with the work teams at both institutions, professional concerns were raised regarding patients' confidentiality. For that reason, it was agreed that any sensitive information relating to the participants themselves or any patients discussed in the meetings would remain strictly confidential and such information has been disguised in the presentation of the data in this thesis. In order to achieve this, the managers approached me at the end of the meetings when necessary to advise me whether there was a patient's case, for instance, that they were not comfortable with me using in this study or which needed to be particularly disguised in the presentation of the data. These recommendations were followed rigorously.

Regarding the dissemination of the findings, I wrote two reports, one discussing some preliminary findings and the second one discussing the overall conclusions of my thesis. These were sent to the managers of both workplaces with the aim of providing feedback and discussing the findings with the participating institutions, as well as thanking the teams for their participation. In both cases I encouraged the managers to make any relevant comments about the reports and to suggest, if necessary, any changes to the document for dissemination with their staff. Finally, upon the completion of the project all recorded data and transcriptions have been securely archived with the Wellington Language in the Workplace Project to which access is restricted to approved researchers.

3.3.4 Phases of the study

Sociolinguistic research that reflects on the complexity of the social environment that surrounds discursive interaction in the workplace calls for an integration of data collection techniques (Denzin and Lincoln, 1998). Employing more than one source of data collection “increases confidence in research findings and strengthens the (...) outcomes” (Hugentobler et al., 1992: 55). In this way, one method can compensate for the weakness of another. And it provides “valuable background information and additional knowledge which substantially advances the interpretation of the linguistic data” (Schnurr, 2009: 1128). In addition, qualitative research involving discourse analysis, such as that presented in this study, is inherently interpretative. To address issues concerning researcher’s subjectivity, it is important to provide more than one source of data collection that facilitates the triangulation of the analysis and warrants, or supports, the researcher’s interpretation of the data (Cameron, 2009). Thus, for example, as Erickson (1986) notes, combining the evidence gathered in field notes when observing the meetings with the evidence found in the transcripts is one way of warranting my interpretations of the findings. This adds depth to the analysis of the findings, as different appreciative perspectives of the data, frequently including those of the insiders, are available to the researcher to cross-check their interpretations of the data (Starfield, 2010).

This approach to the data collection opens up analytical possibilities for the study of the sociolinguistic complexity involved in constructing nurses’ professional identity in

meetings in two healthcare settings in New Zealand. Thus, in line with the observations above, the methodological design of this study adopts a multi-method approach to the data collection. This design has been pilot-tested and builds on the methodological design of my MA thesis, which investigated the role of overlaps in intercultural workplace meetings (Lazzaro-Salazar, 2009). For practical purposes, the data collection process was divided into three phases: 1) observing the meetings and taking ethnographic notes, 2) recording the meetings, and 3) interviewing the managers and caregivers.

Phase 1: observing the meetings and taking ethnographic notes

An important aspect of using IS as a methodological framework is that the researcher is expected to make informed interpretations of the data based on their knowledge of the participants and their institutional settings (Heritage and Maynard, 2006). Thus, as the starting point of the data gathering process, between June and July 2010, I attended one meeting of each type in each workplace, that is to say, a roster meeting and a handover meeting for the hospital (see their description in section 3.4.1), and a clinical meeting and a staff meeting for the clinic (see their description 3.4.2). Having the researcher observe the meetings can potentially threaten the validity and reliability of the data gathered (Lecompte and Goetz, 1982a and b) due to the presence of the researcher at the research site (see ‘the observer’s paradox’ in Labov, 1972). This is usually said to risk the elicitation of less spontaneous speech and non-authentic ways of behaving (Preston, 1996). Guided by my interest in gathering data that reflected participants’ daily interactive reality as closely as possible, during this first phase of the data collection process the risks of the observer’s paradox were minimised by the fact that it was made clear to participants that I would be observing only a few meetings as a non-participant (compare participant and non-participant observation in interactive and non-interactive methods of data collection in LeCompte and Goetz, 1982a and b) and that I would not be present during the recording of the meetings (see description of next phase). This unobtrusive method of data collection is a commonly employed data collection technique in healthcare research because it is expected to wield little influence on the interactive behaviour of participants (LeCompte and Goetz, 1982; see ‘observer effect’ in Pettigrew, 1999; e.g. Pettigrew, 1999 and Caris-Verhallen et al., 2004). Indeed, there was some evidence that my presence as a non-participant observer in those

meetings did not affect the dynamics of the meetings (see ‘unobtrusive observer’ in Blomberg et al., 1993). According to their team managers who approached me at the end of each meeting, participants’ performance and participation was considered typical of these teams’ work meetings. The urgency of dealing with patients’ cases (in handover and clinical meetings) and with urgent administrative issues at hand (in roster and staff meetings) possibly motivated the participants to carry out their meeting tasks as usual.

I seized the opportunity to use these meetings to make relevant ethnographic notes. As an analytical tool, they grant the researcher access to the natural context in which the interaction occurs (Erickson, 1986). This helps the researcher develop a descriptive understanding of participants’ social reality (see Blomberg et al., 1993; also see Boxer, 2002; Coiera and Tombs, 1998; Gerrish, 2001). As the analysis chapters will demonstrate, the kind of exploration of the discursive construction of nurses’ professional identity proposed in this study greatly benefited from the contribution of the ethnographic notes as these also served to gather data concerning the way meeting agendas usually developed, the way work routines of meetings were carried out, as well as aspects of interactional dynamics of the meetings, seating arrangements, identification of salient topics of discussion, contextual cues and prosodic features (Holmes and Stubbe, 2003). This detailed account of the interactional aspects of the meetings was later used to guide and support the interpretation of the data and to inform the choice of extracts for analysis (see section 5.5.2; also see Boxer, 2002).

Observing meetings proved to be of invaluable importance to the research design of this study. By seeing the meeting rooms and observing the dynamics of the meetings I was able to determine the suitability of not only the meetings for the purposes of this study but also the research site for recording purposes (see Holmes and Stubbe 2003). Thus, I identified potential issues with the recording equipment, for instance, where to set up the video cameras and audio recorders so that they would not interfere with the usual dynamics of the meetings (see Holmes and Stubbe 2003). In addition, the room where the handover meetings were held at the hospital was very busy as administrative staff and doctors and nurses who were not attending the meeting would very often come in and out of the room. This raised an ethical issue when these by-passers spoke to someone who was attending the meeting because they had not been asked for consent to be recorded. In order to tackle this possible problem, the

manager and I decided to leave extra project information sheets and consent forms in the meeting room in case there were any later-comers. If the late-comers had not signed the consent forms, I excluded exchanges from the data in which they participated.

As pointed out earlier (section 3.3.3), these meetings also served other vital practical research purposes as the managers introduced me to the teams and I explained what my research project was about. Information sheets and consent forms were handed out and returned during these meetings. In this way, participants had a chance to speak to the researcher to clear doubts regarding the project, the consent forms and/or the questionnaires, and to discuss their concerns with the researcher. Interestingly, the biggest concern that was raised by participants in all the meetings I attended was regarding patients' confidentiality. In this regard, as discussed in the ethics section (3.3.3), participants were assured that any sensitive information would be deleted from the data and they were encouraged to approach me at the end of the meetings to raise any concerns about the content of the meetings so that I would be informed of which information needed disguising, for instance (see chapter 2 of Holmes and Stubbe 2003).

Finally, as anticipated by the managers in our initial meetings, the meetings they had suggested proved to be suitable for the purposes of this study (in the case of the hospital: roster and handover meetings, in the case of the clinic: clinical and staff meetings). As pointed out by Llamas (2007: 13), the selection of the participants (in this case of the meetings) in qualitative studies in the workplace is "neither random nor judgement, but is negotiated within the institutional confines of the setting." This negotiation had fruitful results in the first phase of this research project as the meetings collaboratively chosen were suitable for the purposes of this study and consent was obtained from all participants. The following section discusses phase 2 of the research design of this study.

Phase 2: Recording the meetings

As a discourse analyst, I focus on the micro-level discourse evidence of how nurses negotiate their professional identity in meetings. Thus the data gathering techniques needed to reflect this orientation to social research and supply me with relevant data to meet my

analytical purposes. Considered one of the most important resources in discourse studies, video recording is a widespread practice in workplace research with a focus on the interactional analysis of its social reality and the study of professional performance (see Mondada, 2006 and Knoblauch et al., 2006 for comprehensive overviews of the development of this practice in the field). In particular, it has enjoyed a long tradition of good recognition in research in healthcare settings (see Wilkinson et al., 1998; Mackenzie and Xiao, 2003; Harrison, 2002; Kushniruk and Patel, 1998). Clearly, video-recording offers many advantages, one of which is the considerable improvement of the quality of the data collected (see Jordan and Henderson, 1995).

As an observer, the researcher can only notice a limited number of interactional exchanges and interactional details (such as individual conversations within a meeting and who is looking at whom). Expecting the researcher to make a note of every single detail of interaction in a meeting with multiple participants present seems an impossible task (see Mondada, 2006). To overcome this methodological drawback, video recording offers a “more accurate picture of communication behaviour” (Whittaker et al., 1994: 132), as the eye of the camera captures “the *context* as well as the *action* of an event” (Rosenstein, 2002: 23, emphasis added on original). The greatest advantage of employing video recording in this regard is that it reproduces “the –[contextual] details to which participants orient when they produce and interpret their own and the others’ conducts” (Mondada, 2006: 5). By capturing “such things as hesitations, restarts, pauses, and [most importantly] gaze behaviour of participants” (Adler and Adler, 1998: 100; see Holmes et al., 2007), video recording is a useful tool of data collection technique for preserving relevant details of situated interaction (Mondada, 2006).

The importance of preserving details of situated interaction lies in the fact that “the availability of a record enables *repeated* and *detailed* examination of particular events in interaction and hence greatly enhances the range and precision of the observations that can be made” (Heritage and Atkinson, 1984: 4, emphasis in the original). In this sense, Rosenstein highlights the importance of revisiting the data at different stages of the research process as “new insights can spring from renewed viewing of the initial observation” (Rosenstein, 2002: 25; here see section 3.5.1). In addition, the quality of the interpretations also depends on and

can be compromised by the quality of the recordings (Lapadat, 2000). The advantage of using good quality video-recording over audio-recording rests on the possibility of including paralinguistic features of the interaction, which improves the quality of the transcripts and increases the chances of providing more accurate interpretations of the data (Rosenstein, 2002). In this regard, to ensure good quality recording, I placed additional digital microphones on each of the audio recorders (see Lapadat, 2000).

In addition to the advantages just mentioned, the major reasons for using video recording in this study are linked to the contextual reality of each workplace. From my initial meetings with the managers of the hospital and the clinic (see section 3.3.2), I was made aware of the sensitivity of the workplace context as their conversations centre around patients' information. This informed the methodological decision of employing video recording as a way of minimising the intrusion of the researcher in their workplace activities and its possible effects on the data (see Holmes et al., 2007; cf. observer's paradox in section 3.3.4 phase one and see Llamas, 2007; Kasper, 2000 and Milroy and Gordon, 2003). The sensitivity of the context also raised issues about patients' confidentiality as managers expressed their concern about the disclosure of patients' identity through the use of patient-sensitive data (see section 3.3). This issue was partly addressed by handing participants control over the recording process. Consequently, adhering to the principles of participatory research (Flecha and Gómez, 2004, here see section 3.3.2), participants were free to stop the recording at any point of the meeting they deemed necessary (cf. participatory use of video in Odutola, 2003). Though participants never exercised this option, it was an important aspect of the data collection process in that it helped build a sense of trust between the participants and me (cf. Holmes and Stubbe, 2003).

The recording phase took place between August 2010 and February 2011 and a total of thirteen meetings were audio and video recorded. I set up the recording equipment ten minutes before the start of each meeting and waited for the meeting to finish in other meeting rooms or offices of the wards, as the manager indicated. Once the meetings had finished, one of the staff members, usually the managers, let me know the meeting was over so that I could collect the equipment. Two sets of audio recorders and two sets of video recorders were employed at each meeting. Three main methodological reasons guided the decision of

including four recording devices at each meeting. First, each recording acted as a backup resource in case of any malfunctioning issues with the recording equipment (Holmes and Stubbe, 2003). There was an episode during one of the handover meetings at the hospital when one of the video-cameras recorded only thirty minutes of the meeting for no apparent reason. In that case, the other video-camera and the two audio-recorders captured all the conversation that took place at the meeting, which made it possible to use this meeting for analysis. Second, the meeting rooms were usually large and situated next to the reception areas of the wards. This meant having sometimes very loud ambient noise of telephones going off, patients and staff talking at the reception desk, and sometimes even having people sporadically rushing in and out of the meeting rooms. In this regard, another problem to tackle was that, with the exception of the roster meetings in which participants sat around a rectangular table, participants often sat scattered around the meeting rooms, which turned the recording task into a challenge. Last but not least, the decision of using multiple recording devices was also based on the fact that I had not met the participants before this project started, which made the task of recognizing their voices an impossible one without video recording. As Holmes et al. (2007: 436) explain, the use of video recording “ensures more accurate speaker identification which can be difficult when relying on audio data alone.” Thus, by using four recording devices that were placed on opposite sides of the rooms (see figures 3.1, 3.2 and 3.3 in section 3.4) I addressed the challenge of maximising the chances of providing good quality recordings of the data and of capturing every bit of conversation relevant to the meetings.

Phase 3: Interviewing the managers

Once I carried out a preliminary analysis of the data (see section 3.5.1), pertinent questions arose as participants usually made reference to certain workplace manuals, computer programmes that organized the monthly rosters (in roster meetings), ward-specific ‘modules’ (such as the bedside handover module, see chapters 4 and 6), and ward-specific protocols (see chapter 5), all of which were new to me. In order to understand the propositional content of what was discussed at some points during these meetings I needed clarification of these concepts. In this regard, managers actively collaborated in this study as I

emailed them some of these questions and they promptly replied with vital information that enriched my understanding of the data.

Another technique I employed to gather this kind of information was by conducting what Briggs (1986) calls ‘key-informant interviews’ (also see LeCompte and Goetz, 1982a and b). These are categorised as informal interviews that derive from “a [...] concern with the interpretation of meaning and with understanding the point of view of the Other” (Jessor, 1996: 6, emphasis on the original). Thus, in the context of this study, these loosely structured informal interviews centred on my questions with the aim of gathering detailed or specialised information from a key member of the community, their manager (see Llamas, 2007). Through these interviews I was familiarised myself with those aspects of the wards’ regulations, protocols and functioning that were made relevant in the meetings I recorded. I learnt, for instance, about how the roster computer programme operated, what the procedures for roster changes were, and which responsibilities a given professional role entailed. A representative example of this is how nurses were divided into operational teams within the wards for training purposes. One team, for example, was in charge of the bedside handover while another team was in charge of the medication module. This information was highly relevant to make valid interpretations of certain communicative events since some meetings were entirely devoted to providing feedback on how nurses thought the modules were working (see in particular chapter 4). With the guidance of the managers, I also read documents such as the mission statements and manuals of regulations of the institutions to which participants referred in meetings in order to understand the contextual environment and implications of some exchanges. This, again, provided me with valuable insights. In addition to enabling me to understand and reflect on the workplace activities and regulations, these interviews became useful tools for dealing with the researcher’s subjectivity by triangulating some of my preliminary interpretations of the data (Holmes et al., 2007; here see section 3.6).

Interviews were usually no more than thirty minutes long and were recorded as it was difficult to make notes of all the information managers provided. In the case of the hospital I undertook only a few interviews because the managers were often very busy and had little free time for interviews. However, I also seized the opportunity to ask questions and to talk to

the manager at the hospital whenever I saw her after the meetings. In the case of the clinic, interviews were more frequent as I saw the manager every time I recorded a meeting.

3.4 Meetings and participants

As discussed in the previous chapter, meetings provide an important context in which nurses negotiate and enact their professional identities. Thus, in order to address the research questions posed in chapter 2, the data collected for this study comprises staff meetings of four different kinds in two healthcare workplaces in New Zealand, one public and one private (“the hospital” and “the clinic” respectively). As nurses presented patients’ cases in handover and clinical meetings, and discussed institutional issues in roster and staff meetings, these meetings provide suitable interactional environments where the healthcare teams of both workplaces can enact and negotiate their professional identities while they engage in professional socialization (see section 2.2.2.1 of chapter 2). Thus, the different types of meetings selected for data collection are expected to give a comprehensive insight into how nurses enact their professional identities in a range of meetings they attend regularly (see phase one of data collection process for details on meeting selection). The following tables show the types of meetings, their duration and frequency, the number of meetings recorded and number of people who, on average, attended each meeting in each of the workplaces.

<i>Type of meeting</i>	Handover meetings	Roster meetings
<i>Duration</i>	20-30 minutes	1 hour
<i>Number of meetings recorded</i>	4	3
<i>Number of participants</i>	10	10
<i>Frequency of meetings</i>	Daily	Once a month

Table 3.1 - Details of meetings at the hospital

<i>Type of meeting</i>	Clinical meetings	Staff meetings
<i>Duration</i>	30-45 minutes	30 minutes
<i>Number of meetings recorded</i>	3	3
<i>Number of participants</i>	4	8-9
<i>Frequency of meetings</i>	Once a month	Once a month

Table 3.2 – Details of meetings at the clinic

The forty participants (approximately) that took part in this study were all members of staff, which included the managers who chaired the meetings, nurses, specialized clinicians, staff coordinators (such as nurse coordinators) and administrative staff members. However, for analytic purposes and in line with the research questions, nurses and clinicians, as opposed to doctors, remain the focus of this study. As an additional demographic feature of this data set, the four kinds of meetings represented in this study were characterised by a plurality of cultural backgrounds (see appendix F; also see introductory chapter).

As will become evident in the description of each meeting, control over the agendas of the meetings reflected the degree of formality of the meetings (Koester, 2006). In this regard, the four types of meetings included in this study can be grouped into two sets, ranging from semiformal, roster and clinical meetings, to more formal kinds of meetings, handover and staff meetings. In the case of the roster meetings (hospital) and the clinical meetings (clinic), while the overall aims of the meetings were clear, participants addressed the agenda in dynamic ways as they leaned towards a more democratic, or emergent, construction of their agendas (see Svennevig, 2012). Though these meetings were task-oriented in that their main topic was clear to all participants, the participation dynamics oriented to a more informal development. Participants were proactively responsible for bringing their own agendas to the meetings discussing key issues related to the roster or to their own patients' cases (see Vine, 2010; also see Koester, 2006 and Engeström and Kerosuo, 2007).

Roster and clinical meetings can be categorised as semiformal because they are characterised by a casual conversation style and free turn taking (see Kangasharju and Nikko, 2009). Though they lacked a fixed agenda, the manager still chaired the meeting and participants could only bring up topics they were interested in within the confines of the main focus for the meeting (see Koester, 2006; cf. Kangasharju and Nikko, 2009; also cf. Svennevig, 2012). The second set of meetings, handover meetings (hospital) and staff meetings (clinic), followed a more traditional format which can be categorised as rather formal. These meetings construct a more hierarchical relationship between participants as meetings are presided over by a chair who has control over the topic management, turn taking and the opening and closing phases of the meetings (see Holmes and Stubbe, 2003). This formal structure of meetings gives the chair the opportunity to assert their status and wield power and to establish a hierarchical relationship with their teams (Holmes, 2008; Vine, 2010). In the case of the handover meetings, though these meetings lacked a formal written agenda (unlike staff meetings at the clinic), the procedural dynamics of handover meetings were always observed in the same fashion and the meeting agenda was replaced by the ‘template’ of patients’ information on the whiteboard (Svennevig, 2012; see description of handover meetings below; see ‘template agenda’ in Fletcher, 2011).

The following sections describe in detail the four types of meetings included in this data set.

3.4.1 The hospital

The public healthcare institution referred to as ‘the hospital’ in this study is one of the major tertiary hospitals in New Zealand and it is managed by one of the twenty District Health Boards (DHBs) operating in New Zealand. DHBs are organisations that have been established by the New Zealand Public Health and Disability Act 2000, and are regulated and funded by the New Zealand Ministry of Health. DHBs are responsible for meeting the costs of medical practice and ensuring the provision of health and disability services to

communities within a well-defined geographical area of the country (see Doolin, 2002, and Johnston Taylor and Holmes, 2009)⁸.

Two kinds of meetings were audio and video recorded at this institution, namely, handover meetings and roster meetings. The hospital data equates to approximately five hours of talk, with approximately two hours forty-five minutes corresponding to the handover meetings and two hours fifteen minutes to the roster meetings.

The Handover Meeting (HM)

The handover meetings recorded constitute the second of two rounds of morning handovers of the ward, which took place daily. The first handover meeting, which was not recorded or included in this study, took place at around 7 am every morning and was attended by all nurses coming into the new shift, nurse coordinators and nurses from the night shift. During the first handover meeting, the nurses entering the new shift received information regarding their patients, an update of how the cases developed during the night. The second handover meeting, five of which were recorded for this study, was a daily meeting which acted as an update session of the first handover meeting of the day. The meeting typically lasted twenty to thirty minutes, depending on the number of patients admitted into the ward. The agenda of these meetings is to share and discuss patients' diagnosis. Thus, for instance, participants discussed whether patients should have been discharged or sent to another ward, or whether the patient needed to stay in that ward in which case they discussed the treatment to follow.

The charge nurse manager and the associate charge nurse manager of that ward took turns to chair these meetings. In addition to the chair, these meetings were usually attended by social worker coordinators, physiotherapist representatives, and nurse coordinators (for example, the medication module coordinator). Other nurses did not frequently attend these handover meetings since they coincided with their medication rounds. For this reason, the chair's and the nurse coordinators' job was to represent those nurses by communicating to the

⁸ See description of the Medical Council of New Zealand at <http://www.mcnz.org.nz/>

rest of the ward what had been said in the first handover meeting of the morning (see above) and any other relevant updates that the nurses may have given the coordinators. On average, ten clinicians attended these meetings (see table 3.1 above).

The meetings took place in a common room next to the reception desk of the ward (see figure 3.1 below). This common room had three doors; one connected the room with the reception office, while the other two doors (opposite each other) faced two corridors of the ward. The room was rectangular in shape and one of the two long walls was made of glass in front of which was a long desk with telephones and computers. On the other long wall was a whiteboard with a grid containing all the bed numbers and patients' names. Each patient's grid was in turn subdivided into the different professional areas of the ward (for example, social workers and physiotherapists). In each of these slots clinicians wrote information about their patients using a common coding system of acronyms which stood for the kind of treatment the patient was receiving. In these slots, clinicians also used colour dots to indicate the different treatment stages; a red dot meant the patient still needed to be seen by a given clinician; orange meant the patient was still being treated by that clinician; and a green dot meant either that the patient had completed treatment or that they could be discharged. Because the meetings were held at such a central spot in the ward and the room where they were held was used as a common room for all staff members, nurses and doctors who were not attending the meeting would enter the room to check patients' information on computers and the whiteboard, to deliver tubes with samples to the laboratory or to talk with somebody else in the meeting about a patient⁹. For recording purposes, this meant having sometimes very loud background noise that could affect the quality of the recording. The set-up of the cameras (see V in figure 3.1) and audio recordings (see A in figure 3.1) was strategically thought to maximise the chances of providing good quality recordings out of the data and of capturing as much of the conversation as possible that was relevant to the meetings (see phase two of data collection).

⁹ See ethical considerations in section 3.4 of this chapter.

Figure 3.1 – Meeting room for handover meetings at the hospital

In terms of the procedural dynamics, HMs followed a more traditional and formal format since the chair opened the meeting and started the discussion by reading the bed number and the name of the patient in the order they appeared on the grid. If the chair had any relevant comments concerning a patient, they would then proceed to read the nurses' notes on that patient. After this, any other clinician present who had a relevant comment about the current patient would step in and contribute to building the patient's case. Most participants present in these meetings were active in these discussions. During these, the information on the whiteboard was usually updated by the chair of the meeting, that is to say, by either the charge nurse coordinator or the associate charge nurse. However, at times the whiteboard was used by many participants. Once the update on a patient's case was complete and/or decisions for follow-up steps were made, the chair continued with the next patient.

Handover meetings			
When	Participants	Location	Aim
Daily	CNM, ACN, social workers coordinator, physiotherapist representative, nurse coordinators, nurses	Common room at reception	To share and discuss patients' diagnosis and cases

Table 3.3 - Information of handover meetings at the hospital

The Roster Meeting (RM)

Roster meetings were held monthly, usually on the last Friday of the month. Three one-hour roster meetings were recorded for this study. The meetings were attended by nurses (those who were on duty but free at the time of the meeting), the charge nurse manager (CNM) or the associate charge nurse (ACN), and occasionally by the nurse coordinators. The CNM or the ACN ran the meeting. On average, ten participants attended this meeting (see table 3.1 above).

Roster meetings took place in one of the ward's seminar rooms. This seminar room had one door and the room was rectangular in shape (see figure 3.2). It had a long rectangular table in the centre and a small desk with a computer behind the table on the left. There was one chair at the computer desk and several chairs around the table. The wall opposite the door was used for the projection of the roster, monthly workload timetable, which was edited and projected from the computer. For the recording of the meeting, one video camera was located close to the computer and the other camera was located on the right corner at the bottom, both facing different sides of the table to capture all the participants. In addition, two audio recorders were located at the ends of the table (see figure 3.2 below).

Figure 3.2 - Meeting room for roster meetings at the hospital

Understanding the procedures involved in drafting the roster was central in the development of some of these meetings (see chapter 4). The roster for the following month was made available to the nurses through the ward's website two weeks before the meeting was held so that the nurses had time to look at it and submit change requests. Following this, the charge nurse manager needed a week to make any requested changes to the roster, after which the roster meeting was held to discuss any further matters. Generally speaking, the meeting agenda involved discussing any additional matters related to the nurses' roster for the following month, for instance, issues around annual leave and shift allocation. The importance of these meetings at the time of the recording lay in the fact that there had been some changes to the nurses' roster statute and the charge nurse manager was responsible for enforcing these changes. In addition, the web-programme that was used for designing the roster was new and, according to the CNM, at the time of these meetings they were still testing it. So there were often times in the meetings when participants discussed problems they had encountered when using, accessing and making changes to the roster. Furthermore, many of the discussions about the roster centred around discussions of the hospital's statute containing the institutional regulations of nurses' shifts and holiday leave. Finally, when the ACN chaired these meetings (RM 3 & 4), they were divided into two blocks, one dealing

with the roster and the second one dealing with either bed-side handover feedback or feedback for the medication module.

Roster meetings			
When	Location	Participants	Aim
Last Friday of the month	Seminar room of the ward	Nurses, nurse coordinators, charge nurse manager and associate charge nurse	<p>To discuss roster changes, which involved reviewing clauses of the hospital's statute</p> <p>and</p> <p>To provide feedback on training modules</p>

Table 3.4 – Information of roster meetings at the hospital

3.4.2 The clinic

The clinic receives referrals for acute, short term and long term disability prescription orthoses from primary, secondary and tertiary care specialist referrers for any person eligible for orthotic management of any type. Users range from those with a temporary orthotic requirement to those with ultimately more severe, complex chronic disabilities, requiring longer term use of orthoses. Being a contracted provider to the local DHB, the clinic operates partly as a private and partly as a public centre since it provides services to private and Ministry of Health (MOH) funded clients.

The Clinical Meeting (CM)

Clinical meetings were held monthly and they were attended by the manager of the clinic, a technician and two clinicians. Occasionally, the meetings were also attended by a student undertaking an apprenticeship in the institution. These meetings took place in the manager's office, which had a square shape (see figure 3.3). The manager sat at her desk and the other participants sat in a semi-circle around the manager's desk. The two cameras and the two audio recorders were located facing opposite sides of the room to capture all participants (see figure 3.3 below).

Figure 3.3 - Meeting room for clinical and staff meetings at the clinic

In these meetings, the clinicians¹⁰ and the manager, who was also a practicing clinician, raised issues of concern regarding patients' cases. For example, it was often the case that the clinicians had a query about how to proceed, according to professional standards and protocols, with a treatment (see chapter 5). The aim of these meetings was also to share information and papers about new treatments and professional developments in general in their area of practice. These meetings served as consultation and feedback sessions in which the clinicians debated protocols, procedures and the development of patients' cases in depth.

¹⁰ The term 'clinician' is used as a sign of respect and recognition of the nurses working at the clinic who have pursued a specialization. However, clinicians and nurses are used interchangeably when discussing the clinic data.

Clinical meetings			
When	Participants	Location	Aims
Monthly	Manager, one technician and two clinicians, occasionally also a student	Manager's office	To discuss issues related to patients' cases and to share information about professional developments.

Table 3.5 - Information of clinical meetings at the clinic

With a more dynamic and democratic orientation to the conception and development of meetings, participants took turns to chair these meetings (see Moran, 2006). Being in charge of the meeting involved bringing their own clinical cases to the forum and/or other professionally-related papers they found interesting and relevant to their professional practice for discussion with the rest of the team. The manager explained she encouraged the technician and the two clinicians to chair the meeting for a number of reasons. First, assigning them a meeting to chair meant that they would have to read professional literature to share with their community. This, the manager believed, would help them develop professionally as they updated their knowledge of professional practice (see Phelan et al., 2006). Second, the manager strongly believed that implementing a participatory workplace strategy by handing her team control over the management of workplace activities, such as in this case meetings, was a means to empower participants and help develop a sense of active participation and belonging towards the institution (see Moran, 2006; this topic is further developed in chapters 5 and 6).

The Staff Meeting (SM)

Staff meetings were also held monthly and attended by the clinic's CEO (who came from another city where the main branch of the clinic was located), the manager of the clinic, a technician, two administrative staff members and two clinicians. Occasionally, the meetings were also attended by a student doing their apprenticeship. As for clinical meetings, staff meetings took place in the manager's office, thus the same room and recording description from above applies here (see figure 3.3 above).

Following formal meeting procedures (Holmes and Stubbe, 2003; see handover meetings above), the manager of the clinic chaired the meetings. Meetings were opened by reading the minutes from the previous meeting, which were passed around so that participants could quickly read and comment on them. Sometimes amendments were made as there had been some change of dates of some institutional planning. Following this, the agenda for the current meeting was handed out and the discussion of the topics followed in the order provided in that agenda. The aim of staff meetings was to discuss issues related to the administrative duties of the clinic, such as organizing the Christmas party, cleaning the clinic's workshop and discussing the purchasing limits of medical devices and stocks.

Staff meetings			
When	Participants	Location	Aims
Monthly	The clinic's CEO, the manager of the clinic, one technician and two clinicians	Manager's office	To discuss administrative issues of the clinic

Table 3.6 - Information of staff meetings at the clinic

Thus, the interactional features of the meetings described above serve as a rich site for the exploration of those aspects of nurses' and clinicians' professional identity covered in the research questions presented in chapter 2.

3.5 Analysis

Supporting the theoretical stance developed throughout chapters 1, 2 and 3 with the aim of answering the questions posed in the previous chapter, the principles behind the three complementary theoretical and analytical frameworks of SC, SIT and CofP provide the grounds for explaining how language is used to negotiate, construct and display nurses' professional identity in workplace meetings. In this regard, social constructionist views on discourse analysis allow the researcher to provide linguistic evidence that illustrates nurses' discursive practices as they interact with relevant others, and that support my interpretations of interactional phenomena. Moreover, SIT provides the views on identity formation that are embraced in this study and that inform the interpretation of the data. Finally, the CofP framework allows the researcher to investigate the discursive display of professional identity in these two intercultural workplace contexts from an appreciative inquiry approach as I investigate how nurses successfully construct their professional identity at both local and wider community levels (see chapters 5 and 6). Very importantly, what these frameworks have in common is their view that identity is enacted and constructed through social practices in social activities (see Corder and Meyerhoff, 2007). The interpretation of the data offers an account of the particularities of the interactional phenomena in the construction of professional identity while, at the same time, considering their pragmatic relevance in the meetings (cf. Gallois et al., 2005; Eckert and McConnell-Ginet, 2003).

In this way, this research project takes on a situated qualitative approach to the discursive study of professional identity. Regarding professional identity from a 'situated' perspective means to explore its construction, negotiation and display in the immediate context of interaction, which, in the case of this study, are workplace meetings. As Erickson (2004: 107) explains "talk is always done locally [...] within an immediate physical and social environment" (also see Johnstone, 2000). The social environment refers to the nature of the meetings, the people present at the meetings, the participants' roles in those meetings,

etc. All these contextual factors strongly influence the team's interactional dynamics, such as politeness conventions, situated social norms of conduct, and need to be taken into account in the analysis and interpretation of the findings. This pragmatic view on the close relationship language use and the interactional context is embraced throughout the analysis chapters.

3.5.1 Data exploration instances: Topic maps

Broadly speaking, discourse analysis aims to explore and help to understand the relationship between “language choices and what [people] mean by these choices” as it is through language that social actors present, construct and reconstruct their social world in a particular context of interaction (Paltridge and Wang, 2010: 256). These topic maps are used as an analytical tool that enables the structuring, navigation and processing of large amounts of information, which can be arranged into semantic networks, indexes and so on (see Nordborg, 2002; see also ‘structuration maps’ in Bleicher, 1994; and ‘discourse maps’ in Hogan et al., 1999). This method of knowledge management is widely used as an information resource that allows the researcher to dive into the complexities of organizational routines, norms and practices. Topic maps depict topic and discourse structures by describing local practices, topics, occurrences (that is to say, instances of discursive phenomena) and associations (that is to say, how topics and occurrences are related to each other) (see Nordborg, 2002). This level of description allows the discourse analyst to identify and categorise, or code, relevant information and to make sensitive associations of the data that form the basis of the researcher's interpretations of their findings.

In order to explore the ways in which nurses construct their professional identity through their discursive practices, I adapted the notion of topic maps designed by the research team Wellington Language in the Workplace to suit the context of my study and created one for each of the meetings recorded to describe interactional aspects and the contents of those meetings in great detail (see Holmes et al., 2011; see example of a complete topic map in appendix G). As an initial approach to the interpretation and coding of my data, topic maps were devised to contain information such as the code number of the meeting, the duration of each of the recordings of each meeting, date and time of the meeting, type of meeting and its overall topic, list of participants present, contextual information such as whether the meeting

started on time, whether any of the cameras failed to record, or whether the meeting took place in the usual room (cf. Richardson, 1992). Topic maps also include a map of the room to show seating arrangements and location of computers and whiteboards, for instance. This is followed by a detailed account of what is discussed in the meeting, which includes topic location in minutes. As an example see this extract from clinical meeting 3 from the clinic:

- [04.59] Sarah overlaps Martin and asks him if he has seen the patient lately. His answer is no but that's what he recalls the problem was. Sarah says that that's alright then and puts the folder away.
- [05.11] Sarah greets Rod and says that they'll have a quick meeting because it's the clinical meeting.
- [05.17] Sarah says that there are a couple of things they need to talk about and tells Martin that the case they just talked about is fine with her.

[From CM3 at the clinic]

As noted by Nordborg (2002), topic maps are particularly useful for operating at different levels of analysis: at the topic level, at the discursive level and at a more abstract level of analysis, which, together with its meaningful coding, makes the data more readily accessible and easy to work with. Thus, a preliminary analysis of the data was then carried out, which involved coding the data through the provision of brief descriptions of relevant recurrent themes, and identification of the interactional dynamics of the meetings and the discursive practices employed in displaying or negotiating a given aspect of nurses' professional identity (cf. Riessman's dialogic/performative approach to the study of identity in Block, 2010). This coding also often involved the use of keywords that stemmed from my comments, which greatly facilitated later exploration of the data. In this way, my preliminary analysis of the topic maps aimed to point out and describe sociolinguistic aspects of the interactional dynamics involved in professional identity construction. As illustrated in the following example, my comments are in italics and in brackets, and those topics identified for analysis are highlighted in bold.

[14.53] Nick reads name of patient 9. Nick asks if the patient was discharged today. Melissa and XF reply. Melissa thought that the patient had gone to a rest home. Nick passes on the nurses' report of this patient. Melissa gives her opinion of the patient and talks about her past experience with this patient. XF gives quite a long report of the patient's case, reporting on behalf of what seems to be another group of nurses. She thinks the patient will be discharged today, to which Nick replies "excellent". *[At the end of the discussion of each case Nick offers some kind of closing comment regarding either the patients or the staff. In this sense, he almost*

*always has the last word. By doing this he may be signalling the end of this patient's discussion, which provides evidence to support his role as the **leader** of the group, as a way of reclaiming a **powerful** role within the group. Professional identity]*

[From HM 4 at the hospital]

The final stages in the exploration of the topic maps involved short-listing relevant topics for analysis, transcribing illustrative extracts for each topic, identifying other possible instances to transcribe while also reducing the data to an appropriate number of working exchanges, grouping these by topics of analysis and making more detailed notes of the chosen analytical dimensions to be explored (see phases of data management in Huberman and Miles, 1998; also see Holliday, 2010).

One of the strengths of using topic maps when exploring naturally-occurring data is that the analytical dimensions emerge from the data itself instead of from predetermined categories of analysis (see Adler and Adler, 1998). As a ‘qualitative observer’ of the data the researcher is not “bound [...] by predetermined categories of measurement or response, but [is] free to search for concepts or categories that appear meaningful to subjects” in the course of interaction (Adler and Adler, 1998: 81). In this way, the researcher focuses on those aspects that are relevant to participants in their interactional reality rather than in the researcher’s mind (see Holliday, 2007). Thus, each time I revisited my topic maps, I focused on emergent themes and practices that answered my research questions.

In this study, data analysis and interpretation were part of a fluid process of data exploration as topic maps were revisited and refined at different stages of the data collection and analysis processes, starting when data was still being collected (see Hesse-Biber and Leavy, 2011). Exploring the data as the study is still in progress gives the researcher a chance to revisit the data, to gain greater familiarity with it (see Hesse-Biber and Leavy, 2011), to decide if they need to discard and/or collect more data and to closely reflect upon the extracts chosen for analysis.

3.5.2 Selection of extracts for analysis

To avoid the risk of focusing on phenomena that are not well supported in the data (see Cameron, 2001, 2009), I identified a significant number of examples of the discursive phenomena explored in this thesis as a way of warranting my interpretations of the findings (Street and Leung, 2010; also see ‘evidentiary warrant’ in Erickson, 1986). Thus, the extracts presented in this thesis are selected from a larger collection of instances of the same nature for each aspect of professional identity construction explored. They were selected for their capacity to illustrate common discursive practices and relevant socio-pragmatic features that were observed to characterise the interactional routines of the two workplaces of the participating nurses (see Lazzaro-Salazar, 2009). In addition, special attention was paid to the clarity of the extracts chosen in illustrating the different points of analysis. This choice was based on two criteria: 1) the examples represent typical sequential environments (see Kangasharju and Nikko, 2009) and 2) they occurred “within a coherent bounded speech event that can be comprehended as a stand-alone episode” (Holmes et al., 2011: 540). This resulted in two of the four types of meetings recorded (namely, the clinical and the roster meetings) being more widely represented in the analysis chapters. However, the choice of analysis topics was based on the linguistic evidence found to characterise the discursive practices of nurses in all four types of meetings recorded. Moreover, some extracts from both staff meetings and handover meetings have been used to illustrate the use of topic maps (see section 3.5.1 and appendix G) and specific analytical points in, particularly, chapter 6.

3.6 Triangulation and validity

A ‘thick description’ of the data (see Geertz in Starfield, 2010) comprises a rich description of the data as well as a rich discussion on the interpretation of the findings. In sociolinguistic research it is vital to establish the validity of the findings as this represents the degree of trustworthiness of the interpretation of the findings “for other colleagues to rely on them in their own research” (Starfield, 2010: 55). In order to strengthen the validity of the interpretations of the findings, the triangulation of these interpretations with other sources of data collection becomes of central importance to any scholar endeavour (Starfield, 2010). As an approach to integrate different perspectives to the data analysis, I employed two methods

for the triangulation of my interpretations of the findings. First, I cross-checked my interpretations against those of the participants who had supplied the data (see ‘member-checks’ in Burns, 2010 and respondent validation in Titscher et al., 2000). Following the participatory paradigms that characterise this study’s methodology, participants were encouraged to participate in as many stages of the research process as possible. To this end, adopting an appreciative enquiry approach to the analysis of the data (see Marra and Holmes, 2008; Holmes and Stubbe, 2003), I sent out two reports to each of the two workplaces that participated in this study, one in my second year of studies and another one after completing my thesis. The first of these is what Sarangi and Candlin (2003) refer to as ‘hot feedback’, which, in this case, fulfils two interrelated aims: 1) that of providing feedback on some of the findings of the study so that participants “do not wait too long to know what relevant findings can be put into practice” (Sarangi and Candlin, 2003: 277; see ethics section 3.3.3), and 2) that of using these reports as an opportunity to obtain feedback from the participants (see Starfield, 2010; cf. ‘collaborative ethnography’ in Starfield, 2010). In this regard, I made it clear to participants that contributions or feedback concerning the content of the reports were welcomed. This suggestion was for the most part taken up by the managers of both workplaces who emailed me to provide feedback after reading the reports. Moreover, managers were also consulted at different stages of the data collection and data analysis processes by conducting informal interviews and emailing them questions of relevance to the interpretation of the findings. Finally, having worked in the School of Nursing, Midwifery and Health at Victoria University of Wellington (see section 3.2.1), I also had the chance to be in regular contact with a group of practicing nurses and peer PhD students who provided me with reading material and who willingly cleared my doubts as I engaged in the analysis of the data.

Second, as an important source of triangulation of the data analysis and interpretation, I cross-checked my interpretations against those of other discourse analysts (see ‘peer comparison’ in Burns, 2010; also see Kayrooz and Trevitt, 2005; Johnstone, 2000). For that reason, the data presented in the following chapters was also made available in four sessions of the Research Network for Workplace and Organisational Discourse¹¹, which is a discourse

¹¹ <http://lists.vuw.ac.nz/mailman/listinfo/rnwod>

analysis discussion group, and presented in four PhD thesis groups and one School seminar at my School. After long discussions, intersubjective agreement was more often than not reached in terms of the interpretative views of the data (cf. Le Baron et al., 2003). Moreover, presentations at seminars and conferences also proved to be fruitful opportunities for obtaining feedback from other sociolinguists in general and discourse analysts in particular. Last but not least, all the data used for triangulation purposes was anonymised, observing ethical considerations as to the protection of the identity of the workplaces, wards and participants. All of these sources of feedback provided me with very valuable insights of the topics developed in the analysis chapters.

3.7 Summary

The methodology proposed in this chapter aims to advance our knowledge and understanding of how nurses' professional identities are negotiated in actual interaction, in an attempt to move away from the traditional approaches of self-reporting and perceptions studies that frequently inform the field. Focusing on the interpretation of authentic linguistic data, an effort has been made to show the ways in which IS, SC, SIT and CofP underpin this study by establishing their theoretical relevance and complementariness to the study of nurses' professional identity formation. While using IS as a methodological approach enabled me to design a methodology that is in line with the goals of this study and my theoretical stance on professional identity construction, analysing the construction of nurses' professional identity through the lens of SC, SIT and the CofP framework allows me to explore professional identity as it emerges within the boundaries of local interaction and practices.

Very importantly, following a participatory approach to the design of the study and the interpretation of the data, instances of participants' and relevant others' consultation provided me with a deeper understanding of the social practices of these two communities of nurses, which hugely enriched, and triangulated, the analysis and interpretations of the findings discussed in the next three chapters.

As a salient aspect of nurses' professional identity construction, the next chapter explores how multiple group memberships are a salient discursive tool when voicing and responding to complaints.

Chapter 4

As Nurses Complain: In-groups and Out-groups in Nurses' Professional Identity Construction

4.1 Introduction

As discussed in chapter 2, social identifications, or group memberships, influence and reflect salient aspects of the interactional negotiation of professional identity. The context of workplace socialization, understood here as an interactional process through which a social actor claims membership of a group, provides a rich environment for this kind of negotiation as social actors engage in workplace activities (see Ashforth and Mael, 1989).

The formation of in-groups and out-groups is an integral part of the interactional process involved in professional identity construction. As workers engage in workplace activities, for instance, by interacting with other co-workers in tea rooms and meetings (see section 2.2.2.1 chapter 2), they order their social environment into groups of people with whom they identify (in-groups) and those with whom they do not identify (out-groups) (Tajfel, 1974). This allows social actors to create and give sense to their social structure as they form meaningful alliances that construct their professional self. Turner (1975: 7) explores the relationship between identity and group membership construction when explaining that “an individual defines himself as well as others in terms of his location within a system of social categories – specifically social group memberships - and social identity may be understood as his definition of his own position within such a system.” Hence, the relevant social groups with which nurses identify contribute to the construction of nurses' professional identity as these group preferences reflect their values, beliefs and attitudes (see Beijaard et al., 2000; Apker and Eggly, 2004; Gergen and Davis, 1985).

Taking an appreciative inquiry approach to the study of nurses' interaction (see chapters 1 and 3), this chapter addresses the first research question posed in chapter 2 by

examining the discursive construction of in-groups and out-groups as one way that nurses build their professional identity according to the interactional norms of their community. To do so, this chapter explores the data recorded at the hospital. There is considerable evidence in this data (see section 3.5.2 of chapter 3) for how professional identity is enacted through group membership. The extracts explored in this chapter were chosen for displaying work-specific memberships and for their ability to illustrate several points of the relationship between membership formation and professional identity construction observed throughout the data. As the analysis of this chapter shows, nurses actively construct multiple group memberships that help them to cope with the interactional demands of voicing complaints. The chapter explores those discursive strategies that are employed to this end, particularly focusing on the dynamic use of pronouns, which serves to illustrate the shifting and fluid nature of professional identity construction in addressing interrelated interactional purposes.

4.2 Drawing the boundaries: who we are and who we are not

4.2.1 Building the in-group

Social actors claim and maintain membership of certain social groups when they identify with those groups. As part of the socialization processes in-group members build aspects of the group's professional identity and thus their professional self as part of that group (Hogg and Terry, 2000). They build, for instance, mutually held expectations of their roles within the group. They also build attitudes and perceptions of what members should be like, and what group members can or cannot do as part of that group. Thus, in-group members are expected to share their way of behaving and of speaking, their "intentions, attitudes and system of beliefs" (Tajfel, 1974: 69). In this process, discourse plays an important part in enacting in-group memberships, as extract 1 illustrates.

When Martha¹², a nurse at the hospital, asks how many nurses work on the same shift, Nick, the charge nurse manager (CNM), replies that the target is to have seven nurses. However, he acknowledges that sometimes there is a nurse shortage as some take leave and

¹² See participants' information in Appendix F.

replacements cannot be found easily. He also explains that the ward has budget constraints and hiring more nurses at the moment is not possible. He explains that if some of them apply to go to a training course the following year, then they could hire new people. Nick finishes his turn by saying the following:

Extract 4.1 (RM2): Building our RN numbers

1. Nick: and maybe build our rn¹³ numbers up in that way
2. but in the meantime
3. we've got um
4. we've got what we've got

Nick addresses the problem raised by Martha by building himself and possibly the nurses he is talking to as part of the same team ('our rn numbers' line 1, 'we've got what we've got' lines 3 and 4). This acknowledges the fact that issues with the staff numbers equally affect the nurses and the managers; at this point in the interaction, we can interpret them as belonging to the same in-group.

4.2.2 Intergroup comparison: building the in-group / out-group relationship

This process of in-group identification becomes relevant when its members engage in an intergroup comparative process in which they measure their own social positioning in relation to those of others. In this sense, Tajfel, in his seminal work, explains that "a group becomes a group in the sense of being perceived as having common characteristics or a common fate only because other groups are present in the environment" (1974: 72). As an inherent part of the definitional process of in-groups, members evaluate, reconceptualise and reformulate their actions, values and beliefs in regards to those of other groups in their relevant social networks (see Tajfel, 1974; Turner, 1975; Abram and Hogg, 2001). In the case of extract one above, the in-group constructed by Nick is only relevant in relation to its out-

¹³ RN refers to registered nurses.

group in the organizational context in which they work, as ‘our’ and ‘we’ distinguish them from other teams in the ward and in the hospital.

Furthermore, as previously discussed, individuals claim group membership when they identify with a group’s way of behaving, beliefs, attitudes and values. These characteristics of in-groups are not static but re-considered and re-evaluated as the members engage in meaningful interactions with relevant others (both in-group and out-group members). The group’s self-evaluation is believed to have a direct impact on the positive construction of social actors’ identity. According to social psychologists like Tajfel, positively valued distinctiveness that builds a positive (satisfactory) social identity can only be achieved “in the establishment of appropriate kinds of intergroup comparison” (1974: 84). In order to have a positive impact on members’ social identity, these aspects of in-group need to be ‘consensually valued’ if they are to reflect a given image of its members in relevant social contexts (see Tajfel, 1974). Logically, social actors claim membership to not only those groups with whom they share the same set of values and beliefs but also those groups that enable them to construct a positive self-image of a targeted type of social identity (Tajfel, 1974).

Pragmatically speaking, group membership is “a process ongoingly produced and oriented to by the parties and not necessarily an explicit naming or describing of oneself, or the other” (Psathas, 1999: 156). The provision of membership relevant information and appropriate membership orientation (as illustrated in extract 4.2 below) requires “no explicit naming of *who I am* [...] done by either party. Rather, *who I am* is accomplished in the *doing of the action*” (emphasis in original, Psathas, 1999: 148). Thus, the comparative definitional process explored above is an interactional achievement in which the intergroup social positioning is achieved through the discursive performance of acts and display of stances (see Ochs, 1993; Bucholtz and Hall 2005; Turner, 1975; see section 2.2.2.2 of chapter 2). One of the questions that arises from these considerations is: if no explicit naming of the group memberships invoked in the interaction is necessary, what are the linguistic resources the nurses in this study employ to make salient aspects of their memberships that are relevant to a given interactional context? In this regard, in addition to other more subtle discursive strategies used to position themselves as in-group members and others as out-group members,

nurses attending roster meetings at the hospital use personal pronouns in dynamic ways to build team and individual professional identity.

4.2.3 Personal pronouns in group membership

Scholars from various disciplines have explored the relationship between the use of personal pronouns and the construction of social identity. Personal pronouns are frequently referred to as deictics because they are “linguistic forms which are dependent on context for their (referential) meaning” (Fasulo and Zuccheromaglio, 2002: 1121). Thus, in the sentence ‘*maybe build our rn numbers up in that way*’ (in line 1, extract 1), the meaning of the pronoun ‘our’ depends on the contextual features of the interaction such as who utters the sentence, to and of whom, when and where. As Nick belongs to different professional communities, ‘our’ could be the referent for the hospital as a whole, his ward in particular, his team of nurses, the team of hospital managers, etc. It is only through the contextual information of the local interaction that we are able to identify ‘our’ as referring to Nick and his team of nurses. Most research on the pragmatic meaning of pronouns has focused on how social positionings are marked and reinforced by the use of pronouns. Enyedy and Goldberg (2004), for instance, have investigated the use of exclusive (*I, you, she, he, they*) and inclusive (*we*) pronouns in classroom activities. They explain that the use of pronouns is part of this community’s participatory framework and that they are an interactional resource that is dynamically employed to enact fluid group memberships. This allows the teacher to build herself as part of the classroom community when assessing classwork and as an out-group member when giving instructions (also see He, 2004). Similarly, Fasulo and Zuccheromaglio (2002) investigate the markedness and indexical meanings of the pronoun ‘I’ in Italian workplace meetings. They focus on how the indexical meaning of the pronouns is interactionally achieved and “how marked pronouns can foreground selected identities in the cluster of selves that members of a work group can present to each other” at a given point in the interaction (Fasulo and Zuccheromaglio, 2002: 1119).

The following extract illustrates some of the discursive functions of pronouns related to group membership construction.

Extract 4.2 (RM2): Our target

1. Nick: our target is always to have seven nurses on
2. in +
3. Marta: yeah
4. Nick: that's what we always try to
5. that's what we try to roster to
6. Marta: mmm
7. Nick: and that's what we request too

This extract is a continuation of the conversation undertaken in extract one above. On the matter of being understaffed, Nick explains that 'our target is always to have seven nurses on' (line 1). Nick then goes on to explain that they always try to plan the roster so that seven nurses work on the same shift (lines 4-5). He later clarifies this comment by stating that that is what they request in each shift (line 7).

Nick's identity stance in this exchange is not as straightforward as might be expected. Broadly speaking, the use of the pronoun 'we' is expected to include the speaker and their interlocutors as part of the same in-group (see Enyedy and Goldberg, 2004). However, the explicit naming of the 'nurses' in that same line suggests that 'our' and the 'nurses' do not belong to the same group. In addition, designing the roster is a task that is only assigned to the manager(s) of the ward. Thus, the pronoun 'we' in statements such as 'that's what we try to roster to' (line 5) and 'that's what we request too' (line 7) does not include the nurses as referents in the action of 'requesting' the roster. On the contrary, the very nature of the actions evoked by Nick assigns the pronoun 'we' a different indexical value in which the nurses are excluded, rather than included, from Nick's in-group. 'We', then, is most surely the referent for Nick and Eve, nurse manager and charge nurse manager respectively, who are in charge of the administrative tasks of the ward.

In providing a justification for staff shortages, Nick's professional identity orientation is directed towards displaying a salient aspect of the power¹⁴ differentials that characterise his relationship with the nurses. In this way, Nick's discourse orients to his role as the manager of the ward, placing himself in a more powerful and, thus, privileged position to the nurses who become, by implication, his out-group, his subordinates. Moreover, Nick's in-group and out-group claims seem to be accepted by Marta, one of the nurses present at this meeting, as she provides positive backchannelling comments ('mmm' and 'yeah' in lines 3 and 6).

This extract provides a first glance into the complexity of the use of pronouns and their relevance in the construction of professional identity. In order to explore this linguistic evidence in more detail, an analysis of exchanges characterised by an active construction and negotiation of group memberships and the salient use of pronouns to enact those memberships shows that, often, these are embedded in the interactional context of complaints. This is addressed in the analysis provided in the following section.

4.3 Group membership: The case of complaints

The decision to focus on complaints as a discursive context of group membership construction was made on the basis of a detailed analysis of the hospital data which showed that, as nurses use these meetings as feedback sessions, they frequently engaged in complaining behaviour. This revealed that being a nurse in part involves knowing how to make a complaint appropriately in order to manage workplace discourse. Nurses construct multiple group memberships, which involve a dynamic use of the pronouns, as they complain about issues related to the roster while observing 'politic' behaviour (Locher and Watts, 2005) that favours a positive enactment of their professional identities by establishing or maintaining "a state of equilibrium the personal relationships between individuals of a social group" (Watts, 1992: 50).

¹⁴ Power is conceptualised as dynamic and multidimensional, constructed, enacted, and reconstructed as an interaction unfolds (Thornborrow 2002); see also Holmes, 2000 for considerations of explicit and implicit forms of power in institutional contexts and Holmes 2005a for a social constructionist reading of power in a leadership context).

In general terms, a complaint can be defined as “the expression of dissatisfaction [and/or disappointment] to an interlocutor about oneself or someone/something” (Boxer, 1995: 219; Cupach and Carson, 2002). Two kinds of complaints are commonly distinguished: direct complaints and ‘whinging’ (or indirect complaints). The former refers to instances where the voicing of the complaint has the purpose of changing the undesirable state of affairs and to that end the complainer addresses the complainees directly (see retrospective and prospective complaints in Padilla Cruz, 2010). The latter refers to instances in which the complainer does not hold the hearer responsible for the complaint and the complaint does not have the purpose of bringing about any change to the current situation (see Daly et al., 2004; see ‘the subjective side of complaints’ in Edwards, 2005; Boxer, 1993). These two kinds of complaints have different socio-pragmatic functions as they index different orientations of the self and other (see Padilla Cruz, 2010). While whinges are believed to be oriented to the affective goals of an interaction through the building of rapport and solidarity, direct complaints orient towards the transactional goals of the interaction as speakers bring forward a problem and request for action to be taken accordingly (see Holmes and Riddiford, 2010). For practical purposes, the instances explored in this study correspond to direct complaints.

Studies on workplace discourse concerned with the role and enactment of complaints have widely framed them within the categorization provided by Politeness Theory as a face-threatening speech act (Brown and Levinson, 1987; also see Leech, 1983; Daly et al., 2004; and Boxer, 1993). In this light, complaints can be regarded as socially negatively evaluated speech acts because they may damage interactants’ face, threatening their self-image (see the postulation of the concept of ‘face’ in Goffman, 1967). Complaints then have the potential to threaten the complainer’s positive face, i.e. the need to be approved of, as the complainer voices disapproval of the complainees’ actions, possibly causing the former to lose face with the latter. Moreover, complaints can threaten the negative face of the complainees, namely, their need to be unimpeded and autonomous, as the complainer requests the addressee to undertake some kind of action that will change the current state of affairs. Though the complaint situates the recipient in a discredited position and the complainer in a negatively evaluated one, the interlocutors can, however, positively manage their social relations (see ‘rapport management’ in Spencer-Oatey, 2000) by discursively managing the act of

complaining so that they mitigate the effect of the complaint and avoid relational devaluation (Cupach and Carson, 2002).

A review of workplace literature shows that discourse analysts have predominantly examined the role of complaints through this pragmatic lens. Scholars have, for example, addressed issues regarding the socio-pragmatic competence of immigrant workers in voicing complaints (Newton, 2007; Holmes and Riddiford, 2009, 2010), focusing, for instance, on the employment of linguistic politeness strategies that meet the face needs of their addressees (Daly et al., 2004). Others have investigated the reactions of the recipients of complaints (Nguyen, 2011), the interactional style of customers' complaining behaviour (Lerman, 2006), and the negotiation of the complaint narrative between supervisor-student (Vásquez, 2009). Finally, the socio-cultural norms rooted in the enactment of complaints have also been explored in a variety of culturally different contexts (see Holmes and Riddiford, 2010 for a list of these). However, to my knowledge, the pragmatic role of personal pronouns in voicing complaints has, to date, scarcely been explored (see Meinel, 2010).

In this study, complaints are used to constitute the interactional context which serves to trigger and negotiate participants' multiple memberships. The formation of in-groups and out-groups is situational, or context-dependent, and meaningful only 'at a particular point in time' (Turner, 1975). Thus, group memberships need to be contextually relevant or appropriate and are evoked in interaction according to the changing interactional goals that call for their use. This allows interactants to make informed choices that appropriately display a positive social identity. The multi-layered complexities of the orientations of the self and others involved in the act of complaining makes it a rich interactional context for the exploration of the discursive negotiation of group memberships. As the analysis below will demonstrate, this group of nurses saliently negotiates their group memberships at various points in instances of direct complaints, particularly when complaining on behalf of an absent person or group of people.

4.3.1 Nurses voicing their complaints

There are instances in which the speaker argues they voice a complaint on behalf of a third party who is presumably not present at the meeting. These complaints are regarded as direct since, in spite of being on behalf of a third party, the recipient of the complaint is present when the complaint is voiced and a change of the course of action is expected to occur (see Boxer, 1993). To give an example, the following conversation takes place between Susan, the nurse delegate, and Nick, the CNM, who is chairing this roster meeting (RM). As participants share their concerns with issues they have had regarding the drafting of the roster, Susan explains that some nurses have complained about the number of night shifts they have to do in a row. Nick responds that the management team is working to improve the situation and that there are no nurses rostered five nights in a row in the following month. He also encourages Susan to look at the roster closely as ‘a fresh set of eyes can pick things up’. Susan replies to this with an explanation or additional information for her initial complaint.

Extract 4.3 (RM2): Those girls

1. Susan: /yeah i told that's what\\ i told um
2. those the girls
3. if five nights or six m- mornings comes up
4. just relook at the roster and
5. you know ⁰⁰//and\\ come and
6. see you can explain to them //how that works\\⁰⁰
7. Nick: /yeah\\ /that's right so an-\\
8. and if they ARE saying to you
9. just explain again
10. if you've got four nights
11. and three days off afterwards
12. that's seven days

Susan begins the explanation of her initial complaint by positioning herself as an outsider to this group of ‘girls’ (line 2) whose complaints she voices in the meeting. Susan

discursively achieves this by positioning herself as the advisor and the 'girls' as the advisees. As Susan explains what she suggested 'the girls' should do if they happen to have five nights or six mornings in a row assigned in their roster (lines 1-6), she orients to her role as the nurse delegate rather than to her role as a fellow nurse within the team. This role places her in the powerful position of being the link between management and the nursing staff. As a nurse delegate, Susan is expected to represent the other nurses (in practice, her other nurse colleagues) in meetings with the managers and the union delegates and to voice issues and concerns both ways.

It is interesting, however, to note Susan's lexical choice in constructing the out-group. On the one hand, the phrase 'the girls' (in line 2) is here used to construct Susan as a non-member of that group of nurses. Susan later reinforces her stance as an outsider through the use of 'them' (line 6) to refer back to 'the girls', with no explicit reference of herself being part of 'the girls' group at any point later in the conversation. On the other hand, 'the girls' also seems to be an emotionally loaded term in a positive way as in this data set it is commonly employed to index a certain familiarity with the group of women joined under that phrase (see considerations of 'collectivism' in Kashima et al., 1995 and of 'relational turns' in Koester, 2004). Thus, although in the context of this conversation this phrase is used to display disaffiliative behaviour as Susan voices the complaint on their behalf, she may be also indexing a certain closeness with the group by making this apparent familiarity relevant through her discursive choice of the phrase 'the girls'. This could suggest that Susan may not regard 'the girls' as an out-group at all times; rather she may sometimes consider herself a member of this group but given the potentially face-threatening context of the current interaction she may find it more useful to distance herself from that group momentarily. Thus, within the team with which she works, Susan can choose to orient to at least two different group memberships: her membership as a leader of the team enacted in her role as a nurse delegate, and her membership as an equal co-worker when it comes to daily issues of professional practice when working 'on the floor'. A possible explanation for why she orients to her role as a delegate could be linked to the discussion of the role of context in chapter 2 in that the very context of a meeting with the manager prompts Susan to orient to her role as a delegate. In fact, this is probably in line with the general expectation of her role obligations in those meetings. In other words, in the context of roster meetings Susan is socially expected to

fulfil her duty as a delegate, which favours this aspect of her identity over her in-group membership as a nurse colleague. The context, then, dictates interactional (both transactional and affective) goals, which prompts nurses to orient to one group membership over others. A nurse's professional identity is an amalgam of memberships to which she resorts according to the context of the interaction.

Furthermore, identity is not a one-sided interactional process. As Susan builds her professional identity, she is also ascribing the professional identity of her recipient (see Beijgaard et al., 2004). Susan constructs Nick as being higher in the hierarchy scale than her. She achieves this by positioning Nick as more knowledgeable of the matters around the roster than her. In lines 5 and 6 Susan explains how she suggested the nurses to see Nick if they had any queries regarding the roster ('⁰⁰//and\ come and see you'). By assigning Nick this sort of responsibility, which includes answering queries, dealing with complaints and solving possible problems, Susan reaffirms Nick's role as a superior in the team. This is followed by 'you can explain to them //how that works\⁰⁰' (line 6), which, by disclaiming such responsibility in answering to those matters, also places Nick in the position of knowing the roster system better than anyone else, or at least better than Susan. As she raises her voice when Nick overlaps, Susan's discourse makes this aspect of Nick's identity relevant to the development of this interaction. Thus, Susan seems to find it necessary to acknowledge the fact that while she may be a leader within the team of nurses with whom she works, she is also a subordinate when she is in the presence of Nick, the manager of the ward. Susan's discourse then acknowledges the professional status assigned to both Nick and herself by the power roles they enact within the context of this meeting.

Moreover, part of constructing one's professional identity also involves how relevant others react to our display of stances, that is to say, how they accept or reject our positioning in interaction. In the case of this extract, Nick first uses overlapping speech to display his agreement with Susan as she explains she suggested the other nurses should talk with him about their roster concerns ('/yeah\\ /that's right so an-\\' see lines 5-7). In this way he accepts the identity assigned to him as a superior within this team and as a knowledgeable person when it comes to dealing with issues about the roster. Nick also accepts Susan's self-positioning as a non-member of 'the girls' group in line 8 when he uses the pronoun 'they' to

make reference to ‘the girls’ and later addresses Susan by the pronoun ‘you’ which further supports his construction of Susan’s identity as different from that of ‘the girls’ (‘and if they ARE saying to you’). Also, Nick aligns with Susan’s identity claim as a leader within the team of nurses when he acknowledges the other nurses approach her for consultation (line 8) and when he tells her what to explain to ‘the girls’ (‘just explain again’ in line 9) in case they ask her about this again.

But not all such instances of identity construction align with the hierarchical status of the participants. In other cases, identity claims need to be actively negotiated so that interlocutors accept the speaker’s stance.

Extract 4.4 (RM2): A couple of staff were saying

1. Susan: yeah a couple of staff were saying that
2. they still find five nights pretty um
3. pretty tiring
4. Nick: sure five //nights IS tiring\
5. Susan: /at times\\
6. Susan: yeah
7. and also um
8. the am after the nights
9. Nick: yeap
10. Susan: they still find that it
11. it is still going and it is=
12. Nick: =and you’d rather come back on a pm after the //nights\ than the ams
13. Susan: /yes\\ yes that’s um yeah
14. what they were waiting
15. Nick: ok that’s fine I mean uh
16. this rostering reference guidelines that I read or something
17. said that it was better to come back on a a or what not but
 {second ‘a’ stands for ‘AM’}
18. if the majority of people round here don’t agree with it

19. that's fine

It takes Susan a number of turns to negotiate her group membership with Nick who initially rejects her construction of the other nurses as a different group to her. At the beginning of this extract Susan voices some complaints from the 'staff' regarding the number of nights they work in a row and the fact that sometimes nurses are assigned a morning shift after doing a night shift. These complaints are brought up in every roster meeting as they have serious consequences in the eyes of the nurses for several reasons. In the first case, nurses should only do four nights and five mornings in a row but sometimes the managers roster for more nights than nurses should do. During one of these meetings, the managers clarify this point explaining that sometimes some nurses go on leave or request short changes, that is to say, they request a change of shift with very short notice (possibly on the same day). This leaves the ward understaffed and the managers need to fill in the places of the nurses on leave. This, Nick and Eve (NMs) explain, results in having some nurses doing a higher number of night or morning shifts than they should. In this regard, nurses explain that this causes them personal complications as they have family commitments to fulfil, and also that this results in them feeling very tired, especially when they need to do many nights in a row. In the second case, being assigned a morning shift the day after doing a night shift means, in Anne's words, that 'I ended up one night not sleeping' (in roster meeting 2). Logically, the fact that a nurse is not able to sleep the night before a morning shift can entail dangerous consequences for their professional practices with the patients in the morning shift. For these reasons, the issues at hand may potentially place the speaker in a highly face-threatening situation as they confront the managers about this problem.

This seems to prompt Susan to once again orient to her identity as a delegate rather than as a nurse who is part of a team of nurses who are complaining. As she lodges the complaint, she attributes it to the 'staff' (line 1), this time choosing a more distancing lexical item than in the previous extract (see 'the girls' above). This discursive choice may be based on two interrelated interactional functions this word could serve: 'a couple of staff' serves to create an out-group for the current speaker which is later reinforced by the pronoun 'they' (lines 2, 10), while it could also be used to make the group to whom the complaint is attributed anonymous. In both cases, the use of the phrase 'a couple of staff' may act as a

face-saving strategy. Firstly, by building an out-group Susan indexes no immediate affiliation with the group of nurses whose complaints she is voicing, which maintains her solidarity when speaking to Nick, the manager, mitigating the threat to face for Nick in this interaction. Secondly, by using a rather generic term such as ‘staff’ to refer to the team of nurses she represents, Susan is protecting the identity of those people who complained about the allocation of shifts. Though this shows that Susan is closer in hierarchy to Nick than to ‘the girls’, it also positions Susan as a collegial co-worker who realises the potential damage that a complaint could cause to her co-workers’ face, while, at the same time, allowing her to protect her own face needs.

Interestingly, though Nick agrees in essence with the complaint (see ‘sure five //nights IS tiring\’ in line 4), this time he rejects Susan’s positioning as a non-member of the group of ‘staff’ in line 12 as he says ‘and you’d rather come back on a pm after the //nights\ than the ams’. The pronoun ‘you’ in Nick’s turn as he first addresses the complaint rejects Susan’s identity claim and includes her as a member of her constructed out-group as he rephrases the petition implied in the complaint. In the next turn, however, Susan rejects Nick’s construction of her as a group member and restates her claim as an outsider to the ‘staff’ group (see ‘what they were waiting’ in line 14). In this way Susan discursively negotiates her group membership orientation with Nick. She succeeds in this endeavour as Nick finally accepts her identity claim in line 18 when he explains that ‘if the majority of people round here don’t agree with’ his (informed) suggestion to do a morning shift after a night shift. The referee in the phrase ‘the majority of people’ is ambiguous enough to reassert Susan’s positioning and exclude her as a member of the ‘staff’ group.

But nurses do not always resort to the same membership alignments to construct their professional identity. In some instances, Susan’s identity orientation, for example, shifts as she decides to claim membership to the group of ‘the girls,’ as the following extract illustrates.

Extract 4.5 (RM2): The ‘we’ in ‘the girls’

1. Susan: the one thing nick
2. are we allowed to do
3. only request night shifts for
4. a month
5. Nick: um
6. Susan: if we request for it
7. Nick: sure

Following the discussion of extract 4.4 above, Susan raises the question of whether the nurses of this ward can request to work only nights over the period of a month. As she does this, Susan includes herself as a member of ‘the girls’ group when she asks ‘are we allowed to do’ (line 2) and ‘if we request for it’ (line 6). She discursively achieves this through the use of the pronoun ‘we’, which positions her as an in-group member. Attention needs to be drawn, however, to the fact that in the context of this extract Susan is not voicing a complaint but requesting information (line 2). Nevertheless, the extract serves to illustrate how this change in orientation makes Susan’s previous group membership orientations even more salient and marked as she discursively moves within a continuum of in-group and out-group construction, which allows her to construct her professional identity in positive ways in the face of the different transactionally relevant goals of the interaction. This also supports the claim that the nurses in this meeting often display disaffiliative behaviour regarding the group they are usually members of as a face-management strategy that aims to protect their face wants and as a rapport management strategy that aims to maintain harmonious relations in the context of workplace meetings.

4.4 Responding to complaints

Complaints have often been investigated as an adjacency pair (Drew and Walker, 2009). Thus, it is expected that when a speaker voices a complaint (initial action), the recipient will respond to this complaint in one of a number of ways available to them (paired action) (see classification of responses in Boxer, 1995). Responding to complaints has

pragmatic significance the way the recipient addresses the complaint displays their acceptance or rejection of the speaker's membership claims and stance as well as the affiliative or disaffiliative stances/actions of the recipient towards the complainer.

In the context of the complaints discussed above, Eve, the nurse manager, has just gone through some of the details of the Christmas roster. She explained that because so many nurses would be on long stretches of annual leave during the Christmas period, some of the other nurses would be assigned more night shifts than usual. Anne asks whether they are all still entitled to get three days off after a night shift, which prompts Eve to provide the following answer.

Extract 4.6 (RM3): Split days

1. Eve: =most- in the last +
2. roster meeting we had
3. you know people were
4. concerned about the number of split days //they were having off\
5. which is you know you're only supposed to have one split day off

On the topic of the discontent about split shifts, the use of the pronoun 'we' in line 2 seems to be rather ambiguous as it is not clear whether Eve is constructing herself as a leader by claiming membership to the management team usually indexed with the pronoun 'we' or whether she is using the pronoun 'we' to refer to the people present at the last meeting. What is interesting in this exchange is how, as the conversation unfolds, Eve's reference to the team of nurses changes from 'people' and 'they' (lines 3 and 4 respectively) to 'you' (in line 5). The number of split days off nurses have after long stretches of leave is a concern that is often raised in these meetings. For obvious reasons, nurses oppose having several split days off in their monthly roster as it means that they will only have half a day free between two full shifts. For example, after working a full eight-hour night shift, a nurse may be free from 8 am until 12 pm and will very likely have to go back to work a full shift after that. As Eve addresses this concern, she assigns different group memberships to this team of nurses. The use of 'people' and 'they', as a referent of people, implicitly constructs the nurses present at

this meeting as an in-group while it explicitly constructs the nurses present at the previous meeting as an out-group ('they'). Interestingly, this is done regardless of the fact that there is actually an overlap in attendees at both meetings. While Eve airs some of the thorny issues raised in the previous meeting, she builds this out-group to exclude the present attendees from any reference to past complaints and problematic talk. The construction of an out-group in this context seems to be employed as another face-keeping or rapport-building strategy that serves to avoid conflict with those present in this meeting.

However, as soon as Eve starts exploring the reasons why these nurses are having several split days off in one month, she also reviews the rules and regulations which the team needs to observe regarding the number of split days off they need to have if they have requested three days off after a night shift. As she does this, Eve leaves the out-group ('people' and 'they') behind and builds a new one ('you' in line 5), to which she refers for the rest of her long turn in the recording of the meeting. It is not clear, though, whether the personal pronoun 'you' is used in its singular or its plural form. The relevance of its usage lies in how Eve conceptualises this in-group. If 'you' is used in the singular form, then Eve may be addressing the question Anne has asked by replying to her directly, where 'you' refers to Anne. If the pronoun 'you' is used in its plural form, Eve is constructing an in-group where 'you' encompasses the whole or part of the team of nurses, those present at the meeting and possibly also those who are not. The plural form of the pronoun corresponds to the most frequent usage of 'you' in the meetings recorded, which also matches participants' clear orientation to avoiding conflict in potentially face-threatening situations. Eve's shift in group membership orientation, from an affiliative 'we' to a disaffiliative 'they' and 'you', may suggest that she is also aware of the face-threatening situation involved in replying to the nurses' complaint, which could be aggravated by the fact that she has to uphold her decision of giving them split days off after long stretches of leave. The change in the orientation through the use of pronouns is subtle since it takes place as her turn unfolds and usually several utterances separate this shift. This change in the use of pronouns allows Eve to index and assign different group memberships possibly in an attempt to build solidarity and further construct positive work relations.

This kind of affiliative – disaffiliative stance that Eve takes in the face of nurses' complaints can be found in every response she gives.

Extract 4.7 (RM4): The group vs. the worker

1. Eve: those are the sort of things we need to
2. really get together as a group
3. and discuss
4. you know
5. what's the most important thing for a
6. full time worker to be having
7. three days off after
8. and having split shifts or not

When addressing the issue of split shifts, for instance, Eve expresses an affiliative stance as she encourages the nurses to reach a consensus regarding their shift allocation preferences by constructing herself as part of this group of nurses (see 'we need to really get together as a group' in lines 1 and 2). This team-building stance quickly changes as, in line 6, she explicitly asks the nurses to decide whether they prefer having three days off after a night shift, which then causes them to have split shifts. This could potentially be interpreted as a face-threatening act. In wielding the power invested in her as the manager of the team, this request could be regarded as an indirect directive (see Holmes et al., 1999). However, Eve manages the potential conflict this may cause by phrasing this request in an impersonal way, making reference to the group of nurses as 'a full-time worker' in line 6. In this way, she avoids personalising the request and works to skilfully observe the positive face needs of the requestee.

Extract 4.8 below provides another example of Eve's affiliative – disaffiliative group memberships. As some nurses complain about being understaffed when others request short changes, Mandy asks Eve whether short changes are indeed allowed. Eve replies the following:

EXTRACT 4.8 (RM3): Short changes

1. Eve: yeah yeah
2. I mean um actually
3. you kn- you know um
4. you're not
5. they are not really allowed at all

While Eve initiates her response with an affirmative ‘yeah yeah’ in line 1, she soon repairs this answer in an attempt to rephrase it as she tries to explain what the regulations in this regard are (see use of ‘actually’ in line 2 as the first indicator that what is done in practice is different to what they are supposed to do). The hesitation in line 3 seems to give Eve some time to think about the appropriate way to word her response, which may indicate that Eve is aware of the potential face-threatening value of her answer. As she attempts to provide the answer to Mandy’s question, Eve starts a new utterance with the pronoun ‘you’ in nominal position (line 4). As in the previous extract, ‘you’ here seems to be used in the plural form, referring to the group of nurses in general. Possibly realising the highly face-threatening potential of telling the nurses what they are or not allowed to do (see Holmes, 2000), Eve rephrases the start of the sentence by changing its subject from an accusative ‘you’ to ‘they’ (line 5), where ‘they’ seems to be the referent of ‘short changes.’ Even if both pronouns display Eve’s disaffiliative stance in regards to the issues of short changes (see disaffiliative response as ‘dispreferred’ in Drew and Walker, 2009), this repair move allows Eve to further mitigate the effect of a negative response to Mandy’s question. At the same time she avoids taking the accusative stance she briefly expressed in line 4.

Dealing with complaints is not an easy task for managers as they struggle to maintain good relations with their team while communicating their decisions on a number of matters. As Holmes et al. (2007: 435) explain “leadership can be productively viewed as a discursive performance in which an effective leader successfully integrates the achievement of transactional objectives with more relational aspects of workplace interaction.” Eve achieves this balance by constantly redefining herself and this group of nurses through the skilful use of personal pronouns. One final extract serves to illustrate this point further.

As a sort of preamble, the first lines of Eve's turn in extract 4.9 provide the context on which Eve's response to a complaint is based.

Extract 4.9 (RM3): Happy nurses

1. Eve: I realise you know
2. that doing roster rotating shifts isn't always
3. um easy on your life so
4. you know I'm happy
5. but I'm I'm happy to work with you to make it
6. you know to make it work for you
7. but if we run into problems like that
8. then I'll just have to say then we'll go strictly by the book
9. and not allow them
10. at the minute you know
11. we're lenient on it because
12. I realise that you have thing-
13. you know when the roster is put out a MONTH in advance
14. and you don't know what's coming up
15. and then suddenly there's something that you want to go to
16. on an a- on an evening and you know
17. then that's why I'm happy to do it
18. and I rather have +
19. you know happy nurses
20. and nurses that can have balance outside of their work
21. but if if we're going into problems with people leaving early
22. or asking for overtime because they (had to stay) or something like that
23. then we won't do it

In lines 1 to 6 Eve acknowledges the nature of the complaint (the difficulty of 'doing rotating shifts' in lines 2-3), and expresses her willingness to work with the nurses to solve this problem (lines 4-6). This unequivocally positions her as the manager of the group by

clearly distinguishing herself ('I' in lines 1, 4 and 5) from the team of nurses ('you' in lines 5 and 6). Though the 'I' – 'you' ingroup-outgroup construction could be said to index a disaffiliative stance on Eve's part, the general message underlying the first 6 lines seems to be a positive one as her willingness to solve the problem as a team prevails. In line 7, however, Eve adopts a much stronger position as she warns nurses that if they run into problems such as being understaffed due to short changes, she will not allow them any longer (lines 8-9).

At this point it is crucial to notice that Eve is concentrating her efforts on achieving two interrelated interactional goals, one transactional and one relational: putting an end to the problems posed by short changes (lines 7-10, 21-23) and promoting, in spite of the potentially tense situation, harmonious work relations (lines 1-6, 11-20). In the case of the former, Eve explicitly explains she does not want to have 'problems with people leaving early or asking for overtime' (lines 21-22). Displaying her understanding for the needs of the nurses, such as balancing work and private life, may serve two interactional purposes. First, it helps Eve to develop a logical explanation for her case, as she rationally argues that there are important institutional and personal reasons for them to support short changes. At the personal level, being able to go to an event on an evening (lines 15-16) is likely to make nurses happy. At the institutional level, this, in turn, is expected to promote job satisfaction and enhance positive work outcomes (see considerations in chapter 7). Second, Eve's understanding on this matter is crucial in fostering a harmonious workplace environment as she sides with the nurses when she displays her understanding of their situation in regards to short changes.

Eve blends these two aims by using multiple self and other group identifications to formulate her response to the nurses' complaint. The pronoun use in line 7 indicates that Eve's stance shifts from an exclusive 'I' (individual identity) in lines 1-6 to an inclusive 'we' which indexes the same group membership for both the nurses and Eve (collective identity). However, she again resorts to identity demarcation when the time comes to make and share managerial decisions. Thus in line 8 her use of pronouns again shifts to an 'I', which indexes individual leader identity, making the nurses the outgroup, as she makes it clear she is the one making the final decisions in this team ('then I'll just have to say'). Interestingly, the subject

of the embedded clause in that sentence is 'we', which could index the same collective group membership as in line 7 and which may indicate that this decision applies to all as a team. The fact, however, that 'we' in line 8 is also the subject of the next coordinated sentence in line 9 raises doubts in regards to whether this 'we' actually includes Eve and the nurses as one ingroup. In this light, unless Eve believes the nurses have the power to 'allow short changes' (line 9), 'we' can most likely be said to exclude the nurses and to refer to a new ingroup involving Eve and Nick (the other manager of the ward). The latter interpretation seems to be supported by Eve's use of 'we' in line 11 when she explains that 'we're lenient on short changes'. This 'we' more clearly aligns with a different group to that of line 7 and serves to represent the management team, Nick and Eve, (see co-leadership in Vine et al., 2008), since they are the only ones in this ward with the capacity to be 'lenient' on management issues.

The use of 'we' in line 22 is again ambiguous. The structure and propositional content of the sentence in line 21 seems to mirror that of line 7. Thus, from this point of view, it could be argued that 'we' refers to the ingroup involving Eve and the nurses. However, when 'we' is regarded in terms of its proximity to the noun 'people' in that same line, the boundaries of Eve's group membership become blurry again. 'People,' as a rather impersonal substitute for 'nurses,' could be said to observe nurses' sociality rights, that is to say, in this case, the social expectancy of showing consideration by not being explicitly mentioned in the context of a work problem (also see 'they' as a referent of 'people' in line 22; see Spencer-Oatey, 2000). This impersonalisation of the actor seems to minimize the illocutionary force of her decision in line 23 by mitigating the effects of the face-threatening act inherent in the communication of a decision that is likely to be problematic among nurses. Thus, in this context, 'we' in line 21, and also that of line 23, is more likely to stand as the referent of Nick and Eve.

As the extract shows, sometimes Eve addresses nurses' complaints by constructing her professional identity as a leader, which becomes evident in her use of 'I' in lines 1-6, 8, 12, 17-18 as she makes this aspect of her professional self more salient (cf. Vine et al., 2008). In most of these instances, Eve displays her professional self as a democratic leader who understands the nurses' situation and is willing to listen to the nurses' suggestions and to

debate with them what the best options are for everybody (see democratic leadership style in Holmes et al., 2007). This democratic approach at times involves partly including the nurses in the decision-making process, which is reflected in Eve's claim that she agrees to continue allowing short changes if that would mean having happy nurses on the ward and if that does not cause any problems to the other nurses. By aligning with the reasons behind the nurses' discontent and sharing their personal interests, Eve displays supportive behaviour that potentially builds and enhances solidarity between herself and the nurses (see lines 14 and 16; see the idea of 'standing behind' the workers in Fairhurst, 1993). In this process, Eve's construction of her identity as a leader also involves expressing some professional values when she defines ideal aspects of the collective self as a team (lines 19-20; see how emotions like 'being a happy worker' are included as a core aspect of collective identification in Ashforth et al., 2008). For instance, when addressing the nurses, 'you' in lines 13-15 becomes 'nurses' in lines 19-20 as Eve seems to evoke this prototypical values of nurses' collective identity (see construction of value-based identities for organizational purposes in Larson and Pepper, 2003).

At other times, Eve addresses the nurses' complaints by resorting to collective identities. As the analysis shows, 'we' is used in dynamic ways to index not one but two group memberships according to the interactional demands of the discussion, namely, as an ingroup for Eve and the nurses, and as ingroup for Eve and Nick. 'We,' as a way to index collective group membership involving Eve and the nurses (line 7, consider also ambiguous use of 'we' in line 21; see line 1 of extract 9), can serve as a source from which to derive a sense of team belonging (see Fletcher, 1999). Appealing to the sense that they are all together in 'the same boat' seems to, regardless of how intentionally this is done, evoke organizational values such as collaborating as a team for the achievement of common goals (cf. internalization of values in Ashforth and Mael, 1989; also see Apker et al., 2009). As Grice et al. (2006: 332) explain: "The more employees identify with a particular organizational group, the more likely it is that they will adopt supportive attitudes towards the group (Mael & Ashforth, 1992), act in the group's best interests (Dutton, Dukerich, & Harquail, 1994), and make decisions that are consistent with the group's objectives (Simon, 1947)" (also see Ashforth and Mael, 1989; Apker et al., 2009). Thus, considering the above-mentioned conversational goals, if Eve succeeds in promoting a sense of group belonging, she may also

succeed in getting the nurses to follow her suggestions regarding short changes for the benefit of all. Moreover, the choice of an inclusive 'we' can have significant effects upon the way in which a leader is perceived by their followers (Fiol et al. 1999; Holmes 2005; Lord and Brown 2004). In this regard, the fact that Eve constructs herself as part of the same team as the nurses plays a significant role in this possibly desired group identification as it is argued that the speaker is more favourably viewed and criticism more favourably perceived when expressed by an ingroup member (see Grice et al., 2006). The argument behind this is that ingroup members are believed, and expected, to safeguard the group's best interests (see Humphreys and Brown, 2002), which Eve very competently does in her nurse-oriented discourse in lines 1-3, 12-16, and 20.

The use of an inclusive 'we' then has significant relational implications as it seems to be instrumentally used to fulfil the interpersonal purpose of enhancing the sense of belonging of the nurses with the ultimate goal of shaping their behaviour in a positively valued way (see Larson and Pepper, 2003). In this light, it could be argued that 'we' is employed by Eve as a mitigating strategy; its team building capacity has the potential of smoothing out potential tensions. Thus, a shared group membership seems to mitigate the effects of Eve's evaluation of the situation (lines 7, 21-22) and the potentially negative impact of her decisions regarding the continuation of short changes (lines 8-9 and 23).

There is, in addition, a more frequent use of 'we' in Eve's discussion that illustrates how pronoun usage can be employed as a resource to display different levels of collective identity and, thus, how the same pronoun can take on different indexical values (see Brewer and Gardner, 1996). I argue that these instances of 'we' are excluding since they exclude the interlocutors (thus, the nurses) while the speaker indexes a group affiliation with members who are not present in that moment in the interaction. Such instances of the collective pronoun 'we' seem to index Eve's identification with the management group, involving Eve and Nick. For transactional purposes, Eve possibly employs 'we' in lines 8-9, 11 and 23 to legitimise her decisions by showing how they are also supported by a non-present other (Nick), which strengthens her argument and re-establishes her authority in the matter (see Larson and Pepper, 2003).

In this way, Eve includes herself in or excludes herself from the team of nurses that she leads, as she juxtaposes solidarity and support with authority in reacting to nurses' complaints. She achieves this through the dynamic shift in her use of pronouns. This gives Eve room to positively build her identity affiliations and that of the other nurses in flexible ways, helping her to manage competing targets while reinforcing preferred group memberships (see Larson and Pepper, 2003). Thus, Eve navigates the leader-member binary of group membership construction which allows her to retain the institutional power vested in her management role as she also works to maintain good relations with the nurses. Displaying multiple group memberships with the aim of achieving both transactional and relational goals seems to be a core aspect of Eve's repertoire of linguistic strategies in the construction of her professional identity.

4.5 Discussion

A fundamental consideration that stems from this analysis is the construction of multiple group memberships that seem to be guided by a number of transactional and interpersonal goals as nurses voice complaints and nurse managers respond to them. From a transactional point of view, interactants aim to solve problems concerning the allocation of night shifts and the request of short changes, for example. In this context, complaints are frequently voiced in the form of direct complaints which, as an inherently face-threatening act (see Lerman, 2006), have the potential to offend the recipient of the complaint, which in this case is always one of the two managers of the ward. This, as a result, may cause both the speaker and the interlocutor to lose face. In order to achieve their relational goal of maintaining harmony, more often than not, nurses, for instance, claim to voice the concerns of 'others' by not including themselves as active members in the act of complaining and by explicitly assigning the out-group the role of the actor in the action of complaining. Moreover, as managers respond to these complaints, they also run the risk of engaging in face-threatening behaviour when they communicate their decisions to the team. It becomes important then, for the sake of interactional and relational harmony, that nurses and managers deal with complaints in such a way that they avoid offending the interlocutor while, at the same time, they are able to lodge a complaint or respond to it without risking losing face or

damaging social relations, as they construct their professional identity in positive ways (see strategic politeness in Kasper, 1990).

One way that this construction of ingroups and outgroups is discursively achieved is through the use of personal pronouns, which seem to play a crucial role as an indexical resource strategically employed in the discursive construction of self and others' professional identity. The majority of the instances of ingroup and outgroup construction recorded in this study show how functional group memberships are built through a similar use of pronouns in characteristically similar interactional contexts and for seemingly the same purposes. This suggests that these interactional practices, together with the norms that govern them, are shared by all interactants. Indeed, the extracts chosen in this chapter are illustrative of what was found to occur throughout the data, which suggests that the discursive features explored are deeply ingrained practices of this community. In addition, the fact that nurses and nurse managers very often use pronouns without immediate referents and that interlocutors are able to mirror pronoun usage and contribute in relevant and appropriate ways to the conversation without asking for the clarification of these referents further legitimises the claim that this is a well-established practice in this community (see extract 5, for instance). In this regard, Carlin (2003: 1) contends that "membership categories are known and shared" within a community and that "[they] are features of the use of natural language, constituent features of ordinary language practices". In this light, then, it is logical to assume that these 'ordinary' discursive practices constitute what Locher and Watts (2005) define as 'politic', that is to say, a kind of social behaviour that is unmarked and appropriate for a given situation. The norms of politic behaviour in this case involve knowing how to appropriately construct and reconstruct group memberships to display both affiliative and disaffiliative stances as participants voice and respond to complaints. As an integral aspect of this, the distinctive use of pronouns seems to be part of this community's shared repertoire of linguistic strategies, which serve to enact appropriate social behaviour that counterbalances the effects of a complaint in order to avoid conflict and to observe the face needs of all involved (see Coakes and Clarke, 2006). This use of pronouns is part of the socio-interactional structure that nurses and nurse managers need to competently manage in order to relevantly and appropriately voice and respond to complaints as legitimate members of this community (see Kasper, 1990; and Bucholtz and Hall, 2005).

Thus, by using ‘we’, ‘they’, ‘I’ and ‘you’ at different times and observing norms of politic behaviour that characterise this community, nurses and nurse managers display their social stance through their affiliations and disaffiliations with certain professional groups as they see fit according to the interactional context of the conversation. In some cases, they voice their complaints through the marked use of ‘I’ in, for instance, ‘that’s what I told those girls’ (lines 1 and 2 extract 5) and of ‘they’ (in subject position or ‘them’ in object position, see extracts 6), which clearly positions the complainers as an outgroup and unequivocally indexes Susan’s disaffiliative stance in regards to the complaints (see Fasulo and Zucchermaglio, 2002). In this way, Susan locally constructs an out-group that seems to be bigger than her functional in-group in which she is possibly the only member, dashing away the belief that out-groups constitute the minority group (Simon and Mummendey, 2012). This illustrates how individuals may isolate themselves from the main group and create their own in-group to meet their interactional needs.

In practice, however, it is common knowledge that roster issues affect all of them, including Susan, in possibly the same ways. In this light, Susan’s disaffiliative stance may not be interpreted by the other participants as her lack of association with the issues posed through the complaints. In this regard, then, the interactional value of Susan’s disaffiliation lies in the relational work this does for her professional identity and that of others. Though the use of pronouns in extract 4.4 frequently shows a kind of disaffiliative behaviour that is likely to be socially negatively regarded, I would like to offer a more relationally-sensitive kind of interpretation by saying that this disaffiliative behaviour works at different levels of identity construction (see “layered simultaneity” in Blommaert, 2005), all of which can potentially be positive for this team of nurses. Susan’s disaffiliative behaviour allows her to do self-oriented, colleague-oriented and recipient-orientated positive identity work that reflects some of the professional values she holds. In terms of her social positioning, it enables Susan to display a positive image of her professional self as a person who distances herself from actions that can give rise to workplace conflict and who favours harmonious work relationships. In addition, the use of outgroup-oriented pronouns, and some general nouns such as ‘staff’ and ‘those girls’, also bears positive implications for the outgroup as they ‘defocalize’ the reference to the complainers (see Trosborg, 1995). In this way, the identities of those nurses who complain are protected in the anonymity of pronoun usage,

potentially enhancing in-group solidarity. Finally, this may build rapport between the complainer and the recipient of the complaint as this vague way of referencing the complainer makes the complaint more ambiguous and it reduces its potential for recipient face damage (see Trosborg, 1995).

Thus, the choice of certain group memberships discursively expressed through the use of pronouns reflects that the strategic decisions this group of nurses employ are based on their desire to avoid conflict and to positively construct their professional identity by protecting the self-image of all participants involved. Thus, even if roster decisions may affect all of the nurses, they seem to find it relationally valuable to voice complaints on behalf of an out-group (cf. third party action in Lerman, 2006) in order to downtone or mitigate the possible negative effects of the complaints (cf. Goffman's concept of 'footing' in Edwards, 2005; also see Nguyen, 2011). Thus, the nurses in this study have devised a strategy to voice what is usually defined as a direct complaint (see section 4.3; Boxer, 1993) with a significant level of indirectness (e.g. Vásquez, 2009), which allows them to comply with what seem to be appropriate norms of social behaviour (Kasper, 1990) as they avoid direct confrontations with the team's managers and other colleagues (Drew and Walker, 2009).

However, as extract 4.5 shows, the construction of these outgroups is temporary as nurses also claim ingroup membership to the bigger group of nurses (previously constructed as the outgroup) in the context of complaints when they ask questions about, for example, what they are allowed to do in regards to requesting shifts (for the managers see extract 11). This serves to raise the point that a multiplicity of organizational memberships is always available to these nurses and nurse managers, which provide such interactional flexibility that "an employee can be an ingroup member on one dimension and outgroup member on another" (Grice et al., 2006: 334). In line with social constructionist views of identity (Widdicombe, 1998: 191; see also Antaki and Widdicombe, 1998), the analysis shows how multiple in-groups and out-groups are constructed as a tool or resource to display nurses' professional identity and that of others in positive ways. In this light, retaining the idea that "we are a bundle of identities which are brought into play through social action" (Giddens, 1991, in Allsop and Mulcahy, 1998: 809), it is logical to assume that the interactional context of complaints may require nurses to claim more than one group membership to meet the

interactional demands of the conversation. As discussed in chapter 2, Tajfel (1974: 69) explains that interactants have ‘social mobility’, that is to say, “if a group does not contribute adequately to an individual’s social identity, [they will move] to another group” (1974: 78) that better satisfies their interactional needs. By engaging in this type of affiliative/disaffiliative activity, nurses ensure that they claim membership of those groups that will satisfactorily display a positive professional identity of themselves at a certain point in the interaction (see ‘procedural consequentiality’ in Psathas, 1999). As exemplified in this chapter, nurses, and their nurse managers, in this data set frequently ‘recycle’ their memberships within the same interaction as they re-evaluate their stances in the face of the changing interactional goals of a conversation (see Abrams and Hogg, 2001) and display the memberships that are congruent with those stances.

4.6 Summary

This chapter has shown how dynamic group memberships, as a significant interactional accomplishment, reproduce the social structure that allows nurses to ‘indirectly’ voice direct complaints and nurse managers to respond to them in appropriate ways. In spite of their face-threatening potential, framing complaints through the enactment of appropriate group memberships minimizes their possible face-damage effects. In this regard, personal pronouns have been found to meaningfully highlight institutional roles (cf. Enyedy and Goldberg, 2004), while, at other times, they have taken on different indexical values to display different workplace relationships. These various group memberships serve interrelated purposes which, tailored by the interactional context, become complementary to, rather than exclusive of, each other as nurses and managers reorient their affiliations with the aim of attending to the face needs of all involved and building rapport. Thus, the nurses in this study have employed the construction of group memberships that would efficiently adapt to the demands of the different interactional goals in order to comply with appropriate face-saving norms. This, in turn, shows how the community values collegiality and in-group solidarity and orients their discursive practices to maintaining positive face-to-face interaction and harmonious work relations. As nurses complain and managers respond to these complaints, they negotiate and renegotiate their professional identity status in

meaningfully appropriate ways through their group affiliations and disaffiliations enacted through their shared discursive norms and practices, including complaining.

Focusing on the data of the clinic, the next chapter addresses the second research question posed in this study, namely, the way in which professional identity is constructed through the discourse of expertise in workplace meetings.

Chapter 5

Expertise

5.1 Introduction

In addition to the display of group memberships, nurses construct their professional legitimacy and status through the discourses of expertise (Hardy et al., 2002). Expertise, frequently conceptualised as a component of someone's professional identity (Hall and Danby, 2003), is generally described as “an in-depth mastery of a field of knowledge” (Sarangi, 2010: 170). The discursive display of professional knowledge is interpreted as expert claims which can legitimate someone's professional status and which endow experts with professional authority. In this regard, Sarangi (2010: 167) contends that “healthcare interaction, as an institutional and professional site, can be seen as an expert communicative system, with complex variations – along different modalities – reflecting different specialties and participant frameworks.”

With this in mind, the analysis offered in this chapter addresses the second research question, namely, the way in which professional identity is constructed through the discourse of expertise in workplace meetings at a clinic. The discussion provides insights that contribute to the understanding of how a group of clinicians display expertise in appropriate ways according to the interactional norms of their local and wider communities as they negotiate their stances through discourse. The chapter also explores expert talk as a fundamental aspect of clinicians' professional identity enacted in workplace meetings. Far from being a static category of the self, the analysis shows how expertise is constantly reoriented in conversation in peer-peer interactions. In particular, these considerations of expertise are explored in the context of the clinical meetings as a site for reflective practice and meaningful expert participation. This provides the researcher with the opportunity to explore the construction and negotiation of expertise through the clinicians' discursive practices.

This opportunity is supported by participants' own reflections on clinical meetings.

Extract 5.1 (CM3): Arena for contributing knowledge

1. Sarah: that's what this environment [the clinical meeting] is
2. is that we should be able to come to this arena and say
3. I didn't
4. I saw this person
5. and I didn't agree based on this, this, this and this
6. Emma: mmm
7. Martin: yeah //I think this is\
8. Sarah: /and what we\\ say here
9. should be
10. is is is is really what we should do
11. Martin: mmm
12. and it's it's + {sighs}...
13. well it's a situation of of contributing knowledge
14. Sarah: mmm
15. Martin: and and um accumulating knowledge
16. and what's the best outcome in treatment for the patient
17. it's got nothing to do with anything else
18. Sarah: and it teaches consensus
19. and protocol formula really

These meetings, according to participants' own words, provide the environment (line 1) in which they can discuss clinical practices (lines 3-5), arrive at a consensus and design protocols (lines 18-19) by contributing professional knowledge (line 13) in order to achieve the best outcome for the patient (line 16).

An exploration of the data follows with the aim of investigating how this group of clinicians makes expert claims in appropriate ways employing a range of available discursive strategies. A detailed survey of the data from the clinic reveals that expertise is actively

constructed through the discursive resources embedded in case presentation and discussion (section 5.5), in discussions of ACC¹⁵ compensation eligibility, reflecting the constraints of the health system (section 5.6), and in instances of workplace learning (section 5.8).

5.2 Defining expertise

A review of the literature on the topic of expertise suggests that expertise is at the heart of what it means to be a professional. In an effort to establish this relationship, sociologists, organizational researchers, and cognitive and social psychologists, among others, have provided an array of definitions of expertise. Professional expertise has been defined as skilled and knowledgeable professional practice (Fook et al., 2000) and as “high and excellent performance in a specific domain” (Sonnentag and Schmidt-Braße, 1998: 450). Though these conceptualisations of expertise are widely acknowledged, they seem to only partially capture the nature of expertise. More specifically, focusing particularly on those definitions provided in the context of nursing studies, Hardy et al. (2002: 201) conclude that “expertise [...] can be regarded as an ability to use multiple forms of knowledge and self, in an apparently seamless way [that produces] care that is tailor-made for the patient.” Drawing on Benner’s (1984) conceptualisation of expertise, Nelson and McGillion define it as “a function of a nurse’s experience, coupled with their accrued capacity to navigate complex clinical situations” (2004: 634). While some definitions focus on the outcomes of being an expert nurse (for example, Hardy et al., 2002) and the skilful application of their experience to solve clinical problems (Nelson and McGillion, 2004), others highlight the analytic dimension of a nurse’s expertise: “the expert performer [...] no longer relies on analytic principle (rules, guidelines, maxims). The expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of alternative diagnoses and

¹⁵ ACC stands for the Accident Rehabilitation and Compensation Insurance Corporation of New Zealand. It is a publicly funded government agency, which “provides comprehensive, no-fault personal injury cover for all New Zealand residents and visitors to New Zealand” (source: <http://www.acc.co.nz/>). Initially a workplace accident compensation scheme, ACC soon covered all types of no-fault injuries (see Schuck, 2008). It is worth clarifying that ACC does not normally provide compensation if the injury is somehow related to a pre-existing condition of the patient.

solutions” (Benner, 1984 in Candlin and Candlin, 2002: 119). These definitions, however, offer a rather static perspective of the construction of expertise by typically relying on the commonly questioned assumptions made in models of professional development proposed by cognitive psychologists (see Dall’Alba and Sandberg, 2006 for an overview of studies).

Within cognitive models, professional expertise has traditionally been categorised as one and the last of a number of stages professionals go through as they learn and acquire knowledge and professional competence and skills to do their jobs efficiently. As Dall’Alba and Sandberg (2006) explain in their critique, a professional acquires expertise when, after going through a number of stages (such as novice and competent), the individual has internalised their professional knowledge to such an extent that they can identify problems, goals, plans and actions intuitively without relying on any explicit guidelines or rules. This, stage model advocates contend, is due to professionals’ sustained involvement in professional activities. In this regard, models of professional development highlight professional experience as one of the most salient factors of becoming an expert (see Bridges et al., 2010): “expertise is primarily a function of time allocated for practice” (Klein, 1997: 348). In other words, expertise is characterised by a compilation of ‘an extensive experience bank’ which “can be built from direct experiences, vicarious experiences (those described by others), and simulated experiences” (1997: 348). According to stage models, then, expertise is acquired in a stepwise manner as professionals accumulate experience and move upwards in the scale of development to become experts.

However, this view of the development of professional expertise is problematic as it “veils or conceals more fundamental aspects of professional skill development” (Dall’Alba and Sandberg, 2006: 383). In their survey of theories of professional expertise, Fook et al. (2000: 179) contend that while experience is required to develop expertise, not all experienced workers are experts. In this way, they distinguish experienced and expert practice explaining that the fact that an experienced worker may be able to “act in a routinized and effective way” does not imply that they have acquired a system of specialised knowledge to do their job. Thus, experience alone cannot account for the fact that an individual is considered an expert.

These critiques suggest that in order to consider how expertise is enacted and displayed discursively in clinical meetings a more holistic conceptualisation of expertise should be considered. In this regard, Candlin and Candlin (2002) point out that professional expertise is multifaceted and should not be explored in the linear fashion commonly proposed by cognitive psychologists. In taking this approach a researcher may overlook the interplay of a number of factors that contribute in the negotiation and construction of expertise. Another option is to characterise expertise instead through its attributes, which, in my view, are:

a) professional/discipline or specialised knowledge (see also scientific/technical knowledge in Sarangi, 2010), which can be divided into substantive knowledge and procedural knowledge (Fook et al., 2000). Substantive, or declarative knowledge (Sarangi, 2010), refers to the facts and/or system of ideas that constitute the body of knowledge of a profession. Procedural knowledge, on the other hand, refers to the type of knowledge that practitioners employ to apply substantive knowledge to medical practice;

b) institutional knowledge (cf. contextual knowledge on Fook et al., 2000 and institutional ethos in Sarangi, 2010), that is to say, knowledge of the rules and regulations of the institution where they work, such as what protocols to follow in case of getting sick and being absent from work;

c) professional experience or experiential/clinical knowledge (see Sarangi, 2010), which refers to a clinician's repertoire of professional experience gained through professional practice, which is built up over time, and which mediates professional knowledge to inform medical decisions (see Perry, 2000; Sarangi, 2010);

d) professional values and ethics which guide professional practices (Fook et al., 2000; see chapter 6 for an exploration of this attribute);

e) repertoire of skills (also see job-specific competencies Sonnentag and Schmidt-Braße, 1998) in, for example, the ability to reflect upon one's professional practice (Perry, 2000); and

f) discursive competence (explored in more detail in section 5.3 below).

The combination of these attributes is often referred to as ‘expert knowledge systems’ (Candlin and Candlin, 2002) and the links between these attributes are believed to result in the exercise of professional judgement to make informed clinical decisions (Jacoby and Gonzales, 1991; Sarangi and Roberts, 1999). The interplay of these attributes is expected to result in the efficient application of scientific knowledge in professional practice. Though the importance of and the relationship between these attributes may vary across professional contexts (Sonnentag and Schmidt-Braße, 1998; Hartelius, 2008), my conceptualisation of expertise brings all of these attributes together as interdependent dimensions of professional expertise, which, in turn, I regard as a salient aspect of interactants’ professional identities (also see Sarangi, 2010).

5.3 Expertise and discourse

An essential dimension of being a professional expert is being able to talk like one. According to Bhatia (2004), discursive knowledge is paramount to the development and enactment of professional expertise. It determines how professionals conduct their communicative practices to make expert claims in appropriate ways in a number of professional contexts. And it is partly through these claims that other professionals, and also lay people, can be made aware of this dimension of our professional identity.

The linkage between discursive practices and the display of expertise has been comprehensively discussed by a number of scholars (see Candlin and Candlin, 2002; see Sarangi and Clarke, 2002 for a comprehensive review of studies). Discursive competence has been found to involve a professional’s knowledge of the use of technical terminology as well as the discursive practices specific to their discipline, which constitutes their ability to discursively, and successfully, navigate the different interactional contexts a professional faces in every day practice. This also involves social actors’ tacit knowledge of the interactional norms that define each interactional context (see contextual knowledge in Sarangi, 2010) and the appropriate application of these norms to different interactional encounters. In this regard, this type of knowledge overlaps with institutional knowledge (see

point ‘b’ above); being discursively competent also involves knowing the institutional norms about how to talk appropriately in, for instance, patient appointments, multidisciplinary meetings, meetings with fellow clinicians (such as in the case of this study) and so on.

Extract 5.2 illustrates how discursive practices of case presentation (see section 5.5.1 for an exploration on this topic) allow Rod to display his professional expertise.

Extract 5.2 (CM2): The AFO

1. Rod: a lady I saw earlier today
2. had a [type] boot
3. and (came) for a requisition for a dynamic a f o¹⁶

Here Rod’s use of medical jargon (see ‘[type] of boot’ in line 2 and ‘requisition’ and ‘dynamic a f o’ in line 3), among other aspects of discourse, contribute to his professional identity construction, enabling him to construct himself as a competent and knowledgeable clinician.

In healthcare-related research, scholars have investigated a number of discursive practices that are characteristic of professionals. Discourse analysts have studied how health practitioners express judgements, deliver decisions to patients, formulate diagnoses (Heath, 1992; Maynard, 1992; Peräkylä, 2002), and provide reassurance in appointments with midwives (Bredmar and Linell, 1999). A topic that still receives considerable attention is the way in which health professionals manage risk and uncertainty through their discursive practices (see Sarangi and Clarke, 2002). Sarangi (2010), for example, explores indirectness in the management of risk and uncertainty in genetic counselling. Similarly, Candlin and Candlin’s introduction to a special issue of *Language and social interaction* (2002) discusses the discourses of probability, such as the use of percentages, in presenting medical evidence in instances of risk assessment during medical diagnosis.

¹⁶ AFO stands for ankle-foot orthoses.

The vast majority of this research (including expert talk in other institutional contexts, see Hall and Danby, 2003), explores interactional practices as a jointly constructed achievement of all interactants involved in a conversation. As Candlin and Candlin (2002: 116) explain “the discursive expression of expertise is to different extents a coparticipative endeavour of all involved.” This, in line with the theoretical frameworks proposed for this study, supports social constructionist views by which expertise is a feature of professional identity that emerges in interaction as interactants co-construct their conversation, rather than a social category attributed to by age, gender or hierarchical rank (Jacoby and Gonzales, 1991). These views reflect the principle that interactions are dynamically constructed with contributions responding to those preceding and affecting the next (Holmes et al., 1999). In this interactional process, it is interesting to note (as will be explored in the analysis of the data below) how expert claims are accepted, contested and sometimes rejected, as speakers renegotiate their expert and professional stance, when new expert claims arise in conversation.

5.4 Reflective practice in clinical meetings

As noted above, the kind of reflective practice in which clinicians are involved during the course of these clinical meetings provides appropriate interactional context to investigate how expert claims are negotiated in professional practice. Reflective practice is highly valued as a socialization activity in most workplaces (Walkington, 2005). This offers opportunities for professional development as experts discuss, problematize and rethink professional practices. Drawing on Schön’s reflective practitioner model, Mott (2000: 28) explains that reflection is “a social process embedded in practice” (see Klein, 1997: 348). These instances of professional development become a ‘forum to expand skills and expertise’ (Wenger et al., 2002: 16). As a way of engaging in knowledge management, reflective practices then provide professionals with the opportunity to come together in order to share their expertise in the hope of expanding their understanding of the discipline and their practices, helping other fellow professionals respond to professional challenges (Mott, 2000), improving and refining their practices, accessing other expert areas within their field of practice (Wenger et al., 2002), and, finally, promoting and ensuring quality practice (see Taylor, 2006). Having the opportunity to reflect upon their practices allows health experts to adapt their practices, and

learn new ones, to cope with new technologies, situations, clinical cases, and so on (Mott, 2000).

In this data set, clinical meetings provide empirical evidence of reflective workplace practices (see Dall’Alba and Sandberg, 2006). As discussed in chapter 3, the goals of these meetings include sharing information from papers and clinical experience about new treatments and professional developments in their area of expertise, in addition to sharing doubts and asking questions regarding patients. Once a month these clinicians have a chance to debate about and formulate protocols and procedures. In these meetings, they share their expert knowledge in an attempt to solve clinical puzzles and make professional decisions. This makes these meetings a highly suitable interactional context for my research.

5.5 Expertise in professional reflections

A comprehensive survey of the clinic’s data shows how clinicians attending these meetings display and negotiate their expertise through the discursive resources, particularly as embedded in case presentations and in discussions of ACC compensation eligibility.

5.5.1 Case presentation and discussion

Routine information exchange, for example the sharing of patients’ information, is one of the most valued communication skills in the nursing profession (Morse and Piland, 1981). This type of information exchange, ‘case presentation’, involves the communication of “salient patient information during treatment and management” (Lingard et al., 2003: 603). Drawing on Atkinson’s work on case presentations, Sarangi and Roberts (1999: 71) explain that “case presentation is a complex speech genre where facts and evidence are assembled and legitimated in an organized way.” Whether by the patient’s bed (Lehmann et al., 1997), in a room full of nurses (Erickson, 1999; see section 3.4 of chapter 3) or in a staff meeting, clinicians get together to reflect on their practices. In this study, the practice of case presentation allows health practitioners to be involved in case management by sharing patients’ information to make informed decisions such as treatment pathways and therapeutic plans (see Lingard and Haber, 1999). Communicating effectively in this interactional context,

then, is paramount as it contributes to the effectiveness of medical care (Hadlow and Pitts, 1991).

Case presentation and discussion thus constitute a rich environment in which clinicians can display their medical competence and thus expertise. The way clinicians describe patients' cases in medical terms serves to display their professional knowledge and, consequently, enact their professional identity. A vital consideration is that clinicians express themselves as effectively as possible (Epstein and Hundert, 2002). According to Erickson (1999), the sanctioned way to do this in the medical profession is by employing specific medical terminology that conveys precise meanings. Although case presentations are characterised by a number of discursive practices that define them as a long-established professional practice in healthcare settings (1999), the appropriate use of medical jargon, a highly specialised register, constitutes one of the most salient characteristics of the professional practice of case presentation and discussion in this data set (Bourhis et al., 1989). Traditionally, medical jargon has also been seen as building asymmetrical power relations (Skelton and Hobbs, 1999). The following extract attests to that.

Sarah, the manager of the clinic, has just received a letter from one of the managers at one of the hospitals where Martin, a clinician in her team, visits patients. In the letter the hospital manager complains about two incidents involving Martin, which took place at the hospital. Sarah is reading the complaint to Martin and updating him on the report that she is sending in response. Martin explains the reasons that led him to take a decision to treat the patients (for which he was criticised) and Sarah provides supporting comments regarding his account.

Extract 5.3 (CM2): Compression stocking

1. Sarah: yeah no //and I don't I don't agree with [name of person who
2. wrote to Sarah] anyway\
3. I think the more vulnerable the skin
4. the more it does require compression
5. you know like you need you need compression

6. it needs to it needs help
7. and I I don't agree with her
8. sometimes you know [specialized field of medicine different from theirs]
 {facial
9. expression showing doubt}...
10. Sarah: yeah
11. that's right
12. the compression would really help the healing
13. Martin: exactly
14. Sarah: because it'll it'll it'll stop the congested fluid
15. and it'll really speed up healing
16. so that that's the idea
17. so that lady when she
18. those nurses will put that compression stocking on her
19. and that will speed her up again
20. if they let that wallowing fluid
21. or just band it circularly around the tourniquet
22. you know the tourniquet
23. they will ruin it

Sarah opens her first turn with a 'yeah' in line 1, which seems to be made in reference to Martin's explanation of why he decided to treat the patients at the time even though he was aware of the fact that they were not his patients and, very possibly, that they were supposed to be seen by other health professionals at the institution he was visiting. This, as the email Sarah received confirms, raised issues concerning his professionalism in terms of his duties and obligations as a visiting clinician. Sarah's support of his actions then gains immense significance in the presence of this professional criticism. The high stakes of the situation prompt Sarah to provide support in an authoritative and persuasive way. Her attempts to achieve this goal include making explicit and implicit expert claims of herself and others.

This is an explicit disagreement which allows Sarah to unequivocally position herself in this matter ('I don't agree with [name of person who wrote to Sarah] anyway', lines 1 and

2) and which is restated as a way of emphasising her positioning in line 7, the use of medical jargon ('vulnerable skin' in line 3, 'compression' in lines 4, 5 and 12, 'congested fluid' in line 14, 'compression stocking' in line 18, 'speed her up' in line 19, 'wallowing fluid' in line 20, 'band circularly' in line 21 and 'tourniquet' in lines 21 and 22) allows Sarah to restate and revise the diagnosis of the situation (line 3), the appropriate way to medically deal with it (lines 4-6) and the assessment of a likely outcome (lines 12, 14-15, 18-19). Similarly, medical jargon plays an essential role in Sarah's evaluation of the treatment pathway suggested by the manager who sent the complaint (lines 20-23). In this way, medical jargon is instrumentally used to build a discourse of scientific rationality, for instance providing a diagnosis of the situation and then an assessment of possible treatment pathways (see Hardy et al., 2002). This gives credibility to Sarah's professional assessment of Martin's decision to treat the patients, and legitimises her role as a health expert (van Leeuwen, 2008 and Hartelius, 2008). Using medical jargon when constructing her diagnosis and expressing support for Martin's decisions helps Sarah to construct her professional identity by establishing herself as an authority in the matter. This further validates and strengthens her support for Martin's decision and, as a result, implicitly constructs Martin as a knowledgeable professional, in other words, an expert, whose assessment of the situation and decision of patients' treatment course was appropriate for the situations under discussion according to Sarah's expert evaluation of the events.

Last but not least, as Sarah constructs herself as an expert, she constructs the other manager as a less knowledgeable professional. This is in line with the traditional views of the role of medical jargon in expert communication. The use of medical jargon has often been related to how health experts exert power over a seemingly less expert interlocutor. This claim of power asymmetry is based on the belief that the hearer will not be able to understand, at least not completely, the terminology the speaker uses (Spiro and Heidrich, 1983).

From this perspective, the study of medical communication skills has placed the medical interview as a core medical skill (Lipkin, 1987). In this arena, the use of medical jargon has typically been researched in doctor-patient consultations where the social distance resulting from its use creates power asymmetry among interactants (Mathews, 1983; Bourhis

et al., 1989; Skelton and Hobbs, 1999). This has received considerable scholarly attention as lay misunderstanding of medical terminology is believed to lead to failure to follow medical advice (Hadlow and Pitts, 1991).

In the case of this extract, however, the professional status of the two managers involved is not as clear-cut as in doctor-patient interactions. Both have the same institutionally assigned role of managers, so it is not possible to deduce from this interaction whether one of the managers has higher professional status than the other. It can be assumed, however, that in order to become a manager of a health institution both professionals are either a health professional of some sort with a degree of knowledge in this expert area to be able to manage it. In fact, Sarah's comment in line 8 stands as a clarification that the absent manager practices a different specialised field of medicine. In this way, Sarah constructs the other manager as an out-group member, which, by implication, works to justify the difference in opinions and also to discredit the other manager's opinion on matters such as, in this case, the two events referred to in the email, that, according to Sarah's comment in line 8, seem to be outside the scope of that manager's specialised area. This seems to be reinforced by the facial expression of doubt that accompanies Sarah's comment. In regards to the use of medical jargon, the fact that one of the managers is not present at this meeting obscures any possibility of considering the extent to which the medical jargon used by Sarah is shared by the two managers and thus whether it actually contributes to construct this now apparent power asymmetry between the two managers. Nevertheless, it is hard to deny the role played by the medical jargon in Sarah's efforts to explore discipline-specific ideas as she provides a rational explanation that supports Martin's decisions, constructs herself as an expert and discredits the views of the other manager. It is this use of medical jargon that legitimises Sarah's role of an expert professional and builds power asymmetry between herself and the other manager.

The use of jargon does not always create such asymmetrical power relationships, however. The data in this study also shows how the use of medical terminology actually operates at different levels for different purposes in horizontal power relationships, that is to say, in peer-peer interactions, as patients' cases are presented and discussed in cooperative interaction. The following extract illustrates this point.

Extract 5.4 (CM2): Open ulcer

1. Martin: I did this morning
2. we had an open ulcer
3. she had a dressing on
4. and uh she sees the nurses every now and then
5. and I fitted the stocking under that
6. Sarah: mmm
7. Martin: I said
8. well keep on wearing those stocking
9. Sarah: good

In this example, Martin is presenting a case to Sarah for the sake of establishing the similarities between this case and another case that was brought to their attention earlier in the meeting. Martin briefly describes the case using terms such as ‘open ulcer’ (line 2), ‘dressing’ (line 3), ‘fit the stocking’ (line 5) and ‘wear the stocking’ (line 8). In this way, he describes those details of the case that he finds relevant using specialised terms to fulfil the aim of establishing the similarities between cases, such as the diagnosis (line 2) and the treatment (line 5) (see Schryer et al., 2005). By presenting this kind of rational knowledge, Martin is utilizing the patient’s information in expert ways to formulate a final professional assessment of the similarities across cases (see Hardy et al., 2002).

Following Martin’s case presentation, Sarah’s backchannel comment in agreement (line 6) and positive evaluation of Martin’s treatment decision (line 9) suggests that the rationalization of the case and the medical jargon he provides is part of the shared knowledge that Sarah and Martin have. In this regard, it is interesting to explore the use of the word ‘stocking’ in more detail since Sarah’s positive backchannel comment in line 6 could potentially carry more interactional meaning and professional relevance than meets the lay eye.

For non-experts in this field of medicine, the word ‘stocking’ would probably not be recognised as a specialised term because we use it in our daily lives to refer to “a close-

fitting, usually knitted covering for the foot and leg made from nylon, silk, cotton, wool, and similar yarns”¹⁷ that keeps our feet warm in winter. For the specialised eye, however, a ‘stocking’ refers to a medical product of different kinds to serve different medical purposes¹⁸ (see Hadlow and Pitts, 1991 for a comparison of the perceptions of medical terms among doctors, nurses and patients). Thus, returning to the positive backchannel comment in line 6, Sarah’s ‘mmm’ does not only potentially encourage Martin to continue with his account of the case but also maybe implicitly index her understanding of what kind of stocking he needed to use to treat this particular case. Martin’s use of the definite article ‘the’ as a modifier of ‘stocking’ in line 5 seems to suggest that he is referring to one particular type of stocking; and the positive feedback Sarah offers could suggest she understands what kind of stockings Martin is referring to. Within this particular context of interaction a word such as ‘stocking’ can convey a very different meaning than when used at a clothing retailer. Their situated context of interaction, for example what they are talking about, who is providing the information and the particularities of the patient’s case, very likely plays an important part in helping Sarah assign a specific meaning to the word ‘stocking’. In this way, both Martin and Sarah construct their expertise on the basis of their shared understanding of the specific meaning of the term.

The use of medical jargon is part of an institutionally ratified routine (Sarangi and Roberts, 1999) allowing clinicians to be more specific in their account of the case when sharing patients’ information. In this way, clinicians actively avoid giving ambiguous information and being misunderstood by fellow clinicians, which, in turn, helps clinicians display a sense of precision (Schryer et al., 2005). As Cowley (2005: 741) explains, “medical jargon is necessary because there is no other efficient way of describing such a complicated and unfamiliar condition with similar accuracy.” This, however, does not seem to create a power imbalance between the speaker and the interlocutor. On the contrary, medical jargon may be positively evaluated by peers as a vital communication skill (see Lindeke and Block, 1998) that aims to ensure interactants understand the information given more effectively. It is through appropriately presenting his case that Martin can actually account for his professional

¹⁷ Source: <http://www.thefreedictionary.com/stocking>

¹⁸ This information was provided by Sarah, the manager of the clinic, in one of our informal interviews.

decisions. Thus, as he effectively explains the diagnosis of the patient in rational and scientific terms (lines 2-3), he also justifies his treatment decisions (lines 5 and 8) (cf. Sarangi and Roberts, 1999). The use of jargon and reliance on shared professional knowledge strengthens his account of patient's cases as he expresses medical concepts, diagnosis and procedures in communicatively competent ways while maximising communicative effectiveness among his peers.

5.5.2 The case of ACC

Expert talk involves not only displaying medical knowledge of local clinical practices, as discussed in the previous section, but also another type of professional knowledge that is closely linked to administrative tasks (see Sarangi and Roberts, 1999; see institutional knowledge in section 5.2). The latter often involves the management of patients' cases for compensation and insurance purposes and is very frequently regulated by state agencies or organizations (Wong, 2004). A vital aspect of clinicians' enactment of their professional identity in discussions of professional practice involves showing their understanding of how the state health delivery system works and how their practices fit within this system. In order to be able to reflect on this, we need to consider the effects of recent healthcare reforms on clinicians' daily practices, if only briefly.

Recent major reforms to the ACC policies, often referred to as 'tort reforms' (Schuck, 2008), have brought ACC discussions to the fore at the clinic as one of the most dominant themes within managerial discourses as clinicians expertly discuss the eligibility of their patients' cases in staff meetings. As Sarah points out when describing what she calls 'the ACC situation' in the extract below, deciding whether a patient is eligible for ACC compensation is under much scrutiny within healthcare institutions in general and the clinic in particular.

Extract 5.5 (CM3): The ACC situation

1. Sarah: the acc situation is really very very confusing currently
2. Martin:mmm
3. Sarah: and um
4. just bear in mind that acc
5. seems to be
6. I mean anything with a chronic + illness
7. despite having had an event

Sarah's comments on 'the ACC situation' indirectly reflects on the latest ACC reform that took place in 2010 (see Bismark and Paterson, 2006 and Schuck, 2008 for a comprehensive review of ACC policies). The result of this is reflected in more stringent regulations that emphasise patients' accountability (and responsibility) in the event and seek to reduce the costs by reducing injury liability (2008). To illustrate this, consider the following extract.

Extract 5.6 (CM3): Stringent ACC regulations

1. Martin:um and um
2. that's just a whole thing now
3. recently with acc and being much more um
4. stringeous [=stringent] with with what they pay (and stuff)
5. for these custom shoes are much more expensive

In this extract, Martin points out the fact that 'this ACC situation' (see extract 5.5) is recent (lines 2-3). He also highlights the fact that the goal of the new regulations, however unclear they are (also see line 1, extract 5.5), is to reduce costs (line 4) and seems to imply that the purchase of a given type of custom shoes may not be approved by ACC because they are 'much more expensive' (line 5). As Martin very clearly points out in this extract, clinicians need to be more cautious as to what products they prescribe to patients because, due to their cost, they run the risk of not obtaining ACC approval for their purchase.

Considerations such as the ones illustrated in extracts 5.5 and 5.6 places ‘the ACC situation’ at the heart of case discussions in clinical meetings; working with consideration of ACC policies and regulations is an integral part of clinicians’ professional practice.

As expert healthcare providers, knowing ACC policies and how the ACC operates are vital professional skills if they are to manage their patients’ cases efficiently. As Schuck (2008: 190) explains, it is “service providers, not consumers, [who] complete paperwork for the ACC.” Thus, in many cases, whether a patient receives compensation may depend on the skills of the health professional to interpret current policies and to frame the patient’s case in such a way that they are considered eligible for compensation. Reflecting on these issues in clinical meetings and participating in collective interpretations of ACC regulations reflects the clinicians’ orientation to developing expert knowledge, which, in itself, constitutes an expert activity. Becoming involved in expert activities such as this one is a key aspect in the development of professionalism, which, by implication, constructs their professional identity as clinicians that are not only aware of current policies but also responsible and assiduous in updating their knowledge in this respect. This is illustrated by the following extract.

The conversation in the extract below takes place in response to Emma’s question of why one of her young cerebral palsy (CP) patients is eligible for ACC compensation if, according to her, the patient’s CP condition is a pre-existing one. As they reflect on the case in an effort to find a satisfactory response to that question, Sarah explains that whatever the reason is, she thinks ACC regulations will change and patients such as Emma’s will no longer be entitled to ACC compensation in the near future.

Extract 5.7 (CM3): That’s gonna change

1. Sarah: I think that’s gonna change {ACC regulations related to CP cases}
2. because I’ve already seen two cp cases
3. one guy who had just an ordinary sprained ankle
4. and he was out work- walking
5. and they said no
6. he’s cp

7. had a preexisting foot condition
8. Emma: yeah but the cp wasn't caused by an accident
9. then they would've maybe given him //(...)\
10. Sarah: /yeah but the sprained ankle\\ was
11. Emma: yeah [sighs]
12. Sarah: a sprained ankle is a sprained ankle
13. Emma: but he had a pre-existing condition
14. Sarah: yeah
15. so they said
16. well that's not an accident
17. so therefore he's under long term disability
18. Emma: but um what I'm saying is
19. it's cp from accident
20. that didn't have a predisposing condition related to the cp
21. was due to an accident?
22. Sarah: yes that's right
23. Emma: that's why it's acc
24. but how are they going to (decide)
25. it could be very difficult
26. Sarah: I don't know
27. and I think
28. it is going to change
29. I'm sure of it

After expressing her opinion that ACC regulations will change with an authoritative sounding 'I think' in line 1, Sarah provides an explanation that justifies and supports it (see 'because' in line 2). This explanation involves retelling her clinical experience in dealing with two CP cases (line 2) and it is framed in the format of case presentation. Thus, in line 3 Sarah presents the patient ('one guy') and the medical problem, which is also the diagnosis, ('who had just an ordinary sprained ankle'). She then explains the origin of the medical problem, that is to say, how the patient sprained his ankle ('and he was out work- walking'). This piece of information is highly relevant in helping Eva decide whether this is an ACC

case since it classifies the sprained ankle as an accidental injury under current ACC policies (the patient was not taking any serious risk by walking). Sarah then presents the ACC decision of declining the patient's application for having a 'pre-existing foot condition' (see lines 5-7), which, according to ACC, makes the patient highly prone to having this sort of injury. Emma opens her turn with a 'yeah but' sentence starter (line 8) in which the 'yeah' seems to be addressing Sarah's main point, the fact that the event was indeed an accident and not the result of a pre-existing condition. Following Emma's acknowledgment, however, she rebuts Sarah's argument saying that the patient's CP condition was not caused accidentally (line 8), which, according to Emma, may explain why ACC has not approved the application (line 9). In this way, Emma's attempt to excuse ACC's decision is expertly built on the clinical evidence of a pre-existing condition and her knowledge of ACC eligibility policies.

This causes Sarah to negotiate her stance on the matter. In so doing, Sarah echoes Emma's sentence starter 'yeah but' (line 10) also to acknowledge the main point in Emma's argument: the fact that the patient's CP was not caused by an accident. Then Sarah restates her initial position by explaining the sprained ankle was indeed an accident (line 10), and Emma agrees with her (line 11). In line 12, Sarah reaffirms her stance once again as she presents the accidental causality of the sprained ankle as a medical fact that cannot be refuted ('a sprained ankle is a sprained ankle'). This comment may also serve the purpose of implicitly displaying Sarah's opinion that this patient should be covered by ACC. However, still not satisfied with Sarah's explanations, Emma again stresses the fact that the patient had a pre-existing condition. The fact that Emma repeats this piece of information seems to suggest that she thinks that the patient's pre-existing condition could have been in part responsible for the accident (line 13). Emma's point of view in this matter seems to represent ACC's way of reasoning the case and it prompts Sarah to acknowledge Emma's position as compatible with ACC views in lines 14-16 when she says 'yeah so they said well that's not an accident.' Sarah then presents the rational way of thinking followed by ACC officials (see 'therefore' in line 17) and explains that thanks to that way of reasoning the case, the patient was classified under long-term disability, which waives ACC of any responsibility for this case. In lines 18-21 Emma refers back to the case she presented earlier which motivated this conversation. Still puzzled at why her patient is receiving ACC compensation, Emma wonders how ACC officials decide which CP patient is eligible for compensation (line 24-

25). Sarah admits not knowing how these decisions are made (line 26) and then restates her claim that she knows regulations around CP cases will change (lines 27-28) with the rather categorical claim 'I'm sure of it' (line 29), which reasserts her initial stance more powerfully.

Discursively, Sarah and Emma construct their expertise in interrelated ways at the content and at the linguistic levels (see Sarangi, 2010a for the importance of considering content in describing identity construction processes). At the content level, both Sarah and Emma competently centre their discussion of this ACC case on the origin of the patient's injury. Instead of focusing on other medical particularities of the case, such as how serious the injury was and what treatment therapy was given, their conversation revolves around determining whether 'the event' (as Sarah refers to accidents when using 'ACC speak') was caused by a 'pre-existing' condition of the patient, in this case CP, or by the patient's clinical 'predisposition' to having this sort of accident (see lines 7, 13 and 20). This orientation is achieved at the linguistic level through the use of specific jargon that enables both speakers to expertly navigate the discourse of ACC case classification at the same time they display medical knowledge. Thus, while words such as 'pre-existing foot condition' (line 7, also see line 13), 'long term disability' (line 17), 'predisposing condition' (line 20) and 'accident' (lines 8, 16 and 19) provide evidence of the fact that Sarah and Emma know how to talk about a patient's case in the context of ACC policy regulations, the use of the acronym CP displays their specialised medical knowledge. The use of acronyms, or diagnostic labels (see Joel, 2006), is a common nursing practice. The shortening of words enables health practitioners to deliver their message succinctly and precisely while also displaying ingroup membership (see Dyer and Keller-Cohen, 2000). In particular, when considering CP, expert knowledge is needed to not only recognise what the acronym CP stands for but also identify which group of non-progressive motor conditions, the root of CP, is affecting the patient under discussion and to be able to discern in what ways a sprained ankle can be related to a case of CP.

As briefly mentioned in the analysis above, another discursive resource employed by both clinicians that positions them as experts is the retelling of clinical experiences, which, in this study, refers to the professional's 'bank of knowledge', or repertoire of experiences, accumulated through the experiences of patients' cases (Klein, 1997). In an effort to address

Emma's initial question and to explicate Sarah's opinion that ACC regulations will change, both clinicians draw on their personal workplace experience in managing CP cases in relation to ACC policies as they weave the canvas of their discussion. Immediately after Sarah voices her opinion in line 1, for instance, she draws on her personal workplace experience to validate and support her point of view on the matter. This experience is used as clinical evidence that supports her initial claim (lines 2-7) (Perry, 2000). Though Sarah explains she has had two CP cases, in her account of clinical experience she decides to focus on one. The fact that she mentioned two cases, however, is interesting in itself if we consider that, within expert systems, it is often believed that the more experience a professional has, the larger their bank of experiences becomes and, consequently, the more expert they are. By saying she has had two, and not one, of these cases, Sarah may possibly be aiming at strengthening the stance expressed in line 1. This display of experiential knowledge is, according to Sarangi (2010), an expert activity since the credibility of professional opinions may depend on the expert's ability to validate their claims through the display of relevant knowledge (see van Leeuwen, 2008). Indeed, expert opinions are not to be taken lightly because they hold health experts accountable for their decisions and actions. Thus, in order to present this information in professionally and interactionally relevant ways, Sarah shares her clinical experience in the form of case presentation (see section 5.5 above), which, as already discussed, is an expert way of discussing patients' information (see Linell et al., 2002). The structure of case presentation allows Sarah to not only present patient information efficiently in a discursive way that is familiar and relevant to all clinicians present but also to rationalise her authoritative opinion and legitimate her expert stance on the matter. By supporting her point of view in this way her claim becomes an expert opinion (see Sarangi and Clarke, 2002). Thus at different discursive levels, Sarah is both ensuring she communicates her ideas successfully and building her professional expertise from her clinical experience (see Hardy et al., 2002). This way of presenting patient information seems to be a core aspect of their professional identity across contexts and themes of interaction.

5.5.3 Discussion

As the analysis shows, expertise is enacted in instances of case presentation and discussions related to clinicians' administrative tasks, specifically concerning issues of ACC

compensation eligibility. The analysis of the discursive practices employed by the clinicians draws attention to a number of considerations that distinctly contribute to the construction of clinicians' professional identity as experts.

For this group of clinicians, enacting their expertise involves displaying their knowledge of clinical and administrative practices (see 'levels of expertise' in Cicourel, 1999). As clinicians engage in professional practices, they display clinical knowledge when they discuss patients' conditions (lines 2-3 in extract 5.4, for instance) and diagnoses (line 3, extract 5.7), for instance, and their administrative knowledge when they engage in discussions of patients' eligibility to ACC compensation (extract 5.7). As Fook et al. note when commenting on Larson's work "the production of professional knowledge is an essential component of the activity of experts" (2000: 5). This expert knowledge system of medical and administrative content is not static, however, as it is subject to the social, economic, technological and politically changing conditions that regularly impact on workplaces (see discussion in section 5.5.2). In this regard, professional expertise also involves displaying a certain level of awareness of the dynamic nature of knowledge systems in keeping up with the new developments in their field to update their knowledge banks (extract 6; see Wenger et al., 2002). Utilizing this information in expert ways enables clinicians to formulate an assessment of a given situation (extract 5.3), to make knowledge-based decisions (extract 5.4) and to express authoritative opinions (extract 5.3), all of which are characteristically part of the experts' reflective activities (see Fook et al., 2000; Hardy et al., 2002; Bhatia, 2004). As clinicians actively participate in discussions of professional practice, they co-construct professional knowledge by sharing their expertise, which legitimises clinicians' expert claims and the resulting expert positions (see Fook et al., 2000).

This knowledge seems to operate at two different but interrelated levels: at the local level of practice and at a wider community level. At a local level, reflected in their case presentations, clinicians discuss those professional practices that are performed as part of the services offered by the clinic, which distinguish the clinic from other institutions (see Wenger, 1998a and b). These practices, however, do not operate in isolation but are embedded within a broad health care system that guides and regulates them through the issuing of national policies and legislation. Knowing that their decisions of how to categorise

a patient under ACC regulations, for example, resonates within higher spheres of professional health care practice and decision-making is also part of the expertise of these clinicians. From this it can be concluded that clinicians' construction of expertise relies on medical and administrative layers of professional knowledge and their awareness of its role within their local professional practices and the broad health care system.

Moreover, displaying these layers of professional knowledge involves doing it in discursively appropriate ways. Thus, expertise is constituted in interaction through, for example, the use of medical jargon to express the two different kinds of professional knowledge that partly characterise the nursing profession. In instances of case presentation, the use of appropriate ways of presenting patients' information, primarily focusing on developing both experiential (extract 5.4 and 5.7) and scientific rationality (extract 5.3), constitute some of the discursive strategies that have been identified in the construction of these clinicians' expertise (see van Leeuwen, 2008). As Hardy et al. (2002: 201) explain "a medical discourse of healthcare expertise is a dominant discourse that privileges rational scientific knowledge" because it enables clinicians to competently validate their expert opinions and decisions (extract 5.3 and 5.7). Displaying their professional knowledge through the use of these discursive practices vests clinicians with authority and legitimises their expert claims (see Sarangi and Roberts, 1999; Sambrook, 2006). With this in mind, one possible way of considering the relationship between the attributes explored in section 5.2 leads to the conclusion that professionals are defined by the kind and amount of specific knowledge they possess, which makes expertise domain or context-specific (see Viskovic, 2005), and by the efficient application of this knowledge in practice, which is mediated by professional experience and realised through discursive practices (Sonnentag and Schmidt-Braße, 1998; Jacoby and Gonzales, 1991; Candlin and Candlin, 2002). In terms of their professional identity, while these practices highlight their professional capabilities, they construct clinicians' as not only knowledgeable but also competent (Lave and Wenger, 1991).

A significant interactional factor to highlight at this point is the fact that clinicians in this study converge (Bourhis et al., 1989) in their use and, judging by their positive and relevant contributions, their understanding of these discursive practices. Clinicians build their arguments as they orient to the use of shared practices that enable them to discursively

display their professional knowledge in appropriate ways in the context of their community. In addition to facilitating rapid and effective communication (Schryer et al., 2005), clinicians' use of medical jargon, for instance, in similar interactional contexts for seemingly the same purposes, seems to constitute a vital interactional norm for the appropriate way of describing a patient's case (see Sarangi and Roberts, 1999). As explored in chapter 2, the choice of discursive practices largely depends on the interactional context as it will favour certain discursive routines over others. Thus, experiential rationality in case presentation is used as a discursive resource that justifies clinical decisions. Moreover, the appropriacy of these practices is in part responsible for establishing the speaker's comments as relevant to the conversation. These contributions should also be expressed in relevant ways, according to the expectations of their community, in order to present a 'coherent self' (see Holland et al., 2001; Benwell and Stokoe, 2006). Thus, clinicians build their professional identity as experts when they successfully respond to the interactional demands of the context through the display of relevant clinical knowledge through preferred discursive practices (cf. Bucholtz and Hall, 2005).

Furthermore, contrary to common assumptions (see sections 5.2 and 5.3 of this chapter), these displays of professional knowledge have not been found to give rise to the power asymmetries that are usually related to the use of scientific terminology in the healthcare literature or the display of expertise more generally (see Wenger et al., 2002). Extract 5.7 serves as an example to illustrate this point and the related idea that "professional expertise is more than an individual characteristic. It is a collective attribute, shared and developed within the professional community" (Stevens et al., 2007: 484). While Sarah and Emma construct their turns on the knowledge they have of ACC policies and related clinical cases, they both seem to positively build their expert roles in dynamic ways. They construct the conversation by using each turn to reposition themselves as knowledgeable experts who seem to equally rebut and support the opinions and arguments on ACC-related issues with the relevant clinical evidence. At the same time they build their professional accountability, each turn is used to legitimate the expert claims made by both clinicians. In the extracts explored in this section, expertise is equally displayed by the clinicians, who do not seem to aim to position themselves as more powerful than the other. Instead, their main focus seems to be the co-construction of institutional and professional knowledge related to both CP and ACC

cases. Clinicians' contributions therefore co-construct a more complete account of each of the cases as they share their expert knowledge (both scientific and experiential) in, what seems to be, equally powerful ways.

From a relational point of view, this type of exchange and construction of professional knowledge and expertise can acquire practical significance in the construction of interpersonal relationships. In this regard, building on shared knowledge and shared practices is considered to “promote interpersonal liking while also reflecting speakers’ conscious or unconscious need for social integration with their interlocutor” (Bourhis et al., 1989: 340). Emphasising this last claim, Wenger (1998) explains that in order to be accepted as part of a given CofP, members need to use the sophisticated lexicon and display the shared knowledge that characterises that community. In other words, shared expert knowledge is constitutive of a CofP as the display of shared practices indexes clinicians’ core membership in a community (1998; see also Eckert and McConnell-Ginet, 1992). In addition, Bourhis et al. (1989) point out that preferred ways of displaying expertise is seen to promote harmonious relations in the workplace as these are positively evaluated by community members. Thus, far from creating social distance, clinicians seem to enact their expertise to not only display a knowledgeable professional self but also to claim and index clinicians’ group membership. This may help participants to build positive relationships with other clinicians. The boundaries of this membership claim cannot be clearly established through their discursive practices because, as discussed earlier, clinicians’ practices can operate at, at least, two levels: the local and the wider community levels. In the case of the latter in particular, Schryer et al. (2005: 247) explain that “this knowledge announce[s] the speaker as belonging to a particular profession.” Thus, while clinicians’ practices may embody a membership claim within their local CofP, constituted by the clinicians present at the meeting, clinicians may also be claiming membership to a larger disciplinary CofP constituted by all or some of the professionals sharing the same specialisation in their clinic (including all branches), in their city, in their region and/or in their country. Wherever the membership boundaries are, however, the main point to highlight in this regard is that expert claims, as made in extracts 5.3-5.7, could indicate group belonging, as opposed to constructing asymmetrical power relationships among peers. Building on the constructs related to in-group/out-group formation explored in the previous chapter, professional practices then serve to show clinicians’

community alignment with immediate and more distant professional groups. Displaying expertise on relevant topics and in appropriate ways is a workplace practice that legitimises clinicians' membership within their local community of practice at the clinic (see Wenger et al., 2002). These practices define them as experts within their community and across other communities. Thus, while on the one hand, this constitutes a way of constructing a clinician's professional identity as a competent, skilful and knowledgeable professional, on the other hand, these practices enact group memberships and act as gatekeepers of harmonious relationships within their community.

5.6 Learning in the workplace: The case of expertise construction

Instances in which clinicians reflect on professional practices provide them with an opportunity to not only display their expertise, as explored in the previous section, but also develop it as they acquire new professional knowledge. This section explores how expertise is negotiated as clinicians are engaged in workplace learning that further develops their expertise.

Acquiring new professional knowledge is not exclusively restricted to instances of formal training such as university courses. The workplace has also been widely recognised as a stimulating environment that promotes and supports professional learning (see Lave and Wenger, 1991; Wenger, 1998; Wenger et al., 2002; Fuller et al., 2005; Rainbird et al., 2004; Eraut, 2007). As Sambrook (2006) points out, learning outside the classroom environment is of central importance, since developing nurses' professional practices is very often more efficiently achieved in informal situations such as those provided in the workplace context. To this, Bhatia adds that it is in backstage situations (see section 2.6 of chapter 2) in the workplace that knowledge is gained and negotiated (2004: 150). With these considerations in mind, then, the very nature of clinical meetings (described in section 5.4) defines them as a workplace arena where the learning agenda is at the centre of its activities. It comes then as no surprise that clinicians explicitly reflect on this opportunity to share knowledge with fellow clinicians in the meetings.

Extract 5.8 (CM3): Shouldn't you educate staff?

1. Emma: yeah
2. because that other person might have made a mistake
3. that you think
4. that you had experience with
5. and decide well
6. shouldn't you educate a person in YOUR experience
7. with this mis- problem
8. and you had better outcomes with YOUR solution
9. than with what they would have suggested

The main argument underlining Emma's comment is about her concern with 'educating a person' (in this context, a clinician) when one has more experience in solving a clinical problem with better outcomes (lines 6-8). Emma's turn is followed by Sarah's clarification that the purpose of holding these clinical meetings is for them to share and construct professional knowledge that helps them improve their practices (see extract 5.1). Thus, Emma's comment serves to highlight the participants' view on the importance of workplace learning in improving professional practices as they explicitly reflect on aspects of knowledge management (see Wenger et al., 2002).

5.6.1 Workplace reality and the sharing of expertise

As pointed out in the introduction to this chapter, technological, social, political and economic changes impact healthcare institutions through the implementation of new policies and issuing of new regulations (see section 5.6) (see Sarangi and Roberts, 1999; Bhatia, 2004; and Doolin, 2002 for a detailed account of the New Zealand case). The current social and professional atmosphere thus supports the vital role of on-going learning in the workplace as a necessary activity in the development of professional expertise because it requires health professionals to update their professional knowledge on a regular, sometimes daily, basis (see Wenger et al., 2002). As they do this, practicing professionals aim to broaden their knowledge by further developing their competences and skills in order to meet the new

challenges. As a result, they restructure the boundaries within and across the different professional communities as professionals redefine their practices, expertise, roles and responsibilities (see Wenger et al., 2002; Marsick, 1988; Illeris, 2003; Evans et al., 2006). This 'constant adaptation of competences' and stances is believed to be more efficient if developed in the workplace and seen as part of a social actor's on-going, life-long professional development (Illeris, 2011: 5).

Much of the existing literature on learning expertise in the workplace typically focuses on how experts can "expertize" the newcomers or novices (Jacoby and Gonzales, 1991) and seems to significantly disregard the fact that professional experts are also involved in life-long processes of professional development. Within the CofP framework, though, Wenger (1998) has made an effort to embrace this workplace reality in what he calls situated learning and legitimate peripheral practice. This is the process by which newcomers learn to be part of that CofP and the old-timers continue to learn (1998). In this light, workplace learning is seen almost as a social process inherent to professionals' participation in the professional activities of their communities (Viskovic, 2005; Eckert and McConnell-Ginet, 1992). Workplace learning is situated as it "takes place in a specific situation or context that co-determines both the learning process and its outcome" (Illeris, 2011: 12). This reflects the collective character of expertise in that social actors need others to develop their own expertise (Wenger et al., 2002). This all rests on the premise that learning is part of social actors' on-going professional development as they continue to acquire new knowledge through practice and build on their expertise as they evolve professionally in the light of the above-mentioned changes (see Wenger, 1998; Wenger et al., 2002; Bhatia, 2004).

Departing from this premise, it can logically be claimed that expertise is not a static characteristic of the professional self but rather one that is subject to constant change and reconstruction as the workplace conditions are modified and clinicians gain new knowledge. This view of expertise is a starting point to move the concept of expertise forward in suggesting that its enactment and construction is more dynamic than commonly claimed. This plays a significant role in understanding the interpretations provided in the analysis that follows.

The following extract from clinical meeting 3 serves to illustrate some of the main points of the discussion by showing how learning expertise takes place in this community of clinicians.

Extract 5.9 (CM3): Learning in the workplace, an example

1. Sarah: rod and I were just talking this morning
2. about a case of a young boy that's got spinal fracture
3. stress fractures of the pars interarticularis
4. and //um\
5. Emma: /where\\ is it?
6. Sarah: in the spine
7. ↓you know in the ++ the pars
8. ↓you know in the +
9. Emma: like the fore (...)
10. Sarah: no no the the bony
11. Cheryl: ah yeah the transverse (processes)
12. Emma: yeah
13. Sarah: yeah yeah
14. Emma: yeah ok
15. Sarah: yeah so there's a fracture there
16. it was a stress fracture
17. it's quite common in young adolescent boys
18. and that play hockey and bend over
19. bend or play cricket
20. and the sudden violent movements of the spine...
21. Emma: what did you fit him with?
22. Sarah: um optec brace wasn't it? {looking at Rod}
23. Rod: yeah optec brace
24. and I also want his hip (joint) attached to it
25. Sarah: yeah to keep him immobilized

This conversation takes place as part of a wider discussion in which Sarah and Emma talk about which cases are covered by the ACC. With the aim of giving an example, Sarah presents a case of a patient whose compensation claim was not approved by the ACC. Sarah's case presentation turns into an opportunity for Emma to expand her clinical knowledge on this type of case (see lines 5 and 21).

Sarah starts by explaining that she has discussed this case with Rod that morning (line 1), which constructs both Rod and Sarah as experts in two relevant ways. On the one hand, it positions Rod and Sarah as the experts who know, at least enough, about the case that they are able to discuss it. This comment also alludes to the fact that discussions of this nature take place not only in clinical meetings but also in other workplace contexts. This suggests that such discussions constitute a kind of expert activity within this community. Being engaged in core professional practices such as this is central as it promotes their professional development (see Wenger 1998). This then also constructs Sarah and Rod as experts for taking part in relevant and appropriate kinds of professional activities in the workplace.

After this first expert claim, Sarah continues to construct herself and others as experts as she carries on with the conversation to provide the details of the case. She gives this information in the form of case presentation explored in extracts 5.3 and 5.4 above. Thus, Sarah mentions who the patient is (line 2) and uses medical jargon in providing expert information of the diagnosis of the case ('that's got spinal fracture', 'stress fractures of the pars interarticularis' in lines 2 and 3). Emma then overlaps Sarah in what seems to be a genuine request for information regarding where the pars interarticularis is (line 5). This question explicitly turns the discussion of this case into a learning opportunity for developing Emma's clinical knowledge on cases of this nature. Pragmatically speaking, the question constructs Emma as less expert and Sarah as more expert in this matter; Sarah is the one who can provide Emma with the information she lacks. Sarah, however, does not seem to find the words to respond to Emma's question and does so in a vague manner (lines 6-8 and line 10). When considering Sarah's response more closely, 'you know' in lines 7 and 8 deserves to be briefly considered as it seems to play an important role in displaying Sarah's perceptions of Emma's expertise at this point in the conversation.

Though the discourse marker ‘you know’ is very often identified as a “boundary marker between information units” that improves coherence among turns (Erman, 1987: 27; Fuller, 2003) and as a ‘verbal filler’ (see Holmes, 1986; see also Holmes, 1993 and Fuller, 2003 on the possible different social meanings of ‘you know’), Sarah’s ‘you know’ on these two occasions seems to function “as a signal that the speaker attributes understanding to the listener” (Holmes, 1993: 99). Conveying what some call ‘the most basic meaning’ of ‘you know’ (see Tree and Schrock, 2002), the falling intonation of the pragmatic particle seems to indicate that Sarah is actually expressing her “confidence concerning [Emma’s] relevant background knowledge” in understanding what she means in her attempt to respond (Holmes, 1993: 100). In other words, ‘you know’ may serve to display Sarah’s assumptions that Emma knows what she is referring to as she seems to assume this is part of their shared knowledge (cf. Macaulay, 2002; see Holmes 1986). This could explain the lack of clarity or specificity of Sarah’s response as she may rely on Emma’s general knowledge on the topic. In the context of this conversation, then, ‘you know’ seems to index some complex interpersonal meaning in that, by conveying this type of interpersonal information (see Tree and Schrock, 2002), Sarah positions Emma as a knowledgeable expert, after Emma’s question had positioned her in a more disadvantaged situation in this regard. In this view then, the use of ‘you know’ may constitute a repair move that renegotiates Emma’s expert stance more positively.

Emma seems to confirm the expert claim made of her by Sarah, in what constitutes a solidarity move (Liddicoat, 2011), when she makes a guess at what Sarah might want to say (line 9). As Emma fails in her attempt to help Sarah find the appropriate word, Sarah is prompted to, unsuccessfully, try to rephrase her explanation (see line 10). Due to Sarah’s new failure at providing a satisfactory answer, Cheryl seizes the next turn and provides the word she thinks Sarah is looking for (‘ah yeah the transverse (processes)’ in line 11). In so doing, Cheryl actively displays engagement in this discussion by relevantly participating in the construction of this clinical case. In this way, her turn undoubtedly constructs Cheryl as an expert for having resolved the issue of answering Emma’s question of where the pars interarticularis is. In this regard, if we were to consider the institutionally assigned roles of those involved in this conversation, Cheryl, as an internship student, is the least expert of those attending this meeting. However, her timely response and the relevance of her contribution seem to locally construct her as an equally powerful expert in comparison to, for

example, Sarah, if only for the duration of her turn. What is more important, expert claims are not socially relevant unless they are legitimately recognised by other experts (see Sarah in line 22 extract 5.7; Hartelius, 2008). Following Cheryl's turn, both Emma and Sarah accept her suggestion in lines 12, 13 and 14, and in this way they reify Cheryl's expert claim, which also potentially serves as a means to index Cheryl's membership within this community of specialised clinicians. As a clear example of the importance of the relevance of the contributions in the locally situated display of expertise, Cheryl's brief participation attests to the interactional nature of professional identity as clinicians construct themselves and others as experts through their discursive practices.

Following Sarah's and Emma's acknowledgment of Cheryl's response, Sarah continues to repeat her diagnosis (lines 15-16), possibly as a way to link her comment back to her last claim in line 3 before Emma's question in line 5. This helps Sarah to expertly maintain the rational development expected of case presentations (see van Leeuwen, 2008). With the phrase 'it's quite common' in line 17, Sarah then provides generalisations that relate certain information of this case to other cases of a similar nature, which includes: who is more prone to having this kind of injury (line 17), under which situations (lines 18 and 19) and how such an injury could occur ('the sudden violent movements of the spine', line 20). Being able to generalise case information in this way has been identified as a common characteristic of experts' knowledge management (Wenger et al., 2002). In line 21, Emma moves the discussion of the case forward to ask about its treatment ('what did you fit him with?'), to which Sarah replies in line 22 in the form of a question directed to Rod.

Rod confirms the information provided by Sarah in line 22 and in so doing also accepts the expert positioning assigned to him by Sarah's question. With his comment in line 24, Rod adds relevant information as to how the case is still being treated, which legitimizes him as a core member of this community. By doing this he continues to build his stance as an expert assigned to him by Sarah in line 22. Moreover, through the phrase 'I also want' (line 24), Rod conveys more meaning than simply expressing his wish that the patient should follow a certain treatment pathway. 'I also want' also strongly positions him as an authority in the management of this case who is actually in a position to demand the kind of treatment

to be followed. Finally, in line 25, Sarah repositions herself as a legitimate expert by providing the justification for using the optec brace.

This analysis of extract 5.9 suggests that questions play a significant role in the construction and enactment of expertise. But before venturing any conclusions in this regard, some more examples should be considered to illustrate the point.

The following conversation was originally embedded in a wider discussion in which Martin explains that he has received some insoles but that they are too big to fit the shoes of his patient. So he asks the others what he should do with those insoles. As Sarah examines the insoles, she asks Rod for his opinion.

Extract 5.10 (CM2): On grinding insoles

1. Sarah: when they come back like that rod
2. do you grind them to the red line
3. or do you leave that black bit on?
4. Rod: not on the arch area
5. on the outside of it
6. Sarah: would you take that bit off? {showing the insole}
7. Rod: mmm
8. Sarah: all the way round
9. and then just leave a little bit there?
10. Rod: just careful down from the arch
11. around the back
12. Sarah: ok

With the purpose of helping Martin decide what to do with the insoles, Sarah explicitly asks for Rod's opinion in the matter by addressing him by name (line 1). In so doing, she phrases two yes-no questions that are linked with the connector 'or' so that they provide Rod with two courses of action to choose from (lines 2-3). As explored in extract 5.9, although Sarah is technically asking Rod a question, which would usually be interpreted as

constructing Rod as more expert than Sarah, some aspects of the phrasing of the questions and their nature suggest that Sarah is also constructing herself as an expert. The specificity of the content knowledge of Sarah's questions expressed in the form of two choices contributes to display her expertise for knowing the technical procedure involved in solving the problem (see 'grind' in line 2) and the possible ways there are to grind these shoes constitutes expert knowledge in their field of practice. The nature of the questions serves to display Sarah's expertise in the field as she is merely asking for confirmation of the procedures rather than requesting new information (cf. line 22, extract 5.9). In addition, not only does Sarah construct Rod as an expert through choosing him to answer the questions but also the use of present simple tense in the formulation of the questions indicates that this is a routine activity for Rod, which contributes to strengthen his position of expertise in this area of clinical practice.

Through his answer in lines 4 and 5, Rod relevantly addresses the topic and accepts the expert position assigned to him by Sarah as he adds specialised information on where to grind the insoles. His response, however, does not seem to answer Sarah's question, at least not directly, since the information he provides seems to go a step further in the grinding process to suggest where not to grind the insole (line 4) and where to do so (line 5), disregarding Sarah's question of how to grind them.

Indeed, Sarah addresses this lack of response in her next turn where she rephrases her second question of the first turn (line 3) as another request for confirmation. In order to do this, some expertise is required of Sarah to be able to interpret how Rod's answer is relevant in the context of her question and how it answers, even if indirectly, her initial query. The expert conclusions she possibly draws from this, in fact, seem to lead Sarah to infer that the first of her options (line 2) is the correct one and negatively rephrases her second option (see 'leave on' and 'take off' in lines 3 and 6) with the aim of confirming its exclusion from the procedure. As Rod confirms this (line 7), Sarah continues explaining the grinding process in line 8 and once again asks Rod for confirmation regarding 'leaving a little bit [of insole] there' (line 9).

Again Rod does not seem to address Sarah's question directly (lines 10-11). Instead of answering whether she should 'leave a little bit there' (line 9), he provides extra information related to how to grind the insole at the arch and around its back. The fact that he does not reply to Sarah's question in any negative way seems to indicate he agrees with the information provided in line 9. In terms of his actual answers, it is interesting to note that in each case he provides extra information as advice¹⁹ in the imperative form (lines 4-5) or as a warning (10-11) (see Pilnick, 1999). Advice giving, as an expert activity, coupled with the overt nature of Rod's answers, place Rod in a more powerful position than Sarah as he presents himself as the authority on the matter (see Pudlinski, 2005). Finally, this is not treated as problematic by Sarah who, in acknowledging Rod's advice with an 'ok' (see Landqvist, 2005), reifies his expert claim from lines 10-11. At the same time she seems to get to a point in which she has succeeded in expertly providing an answer to Martin's problem.

In this extract though Sarah's questions can potentially only serve to position Rod as more experienced, she also expertly uses them to confirm her knowledge on this topic and to make positive expert claims herself. Through his answers Rod strongly positions himself as a more powerful expert in this interactional instance by using each turn to provide extra information in the form of advice. Thus, even though Rod's answers build a temporary power asymmetry between the two, they both negotiate their expert claims by displaying their expert knowledge through their interrogative statements and their answers. In this way, Rod and Sarah indirectly tell Martin what should be done with the insoles as they actively work on co-constructing their expertise on the topic.

In other instances, however, the power imbalance between the clinicians seems to be greater, clearly portraying one of the interactants as an expert and the other one as less expert in the matter under discussion. As can be seen in the following extract, Martin is not allowed to make legitimate expert claims since Rod seizes the floor of the conversation before Martin finishes his turns.

¹⁹ Advice here is used as defined by Heritage and Sefi, 1992.

Still talking about the appropriateness of the insoles, Martin says that these insoles leave very little space for the toes given their height and thickness. He asks Rod how he deals with it.

Extract 5.11 (CM2): On grinding insoles (cont.)

1. Martin: how do you accommodate
2. if you wanna=
3. Rod: =you should grind off to nothing at the toe
4. Martin: ok
5. but if he's got really bad (...)
6. what do you=
7. Rod: =no
8. you leave that part
9. just use
10. grind the front part there to nothing

In both cases (lines 1-2 and 5-6), Martin's questions are targeted at obtaining what to him seems to be new information (cf. extract 5.10; see Eva's questions in extract 8). This can very likely position Martin as less knowledgeable than Rod. But, as explored in the other extracts, questions can be formulated in such a way that they also display the expertise of the questioner. Rod's latched responses in lines 3 and 7, however, deprive Martin of this opportunity as he can only barely manage to say 'how do you accommodate if you wanna' and 'but if he's got really bad (...) what do you' before Rod takes over the conversation to answer Martin's questions. Martin, however, tries to reposition his professional self more favourably when he frames his second question in the context of his clinical experience (line 5). Emphasising this aspect of his clinical practice situates him as a legitimate member of this CofP.

Rod's responses, on the other hand, succeed in positioning him as the sole expert at this point in the conversation as he both predicts the content of Martin's questions and shares his expert knowledge in replying to them. As in the previous extract, Rod's answers are

expressed in the form of advice, which helps him maintain his expert status. As such, they explicitly involve Martin in the response ('you' in lines 3 and 8) while their propositional content expresses some kind of future action (lines 3 and 10; see Pilnick, 1999). Though giving advice can further heighten the power imbalance between the two (Waring, 2007), this kind of response, as in extract 9, does not seem to be problematic since Martin positively acknowledges Rod's contribution (see 'ok' in line 4). Relevant to the understanding of Martin's and Sarah's reaction to Rod's advice-giving responses is the fact that advice is "a common way to respond to others' problems" and is very often perceived as helpful (Goldsmith and Fitch, 1997: 457). Thus, this way of replying seems to be an appropriate discursive practice in the learning contexts in which this community participates (see similar findings in other nursing studies in Pudlinski, 2005).

5.6.2 Renegotiating expert status

One of the claims made throughout this thesis is that professional identity is not an intrinsic aspect of the social self of interactants but is rather dynamically negotiated with the unfolding of conversations. It is then relevant to point out that Martin does not maintain the 'less knowledgeable' stance as seen in extract 5.11 across all meetings and topics of conversation. On the contrary, he constructs himself as an expert at other times as the discussions unfold.

Extract 5.12 (CM4): Measuring for arm sleeves

1. Emma: I have found that
2. that works relatively well
3. is that you measure it
4. measure it above
5. and you take the bigger measure at the top
6. Sarah: yeah that's right
7. Martin: yeah
8. and and specially with the wrist as well
9. there's a gloving

10. a glove that's going to (go) with the sleeve
11. to make it just a slight bit bigger
12. Emma: at the wrist?
13. Martin: yeah
14. Emma: or at the sleeve?
15. at the (...)
16. Martin: you should you should ask the patient
17. some um some patients like the um
18. to put the glove on
19. and then put the sleeve on
20. Emma: alright...
21. Emma: so they put the glove on first
22. and then the sleeve

As the team is discussing the procedures to measure the arm of the patients for arm sleeves, Emma shares her experience (see 'I have found that' in line 1) on how this measurement seems to work best (lines 2-5). In doing this, she indexes her community membership as she is involved in its professional activities while she also positions herself as an expert for having developed, based on her professional experience, what seems to be her own way of measuring the arm sleeves (see Sarangi, 2010a for the importance of using experiential knowledge to supplement professional knowledge). This contribution is positively evaluated by Sarah, who agrees with Emma's contribution and in so doing also accepts Emma's expert claim.

Martin, who previously constructed himself as less expert than Rod (in extract 5.11), soon positions himself as an expert in this discussion. Martin starts his turn by mirroring Sarah's positive acknowledgement token in line 6 (see 'yeah' in line 7). Following this, Martin collaborates in this conversation by further providing more specifications regarding the glove inside the sleeve. Martin does not seem to challenge Emma's expert position. On the contrary, his comment could be interpreted as a solidarity move since it seems to be adding relevant information (see line 8) that helps to further develop, and possibly improve,

the measurement procedure described by Emma. Emma's and Martin's expert statuses then do not seem to be in conflict at this point.

Emma's question in line 12, however, does indeed seem to create a 'status imbalance' between the two as she asks Martin whether the sleeve should be made bigger at the wrist. As Emma continues asking for clarification of where to make the sleeve bigger (line 14), she further stresses this power asymmetry by making more evident the fact that Martin's ideas are new to her. In lines 16-19 Martin, in turn, replies by first offering a piece of advice and then supporting his suggestion with his clinical experience in the issue at hand. In this regard, Pudlinski (2005) argues that the use of the modal verb 'should' is an indicator of overt recommendations or advice. Moreover, a few turns later in the conversation Emma rephrases Martin's suggestion (lines 21-22), which interactionally functions as a 'proper acknowledgement' that Martin's turn has been identified by Emma as advice (see Heritage and Sefi, 1992; Pilnick, 1999). This turn then legitimises Martin's expert claim and maintains Emma's expert status as less knowledgeable than Martin regarding this particular aspect of the measurement of the arm sleeve.

Martin's expert position does not go unchallenged, however.

Extract 5.12 (cont.)

23. Rod: yeah
24. [name of a practitioner] told that from the start...
25. Martin: I heard this morning of a lady
26. so I've seen this often

Some turns later in the conversation, Rod undermines the relevance of Martin's contributions by explaining that what Martin has just explained has already been advised by another practitioner (lines 23-24). This prompts Martin to negotiate, successfully or otherwise, his expert stance by drawing on his experiential knowledge (lines 25-26) with the aim of enhancing his professional accountability for the comments he made in lines 7-11 and 16-19 and reasserting himself as an authority in the matter.

The analysis of expert claims made in extracts 5.9, 5.10, 5.11 and 5.12 demonstrates that expert positions are dynamically negotiated and renegotiated in talk as clinicians construct themselves and others as experts/less expert at different times across different learning situations. Thus, the same clinician can be constructed as the expert at a given point in the interaction and as less knowledgeable than somebody else at another point depending on the topic on which the conversation focuses. So while Emma is constructed as the least expert of the participating interactants in extract 5.9, she is constructed as the expert at the beginning of extract 5.12. However, this soon turns into a learning situation for her as Martin introduces what seems to be new information for Emma, who, by asking clarification questions, is placed in a slightly disadvantaged position with respect to Martin. Similarly, Martin, who has previously been the one asking the questions (see extract 5.11), seizes the opportunity to share his knowledge on arm sleeve measurement in extract 5.12 and repositions himself as a knowledgeable expert. This supports dynamic claims of professional identity construction as an aspect of the self that is constantly renegotiated as participants take on new stances in the unfolding of the interaction.

5.6.3 Discussion

Using these meetings as a “forum for expanding skills and expertise”, this section has explored how clinicians identify gaps of knowledge and they address them as they engage in professional discussions in clinical meetings (Wenger et al., 2002: 16). As the examples show, learning is construed as a process of participation and clinicians’ reflective activities result in “the design of their practice as a place for learning” (Wenger, 1998: 249). Thus, while clinicians self-regulate their learning by participating in this workplace activity, they share and create new knowledge and practices that aim to provide “new solutions, [to] generalise or document them, and integrate them into the community’s practice” (2002: 19). In this way, they expand their capabilities through the acquisition of new and/or refinement of old knowledge (see Illeris, 2011). Building on the argument advanced in the previous section, which contends that being an expert in this community means acquiring professional knowledge of different kinds, the discussions investigated here focus on certain areas of participants’ clinical practice such as on the medical details of a case (extract 5.9), and on the

technical aspects of their practice, like grinding insoles (extracts 5.10 and 5.11) and measuring arm sleeves (extract 5.12).

The learning environment provides a valuable opportunity to not only relevantly participate in community activities by either sharing or gaining expert knowledge but also, in so doing, actively display expert stances in very dynamic ways. In addition to the discursive strategies for the display of expert stances mentioned throughout the analysis of this and the previous section of the chapter, which include the use of jargon, the rational development of case presentation, the display of experiential knowledge to strengthen their professional accountability, and the ability to generalise the particularities of a case to other cases of similar nature, another established discursive practice often employed by clinicians as a vehicle to enact their expertise is the use of questions.

The very nature of clinical meetings situates the question-answer adjacency pair as one of the most salient discursive aspects of the learning instances in which this community is involved. Questions and their answers serve as interactional means through which clinicians enact expert aspects of their professional identity (see Tracy and Carjuzáa, 1993). Thus, the pragmatic role of questions, and their answers, is crucial in understanding how this group of clinicians make expert claims (cf. Drew and Heritage, 1992; see Carlsen, 1991). Considering the questions in lines 21 and 22 of extract 5.9 for instance, Emma's question in line 21 can be said to work at different levels in the construction of her professional expertise. Thus, at the surface level, unlike common considerations of the role of questions in professional practices (see Freed and Ehrlich, 2010; Holmes and Chiles, 2010; Tracy and Naughton, 1994), this question seems to position Emma as the least expert of the two since she is the one genuinely requesting information she does not possess or recall (see epistemic referential questions in Kearsley, 1976). A closer look at Emma's turn reveals that the way she asks the question may, at the same time, constitute a positive expert claim of herself. The question 'what did you fit him with?' seems to stand as an expert way of requesting specific information. Its wording shows Emma recognizes that in this case in particular the patient needs to be 'fitted' with some kind of medical device, rather than, for instance, be given some medicine. Thus, even if the question at the surface level seems to be constructing Emma as less expert than Sarah, at a deeper level of analysis, it is also constructing Emma as an expert within this local community for identifying the kind of treatment needed and for asking about it in what seems

to be the appropriate way to display this knowledge. Similarly, Sarah's question in line 22 could be said to construct her as less expert than Rod, to whom she directs her question (see discussion of extract 5.10). This question, however, is a request for confirmation (as opposed to Emma's question; see direct closed questions in Kearsley, 1976) which, because it contains the answer to Emma's question, helps Sarah maintain her positioning as an expert in this topic. Several considerations stem from this analysis.

In clinical meetings, where the participants enjoy similar institutionally sanctioned power status since they all perform the same clinical duties, the functional realisations of questions seem to be manifold, which makes it possible to offer diverse interpretations of their importance in the construction of clinicians' expertise (see Kearsley, 1976). Quoting Holmes (1986: 5) on the use of the discourse marker 'you know', questions serve to clearly illustrate "the fact that language conveys meaning at a number of different levels simultaneously or expresses several functions at once". Scholarly views on this matter contend that questions, often regarded as an initiation move, wield some degree of social control (Holmes and Chiles, 2010) as they clearly guide the course of the conversation. If we consider, for example, Emma's exchanges in the context of Sarah's case discussion in extract 5.9, it soon becomes evident that Emma's questions redirect the topic of the conversation to address Emma's lack of knowledge of clinically specific information. Also, by directing the question to a specific addressee (in this case Sarah, see also Rod in extracts 5.10-5.11), Emma also controls who answers the question, that is to say, the right of participants to speak (see Carlsen, 1991). This, from a discursive point of view, certainly serves to display Emma's expertise in managing conversations in accordance with the interactional norms of this community (see also Sarah in extract 5.10 and Martin in extract 5.11). From an epistemological point of view, however, in line 5 (extract 5.9), for instance, Emma fails to establish her expertise, in this context regarded as the appropriate display of information and knowledge (Tracy and Carjuzáa, 1993), as she emphasises her lack of knowledge through her question (also see Martin in extract 5.11). Within this peer-peer context, questioning then is often considered as an indicator of the speaker's epistemic stance or lack of expertise in some area (see Tracy and Carjuzáa, 1993; Heritage, 2010; cf. Carlsen, 1991 in the learning context, and Holmes and Chiles, 2010 in commercial organizations and government departments). It is then important for clinicians to formulate questions in such a way that specific knowledge

is built into them in order to display the speaker's knowledgeability amongst, paradoxically, their apparent lack of knowledge (Tracy and Naughton, 1994; see Carlsen, 1991 for the importance of content in questions). This is achieved by providing relevant contextual information to the question (see Martin's attempts in lines 1-2 and 4-6 in extract 5.11; see Tracy and Carjuzáa, 1993). In this regard, confirmation checks, such as in the case of extract 5.10, seem to give questioners a more suitable, although not the only, opportunity to display their own expertise than questions that aim to elicit new or unknown information, such as in extract 5.9 (cf. Freed and Ehrlich, 2010).

Although embedding professional knowledge in the formulation of questions can potentially positively reflect speakers' expertise in their field of practice, the answerers, rather than the questioners, seem to be more powerfully positioned in the interactions explored in this section. In extracts 5.9-5.12 the answerers strongly and authoritatively position themselves as more knowledgeable by not only providing the questioner with the information they request but also frequently doing it in the form of advice (see discussion of extracts 5.10 and 5.11). This advisory stance gives way to the 'ethos of directness' that seems to characterise learning instances in this community (cf. Sarangi, 2010b and Sarangi and Clarke, 2002).

Questions are a powerful resource for the enactment of not only the questioners' expertise but also that of their addressees'. As Benwell and Stokoe (2006) explain, there are different levels and domains of expertise within the same field of practice and even within the same work team. A vital aspect of being able to learn from others involves recognising each other's areas or zones of expertise (see Sarangi and Clarke, 2002; Sarangi and Roberts, 1999). As illustrated in the extracts above, participants in this data set represent complementary areas of expertise as, for instance, Rod seems to be the expert when it comes to technical issues of medical devices and Martin seems to know techniques for measuring the arm sleeves in greater detail than Emma (cf. Waring, 2005). It is part of their expert knowledge to know which area of expertise applies to whom, that is to say, who knows what and how much they know, who can do what and, finally, how they complement each other (Sarangi and Roberts, 1999). The explicit acknowledgement of this is observed in the formulation of questions which are directed to elicit responses from specific clinicians. By

tailoring participation in this way, clinicians actively construct answerers as experts, as the authority in the matter under discussion within this community. In addition, as the questioners choose a knowledgeable person to ask the question to, they in part also display their own expertise in recognising the degree and specialised areas of expertise of others (see Campbell et al., 2003; Wenger et al., 2002). The very act of asking a question provides evidence of the kind, and possibly amount, of knowledge the speaker thinks the recipient has (Tracy and Naughton, 1994). This recognition is legitimized not only by explicitly directing the questions to knowledgeable peers but also by acknowledging and reacting to their answers in positive ways (see Sarah in line 12, extract 5.10 and Emma in line 20, extract 5.12, for instance; also see Pudlinski, 2005 for acknowledgement of questions). In turn, as addressees answer the speaker's questions, they demarcate their own zone of expertise and legitimate their expert stance (see Sarangi and Clarke, 2002).

When describing their cycle of learning, Wenger et al. (2002: 20) explain that learning is based on 'collegial relationships' and that the boss is not a boss but rather a peer as all participants share their "domains of knowledge" at different times. Contemplating different areas and degrees of expertise in the domain makes it possible to construct the same participant both as an expert and as less knowledgeable at different stages of the same interaction and/or across interactions (Wenger et al., 2002). Expert positionings are then recast in the unfolding of the conversation as different areas of expertise become relevant in their discussions.

5.7 Summary

In this chapter I have shown how being an expert in this community is about earning credibility and acknowledgement by arguing for the legitimacy of what clinicians do and think in discursively relevant ways (see Hartelius, 2008). Questions and their answers, medical jargon, and rationality of case presentation are some of the powerful resources that clinicians employ not only for transactional purposes but also for conveying social meaning since they grant clinicians expert status in instances of professional reflection and development. In this way, expert talk becomes a rich discursive site for the display of clinicians' professional identity as they index community membership at the local and wider

levels and portray themselves as knowledgeable, authoritative and competent professionals (see Benwell and Stokoe, 2006 and Halford and Leonard, 2005). The subject positions resulting from these expert claims allow clinicians to navigate the different interactional workplace contexts.

As illustrated, negotiating one's expertise is not a straightforward business. The epistemological and ontological ramifications that extend from the use of these discursive practices are directly related to the construction of clinicians' professional identity at different levels. Thus, the discursive strategies highlighted in this chapter were shown to have implications for multiple identities, that of the speaker and addressee (see Tracy and Carjuzáa, 1993), as well as that of their collective identity as a team. As they are engaged in reflective, knowledge-building activities, this group of clinicians builds their collective identity as a team that works together in solving professional problems and sharing and creating new knowledge (see Wenger et al., 2002). It is by contributing in solving problems of clinical practice that this group of clinicians develop "a shared understanding of what they do, how they do it, and how it relates to other communities and practices" (Brown and Duguid, 1998: 25 in Huq et al., 2006: 341). As practices evolve, communities also evolve when their members update their professional knowledge (Wenger, 1998). In this way communities reproduce their memberships as they find new ways of belonging by, for instance, agreeing on local clinical practices and learning from each other's expertise (Wenger, 1998).

Expertise then, as an intersubjectively constructed aspect of the professional self (see Bucholtz and Hall, 2005), belongs in a dynamic continuum which is actively transited by clinicians as they construct themselves and others as expert and less expert in different aspects of professional practice (see Dall'Alba and Sandberg, 2006). Independently from clinicians' institutionally sanctioned roles, power asymmetries in clinical meetings have been shown to be temporary as they are instrumentally shifted from one social actor to the other when different areas of expertise are brought to the fore to address a number of concerns (see expertise as empowerment in Fletcher, 2001 and expertise as a symbolic power resource in van Dijk, 1997 and Hinkel, 2011). In the construction of medical cases, discussions of ACC compensation eligibility and instances of workplace learning, clinicians need to continually

readjust the boundaries of their professional expertise to be able to make relevant expert claims through the discursive practices that characterise this community (see Sarangi and Roberts, 1999, and Jacoby and Gonzales, 1991).

The next chapter brings together and builds on the constructs of group membership and expertise explored in chapters 4 and 5 respectively to investigate the professional values embedded in discussions of professional nursing practice in high stakes situations.

Chapter 6

Values, Nursing Practice and Professional Stakes

The most relevant and meaningful aspects of the nursing profession to emerge in this analysis of nurses' discourse is professional values. By expressing the values that guide their practices, nurses show what is important to them professionally. From an interpersonal point of view, the display of values serves to index and construct complex social meanings. As they emerge in local interaction, values can be used to display nurses' stances in relation to the beliefs that guide the practices they adopt. In this way, when nurses support or reject certain values, they index their alignment, or disalignment, with their discipline or professional group and/or with their practice community, at both local and wider community levels. Through the display of professionally relevant values and their ability to incorporate and communicate value-based ways of thinking in their clinical practices, nurses build their expertise as part of a professional community (Fook et al., 2000). This enables nurses to position themselves within the social system of the workplace and to shape and reinforce certain features of their professional identity (see Bucholtz and Hall, 2005).

A particular site in which these values emerge is in discussions of current professional practices. In these instances, nurses and clinicians interpret and reinterpret professional experiences as they engage in a self and collective evaluation of professional practices (see discussion in chapter 5, section 5.4). As explored in chapter 2 (section 2.2.2.1), instances of professional socialization, that is to say, "the process whereby individuals acquire and integrate into their lives the expected knowledge, behaviours, skills, attitudes, *values*, roles, and norms deemed appropriate and acceptable to their chosen profession" (MacIntosh 2003: 725, emphasis added), help to "maintain and develop a critical understanding of [a professional] role" (Bathmaker and Avis, 2005: 48; see a detailed review of socialization processes in nursing in Killeen and Saewert, 2007). As indicated in chapter 5, reflective practices are part of the socialization processes which shape and give meaning to workplace activities; they also clearly provide a rich environment for the ongoing formation and re-

formation of nurses' professional identity (see Beijgaard et al., 2000; and Gregg and Magilvy, 2001). They provide evidence of nurses' awareness of and identification with the value system attached to the profession in relation to how they perform and what's expected from them, in other words, what it means to 'do being a good nurse' (see Killeen and Saewert, 2007). Discursively displaying the extent to which their practices and reflections are guided by their professional values helps nurses to develop a sense of professionalism that is here explored as it contributes to the nurses' construction of a positive professional self-image.

At this point, it is important to reiterate that my stance regarding professional socialization differs from other scholars who regard workplace socialization as confined to those interactions involving novices. Following a constructionist approach, I argue that professional statuses and roles are socialized into being in not only new but also already established professional groups. In other words, workplace socialization processes affect novices as well as fully practicing professionals who, by frequently engaging in reflective practices, are constantly reworking the boundaries of their professional and institutional roles in a rapidly changing workplace environment (see discussion in chapter 5; see similar views in Killeen and Saewert, 2007).

In the meetings recorded for this study, nursing values frequently surface when nurses' reflections have the purpose of improving professional practices by evaluating, standardising, and changing them. In these discussions 'professional stakes' are high for both health care professionals and patients, as decisions to change nursing practices inform and regulate their future practices and influence the quality of the service provided (see Killeen and Saewert, 2007). Moreover, as nurses review their practices, they need to decide which of them best reflect their conceptions of being and acting as a nurse and which are in the best interest of the institution. In this sense, the negotiation of professional stakes has other far-reaching relational effects. While nurses evaluate and negotiate the practices, they may also sometimes need to revise and negotiate the values that inform their stance in regards to the implementation of certain practices. Thus, as will be illustrated in this chapter, talk about professional practice can also put nurses' professional image, and sometimes that of the institution, at stake as nurses support or reject each other's points of views and the values

they hold. A clash of values, for instance, may cause nurses to revise and rework their positions in a given interactional context (see Fook et al., 2000).

Exploring the data from the clinic and the hospital, this chapter explores the ways in which nurses discursively build their professional identities in appropriate ways as professional values emerge from nurses' reflections of professional practices. The extracts chosen for this chapter show how these meetings become professional (high) stakes meetings when discussions have the purpose of changing practice to best reflect nurses' conceptions of being and acting as a 'good' nurse and the interests of the two institutions in the data set. This chapter builds on chapters 4 and 5 by drawing on the concepts and the findings explored there to investigate successful communication among nurses from different cultural backgrounds. Thus, important issues concerning, for instance, accountability in the practice of health professions, and construction of expertise and group membership will be discussed in terms of how this helps participants to construct their professional identity in high stakes situations where values and professional practices play a central role.

There is a body of literature focusing on the study of the values in nursing that competently and thoroughly informs the field of nursing. In her study on the professional identity of Norwegian nurses, for example, Fagermoen (1997) concluded that "professional identity was the actualization of the values of dignity, self, humanity and reciprocal trust" (Gregg and Magilvy, 2001: 48). In addition, Fook et al. (2000) explore the values of self-determination, empowerment, confidentiality and professional distance in social workers (also see Chitty, 2011). However, as stressed in chapter 2, studies of this nature have, for the most part, focused on participants' perceptions of the values that inform their actions. This chapter does not attempt to review all the values that have been reported to influence nursing practice. Instead, I focus on those that emerge, sometimes explicitly and at other times implicitly, in nurses' authentic talk as they reflect upon their professional practices.

6.1 Values in nursing

Values are considered an integral aspect of the nursing profession. Since the days of Florence Nightingale, the founder of modern nursing, most definitions of 'nursing' have

relied upon the description of the values that guide nursing practice (see Killeen and Saewert, 2007; Chitty, 2011).

Values represent the ethical principles of a profession (Killeen and Saewert, 2007). Like other professions, for nursing these are regulated by a value system that “give[s] direction and meaning to its members, guide[s] nursing behaviours, [is] instrumental in clinical decision making, and influence[s] how nurses think about themselves” (2007: 58). The values are regulated in the *Code of Ethics for Nurses* (ANA, 2001 in Killeen and Saewert, 2007). In practice, while some are discipline-based, others may be more institutionally oriented and thus more context-specific. Nurses entering the workforce assume the responsibility for practicing nursing in accordance with these values (2007), thus they are expected to influence nurses’ actions and how they make decisions.

In previous chapters, a number of extracts have illustrated some professional values that have been found to surface from nurses’ talk. In chapter four, we saw how Susan fosters the value of collegiality as she constructs multiple group memberships in order to protect the identities of the complainers and those who share their views (see ‘the girls’ in extract 4.5 and ‘a couple of staff’ in extract 4.6, for example). Similarly, in chapter 5, clinicians seem to support the value of teamwork and collaboration, acknowledging the expertise of the other clinicians and working together to tackle issues of clinical practice (see Xyrichis and Ream, 2008). Both values, collegiality and collaboration, have been well documented in the nursing literature and have often been seen to improve and optimize patient care and to promote job satisfaction (see Xyrichis and Ream, 2008; Gardner, 2005; Killeen and Saewert, 2007).

Other values that frequently emerge in these two data sets relate to the ‘fairness’ of the roster system in terms of responsibilities to other nurses. Thus, in roster meeting three, for example, Eve explains that even if the computer system that runs the roster allows them to submit a limitless number of requests, she will not grant them all. To this Eva, a registered nurse, replies:

Extract 6.1 (RM3): It's not fair

1. Eva: no
2. it's not fair...
3. you're just thinking of
4. yourself and yourself alone
5. Mandy: exactly
6. Eva: and ruining it for +
7. Eva: //everyone else\
8. Mandy: /everyone else\\
9. Eva: yeah

Evoking the values of collegiality, responsibility and caring for others, Eva explicitly shares her views concerning the impact that requesting changes to the roster has on the rest of the ward, something with which Mandy agrees. Eva's opinion supports a just outcome for those requesting many changes (see justice as an important value in nursing in Ersoy and Altun, 1998 and Killeen and Saewert, 2007).

In addition, work-life balance also surfaces in nurses' meetings as they discuss shift allocation (see extract 4.11 of chapter 4). In a roster meeting, Eve encourages those nurses with over 200 hours of annual leave to take some time off as, if they do not take annual leave, she does not have enough shifts to give them all. Eve uses the value of having work-life balance as an argument to persuade nurses to take leave.

Extract 6.2 (RM3): Work-life balance

1. Eve: that's the way that
2. the system works for you to be um
3. getting work-life balance as well
4. not
5. you know
6. so you're not working all the time

All these values highlight different aspects of the kind of interpersonal relations nurses and clinicians have, or expect to have, with their colleagues. But, although interpersonal values are represented throughout the data, most discussions regarding professional practices foreground values that are associated with patient safety and providing ‘professional’ health care. The fundamentally patient-oriented values that are explored in the following sections are divided into caring and patient safety, and accountability and autonomy. As will be explored, while some of these values emerge more explicitly and others are rather implicitly dealt with, most of them are negotiated at length.

6.2 ‘This is all about releasing time TO CARE’: caring and patient safety

In some of the instances of reflections of professional practice, values emerge from nurses’ discourse explicitly. In the following extract, for example, Sarah explains that a number of regional hospitals have asked her to write the guidelines for treatment protocols for leg injuries. Following her reading of the points in the document she has written with this purpose, Martin reflects on his own way of practicing medicine.

Extract 6.3 (CM4): On being cautious

1. Martin: I always tend to be like cautious
2. and and + to be like precautionary...
3. and I always ask myself the question
4. ok what’s the safest thing to do
5. Emma: mmm {flat intonation}
6. Martin: and um and if it were you sitting there
7. Emma: yeah {flat intonation}
8. Martin: what would YOU have liked?
9. Emma: mmm {flat intonation}
10. Martin: so um to me it’s like taking no chances
11. it’s another person’s life
12. //and\ um you know if if +

13. you can't umm weigh up the cost of the [medical treatment]
14. Emma:/mm\\ yeah {flat intonation}
15. Martin:to the potential um complications that //the person might\
16. might v- might have
17. //it's MY\ experience
18. Emma:/yeah that's true\\

Martin begins his turn by explaining how cautious he is when he practices medicine (lines 1-2). In any medical profession, being cautious is a quality that is highly valued because it displays a certain level of awareness of the professional uncertainty inherent in the health care professions, showing they know their limitations and those of medical treatments (see Lingard et al., 2003 and Sarangi, 2010; see 'culture of safety' in McDonald et al., 2005; cf. Green, 2006). In explaining how he takes the necessary precautions when treating a patient, Martin says he always asks himself what the safest thing to do is (lines 3-4). In this way, Martin supports and strengthens the stance expressed in his opening statement by displaying how he engages in reflective thinking as part of the decision-making process of treatment-related pathways. Then, structuring it as a hypothetical situation Martin puts himself in the shoes of the patients and reflects on what they would have liked had they been the patients (lines 6 and 8). The rhetorical question does not seem to be intended to elicit an answer in spite of being directed to the interlocutor (see 'you' in lines 6 and 8); instead, the pragmatic function of the question resides in the way he conveys empathy for his patients (see Schmidt-Radefeldt, 1977). Emphatic understanding for the patient, as Killeen and Saewert (2007) explain, is closely linked to the value of 'human dignity' and patient worth and it has been identified as one of the core values of healthcare professions. Building on the value of human dignity and worth as he continues speaking, Martin restates his stance of lines 1 and 2 when he says that he would take no chances when treating a patient (line 10) as what is at risk is someone else's life (line 11).

Towards the end of his turn, Martin introduces a new concern when he explains that clinicians 'can't weigh up the cost of the [medical treatment] to the potential complications that the person might have' (lines 13 and 15). In this way, Martin reflects on the fact that sometimes health practitioners have to make decisions that may be in conflict with other

principles, with the interests of the patient and/or those of the institution. In this way, Martin indirectly addresses the issue of “the ontological divide between nursing practice as caring and nursing practice that is product orientated” (Hardy et al., 2002: 201). In the age of business-led medical services (Wong, 2004), one of the main goals of institutions is arguably to reduce the costs of health care (see value of efficiency in Rawlins and Culyer, 2004), to the point that health care professionals are more highly evaluated by the management when they achieve better outcomes at lower costs (Wong, 2004; see discussion in regards to the ACC situation in chapter 5). These two goals, however, may at times be problematic since providing the best care possible may involve costly treatments (see Dall’Alba and Sandberg, 2006). It seems then that the market-driven focus promoted by the dominant culture of managed health-care is at odds with the humanistic values and practices of nursing (Kenny, 2002). Thus, if clinicians prioritise lowering the cost of the medical treatment, they may risk providing unsatisfactory or even unsafe care, as Martin points out in line 11. In this instance, Martin seems to prioritise the goal that is more closely related to the professional values dictated by his discipline, that is to say, providing good quality health care in spite of its cost.

Finally, building his expertise from his professional experience, Martin finishes his argument by stressing that what he has discussed is based on his own experience of professional practice, possibly implying that this may not be the same for all other clinicians (see discussion of experience and expertise in chapter 5). At this point, and for the sake of clarification, a word or two should be said about Emma’s responses to Martin’s claims. Emma’s lack of involvement, displayed through the flat intonation of her backchannel responses (see lines 5, 7, 9 and 14), may be due to the fact that Martin’s reflection does not seem to be connected, at least not clearly, to the main topic of conversation. In support of this, as soon as Martin finishes his turn, no further acknowledgement of what he said is made and Emma takes up the discussion on the leg injuries protocol, which seemed to be a more pressing business for the team.

The following example provides further support for how nursing values can emerge explicitly in nurses’ conversations.

During ‘the medication module’ feedback session in a roster meeting, Anne and Eva

describe a problem they had with another nurse in the ward. The nurse in question was upset because she had to answer the phone when no one else was available. She complained about it to Anne and Eva. Lisa, a nurse coordinator, explains that when they planned the medication module, they thought it would be useful for the nurses doing the rounds to carry a portable phone in order to call the next nurse when they were done administering their medicines. As the team prepares to evaluate the practice of carrying portable phones during their medication module rounds, Eve starts by rephrasing the problem as she understood it.

Extract 6.4 (RM3): It's rude

1. Eve: in relation to [name of the nurse]'s thing
2. her frustration was that the phone was just sitting there ringing
3. and that one person should be carrying them
4. Eva: mmm mmm...
5. Eve: we have to make sure it's not the person that
6. you know if you're doing the medication module
7. you'll have to //have a portable phone\
8. Eva: /yeah\\
9. /or one of the girls could have the\\ phone
10. //and then a portable phone\
11. Lisa: /but the when I'm\\ coordinating [name of ward] +
12. I don't answer the phone
13. if I'm with the patient being there 1//anyway\1
14. so that's the whole point
15. 2//and\2 (whether you know it) or not at the weekends {looking at Eve}
16. that we've got a workload that
17. the reason why we don't answer the phone is that
18. we're physically doing something with the patient
19. and it's inappropriate
20. and it's °°rude°°
21. how do you (deal) with the patients
22. if you answer the phone if it beats up? {looking around at other nurses}

23. so so that's just like that
24. it's it's the phones will ring and not 3//get answered\3
25. Eve: 1/hmm\\1
26. 2/hmm\\2
27. Mandy: 1/hmm\\1
28. Mandy: 3/maybe maybe the ward (clerk) can\\3 take a few messages
29. Eve: well that's what we thought {everybody backchannels in agreement} ...
30. Mandy: because you're right {talking to Lisa}
31. I mean I wouldn't answer the phone
32. if it was in my pocket ...
33. I mean if you're toileting a patient
34. the last thing you do is go
35. //°°'hello'°°\ {laughs}
36. Eve: /yeah
37. yeah\\ ...
38. Eva: /I can't leave the phone ring\\
39. sorry ...
40. Mandy: this is all about releasing time TO CARE
41. Eve: mmm
42. Mandy: so you're not going to be disturbing your care with
43. with phone calls

As Eve takes the floor, she rephrases the reasons for the nurse's frustration about having had to answer the phone (lines 1-3). This is followed by Eve's directions of what they should do in regards to carrying the portable phone while doing their rounds (lines 5-7). The nature of this discussion is rather problematic since Anne and Eva present the issue as a complaint (see section 4.3 of chapter 4). In replying to it, Eve seems to be aware of this and employs a number of discursive practices to mitigate the potentially negative effects of engaging in conflict talk. She, for instance, uses an impersonal lexical device, 'thing' in line 1, to refer to the issue described by Anne and Eva, avoiding explicit reference to the fact that it is a 'problem' or complaint (see Kreutz and Harres, 1997). Similarly, the subject of the clause in line 3, 'one person' (also see 'the person' in line 5), seems to be used to avoid

explicit reference to the nurse who was supposed to carry the phone and depersonalises the recipient of what also seems to be functioning as an indirect directive for the rest of the nurses (see Holmes et al., 1999). Eve also uses the adverb ‘just’ in line 2 to further downtone the assertive force of her claims (see Kreutz and Harres, 1997). In addition, as explored in chapter 4, when Eve communicates her decision to the team, there is a shift in the use of pronouns from ‘we’ in line 5 to ‘you’ in lines 6 and 7. Eve’s comments in lines 1-7 may be taken to imply that the fact that the phone was left alone in the reception area indicates that somebody was not doing their job correctly. Thus, communicating her decision on this matter may also involve an element of conflict for those nurses who do not agree with her and for those involved in this matter. Relying on the potentially positive rapport resulting from building collective identity, then the use of ‘we’ in line 5 seems to mitigate the impact of a possibly unpopular decision. In this way, Eve tries to mitigate the effects of addressing workplace conflict, orienting towards maintaining positive work relations with the nurses present at the meeting.

In response to Eve’s decision, Eva makes a further suggestion, having ‘the phone’, which in this context refers to the phone of the reception area of the ward, and a portable phone (lines 8-9). Mirroring the discursive strategies used by Eve in lines 1-7, Eva mitigates the propositional force of her turn by using an impersonal lexical item such as ‘the girls’ to refer to the nurses and an auxiliary verb of probability (see ‘could’ in line 9) (cf. ‘the girls’ in chapter 4). Eva’s careful wording of her suggestion may be due to the fact that the institutionally sanctioned role she fulfils may not entitle her to make decisions such as this one and that she may not wish to sound as she is imposing practices on others.

After overlapping Eva, Lisa gains the floor and admits that she does not answer the phone when she does the medication module rounds with a categorical ‘I don’t answer the phone’ (line 12). To legitimise this decision, Lisa takes ownership of her role within the ward (‘when I’m coordinating’ in line 11) and establishes her authority in making such decisions. In line 13, what started as a reflection on the practice of using portable phones, turns into a debate on the standards of care involved as a result of answering the phone when Lisa clarifies that she does not answer it when she is with a patient. From this she concludes: ‘so that’s the whole point’ in line 14. The closest referent of ‘that’ in this context is the clause in

line 13, 'if I'm with the patient being there anyway'. Thus, 'the whole point' Lisa is referring to could be interpreted as 'being with the patient'. Through this statement Lisa displays her conceptions of what practicing nursing means to her; her main professional concern is being with the patient.

As Lisa continues speaking, she finds it necessary to provide further evidence that builds her accountability for the decision expressed in line 12. The tone of the conversation, however, becomes harsher as she seems to accuse Eve (see use of personal pronoun 'you' when looking at Eve) of possibly not knowing the kind of workload they have on weekends (line 15). As she clarifies this last point, Lisa argues that the reason for not answering the phone lies in the fact that they are 'physically doing something with the patient' (line 17). The shift in the use of pronouns, 'I' in lines 11-13 to 'we' in lines 16-18, shows how Lisa draws on collective identity to further strengthen and legitimize her argument (O'Reilly et al., 2009).

Lisa then evaluates the situation and provides a value judgement when she says that 'it's inappropriate and it's rude' to answer the phone when 'physically doing something with the patient' (see lines 18-19). She raises her voice as she says the word 'rude.' This becomes significant in emphasising her previous statement, which seems to be the main point of her argument ('it's inappropriate' in line 19). To support her stance in lines 19 and 20 Lisa draws on common sense ways of thinking (see Cotton, 2002) that are highly relevant to their professional context by posing a question to the others. This question resembles Martin's in lines 6-8 above in that it does not seem to be aimed at eliciting an answer. Instead, the aim of the rhetorical question seems to be to just get the other nurses (and Eve) to reason the issue out her way. What seems to be a simple question does, in fact, raise serious concerns about the standards and quality of practice involved in the routine of carrying a portable phone during rounds.

Lisa concludes her argument in line 23 by saying 'so that's just like that'. The adverb 'just' in this case plays a significant pragmatic role as it "add[s] a comment to the event or state of affairs that is described in the utterance" (Tseronis, 2009: 64). In this regard, it reveals Lisa's stance on the matter. 'Just' can be then categorised as an 'epistemic stance

adverb' (Biber et al., 1999 in Tseronis, 2009) that shows the speaker's evaluation or judgement of the situation by expressing the truth-value of a proposition, making it sound as a fact, a reality. 'Just' in line 23 then seems to indicate that Lisa regards the impossibility of dealing with the patient appropriately if they answer the phone as an absolute reality in the context of their professional practice.

Lisa's tone becomes more conclusive when she then finishes her turn by rephrasing her original decision (compare lines 12 and 24). The passive construction of the last sentence of that line corresponds to what Kreutz and Harres (1997) call a 'structural hedging device', which serves as a strategy to impersonalise the doer of the action. This, in relational terms, can be interpreted as a face-saving move to protect herself, and possibly the other nurses who share her views, from being disapproved of for contradicting Eve and not agreeing to answer the phones (see Schröder and Zimmer, 1997). By using an impersonal construction such as this, Lisa avoids openly disagreeing with those who believe the phones should get answered, for instance Eve, while she orients towards maintaining harmonious relations among colleagues.

Lisa's reflection evokes one of the core values that has been reported as the most salient quality of the nursing profession: caring (see Killeen and Saewert, 2007). Only briefly focusing on the inconvenience that answering a phone causes to nurses (see line 18), Lisa presents her main concern as the fact that if they answer the phone during rounds, nurses may not be able to appropriately look after their patients. She also stresses the importance of the possible impressions of the kind of work done by the nurses that patients may have as a result of this (lines 19-20).

Developing Lisa's ideas even further, Mandy proposes another solution to the problem, suggesting the clerk of the ward take messages when the nurses are doing their rounds (see line 28). As explored with Eva's turn in lines 9-10, Mandy mitigates this suggestion with the adverb 'maybe' and the adjective 'few', possibly for the reason that, as in Eva's case, her role as a nurse (and not as a coordinator, for instance) does not entitle her to make this kind of decision. This suggestion is supported by Eve, who replies 'well that's what we thought' in line 29. As explored in chapter 4, 'we' in line 28 seems to be a referent

for a different group than the one in line 5, not referring to Eve and Mandy (those participating in the conversation), or even to Eve and the rest of the nurses present at the meeting. On the contrary, it seems to be indexing her group membership with the management team with whom she has discussed this idea, which, as explored in chapter 4, legitimises and strengthens her claims.

After everybody backchannels in agreement with Mandy's and Eve's ideas, Mandy continues the conversation by providing explicit support for Lisa's ideas (line 30). Building her stance in this regard and solidarity with Lisa, Mandy rephrases Lisa's decision in line 31, then gives a practical example to support her opinion by building her expertise in the matter (lines 32-33), to again rephrase and show her support for Lisa's decision (lines 34-35). The change in the use of pronouns, from 'I' (and 'my') in lines 31-32 as she explicitly gives her opinion, to 'you' in lines 33-34 as she gives a practical example of why the phone should not be answered enables Mandy to distance herself momentarily from the situation after having provided her blunt opinion in lines 31-32.

In the next turn, Eva disagrees with the views expressed so far (line 38) and apologises, which possibly implies that she will indeed continue answering the phone when it rings (line 39). However, Eva's comment is disregarded by the others, censoring her voice in this matter. As the conversation continues to develop on the basis that answering the phone is not appropriate when with a patient, Mandy emphasises that this is all about 'releasing time to care', stressing particularly the last two words of the phrase (line 40). This idea is reinforced when, in lines 42-43 Mandy emphasises the importance of taking care of the patient by not 'disturbing your care with phone calls', which seems to summarize the main point of the discussion.

Mandy's reflection in lines 40-43 problematizes the practice of answering the phone when with patients even further as she introduces the idea of 'releasing time to care'. For a lay audience, the phrase 'releasing time to care' is possibly self-explanatory, pointing at prioritising their caring duties over other tasks in the ward. Though this is partly true, for the expert audience the phrase 'releasing time to care' embodies a trust-wide programme with the full title 'Releasing Time to Care – the Productive Ward' (see Wilson, 2009). This programme, which started in 2007, is part of the reform of the healthcare system undertaken

in the UK with the aim of increasing patient and staff satisfaction by releasing nurse time from unnecessary or ‘wasteful’ activity (Wilson, 2009). The Productive Ward focuses on “improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency”²⁰. The programme includes a learning package that “offers a systematic way of delivering safe, high quality care to patients across healthcare settings” (2009: 647). Though by not answering the phone they may be disregarding some work duties, Mandy’s contribution may suggest that sometimes they are confronted with work duties that may be in conflict with other work responsibilities or even with some of the values of the profession (cf. Martin’s above). In those cases, they have to decide which of those duties they will prioritise. Thus, Mandy’s contribution, overall, explicitly encourages the value of caring, so deeply rooted in the nursing profession, reminding the other nurses present at the meeting that the strongest professional commitment they have is that of providing good quality care and that decisions like Lisa’s support the implementation of current nursing programmes. In this way, Mandy competently and expertly supports Lisa’s position for not answering the phone when they are with patients.

Moreover, impersonal hedging devices seem to be frequently used by nurses as they express disagreement (as in the case of Lisa above) and also as they voice someone else’s complaint. The latter is illustrated in the following extract.

As Eve reads the name of a patient and gives a brief report on her condition, Donna explains the patient has lodged formal complaints about a number of issues.

Extract 6.5 (HM2): Patient’s complaint

1. Donna: she’s going to put in formal complaints about
2. uh several people
3. and specially about um the man in fourteen...
4. the guy in the treatment um
5. peeing everywhere all around...

²⁰ See http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

6. it's been a problem since last tuesday
7. they're all complaining about [the incident]...
8. there are a lot of people down that corridor
9. quite scared of +
10. um the guy in the treatment room

In this extract, Donna says that one of her patients, and other 'people down that corridor' (line 8), have complained about the habits of another patient (line 5). By not identifying complainers by name and employing the collective noun 'people' (lines 2 and 8) and the personal pronoun 'they' (line 7) with unclear referents (see Kreutz and Harres, 1997 in extract 6.4 above), Donna protects the anonymity of the complainers, which may also be interpreted as a way of showing that nurses care for patients (see ANA, 2001) and of displaying collegiality with their co-workers (see Baltimore, 2006).

Implicit also in the previous extracts are the values of collegiality and solidarity. These are attributes of the professional nurse that are becoming increasingly important aspects of nursing professionalism since they promote "cooperation and recognition of interdependence among members of the nursing profession" (Chitty, 2011: 72; cf. Hansen, 1995 and Koob, 2009). In these extracts, collegiality and solidarity are evident in certain discursive practices adopted by nurses such as the mitigation moves employed in Eve and Mandy's support for Lisa's decision in extract 6.4. This displays nurses' orientation to avoiding conflict and enhancing harmonious relations among colleagues (see Tierney and Rich, 1992; Baltimore, 2006).

6.3 Accountability and autonomy: The case of Evidence-Based Practice

With varying degrees of explicitness and implicitness, the values of accountability and autonomy have also been found to be actively negotiated in discussions of professional practices known as evidence-based practices (henceforth EBP). Though the concept of EBP is a long established one in the nursing culture, it emerged as a more formal practice during the 1990s, gaining considerable momentum over the last five to ten years (for an evolution of EBP see Pearson et al., 2007). Primarily led by the UK, EBP is

the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

(Sackett et al., 1996 in Pearson et al., 2007: 5)

In order to adopt EBPs, clinicians need to be able to find the relevant information, analyse and compare it with their own cases, and establish its generalizability across cases (see Pearson et al., 2007 and Finkelman, 2012).

6.3.1 Sarah's views on EBP

The principles informing EBP are an important aspect of nurses' discourse when reflecting upon professional practices since they embody the professional values that practitioners support. The following extracts illustrate this point.

While reviewing a recent institutional protocol for buying new stock, Sarah explains that orders should be supported with both clinical and scholarly evidence that guarantees the appropriateness of the product requested. Emma asks what happens when a product has not been tested and Sarah replies the following:

Extract 6.6 (CM2): For the sake of patients' safety

1. Sarah: products can't go into the market
2. just because someone wants to put them on the market
3. there's a safety (net) in order to protect patients

Sarah's answer focuses on the importance of having evidence that supports a decision such as putting products on the market (lines 1-2). In line 3, Sarah also highlights one of the main reasons for following an EBP approach: to provide safe and quality care. As Pearson et

al. (2007) explain, the notion of ‘best practice’ is engrained in the principles behind EBP which guide nursing practice with the aim of maintaining high and effective health care quality while, at the same time, they contain costs (Grohar-Murray and Langan, 2011).

In practice, pursuing this goal has led to the creation of “evidence-based practice [...] standards [that are] based on effective care as demonstrated through the conduction of research” (Grohar-Murray and Langan, 2011: 182). In turn, this has led to the creation of protocols that regulate practices (see Green, 2006), as they provide “concise instructions on which diagnostic or screening tests to order, how to provide medical or surgical services, how long patients should stay in hospital, or other details of clinical practice” (Woolf et al., 1999: 527; see a detailed history of the implementation of protocols in healthcare in Woolf, 1990). As the following extract shows, the writing of protocols is often motivated by certain clinically-oriented issues pertaining to their routine practices.

In one staff meeting, Sarah proposes to review standardization of measures for compression garments.

Extract 6.7 (SM4): Standardization of measures

1. Sarah: does a patient stand
2. does the patient sit
3. does a patient lie down
4. when we take the measures...
5. so that we can confidently say that between us
6. we got reasonably similar things...
7. as a team
8. just to have a go at some of the protocol
9. what we think it's the right way to do it

Sarah's reflections are consistent with the current tendency in health care professions regarding standardisation protocols (see Frush et al., 2006). Deciding on clinical procedures (lines 1-4) that are implemented with a certain degree of uniformity (lines 5-6) by

following protocols (line 8) is part of what it means to standardize their care (Rycroft-Malone et al., 2009). Sarah further explores this point in another meeting when she explains that her main concern is that the same patient may get different treatment therapies depending on who they see within the clinic. Thus, as a way of addressing this concern, she encourages the other clinicians to participate in the drafting of a protocol (line 8) that reflects their standards of practice (line 9). This presents them as a team whose practices are consistent (see ‘local universality’ in Timmermans and Berg, 1997).

Another compelling reason that leads healthcare practitioners to standardise their practices through protocol use is related to practitioners’ ability to ‘justify’ their decisions in the context of, for instance, legal threats (Frush et al., 2006). Thus, in the next extract, Sarah suggests that when they want to try a new product, they should approach her to look for evidence and ‘crack up a document’ that supports their choice.

Extract 6.8 (CM2): A very litigious age

1. Sarah: we’ll have a justification
2. because the risk is very high
3. that an untried product on a patient
4. that possibly does some harm
5. we’ve got no paper trail
6. to say why we justify this or that product
7. and in this very litigious age
8. we have to have that

Sarah begins her turn by expressing her concern for the safety of the patient. As she explains, engaging in this kind of practice protects the patients, and clinicians, from the risk (line 2) of choosing ‘an untried product’ (line 3) that can potentially ‘harm’ a patient (line 4). She then orients more strongly towards a managerial type of discourse (see Traynor, 1996) and emphasises that standardising care through the creation of protocols (see line 5) that ‘justify’ (see lines 1 and 6) their choice of therapeutic products also responds to legal concerns (line 7).

Sarah's reflections on EBP in extracts 6.6, 6.7 and 6.8 embody the values of efficiency, safety and accountability, which are core values that characterize the nursing profession (Killeen and Saewert, 2007; Fook et al., 2000). By indexing her support for these values, Sarah constructs herself as a core member of the nursing community at the same time she constructs herself as responsible manager within her particular work team. Efficiency is related to the search for the appropriate evidence that supports their decisions with the aim of minimizing the risks of medical errors and improving clinical practice (see extract 6.3) (see Aiken et al., 2001). In turn, if efficient ways of practicing medicine are followed, through the implementation of protocols that standardize practices, then high quality care and thus patient safety are maximized (see extracts 6.6 and 6.8). Behind the value of safety is nurses' conception of 'caring' or 'caregiving', identified by nurses as the major professional nursing value (Killeen and Saewert, 2007; Joel, 2006; Black, 2001). By openly displaying her support for following safe practices, Sarah prioritises patients' needs and shows a patient-centred orientation to care, constructing her as a mindful, caring and considerate healthcare provider, attributes that are highly desirable in the nursing discipline (Fagerberg and Kihlgren, 2001).

In addition, these views inform Sarah's understanding of the value of accountability, that is to say, demonstrating "sound judgement, critical thinking, and competence in the caregiver role" (Killeen and Saewert, 2007: 61), which she explores from two different yet complementary perspectives. First, she builds herself as an accountable professional when she suggests finding evidence that supports their choice of products (extract 6.6) and their clinical decisions (extract 6.7). This builds her professional credibility and expertise since her practices are supported by clinical evidence (see Hartelius, 2008). This is in line with current ideas of professionalism in nursing which rely on the fact that their professional practices must be based on knowledge (Bonaldi-Moore, 2009). Second, today's healthcare workplaces are affected by a growing number of litigious actions against them, possibly due to patients' increasing awareness of healthcare services (see Doderer, 1988). Thus, professional accountability, an integral part of everyday nursing, is highly needed since it safeguards the interests of institutions, professionals and patients (see Rowe, 2000). For many practitioners, protocols provide a viable and effective way of doing risk management when dealing with this reality (Doderer, 1988). In this context, protocols become a tool for the implementation of safety programmes such as the EBP scheme, which are expected to minimize the number of

legal actions against healthcare institutions (Frush et al., 2006). Thus, in this way, while adopting EB practices shows how Sarah values patients' safety and high quality care, they also become a professional tool that strengthens their accountability in appropriate ways as they use protocols to support their medical decisions. As extracts 6.6, 6.7 and 6.8 show, the professional values supported by Sarah guide these decisions of clinical practice and index her professional identity as a responsible and competent practitioner as she adheres so strongly to those practices that construct her accountability and caring orientation to practice.

While Sarah develops her ideas on professional practices, she constructs herself and the other clinicians as an ingroup (see 'team' in line 7 of extract 6.7 and 'we' in extracts 6.7 and 6.8). Drawing on collective identity, as explored in chapter 4, promotes a sense of team cohesion that can potentially enhance positive work relations (cf. Henderson and McEwen, 2005). In these extracts, ingroup alignment seems to be based on the conception that all of its members share the same values and ways of rationalizing clinical practice. Indeed, because values guide actions, it is important that they all share the same values to agree on the same kinds of practices if they want to standardise them (Räsänen and Linde, 2004). Thus, Sarah seems to be using group memberships as a discursive tool to persuade the other clinicians to follow those professional practices she favours (see Henderson and McEwen, 2005).

6.3.2 Clinicians' response to EBP and Sarah's persuasion moves

It is indeed relevant then to explore how the other clinicians present at the meetings respond to Sarah's reflections on the values of efficiency, safety and accountability. In the following extract, for example, Emma expresses her views on some of the issues regarding the implementation of EB practices.

Extract 6.9 (CM2): I do support it but...

1. Emma: I support it
2. I DO
3. I just think we must be careful of not making it too complicated...
4. you're gonna maybe discourage

5. and people don't actually wanna go through the rules
6. //and things\ will just stay (the same)
7. and you'll be using the same products for +
8. twenty or thirty years

Emma begins her turn by, first and foremost, positioning herself in favour of what Sarah has explained (line 1) regarding the procedures involved in ordering new stock (see extract 6.6), which she emphasizes in line 2 (see emphasis on auxiliary verb 'DO'). Emma then expresses her concerns regarding how complicated the processes could be (line 3). She points out this may discourage 'people' to look for evidence (lines 4-5), which, she is certain (see use of future simple tense in lines 6-7), will result in using the same products for many years (lines 7-8).

In spite of her alleged open support for Sarah's ideas, Emma's use of personal pronouns seems to show a certain degree of ambiguity of opinion as they seem to be used to express contradictory ideas. Initially, Emma uses first person singular pronoun to support Sarah (lines 1-3). However, as she expresses her concern regarding the complicated process involved in stock ordering, Emma shifts to 'we' in line 3. Emma may be aware of the fact that the negativity of her comment (see 'careful', 'not' and 'complicated') could be interpreted as a criticism of Sarah's ideas. Moreover, basing her opinion on what seems to be her professional experience, Emma builds herself as an expert in this matter for taking into consideration aspects Sarah might have overlooked, which eventually may construct Sarah as less expert. Thus, Emma initiates a self-repair move using 'we' and the adverb 'just' as mitigating devices to downtone the effects of her opposition to 'making it too complicated' (cf. Kaur, 2011). In this way, she does positive face work for Sarah and for herself by not addressing Sarah explicitly, which shows Emma's orientation to promoting harmonious work relations (cf. use of 'we' in complaints in chapter 4). But as the conversation continues and Emma supports her opinion in greater detail, the subject pronoun changes to 'you', this time directly addressing Sarah (line 4). Thinking beyond its potentially face-threatening power, the claim in line 4 seems to serve as a way for Emma to distance herself from the decision to follow certain procedures when ordering stock, emphasising the fact that she does not support this practice. This positioning seems to contradict Emma's initial stance in line 1, making it

more evident that it is Sarah who takes the decisions and, consequently, orienting towards their institutionally sanctioned roles of manager-clinician.

Following this, however, Emma initiates another self-repair move in line 5 by using a collective noun, 'people', as the subject of the sentence. The connotation underlying this comment can considerably damage the professional image of the team. When explaining 'people do not want to go through rules', the very heart of EBP, Emma may claim that those 'people' do not support the implementation of one of the most prominent practices in current healthcare. Thus, she depersonalizes the doer of an action, mitigating the effect of the statement which can potentially affect the team as a whole (see extract 6.4). Similarly, 'you' in line 7 seems to be used in its more impersonal form (see considerations in chapter 4; also see Kitagawa and Lehrer, 1990), not addressing anybody in particular and possibly still mitigating the claims made in lines 4 and 5. This serves Emma to display her orientation to maintaining positive work relations with her co-workers as well as with the manager (also see line 3).

Sarah addresses Emma's concern and replies:

Extract 6.10 (CM2): That's a risk

9. Sarah: well that's a risk
10. but I think we've got sufficient drive within the company
11. people DO want to see changes...
12. it'll be a question of thinking about what they're doing
13. and why they are doing it
14. why the change is necessary
15. and at what cost
16. and that is a process I believe when you're passionate about
17. and you NEED to see something
18. a better improvement for your patient
19. you WILL pursue that
20. and of course everyone can help you do that

21. you won't be on your own trying to get a new product in
22. but um we have to have the structure

Sarah starts by acknowledging Emma's point, the fact that clinicians may not look for supportive evidence and will consequently keep ordering the same products in line 9. She then explains that there is sufficient drive within the company to adopt EB practices (line 10) and to promote change (line 11). She rephrases some of her previous claims regarding how clinicians need to reflect on their practices (lines 12-13), thinking in particular about the kind of contribution that a certain change may make to the institution (line 14) and at what cost (line 15; see Wong, 2004 for cost-related issues of EBP).

At this point it seems relevant to reflect upon the relational goal of the claim in line 10. Drawing on collective identity, Sarah expresses her opinion (see 'I think' in line 10) that possibly all the professionals in the institution have sufficient drive to adopt the practices she has described and supported so fervently in previous discussions. This claim relies on the assumption that they all share the same work orientations and it serves as a vehicle to index the kind of stance that she favours in this matter. In other words, Sarah attributes certain kind of work motivation that is in line with the professional image she values as part of that institution (see 'attributions of motivation' in Miller et al., 1975).

Similarly, in line 16 Sarah shares her assumptions on the kind of personal attributions (to be 'passionate') the professionals working at the clinic should have to be able to favourably evaluate the kind of practices she proposes (Miller et al., 1975). She then seems to imply that the obvious course of action to follow if they are 'passionate' about, for instance, introducing changes (lines 11-14), is to do something that improves the outcomes for the patient (lines 17-18). Stressing the word 'need' in line 17, Sarah emphasises what she believes should be a compelling 'drive' for changing and improving practices. She further supports her claims with the assertion 'you WILL pursue that' in which the emphasis on the auxiliary verb increases the illocutionary force of the statement and demarcates good (or at least, desired) behaviour (Barker and Cheney, 1994). Thus, Sarah seems to assume that promoting change is a logical (and desirable) outcome of being 'passionate' about the work. She then softens the commanding force behind the claims in lines 10, 16-19 by orienting

towards more democratic and supportive work views explaining to Emma that she will be helped if she wants to order a new product (lines 20-21). Sarah concludes her turn, by rephrasing her initial stance, that is to say, she promotes EB practices as a way of creating the structure they need to make informed decisions and to practice safely.

As illustrated in this extract, when dealing with disagreement or resistance by clinicians, Sarah faces the challenge of persuading them to adopt the practices she supports. Sarah's discourse contains most of the elements that, according to Miller et al. (1975) and Conger (1998), are necessary to achieve successful outcomes, namely, the repetition of a message (lines 11 and 14), strong arguments supporting change (lines 16-19) and explicit statement of conclusion or decision (line 22). She also reinforces the team's collective identity (see lines 10-13 and 22, extract 6.5) and assigns certain preferred personal, emotional and work attributions to individuals (see lines 16-21). This may aim to shape clinicians' subjectivities "such that [they] come to embody and enact organizationally privileged modes of thought and behaviour, in turn achieving organizationally desired outcomes" (Halford and Leonard, 2006: 657). It is a way of exerting social control that seeks to 'normalise' individual and collective behaviour on the basis of the professional values that guide their practices (see Foucauldian principles of communication in Barker and Cheney, 1994; see normative power in Reed, 2001). Arguments that make value-based appeals usually act as a highly motivating mechanism that successfully promotes change in organizations (Barker and Cheney, 1994). In Reed's view (2001), this kind of control is necessary to maintain collective action in organizations (see also Hardy et al., 2005). Thus, Sarah, whose views and claims represent those of the dominant group within the institution, very likely aims at shaping the identity of individuals, discursively building the preferred image of the professional self as she conceptualises it, so that clinicians align with her beliefs and professional values (see Miller et al., 1975), and support those EB practices that she favours (cf. Henderson and McEwen, 2005; see development of rational and normative rhetorics of control in Barley and Kunda, 1992; see identity regulation as social control in Alvesson and Willmott, 2002).

Another discursive strategy Sarah employs to this end is analogies, which have been studied by discourse analysts for their persuasive capacity (Whaley, 1997). Analogies are a means for interactants to rationalise a problem through the presentation of a story that makes

the speaker's point more concrete and usually memorable for the interlocutors (Conger, 1998; see technical definition of analogy in Whaley and Holloway, 1996). In other words, an analogy paints "a vivid word picture and, in doing so, lends a compelling and tangible quality to the persuader's point of view" (Conger, 1998: 92). To give a brief example, as Emma responds to Sarah's comments above, she raises her concern about the lack of evidence on new products, explaining it may be difficult for clinicians to build their accountability through scholarly evidence. In support of this, Pearson et al. (2007: 13) contend that "the need to base practice on evidence has only relatively recently become a concern for the health professions" and for particular problem areas of nursing the research is either non-existent or inconclusive (Finkelman, 2012).

When Sarah replies, she maintains her position of needing to find evidence to support their practices and product choices to build their professional accountability. To support her claim Sarah uses 'a pharmacy analogy' (see 'rebuttal analogy' in Whaley, 1997), through which she encourages Emma to reflect on the hypothetical situation in which a pharmacist advises Emma to buy a drug that was recommended to him by a pharmaceutical representative but for which they have no supporting evidence. Resorting to similar discursive strategies as Martin above (see extract 6.3), Sarah builds her case using what seems to be a reflective question on the importance of professional accountability from the point of view of the patient. Thus, Sarah asks Emma: 'would you be happy unless you knew that there was evidence to support that?', to which she quickly adds 'of course you wouldn't be happy... you can't function like this'. In this way, Sarah draws on 'standard operating procedures' that build professional accountability by making reference to common sense issues of professional practice (see Barker and Cheney, 1994) and to emotional aspects of those practices as she tries to evoke a feeling of empathy for their patients (see Conger, 1998). The pragmatic value of these last two statements seems to be similar to those in lines 16-19 above; they seem to have the purpose of shaping norms of professional behaviour by assigning Emma certain emotional and work attributes (see Miller et al., 1975; Sveningsson and Alvesson, 2003). In this example, then, Sarah uses an analogy as an argumentation strategy that supports her stance on the matter and as a persuasive strategy that aims to shape the professional practices of the team, focusing in particular on Emma (see Whaley, 1997; Whaley and Holloway, 1996).

6.3.3 Clinicians' views on protocols

More polarized views are expressed when reflecting upon the use of protocols. In one of the clinical meetings, for example, Martin favourably reflects on the usefulness of protocols. First, he explains that to him protocols are useful in assisting his care when other professionals are not around for consultation. Second, he explains that sharing that kind of paper document with the patients is of great help since, at the end of the day, 'we're also humans.' Thus, as he supports the implementation of protocols, he indexes his support for maintaining professional standards of practice and his awareness of the limitations of his role, which is highly valued in a culture of safety promoting the reduction of medical error (see Frush et al., 2006; see 'precautionary principle' in Green, 2006; see extract 6.3). Similarly, as Martin, Sarah and Emma contribute to the conversation, they agree that they may forget to mention certain information to the patient or that the patient may not be able to retain so much information and, for that reason, protocols are, in Sarah's words, a 'safety mechanism.' These views are in line with those of practitioners and health care providers who see protocols as "a tool for making care more consistent and efficient and for closing the gap between what clinicians do and what scientific evidence supports" (Woolf et al., 1999: 527). Thus as they base their support for the use of protocols on these arguments, clinicians reinforce their identity claims as caring and responsible healthcare providers.

However, more often than not, clinicians reject the idea of using protocols. To give an example, Sarah asks if they have anything to add to the stocking fitting form that she has designed and Rod replies the following:

Extract 6.11 (CM4): It always looks difficult

1. Rod: try anything
2. and no matter what you write there
3. it always looks difficult

With this comment Rod reflects on how hard it is to write protocols that are suitable not only for health professionals but also for patients, as Sarah proposes to share these

protocols to facilitate patients in self-managing their illness (see ‘consumer versions’ in Woolf et al., 1999; also see Woolf, 1990). Here, Rod seems to embody the voice of experience and expertise by presenting his reflection as a categorical truth (see ‘no matter’ in line 2 and ‘always’ in line 3). His stance is displayed through not only the propositional meaning expressed in lines 1-3 but also the use of the subject pronoun ‘you’ (referring to Sarah) in line 2, which serves him as a discursive strategy to display his disaffiliative stance and thus to distance himself from being involved in the process of writing the protocol (cf. Emma’s use of ‘you’ in extract 6.9).

To give another example, in clinical meeting three, Emma raises a clinical question regarding the use of protocols; she explains that when dealing with diabetic patients there are risk factors that may not be easily observed but which affect their treatment decisions. By raising this point, Eva highlights an often-questioned aspect of the protocols: what happens when the patient presents symptoms that are not described in the protocols (Feder et al., 1999). In this regard, Martin reflects: ‘I’m more with what’s presented to you in the moment.’

Both Emma’s question and Martin’s answer implicitly reflect upon the value of professional autonomy. Autonomy refers to their ability to be self-governing and independent, that is to say, to make their own clinical decisions (Killeen and Saewert, 2007). According to Adams and Miller (2001), outstanding levels of professionalism are achieved when nurses can make decisions autonomously. In this context, then, the standardising and normative nature of protocols may be perceived as failing to acknowledge the experience and expertise of clinicians (see doctors’ arguments in McDonald et al., 2005), threatening their ability to make decisions and damaging their professional image (see Rycroft-Malone et al., 2009). In line with Emma’s reflection, an overriding argument used by those who oppose the implementation of protocols is that “every patient is different” (see McDonald et al., 2005: 292). Experienced health practitioners are aware of the unpredictability or uncertainty of patients’ cases and expertly rely on their knowledge and experience for making decisions (2005).

From the point of view of the management (see extracts 6.1-6.3), protocols are professional tools that, on the one hand, “empower patients to make more informed

healthcare choices and to consider their personal needs and preferences in selecting the best option” (Woolf et al., 1999: 527), and, on the other hand, “can improve the quality of clinical decisions” by standardising care (1999: 528; also see McDonald et al., 2005; Woolf, 1990). From the point of view of the clinicians, however, though they recognise the value of protocols in helping patients deal with the illness at home and make informed decisions, protocols restrict their professional autonomy (see Lawton and Parker, 1999; cf. McDonald et al., 2005). As illustrated in extract 6.10, these conflicting positions are apparent in the discourse of the manager as she employs identity regulation techniques in an attempt to persuade her team to adopt the practices she supports. In the case of the clinicians, the disaffiliative stance enacted through the use of pronouns such as ‘you’ (see Emma in extract 6.9 and Rod in extract 6.11) displays their reservations about following certain practices proposed by Sarah.

In an attempt to reconcile the opposing perspectives, Sarah acknowledges clinicians’ point of view as she explains the following.

Extract 6.12 (SM4): Cook book medicine

1. Sarah: it doesn’t mean everyone has to absolutely do it like cookbook medicine
2. but it does mean if we’ve got an idea

Sarah acknowledges Emma’s and Martin’s claim and refers to it as ‘cookbook medicine’, which is the common title given to the use of protocols in the literature of healthcare since, some practitioners contend, they tend to oversimplify medicine and clinical procedures, and to reduce professional autonomy (see Farquhar et al., 2002). As she explains this, Sarah employs the pronoun ‘everyone’ (line 1), which, given its ambiguous referent, seems to be used to maintain the anonymity of those who oppose her ideas. Sarah’s lexical choice potentially builds and/or maintains positive work relations as it observes Emma’s and Rod’s sociality rights of not being publicly involved in conflict (see Spencer-Oatey, 2004). Sarah’s facework efforts are then enhanced by ‘we’ in line 2, which constructs collective identity of the team (see considerations in extract 6.10) as she rephrases her sustained support for using medical protocols.

Following this short exchange, Sarah adds that because they share patients, it is important that they have a protocol ‘to guide them’ (cf. line 2) with a certain degree of ‘flexibility’ for clinicians to decide what to do. In this way, Sarah accepts the expert claims made by Emma and Martin as she opposes the ‘rigid employment’ of the protocols (see Woolf, 1990). Giving them flexibility for making their own decisions and displaying her trust for their professional judgement observe their professional right to practice medicine autonomously. This, in turn, constructs their professional identity in positive ways, which, as pointed out earlier, is a vital aspect of maintaining and enhancing collegial relations (see McDonald et al., 2005).

As a way of negotiating these disagreements, Sarah looks for democratic solutions that apply to the writing of the protocols so that all clinicians have a chance to have a say, as the next extract shows.

Extract 6.13 (CM4): Getting consensus

1. Sarah: just talking about
2. the last stage of the dvt²¹ protocol
3. and whether we can get some consensus now
4. about whether we treat the affected leg
5. AND the unaffected leg as a form of good prevention
6. or do we just all treat the affected leg
7. and what do you think?

After setting the agenda for their new topic (lines 1-2), Sarah adopts a democratic or participative leadership style (see Eagly and Johnson, 1990) regarding the drafting of the DVT protocol, which is especially evident in the use of the pronoun ‘we’ and the noun ‘consensus’ in line 3. As she presents clinicians with two choices of treatment (lines 4-6), she develops the one she seems to favour in more detail (cf. second choice in line 6) by clarifying that treating both the affected and the unaffected leg is ‘a form of good prevention’ (lines 4-

²¹ DVT stands for Deep Vein Thrombosis.

5). The adjective ‘good’ expresses Sarah’s positive value judgement for the first of her two choices, displaying her preference for it. She then closes her turn by reasserting her stance as a democratic leader when she asks for their opinion on the matter (line 7).

It is relevant to notice that Sarah’s opinion in line 5 has the power to potentially influence clinicians’ answer to her question ‘what do you think?’ (line 7). However, her overall approach to the writing of protocols (as illustrated in this extract) is democratic as in every meeting recorded she encourages clinicians to reflect upon protocol-related issues and to actively participate in the writing of these guidelines, often by building the team’s collective identity (see lines 3, 4 and 6) and emphasising that decisions are taken in a participatory way through the use of questions (line 7).

As she encourages clinicians to participate in the drafting of the protocols (see ‘democratic professionalism’ in Sachs, 2001), Sarah draws on the team’s expertise as a way of supporting their local development (see Lawton and Parker, 1999). From a transactional point of view, exploring techniques of collaborative team work and collective decision-making (also notice use of ‘we’ in extract 6.9) involves benefiting from professionals’ specialised areas of expertise (including both professional knowledge and experience, see discussion in chapter 5) in the comprehensive drafting of protocols. By promoting the co-construction of expert knowledge Sarah also potentially avoids having some of the problems often associated with protocols that are written in a top-down mode, such as misleading statements and misinterpretation of information (see Woolf et al., 1999). This democratic approach to problem-solving and decision-making is considered to be a key factor in effective leadership since it is expected to enhance organizational performance (Ford, 2006; see contextual factors influencing organizational group members’ preference for democratic leadership in Foels et al., 2000).

From an interactional point of view, this democratic approach to the writing of protocols is core to the value of interprofessional collaboration, which is closely related to ideas of professionalism. Reflecting on Larson’s ideas of professionalism, Fook et al. note that “the production of professional knowledge is an essential component of the activity of experts” (2000: 5). Thus, promoting everybody’s participation in the drafting of protocols

legitimizes their professional activities, which seems to be a step forward towards recognising them as experts in their fields and supporting their professional autonomy in decision-making instances. Moreover, involving clinicians in the drafting of protocols may be a way for Sarah to manage the conflict generated by their opposing views on the usefulness of protocols (see ways of managing conflict in Holmes and Marra, 2004). Thus, as she builds positive in-group rapport, maintaining members' social relations in harmony, this approach to the management of the protocols may be expected to result in clinicians ultimately adopting the practice of using them in medical consultation.

6.4 Discussion

The reflections underlying the extracts analysed in this chapter extend beyond the limits of addressing routines of professional practice. As nurses and clinicians debate the 'appropriate' implementation of EBP and those practices supported by the Releasing Time to Care programme, for instance, their reflections show how these practitioners operate on the value system that characterises their discipline (Chitty, 2011). In this regard, this chapter has particularly focused on the values of caring, patient safety, accountability and autonomy, in addition to some related values, such as human worth, efficiency and collegiality, as they emerged in their reflections of professional practice. Whether one value is more salient than the other(s) or displayed more explicitly, or implicitly, than the other(s), these are addressed and negotiated in most conversations on professional practice in the data presented here.

For example, whether they explicitly focus on the value of caring as in extracts 6.3, 6.4 and 6.6, or they deal with it more implicitly (see extracts 6.8, 6.10 and 6.13), when these nurses make decisions regarding their professional practices, they usually prioritise patients' care above other work duties, valuing their time with and promoting respect for their patients. In particular, more often than not, they seem to support what Maas (2006) calls 'human caring', which means abiding by the best standard of care possible guided by the value of human worth (also see Killeen and Saewert, 2007). Constructing themselves as considerate healthcare professionals is evident, for example, in extract 6.3 when Martin encourages the other clinicians to put themselves in the patients' shoes when making clinical decisions. Caring is a core aspect of the professional work that nurses provide and caregiving is

identified by nurses as the major professional nursing value (Killeen and Saewert, 2007). In line with a report issued following the Health Professions Education Summit which identifies five core competencies of nursing practice, care is the first of those since its provision is patient-centred (see ‘patient-centeredness culture’ in Down, 2004; also see Chitty, 2011; Fagerberg and Kihlgren, 2001). In this way, the value of caring is closely linked to the value of altruism as a “patient-focused, individualized, and humanistic” approach to care (Fagerberg, 2004: 285). Altruism, “unselfish concern for or devotion to the welfare of others,” ‘a service ideal’, shows an important degree of commitment with the profession “as the overall philosophy that guide[s] practice” and for that reason it is highly valued within the community (Killeen and Saewert, 2007: 60). Displaying their support for the dominant values of caring and altruism, these nurses and clinicians construct their professional identity as core members of this professional community (see Gregg and Magilvy, 2001).

In addition, patient safety, accountability and autonomy have also been identified as core aspects of the nursing culture (see Maas, 2006; Fook et al., 2000) and they, together with caring and altruism, distinguish this group of nurses and clinicians from those of other professions (see Killeen and Saewert, 2007). An exploration of these values in these two data sets shows that they are indeed the guiding principles for conduct (Gray and Thomas, 2006; see Jingree and Finlay, 2008) as nurses and clinicians build their professional accountability through them. They also define nurses and clinicians professionally as the value orientations displayed in talks of professional practice index their stance on the matters under discussion. Adopting practices that are congruent with the professional values to which they subscribe helps clinicians and nurses construct different facets of their professional identity in preferred ways (Bucholtz and Hall, 2005). Thus, as Martin draws on the values of human worth and patient safety to support his professional decisions in extract 6.3, he builds himself as a caring, empathic and responsible professional. Similarly, in extract 6.4, Lisa constructs her professional self-image as a caring and respectful nurse when she builds her case on the use of portable phones during medication module rounds.

As they engage in discussions of quality improvement practices, these nurses, clinicians and managers construct themselves as experts and as members of these two professional communities by displaying support for core values of the profession and

established norms of practice, which represent high clinical standards for the nursing profession (see Finkelman, 2012). Through these discussions clinicians also display their critical thinking skills, research and data interpretation skills, willingness to provide the ‘best practice’, skills in updating their ‘ever-changing knowledge base’, their value-driven orientation to practice (2012). By displaying adherence to EBP principles (e.g. extract 6.9), for instance, clinicians index one of the most salient qualities of professionalism: making informed clinical decisions (see Hardy et al., 2002). The fact that they are involved in following quality improvement practices may be an indicator of the making of clinically sound decisions. This, it is argued, is one of the core competencies of modern nursing practice (Chitty, 2011) and it vests them with professional integrity (see Pearson et al., 2007). Being able to base their professional practices on scholarly evidence becomes a performance measure against which health practitioners are professionally judged as competent or not competent (Wong, 2004). However, as the analysis shows, nurses’ and clinicians’ professional values may often be in conflict with certain suggested practices and even with other seemingly competing values.

In extract 6.4, for example, the values of caring and respect for the patient that Lisa and Mandy so strongly support are clearly in conflict with the practice of carrying a portable phone supported by Eve. In this case, answering the phone when with a patient is presented as being in conflict with Lisa’s ethical and moral standards, which, as she explains it, become part of the role expectations that patients have of nurses, she argues that adopting this practice is ‘rude’ and ‘inappropriate’ (see Doane, 2002). This example serves to illustrate how the relationship between responsibilities and obligations, and moral identity is a close one and they sometimes overlap as nurses decide which practices are in harmony with their professional values (2002). For nurses their moral duties may be dissonant with other proposed ward duties (see Watson, 2006). Thus, although at first glance Lisa’s position could be thought to be negatively evaluated for expressing open disagreement with Eve’s opinion on the matter, careful consideration of her (moral) stance supported by attention to discursive features of the interaction reveals that in fact she bases her argument on the main principle behind the programme *Releasing Time to Care*, focusing on the patient at the expense of other work duties.

Extract 6.9 also shows how nursing values and practices can be in conflict. Although Emma seems to understand and even claims to support Sarah's arguments in favour of EB practices and clinical protocols, she has an ethical dilemma when she realises EB-related practices may bring about unforeseen consequences in practice that may in fact be more detrimental than fruitful (also see Rod in extract 6.11). Emma's position problematizes the conventional, and rather simplistic, assumption that "professional standards guide appropriate nursing practice" (Grohar-Murray and Langan, 2011: 184) when she questions the operationalization of certain highly-valued practices and how they are in conflict with other professional values.

The sometimes conflicting positions arising from supporting certain values and evaluating certain professional practices are apparent in the discourse of the clinicians and nurses. Using similar discursive strategies as the ones explored in chapters 4 and 5, when nurses express open disagreement (extracts 6.1 and 6.4), express some kind of concern (extracts 6.6, 6.8, 6.9 and 6.11), or respond to complaints (extract 6.4), they manage conflict talk (see Holmes and Marra, 2004) in particular through the salient construction of group alignments and the use of impersonal constructions. This allows them to build their argument for supporting certain practices and/or values while also minimizing face threats. Thus, for example, the threats of engaging in conflict talk as Eve responds to Anne's and Eva's complaint in extract 6.4 are minimised by building multiple group alignments that are crafted so that the anonymity of the nurses involved in the problem is protected. Nurses' anonymity is also maintained through the use of impersonal constructions (such as passive structures and vague lexical items like 'people' and 'everyone', see extracts 6.4 and 6.9), which also allow them to do positive face work and maintain relational harmony within the team. In addition, as illustrated in extract 6.10, for instance, the disaffiliative stance enacted through the use of the pronoun 'you' (see also Emma in extract 6.9 and Rod in extract 6.11) displays clinicians' reservations about following certain practices proposed by Sarah. This use of personal pronouns allow these nurses to build their institutionally assigned roles (see Lisa in extract 6.4 lines 11-13) at the same time they legitimise their claims and construct their expertise as a nurse coordinator, a member of the nursing team, etc. Collective identity also seems to serve the goal of further supporting nurses' and clinicians' arguments (e.g. extract 6.4 lines 16-18; see discussion in section 4.4 of chapter 4). As explored in extracts 6.4 and 6.8, while

managers seem to build collective identity to mitigate potentially face-threatening comments with the aim of observing participants' face needs, nurses and clinicians seem to draw on collective identity as a way to index their support for the values of their profession, legitimising and strengthening their claims.

In these discussions professional stakes are high for both health care managers and nurses/clinicians, as decisions to change nursing practices inform and regulate their future practices and influence the quality of the service provided (Killeen and Saewert, 2007). While they review current professional practices, managers, clinicians and nurses need to decide which of them best reflect their conceptions of being and acting as a nurse/clinician/manager and which are in the best interest of the institution. As they highlight different aspects of these practices that are in conflict with some of the professional values clinicians and nurses support, such as accountability and autonomy, two levels of professional stakes can be identified: 1) those involving the professional image of the institution, and 2) those involving the professional self-image of clinicians and nurses.

At the institutional level, health care establishments are held accountable for patients' diagnosis, treatment pathways and outcomes. Thus, the professional image of the institution is at stake in these discussions since it is ultimately the institution that is legally responsible for any instances of medical malpractice or clinical inconsistency (see Pearson et al., 2007). Sarah's words in clinical meeting 2 serve to illustrate this point (also see extract 6.8).

Extract 6.14 (CM2): The buck stops at me and the CEO

1. Sarah: at the end of the day
2. the buck stops at me and [the ceo]
3. if anything goes wrong
4. and I I we can-
5. I can't function like that
6. and neither can we
7. and indeed neither can the board

In this light, institutions support EBP and other quality improvement, standardising practices exemplified in this chapter as a safety measure of health practice (Woolf et al., 1999; Lawton and Parker, 1999; McDonald et al., 2005; see managerialism in Germov, 2005). This is made evident in the drafting of protocols (see extracts 6.9-6.12), which, in Woolf's et al. words, are "tool[s] for making care more consistent and efficient and for closing the gap between what clinicians do and what scientific evidence supports" (1999: 527). For the institution, designing protocols and following EB practices enhances professionals' accountability as they rely on solid basis for their clinical decisions; and this is expected to prevent the institution from being sued (see Pearson et al., 2007). In this context, the managers, Sarah and Eve, mediate between those who are higher in the hierarchical scale, such as the CEO and the board of directors of the institutions (see lines 2 and 7), and those who are in a lower position in the scale, the practitioners. The managers represent the interests of the institution and, for this reason, they become its gatekeepers since they are responsible for ensuring that practices are followed and that the safest service possible is provided (see Nieva and Sorra, 2003; see institutional gatekeeping in Johnston, 2008). In this regard, Jingree and Finlay explain that "the power differential in a high-stakes gatekeeping encounter means that it is the institutional representative who has greater power to acknowledge a similarity, [or display preferred practices,] build upon it, drop it, or refute it" (2008: 24). As the analysis shows, Sarah's and Eve's interactional stances often have the goal of protecting the image of the institutions and are indexed through the content of the discussions and the above-mentioned discursive practices.

On the other hand, from the clinicians' point of view, however valid this institutional stance on the issue of accountability may be (see Martin's views expressing support), it does in fact seem to be perceived as depriving them of their professional autonomy (see Swinkels et al., 2002). This duality present in the application of EBP and EB-related practices has been acknowledged and discussed at length in the nursing literature (see Colyer and Kamath, 2001). As McDonald et al. (2005: 290) explain "the current orthodoxy within patient safety research and policy is characterised by a faith in rules based systems which limit the capacity for individual discretion." Professional autonomy refers to nurses' and clinicians' ability to make their own decisions based on their knowledge and experience, in other words, their expertise. Killeen and Saewert (2007) explain that being autonomous implies having control

over their practices by developing their own standards of practice and being accountable for their own actions. Autonomy is in fact argued to be a precondition for accountability (Batey and Lewis, 1982). In this light, being autonomous is a synonym of professional status, and it involves a feeling of empowerment (Wade, 1999). It is then, from clinicians' point of view, their professional image that is at stake as standardising routines may threaten their authority in their field of practice, and, consequently, damage their professional self-image. In this way, values that are highly cherished in the nursing profession, such as accountability and autonomy, are in conflict; this constraints professional practice and puts the institution's and practitioners' professional images at stake (see Chitty, 2011).

Professional identity seems to come to the forefront more explicitly when stakes are high for interactants as social actors need to enhance their professional image to legitimize their opinions and decisions or to repair it when in the presence of face-threatening acts. Although these nurses' belief and thoughts about their professional standards may be shared, their different role positionings and the stakes these represent in discussions of professional practice seem to lead them to weigh and prioritise these values in different, and sometimes competing, ways, as the above discussion shows. Their professional identities are re-considered as they negotiate professional practices and directly (see the case of 'caring' in section 6.2) or indirectly (see 'autonomy' in section 6.3) the values that guide them. This suggests that values are differentially regarded according to the professional role each interactant fulfils within the institution (see McDonald et al., 2005).

Possibly motivated by the high stakes involved in displaying powerful stances that would legitimate and enhance a positive professional image of practitioners and managers, values and practices are both actively negotiated as interactants discursively argue for and build their professional stance (see Doane, 2002). As discussed earlier, in this negotiation the goal of the managers is to standardise practices (see section 6.3.1). Professional standards can only be built upon a shared understanding of the quality of care patients should receive and of the values that guide their practices and clinical decisions. Indeed, autonomous action within the organization can be in tension with organizational norms of conduct, which can be perceived as lack of internalization of values and norms valued by those communities (Kosmala and Herrbach, 2006). It is important then that managers are able to confront

practitioners' rejection to following certain practices by persuading them to identify with the values these practices are thought to embody (2006).

Thus, in order to shape collective conduct and promote teamwork cohesion, managers employ a number of discursive strategies that act as social control or identity regulation mechanisms (see Alvesson and Willmott, 2002). These include explicating values, membership affiliation, analogies and defining the context, for example (see extracts 6.8, 6.10, and 6.12; also see Kosmala and Herrbach, 2006; Jingree and Finlay, 2008; Doane, 2002). These techniques are used so that clinicians are "enjoined to develop self-images and work orientations that are deemed congruent with managerially defined objectives" (Alvesson and Willmott, 2002: 619). As they build the arguments that support their stances, the managers of both workplaces construct group memberships in dynamic ways, sometimes aligning with their sanctioned institutional role (e.g. Eve in lines 5-7, extract 6.4) and other times with the team's collective identity, with the aim of achieving the transactional and relational goals of the interaction (Johnston, 2008). In particular, collective identity seems to allow managers to give directives (e.g. extract 6.4) and respond to complaints, disagreements and concerns in appropriate ways while they build in-group solidarity. Ultimately drawing on collective identity as a way of building positive team rapport is expected to improve organizational performance (Alvesson and Willmott, 2002), and in the context of this study, it may serve to persuade clinicians to adopt the practices suggested by managers (see extracts 6.6, 6.7 and 6.8) or follow their directives (see extracts 6.4 and 6.10).

However, as the extracts show, it is not all about imposing organizational norms and values. Recognising the need of professionals to practice autonomously, managers also encourage reflection, feedback and participation as ways to acknowledge nurses' and clinicians' expertise. Through 'participatory practices' (see Billett, 2004), Sarah and Eve empower team members by giving them some responsibility on the decision-making process (see protocol writing instances in the clinic and feedback sessions in the hospital). When encouraging staff members to participate, Eve and Sarah promote professional accountability since, if clinicians participate in the decision-making process of drafting the protocols, they can also be held accountable for what they decide to include, or exclude, from the document and for how this will shape their future professional practice as a community. In this way,

practitioners are given some ‘autonomy’ as they actively monitor and revise their practices in collaborative ways (Killeen and Saewert, 2007: 53, 55). This democratic approach (see Holmes et al., 2007) to the discussion of professional practices may have positive outcomes in at least three ways. First, they aim to promote the standardization of guidelines for safer practice and lower medical costs. Second, it is likely that by promoting active involvement in decision-making processes, clinicians may take ownership of the practices agreed upon (see Miller et al., 1975). Third, stressing its importance from a relational point of view, these participatory practices may foster harmonious workplace relations and job satisfaction as nurses feel their expertise is valued and respected (see Pearson et al., 2007; cf. Aiken et al., 2001).

Identity claims are an obvious ingredient of this negotiation as clinicians display their expertise to build their credibility and arguments when supporting certain stances. In these two data sets, professionals position themselves in the context of the conversation by drawing on professional values to make argument points. When managers, nurses and clinicians express their opinions on the professional practice they are evaluating, they draw on the values that inform these opinions as a means to support their stances (cf. Myers, 1998). Whether these values are referred to explicitly or implicitly, they seem to be used as argumentation tools that give sense and provide justification for their decisions on which practices to implement and how (see Doane, 2002). In this way, speakers are ‘doing professional accountability’ which involves choosing those practices that support their values, as well as choosing the appropriate values to support certain practices from a set of values that inform the profession (cf. O’Reilly et al., 2009). Orienting towards professional values, the pillars of nurses’ professionalism, enhances the quality of their opinions and suggestions, displays the appropriate professional self-image and contributes to the construction of their professional identity as experts.

Moreover, these values allow nurses and clinicians to construct their professional identity as core group members at a local and a wider community level. At the local level, nurses and clinicians index their group membership as core members of their work team, and, very likely, also the organization they work for by supporting and sharing their expert knowledge in regards to specific practices followed at their institutions. From a discursive

point of view, nurses and clinicians display local group alignment through their (oftentimes, similar) use of linguistic resources (see discussion above) that allow them to manage conflict talk while they orient towards maintaining harmonious work relations. At a wider community level, nurses and clinicians construct themselves as experts by displaying their support for those values that index their alignment with their professional discipline. In this way, displaying support to core values such as caring and altruism, and to established norms of practice that represent high clinical standards for the nursing profession, nurses and clinicians position themselves within the social system of the workplace and that of the profession (see Wenger et al., 2002), providing evidence of what it means to nurses to ‘doing being a good nurse.’

In the context of the discursive negotiation of professional practices, those values upon which practitioners build their professional stance are negotiated as speakers reorient their social positions in conversation when, for example, reflecting upon the opinion of other experts. Thus, speakers’ interpretations of these values may be prone to shifts in meaning and prevalence in conversation as these aspects are negotiated in interaction. As a result, nursing culture, as an integral aspect of healthcare practitioners’ professional identity, is in constant state of flux, actively redefined as values are reconsidered and renegotiated in the face of changing workplace practices (see Gray and Thomas, 2006). From a social constructionist perspective, values, as an integral aspect of nursing culture, nursing culture, as an integral aspect of nurses’ professional identity, and nurses’ professional identity, a defining characteristic of professionals, are all socially negotiated and constructed on an ongoing basis as different viewpoints are debated in reflective instances of professional practice.

6.5 Summary

The chapter has explored the values informing nurses’ professional identity in reflections of professional practice. These discussions provide evidence of the nurses’ awareness of and identification with the professional value system attached to the profession and, in relation to this, what it means to them to ‘doing being a good nurse.’ Examining the data from both workplaces, this chapter has examined how professional identity is enacted and negotiated in the context of professional high stakes discussions as nurses and clinicians

negotiate their practices and values as a way of supporting their stances and ‘doing’ their professional identity. Ethical dilemmas involved in conflict of values raise the stakes for interactants, which prompts them to further negotiate their stances and practices in salient ways. In particular, the chapter has shown how managers employ certain discursive strategies as mechanisms of social control with the aim of persuading practitioners to follow certain EB and EB-related practices. In this way, managers use reflective practices to reinforce “collective understandings of their professional practice” and values to persuade nurses and clinicians to adopt certain practices (Allsop and Mulcahy, 1998: 820; Henderson and McEwen, 2005).

The final chapter summarises the findings of this thesis, how these address the research questions specified in the introduction and the implications of the findings.

Chapter 7

Conclusion

The aim of this study has been to shed light on the discursive enactment and construction of nurses', and clinicians', professional identity. Fagermoen's definition of professional identity, that is to say, "the nurse's conception of what it means to be and act as a nurse," has been guided the conceptualization of identity in context (1997: 435). Throughout this thesis, I argued that this encompasses nurses' professional values and beliefs, ways of belonging to their communities and type of practices they adhere to. Moreover, professional identity is partly enacted and negotiated by nurses' discursive practices, which constitute an integral part of who they are as nurses. These practices allow nurses to index a number of group alignments, make expert claims and display professional values that guide their practices, all of which display their professional orientation and construct their professional identity.

Guided by social constructionist views, this professional aspect of the social self has been explored as an inherently social phenomenon that emerges in interaction as speakers dialogically construct and negotiate their stances, that is to say, the social positioning of self and other. In this negotiation, different aspects of their professional identity become more or less relevant and meaningful at different points in relation to the contextual factors that characterise an interaction and the communicative goals of interactants. Aspects of professional identity have been shown to be reinterpreted and reformulated in the context of social experiences on an ongoing basis. In this way, recognising the role of contextual factors in the choice of identity-related practices has allowed me to investigate professional identity as it is constructed in local (or situated) interaction.

As discussed in chapters 1-3, this research was partly motivated by the lack of empirical evidence of the discursive construction of nurses' professional identity in the context of nurse-nurse backstage interaction. Nurse-nurse communication has received little attention when compared to that of the doctors and patients, and to front-stage interactions.

This research focus has often led to the investigation of medical discourse in the construction of asymmetrical power relations, in which nurses are frequently compared with doctors. In addition, most studies exploring nurses' professional identity have been conducted with nursing students, as the focus of interest has traditionally been placed on how professional identity is initially constructed and maintained through learning experiences in the pre-graduate/novice environment. Moreover, research involving fully practicing nurses has almost exclusively described nurses' self-reported perceptions of their professional identity through the use of questionnaires and interviews.

Moving away from the traditional approach taken to the study of nurses' professional identity, this thesis has highlighted the value of focusing on discursive practices as a way to explore nurses' professional identity in naturally-occurring situations. Discourse, as a social practice, is seen as a vehicle through which nurses perform certain acts and index certain stances. In this light, discursive practices have been shown to play a central role in the intersubjective negotiation of nurses' professional identity as nurses and clinicians claim, contest, and re-construct their professional identities. From this standpoint, knowing how nurses 'do being' nurses in the context of local practice is a more relevant focus than what they report they think they do in reflexive practice. As will be explored in subsequent sections, this approach has much to offer to improving professional practices.

In this context, professional socialisation has been emphasised as the interactional site in which professional statuses and roles are socialized into being in not only new but also already established workplace groups. Differing from general considerations on this matter, workplace socialization should, in my view, be, as here, applied more flexibly to contexts involving workers other than novices in order to embrace and account for the rapidly changing social reality of workplaces in which professionals find themselves constantly reworking the boundaries of their professional and institutional roles.

Backstage interactions are a vital context for socialization processes and a rich environment for the exploration of nurses' professional identity. To access this context, four kinds of meetings at two healthcare workplaces, one that I have identified as public, the hospital, and one that I have identified as private, the clinic (see their descriptions in chapter

3), were included in this research. The data sets were composed of two different kinds of meetings from each workplace, namely, roster and handover meetings from the hospital, and clinical and staff meetings from the clinic. These meetings can be categorised as semiformal (roster and clinical meetings) and formal (handover and staff meetings). These have been shown to be valuable sites where nurses and clinicians build their professional identity as they reflect upon their clinical practices and discuss other professional concerns, such as patients' cases. In this context, nurses' and clinicians' roles and thus, their professional identity, have been actively evaluated, considered, enacted, shaped, constructed and sustained through their discursive practices.

Focusing on the interpretation of authentic linguistic data, the frameworks of social constructionism (SC), social identity theory (SIT), Interactional Sociolinguistics (IS) and Community of Practice (CofP) underpin this study for their theoretical and methodological relevance and complementariness to the study of nurses' professional identity formation. While using IS as a methodological approach enabled me to design a methodology that is in line with the goals of this study for its ethnographic value and its focus on context and culture, my theoretical stance on professional identity construction, is reflected in the use of SC, SIT and the CofP frameworks, allowing me to explore professional identity as it emerges within the boundaries of local interaction and practices. Very importantly, the analysis has been built upon close consideration of the audio and video recorded data, my own observations and ethnographic notes of meetings, interviews with managers, informal meetings with other PhD students and staff members of the School of Nursing, Midwifery and Health, my participation in discourse analysis data sessions and conferences, and an extensive study of the literature regarding professional identity construction, and pragmatic and organizational phenomena. This provided me with a deeper understanding of the social practices of these communities of nurses and allowed me to triangulate my interpretations of the data.

In what follows, I explore the research questions that guided this study and summarise the findings presented in each chapter.

7.1.1 Research questions

This thesis has shown how nurses' professional identity is a dynamic and fluid aspect of the social self that is constantly reoriented within and across interactions with the aim of fulfilling certain interactional goals. This has been shown through the investigation of professional identity from three complementary aspects that correspond to the research questions posed in chapter 2. These are:

1. How does the formation of in-groups and out-groups contribute to nurses' discursive construction of professional identity in workplace meetings?
2. How is professional identity constructed through the discourse of expertise in workplace meetings?
3. What are the values that characterize nurses' professional identity and how are these presented through discourse? What professional stakes do these values represent for nurses?

The analyses carried out in response to these questions in chapters 4-6 show how, during workplace meetings, nurses and clinicians engage in acts of identity as a routine activity when they evaluate their professional practices. They also highlight the construction of professional identity as a context-specific (see Pennycock, 2010; Renkema, 2004; Dannels, 2000) and intersubjective achievement as the speaker exercises agency in making self and other identity claims (see Korsgaard, 2009), particularly emphasising identity ascription as an integral aspect of the negotiation process (see Beijaard et al., 2004). Nurses and clinicians are then involved in interpretative and evaluative processes of identity claims, which results in them accepting or rejecting these identity positionings (see Buchlotz and Hall, 2010). This highlights the partial nature of identity construction as other-initiated claims, for instance, cause nurses and clinicians to re-consider and negotiate their stance with the purpose of orienting towards a preferred professional image of themselves. In particular, this thesis has shown how interactants exercise agency in the professional identity construction process by making situationally motivated selections of their discursive resources to craft their identity

claims (see Bucholtz and Hall, 2005). These choices have been explored in the context of complaints, the display of expertise and reflections of professional values that guide nurses' practices, as captured in the research questions above.

In the case of complaints, the data from the hospital has illustrated how the choice of personal pronouns for the display of multiple group alignments plays a significant role in nurses' identity construction processes when voicing and responding to direct complaints. I have argued that, in spite of their face-threatening potential (Lerman, 2006; Daly et al., 2004; Boxer, 1993), framing complaints through the appropriate group memberships can minimize their possible face-damage effects. Tailored by the interactional context, nurses adopted various group memberships in the course of an interaction to fulfill interrelated interactional purposes: in-group/out-group alignments reproduce the social structure that allows nurses to 'indirectly' voice direct complaints and nurse managers to respond to them in community-appropriate ways, and, in this way, they also allow nurses and managers to attend to the face needs of all involved (see Kasper, 1990). Thus, the nurses in this study have employed the construction of group memberships that efficiently adapt to the demands of the different interactional goals in order to comply with appropriate face-saving and rapport building norms. In this context, personal pronouns have sometimes been found to meaningfully highlight institutionally sanctioned hierarchies (such as that of managers and nurse representatives), while, at other times, they have taken on a number of indexical values to display various hierarchies based on the speakers' closeness to participants which differed from their institutionally assigned roles. As nurses complain and managers respond to these complaints, these multiple alignments become complementary to rather than exclusive of each other; the nurses and managers reorient their affiliations and negotiate their professional identity status in meaningfully appropriate ways through their shared discursive norms and practices (see Coakes and Clarke, 2006; Bucholtz and Hall, 2005).

In response to the second research question, it was found that question-answer adjacency pairs, medical jargon, and rationality of case presentation are some of the powerful resources that clinicians employ not only for transactional purposes but also for making relevant expert claims. Using the data from the clinic, I have shown how gaining expert status in this community is about earning credibility, authority and acknowledgement by arguing for

the legitimacy of what clinicians do and think (see Hartelius, 2008). It was argued that the epistemological and ontological ramifications that extend from the use of these discursive practices are directly related to the construction of clinicians' professional identity at different levels, namely at the speaker and addressee level, and at the level of their collective identity as a team. Thus, for instance, it was found that question-answer adjacency pairs position not only the answerer as a knowledgeable professional (see Freed and Ehrlich, 2010) but also the questioner as they skilfully design and direct the questions in expert ways (see Tracy and Carjuzáa, 1993). In this light, it was suggested that, independently from clinicians' institutionally sanctioned roles, power asymmetries in clinical meetings are temporary as they are instrumentally shifted from one social actor to the other when different areas of expertise are brought to the fore. In the construction of medical cases, discussions of ACC compensation eligibility and instances of workplace learning, clinicians need to continually readjust the boundaries of their professional expertise to be able to make relevant expert claims through the discursive practices that characterise this community. In this context, recognising the expertise of the others seems to maintain power balance among clinicians. The validation of each other's authority in specific areas or domains of expertise may ultimately contribute to the promotion of harmonious workplace relations (see Bourhis et al., 1989).

Moreover, chapter 5 shows that negotiating one's expertise is not a straightforward, linear business, as some advocates of cognitive stage models seem to suggest (see Dall'Alba and Sandberg, 2006; Bridges et al., 2010), and that this activity is not restricted to novices but is also undertaken by fully practicing experienced professionals who constantly negotiate their expert status at both local and wider community levels in the rapidly changing workplace reality. This, as I propose, is part of an ongoing process of professionalization in which expertise, as an intersubjectively constructed aspect of the professional self (see Sarangi, 2010; Candlin and Candlin, 2002), belongs in a dynamic continuum which is actively transited by clinicians as they construct themselves and others as expert and less expert in different aspects of professional practice. As illustrated in relation to the second research question, expert talk becomes a rich discursive site for the display of clinicians' professional identity as they portray themselves and others as knowledgeable, authoritative and competent professionals. Similarly to the findings presented in chapter 4, the multiple

subject positions resulting from these expert claims allow clinicians to navigate the different interactional workplace contexts in expert ways.

Finally, research question number three is addressed in chapter 6, which, building on the constructs explored in chapters 4 and 5, extends the discussion of nurses' and clinicians' professional identity construction by investigating their evaluations of professional practice. Examining the data from both workplaces, this chapter explored how professional identity is enacted and negotiated in the context of professional high stakes discussions when nurses and clinicians negotiate their practices and values as a way of supporting their stances and 'doing' their professional identity. In the meetings recorded for this study, nursing values frequently came to the surface when nurses' reflections had the purpose of improving professional practices by evaluating, standardising, and/or changing them. In this context, professional values emerge in nurses' discourse as one of the most meaningful aspects of their professional self. This chapter has particularly focused on the values of caring, patient safety, accountability and autonomy as they emerged in their reflections of professional practice. Whether one value is more salient than another or displayed more explicitly, or implicitly, they have been made relevant in most conversations on professional practice in the data presented here.

These values allowed nurses and clinicians to construct their professional identity as core group members at a local and a wider community level. At the local level, by supporting or showing their expert knowledge in regards to specific practices followed at their institutions, nurses and clinicians index their local group membership as core members of their work team, and possibly also the organization they work for. At a wider community level, nurses and clinicians construct themselves as experts by displaying support to core values of the profession, such as caring and altruism, and to established norms of practice, which represent high clinical standards for the nursing profession. Thus, as nurses and clinicians debate on the 'appropriate' implementation of Evidence-Based Practice and those practices supported by the Releasing Time to Care programme, for instance, their reflections show how their decisions are based on the value system that characterises their discipline. Because values display nurses' stances in relation to the beliefs that guide the practices they adopt (see Doane, 2002), when nurses support or reject certain values, they index their

alignment, or disalignment, with their discipline or professional group and/or with their local practice community. This enables nurses to position themselves within the social system of the workplace and that of the profession and provides evidence of what it means to nurses to 'doing being a good nurse' (see Killeen and Saewert, 2007). Discursively displaying the extent to which their practices and reflections are guided by their professional values at both local and wider levels may help nurses to develop a sense of professionalism that contributes to their construction of a positive professional self-image.

The analysis shows that some of the professional practices nurses and clinicians reflect upon conflict with the values they support (see Watson, 2006). As illustrated in chapter 6, ethical dilemmas involved in conflict of values raise the professional stakes as nurses have to sometimes choose between following a practice that is supported by the managers and following the practices that best represent the values they hold. These stakes have been shown to be high at an institutional level, since by following certain practices, institutions hope to improve the quality of the service provided, and at a personal level, as decisions on nursing practices inform and regulate their future practices and influence the quality of the service provided, putting nurses' professional image at stake. Thus a clash of values and practices, for instance, has been shown to cause nurses to revise and rework their positions in a given interactional context to better reflect their conceptions of being and acting as a nurse. In these discussions discourse plays a significant role in that it is the tool nurses and clinicians use to support certain values and practices, and negotiate their stances (see Henderson and McEwen, 2005; Bucholtz and Hall, 2005). Thus, nurses and clinicians manage conflict talk (see Holmes and Marra, 2004) in particular through the salient construction of group alignments and the use of impersonal constructions, which allows them to build their argument for supporting certain practices and/or values at the same time they observe participants' face needs by minimizing face threats. It was also shown that managers employ certain discursive strategies also build group memberships, especially collective identity, and make analogies as mechanisms of social control (Alvesson and Willmott, 2002) with the aim of persuading practitioners to follow certain EB and EB-related practices.

7.2 Implications

The implications of this study can be divided into three broad categories. There are theoretical implications arising from the insights gained when exploring professional identity, reflecting upon one of the most salient contextual aspects of the interactions explored in this thesis. There are also methodological implications related to the importance of analysing naturally-occurring data and some considerations of the study of professional identity in multicultural workplace settings. Finally, there are implications for the workplaces as the findings presented in this research can inform professional practices with the hope of improving workplace relations. These implications are explained in more detail below.

7.2.1 Theoretical implications

Through examples of naturally-occurring conversations, this study has demonstrated how nurses' and clinicians' conceptualisations of identity are reflected in the way they exercise agency in the construction process, reproducing preferred aspects of their professional identity through their linguistic choices. An important aspect of displaying their professional identity that surfaced clearly in the data is that of indexing group memberships both at a local level, thus identifying with the team they work with, and at a wider community level, showing support for the values and other discipline-specific modes of identification (see chapter 5) that distinguish the nursing profession (and culture) from others. In particular, this thesis has shown that nurses' and clinicians' group memberships play an important role in the linguistic choices available to them. In this context, language then is used as a vehicle through which nurses index their affiliations to appropriate groups drawing on their shared professional conceptualisations and specific knowledge, and their repertoire of linguistic resources for fulfilling their relevant activities (see Hall, 2012; Lingard et al., 2003). Although participants in the two data sets may at times index their group affiliations in different ways (see chapter 6), at other times they seem to use the same discursive strategies for similar socio-pragmatic purposes. The managers of both workplaces, Sarah and Eve, for example, use personal pronouns to index multiple group memberships in similar ways. Whether this is a cultural trait (both are New Zealanders), a gendered characteristic (both are

female), a form of leadership style or a combination of these remains unclear and could be addressed in future investigations.

As nurses and clinicians claim legitimate membership of a number of groups at more local (such as, in the case of the hospital, the team they work with and the ward they work in) and distant levels (such as their membership of the institution they work in, as healthcare providers of a particular city or region, in a given country), they position themselves within a complex professional network of communities that serve them different purposes but all of which seem to contribute to the same goal: displaying a preferred image of their professional self. In this sense, this thesis hopes to have advanced sociolinguistic understanding of the construction of professional identity by illustrating with examples of spontaneous talk the dynamism of the negotiation process involved and resulting in the display of a given stance.

Although most current studies on professional identity adopt a social constructionist approach, nurses' professional identity had not been explored as an interactional accomplishment in the context of workplace meetings before. Then possibly the major contribution this research aims to make is based on the unique combination of contextual factors that were considered when investigating nurses' professional identity, that is to say, the exploration of professional identity through the analysis of naturally-occurring data and the employment of methodological approaches such as interactional sociolinguistics, socio-constructionism and the framework of CofP, in the context of nurse-nurse backstage interaction. The approach to nurses' identity construction adopted in this thesis then builds on the knowledge provided by the considerable body of research contributed by self-report studies on nurses' professional identity, providing enriching insights of its construction in spontaneous interaction.

Considering the study of identity more generally, a final reflection in this regard, which requires further investigation, is that if we assume that professional identity construction is dynamic and an intersubjectively negotiated aspect of the self, then the constructs through which we investigate identity claims also need to be viewed as dynamic (as opposed to stable or fixed) outcomes of social interaction. This is the case of, as explored in this thesis, power asymmetries, expertise and group memberships, which as dynamic and

socially constructed aspects of self, are subject to evaluation and re-positioning as the context of the interaction changes, sometimes regardless of the institutionally sanctioned roles of the participants. This approach to identity construction highlights the multidimensional and temporary aspects of it as nurses and clinicians index their memberships at local and wider community levels and reorient these alignments in relevant ways to suit their interactional goals and to display a positive professional self-image.

7.2.2 Methodological implications

An investigation that provides insights into the kind of dynamism in the identity construction process referred to above was made possible through discourse analysis. As argued at various points in this thesis, this approach to the investigation of professional identity construction is widely supported by sociolinguists who have stressed the need to use authentic data in workplace research for the insights that this kind of data provides (Tannen, 1994; Bilbow, 1997; Holmes and Marra, 2002; Holmes, 2006; Habib, 2008; Ladegaard, 2011; Schnurr et al., 2007; Schnurr and Chan, 2011; Vine, 2009; Lazzaro-Salazar, 2009). Although this emphasis on empirical evidence has been reflected in the study of professional identity in healthcare settings (e.g. Rees and Monrouxe, 2010; Heritage and Maynard, 2006; see studies in Drew and Heritage, 1992; Heritage and Clayman, 2011; Major et al., 2008), the above-mentioned research has not focused on the discursive construction of professional identity of nurses as they interact with other nurses in backstage work. In the context of this study, using a qualitative approach to the study of nurses' professional identity, naturally occurring discourse has been shown to offer insights into the sociolinguistic behaviour in which nurses engage to socially construct their professional identity in interaction, as opposed to how they 'think' they do it (see Koester, 2002, 2010).

Moreover, one of the aspects that characterised this study was that its participants come from a number of ethnic backgrounds. However, no evidence was found in the discourse used by nurses or clinicians to support the premise that there exists some intercultural difference in the way they discursively construct their professional identity. Using the community of practice framework as an analytic tool allowed me to explore the construction of professional identity in the context of a jointly negotiated enterprise and to

account for the similarities in the use of linguistic strategies observed in the data in spite of the ethnically diverse backgrounds of the participants.

In an era of workplace multi-culturalism, however, a growing concern for managers seems to be bridging cultural differences among their staff members since these are mainly perceived as detrimental to successful communication (see Koester and Lustig, 1993; Spencer-Oatey, 2004; Kotthoff and Spencer-Oatey, 2007; e.g. Schouten and Meeuwesen, 2006; Moran et al., 2010). In this regard, I noticed in particular that some of the ‘foreign’ nurses did not verbally contribute in the meetings. Whether this was due to lack of language to express their ideas appropriately or to other sociocultural considerations such as cultural expectations of how and when to address a superior (see Tannen, 1983), for example, the researcher cannot access such information without interviewing the participants. Although I interviewed the managers of both workplaces rather formally, I did not have, at the time, the opportunity to interview nurses or clinicians. Thus, an idea to enrich the insights gained in this study in that regard would be to combine the data collection methods of recording naturally-occurring conversations and collecting self-report data through introspective interviews, for instance, to have participants reflect upon their participation (or lack of it) in different instances by watching parts of the video-recording and reflecting upon them (e.g. Lazzaro-Salazar, 2009).

7.2.3 Implications for the workplaces

7.2.3.1 Importance of identity-related issues in organizational life

As argued throughout this thesis, a central aspect of the identity construction process is its enactment. In the context of this study, the enactment of nurses’ professional identity is mediated by their conceptions of the values of the profession and of what it means to be a ‘good’ nurse (see also Gregg and Magilvy, 2001). Here lies the relationship between ‘doing’ and ‘being’ inherent in a coherent presentation of the professional self (Pratt et al., 2006). As demonstrated particularly in chapter 6, these beliefs, which characterise their professional identity, guide and shape nurses’ decisions on the kind of clinical practices they adopt. Professional identity does then play a significant role in organizational life as it has the power

to influence nurses' work performance (see rich discussion in Pratt et al., 2006; Ibarra, 1999). In addition, conceptions of what it means to be a good nurse also influence interpersonal dimensions of workplace interaction (e.g. Ely, 1994; see collegiality among nurses in section 7.2.3.3 below). Emma's reflection on how making short changes 'ruins it for everyone else' in extract 6.1 of chapter 6 provides evidence of this. A possible interpretation of her complaint would be that in her view being a good nurse involves thinking about what is best for the other co-workers and being considerate with the team before requesting short changes. The contribution this study makes in this regard relates to the kind of evidence a discursive analytic approach to professional identity can offer in terms of, for instance, which values inform professional decision-making in actual practice and how these are negotiated, how expertise is displayed in appropriate ways in given communities (e.g. acknowledging the expertise of others when asking for help), how complaints should be voiced and responded to in order to comply with the norms of a particular group, etc. This kind of analysis can also provide organizations and staff members more generally with discursive tools to, for example, persuade team members to follow institutionally supported practices while maintaining good rapport among interactants (consider extract 9 and the pharmacy analogy example in chapter 6). Such considerations of professional identity can be highly relevant to the improvement of communication among nurses and nursing practice (see Gregg and Magilvy, 2001).

Very often, these findings are made accessible to organizations through pedagogical material. Increasingly, linguists and sociolinguists have devoted themselves to the application of discourse analysis findings in organizational life (e.g. Holmes and Marra, 2011; Angouri, 2010; Newton, 2007a; Newton and Kusmierczyk, 2011). In particular, the team of the Language in the Workplace Project, with a long trajectory working with organizations, provides this kind of information through feedback sessions, reports, and leaflets or brochures, occasionally also publishing some of their work in the organizations' newsletters or magazines (e.g. Newton, 2007b; Holmes and Major, 2002; Holmes, 2007). Specifically, since educating nursing students on, for example, the values of the profession is contemplated within the syllabuses of the nursing training courses (Ryan and Brewer, 1997; see Fagerberg and Kihlgren, 2001 and Niemi, 1997), findings such as the ones presented in this study can potentially inform pedagogical material in the area of nursing education for training purposes

(see Pratt et al., 2006). Providing this type of feedback to organizations emphasises the aim of this study of doing research *with* (as opposed to *on*) participants and their institutions (Cameron et al., 1992).

In the light of the findings discussed in this thesis, some suggestions for the organizations are made in the following two sections.

7.2.3.2 The value of reflective practice: A way of promoting future direction

When considering the applications of this study to nursing environments, a final reflection should be made on the value of reflective practice. As illustrated in this thesis, nurses and clinicians build their professionalism in different ways and one way of doing this is to engage in discussions of professional practice. In this regard, some scholars claim that professionalism can be defined through the intellectual activities in which professionals engage (see Swick, 2000; Bossers et al., 1999; Bonaldi-Moore, 2009). In chapter 5, and further developed in chapter 6, I have discussed that reflective practices, as a key activity in nurses' socialization processes, are a rich environment for building professional knowledge. Engaging in reflective activities allows nurses to learn to act professionally in the institutional contexts relevant to them (see section 5.6 in chapter 5) through the acquisition of values, skills, behaviours and professional norms (see Killeen and Saewert, 2007). In this study, for instance, chapter 4 explored how nurses and managers negotiated their norms for complaining and responding to complaints; in chapter 5 clinicians displayed appropriate ways of enacting expertise; and in chapter 6 nurses and clinicians negotiated their professional values and practices. In this light, reflective practice then also provides a rich site for the ongoing formation and re-formation of nurses' professional identity as nurses and clinicians interpret and reinterpret professional experiences while engaging in a self and collective evaluation of professional practices.

While nurses and clinicians develop their individual professional identity by participating in the evaluation of professional practices, they also build their collective identity as a team that works together in solving professional problems, and sharing and creating new knowledge. It is by contributing to solving problems of clinical practice that

social actors are believed to develop “a shared understanding of what they do, how they do it, and how it relates to other communities and practices” (Brown and Duguid, 1998: 25 in Huq et al., 2006: 341). As discussed earlier, an integral part of how they ‘do being’ a nurse/clinician is the use of a shared repertoire of discursive practices that allow these groups of professionals to build their professional identity in relevant and appropriate ways as members of a number of professional communities. Thus, instances where nurses can reflect upon their practices may contribute to the construction of a shared repertoire of discursive practices, a shared goal, purpose, and value system, which may develop a sense of ‘unity and association’ (Carpenter and Platt, 1997) or, as Wenger et al. (2002) explain, a sense of group belonging. This kind of organizational and/or group identification can potentially influence a team's cohesiveness (Lee, 1971; Hogg, 1993; Dukerich et al., 2002). When the conceptions of how a professional identity should be discursively or otherwise enacted and what it entails [stance], and of which practices best represent the mission of the institution and nurses’ conceptualisations of their professional role, for example, are socially shared by members of a work team, they are likely to also share a sense of future direction (see Fagemoen, 1997; Postmes, 2003). This is argued to result in more committed workers and improved performance (Van Knippenberg, 2001; Pillai and Williams, 2004).

Thus, taking up the suggestion made by earlier scholars, workplaces need to “provide opportunities for nurses to consider the meaning and value of each experience” (Gregg and Magilvy: 2001: 53) so that they are provided with a meaningful environment where their professional identities are brought forward and discursively negotiated, reinforced or changed in the context of professional reflection with the goal of improving the quality of care. As discussed in the previous section, research such as that presented in this thesis can inform this area of professional development.

7.2.3.3 The positive side of conflict

The three interactional contexts in which nurses’ and clinicians’ reflections were explored each represents some form of conflict talk (see possible definitions of conflict talk in Leung, 2005). Possibly the clearest example is chapter 4 since complaining is unequivocally defined as a face-threatening act. As discussed in chapter 5, an exploration of

the literature of knowledge management reveals that the construction and display of expertise is mostly viewed as a discursive move that is used to exert control and to emphasise power asymmetries. In chapter 6, reflections on professional practices and values have been shown to sometimes give rise to disagreement, particularly those in extract 6.4, which focused on the issue of answering the phone when with a patient. However, the analysis in each chapter suggests that engaging in conflict talk does not always have to be negative, and it may, in fact, have positive outcomes. Thus, for instance, as they share their expertise, clinicians build professional knowledge that promotes professionalism while they work to improve their local practices. Similarly, as nurses complain about certain aspects of their professional practice and debate about their professional values, for instance, they reflect upon these practices, make informed/expert decisions on what is the best practice according to the interests of the patients and the institution, etc. Disagreeing, complaining and sharing expertise are integral to the process of professional reflection and, if appropriately managed, they can bring about positive outcomes (see Jehn, 1997 and Angouri and Locher, 2012; e.g. Holmes and Marra, 2004). Engaging in conflict talk allows social actors to discuss an issue from different, and very often constructive, perspectives, which increases decision quality (see ‘productive conflict’ and ‘task-related conflict’ in Jehn, 1997, 1995). It is, however, relevant to stress the importance of expressing knowledge, opinions and beliefs in appropriate ways according to the social norms of their specific communities so that good rapport among nurses is maintained and face needs are observed (see the case of disagreement in Sifianou, 2012 and Angouri, 2012; see also Jehn, 1997; Leung, 2005). Thus learning to disagree, complain and display expertise in relevant ways is a vital aspect of nurses’ and clinicians’ professional identity construction process. In this way, for instance, clinicians construct their own expertise and that of others by phrasing questions in salient ways. Conflict then can be positive when social actors engage in collaborative negotiation of consensus (see Holmes and Marra, 2004). Reflecting upon this matter, Kenny (2002: 65) explains “the presence of conflict in itself should not be viewed only in a negative light. The very nature of the debate about care delivery allows nurses the opportunity to present their perspective on patient care”, and that contributes to professional development.

7.2.3.4 Building collegiality and rapport

As pointed out throughout the thesis, the nurses and clinicians involved in this study orient towards building rapport and maintaining positive workplace relations by constructing in-group solidarity through their discursive practices (e.g. use of impersonal references, impersonal passive structures and display of group alignments). In the light of the findings, it seems logical to suggest that for the communities at both institutions being a good nurse or clinician is closely linked with maintaining positive relations with their co-workers.

Collegiality, the fostering of positive workplace relations through the promotion of collaboration and solidarity (Chitty, 2011), plays an important role in workplace interaction since it has been found to contribute to a feeling of job satisfaction (Mills and Blaessing, 2000; Kangas et al., 1999). A current shortage of nurses in health care institutions has led scholars to reflect upon issues that might prompt nurses to leave their jobs (e.g. Tzeng et al., 2002; Andrews and Dziegielewski, 2005; Lu et al., 2005). Promoting job satisfaction is claimed to be paramount in any attempt to prevent nurses from leaving their workplaces (see Aiken et al., 2001). In this regard, Chitty (2011) explains that collegiality, as an increasingly important aspect of professionalism in nursing, is very often overlooked as a major contributor to job satisfaction. Providing feedback on the kind of discursive strategies that promote and enhance positive work relations may empower nurses, helping them to become agents in the improvement of their own job satisfaction. An interesting point to develop further then would be to investigate co-worker collegiality in greater depth, for instance, by exploring ways of discursively building and promoting it across communities and organizations, with the aim of improving job satisfaction. As Chitty (2011: 72) reflects: “the practice of nursing would be enhanced if the commitment nurses feel toward their patients were equalled by their commitment to one another.” This can certainly contribute to maintaining harmonious work relations.

7.3 Future avenues of research

Given the little attention paid to this area of sociolinguistic research, the potential areas for investigation of professional identity in nurse-nurse naturally-occurring backstage

interactions are numerous. One area that could be explored further is the formulation of advice, only briefly reflected upon here in chapter 5, which would contribute to the existing socio-pragmatic research that explores this function of discourse (see Limberg and Locher, 2012). Moreover, an angle that is currently being explored by a PhD student at another School in this university looks into nurse-nurse backstage interactions in tearooms and staff rooms (Rook, in progress). This data, I believe, complements mine in many respects, and a comparison of the findings of the two studies would be most fruitful in establishing the differences in professional identity construction between more formal backstage interactions (as illustrated in this study) and more informal backstage interactions.

Moreover, managing medical uncertainty of patients' cases has been identified as an important aspect of doctors' expertise (e.g. Sarangi and Clarke, 2002). This topic has been almost exclusively explored in doctor-patient interactions. I have noticed, however, that expressing uncertainty when reflecting upon patients' cases is also part of the discourse that nurses engage in and need to manage as they discuss patients' cases in meetings. It would then be interesting to investigate this in relation to how this type of discourse mediates nurses' construction of their professional identity and how different, or similar, this is in relation to the findings in doctor-centred studies.

Finally, an area that I would very much like to explore is (possible) gendered enactments of professional identity (see Harris, 2007; Mullany, 2006). The two data sets explored in this study contain both female and male nurses and clinicians who actively participate in the meetings. It would be interesting to compare how male and female nurses display and negotiate their professional identity and to establish the extent to which their practices are gendered representations of the self.

7.4 Closing remarks

In this thesis, I have demonstrated how professional identity is emergent and temporary as nurses' identity claims are subject to interpersonal processes in which these can be contested, (re)evaluated and reformulated (when necessary) in order to display interactants' preferred images of their professional self. Employing a discourse analytic

approach, this thesis has shown how nurses' and clinicians' professional identity is constructed and negotiated through a range of situated discursive practices in the course of spontaneous conversation in backstage interaction. It has demonstrated that these practices are part of the linguistic repertoire of these groups of nurses and that these allow them to index multiple group memberships at local and wider community levels. These practices are, in turn, tailored to suit participants' interactional goals, allowing nurses to display and negotiate their expert status in communicatively relevant ways. The professional values embedded in discussions of professional practices have also been shown to represent high stakes for nurses as these guide professional conduct and action, and reflect their professional self images. All in all, nurses' discourse has been found to be oriented towards maintaining harmonious work relations, enabling nurses to engage in conflict talk in productive ways. I hope that this thesis has moved the investigation of nurses' professional identity a step forward by providing a greater understanding of discursive phenomena involved its construction and that it motivates future areas of enquiry that explore in particular healthcare communication in backstage contexts and spontaneous conversation.

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Medical Council of New Zealand webpage: <http://www.mcnz.org.nz/>

ARCH project: <http://www.otago.ac.nz/wellington/research/arch/projects/index.html>

Report of UK Department of Health:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_4134613

Health Workforce Australia (including New Zealand) Annual Report 2011-2012:

https://www.hwa.gov.au/sites/uploads/HWA-Annual-Report-2011-2012_0.pdf

APPENDICES

Appendix A - Transcriptions conventions

ME	Capital letters to indicate emphatic stress
{laughter}	Paralinguistic features and clarifications in square brackets
+	Pause up to one second
=	Continuing speech / latching
//\ /\	Simultaneous speech
(ok)	Transcriber's best guess at an unclear utterance
?	Question intonation
-	Incomplete or cut-off utterance
[laughter]	Deleted words to protect participants' identities
↑↓	Arrows indicate upward or downward intonation of the word they precede
°me°	Degree marks indicate decreased volume of materials between them
°°me°°	Two degree marks indicate increased volume of materials between them
me:	Colon indicates stretching of sound it follows
...	indicates that some lines of transcription have been deleted

All names used in the excerpts are pseudonyms.

Appendix B – Confidentiality agreement for the clinic

PhD project: Analysing discourse in intercultural health settings

Mariana V. Lazzaro Salazar

Researcher's Confidentiality Agreement

I **MARIANA VIRGINIA LAZZARO SALAZAR** agree to carry out data collection in accordance with Victoria's Human Ethics Committee (HEC) and the Wellington Hospital's Central Regional Ethics Committee (CREC) guidelines. The data collection process will begin once the project has been given ethics approval.

I agree to give participants an information sheet outlining the nature and purpose of the study and to provide them with an opportunity to ask questions about any aspects of the project.

Throughout the study and dissemination of the findings, participants' identities and any information that could be directly related to them will remain confidential. Participants' names will be replaced with pseudonyms in the transcriptions of the meetings. Any sensitive information related to the participants or to any patients discussed will remain strictly confidential and will be disguised in any written form of the data. Patients' names will be electronically deleted from the recordings. Participants who do not wish to take part in the project will be edited out of the data gathered.

Upon completion of the project all audio recorded data and transcriptions will be securely archived with the Wellington Language in the Workplace Project to which access is restricted to researchers approved by the Project Director. Video recorded data will be electronically wiped after completion of the project.

Signature: **Date:**

Appendix C – Project Information Sheet

Project Information Sheet

PhD Project:

Analysing discourse in intercultural health settings

Mariana V. Lazzaro-Salazar

My name is Mariana Lazzaro and I am a PhD student in the School of Linguistics and Applied Language Studies at Victoria University of Wellington. I am undertaking PhD research using discourse analysis to investigate the use of communicative strategies in intercultural workplace communication.

About the project

The goal of this research project is to identify communication strategies that can potentially lead to an improvement in organizational practices in the health area.

According to a report issued by the New Zealand Nurses' Organization (2009), New Zealand health care providers have been recruiting international nurses in an effort to tackle the existing shortages of nursing staff around New Zealand. To date, it is estimated that 23 percent of the registered nurse (RN) workforce comes from overseas and that this number will continue to rise due to an increasing demand for health services. The fact that a large proportion of the RN workforce comes from overseas and that these nurses represent 95 different ethnicities brings cross-cultural issues to the fore.

I hope to contribute to a growing body of research that has been primarily concerned with promoting a better understanding of workplace relationships and addressing interactional aspects of intercultural workplace communication.

What will the researcher do?

A series of meetings will be video and audio recorded. Following this, some participants will be asked to take part in brief interviews the day after each meeting. During these interviews, participants will be invited to comment on extracts from the meetings in order to help the researcher interpret the material.

If participants agree to be videotaped, the videotapes will be used as a memory cue for what occurred in the meeting. Relevant sections of the meetings will be transcribed to analyse

communication patterns. As a researcher, I am not interested in the content of the meetings; rather my focus is on process, that is to say, how people talk and what strategies they use. You may choose to withdraw from the project before data collection is complete by contacting the researcher or her supervisors.

What will the data be used for?

The recordings and other information I collect from you will be used only for the purposes of linguistic research: i.e. the thesis and associated academic publications and presentations.

Why video record the meetings?

Video recordings are a very important source of data that cannot be captured by audio recordings. In this project video recordings serve two purposes. Firstly, they will help the researcher identify the speakers' voices accurately and capture valuable data such as seating arrangement, which facilitates a more accurate analysis of the data. Secondly, some extracts taken from the video recordings will be used as memory cues when the data is discussed with interview participants after the meetings. Please be assured that all video recordings will be electronically wiped once the data analysis has been completed.

Confidentiality

Real names will be replaced with pseudonyms to protect participants' identity. Any sensitive information related to the participants or any patients discussed will remain strictly confidential and will be disguised in any written form of the data. All recordings and other information collected as part of this project will be securely stored at Victoria University of Wellington at all times. Only my supervisors, Dr Meredith Marra and Prof. Janet Holmes, and I will have access to this material for the duration of the project. Upon the completion of the project all audio recorded data and transcriptions will be securely archived with the Wellington Language in the Workplace Project to which access is restricted to approved linguistic researchers. All video recorded data will be electronically wiped. We will not play any recordings to other staff or managers in your organisation. Nothing will be reported back to management after the meeting or discussed with anybody inside or outside Victoria University of Wellington. All the data collected is completely confidential. We may wish to play recordings for exemplification in academic presentations but in this case we will explicitly seek your permission. Once the data analysis has been completed, I would be happy to deliver a feedback session to share the findings with you.

Contact details

If you should have any questions or would like more information, please do not hesitate to contact me at mariana.lazzaro@vuw.ac.nz or on 0211415628, or contact my supervisors, Professor Janet Holmes and Dr Meredith Marra at the School of Linguistics and Applied Language Studies, Victoria University of Wellington, PO BOX 600 Wellington 6140, New Zealand, phone 04 463 5600.

Appendix D – Participants' Background Information Sheet

Background information

PhD Project: Analysing discourse in intercultural health settings

Mariana V. Lazzaro-Salazar

1. Were you born in New Zealand? ☐ Yes ☐ No
2. If no, (a) where were you born? _____
(b) at what age did you come to New Zealand? _____
(c) how long have you lived in New Zealand? ____ years ____ months ____ weeks
3. Which language(s) do you often speak in your home?

4. Gender: ☐ Female ☐ Male
5. Circle your age group:

under 20	20 - 24	25 - 29	30 - 34
35 - 39	40 - 44	45 - 49	50 - 54
55 - 59	60 - 64	65 years and over	
6. Which ethnic group(s) do you identify with? (e.g. Irish)

7. At this workplace:
 - a) What is your role at the institution? (e.g. manager) _____
 - b) How long have you been working in this institution? ____ years ____ months ____ weeks
 - c) How long have you been working in this team? ____ years ____ months ____ weeks
 - d) What language do you use most at work? _____
 - e) Do you use any other language at work? If yes, which language? _____

- f) (If applicable) How long have you been a member of your particular team? _____
- g) Please describe your proficiency in English (e.g. fluent, good, fair, minimal) _____
8. Nursing qualifications: (If applicable)
- a) Where did you complete your nursing qualifications? _____
- b) In which country have you worked the most? _____

Appendix E – Participants’ Consent Forms

Consent Form

PhD Project: Analysing discourse in intercultural health settings

Mariana V. Lazzaro Salazar

Project information:

I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have them answered to my satisfaction. I understand that my participation in this project is voluntary and that I may withdraw myself (or any information I have provided) from this project (before data collection is complete) without having to give reasons.

I understand that any information I provide will be kept confidential to the researcher and the supervisors, the published results will not use my name, and that no opinions will be attributed to me in any way that will identify me. I understand that the video recordings of the meetings will be electronically wiped at the end of the project and that the audio recordings of meetings and interviews will be securely archived with the Wellington Language in the Workplace Project to which access is restricted to approved researchers.

I give permission for (✓ for YES, **X** for NO):

☐ the video recording of three meetings I will attend (and associated transcription) to be used for linguistic research purposes and I understand that my identity will not be disclosed.

☐ the audio recording of three meetings I will attend (and associated transcription) to be used for linguistic research purposes and I understand that my identity will not be disclosed.

If I am asked to participate in a follow-up interview, I give permission for:

- ☐ the audio recording of this interview (and associated transcription) to be used for research purposes and I understand that my identity will not be disclosed.

Signed: _____ Print Full Name: _____ Date: / /

- ☐ I would like feedback regarding the results of this study.

Appendix F – Participants’ information

THE CLINIC		
Participants’ names	Institutional role	Ethnicity
Sarah	Branch manager	New Zealander
Jack	CEO	Romanian, New Zealander
Emma	Clinician	South African
Martin	Clinician	South African
Rod	Technician, fulfilling clinical duties	New Zealander
Cheryl	Student	New Zealander

THE HOSPITAL		
Participants’ names	Institutional role	Ethnicity
Nick	Charge nurse manager	New Zealander
Eve	Associate charge nurse manager	New Zealand-Maori
Lisa	Nurse coordinator, registered nurse	New Zealander
Mandy	Registered nurse	European
Anne	Registered nurse	Filipino
Eva	Registered nurse	New Zealander
Susan	Nurse representative, registered nurse	Maori
Martha	Registered nurse	American
Donna	Nurse Coordinator, registered nurse	New Zealander

Appendix G – Example of topic map

CLINIC (LANGUAGE IN THE WORKPLACE)

Sample: SM3C

Processing details:

Description: YES
Describer: Mariana Lazzaro-Salazar
Date last amended: 5 May 2011

Topic Map Y/N: YES
Mapper: Mariana Lazzaro-Salazar
Date last amended: 5 May 2011

Transcript: NO
Transcriber:
Date last amended:
Status:
Transcript word counts:

Keywords: PROFESSIONAL IDENTITY, PROFESSIONAL VALUES, FACE MANAGEMENT,
PHASES IN MEETINGS, USE OF 'JUST', 'DENOUNCING' BEHAVIOUR, REQUESTS/ORDERS,
DECISION-MAKING, SUGGESTION

LANGUAGE IN THE WORKPLACE

Sample: SM3C

Original Location: SM3C (VIDEO)
SM3C part B (DVD VIDEO)

SM3CpartA28-09 (AUDIO)
SM3CpartB (AUDIO)

Start Time: 2 PM

Date of recording: 28/09/10

Time of Day: 2 PM

Length (time):

Video recording camera A: 45 minutes 19 seconds

Video recording DVD camera B: 35 minutes 19 seconds

Audio recordings: (recorder a) 51 minutes 58 seconds
(recorder b) 52 minutes 06 seconds

Type: staff meeting

Topic: institutional issues, administration issues

Cross References: details given regarding the room where the meeting takes place, the aim of the meeting, and its participants in document for SM1 apply here.

Participants:

Manager: Sarah
CEO: Jack
Clinician: Martin
Student: Cheryl
Admin lady: Susan
Admin lady: Liz

Contextual Information:

The meeting takes place at Martin's office. The layout of the room is the same as Sarah's so the recording was done in the same way as always. The cameras were in the same places.

Recordings were taken from two small audio recorders operating on a desk and a stretcher and two cameras operating from two corners of the office.

The DVD on camera B only recorded 35 minutes of the meeting.

There was nobody standing up in this meeting.

Sarah is chairing this meeting and Susan is taking the minutes.

Map of the room (seating arrangement):

Transcription notes: NO

Topic Map:

VIDEO A:

- [00.00 to 09.01] Setting the recording equipment up. The office is empty after I set everything up.
- [09.02] Martin comes into his office and prepares the room for the meeting.
- [10.04] Sarah comes into the room bringing more chairs. Jack comes in bringing his chair and comments on the two cameras present. Sarah leaves the room to look for Cheryl so that she can read through the documents Sarah has in her hands.
- [AUDIO A minute 17.59; AUDIO B minute 18.00]
- [10.24] Sarah and Martin come into the room again and Sarah checks with Martin if Rod has a patient he's seeing at the time of the meeting. Martin and Susan confirm this.
- [10.32] Jack asks if Emma is on holiday and Sarah confirms this. Susan and Sarah briefly talk about the patients Rod is seeing and the time of the appointments (in an informative tone).
- [10.41] Cheryl comes into the room.
- [10.49] Susan tells everybody to grab a copy of the minutes from the last meeting.
- [10.52] Sarah introduces Cheryl to Jack.
- [10.55] Sarah hands out a document to Cheryl and says she needs to read it and that it's about one of their patients. Sarah apologises for not giving it to Cheryl before but Cheryl says it's ok because Sarah has mentioned the case before. [Face management-superior and subordinate.]
- [11.08] Sarah says Emma sends her apologies for today's meeting.
- [11.11] Sarah asks who's chairing. [The meeting seems to have started. There is no clear-cut beginning to it. The transition from pre-meeting time to meeting time is smooth and seems to be marked by everyone's sitting. Also during all this time, Sarah has been standing at the

- front of the room, next to the desk. Tasks of her role.]
- [11.14] Susan says Sarah is chairing. But Sarah asks who as she did not understand well. So Susan points at the desk and says that the agenda is on the desk. Sarah approaches the desk and confirms it's her who's chairing the meeting.
- [11.24] Sarah grabs some papers and starts handing the out saying it's the minutes from the previous meeting and today's agenda. Susan leaves the room to look for more copies of the minutes and Martin changes seat and sits in Susan's place [It's funny he did that but that seat is right next to his desk, which could explain why he did it].
- [12.01] Sarah asks Susan if she has the copies.
- [12.06] Sarah: "ok mm" [a possible "formal" start of the meeting?] and she asks if anyone has anything to say in relation to the last meeting.
- [12.22] Sarah explains she'll quickly go through the points in the minutes of the previous meeting.
- [12.26] Sarah explains the situation with the DSB sheets. She says that she brought up the issue at a meeting in [name of the city] and that one of her colleagues as kindly agreed to design the (electronic) data entry sheet. She also says that another person will be doing the data entry at the time of the invoicing. She explains they need to fill in the form and this other person will enter the data.
- [12.53] Jack overlaps Sarah and pointing at the minutes says that they haven't changed the date of the meetings since March. They laugh nervously and Liz apologises for that.
- [13.07] Sarah takes up the issue about the DSB sheet and says that "how we'll manage that we'll discuss that within the meeting" [so when is the meeting officially started?? Sarah seems to think that the meeting has started when they start discussing the issues of the new agenda.]
- [13.15] Sarah says she discussed the issue of the toilet bars with the toilet clinical staff and with [name of another person] and says that it's in their hands now.
- [13.28] Sarah moves on to some changes they made to their feedback forms about requiring a follow-up review appointment with them. She says that Susan has changed that already.
- [13.33] Susan confirms this and says that Emma wanted to bring up the issue of including that sentence in bold. Sarah agrees and asks Susan to do it.
- [13.43] Sarah says that about the case studies, Martin was supposed to follow up all on them and to find out how many they needed to do.
- [13.49] Martin says that he did and says that he hasn't got their feedback yet but that for now they should presume it's six case studies per year that they need to do. He says he's still waiting for a clearer reply from the team.
- [14.23] Sarah says that the lock system issue is pending so she'll put it down as something that needs to be done for the next meeting.
- [14.34] Sarah asks if they can all confirm that the minutes from the previous meeting are accurate. Susan and Jack confirm this, then some seconds of silence follow.
- [14.54] Sarah says they need a chair person and a person to take the minutes for the next meeting.
- [15.00] Sarah asks Martin if he has chaired recently. He says he hasn't and Sarah says he'll be chairing next meeting.
- [15.07] Susan says that Emma can take the minutes. Sarah agrees.
- [15.16] Sarah says that they have dealt with matters arising from the previous meeting [reading the agenda for this meeting.]

- [15.19] Sarah says that now they'll talk about the DSS form and asks Susan if she wants to talk about it.
- [15.25] Susan says that she wants to talk about the footwear calculator form. She says she doesn't know how often it's been handed out but that when she hands them out, she has noticed that it doesn't get filled in by the clinicians. [Throughout the meetings she's consistent with this way of ascribing professional identity to most of the others in the room. She particularly does this when she is complaining about something "the clinicians" did or didn't do. She says she doesn't know whether they're giving the form to [name of person] or to Martin but in any case she needs to know. "I don't know all of a sudden I don't seem to be seeing many getting filled out or coming through and that is still a requirement." She then asks Sarah when specifically it becomes a requirement to fill them in. [This last question might be a repair move for the possible negative effect her previous comment had. FACE MANAGEMENT. All the matters that she seems to need to bring up in the meetings seem to be related to some kind of complaint as to how the "clinicians" do their job. This could be interpreted as a way to assert her positioning within the group by wielding some kind of power over them.]
- [16.06] Sarah confirms that this is a requirement for any footwear that is prescribed as it's a scoring footwear system. Susan takes down notes.
- [16.14] Sarah says that if it's been done in the last five months, it doesn't need to be done again but that otherwise, they need to do it.
- [16.21] Susan says that the other issue she wanted to discuss is related to their internet address. She addresses Sarah and says that she's discussed this with her a couple of weeks ago. She explains that their website has the correct address but that when patients try to google them, patients get a google map with the previous address of the clinic. She explains she's tried changing that but she hasn't been successful for the past two weeks. She says she's checked it every day [*positioning herself as a diligent worker - **professional identity***] and that she has mentioned it to [name of person in charge of computing issues] but she doesn't know what's happening on that side of things [*'denouncing' behaviour - **ascribing professional identity** - by making this sort of comments Susan is creating an identity of the other people in her work team as not being diligent*]. She explains that the reason why she's bringing this up is because she gets very angry calls from a radio as they are getting patients turning up there as that's the only address they get in google.
- [17.21] Susan also says that another problem they have is that when patients type the name of the clinic, the third link they get is a 'finder' site which also has the old address. She says she's tried correcting it to no luck.
- [17.42] Jack says that they are no longer on 'finder' so he reckons they are just keeping the clinic there. He explains they are not paying anymore so they haven't been part of that system for two years. Sarah confirms this. Susan overlaps Jack to say that in any case, they have the wrong address there.
- [17.54] Susan repeats that that's what the patients see when they google them. She says that they should find a way to update that information in any way. She explains Liz and herself have had calls from patients desperately calling to ask where they are. [*Susan seems to be Liz's spokesperson! Liz rarely speaks in these meetings*

- but Susan seems to be including her in her complaint as a way of **strengthening her case**. Liz does not confirm nor does she deny it.]*
- [18.20] Jack asks her if she's spoken to [name of person in charge of computing issues].
- [18.22] Susan says she spoke with him a couple of weeks ago to see if there was any way in which he could fix the google map. She says she doesn't know if he's checked or not but that she's checked today and the map is still wrong.
- [18.36] Jack says he'll speak to [name of person in charge of computing issues] when he gets back home.
- [18.42] Sarah says that Emma is not present (she's next on the agenda). Susan says that she has a note of the issues Emma wanted to discuss with her.
- [18.50] Susan says that, about the appointments, Emma says that patients are still turning up without the item that needs to be reviewed. Emma wonders if when they are doing review appointments they could find a way to tell patients to bring the items.
- [19.16] Sarah says that she thought they had agreed to that.
- [19.18] Susan says that she doesn't know whether it's on the letter to the patients or not [looking at Liz who was in charge of adding this information to the letter patients would get when having a review appointment]. Liz nods and Susan asks for confirmation. Sarah says that they discussed this in the previous meeting. Sarah reads the script that they prepared the previous meeting.
- [19.30] Susan says Emma explained that this is still not happening.
- [19.32] Sarah addresses Liz and asks her to look into it. Liz says that she's included that clause in the letter already. *[Sarah in her **role** as the manager of the team in making the **decisions**.]*
- [19.39] Susan says that in that case they've done all they can and patients should start reading the letter. Sarah agrees.
- [19.47] Susan reads the points on Emma's agenda and says that she hasn't mentioned the last point to her and that she doesn't know what that is about. She then reads the next point and says she has brought that up when they discussed the minutes from the previous meeting.
- [20.00] Sarah says she wanted to talk about the [name of the hospital / institution] stock. She says that they need to work harder so that the [name of the city] stock is up-to-date so that they don't get a huge flood of replacements that leaves Martin and herself short on stock for [name of another clinic] on Friday. Sarah says that her suggestion is that every time they go to the hospital, they go in there [the storage room] and have a look. She says that it's also showing their face as a representative of the institution and that will give them more credit. "It just provides us with a bit of exposure up there and keeps us in their thoughts so can you just be aware of that big order for [name of the city]." *[In her **role** as a manager, here Sarah is making a **request** to her team of clinicians but she formulates it as a **suggestion** in the first instance and then she turns it into a stronger form of request when she tells them what they 'have to do' and what not to do using **auxiliary verbs of obligation**. Also notice the use of **just** as a possible **downtoner** or **mitigator**.]*
- [21.18] Jack overlaps Sarah as she tries to move on to the next topic and asks her if she is done with this topic as he wants to ask who did the May round. Susan replies that she did it together with Sarah and so Jack says that he wants to remind her that there'll be another round in November. Susan laughs and says that she had 'diaried' it *[Susan is building her **professional identity** as being cautious and diligent.]* Jack: "good then I didn't have to say anything did I" [he

smiles] *[With this comment he is acknowledging and accepting Susan's positioning].*

- [21.42] Sarah moves on to the next topic which is 'the workshop'. She explained that [name of the person] was very embarrassed today when showing the board of [name of the institution] through the workshop as it was 'very very messy'. Sarah: "it's very very messy I think well by my standards anyway and I think we NEED to talk about some issues around safety particularly around the earthquakes and some of the things that may be toppling [...] and the general tidiness and reducing the storage now Rod isn't here there's some stock that we would like to Martin and I would like and Emma would like to remove we don't think it's been touched since [she pauses and Jack adds: "a long long time", by adding this he's showing support towards what Sarah is saying]". *[Decision-making, request/order. It is interesting to see how she started explaining the problem as something brought up by another person but soon after which Sarah takes full responsibility, it's very very messy I think well by my standards anyway, to make the request of what they need to do about it. By doing this, I believe Sarah is strengthening her request as it is to her, the manager of the institution, that they need to respond to.]*
- [22.22] Susan overlaps Sarah and reads the word 'remove' from her notes and laughs and wants to confirm that 'remove' is a general word they are using in this case.
- [22.26] Sarah agrees and says that "and we DO want to think what to do with it". Susan nods and takes down notes.
- [22.33] Sarah asks Susan to make a note so that they discuss this issue in the next clinical meeting.
- [22.40] Sarah: "do you think Martin that we can [Martin starts nodding] have a clinical meeting that says let's have it in the workshop" *[making requests as suggestions - I'll find further evidence to support this in previous papers of New Zealanders in their role as managers - obviously face management will come into the discussion here together with Sarah's orientation towards maintaining the harmony in the team.]* Martin agrees and says that that'll be good.
- [22.47] Sarah says that she'd really like to "finalize the workshop".
- [22.55] Sarah explains that there will be locks in the hallways that they'll need to use a code. Susan wants to clarify which hallways Sarah's talking about and Sarah clarifies this for her.
- [23.05] Sarah says that they have to have those locks.
- [23.11] Sarah says that regarding the DSS data entry 'they' are still looking at waiting lists and waiting times for them *[I don't have sufficient context to know who 'they' are]*. She says that so far they have been good in general but that the only way to improve that is with the data entry form *[Professional identity - Sarah usually stresses the positive first and then suggests how to improve something or what she wants them to do]*. She tells them to keep filling them and keep giving the forms to the clinical staff, "keep them under everyone's noses". *[Requests/orders]* Sarah repeats that somebody else will do those forms together with the invoicing [this was discussed at the beginning of the meeting]. She quickly explains the procedure involved in using this form.
- [23.48] Sarah moves on to case study requirements and says that she hasn't seen a case study for ages. Sarah: "so I'm just hoping everyone's doing one." *[The use of 'just' is recurrent. This is also an instance of a different way to make a request or give an order to them, which is less face threatening than asking a direct question about it or requesting them to work on case studies more bluntly.]*

- [23.59] Jack asks if they found out about how many case studies they should be doing.
- [24.01] Sarah overlaps and says that Martin explained that at the beginning of the meeting, that he was told they should be doing six per year but they were not specific about whether it is six a year or one every two months.
- [24.08] Martin explains that he hasn't got any feedback about that yet.
- [24.13] Sarah repeats they haven't got feedback about that yet and says: "so I'd just quite like us to keep ticking them over." [**Request** - use of 'just']
- [24.19] Sarah says that the only other thing she needed to talk about is the staff changes. She explains that Emma is going down to point six and she explains Emma's new schedule and what clinics she's keeping. She adds that they'll be welcoming a new staff member.
- [24.57] Susan asks [untranscribable], and Sarah replies "not yet".
- [25.01] Jack warns Sarah to watch the space. Sarah agrees.
- [25.03] Susan asks if that would be a full-time staff member. Sarah confirms this.
- [25.07] Sarah: "we'll have a nice new full-time colleague". And Susan says "ok".
- [25.12] Sarah, Martin and Jack discuss where Martin should go. They agree on which room is suitable for Martin. Susan is taking down notes saying them out loud as she writes.
- [25.39] Susan says Rod asked where they were doing the casting, whether it is in individual rooms.
- [25.46] Sarah says that they'll just play it by ear. She explains that Martin is not at the clinic a lot of the time so they'll figure that out as they go.
- [25.56] Sarah says that that is another reason why she wants the workshop tidied up a bit more.
- [26.02] Sarah says that next Friday she wanted to invite [names of two students who have worked with them, Cheryl is present] to celebrate and farewell them because they have finished their degree and to thank them for the support work and contributions. She also says she would like to thank everybody for putting up with them [the students] and they all laugh. [**Humour**] Sarah explains that they'll have drinks and that they'll invite two other teams to come as well. She says some people have replied already and they're keen to come. [*ascription*]
- [26.54] Susan asks if it'll be at their clinic or somewhere else. Sarah says she's not sure yet but that she would quite like the other teams to come to the clinic to have a look at it. Sarah says she still needs to work on that and that she'll let them know. Sarah: "and that's just a nice collegial thing just to finish up what was quite a successful placement and we've certainly all benefited from that and I've loved being involved in undergraduate again so for me particularly it's been great." She explains that she knows Emma has enjoyed their company and collegiality too. Sarah tells Susan that she wants all of this written in the minutes. [*Evidence of the manager's values*]
- [27.47] Sarah asks if anybody has any other general business that they want to talk about. She then asks Cheryl if she wants to say something.
- [27.52] Cheryl says that it's been interesting working there. She explains what she's gained from the experience.
- [28.24] In reference to something Cheryl mentioned, Martin adds that he's noticed that, on their schedule with the patients they see at the clinics [the other clinics they visit], the times they have on the patients' lists and on the patients' letters are different. Sarah

- agrees. Martin explains that he's had people coming in late and when he asks for their patient letter, and the time was right and the patient wasn't actually late. Then he talks about a case he had that morning.
- [29.18] Sarah says that they've talked about that already that morning with the admin people and "we're gonna try and work very hard on that because it has come up with the admin staff as well." [*Sarah brings herself into the problem building herself as part of the admin team that needs to work on this, which acts as a **face-saving move** towards the admin team.*]
- [29.30] Martin says that this is very disruptive. Sarah agrees. He explains he came back late this afternoon due to that. Sarah says she's noticed he came back late as when she and Jack left for lunch, he was not there. Sarah agrees with him.
- [29.45] Martin says that when he came back there was nobody at the office so he's sure it was late.
- [29.51] Sarah says that there seems to be something going on with the appointments and how they're working.
- [29.59] Martin suggests what they can do about it.
- [30.04] Sarah says she knows how that drives them crazy. She asks Martin if he had a hard day that morning.
- [30.14] Martin says that actually they had a period in which they had fifteen minutes free.
- [30.23] Susan overlaps and says that they've had many cancellations.
- [30.28] Martin says that it's nobody's fault. [**Face-saving move**] He explains how according to him the patients are late but according to the patients they are on time.
- [31.01] Sarah repeats something's going on there and something is going on at the clinic [one of the clinics they visit]. She says she had noticed it herself at one of the clinics and she has joked with Martin about having another patient come in late and "what you see is not what you get". Martin laughs.
- [31.21] Susan overlaps Sarah and says that they usually get twenty minutes [I guess she means 20 minutes for each patient]. She says she doesn't know why it happens and that she's been trying to solve the problem.
- [31.31] Cheryl says that it could be a computer error.
- [31.34] Susan explains one possible cause of the problem (the fact that the appointment time in the programme is 8.35 for instance, but that then that needs to be corrected because the appointment starts at 8.30). She explains it's very annoying but that's what the appointment system does. She then gives a longer explanation of this problem and explains some cases they've had with the time of the appointment changed. [*Martin's, Cheryl's and Susan's are all **face-saving moves** so that Susan does not look bad in face of this problem.*] She says they shouldn't send out the appointment letter without changing the time of the appointment in their main screen.
- [32.37] Sarah says that she talked to people who are in charge of the computer system from another branch and they asked her what she wanted to 'attack' first in terms of improving that area. She says she told them they needed to work on appointments. She says she wants that tidied because "it is all very prone to human error" [*Sarah is also doing **face work** for Susan here*]. Susan agrees. She says that there will be developments soon and that some of them will be able to play with the new system.
- [33.11] Jack overlaps to clarify that what they are proposing to do is using 'their' version [the one used at the other branch] and that he's not sure they might be able to have access to it in this clinic. He then

- says he thinks they might be able to have access to that.
- [33.17] Sarah says that anyway the problems with the appointments arise because the system is tricky. [*Doing **face work** for Susan again. I have to say that the fact that they all engage in doing repair work for Susan when in fact Susan displays quite a 'denouncing' attitude towards everyone else in the team is something that calls my attention.*]
- [33.22] Sarah explains that there are other areas that also need looking into. She says that Susan, Liz and herself need to follow the issue of the appointments up because in the hospitals it has become a nightmare. Sarah: "it's just too tough I know it myself." [*Sarah ends the discussion on this topic telling Susan and Liz what needs to be done about it. In doing so, and consistent with her orientation to maintaining the harmony in the team, she includes herself as one of the parties that will work to solve the problem and then she strengthens the request to work on that problem by saying she 'knows' about it as she has experienced the problem, which also revalidates the issue Martin raised. **Face work***]
- [33.44] Sarah asks if there's anything else anyone needs to talk about.
- [33.45] Susan says that the annual diaries are due and she talks about the order and its price. Martin asks for clarification and Susan explains what diaries she's talking about. She asks them to make a decision on what diaries they want by the following day to make the order.
- [34.04] Jack says that they have ordered 'theirs' [at the main branch] on Friday last week.
- [34.10] Susan explains they never order massive loads so they don't need many. But she says that with the GST changes, they'll cost more.
- [34.24] Sarah asks Jack if he has anything to say.
- [34.25] Jack talks about the Christmas party. He asks who's going and when.
- [34.35] After four seconds of silence, Sarah says: "well hopefully we're all going" [*another **request?***]. She asks Martin if he's coming and he confirms this.
- [34.40] Jack looks at Martin and asks again: "are you coming?" [It seems that Martin has said he would come to the party before but then he doesn't]. Martin laughs. He says he thinks so.
- [34.46] Jack looks at Susan and tells her that they need numbers. They need to know who is coming and when. He says that Sarah can't do a Saturday so they'll try to do it a Friday night.
- [34.52] Susan wants confirmation of the exact date.
- [34.54] Martin says he hasn't heard anything with regards to the party yet. Jack confirms the date.
- [34.56] Susan asks if they had agreed on a place.
- [34.59] Sarah explains to Martin that the original plan was to make it on a Saturday but that sat. She has a family commitment. She asks them if it's alright. She says there are two options, for them to have it on the Sat or for her to be there on the Friday. [***Orientation to harmony** - keeping everyone informed and part of the **consultation** process makes them feel part of the team*]. Sarah says Jack is ok with it.
- [35.49] Susan says Emma thinks it's ok because she has asked her.
- [35.53] Sarah says that it's been suggested to do something completely different this year and instead of going for dinner, they could do a charity event in which they could build a bike as a team. Sarah: "we build a bike as a team and give it to an underprivileged child you know given the nature of our work." [***Principles behind their work***]. She explains Emma was keen on doing that. She says she didn't have a chance to have a good look at it but it was certainly a good idea

- and that Emma was quite interested in it.
- [36.36] After a few seconds of silence, Sarah says that alternatively they can just go to have dinner at a very nice French restaurant on [name of the street].
- [36.47] Rod interrupts [he is not attending the meeting] and asks Susan for some patient's information. Liz goes to look for it instead.
- [36.56] Sarah says that they should probably book the restaurant anyway.
- [36.59] Susan asks for confirmation to book the restaurant. Sarah confirms this.
- [37.06] Sarah says Jack wanted to know if they would do them a set menu. Jack confirms this.
- [37.14] Susan says that she checked the restaurant's website but it said they didn't have set menus but she'll check again.
- [37.23] Sarah says that is strange for a French restaurant and Jack agrees. He says what French restaurants sometimes do is limit the menu and they could do that.
- [37.33] Susan says that maybe their website has been upgraded now due to the time of the year and the fact that people are organizing these parties.
- [37.47] Sarah asks if there's anything else they need to talk about.
- [37.48] Jack says he has nothing else to say.
- [37.51] Sarah asks Martin if he has anything else to say and he says he doesn't.
- [37.57] Sarah: "ok well that's good". And Susan looks at the time and writes it down [signalling the end of the meeting].
- [37.59] Sarah says that Jack will be back on Wed 27th of October. Susan makes a note of it. So she asks Susan to schedule the next meeting at the same time that day.
- [38.12] Jack says that he just realised that it's been three months in a row that he's travelled on the 27th. Susan and Sarah make short funny comments and smile. He says: "it's spooky" and laughs. [**Humour**]
- [38.25] Sarah asks Susan if she has the DSS forms. Meanwhile Jack is saying that he forgot there were cameras in the room. Cheryl agrees.
- [38.29] Susan says that now that Liz has shown her how to do them, she has done them often so that it would be updated by the time she processes it all. Sarah says that that is good. Susan says that works quite smoothly.
- [38.46] Sarah tells her that anything that she doesn't want to do, she can get [name of the other admin person in a different branch] to do it for her.
- [38.53] Susan says it's ok because she's always loved data entry. [**Building professional identity**]. She also says that if there are three people working on the forms, Liz, the other admin person and herself, then they'll have it all updated soon. She says they still have a pack to update and that she has sent it to [name of computing manager]. She asks if he has sent it back. Sarah says she doesn't know.
- [39.21] Sarah asks Liz if she has anything to add. She doesn't reply.
- [39.29] Sarah: "no troubles? ok well that's it, that's the meeting". Meeting finishes. Sarah thanks them.

Delete Video recording camera A from minute 00.00 to 09.00 and from 39.40 onwards.

Delete Audio recording A from minute 00.00 to 17.00 and from 47.40 onwards.

Delete Audio recording B from minute 00.00 to 17.00 and from 47.40 onwards.

Transcript:

[starts]

[ends]

Appendix H – List of acronyms

Acronyms	
SC	Social constructionism
SIT	Social identity theory
CofP	Community of practice
IS	Interactional sociolinguistics
SLA	Second language acquisition
RN	Registered nurse