How do nurses describe health care procedures? Analysing nurse-patient interaction in a hospital ward

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ABSTRACT

Objective
Nurses' communication skills have a significant impact on their professional effectiveness. This study examines the communication strategies used by nurses on the ward in one aspect of the job, namely the ways that they describe health procedures to patients.

Design and setting
The data used in this project was collected by nurses on a busy hospital ward as part of Victoria University's Language in the Workplace Project. Three nurses carried minidisc recorders as they went about their normal working day, recording their conversations with patients, visitors, and other staff. Relevant sections of this talk (totalling 300 minutes) were transcribed and analysed using a discourse analysis approach, thus providing a sound basis for analysing the communicative act of describing a health procedure and for identifying a range of relevant sociolinguistic components of the interaction.

Subjects
The data was collected in a women's hospital ward. All patients, nurses, cleaners and ward clerks were female; two doctors were female and two were male.

Results
Twenty three instances where nurses described procedures to patients were identified in the data set. The analysis identified several typical components; indicated there was no fixed order of components; and demonstrated that all except the core component of describing the procedure were optional rather than obligatory elements.

Conclusions
This is qualitative and exploratory research. Our findings demonstrate the benefit of discourse analysis within a sociolinguistic framework for the analysis of nurse-patient interaction. The results indicate that health discourse is not one-sided, nor is it as straightforward as many nursing textbooks suggest.

INTRODUCTION

"[A] nurse with the gift of making her patients feel at home and free from fear, inspires confidence and provides an atmosphere of peace, serenity and security which is so important an adjunct to the relaxation of mind and body necessary for recovery from disease" (Pearce 1941 p.2).

As this quotation from the 1940s indicates, good communication has long been recognised in nursing as a skill essential for achieving immediate work goals and for contributing to patients' wellbeing and accelerating their recovery. While many textbooks stress the importance of communication skills, surprisingly few indicate how they may be acquired and developed. Recent sociolinguistic research has begun to address this gap by examining features of nurse-patient communication in context, illustrating how effective nurses actually communicate with patients in hospital wards.

The analysis in this paper is part of a larger sociolinguistic study of communication between staff and patients in a busy New Zealand hospital ward. In this study the focus is on how nurses impart information about health care procedures to patients. We use the term 'health care procedures' to include the preparatory procedures relating to an up-coming operation, as well as more routine procedures such as taking the patient's temperature or giving an injection.

Drawing on recorded data, the various components of the descriptions which nurses provide to patients of the procedures they are undergoing, or are about to undergo, are identified. According to Tuckett et al (1985 p.214) "...teaching about the tasks of explaining to and sharing understanding with patients have (sic) been virtually absent in medical education and they still have a very low priority." Although this was written more than twenty years ago with a focus on doctor-patient communication, the need to teach health care practitioners how to communicate effectively with patients remains an area of concern. As Hulsman et al (1999 p.655) note, "...interest in the teaching of communication skills in medical schools has increased since the early

seventies but despite this growing interest, relatively limited curricular time is spent on the teaching of communication skills".

Some nursing textbooks do address this issue (eg Potter and Perry 2005) but it is rare to find models or discussion based on direct interactions between nurses and patients. There is reliable evidence that providing information to patients and describing what is happening to them has a positive impact on patient wellbeing (Henderson and Chien 2004). Hence there is undoubted value in focussing on the detail of what makes for effective nurse-patient communication around the issue of necessary health care procedures.

The term, 'describing procedures', is used for this essential component of the nurse's role. There is currently little material based on real life communication available to guide nurses on how to impart information to patients about procedural (current or upcoming) events. The approach taken in this research was to use authentic data as a basis for illustrating and identifying the components of the communicative act of describing a health care procedure and using a discourse analysis approach to examine features of talk beyond the sentence level (such as turn taking and interaction) and to describe the way talk functions in the health care context (Schiffrin 1994 p.14).

A sociolinguistic approach to health care communication

The ability to communicate is now widely regarded as an essential skill in nursing and much has been written about communication skills in academic journals and more recently in introductory texts on communication for nursing students. These studies can be divided into those relatively few that are based on natural or 'authentic' language data and the much larger group which use reported or intuitive data of some kind. There are many questionnaire based studies on nurse-patient communication. Breemhaar et al (1996), Leinonen et al (1996) and Henderson and Chien (2004) used questionnaires to collect information about patient perspectives on quality of care. Similarly many textbooks emphasise

the importance of communication however few provide examples of what constitutes effective communication.

This research aimed to identify characteristics of effective nurse-patient communication in real life interactions. People do not always recall the detail of interaction accurately; often editing out hedges (such as 'perhaps' and 'you know') and the social talk which is so important to establishing empathy. The importance of these apparently trivial features of talk, typically omitted from responses provided in interviews and questionnaires, is frequently underestimated. These aspects of interaction are crucial for establishing rapport; a foundation of the nurse-patient relationship.

The literature review examines studies of the discourse of health care interactions, as opposed to 'praxis' or linguistically a-theoretical literature (see Ainsworth-Vaughn 2001). The focus is on research which analyses talk and which "takes into account the medical and social functions of the consultation in order to consider the nature of language use within its functional context" (Ainsworth-Vaughn 2001 p.266). The majority of studies which are referred to in this research, focus on doctor-patient consultations, reflecting the fact that comparatively few discourse studies have focused on the nature of nurse-patient communication on the ward. While there are obvious differences between doctor-patient consultations and nurse-patient ward interactions, this research identified enough similarities to consider them useful background for the research. Both types of interactions involve a (potentially anxious) patient and a health care professional and both rely on effective communication to achieve long term goals such as patient recall, compliance and ultimately, patient wellbeing.

According to Maclean (1989 p.264), little attention has been paid to the actual language used in health care. Given how important communication is considered to be in the health care setting and in nursing in particular (Candlin and Candlin 2003), it seems surprising that so few sociolinguistic studies have been conducted in this area.

Participant roles in health care discourse

This research discusses the relative roles of the health care professional and patient in interaction with the goal of identifying useful indicators of effective communication to assist with discourse analysis. The hierarchical nature of the professional-patient relationship has traditionally meant that patients tend to be viewed as having little to contribute to the interaction (Tuckett et al 1985 p.14). Studies of doctor-patient consultations frequently report that interactions are predominantly one-sided, with doctors doing little to encourage patients to express their opinions (eg West 1990; Davis 1988; Tuckett et al 1985 pp.204-205). This is clearly counter-productive in terms of effective communication. Maguire et al (1986 cited in Silverman et al 1998 p.91) reported that the doctors they surveyed were weakest in many of the precise techniques which had been found to increase patient satisfaction and compliance with advice and treatment.

It has been suggested that the roles of 'expert' and 'non-expert' in health care discourse are often based not only on traditional hierarchical views but also on the way participants present themselves in the interaction (Gülich 2003). Patients themselves often limit their contributions, allowing the doctor to dominate the interaction. Again this is unhelpful in terms of effective communication and desirable outcomes. Both Gülich (2003) and Tuckett et al (1985 p.79) point out that patients have in some respects greater expertise than doctors in the consultation; they are the only ones who can describe how they are feeling, which is an important basis for diagnosis and treatment plans. Such an imbalance in contributions to the interaction has obvious communicative consequences; the health care professional cannot be sure that the patient has understood them and the patient can not be sure they have been understood or that their understanding of the professional is correct (Tuckett et al 1985 p.205). Effective communication is thus more likely when health care professionals seek contributions from patients and check understanding.

Research which emphasises the importance of the patients' contributions to the interaction also highlights the importance of analysing extended discourse in context rather than isolated de-contextualised utterances. Barton (2000 p.262) examined 32 referral sequences and 19 account sequences between specialised medical physicians and families with disabled children (ie families that are often required to see a number of specialists). She examined in particular the way in which a family's lay expertise (or lack of it) and compliance behaviour affected the direction of the discourse and the decisions made by the health care professional. Barton's analysis demonstrates that such interactions cannot be accurately researched or represented by taking the health care professional's utterances in isolation; the situation is inherently more complicated. The interpretation of any utterance depends on examining what it means within that particular discourse context (Vine 2004).

In recent years the emphasis has moved from a focus on the contributions of the health care professional to an examination of the whole interaction. The relevance of the patient's expertise has been increasingly recognised and health care professionals have been encouraged to view and interact with patients as equals, seeking their views and checking their understanding (Gülich 2003; Silverman et al 1998). At the same time, patients have become more educated about health care to the point of sometimes questioning recommended procedures or treatments. Consequently, there is now more consideration of the patient's point of view and thus greater interest in patterns of communication within health care relationships (Maclean 1989 p.270).

Effective communication in health care interactions
In 1988, the New Zealand Department of Health conducted a survey of 1,249 nurses. One of the major findings was the importance that nurses placed on effective communication, listing 'communication with patients' and 'communication with other health professionals' among the top four characteristics of a good hospital (Ng et al 1992 p.15). More

recently, MacDonald (2002 p.15) suggests that in some situations, good communication *constitutes* good nursing practice. Two components of effective communication between health care professionals and patients, empathy and the descriptions of procedures, are relevant for our subsequent analysis.

Empathy
The ability to respond flexibly and with empathy to patient anxieties has been highlighted as one key skill for health care professionals in general and for nurses in particular. Street (1991) suggests that professionals accommodate by adopting different roles according to the patient's anxiety levels. A number of researchers suggest that empathy encourages open communication between nurses and patients (eg McCabe 2004; Barton 2000; Sheppard 1993) allowing nurses to collect the information they need in order to make accurate assessments. Morse et al (1992) claim "...the essence of the nurse-patient relationship is engagement, the identification of the nurse with the patient" (1992 p.819) and they note that empathetic responsiveness is a way to achieve this engagement. This further supports the value of a discourse analysis approach to practitioner-patient interaction; a study of the practitioner's language in isolation cannot identify evidence of understanding or empathetic responsiveness.

Describing procedures
The ability to clearly describe procedures to patients is another crucial skill for the health care professional, since patient understanding is likely to encourage compliance and, assuming the advice is sound, patient wellbeing. Patients typically require different types of information at different stages of their treatment (Henderson and Chien 2004 p.961). These often require rather different communication strategies varying in the amount of detail provided. In a textbook on communicating with patients, Silverman et al (1998) recommend a range of strategies for describing procedures to patients including achieving a shared understanding by incorporating the patient's perspective, using

shared decision making, discussing options with patients, as well as "gauging the correct amount and type of information to give each patient" (1998 p.92). While the word 'correct' seems prescriptive, given the range of individual and contextual variation involved in dealing with patients, health practitioners must work hard to ascertain exactly what kind of and how much information will benefit the patient. A study of the attitudes of neurologists and their epileptic patients toward disclosure of information found that practitioners gave less information about rare side effects of medication than patients wanted believing this would increase patient compliance (Faden et al 1981). The patients however wanted detailed information about even very rare side effects and reported this would improve their compliance.

A questionnaire based study of information sought by Hong Kong Chinese patients in hospital for surgery indicated the patients wanted a great deal of information, delivered at appropriate times and in a culturally appropriate manner (Henderson and Chien 2004). In the Netherlands, a study of two hospitals, using observations as well as interviews with staff and patients, found that even though providing information to patients is considered important, it was not always done consistently or thoroughly (Breemhaar et al 1996). The researchers found that patients wanted more procedural details: "…many patients were not aware of the things that were to happen in the first days after the operation and were unpleasantly surprised by drains, the need to mobilise quickly…" (Breemhaar et al 1996 p.38). Clearly, communication about exactly what to expect at different stages of hospitalisation is essential for patient comfort.

Using a combination of discourse and ethnographic analysis over a one year period, Johnson (1993) conducted a study aimed to identify whether communication strategies used by nurse practitioners differed from those described in the literature on doctor-patient interaction. She identified a clear difference in approach: "the focus of patient care by physicians is disease, whereas the 'whole person' orientation of the (nurse practitioner) places

emphasis on prevention and continuity of care" (Johnson 1993 p.156). The nurse practitioners described to patients what they might expect to happen and discussed follow-up choices, giving patients a sense of control and demonstrating an awareness of the patient's subjective experience (1993 p.152). The nurses in this study were clearly skilled in developing empathy and rapport with patients and responding to the needs of each patient. This study is one of the very few which used recordings of direct interaction to examine how nurses interact with patients.

More research which focuses specifically on the ways in which nurses communicate with patients is needed. Previous research by Holmes and Major (2002) has looked at social aspects of nurse-patient interactions, demonstrating that effective nurses use humour and small talk in skilful ways which are well-integrated with the more clinical aspects of patient care, as well as the ways in which nurses respond to patient's complaints and the ways in which they obtain compliance from patients using a diverse range of strategies for giving directives, which again pay attention to the interpersonal needs of patients in their care (Holmes and Major 2003).

Methodology

Data for this study was collected in 2001 by members of the Wellington Language in the Workplace Project, as part of a larger study of communication in Ward X, (Holmes 2000). Ward X is a women's ward and at the time of data collection, all patients, nurses, cleaners and ward clerks were female; two doctors were female and two were male. A co-operative methodology with the team on the ward was developed. At separate times, three nurses (who had been identified by their colleagues as being skilled communicators) carried minidisc recorders as they went about their normal working day, recording their conversations with patients, visitors, and other staff. This provided a wealth of natural discourse data in a hospital setting (around 300 minutes of transcribable talk).

While recording was in progress, one of the researchers (George Major) remained onsite to make observations. She positioned herself in the nurses'

station to limit interference with the communication process and to protect patient privacy. This observation period (together with a debriefing with each nurse following each recording session) provided a significant amount of contextual information which proved crucial in helping to understand the socio-pragmatic meanings of communication in this workplace (Holmes and Stubbe 2003). All those involved in the study provided informed consent for the recordings and use of the material collected for research purposes. Ethics approval for the research was provided both by the hospital and by Victoria University's Human Ethics Committee. A complete account of our methodological and ethical considerations can be found in Major and Holmes (2001).

Analysis of instances of 'Describing Procedures' (DPs)

All instances in the data set where nurses described procedures to patients were identified. There were twenty-three such instances in total, with considerable variability in length. The instances could be further separated into those preparing the patient for a future procedure such as an operation, or the removal of a drain or a dressing (15 instances), and those describing a concurrent procedure such as taking blood pressure or temperature (8 instances). The former were usually longer and considerably more complex than the latter. The shorter DPs focussing on concurrent procedures were typically accompanied by (constructively distracting) social talk. The following discussion focusses mainly on the longer more complex DPs which were concerned with preparing patients for an anticipated procedure.

A discourse analysis of the DPs was then undertaken to identify the various components of their structure in order to discover how much variability there was between different DPs, as well as which components appeared to be core or obligatory components, and which were optional.

Analysis of DPs

The analysis established that only the core component of a DP is obligatory; all other components are optional, though some occur more frequently than others. The analysis also indicated that the components do not occur in any fixed order within the DP. This paper focusses primarily on the nurses' utterances which were carefully analysed in their wider interactional discourse context in order to identify the socio-pragmatic functions of utterances.

Components of DP

- Describe procedure: core component of DP,

- Provide reason for the procedure,

- Provide reassurance,

- Provide options,

- Provide information on likely reactions,

- Provide supplementary written or visual information,

- Check if patient has any questions.

Each of these components, using examples from the dataset, are described and exemplified. The examples are transcribed as accurately as possible from the recorded material with as much relevant information as is considered helpful to assist understanding.

Nurses had constant access to patients and they would often 'do the DP' and then return later to follow up with supplementary information, or to repeat and reinforce the information they had given. Hence the absence of any specific component in a particular instance of a DP should not be interpreted as an indication that it did not occur at all in the nurse-patient interaction; it could well have been a component of a later follow-up interaction.

Describe the procedure: core component of DP

The core speech act of 'describing the procedure' occurred in each instance of a DP, but the way it was expressed varied greatly. Instances ranged from a relatively succinct statement, such as *"okay I'm just gonna pop this wee injection into your tummy again"*, to an extensive interactive dialogue between nurse and patient which might extend over several turns.

Example 1 illustrates a relatively succinct DP in which there is little questioning or verbal feedback from the patient. It occurs within a longer interaction,

where Tara (the nurse) is helping Casey (the patient) prepare for surgery the following morning. The talk is predominantly transactional or task-oriented; Tara is going through a pre-operation checklist, as well as making sure Casey understands the upcoming procedure. The core component, describing the procedure (of what will happen in the morning) is in bold. All names used in examples are pseudonyms.

Transcription conventions

[laughs] : :	Paralinguistic features in square brackets, colons indicate start/finish
+	Pause of up to one second
(3)	Pause of specified number of seconds
… /……\\ …	Simultaneous speech
… //…….\ …	Simultaneous speech
(hello)	Transcriber's best guess at an unclear utterance
-	Incomplete or cut-off utterance
[place]	An identifying feature has been removed

Example 1

Tara: okay + [drawls]: um: have you had any broken bones that have been repaired with metal pins or plates + no and have you got any um nail polish on

Casey: no

Tara: no great + okay well that's wonderful ++ you've signed your consent form here for an examination under anaesthetic and a [procedure] + [drawls]: and: we're second on the list in the morning to go so that's that'll usually be about nine o'clock perhaps yeah **about nine o'clock you'll leave the ward** so **the night nurses** will make sure if by chance you're still asleep **they'll wake you you can have time for a shower and put one of our gowns on** and all those sorts of things

This example is one of the few with very little audible feedback from the patient. Typically patients provide a good deal more verbal evidence that they are following the nurse's talk. It is likely that the patient conveys this non-verbally in this example. Examples 2 - 8

illustrate that while the core component is crucial, other strategies are also used by the nurses within the DP interactions.

Provide reason for the procedure

Many DPs include some explanation to the patient about what is required of them. In example 2, for instance, the nurse (Holly) describes why the patient (Isla) needs to have someone with her when she gets out of bed.

Example 2

Holly: okay when you do need to get up to the toilet just give me a buzz and let me know or um you can get your partner to help you I mean it's //up to you + it's just as long as\ someone's there

Isla: /yeah + yeah\\

Holly: **cos sometimes you can feel a bit light headed getting up for the first time**

Isla: yeah yeah no Dave will help me

Holly's reason for the DP warns Isla what the consequences of not following the instructions might be. Isla's feedback shows she is attending and she further indicates her understanding of Holly's message by stating that her partner will help.

Provide reassurance

Providing reassurance was another very frequent component of DPs. In example 3, reassurance (in bold) is spread throughout the DP with repeated reassurances at different points. This excerpt occurs immediately after the nurse (Holly) has described the patient Naomi's upcoming surgery. Naomi's parents Riley and Gail, who are also in the room, have been taking an active role in the conversation, including expressing their anxieties about their daughter's upcoming operation.

Example 3

Naomi: can you ask can you have a certain hand I want it put it in my right hand //+ not my left\

Holly: /you do you - you just\\ tell them that and that's fine they'll put it in wherever

well it providing that you've got all right // veins there\

Naomi: /yeah yeah //that's\ easier\\

Riley: /mm\\

Holly: and they'll um put that in **but it's all it's all very quick** + you'll find that and you'll probably feel have you been - have you had a lot of pain prior to this

Naomi: no

Holly: no I was gonna say **if you had you'd find that you feel a lot better afterwards I mean most patients just have a bit of panadol** and um sometimes something a little bit stronger if they need it

Gail: mm

Naomi: okay

Holly: **but you'll be fine**

In this excerpt, the nurse Holly directs her reassurance to Naomi, while simultaneously skillfully addressing the parents' concerns. In the dataset for this research, reassurance typically takes the form of telling the patient that everything is *fine.* Moreover, while it appears to occur unsolicited in the DPs relating to a complex future procedure (such as an operation), it occurs less frequently in routine DPs (such as taking a patient's blood pressure) except in response to patient anxiety.

Provide options
Nurses frequently presented the patients with options within DPs, suggesting that they recognised and respected patents' autonomy and wished to provide them with as much room to exercise this as possible. In example 4, the nurse (Tara) is describing to the patient (Sophie) what she can do if she has problems once she has returned home. She gives Sophie several options (in bold).

Example 4

Tara: yeah and the you know r- sutures can come out in four to five days

Sophie: yep

Tara: um + just + be careful of heavy lifting + just steer clear of that um + and if you've got any problems //**either\ ring the ward**

Sophie: /yep\\ yep

Tara: **um or come back in level Y**

Tara: which is women's //h-\ women's health assessment unit

Sophie: /yep cool\\

Tara: **or um go to your GP**

Sophie: sweet

Much of the nurses' talk throughout the DPs in the dataset serves to minimise patient (or parent) anxiety. It seems here that Tara is working to minimise Sophie's anxiety before it occurs by letting her know that problems at home are nothing to worry about because there are many possible solutions or steps she can take to address them. The interactive nature of a typical patient-nurse exchange is again well illustrated here with the patient providing abundant albeit brief verbal evidence that she is attending to the nurse's guidance (eg *yep cool, sweet*).

Provide information on likely reactions
In example 5, the nurse (Tara) describes to the patient (Sophie) what she might experience as she undergoes the procedure which is being described to her (the removal of a drain from the body).

Example 5

Tara: now when I take this out

Sophie: yep

Tara: people don't usually say it's really painful more they explai- er they describe it as like a a bit of a burning //sensation +\ which sounds painful

Sophie: /(okay)\\

Tara: but um but i- it's more that the effect of the little um drainage holes coming through +

Sophie: yep

Tara: past your flesh

Sophie: yep

It is interesting to note that the nurse in this example explicitly attributes her information to other patients who have told her what they have experienced, rather than presenting it as if she personally 'knows' what the patient will feel. This has the effect of emphasising the integrity or sincerity of the nurse's communication. This example also illustrates the way that Tara talks to Sophie in an open, fully informative manner, without brushing over or omitting unpleasant details.

Provide supplementary written or visual information

Nurses sometimes provided additional information for patients in written or visual form. Example 6 occurs immediately after the nurse (Holly) has outlined an upcoming clinical procedure for a patient (Naomi).

Example 6

Holly: I'll get you some information on the operation did you get given some //information\

Naomi: /I got\\ some on the [name of technical procedure] yeah //about\ what they what they do

Holly: /yep\\

Naomi: so

Holly: yep

Naomi: kind of [softly]: (yep yeah //):\

Holly: /a- and I'll give\\ you a little bit on [another component of the procedure]   I'll give you //some information on that you can have\ a read

Naomi: /[softly]: (oh yeah okay):\\

Holly: just so you feel a bit more aware I'll bring it down shortly

Naomi: yeah that'd be good

Here Holly offers to provide more information for Naomi to supplement the information she has already been provided with, and has read. Note that Holly explicitly states that she is concerned that Naomi is fully informed about what to expect: *just so you feel a bit more aware.* Moreover, Naomi is clearly appreciative of the offer: *that'd be good.*

Check if patient has any questions

At the end of describing the procedure, the nurse would sometimes explicitly ask the patients if they had any questions, as in example 7. This exchange occurs shortly after the excerpt we used in example 1: the nurse (Tara) has just finished explaining to the patient (Casey) what will happen before her operation the following morning.

Example 7

Tara: that's about it that I need to do tonight you've got everything else + so have you got any questions about +

Casey: no I've sort of asked everything and //I'm\ waiting really for tomorrow

Tara: /yeah\\

Casey: //till I can\ get results

Tara: /yeah\\ yeah yeah

Casey: to see where I go from there yeah

In response to Tara's very open -ended checking question (*have you got any questions about*), Casey explicitly indicates that all her current concerns have been addressed*: (no I've sort of asked everything*). She goes on to indicate that her concerns are rather with the results, and Tara's repeated feedback (*yeah yeah*) signals her understanding. This empathetic exchange with its abundance of positive minimal feedback (*yeah yeah*) clearly suggests that the nurse and patient are on the same wave-length. The overlapping talk is a reliable discourse indicator of good rapport between the two women (Coates 1996).

Examples 1-7 have illustrated the main characteristics that we observed in the DP dataset. The core DP is typically accompanied by a number of other components which are oriented not simply to describing what will happen or is happening in the relevant procedure, but rather to satisfying the patient's need for reassurance and anticipating the additional information which they may need to feel comfortable.

The scope of the data collection did not include interviews with the participants after the data collection had been completed. This would have been a valuable way of learning whether or not the DPs were considered effective from the patients' point of view. The internal evidence from the recordings, including patients' questions, requests for clarification and feedback, suggest that the nurses DPs were generally very effective, but post-data collection interviews would clearly be a useful addition to the methodology of a future DP study.

Socio-pragmatic features of nurse-patient interaction

Establishing rapport and expressing empathy were undoubtedly regarded as important by nurses when engaged in preparing patients for procedures. This was evident in a variety of ways such as: the occurrence of social talk; the extensive use of socio-pragmatic particles; patient-oriented repetition; and paraphrasing. This finding highlights the value of discourse analysis of authentic interaction in its context of occurrence compared to interviews and questionnaires. Neither questionnaires nor interviews can capture the rich and practical uses of these crucial interactive social and socio-pragmatic components of talk which tend to be overlooked or edited out of recollections of what went on in an interaction.

Previous analyses of the dataset (Holmes and Major 2002) found that social talk plays an important role and serves a range of crucial functions in interaction on the ward. These range from establishing rapport between the nurse and the patient to distracting the patient's attention from an unpleasant procedure such as an injection. While the nurse was engaged in doing a routine procedure, such as taking a temperature, blood pressure, or even during a more intrusive procedure such as removing a drain or a dressing, social talk referring to the weather, the patient's family, or even the nurse's social activities was a frequent component of the interaction. The social talk was often introduced by the nurse, but when a patient introduced social talk, the nurse would typically respond by supporting and extending it as is

illustrated in example 8 where the nurse (Rebecca) is chatting with the patient (Violet) about her family while at the same time giving her panadol and taking her temperature.

Example 8

Violet: but er + I thought of that with Jane it only seemed she would it- it would //(work up at [name of place]) + you know\

Rebecca: /yeah at [name of place] cos she's\\

Violet: (and I'm better) I was quite cold I had to get put this on for a start ...

Rebecca: /[inhales] now this is a\\ couple more panadol ++ okay and I'll go and- I'll- take your temp ++ there you are (3) I'll just take this temperature + gosh it's a lovely day out there isn't it

Violet: yes he said he had a terrible migraine and he

Rebecca: oh did he

Violet: me son before he came up yeah

Rebecca: has it gone

Violet: I don't know they've- th- they've gone away to get their lunch

This excerpt also illustrates the nurse's use of social talk to respond to the particular needs of the patient. Violet especially likes to talk about her family and rarely responds to talk about health care procedures. Rebecca encourages this and responds positively to Violet's talk, indicating that she is listening to Violet with feedback and encouraging questions (eg *oh did he, has it gone*). In terms of the DP, Rebecca accommodates to Violet's preferences and provides the minimum amount of necessary information (the core DP) as this information is clearly not a priority from the patient's perspective.

As illustrated in most of the examples above, social talk was almost non-existent during the more complex DPs which prepared patients for future more extensive procedures. These DPs were very information focussed and any personal comments

were directed to reassuring the patient about the anticipated procedure.

Nurses typically make extensive use of hedges while doing a DP (ie words such as *just, if, yeah, sort of*). They use interactive pragmatic particles (such as *you know*, *you see*); and they use softening devices, including minimisers such as *little* and *just* (for example, *little dressing, little stitch, just pull through*). They also use colloquial words and expressions such as *a little bit of bleeding, a bit oozy, a little bandaid,* with a similar softening effect (Holmes and Major 2002 p.15). Nurses also repeat and paraphrase their message to ensure patient understanding.

All these features indicate that the nurses were paying attention to the need for establishing empathy as well as ensuring their message was being understood. Hence while the core DP contained the nucleus of the information to be conveyed, the analysis indicates that nurses went well beyond this core component to add a range of additional components and socio-pragmatic features which were oriented to patient comfort and understanding.

DISCUSSION AND CONCLUSION

This paper has identified and illustrated a range of components which constitute the discursive behaviour 'Describing Procedures' in recordings of nurse-patient interactions. This information-oriented type of talk forms a central component of the nurses' daily responsibility to each patient and deserves careful attention.

The analysis of DP patterns was less straightforward than had originally been anticipated: while a core DP component could be identified, exactly which additional components would occur in any particular interaction could not be predicted (based on the type of procedure for example), nor could any preferred order of components be established. Elements occurred in a wide diversity of orders depending on micro-level aspects of the interaction and reflecting the nurses' responsiveness to the particular situation and the specific needs and concerns of their patients. If a positive patient-nurse relationship achieved through patient-centred communication is regarded

as "essential for quality nursing care" (McCabe 2002 p.47), then this analysis provides evidence of one means by which this can be achieved.

In addition to the core component 'describe the procedure', there are a number of additional components which occur relatively frequently in DPs, namely, provide reason for the procedure, provide reassurance, and provide options. Reasons for the procedure included explaining the consequences to the patient if instructions are not followed. Nurses frequently provided reassurance, usually by telling patients that everything will be *fine,* especially in relation to future complex procedures and other instances where patients appeared to be anxious. By providing options to patients, nurses are clearly working to minimise patient anxiety as well as encourage an empathetic relationship between them and their patients by showing respect for patients' autonomy. Throughout the DP examples, there is usually a great deal of feedback from patients and overlapping talk between nurses and patients, further illustrating the good rapport between nurses and patients on the ward.

Less frequent components in DPs are: provide information on likely reactions, provide supplementary written or visual information, and check if the patient has any questions. In terms of providing information on likely reactions, even unpleasant reactions, this was usually attributed to what other patients have said, showing a sincerity on the nurses part, by not pretending she knows how it might feel. Nurses sometimes provided extra written information or asked explicitly if the patients had any questions. However, as mentioned earlier, the nurses had constant access to the patients, and would often come back later in the day to follow up on and ensure patient understanding. So the absence of these components in any particular recorded interaction was not evidence that they did not happen. It will require further research with a larger database to ascertain whether these patterns are idiosyncratic to this data set. However it is striking that these additional components address different aspects of patient comfort and the need for reassurance, crucial aspects of quality nurse-patient communication.

The analysis also revealed that social talk, which constitutes a high proportion of patient-nurse interaction in general (Holmes and Major 2002), did not occur at all during the process of preparing patients for (often serious) future procedures, although it did occur within DPs which were concurrent with the administration of a (usually routine) procedure. Some particularly striking socio-pragmatic features relating to the way DPs were expressed by the nurses in our data, namely hedging strategies and repetition or paraphrase, were also identified.

Clearly, there is much more to be discovered about the ways in which nurses and patients negotiate the description of health care procedures. It seems evident that nurse's choices are often influenced by the contributions of patients, but precisely how this operates is an area where more detailed analysis is required. The negotiation and the complex inter-meshing of the exact level of each patient's need for information with the nurse's assessment and provision of this information merits considerable further examination.

While still exploratory, our findings nevertheless illustrate the benefit of discourse analysis within a sociolinguistic framework for the analysis of nurse-patient interaction. These interactions are not one-sided, and nor are they as straightforward as some textbooks might suggest. The very fact that it is not possible to establish a definitive set of obligatory components of a DP, or a consistent pattern for the order of components in a DP, illustrates the value of collecting and analysing authentic data. The analysis in this paper suggests that nursing textbooks using fabricated, over-simplified examples are unlikely to prepare nursing students for the complexity of real-life communication on the ward. In the future we hope to use this type of analysis to develop more effective nurse-education resources. The use of authentic data provides a more realistic basis for introducing student nurses to the complexities of health care communication on the ward.

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