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Artículo de Investigación

Expert Claims in Clinical Meetings: Analysing the Relational Role of Medical Jargon

Posturas de expertos en reuniones clínicas: analizando el papel relacional de la jerga médica

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Abstract: This paper explores how a group of clinicians discursively constructs their expert stances using medical jargon as they discuss their professional practices and patients' cases at a clinic. Guided by the discursive analytic tradition of interactional sociolinguistics, the analysis is based on naturally-occurring conversations that have been audio and video recorded during four clinical meetings in a healthcare setting in New Zealand. This paper shows that the use of medical jargon plays a vital role in constructing expert stances that address the interactional, and especially relational, needs of participants in these clinical meetings. In particular, the paper discusses the role of medical jargon in the construction of clinicians' expert stances when building ingroup alignments, managing professional criticism and managing disagreement in peer-peer interactions. Concluding remarks offer reflections on the role of medical jargon in the construction of clinicians' relational stance and the need to further investigate the use of specialised jargon in other contexts of peer communication.

Keywords: clinicians - expert talk - interactional sociolinguistics - socio-constructionism - specialised jargon

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Resumen: Este artículo explora cómo un grupo de enfermeros/as clínicos construye discursivamente sus posturas de expertos utilizando jerga médica mientras discuten sus prácticas profesionales y los casos de los pacientes en una clínica. Guiado por la tradición analítica discursiva de la sociolingüística interaccional, el análisis se basa en conversaciones naturales que han sido grabadas en audio y video durante cuatro reuniones clínicas en una institución de la salud en Nueva Zelanda. Este artículo muestra que el uso de la jerga médica juega un papel vital en la construcción de posturas de expertos que observan las necesidades interactivas, y especialmente relacionales, de los participantes en estas reuniones clínicas. En particular, el artículo analiza el papel de la jerga médica en la construcción de las posturas expertas de los enfermeros/as clínicos cuando construyen alineaciones dentro del grupo, manejan la crítica profesional y manejan los desacuerdos en las interacciones entre pares. Las observaciones finales ofrecen reflexiones sobre el papel de la jerga médica en la construcción de la postura relacional de los enfermeros/as clínicos y la necesidad de investigar más a fondo el uso de la jerga especializada en otros contextos de comunicación entre pares.

Palabras claves: enfermeros/as clínicos - charla de expertos - sociolingüística interaccional - socio-construccionismo - jerga especializada

1. Introduction

An essential dimension of being a professional expert is being able to talk like one. In peer-peer interaction in clinical settings (that is, interaction among members of a group of fellow clinicians who practice the same field of specialised nursing/medicine and engage in collaborative and meaningful team work on a daily basis), expert talk is a core component of professional socialization and practice because it allows professionals to, for instance, interact in appropriate ways with their peers, to claim preferred disciplinary membership, and to jointly discuss and evaluate patients' cases (Lazzaro-Salazar, 2013; Linell, Adelswärd, Sachs, Bredmar & Lindstedt, 2002; Wolf, 1989). In spite of its centrality to socialization and practice, professional nurse-nurse talk has received relatively little attention in discourse studies over recent years. The importance of the discursive construction of professional expertise is addressed in most of this existing literature to date, but predominately in relation to nurse-patient

(e.g. Macdonald, 2016), doctor-nurse (Gonçalves, Mendonça & Camargo Júnior, 2019; Radford, 2012), and interdisciplinary team communication (e.g. Lokatt, Holgersson, Lindgren, Packendorff & Hagander, 2019) in frontstage interactions, that is, when either the patients or their families are present. Interactions among nurses in backstage encounters, that is, when nurses interact away from the public eye, for example in staff meetings (Lazzaro-Salazar, 2013), however, seem to have been of much less interest (consider Lazzaro-Salazar, 2020).

Moreover, nurse-nurse expert talk has also mostly been explored through the lens of the traditional views on expertise deriving from cognitive models, where the focus has been on examining knowledge transfer and the accomplishment of transactional goals as a way of building expertise. Studies have then mainly investigated the kind, amount and ways of sharing medical knowledge in conversation to assess its potential impacts on clinical problem-solving and decision-making (e.g. Nelson & McGillion, 2004) and patient care outcomes (e.g. Kumpula, Gustafsson & Ekstrand, 2019; see Hardy et al., 2002). Though these contributions are very valuable and widely acknowledged in the sociolinguistic literature, this exploration of expert knowledge has often been approached as a continuum of professional development, even when investigated from a discursive perspective (consider Philip, Woodward-Kron & Manias, 2019), and, as a consequence, its underlying assumptions of rather fixed categories and stages of expertise have commonly been questioned (Lazzaro-Salazar, 2013; Dall'Alba & Sandberg, 2006). As a result of this scholarly focus of nursing talk, the way expert stances may serve purposes other than transactional ones, for instance, relational purposes (as proposed by Fletcher, 1999), in nurse-nurse communication has seldom been addressed (consider McDowell, 2015, 2018; Lazzaro-Salazar, 2022).

Studies on nurse-nurse communication then seem to only partially capture the nature of expert talk in that interactional context, as they have not always succeeded in showing the dynamism in the construction of nursing expertise and its relational potential in actual conversation (Lazzaro-Salazar, 2013). Thus, overall, the emphasis of nurses' expert talk has been placed on how knowledge transfer allows nurses to build their expertise in frontstage interaction, largely disregarding the relational aspect of expert talk in peer-peer backstage interaction. To address this gap in the literature, this paper explores excerpts of exchanges between a group of clinicians in a series of clinical meetings in which they discuss professional practices and patients' cases, in order to analyse the discursive practices and linguistic resources that allow clinicians to build their expert stances to fulfil different relational purposes. It should be noted that the term 'clinician' is here used as a sign of respect and recognition of those registered nurses who have pursued a specialization (also see Pirret, Neville & La Grow, 2015). However, clinicians and nurses are used interchangeably when discussing the data. Moreover, the analysis focuses, in particular, on the role of the use of medical jargon to these ends as the data show how clinicians build their expert stances in peer-peer interaction not only in the use of formal technical language, but also in coded exchanges using quite simplified and casual language which may not sound like expertise until it is unpacked.

2. Expert stances in this study

Underpinned by the sociolinguistic theory of stance (e.g. Lazzaro-Salazar, 2016; Lazzaro-Salazar, 2017a; Ushchyna, 2020), expert stances in this study are viewed as "the display of evaluative, affective, and epistemic orientations in discourse" that

allows interactants to construct relevant aspects of their identities in conversation as part of both a subjective and an intersubjective phenomenon (Bucholtz & Hall, 2005, p. 595; also Ochs, 1992). Expert stances are built in interaction through any number of linguistic resources, and a discursive analysis of an interaction offers a description of the micro-linguistic level structures, such as grammar, phonology, and lexis, which allow interactants to position themselves in conversation while they align or disalign with others' stances.

In line with this view of stance, our understandings of clinicians' expert stances are then informed by socio-constructionist approaches to social interaction, which assume that discursive practices constitute a jointly constructed achievement of all interactants involved in a conversation (Lazzaro-Salazar, 2017b). To that end, the study draws on relevant discourse literature on expert talk in nursing (e.g. Crawford, Roger & Candlin, 2017), in other medical contexts (e.g. Gonçalves, Mendonça & Camargo Júnior, 2019), as well as in other institutional contexts (e.g. Hall & Danby, 2003). Following socio-constructionists views, clinicians' expert stances are here then conceptualised as being multifaceted (Candlin & Candlin, 2002), including elements of discipline specific knowledge, institutional knowledge, experiential knowledge, professional values, and a repertoire of linguistic resources and discursive practices (consider Fook et al., 2000; Perry, 2000; Sarangi, 2010). Though the importance of these attributes and their inter-relationships may vary across professional contexts (Sonnentag & Schmidt-Braße, 1998), my conceptualization of professional expertise brings all the attributes together as interdependent dimensions of clinicians' expert stances in peer-peer interactions in a semi-private healthcare institution in New Zealand.

3. Methods

The data comprises four clinical meetings which were held monthly at a semi-private institution we here call 'the clinic', in New Zealand. The clinic receives referrals from primary, secondary and tertiary care specialist referrers for people eligible for orthotic management of any type. Being a contracted provider to the local District Health Board of New Zealand (DHB), the clinic operates partly as a private and partly as a public centre providing services to private and Ministry of Health (MOH) funded clients.

The four clinical meetings were attended by a technician (Rod), two clinicians (Martin and Emma) and the manager of the clinic (Sarah), also a practitioner. The manager and the two clinicians are registered nurses (that is, a state-licensed medical professional) who specialised in orthoses. On average, participants had worked in the clinic for five years at the time the data were collected (Lazzaro-Salazar, 2013). Meetings were thirty minutes to an hour long each and held in the manager's office, and were audio and video recorded in 2010 as part of my PhD research (Lazzaro-Salazar, 2013). In these meetings, participants raised issues of concern regarding patients' cases. Thus, these meetings served as consultation and feedback sessions in which the clinicians debated and formulated protocols, procedures and treatments, while also sharing information and research about new treatments and professional developments in their area of practice.

This study, as in my previous research (e.g. Lazzaro-Salazar, 2013, 2020), follows the methodological principles of interactional sociolinguistics (IS). As a qualitative and interpretative approach to the study of language and social interaction (Trudgill, 2003), IS enables us 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). Ethical approval to conduct this study was gained from Victoria University's Human Ethics Committee and the relevant District Health Board.

The study was conducted in three phases. The first phase involved observing a number of meetings to become familiar with the workplace context, the participants and their work culture, and the interactional routines of the meetings (see Holmes & Stubbe, 2003). The second phase involved video and audio recording four clinical meetings, with two video cameras and two digital audio recorders facing opposite sides of the meeting room to capture all participants. Finally, the third phase of the study involved conducting 'key-informant interviews' (Briggs, 1986) with the manager of the clinic in order to gather detailed and specialised information regarding those aspects of the clinical and institutional practices with which we were not familiar (consider Llamas, 2007). The information gathered in phases one and three was highly relevant to triangulate my interpretations of the communicative events analysed. The latter are drawn from verbatim transcriptions (see conventions in Appendix 1) of the audio and video recordings obtained in phase two of the study. To protect the identity of individuals, we use pseudonyms throughout.

4. Analysis

Routine information exchange, often referred to as 'case presentation', involves the communication of "salient patient information during treatment and management" (Lingard, Garwood, Schryer & Spafford, 2003, p. 603) and is one of the most valued communication skills in the nursing profession (Pirret et al., 2015). In this study, case presentation provides clinicians with a chance to get together in clinical meetings to discuss their practices, protocols and procedures in order to manage their cases and make informed decisions regarding treatment pathways and therapeutic plans (see Lingard & Haber, 1999). Communicating expert stances effectively and appropriately in this interactional context is paramount to maintaining harmonious workplace relationships (e.g. McDowell, 2015). In what follows, I show how clinicians use medical jargon in distinct ways to serve different interactional purposes as they discuss clinical cases and build their expert stances.

4.1 Building ingroup alignments

The following extract illustrates how clinicians construct themselves and their peers as experts in the context of case presentation in these meetings. This extract is a good example of an apparently light-weight conversational exchange using seemingly non-technical language, yet underneath there is a whole layer of unspoken expertise.

Extract 1: Open ulcer

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

In this example, Martin presents a case to Sarah for the sake of establishing the

similarities between this and another case discussed earlier in the meeting. Martin succinctly describes the case using terms such as 'open ulcer' (line 1), 'dressing' (line 2), 'fit the stocking' (line 4) and 'wear the stocking' (line 7). He presents the rational knowledge of the case as he describes those details that he finds relevant to establish the clinical similarities between cases (see Schryer et al., 2005), such as their diagnosis (line 1) and treatment (line 4). In this way, Martin provides the patient's information to support the final professional assessment of the case (see Hardy et al., 2002). Following Martin's case presentation, Sarah backchannels in agreement (line 5) and makes a positive evaluation of Martin's treatment decision (line 8). Interestingly, while some of the medical jargon Martin uses is specialised (such as 'open ulcer' and 'fitted'), other terms, such as 'stocking' and 'dressing', seem to be rather lay terms, and, thus, Sarah's alignment could potentially carry more subtle 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 recognized as a specialised term because we use it in our daily lives to refer to a piece of clothing that keeps our feet warm in winter. For the specialised eye in this clinical context, however, 'stocking' refers to a particular kind of medical product used to treat foot problems (as Sarah, the manager of the clinic, explained in an informal interview), yet in medical terms this is a highly broad word that could refer to any number of kinds of stocking available to treat ulcers. Thus, Sarah's positive backchannel comment in line 5, for instance, not only potentially encourages Martin to continue with his account of the case but may also implicitly index her understanding of what kind of stocking he required to treat this particular case. Martin's use of the definite article 'the' as a modifier of 'stocking' in line 4 seems to suggest that he is referring to one particular type of stocking; and the positive feedback Sarah offers suggests she understands what kind of stocking Martin is referring to. 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, plays an important part in helping Martin to evoke and Sarah to assign a specific meaning to the word 'stocking' (as well as for 'dressing' in line 2). As a result, Martin and Sarah partly co-construct their expert stance regarding their evaluation of this case and of the interactional situation based on their shared understanding of the specific meaning of a seemingly general term that is, in fact, highly coded in this clinical context as it carries a complex specific professional meaning.

The use of technical medical jargon is part of an institutionally ratified routine (Jones, 2011). From a transactional point of view, in medical contexts it allows clinicians to construct the scientific rationality of their case and to facilitate effective communication and is positively evaluated as a vital communication skill used to perform clinical practices appropriately (see Lindeke & Block, 1998). By employing specialised jargon in peer-peer interactions, clinicians are believed to actively avoid giving ambiguous information and being misunderstood by fellow clinicians, while they display a sense of precision (Schryer et al., 2005) and a high degree of professionalism (e.g. see the case of nursing in Hills & Watson, 2011). However, from a relational point of view, studies show that the use of specialised jargon may also often index a high level of formality among peers (Brown, Anicich & Galinsky, 2020), which may not only be inappropriate for these clinical meetings but also jeopardise positive relationships in peer-peer communication. Thus, Martin seems to navigate the complexities of the preferred transactional and relational outcomes of using medical jargon when discussing patients' cases with peers by employing a mix of specialised and seemingly less specialised (yet coded) jargon to draw on the teams' both explicit and tacit medical

knowledge as a way to acknowledge their shared expertise (Collins & Evans, 2007). The former allows him to provide precise clinical information to discuss the case, while the latter seems to be strategically used to reduce the levels of formality and, thus, index closeness to his peers. Using a mix of specialised and coded jargon in this way helps Martin to construct self and others' expert stances in a relaxed social context and to facilitate social bonding and ingroup membership based on the understanding that the meaning underlying this jargon is based on their shared medical knowledge and expertise (consider Wenger, 1998; and Brown et al., 2020).

Bhatia (2004) explains that discursive knowledge (e.g. the use of technical terminology) is paramount to the development and enactment of expert stances. Being discursively competent involves social actors' knowledge of the interactional and institutional norms that define each interactional context (see Sarangi, 2010) and the appropriate application of these norms when talking appropriately in different interactional encounters. In this light, the norms for the use of medical jargon described above can then be assumed to shift when the context, including the interactional aims of the conversation, change. The section below illustrates this point.

4.2 Managing professional criticism

Indeed, as topics and interactional needs change, so do speakers' use of linguistic resources and practices. This section discusses the role of medical jargon in constructing expert stances in instances when the relational goal of the conversation is oriented towards facing the threat posed by external criticism of their professional practices.

In the context of the following conversation, Sarah has just received a letter from a manager (henceforth, M2) at one of the hospitals where Martin visits patients. In the letter, the hospital manager complains about an incident involving Martin, which took place at the hospital. The complaint raises issues concerning his professionalism in terms of his duties and obligations as a visiting clinician. Sarah's support of Martin's actions then gains immense significance in the presence of this professional criticism. As Sarah reads the complaint to Martin and updates him on the report that she is sending in response, Martin explains the reasons that led him to take the decision of treating the patients (for which he was criticized). Sarah then proceeds to provide her expert stance on this matter.

Extract 2: Compression stocking

1.	Sarah:	//I don't I don't agree with [name of M2] anyway\
2.		I think the more vulnerable the skin
3.		the more it does require compression
4.		you know like you need you need compression
5.		it needs to it needs help
6.		and I I don't agree with her
7.	sometimes you know [name of specialised field of medicine different from theirs]	
8.	{facial expression showing doubt}…	
9.	Sarah:	yeah
10.		that's right
11.		the compression would really help the healing
12.	Martin:	exactly
13.	Sarah:	because it'll it'll it'll stop the congested fluid
14.		and it'll really speed up healing
15.		so that that's the idea
16.		so that lady when she

17. those nurses [used in impersonal way] will put that compression stocking on her
18. and that will speed her up again
19. if they let that wallowing fluid
20. or just band it circularly around the tourniquet
21. you know the tourniquet
22. they will ruin it

Sarah opens her first turn with an explicit disagreement in relation to M2's evaluation of the situation, which allows her to unequivocally position herself in this matter (line 1) and which is restated as a way of emphasizing her expert stance in line 6. With her interactional moves, Sarah seems to achieve two interrelated purposes: to build her own and Martin's credibility through their expert stances, and to discredit M2's professional opinion, both in an effort to ward off external criticism.

First, Sarah's support for Martin's decision to treat this patient is built through a carefully crafted discourse of scientific rationality (see Hardy et al., 2002) on the basis of her legitimate physiological knowledge. She achieves this by providing a diagnosis of the initial situation (line 2), an assessment of the appropriate treatment pathways (lines 3-5) and its possible outcomes (lines 13-15). She also provides an evaluation of what any nurse would do in this case (lines 17-18), which seems to set the standard for what is expected as appropriate practice in their field of medicine. In this way, Sarah draws on professional conceptual understandings of causation, classification and intervention (see Lingard et al., 2003) to build her credibility (Zimmerman & Jucks, 2018), legitimize her role as a health expert and as an authority in the matter (van Leeuwen, 2008), while also giving credibility to Martin's actions. This validates and strengthens her support for Martin's decision, which, as a result, implicitly constructs Martin as a knowledgeable professional, in other words, an expert, whose assessment of the situation and treatment decision was appropriate for the situation under discussion.

Second, in the process of constructing Martin's and her own expert stances, Sarah's exploration of discipline-specific ideas and the rational development of the case seem to discredit the views of M2 and to construct M2 as a less knowledgeable professional. Sarah's expert stance then could also be interpreted as a way of displaying a certain degree of professional criticism towards M2 (see peer-peer criticism in Barone and Lazzaro-Salazar, 2016). This becomes apparent with Sarah's comment in lines 7-8 which stands as a clarification that M2 practices a different specialised field of medicine, constructing a discourse of othering in which M2 is an outsider to this professional community (see Lazzaro-Salazar, 2017b). This othering move is reinforced by Sarah's evaluation of the possible outcomes of pursuing the treatment pathway suggested by M2 (lines 19-22) and her comment of what would be appropriate standard practice in their field of medicine in lines 17-18.

Very importantly, Sarah accomplishes both these interrelated purposes and the various discursive moves discussed above mainly by using highly specialised medical jargon throughout her turns (e.g. 'vulnerable skin' in line 2, 'compression' in lines 3, 4 and 11, 'congested fluid' in line 13, 'wallowing fluid' in line 19, and 'tourniquet' in lines 20 and 21). These choices seem to make the conversation more technically oriented and framed in a more solemn tone when, for instance, comparing this extract to extract one. In this context, the linguistic choice of medical jargon may be interpreted as a strategy that affords Sarah the right degree of formality (consider Brown et al., 2020 above) that this situation requires to manage M2's criticism while also managing Sarah's own

criticism towards M2's views. In regards to the latter, drawing on Goffman's (1967) concept of facework and Brown and Levinson's (1987) politeness theory, Trees and Manusov (1998, also see Barone and Lazzaro-Salazar, 2016) explain that criticism is often considered a threat to positive face needs because it jeopardizes the desire to be respected, in this case in terms of the managers' expert stances. The face threat is perceived to be higher when the people involved have a similar social status, as is the case of Sarah and M2, who hold the same institutionally sanctioned roles, that is, they are both managers at the health institutions they work in. With this in mind, highly specialised medical jargon may be seen as a positive politeness strategy that aims to redress the potential face threat of Sarah's criticism politely by giving a formal tone to the conversation and making lexical choices that are congruent with the expertise and status of both Sarah and M2 (Pretorius, 2018). This then allows Sarah to deal with the high-stakes involved in constructing different expert statuses (albeit for the discussion of this case) of the two managers while responding to the criticism made by M2 and voicing her own criticism towards M2 in support of Martin's decisions.

4.3 Managing disagreements

Similarly to responding to and voicing criticism among peers, managing disagreements with one's peers in professional talk is a sensitive face issue (Angouri & Locher, 2012), and so this section briefly considers the role that specialised medical jargon may play in these situations. In the context of the conversation below, Emma begins reflecting on why one of her young cerebral palsy (CP) patients is eligible for ACC compensation. The ACC (which stands for Accident Compensation Corporation) provides compulsory insurance cover for personal injury for everyone in New Zealand who has had an accident. As the conversation continues, Sarah and Emma do not seem to initially agree on what kind of CP patients are entitled to ACC compensation.

Extract 3: It's CP from accident

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
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

In this extract, Sarah begins by building her expert stance with her opinion that ACC

regulations will change with an authoritative sounding 'I think' in line 1. Drawing on her bank of knowledge to support her stance (Klein, 1997), Sarah provides clinical evidence based on her clinical experience (Perry, 2000) in dealing with two CP cases (lines 2-4) framed in the format of case presentation (Lazzaro-Salazar, 2020) where she discusses the medical problem and her diagnosis. This piece of information is highly relevant in helping Emma decide whether this is an ACC case since it classifies the sprained ankle as an accidental injury under current ACC policies. Sarah then presents the ACC decision of declining the patient's application for having a 'pre-existing foot condition' (lines 5-7), which, according to the ACC, makes the patient highly prone to having this sort of injury. In lines 8-9, Emma tries to make sense of the ACC decision explaining that the patient's CP in Sarah's case was not an accident but a pre-existing condition (line 13), which may explain why the ACC did not approve the application (consider line 9). This prompts Sarah to negotiate her initial stance by emphasizing that the sprained ankle was indeed an accident (line 10), reaffirming her stance 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' in line 12). This comment also serves the pragmatic purpose of implicitly displaying Sarah's opinion that this patient should have been covered by the ACC. Though Emma aligns with Sarah in line 11, she again emphasises the fact that the patient had a pre-existing condition, which again stresses the causality of the injury (line 13). Sarah then agrees and presents the rational way of thinking followed by the ACC officials for which the patient was classified under long-term disability (lines 14-17), which waives the 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 the ACC officials decide which CP patient is eligible for compensation (line 23-24).

Discursively, Sarah and Emma construct their expert stances also in interrelated ways at the content and at the linguistic levels. At the content level, both Sarah and Emma competently centre their discussion of this ACC case on the origin of the patient's injuries. Instead of focusing on other medical particularities of the case, such as how serious the injury was and what treatment therapy was given (see extract 1), their conversation revolves around determining whether 'the event' (as Sarah refers to accidents in these meetings) was caused by a pre-existing condition of the patient or by an accident. At the linguistic level, this discussion is shaped through the use of specialised jargon that allows Sarah and Emma to expertly engage in 'ACC speak' as they navigate the discourse of ACC case classification at the same time they display their medical knowledge. Thus, while words such as 'pre-existing foot condition' (lines 7 and 13), 'long term disability' (line 17) and 'predisposing condition' (line 20) 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 (Schuck, 2008), the use of the acronym CP, a common nursing practice (consider diagnostic labels in Joel, 2006), for instance, displays their specialised medical knowledge (see Dyer and Keller-Cohen, 2000). In this regard, expert knowledge is needed to not only recognize 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 to be able to discern in what ways a sprained ankle can be related to a case of CP. The fact that Sarah and Emma do not need to discuss this information suggests that both interactants build their arguments on their shared knowledge of this patient's case, possibly also on CP cases more generally, in addition to, ACC regulations.

Thus, Sarah and Emma build their expert stances by considering and rationalizing cases from multiple perspectives as they show how they are able to evaluate a case from the point of view of treating clinicians while, at the same time, they are able to 'think ACC' to evaluate the case from the point of view of the insurance corporation. Indeed, the latest reforms of the ACC policies, often referred to as 'tort reforms' (which involve more stringent regulations that emphasize patients' accountability in the event to reduce costs by reducing injury liability, see Bismark & Paterson, 2006), have brought ACC discussions to the fore at the clinic as one of the most dominant themes within managerial and administrative discourses (Lazzaro-Salazar, 2013). As Sarah points out in another clinical meeting, 'the ACC situation is really very confusing currently', and, thus, deciding whether a patient is eligible for ACC compensation is under much scrutiny at the clinic. For expert healthcare providers, then, knowing ACC policies and regulations, and how the ACC operates are vital professional skills through which to manage their patients' cases efficiently (Schuck, 2008). Thus, participating in collective interpretations of ACC regulations reflects the clinicians' orientation to revising, improving and developing expert knowledge, which constitutes an expert activity (Sarangi, 2010; Linell et al., 2002). Thus, by showing they are able to 'think and speak ACC' using specialised jargon to discuss relevant aspects of the case (van Leeuwen, 2008), support their opinions and discuss clinical information efficiently and in relevant ways serves to legitimate speakers' expert stances on the matter and manage their different points of view (see Hardy et al., 2002).

Relationally speaking, then, being able to speak ACC using specialised jargon allows Sarah and Emma not only to show membership to their professional group (Lave & Wegner, 1991) but also to position themselves from the ACC standpoint (rather than a more personal one) to present their case evaluation and manage their disagreement of their points of view of who should be eligible for ACC cover. In other words, rationalizing their reflection of these cases in the form of ACC talk allows Sarah and Emma to present a more factual position on the matter, similarly to what Li, Huang, Zhou and Lee (2010) refer to as impersonal views in professional talk. Such impersonal views or opinions often aim to express objective evaluations (2010), and, thus in this case, seem to help the speakers to distance themselves from the evaluation that is the cause of their disagreement. All in all, as with the previous examples, this may work to keep harmonious workplace relations and interactants' face needs, in this case when managing disagreement between peers. It follows, then, that clinicians' use of specialised (and sometimes coded) medical jargon then allows them to build their relational stance (Tapp, 2000) which is part of their expert positioning and that plays a vital role in maintaining harmonious peer-peer relations.

5. Discussion and conclusion

The analysis above draws attention to a number of considerations in the use of specialised jargon that distinctly contribute to the construction of clinicians' expert stances in peer-peer interaction in meetings. In these meetings, enacting clinicians' expert stances involves displaying their knowledge of clinical practices, such as case presentation and administrative practices, the latter specifically concerning issues of ACC compensation eligibility. Displaying these layers of professional knowledge involves doing it in discursively appropriate ways (Lave & Wenger, 1991) to achieve certain relational aims and build their relational stance (Tapp, 2000). In this regard, this paper has shown that medical jargon plays a vital role in constructing expert stances that observe the interactional needs, and especially relational ones, of

participants in these clinical meetings. The analysis explores how specialised medical jargon can help to build different levels of formality to index closeness to peers during case presentation (extract 1), and to address positive face needs when responding to and voicing professional criticism (extract 2), and to express impersonal views that help manage disagreement (extract 3).

The use of medical jargon as a mix of specialised lexicon and seemingly non-technical language seems to help interactants construct some degree of informality and closeness to each other during routine case presentations. Perhaps surprisingly, at times, these exchanges are quite coded, appearing on the surface to be casual and non-technical, yet further examination shows that, in fact, those terms in context convey highly technical meaning and a great amount of tacit knowledge. In other words, professional expertise may be displayed amongst peers in subtle and quite informal ways that belies the degree of formal knowledge that underpins the professional understanding involved. From this point of view, then, expert stances become a collective attribute, shared and developed within the professional community (Stevens et al., 2007), that is, it constitutes locally situated practice (see Wenger, 1998) through which clinicians display their expert stances in ways that are recognizable to each other but may not necessarily be so for outsiders. In this light, Bourhis, Roth and MacQueen (1989; see also Wenger et al., 2002) point out that preferred ways of displaying expert stances index group belonging and promote harmonious relations in the workplace as these are positively evaluated by community members, which also seems to be the case of the data analysed here. Yet possibly a point of departure from previous literature is that it is often claimed that in order to be accepted as part of a given community, members need to use the sophisticated lexicon of that group (Wenger, 1998). The point raised in this paper is that sophisticated lexicon may not exclusively involve highly technical terms but also coded jargon or language that displays the shared knowledge that characterizes the professional community.

In addition, the analysis of the data also shows that when the context of interaction calls for a more serious and less relaxed tone, highly technical jargon is more often used. In these cases, specialised jargon plays an important role in the construction of expert stances when responding to and voicing professional criticism among peers and when managing disagreement with close peers. Displaying their expert stances using specialised jargon vests clinicians with authority and legitimizes their expert claims (see Fook et al., 2000; Sambrook, 2006) and increases their credibility (Zimmerman and Jucks, 2018), which enables clinicians to formulate an assessment of a clinical case (extract 2), express authoritative opinions (extracts 3), and validate their expert decisions (extract 2) in preferred ways. This, naturally, also contributes to building harmonious relations among peers as medical jargon is used in relevant and appropriate ways (Wenger et al., 2002).

The fact that using technical jargon helps interactants to construct themselves as members of a given professional group or community and that, at the same time, it allows them to build positive relations among members of the same group, that is, it helps build rapport among them, has been acknowledged before in organizational literature, and though this paper contributes to the literature on nursing talk by exploring it in an often understudied context (i.e. staff meetings and peer-peer interaction), possibly the most valuable contribution this paper makes rests on showing how dynamic the use of this jargon could be to fulfil relational purposes in conversation. Professional expertise involves displaying a certain level of awareness of the dynamic use of medical jargon as

a discursive strategy that aims to meet the interactional needs of these meetings. This dynamic use of medical jargon is certainly reflected in the dynamic positioning and repositioning of interactants' expert stances throughout the conversations explored here (consider Cicourel, 1999) as clinicians construct, for instance, different levels of formality through their choices of medical jargon. This supports the claim that 'the discursive expression of expertise is to different extents a co-participative endeavour of all involved,' that is, it is interactionally achieved (a view that is common in current social research but which has not often been explored in the field of nursing practice) (Candlin & Candlin, 2002, p. 116). Building expert stances in such ways seems to be the appropriate way of performing clinical practices in this context, which supports the view that clinicians' dynamic use of specialised jargon is part of their sanctioned socialization practices. In this light, clinicians in this study converge in their use and, judging by their positive and relevant contributions, their understanding of the use and functions of this jargon (see Bourhis et al., 1989). In other words, clinicians build their arguments as they orient to the use of shared practices in the dynamic use of specialised jargon that enable them to discursively display 'coherent' expert stances (as in Benwell & Stokoe, 2006) in these clinical meetings. Thus, the dynamism afforded by the different kinds and functions of medical jargon allows clinicians to build their expert stances (at least partly) to successfully respond to the interactional (both transactional and relational) demands of doing case presentation and managing criticism and disagreement through the display of locally relevant clinical knowledge and preferred discursive practices.

In this light, this paper has explored possible uses and functions of medical jargon in one particular setting (i.e. clinical meetings) and three specific interactional contexts (doing routine case presentation and managing criticism and disagreement). Future research then should investigate the kinds and functions of medical jargon in other backstage contexts of interaction when, for instance, clinicians interact with more mixed groups of professionals, and also possibly different (higher and/or lower) statuses to advance sociolinguistic knowledge of the relational potential of the use of medical jargon in institutional settings.

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Appendix 1: Transcription conventions

( )	unclear speech
(well)	transcriber's best guess at unclear speech
we-	cut-off word
//well\	simultaneous speech
/yes\\	
[laughs]	editorial comments
{ }	paralinguistic features
…	section of transcript omitted