An exploration of interactions in intercultural nurse-patient encounters

Tonia Crawford

RN, BHlthSc(Nurs), MHlthSc(Ed), TESOL Cert,
Postgrad Cert Linguistics Research

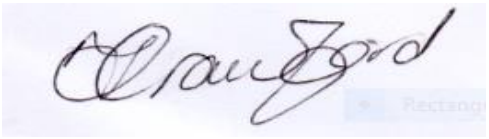
Thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy

Department of Linguistics
Faculty of Human Sciences
Macquarie University
January 2017

DECLARATION

I hereby declare that this thesis is my own work and that, to the best of my knowledge, all sources of information previously published or written have been cited in this body of work. All assistance provided in the research and writing of this thesis has been acknowledged. I also declare that the work in this thesis has not been previously submitted to any other institution for, or as part of, a degree.

This study was granted approval by the Macquarie University Ethics Review Committee (Human Research) (reference 5201400783), and was conducted in accordance with the guidelines stipulated.



Tonia R. Crawford

January, 2017

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

LIST OF ORIGINAL PUBLICATIONS

This thesis is based on the following original publications, which are referred to in the text as Chapters Two to Seven. Original publications are reproduced with permission from their copyright holders. Different referencing conventions and formatting are used in papers each constituent paper according to the journal requirement (as per Macquarie University guidelines) and have not been reformatted according to APA guidelines.

I. Crawford, T, Candlin, S., & Roger, P. (2017). New perspectives on understanding cultural diversity in nurse-patient communication. *Collegian, 24*(1) 63-69. DOI: 10.1016/j.colegn.2015.09.001

II. Crawford, T., Roger, P. & Candlin, S. (In press, accepted Jan 2017) "Are we on the same wavelength?" International nurses and the process of confronting and adjusting to clinical communication in Australia. *Communication and Medicine*.

III. Crawford, T., Roger, P. & Candlin, S. The consequences of diverse empathic responses in intercultural nurse-patient interactions: a discourse analysis. Submitted to and under review at *Journal of Communication in Healthcare*.

IV. Crawford, T., Roger, P. & Candlin, S. (In press, accepted Nov, 2016). Tracing the discursive development of rapport in intercultural nurse-patient interactions. *International Journal of Applied Linguistics*. DOI: 10.1111/ijal.12166

V. Crawford, T., Roger, P. & Candlin, S. (2017). The interactional consequences of 'empowering discourse' in intercultural patient education. *Patient Education and Counselling, 100*(3) 495-500. DOI: 10.1016/j.pec.2016.09.017

VI Crawford, T., Roger, P. & Candlin, S. Supporting patient education using schema theory: a discourse analysis. Submitted and under review at *Collegian.*

LIST OF CONTRIBUTORS

Tonia Crawford (TC), Peter Roger (PR), Sally Candlin (SC)

	Paper I	**Paper II**	**Paper III**	**Paper IV**	**Paper V**	**Paper VI**
Conception & Design	TC	TC, PR, SC	TC, PR, SC	TC, PR, SC	TC, PR, SC	TC, PR, SC
Planning & implementation		TC, PR, SC	TC, PR, SC	TC, PR, SC	TC, PR, SC	TC, PR, SC
Data collection		TC	TC	TC	TC	TC
Analysis & interpretation		TC, PR	TC, PR, SC	TC, PR, SC	TC, PR, SC	TC, PR, SC
Writing the article	TC	TC	TC	TC	TC	TC
Review of the article	SC, PR	PR	PR, SC	PR, SC	PR, SC	PR, SC

ACKNOWLEDGMENTS

This thesis would not have been possible without the valuable assistance and support of many people who I would like to acknowledge. Firstly, I would like to warmly thank my supervisors, Peter Roger and Sally Candlin, for their insightful guidance, attention to detail, and support throughout my candidature. I am grateful to Peter for guiding the novel ways to approach and think about the data when I was at a loss. Thank you to Sally for persevering with my project despite your personal circumstances. I would not have embarked on this journey without your encouragement and interest during an earlier research project.

I would also like to thank, and am greatly indebted to the RNs who participated in this research, and to the participating hospital for supporting the project, enabling access to the research site. None of this work would be possible without their willingness in allowing me to record and observe their interactions with their patients. While I have never met her, I would also like to thank Catherine O'Grady for the recurring inspiration I drew from her PhD project and thesis when I needed it.

Special thanks are reserved for my family: my husband Liam for your support during this project and my daughter Tara for hours of play time to distract my mind and enable 'back-brain' work that helped to clear the fog! Thank you to my parents for your boundless love and belief in bringing this project to completion. Last but not least, to my brother Paul, who listened patiently, brain-stormed ideas and whose expert analytical skills quickly identified key concepts that helped to crystallise my thinking. You are an inspiration personally, professionally and academically to me. This project was carried out with the valuable support of an Australian Postgraduate Award.

TRANSCRIPTION SYMBOLS

(.)	Seconds of silence.
Bold	Emphasis given to the words by the speaker.
//	Overlapping of speech by both parties.
=	Latching of one speaker's utterance with the next speaker's utterance with no discernible silence between them.
(( ))	Descriptions of events and what is happening in the background or during a period of silence.
***	Inaudible or seconds of indecipherable talk
(?)	An indecipherable syllable

ABSTRACT

This research explores interactions between registered nurses (RNs) from culturally and linguistically diverse (CALD) backgrounds and their patients in the Australian healthcare setting. Increasing migration of healthcare workers and patients to Australia has led to increasing language and cultural diversity in the workplace. This has led to concerns regarding the management of clinical communication in a second language, and the communicative competence of healthcare workers from CALD backgrounds which can impact on health outcomes and patient safety (Chiang & Crickmore, 2009; Hamilton & Woodward-Kron, 2010; Shen et al., 2012). Yet, rarely has linguistic analysis of intercultural communication between patients and health providers occurred (Collins, Peters, & Watt, 2011; Ulrey & Amason, 2001). The aim of this project is to explore communication between RNs from CALD backgrounds and their patients in the workplace, using the knowledge to contribute towards greater awareness of communication strategies that support communicative competence.

Data is drawn from two phases. Phase one involved interviews of RNs from CALD backgrounds. Five themes emerged through thematic analysis of the data, with the central theme of 'adjustment' identified as fundamental to the experiences of the RNs. This theme interrelated with each of the other themes that emerged: professional experiences with communication, ways of showing respect, displaying empathy, and vulnerability. The second phase involved participant observations and audio-recording of interactions between the RNs and their patients. Interactional sociolinguistic (IS) and theme orientated discourse analysis of the second phase

identified 'Focal themes' (Roberts & Sarangi, 2005) that include the display of empathy, building of rapport, and the provision of empowering patient education.

Discourse analysis of this interactional data has made available the strategic, discursive choices that these RNs make. It also provides resources for communication training workshops that support the development of communicative competence of RNs who are new to the Australian healthcare environment, therefore supporting improved health outcomes and patient safety.

Chapter 1

Introduction to the Study

Intercultural communication has been an area of research interest for a relatively short period of time, and with globalisation, it has become an area of concern in many subject areas and disciplines including education, tourism, management and marketing and health (Jackson, 2014). Research comparing different nationalities' communication styles (e.g. Geert Hofstede) emerged in the 1940s (Piller, 2011). Post World War II migration, increasing international trade and business, and the increasing ability to travel in the late 1960s and early 1970s led to a growing need to communicate with people from diverse backgrounds (Blommaert, 2010; Jackson, 2014; Piller, 2011). According to Piller (2011), business interactions became the focus of much of the intercultural communication research in the 1980s. Intercultural communication involves interactions between 'individuals or groups who are affiliated with different cultural groups and/or have been socialized in different cultural (and, in most cases, linguistic) environments' (Jackson, 2014, p. 3).

In more recent years, intercultural communication in the context of doctor-patient encounters has been examined extensively from various disciplinary perspectives that include anthropology, linguistics, psychology, sociology and communication. Early research focusing on the impact of language diversity in the workplace (Gumperz, 1982) concentrated on specific cultural groups, for example, interactions between workers of Indian and Anglo-Saxon descent. However, with increasing migration there is consequently increasing language and cultural diversity in workplaces, thus raising the complexity of workplace communication which underpins the growing interest in this area of concern.

Reflecting global trends, Australia has also experienced increasing language and cultural diversity, and over a ten year period the proportion of the population born overseas increased from 23% to 27% (Australian Bureau of Statistics, 2012). The migration of health professionals has been supported through the Australian Government skilled migration or employer sponsorship programmes to fill workforce shortages (Ohr, Parker, Jeong, & Joyce, 2010), and by 2006 one in three health workers were born outside of Australia (Australian Institute of Health and Welfare, 2012). Both patients and healthcare workers come from a wide range of culturally and linguistically diverse (CALD) backgrounds that include First Nation peoples. This diversity impacts all healthcare providers in the Australian context (particularly in major cities). As well as being a diverse population, health professionals from CALD backgrounds will also encounter patients from a range of CALD backgrounds, with potentially different experiences/expectations of communication in healthcare contexts. The focus of this study is on nurses who grew up and trained in countries other than Australia, who are faced with the need to adjust to new 'systems' and institutional cultures/expectations as well as patients from cultural backgrounds different to their own. This diversity in culture has resulted in concerns among regulatory agencies, employers and health professionals themselves in relation to the management of clinical communication in a second language and the intercultural competence of healthcare workers from CALD backgrounds (Chiang & Crickmore, 2009; Shakya & Horsefall, 2000; Shen et al., 2012). Intercultural competence is based on an inclusive and integrative world view, and refers to the ability to adapt, acknowledge, respect and integrate cultural differences (Blommaert, 2010; Holliday, 2012; Jackson, 2014; Piller, 2011).

I became interested in intercultural health communication as a result of living as a child, and working in several countries in the south Pacific region and in Europe. Being a registered nurse enabled me to work in various health-related roles in relief and development in Papua New Guinea and Kosovo, as well as typical nursing roles in Ireland. While working as a university lecturer, I developed an interest in the language needs of international student nurses, conducting English language workshops and social support groups for international nursing students. Earlier research examining the language needs of international students seeking to pursue careers in nursing in Australia (Crawford & Candlin, 2013) ultimately led to commencing this PhD project. Given the documented concerns regarding communicative competence of health professionals from CALD backgrounds as noted earlier, I wanted to explore how registered nurses (RNs) from diverse backgrounds interacted with their patients, to identify strategies that assisted their communication. With an interest in the practical relevance of the research findings and solving practical problems, the aim of this project is to examine and make explicit through detailed case studies, unconscious practices in the workplace. This knowledge can contribute to towards a greater awareness of communication problems and strategies that support communicative competence. The questions raised include

- The approaches that RNs from CALD backgrounds take to manage communicative encounters with their patients, and how these approaches align with the broad societal expectations from an Australian perspective.
- The forms of discourse or communication that are called upon to accomplish nursing tasks or actions and the accomplishment of therapeutic relationships with patients.

- The role that culture, discourse systems or membership in particular 'communities of practice' (Lave & Wenger, 1991) play for nurses from CALD backgrounds.

The exploration of this area of concern intersects three fields of knowledge: health, communication and intercultural studies as illustrated in figure 1.

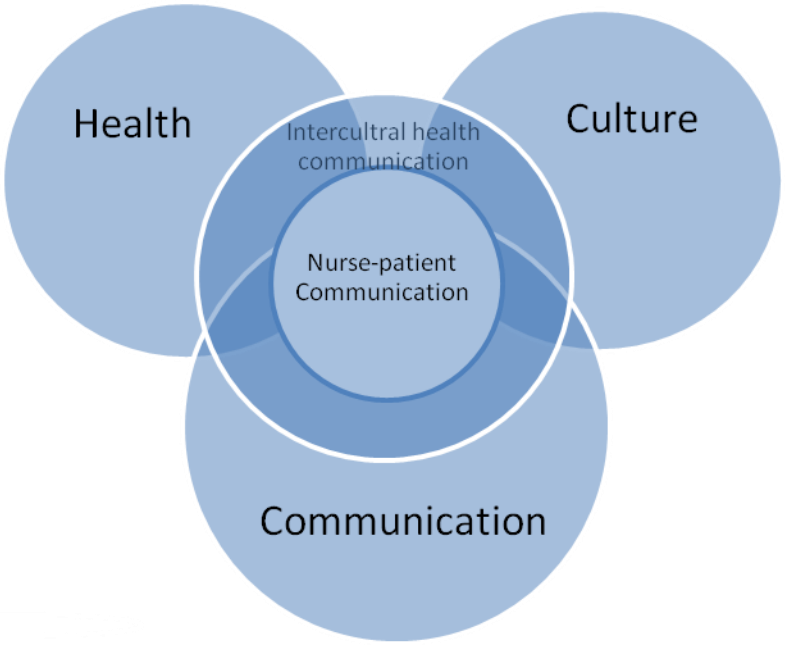


Figure 1: Fields of knowledge that underpin this research

Cultural diversity adds complexity to communication, particularly in the healthcare sector where there are also complex and distinct language and belief subsystems of professional teams, all of which can contribute to miscommunication (Ulrey & Amason, 2001; Watson, Gallois, Hewett, & Jones, 2012).

This chapter sets the scene for the study and begins by outlining the understanding of culture that underpins this study. Turning to the state of play with intercultural health communication research and the skills approach to communication training, this chapter sets out to critique and expose the gap in

knowledge that this research seeks to address. Against this backdrop, the theoretical frameworks of interactional sociolinguistics and theme-oriented discourse analysis are explained, followed by a discussion of the methodology and analytic methods that are utilized. An outline of the thesis structure concludes the chapter.

Towards an understanding of 'culture'

The conceptions of culture have changed over time, stemming from the Latin word to cultivate the ground, referring to the arts, well-educated and/or wealthy, as well as the anthropological view of social systems of behaviour, artefacts and symbols within different contexts (Jackson, 2014). The term 'culture' still has many definitions and dimensions and has also been used to refer to workplaces such as hospitals, and 'communities of practice' (Lave & Wenger, 1991) that include health professionals. While less dominant now than in previous years, several authors (e.g. Jackson, 2014; Kumaravadivelu, 2007; Piller, 2011) have pointed out that the traditional 'structuralist/functionalist' consideration of culture that takes a reductionist stance (the tendency to ignore variations within cultures) is still evident in many intercultural communication textbooks.

The 'structuralist/functionalist' paradigm refers to culture as large groups of people, what they have in common from their history and worldview, their language and/or geographical location (Piller, 2011; Scollon & Scollon, 2001). Individual differences and power relationships between groups are therefore not acknowledged. The 'structuralist/functionalist' approach has been criticised for viewing culture too simplistically, for reinforcing stereotypes and having the tendency to homogenise cultures (Martin, Nakayama, & Carbaugh, 2012). Group members are asserted as having characteristics that are attributed to the whole group. Stereotyping justifies preferential or discriminatory treatment by others who hold greater political power,

therefore limiting our view of human activity, standing in the way of successful communication (Scollon & Scollon, 2001). Many scholars have called for a reassessment and redefinition of many assumptions regarding culture, having more awareness of cultural hybridity, power relations, cultural conflicts, and trans-national movements that create multiple identities (Martin et al., 2012). According to Holliday (2012), the outcome of stereotyping is 'othering'; defining a particular individual or group of people with negative characteristics to explain their behaviour. Occasions of low achievement are often stereotyped as being due to cultural background.

More recent work in intercultural communication rejects cultural overgeneralisation and acknowledges the wide diversity *within* cultures (Holliday, 2012; Kramsch, 1998; Piller, 2011). Over the last 10 years' greater awareness of theoretical and methodological shortcomings of traditional approaches, growing awareness of ethnocentric Western bias, and acknowledgement of historical, socio-political and power interests that contribute to relationships between cultures, have led to critical approaches to intercultural communication research and practice (Blommaert, 2010; Jackson, 2014; Kramsch, 1998; Piller, 2011). This 'critical cosmopolitan' approach underpins this research and will be explained in more detail.

The critical cosmopolitan view of culture.

The 'critical cosmopolitan' paradigm is drawn from critical sociology and considers 'culture' as a

> …social construction that is manipulated by politics and ideology. It is generally accepted that 'cultures' or constructions of 'culture' operate at local and global levels, from small communities, work groups, households and so on to whole nations and even larger entities (Holliday, 2012, p. 37).

The proponents of the 'critical cosmopolitan' view argue that the 'structuralist/functionalist' image of culture is forged by global inequality and Western ideology from society in general, as well as by Western academics, resulting in a 'sustained and profound cultural disbelief with regard to an imagined non-Western Other' (Holliday, 2012, p. 48). It is argued that culture is socially constructed, that people may be influenced by national traditions and educational practices but do not have to be confined by them; rather they may be constrained by societal and material conditions that privilege some and disadvantage others. Holliday (2012) argues that the 'critical cosmopolitan' approach attempts to address researcher subjectivity and ideology in that it seeks to 'allow meanings to emerge from the non-aligned, de-centred piecing together of what is found, rather than imposing the *a priori* narratives implicit in the neo-essentialist approach' (p. 46).

The 'critical cosmopolitan' view of culture informs the methodology of this project. By taking an interpretive approach, seeking a broader picture, and looking for the hidden and unexpressed, the meanings are allowed to emerge. Holliday (2012, p. 47) explains it as 'seeing through the discourses and ideologies of culture that have become reified to insiders'. As an analyst of intercultural communication, it is important to be conscious of the paradoxical situation of looking for differences which may lead to miscommunication, but being careful not to resort to positive or negative stereotyping (Scollon & Scollon, 2001). One technique that helps to locate prejudices that will colour the viewpoint of the researcher is 'bracketing' and 'making strange'; consciously putting assumptions and expected practices aside, approaching social practices as a stranger in order to work out from first principles how the culture works, and seeing through the ideologies of culture (Holliday, 2012; Piller, 2011; Wallace, 2003). To do this I need to reflect, locate and deconstruct any deep cultural

prejudices, or put them aside. The participants have to be thought of firstly as registered nurses rather than as 'representatives' of their respective culture or origin, so that any situations of miscommunication are not simply ascribed to their cultural background. More research and education towards cultural awareness with a belief in what the cultural 'Other' can 'do' and contribute is needed (Holliday, 2012; Wallace, 2003).

Intercultural health communication research

It is increasingly recognised that effective communication can have a significant influence on patient safety and healthcare outcomes (Collins et al., 2011; Hamilton & Woodward-Kron, 2010; Xu, Shen, Bolstad, Covelli, & Torpey, 2010). There has been a significant focus on doctor-patient communication using diverse methods from quantitative and qualitative paradigms, for example, randomised control trials (Heritage, Robinson, Elliott, Bechett, & Wilkes, 2007), surveys (Little et al., 2001), focus groups (Bell, 2009), document analysis (Shaw & Greenhalgh, 2008), coding schemes (Roter & Larson, 2002), corpus linguistics (Harvey, Brown, Crawford, Macfarlane, & McPerson, 2007), observation and ethnography (O'Grady, 2011a); conversation analysis (Heritage & Maynard, 2006) and discourse analysis (Roberts, Moss, Wass, Sarangi, & Jones, 2005). However, the majority of research has focused on monocultural interactions. While much has been written about communication skills in academic journals and text books, there are few examples provided that demonstrate effective communication, show the outcomes of different communication styles, or are based on authentic interactions. Furthermore, minimal focus has been given to working with cultural difference or how this impacts the everyday practice of health professionals (Grant & Luxford, 2011). Rarely has linguistic analysis of intercultural communication between patients and health

providers occurred (Collins, Peters, & Watt, 2011; Jackson, 2014; Ulrey & Amason, 2001).

As in the practice of medicine, communication in clinical nursing practice is critical to safe and competent patient care, and miscommunication can have serious impacts on health outcomes and patient safety (Hamilton & Woodward-Kron, 2010; Xu et al., 2010). Good communication therefore, underpins good nursing practice (Candlin, 1995), particularly as many nursing roles such as patient education, counselling, advocating, and advising consist only of discourse (Candlin, 2002). With increasing cultural and linguistic diversity among both nursing staff and patients, understanding how language and socio-cultural factors interconnect is important for successful communication and the provision of appropriate nursing care (Hearnden, 2008). There have been several nursing studies using a variety of methodologies focusing on issues and impacts of differences in culture and language on communication (Cioffi, 2003; Gerrish, 2001; Hearnden, 2008; Holmes & Major, 2003; Lum, Dowedoff, Bradley, Kerekes, & Valeo, 2015; O'Neill, 2011; Philip, Manias, & Woodward-Kron, 2015; Xu et al., 2010), as well as experiences of adjustment for nurses from CALD backgrounds (Deegan & Simkin, 2010; Omeri & Atkins, 2002; Shakya & Horsefall, 2000). These studies have raised awareness of the difficulties faced, however there have been relatively few *discourse studies* focusing on the nature of authentic workplace interactions, particularly examining intercultural nurse-patient communication, with attention paid to the entire interaction and actual language and strategies used. Furthermore, with many studies focusing on the difficulties, barriers and problems that arise with intercultural communication, minimal attention has been paid to the positive contributions from nurses of CALD backgrounds, or how they successfully communicate with their patients. Major and

Holmes (2008) argue that more research focusing on *ways* in which nurses communicate with patients is needed, and this project attempts to address this gap.

The risks associated with poor clinical communication and the need for training in communication has been recognised for some time, particularly when barriers exist such as diverse linguistic and cultural backgrounds. Consequently training of communication skills has been implemented both in nursing and medicine, and is often combined with the concept of intercultural competence as a consequence of the increasing cultural diversity in health-care settings of health professionals and patients (Collins et al., 2011). However, despite an increased focus on communication training, problems continue due to many barriers to effective communication such as cultural differences, stereotyping, the complex medical system and busy healthcare professionals who are technology focused, and patients who are unfamiliar with the hospital setting and medical terminology often used (Robinson & Gilmartin, 2002; Ulrey & Amason, 2001). This suggests that communication training is not straightforward in terms of equipping health professionals to deal with complex communicative encounters, particularly when interlocutors come from diverse cultural and linguistic backgrounds. The healthcare setting itself represents a different culture for all 'newcomers' to the system: professionals as well as patients. Nurses from CALD backgrounds are particularly vulnerable to the stresses of this 'new' environment. To understand how to strengthen communication training, a focus on the interactions themselves is necessary.

Communication training for health professionals from CALD backgrounds

It has long been acknowledged that training programmes need to be implemented to strengthen communication for healthcare providers from CALD

backgrounds (Ulrey & Amazon, 2009). Medical schools have implemented communication training for international medical graduates (IMGs) for many years, initially taking a remediation approach and teaching essential English-language skills, paying less attention to more subtle or informal forms of communication (Fiscella & Frankel, 2000). A systematic review of the literature relating to issues in communication training of IMGs (Pilotto, Duncan & Anderson-Wurf, 2007), reported that respondents articulated a need to understand the nuances of the English language, including colloquial forms of English, and how to phrase questions and listen reflectively. Learning needs relating to the ability to respond to non-verbal cues with cultural appropriateness, establishing rapport, responding to patients' emotions and expressing empathy were also expressed. Similar results were found in a needs assessment of communication skills and training requirements of IMGs in Canada (Hall, Dojeiji, Byszewski & Marks, 2009). Challenges in establishing rapport, projecting a willingness to listen, and displaying empathy are also reported in more recent literature (Cordella & Musgrave, 2009; Dahm & Yates, 2014; Dahm, Yates, Ogden, Rooney & Sheldon, 2015).

According to Woodward-Kron, Stevens and Flynn (2011), there are frameworks that assist with communication training for medical students that make explicit, the principles of good communication while providing feedback; however, rarely do they take the roles of culture and language, into account. The authors developed and described a Communication and Language Feedback (CaLF) tool to enhance intercultural communication of IMGs that also assists educators in improving feedback on video-recorded doctor-patient role play in simulated settings. Three types of feedback were provided: clinical communication by a medical educator, a patient's perspective by a simulated patient, and a language perspective

by a linguist. A summative evaluation was hampered by irregular attendance due to roster commitments, and low response to survey and focus groups, however improved communication of individual IMGs was observed via longitudinal comparisons of their performances and feedback (Woodward-Kron et al, 2011).

Intercultural communication training for nurses. While there has been a substantial amount of research focusing on communication training for IMGs, the same cannot be said for nurses from CALD backgrounds. A systematic review of communication training for international nurses (Zizzo & Xu, 2009) found only one intervention study (Yahes & Dunn, 1996), and reported that most health care organisations fail to provide tailored programmes to assist the transition of international nurses. Rarely did they address language challenges. Since this review, Shen et al. (2012) reported on a quasi-experimental intervention by a speech pathologist that examined the effects of a 10-week linguistic programme. A reduction in phonologic errors in foreign accents of international nurses was noted after the intervention. Given the apparent success of this pilot study, it is recommended that larger scale studies be conducted to validate these findings. Furthermore, it is recommended that more comprehensive communication training programmes addressing linguistic and socio-cultural aspects of communication in the clinical setting be developed (Shen et al., 2012).

Historically, textbooks on health communication for RNs more broadly have focused on a skills-based approach (for example competency-based assessments of skills such as how to implement specific active listening, paraphrasing, conflict management of aggressive behaviour, and self-awareness). These types of text reduce the complexity of interactions into individual skills. Roberts et al. (2005) argue that neither a skills-based approach to communication training, nor the use of

interpreters provide adequate solutions for settings where interlocutors come from diverse cultural and linguistic backgrounds. Gallois (2003) argues that it is essential to consider the level of power one speaker has over others, particularly in intercultural interactions where people from majority and minority cultures/ethnic groups are interacting. There can be difficulties understanding different accents and there may be lack of respect and micro-aggressions between health professionals belonging to the majority culture and those of minority ethnic groups (Alexis & Vydelingum, 2005). Furthermore, general communication training and advice provided in introductory textbooks are often based on mono-cultural interactions and might not be drawn from authentic consultations or observations of how people interact. While skills-based approaches to communication training can be successful in helping resolve difficult communication encounters, or specific situations such as giving bad news, they do not account for differences in interlocutors' *approach* or *attitudes* towards the other speaker or to the interaction. Consequently, it is argued that this approach is too limited, resulting in the need for greater consideration of the socio-cultural and historical context, how meaning is negotiated, and how these factors influence communicative behaviour (Gallois, 2003; Roberts & Sarangi, 2005; Sarangi & Roberts, 1999; Watson et al., 2012).

As workplaces become more diverse, intercultural competence is becoming more important. More ethnographic studies and discourse analyses of authentic workplace interactions that examine actual use of language and non-verbal codes in interaction, are needed to support this type of communication training (Piller, 2011). According to Dahm et al. (2015), there is little interdisciplinary research that incorporates insights from an applied linguistic perspective, with most research drawing on interview or focus group data rather than on interactions involving

patients. Although focusing on IMGs, Hoekje (2007) argues that linguists and language experts have a role to play in the education and acculturation of health professionals from CALD backgrounds, including issues relating to the establishment of rapport with patients. Dahm et al. (2015) reported on a pilot study that analyses and provides feedback on communicative practices between IMGs and their patients, using insights from both medical and linguistic experts. Both the clinical educators and the applied linguistics experts identified similar areas of communicative difficulty, however the clinical educators often did not provide specific explanations or suggest alternative communicative strategies. The linguists' understanding of the technical and structural knowledge of communication complemented the medical expertise and tacit understanding of English, thereby providing explicit analysis of the causes and potential methods for remediation of issues. Furthermore, education of socio-pragmatic strategies (such as small talk, social distance, showing active listening) that support communication could be provided. To produce evidence-based outcomes that have practical relevance towards supporting this type of communication training for nurses from CALD backgrounds, a theoretical framework that accounts for socio-cultural and historical contexts is required.

Theoretical framework

Early reading led me to examine this area of concern from an interactional sociolinguistics perspective within the field of applied linguistics. Applied linguistics is a broad, interdisciplinary field of study that focuses on analysing language related problems and language in use in a natural setting (Coffin, Lillis, & O'Halloran, 2010; Croker, 2009). Interactional sociolinguistics (IS), developed primarily by Gumperz (1982), is a qualitative interpretive approach to the analysis of social interaction that draws from sociology, anthropology and linguistics (Gordon, 2011). This approach

offers theories and methods, through the analysis of discourse, that enable both the exploration of how language works, but also the social processes that individuals use to build and maintain relationships, project identities and create communities. Through explicating interpretive procedures between members of different cultural groups, IS can be used to explain interactions and communication, especially important in increasingly diverse workplaces (Gordon, 2011). Scollon and Scollon (2001, p. 241) argue that 'while words may be understood, the meanings are interpreted within a cultural envelope created by discourse systems'.

There are several differing views of what discourse is. These range from a broad conception of discourse as a social construction of reality that include conversation interactions such as opening, closing and taking turns in conversation, to a much narrower conceptualisation of 'discourse' as language at the level of text, for example paragraph structure and the organisation of whole texts (Paltridge & Wang, 2010). A broad definition of discourse was adopted for this research. Discourse is considered a combination of language, actions and interactions, ways of thinking and using a variety of tools or symbols to enact one's identity in social situations (Gee, 2011). Scollon and Scollon (2001) describe a discourse system as being made up of ideology, socialisation, forms of discourse, and face systems. They define 'face' as 'the negotiated public image, mutually granted each other by participants in a communicative event' (Scollon & Scollon, 2001, p. 45). Discourse analysis (DA) examines patterns of language across texts, considering the relationship between the language used and the social and cultural contexts within which it is used. It also examines how the use of language is influenced by the relationships between the participants (Paltridge, 2012).

According to Gumperz (1982), sociocultural background knowledge and context are important in inferring meaning from conversation, a process he called 'conversational inference'. Conversational inference works one turn at a time as participants interact, simultaneously interpreting the preceding discourse, giving an indication of their own inferences drawn from the conversation, and making their contribution toward the continuation of the interaction (Scollon & Scollon, 2001). It is a complex process that is essential to communication but also a major source of miscommunication. Metamessages (non-verbal cues such as gestures and body language that supplement verbal communication) are encoded and superimposed on the basic message that we are familiar with, and which indicate how we want someone to take our basic message (Scollon & Scollon, 2001). Because of this complex process, Gumperz (1982) argues that a basic message by itself cannot be interpreted, and consequently speakers use 'contextualisation cues' to convey what they mean in ordinary conversation. Contextualisation cues are the signalling mechanisms that include important sources for making inferences beyond the grammatical system of the language itself; cohesive devices (verb forms, conjunctions), cognitive schemata (scripts from previous experience, world knowledge), prosodic patterning (intonation, timing, pitch and stress) or paralinguistic (tempo and pauses) features that are culturally shaped to indicate what is meant in conversation. These processes are largely unconscious in normal social interaction and can be difficult to consciously alter, however they help interlocutors to draw inference and make meaning, using interpretive resources such as their background ideological, cultural and metapragmatic assumptions. When there are different histories of socialisation (as found when people from diverse cultural backgrounds are interacting), then variations in the signalling values of

contextualisation cues may inhibit the shared interpretation of the interaction, paving the way for misunderstandings to occur (Sarangi & Roberts, 1999).

Sarangi and Roberts (1999) argue that workplaces are social institutions held together by communicative practices that include talk, text, and use of social space and artefacts such as technical equipment. Consequently, the social context and the structuring of social participation must be taken into consideration when analysing communication in these settings. Understanding and promoting effective communication between work colleagues and their clients is vital for the smooth operation of the organisation (Holmes, 2000). The study of workplace interactions can contribute to our understanding of 'how professions are constituted and relations of power are fashioned out of talk at work' (Sarangi & Roberts, 1999, p. 2).

Roberts and Sarangi (2005) drew on IS to develop theme-oriented discourse analysis as an approach that focuses on how language constructs *professional practice* within health-care settings. This approach to discourse analysis (DA) also examines the micro level of detailed features of talk over an entire interaction. With this approach, analytic themes drawn from sociology and linguistics (detailed features of talk that trigger inferences about what is going on, for example contextualisation cues, lexical choices and how social identities are portrayed) are linked to focal themes relevant to professional domains (for example shared decision making or intercultural misunderstanding) (Roberts & Sarangi, 2005). Theme-oriented discourse analysis requires 'a bifocal gaze, noticing both the health content and the means of structuring talk and sustaining relationships' (Roberts & Sarangi, 2005, p. 639). This process sheds light on interpretive processes and patterns that emerge across an activity, thus providing a new lens for looking at an interaction or problem within the health-care context. This enables the development of research-based

educational interventions and tools that can be used for training purposes and continuing professional development, thereby enabling a better understanding of communication in healthcare interactions. IS and theme-oriented discourse analysis therefore provide applicable theoretical frameworks and methodologies for this research that will enable practical outcomes.

Methodology

Each constituent paper in Chapters Three to Seven contains an account of the research methodology undertaken, however an overview for the whole process, together with a discussion of the theoretical underpinnings of the chosen methods is provided in this chapter.

Given that this project aims to examine intercultural nurse-patient communication in the natural setting of a hospital, qualitative methods were chosen as 'qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them' (Denzin & Lincoln, 2005, p. 3). The primary aim of qualitative research is to get to the bottom of what is going on in social situations that are considered to have specific cultures of activity such as schools, factories and hospitals (Holliday, 2010). The in-depth reporting of the data and rich descriptions of qualitative methods (as opposed to measurable, quantifiable data) are useful for gaining an understanding of social context and process, to examine phenomena holistically, and for assessing participants' interpretation of events (Roper & Shapira, 2000). The inductive nature of qualitative analysis is amenable to change and sensitive to subjective aspects of life (Burns, 2000; Roper & Shapira, 2000) as analysis is very much integrated with data collection. Each piece of data contributes to an emerging picture of what is going on with gradual refinement on data collection choices. Quantitative research,

on the other hand, focuses on controlling variables, collecting numerical data, analysing the data using statistical methods, and minimizing the influence of the researcher (Burns, 2000). Qualitative research approaches have therefore been adopted for this research project as the varied and changing situations in hospitals are too complex to be viewed from a single perspective, and attempts to isolate variables required in quantitative data collection and analysis may result in reporting of unrealistic scenarios with little practical applicability.

There are a wide range of approaches to data collection in qualitative research, for example, observations, interviews, journaling and open response questionnaires, in order to gain fuller, richer perspectives from the participants (Croker, 2009). IS methodology also includes a combination of these methods combined with critical IS analysis. IS analysis has been criticized for perceived over-reliance on the researcher's interpretations to identify and analyse speaker intent and listener interpretation. However, using several data collection methods mitigates this criticism, and the validity of the research is enhanced.

Research design and participants

Ethnographic methods were used for this study in two phases, beginning with interviews of participants regarding their experiences in the Australian clinical setting. The second phase involved participant observations, audio-recordings, and researcher journaling to describe and analyse therapeutic interactions and communication between RNs of CALD backgrounds with their patients in a hospital setting. It was anticipated that 10-15 RNs would participate in the research, however despite extensive efforts to recruit, only four RNs from various backgrounds (China, Philippines, Iran and Zimbabwe) with between three and ten years' experience working in Australia volunteered to participate - see table 1.

Name (pseudonym)	*Gender*	*Age*	*Country of origin*	*Years of employ-ment in Australia*	*Highest level of Education*	*IELTS score*	*Hospital department*
Andrea	Female	mid 40s	Philippines	3	Certificate and bridging course to work in Australia	7	Neurology unit
Betty	Female	mid 40s	Zimbabwe	10	Masters degree	7	Neurology unit
Jenny	Female	mid 20s	China	3	Bachelor degree	7	Day surgery
Elaine	Female	mid 30s	Iran	6	Certificate - RN for 6 years in Iran, studying for a Bachelor degree	6.5	Various surgical units

Table 1: Participant details

The four RNs participated in the first phase, however two left the project early into the second phase. Andrea left the study after 8 hours of observation due to an interstate move, and Elaine experienced a workplace accident and was therefore not able to participate in the observational phase of the study. Consequently, there are a small number of interactions from Andrea included in the thesis with no interactions from Elaine. Due to the limited number of participants, the design was modified and this thesis therefore takes a case study approach, providing an in-depth exploration of the communicative behaviours of the remaining participants. The research site was chosen due to a high proportion of overseas trained RNs, and a second site was subsequently considered, however extending the recruitment to another hospital would have involved additional ethics reviews, institutional approvals and recruitment that was not feasible in the timeframe of the project.

Data collection

Data collection took place over two phases in a private hospital in Sydney, Australia that has recruited many nurses from CALD backgrounds. The hospital managers had expressed interest in the study due to this diverse workforce and readily granted permission for the research to occur on site. Once permission had been granted by the hospital, ethical clearance was sought from the Macquarie University Ethics Committee and approval was granted in November 2014 (see appendix 2 for the approval letter).

I obtained written consent from the RNs and all patients who participated (see appendix 3 and 4) and carried out the audio-recordings. All the transcriptions were carried out by myself. Identifying features were removed and pseudonyms were provided to protect the identities of the participants. Using a variety of methods of data collection from more than one standpoint assisted triangulation in the data analysis, thereby reducing risk of bias and improving the internal validity of the results. Each of these methods will be discussed in detail.

Phase 1: Interviews. Interviewing is a frequently used and well known qualitative research instrument because it is a common communicative routine with a one-to-one professional conversation. It has the purpose of obtaining rich descriptions and meanings of the life world of the participant (Burns, 2000; Dörnyei, 2007). An unstructured or 'ethnographic' interview style was used thereby allowing for maximum flexibility to follow the participant's experience. The intention was to create a relaxed atmosphere and develop good rapport to elicit more in depth responses from the participants than a more formal interview may elicit. This type of interview is most appropriate when a deep meaning of a particular phenomenon or personal historical account is required (Burns, 2000; Dörnyei, 2007; Polit & Beck,

2008). There was little interference from the researcher except for a few initial questions and occasional clarifications and reinforcement feedback. Initially the participants were asked how long they had worked in Australia, exploring when and how they learned English, in what domains (if any) they had used English before coming to Australia, and how they found the variety of English encountered in Australia. The participants were then questioned on their perceptions and experiences working in the Australian hospital setting and communicating with patients, if they had experienced any problems understanding the patients, or patients understanding them, and if there had been any occasions of miscommunication. They were also asked what had helped or hindered their communication with patients, strategies they used, and if anything about the health system contributed to any occasions of miscommunication (see appendix 1). The interviews were audio-recorded, transcribed verbatim and analysed thematically. The transcripts and analysis were checked by the participants for accuracy, thereby enhancing validity.

Dörnyei (2007) argues that while the interview method is a socially acceptable way of collecting information that most people are familiar and comfortable with, it also requires good communication skills on the part of the interviewer to draw out sufficient data without generating too much less-than-useful information. There is also a chance that the interviewee might try to present themselves in a better than real light, although this risk was mitigated by collecting additional types of data during participant observations and audio recordings in phase two of the research.

I also maintained a research journal during the course of the project containing 'metadata' – insights, real-time comments, annotations and field notes which formed an audit trail and became part of the dataset (Polit & Beck, 2008). This

documented the development of thinking, reflections, overall outcome of the interview, thus strengthening the validity and reliability of the research. This data contributed to the analysis and interpretation process.

Phase 2: Ethnography. Ethnography has its roots in cultural and linguistic anthropology of the early twentieth century, and since the 1960s have been embraced by the broad fields of sociolinguistics and applied linguistics that study the 'social turn' in the study of language (Starfield, 2010). The purpose of ethnographic research is to examine social, cultural and normative patterns (Burns, 2000; Roper & Shapira, 2000); it is therefore useful for describing nursing as a cultural phenomenon with unique beliefs and practices within the general health system. Ethnographic techniques allow the ethnographer to get 'inside the picture' which is useful for obtaining 'rich descriptions' of cultural influences on language use and social processes.

Applied linguistics uses ethnographic approaches to study language practices in communities and institutions familiar to the researcher, in this case, a health-care setting. Ethnography facilitates interpretation and a deeper understanding of the process of social interaction among people from different cultures and organisations from the 'emic' or native's point of view. A variety of techniques such as participant observations, interviews, audio recordings, and field notes take place in a natural setting which enables both a deep understanding of the research site and triangulation of the data (Hammersley & Atkinson, 2007; Robinson, 1988; Roper & Shapira, 2000; Starfield, 2010).

A drawback of this approach is the extended length of time required to engage with the participants in their natural setting to gain a deep understanding of the social processes that are occurring. Another drawback is balancing the 'insider/outsider

dilemma' which requires a balance between insider and outsider perspectives (Burns, 2007). This dilemma was managed in this particular study by keeping a research journal, reflecting and questioning my own perspectives and checking with the participants that my interpretation of the interaction was aligned with theirs.

This phase of the research involved participant observations and audio recordings of interactions between the RNs and their patients with the focus primarily on the RNs' contribution to the encounter. The term 'encounter' is used in this thesis to refer to the interaction between a patient and the RN for the purpose of assessing their health status and providing nursing care. Observations of nurse-patient encounters occurred over a six-month period of 2015, and over 31 interactions from between 5 and 60 minutes of duration were observed and recorded. Observation time extended from 8 hours with Andrea, to several shifts with Betty and Jenny. The time spent with the participants during the interviews, and subsequent participant observation, encouraged rapport-building which helped to embolden the participants to share their perspectives of their interactions with their patients (Gerrish, 2011). This allowed the researcher to take a holistic view, to understand more fully what is going on (Dörnyei, 2007; Roper & Shapira, 2000). Field notes were also taken, noting contextual details such as the type of hospital setting/ward, surgery or condition of the patient, the task the RN was undertaking, and any non-verbal interactions, and personal reflections to assist with the analysis of the interaction.

While observing the participants, I typically positioned myself in the corner or back of the room so I would minimize any interference on the interactions between the RN and their patient, and the tasks that needed to be accomplished. I obtained informed consent from the patients and operated the audio-recorder. I had minimal interaction with the patient except to develop rapport and reassure the patient about

my presence, or if they addressed me directly. My background as an RN, and knowledge of nursing practices in many hospitals informed my observations, and reflections in the journal/field notes about my role as a researcher and the nursing practices and procedures being observed, attempted to address any biases and assumptions that might impact the analysis of the interactions.

The audio recordings were transcribed verbatim and analysed using IS approaches described later. The transcripts and analysis were checked by the participants to ensure accuracy of transcripts and analysis, allowing subjective interpretation of their own behaviours, and gaining their perceptions and insights into the communication episodes (Dörnyei, 2007). Triangulation through varied methods of data collection and involvement of the participants in the data analysis enhanced the validity and trustworthiness of the research (Dörnyei, 2007; Roper & Shapira, 2000). Bias was minimized by the researcher not pre-structuring or pre-categorising the participant observations, therefore leading to more objective observations (Dörnyei, 2007; Roper & Shapira, 2000; Hammersley & Atkinson, 2007).

Data analysis

Phase one: interviews. Interviews of each participant were listened to repeatedly and transcribed verbatim. This enabled a deep immersion into the data and an initial identification of key themes relating to the participants' experiences. An inductive and iterative process of repeatedly reading the transcripts, identifying and reflecting on themes, and pre- coding themes began the analysis of the interviews (Dörnyei, 2007; Gibbs, 2007). Initial and descriptive codes were gradually replaced or supplemented by more analytical codes as more salient themes emerged. As patterns and more abstract commonalities emerged across the data, a second level of coding was identified. These codes were checked by another researcher to enhance

reliability of the analysis. The codes were tabulated, enabling a case by case comparison of themes that identified relationships and causal influences between themes (Gibbs, 2007).

Phase two: participant observations, audio-recordings and field notes. Discourse from transcripts of audio-recordings, supplemented by field note data drawn from participant observations, were analysed using a coherent framework to explain how 'meaning-making' occurs in natural conversations (Gordon, 2011). Passages from entire interactions were transcribed 'bringing in as much phonetic, prosodic and interactional detail as necessary, with surface content and ethnographic background necessary to understand what is going on and, finally, analysed interpretively both in terms of what is intended and what is perceived' (Gumperz, 1982, p. 134). The data was analysed at three levels. Firstly, the overall speech act/function or the activity being undertaken (for example giving medication or dressing a wound) in consideration of the focal themes in the health-care context (Roberts & Sarangi, 2005). Secondly, the choice of discourse strategy such as turn-taking and topic control (who did most of the talking and controlled the topic of conversation). And thirdly, the actual linguistic forms used, for example hedging & pragmatic devices (use of 'I think', 'perhaps', interruptions and 'alright' to indicate a change of topic). This framework provided a valuable and practical way of tracking how individuals communicate their professional identities and how they express power and politeness at work (Holmes, Stubbe, & Vine, 1999). IS has been criticised for always being interpretive and consequently having difficulty interpreting speaker intent**;** however, the participants checked the transcripts and analysis and no amendments were suggested. While there might be a risk that member checking results in participants resisting interpretations of the data that cast them in a light that they consider less

favourable, this did not occur. Through this process, the accuracy and validity of the data was strengthened.

According to Scollon and Scollon (2001), analysis of intercultural interactions does not result in theories about what might happen when different cultures interact, nor does it describe discourse systems. Rather it focuses on people acting in particular and concrete tasks, and asking: what roles are culture, ideologies and discourse systems taking to inform these actions, or how are actions productive of culture or 'communities of practice'? How might these actions produce 'others' through practices of inclusion and exclusion? What forms of discourse or communication are called upon to accomplish the task, practice or action? To what extent are social relationships and identities (face systems) claimed or invoked in this task? By examining the interaction as a whole, the ways in which the various elements of the interaction relate to its outcomes can be analysed.

IS and theme-oriented discourse analysis helps to explicate interpretive procedures underlying talk in health-care settings which enables greater awareness of the consequences of every-day interactions, as well as allowing for misunderstandings to be addressed. Scollon and Scollon (2001) argue that by providing alternative ways of understanding how and why people communicate as they do, it is less likely that negative interpretations about intercultural communication are made, therefore stereotyping and othering may be reduced.

Outline of the thesis

This thesis follows the 'thesis by publication' format, approved by the Macquarie University Higher Degree Research Office as an alternative to traditional theses. This thesis contains eight chapters, six of which are articles that have been submitted for publication/published in peer-reviewed academic journals and

conference proceedings (Chapters Two to Seven). Each journal article is included with the formatting style required by the particular journal to which each paper was submitted. While each paper is designed to be read independently, the theme of each paper aligns with the overall research aims as outlined in the introduction. To provide a coherent thesis, the articles (chapters) are linked by short bridging sections (interludes) explaining how each paper links to the previous chapter and how it relates to the research question.

This introductory chapter has set the scene for the thesis, discussing the concept of culture that underpins the approach I have taken to analysing intercultural nurse-patient communication. An overview and critique of previous research in medicine and nursing has identified where there has been little focus on intercultural nurse-patient communication, particularly from a linguistic perspective. Against this background, skills-based communication training in health settings was critiqued, proposing an alternative approach that uses entire interactions to demonstrate the interactional consequences (O'Grady, 2011b) of different communication approaches that may be taken. The theoretical frameworks that underpin the methods adopted for the data collection and analysis were then explained. As this study aims for outcomes of practical relevance, ethnographic approaches and analytic methods that combine IS and theme-oriented discourse analysis are argued for and explained.

Chapter Two discusses the theoretical frameworks that this study draws from in more detail. It is a paper that speaks to a nursing audience and presents a broad introduction to linguistics frameworks and tools that provide an alternative way of analysing communication problems that result in miscommunication. Given the complexity of communication in the health-care setting, made more complex by increasing diversity in the workforce, discourse analysis from a linguistics

perspective is argued for. The Process Model of Intercultural Communication (Szalay, 1981) is described as it forms a useful foundation for understanding concepts such as 'conversational inference' (Gumperz, 1982) and 'interactive framing' (Tannen, 1993). Tools that come from these concepts, for example contextualisation cues and frame analysis, assist in achieving a deeper understanding of the communication processes, making unconscious practices explicit, and therefore uncovering key elements that make for effective (or in some case less effective) communication. This awareness allows for these key elements to be recognised and labelled, and therefore discussed in contexts where nurses (or student nurses) are learning about communication.

Chapter Three presents the results of the first phase of this study. Four RNs from CALD backgrounds were interviewed about their experiences working in Australia, eliciting their critical reflections on clinical encounters and instances where they had experienced either effective or problematic communication. They were also asked to reflect on factors that hindered and strategies that they used to support their communication. Five interrelating themes that were derived from thematic analysis of the interviews are discussed. The central theme of 'adjustment' was identified as fundamental to the experiences of the RNs and this theme interrelated with each of the other themes that emerged: professional experiences with communication, ways of showing respect, displaying empathy, and vulnerability. Secondary themes that arose out of these primary themes are discussed in this chapter. This phase set the context for the second phase of the study by enabling my understanding of the participants' experiences adjusting to the Australian healthcare environment and what strategies they reported they used to support their communication skills. It also served to build trust between the researcher and the participants.

Chapters Four, Five, Six and Seven present results from the second, discourse analytical phase that is central to this study. These chapters focus in turn on each of the three focal themes that arose out of the discourse analysis of the nurse-patient interactions; displaying empathy, building rapport, and providing patient education.

Chapter Four traces the interactional consequences of empathy by two nurses from CALD backgrounds, albeit with different levels of affiliation or connection with the patient, using a schema of professional responses (Ruusuvuori, 2007). The interactions demonstrate the outcomes of 'extended' responses and 'minimal affiliative' responses (Ruusuvuori, 2007) respectively, which allows for a greater understanding of the consequences to various communicative approaches and levels of engagement.

Chapter Five sets out the interactional accomplishment of rapport against the analytic frameworks of novice to expert and professional expertise (Benner, 1984; Shön, 1983). The hallmarks of higher levels of communicative expertise are demonstrated by more experienced RNs, and include the ability to smoothly and expertly interweave between different frames to achieve clinical and rapport-building goals during patient care. These interactions are contrasted against the interaction of a less experienced RN where these strategies are used less frequently and there is more focus on achieving clinical goals.

Chapters Six and Seven both present the focal theme of patient education. Chapter Six takes a case study approach that presents the discourse analysis of an entire interaction to trace the consequences of patient education where empowering discourse (Kelo, Martikainen, & Eriksson, 2013; Leino-Kilpi, Luoto, & Katajisto, 1998) is displayed. This paper illustrates how empowering behaviour can be integrated into patient education, thus offering an alternative to traditional

approaches. Chapter Seven maps authentic interactions between the participants and their patients against cognitive learning theories drawn from education; schema theory (Ormrod, 1995; Wilson & Anderson, 1986) in particular. The interactional consequences, when elements drawn from these theories are implemented, are clearly observable in the data. This chapter explains how an awareness of these elements can help to structure patient education that better supports patients' learning.

Chapter Eight takes up the aim of practical relevance and sets out how the results of this study might be used to support communication training programmes, particularly to support the communicative competence of RNs from CALD backgrounds. A place for discourse analysis and the use of entire interactions in communication training is suggested.

Chapter 2

New perspectives on understanding cultural diversity in nurse-patient communication

Abstract

Effective communication is essential in developing rapport with patients, and many nursing roles such as patient assessment, education, and counselling consist only of dialogue. With increasing cultural diversity among nurses and patients in Australia, there are growing concerns relating to the potential for miscommunication, as differences in language and culture can cause misunderstandings which can have serious impacts on health outcomes and patient safety (Hamilton & Woodward-Kron, 2010). As Ulrey and Amason (2001) point out, intercultural communication and patient-health provider communication have both been examined extensively (with many publications focusing on communication skills for nurses), however, rarely have the two areas been examined together. Furthermore, there has been minimal examination of intercultural nurse-patient communication from a linguistic perspective. Applying linguistic frameworks to nursing practice can help nurses understand what is happening in their communication with patients, particularly where people from different cultures are interacting. This paper discusses intercultural nurse-patient communication and refers to theoretical frameworks from applied linguistics to explain how communication problems may occur. It illustrates how such approaches will help to raise awareness of underlying causes and potentially lead to more effective communication skills, therapeutic relationships and therefore patient satisfaction and safety.

Background

Globalisation has resulted in cultural diversity in many countries including Australia, with migration of healthcare workers such as nurses. In the last ten years the proportion of the Australian population of people born overseas has increased from 23% to 27% (Australian Bureau of Statistics, 2012), with 1 in 3 health workers in 2006 born outside of Australia (Australian Institute of Health and Welfare, 2012). Migration of nurses from overseas has played an important part in meeting shortages in Australia's healthcare workforce through Government strategies such as the skilled migration or employer sponsorship programs (Ohr, Parker, Jeong & Joyce, 2010). However, Chiang and Crickmore (2009) found that English language, clinical communication skills and intercultural competence are areas for concern regarding international Registered Nurses (RNs). Shakya and Horsfall (2000) found that development of advanced English communication skills related to clinical practice was urgently needed in clinical settings, consequently intercultural communication between nurses from culturally and linguistically diverse (CALD) backgrounds and their patients is of particular interest. In Australia, patients may include not only native English speakers but many will also come from a range of CALD backgrounds that include Indigenous Australians. Shen et al. (2012) argue that language and communication barriers are consistently ranked as a top concern by employers, regulatory agencies and international nurses themselves. The National Competency Standards for Registered Nurses in Australia requires that RNs 'communicate effectively with individuals/groups to facilitate provision of care' (Competency 9.2, Australian Nursing and Midwifery Council, 2006), however there are no guidelines provided to help ensure this occurs. How then might nurses, hospital administrators or nurse educators promote effective communication to ensure this standard is met?

The examination of communication can help to identify potential problems, contribute to an understanding of issues that arise in health consultations, and therefore how to support more effective communication. Applied linguistics is the study of discourse or language use in a variety of settings including professional settings, particularly in relation to practical problems, and draws on but is not dependent on areas such as sociology, psychology, anthropology and education (Pennycook, 2001). Discourse is seen in many different ways; however, in this case we use a broad definition of discourse, that is, a combination of language, actions and interactions, ways of thinking and using a variety of tools or symbols to enact one's identity in social situations (Gee, 2011). This paper will first discuss issues surrounding nurse-patient communication in culturally diverse healthcare settings, and then illustrate how drawing from linguistics and applying theoretical frameworks explained by Tannen (1993) and Gumperz (1982) can assist in understanding intercultural communication.

Communication is complicated!

Guttman (2004) suggests that the nurse-patient relationship is built on communication, and as such, effective use of language is essential. Candlin (1995) argues that good nursing practice is underpinned by effective communication, required to build trusting relationships and thus have the ability to accommodate, empathise and affiliate with patients. However, one's expectations and ways of seeing the world are culturally defined, and without clarity and understanding there is potential for not only communication breakdown, but also failure to achieve nursing goals (Candlin, 1999, 2002). Communication barriers in healthcare created by differences in gender, education and socio-economic status may be accentuated when there are differences in language, cultural patterns of behaviour and different values between the nurse and patient (Candlin, 2002). Ulrey and Amason (2001, p. 452) argue that 'culture adds

another dimension to an often already difficult communication situation'. Many barriers to effective intercultural communication include stereotyping, busy healthcare professionals who are too technology focused, the complex medical system, and patients often being too fearful of novel situations to focus on communication (Ulrey & Amason, 2001; Robinson & Gilmartin, 2002).

The ability of the healthcare provider to speak clearly and accurately with patients requires linguistic competence; an important component of communication and refers not only to the subconscious and appropriate use words, grammar and syntax, but also to the practical features of the language such as topic control and turn taking, use of metaphor and the 'hidden rules' of interaction. Linguistic competence is particularly important, as many nursing behaviours are mediated through discourse, and some roles such as patient education, counselling, advocating, and advising consist only of discourse (Candlin, 2002).

Roberts and Sarangi (2005) point out that regardless of whether English is a native language or not, different ethnic groups may use culturally specific styles of communicating that differ from the local form of English. Differences can occur, for instance, in how personal or direct it is appropriate to be in a particular context, as well as differences in stress patterns, intonation and speech rhythm. Xu, Shen, Bolstad, Covelli and Torpey (2010) found that some international nurses were perceived as 'cold' due to a lack of touch or personal connection with patients, for example, when not engaging in 'small talk' with patients while attending to patient care. Despite this, the nurses thought of themselves as caring and compassionate. While professional migrant employees are often proficient in the tasks required for the job, learning to communicate and relate in ways that are appropriate in a particular cultural environment are typically

more taxing (Holmes, Joe, Marra, Newton, Riddiford & Vine, 2011). This is illustrated in interviews of international nursing students as part of an earlier research project.

> There are so many incidents with regard to misunderstanding or difficult to understand each day. I often need to repeat what I was saying to people. Most of them are related to my incorrect pronunciation or mis-stress on the tone… I have been experiencing some kind of pressure during clinical placement to primarily focus communication with patients or the nursing team. My brain is taxed on the nursing physical task and there is little space or time to build rapport with patients and cultivate communication in reality (Crawford, 2011, p. 37).

> ...some patients they ...have a casual communication would tell what's happening in their family and all through his life. I couldn't grasp what they were talking about, that's happens very frequently. So, in that I realise that doesn't help me to form a very therapeutic relationship with my patients (Crawford & Candlin, 2012, p. 799).

These students' experiences may explain how some nurses might sometimes appear 'cold' when they are mentally translating or learning the local form of English, and highlights the stress they feel when adjusting to work in an environment where English is not their native language. Communication between patients and nurses from CALD backgrounds is hindered by unfamiliar accents and intonation, word stress patterns, and pronunciation. Lack of familiarity with slang, colloquial language, and other aspects of socio-cultural language use can result in a negative perception of the nurses'

competence by patients, peers and other health professionals (Shen et al. 2012; O'Neill, 2011).

According to Hamilton and Woodward-Kron (2010), differences in language and culture can cause misunderstandings which can have serious impacts on health outcomes and patient safety. Xu et al (2010) argue that deficiencies in communication skills raise concerns about risks to patient safety as effective communication is critical to safe and competent patient care. This is particularly pertinent for comprehending instructions from doctors, doing patient assessments and giving patient education. Research examining communication between district nurses in the United Kingdom and South Asian patients shows that when communication difficulties exist, the provision of equitable and quality healthcare is compromised. Without an understanding of the patient's health needs there is danger of the care becoming routine and based on stereotypical assumptions (Gerrish, 2001). According to Grant and Luxford (2011) there is little research into the way health professionals approach working with cultural difference or how this impacts their everyday practice. Therefore, a greater understanding of intercultural communication and strategies that can be applied to practice are needed in order to support nurses from CALD backgrounds in their work with patients from cultures other than their own.

How can linguistics help to understand nurse-patient communication?

Analysing discourse through slowing down the talk-under-scrutiny can help us to understand both the patterns of communication as well as the overall activity (Roberts & Sarangi, 2005). The benefit of analysing discourse is that language is *the* way in which many activities are conducted. As Roberts and Sarangi (2005) point out, talk *is* work in institutional settings.

Analysing discourse and applying the findings to nursing practice can help nurses understand what is happening in their communication with their patients, particularly where people from different cultures are interacting. Discourse analysis (DA) adds a different perspective to understanding communication in nursing as it examines the practical aspects of communication: for example, speakers' choices of vocabulary, grammar, intonation, how interactions are sequenced and how the content at each turn of talk is managed. Communication textbooks provide advice on improving communication and listening skills but as Roberts et al (2005) point out, these skills are not always sufficient to meet the demands of a multilingual population, as they tend to be based on mono-cultural and monolingual consultations where talk itself is typically not the problem. Furthermore, such textbook advice might also be based on intuition rather than on actual observations of how people talk in such contexts.

The analysis of discourse contributes to our knowledge of how social relationships are managed in talk; for example, how nurses and patients establish relations, how they take account of each other's relative knowledge and emotional state and how they may use various face-saving strategies (how they maintain a positive public self-image) (Roberts, Wass, Jones, Sarangi & Gillett, 2003). DA therefore complements other approaches to understanding communication that are informed by disciplines such as psychology, philosophy and anthropology, as it brings new insights and therefore greater understanding of how meaning-making occurs in interactions. Critical discourse analysis (CDA) is one form of DA and takes a critical stance which considers ideology, use of power and inequality; it is therefore useful for examining the manifestation of power in healthcare settings. This includes how it is used in interaction with patients, or interactions between majority group health providers and

patients, and interactions with immigrant nurses (Sarangi & Roberts, 1999; Watson, Gallois, Hewett & Jones, 2012). Roberts et al. (2005) argue that while discussion of diversity and culturally different health belief models have occurred in education of health professionals, as well as communication training in general, specific training in identifying communication problems and how to prevent/repair them is essential. Consideration of theoretical frameworks such as those explained by Goffman (1974), Tannen (1993) and Gumperz (1982) may help to develop such training as they provide tools for raising awareness, for understanding background influences, and for interventions to develop new skills for intercultural communication which are based on the ways in which nurses and patients actually communicate.

Theoretical frameworks

Theoretical frameworks help to interpret the situation being examined and provide an organising structure for explaining each person's behaviour. According to Holmes, Stubbe, and Vine (1999) using a number of different theoretical perspectives and analytic frameworks produces a richer, more comprehensive analysis which helps to take account of wider contexts of interaction and their dynamic nature. This paper draws from the work of three theorists to explain how communication problems may occur in order to better understand how to support effective communication. Firstly, frames and 'interactive framing' (Tannen & Wallet, 1993) is discussed as it forms the foundation for describing Gumperz' (1982) 'conversational inference'. These theorists are linked through the concept of 'frames of reference'. Interpretation of a message is influenced by one's frames of reference which are culturally informed.

Discourse analysts and sociologists refer to frames of reference for interpreting discourse. Bateson (1955) introduced the term 'frames' which was developed further in various fields such as sociology, anthropology, and linguistic anthropology, and was

used by Goffman (1974) to describe ways humans make sense of events, communicate and discern 'what is going on here'. A frame provides the basis of one's interpretation of their experience of the world in a given culture - how one organises knowledge about the world and uses this to predict interpretations and relationships; new information, events and experiences in particular. People within the same culture or society share similar principles of organisation which govern social events; hence expectations about interaction differ across cultures for the same speech event causing participants from diverse cultures to interact differently (Tannen, 1993). For example, for international RNs, performing roles that are not part of usual routines in their home countries could be challenging as they may lack appropriate frames of reference for these particular roles and therefore struggle while attempting to fulfil them. RNs from China explained that they were not expected to participate in small talk with patients while giving patient care and were shocked at what seemed like over-familiarity in the Australian healthcare setting. They struggled with a change in perception of professional conduct from what could be framed as 'quiet application to duty' in China, to a frame of 'building rapport' in Australia which manifested as chatty familiarity between patients and nurses (O'Neill, 2011).

Differing frames can also be illustrated between Western and Australian Indigenous cultures when it comes to making decisions. In Western cultures, the decision to undergo surgery may rest primarily with the person concerned and perhaps the immediate family, therefore for a Western RN a decision-making encounter may be framed as one with a more imminent decision. However, in some Indigenous cultures the situation must be discussed with the wider community/group before a decision is made which may require extended periods of time (Randall, personal communication, 2014). For these groups decision-making, may be framed as a preliminary exploration

of options. Tannen (1993) adopted Goffman's concepts of framing and face (explained as how people present themselves in everyday interactions) arguing it is valuable for analysing discourse. These concepts provide a strong foundation for the analysis of interaction as they explicate mechanisms of cross cultural communication which therefore form the basis for identifying causes of miscommunication among different cultures.

Tannen uses the concept of 'interactive frames' (Tannen, 2009, 1993; Tannen & Wallat, 1993) to explain how participants in an interaction draw on their understanding of 'what is going on' at any given moment to convey and interpret meaning. To comprehend speech, participants must know within which frame it is intended; for example, a joke might be interpreted as an insult if participants do not share the same understanding of the frame in operation at a given moment. Participants' expectations about people, events and settings are drawn from prior experience in the world (knowledge schemas) and this is used to infer meaning and understanding for any un-stated information in the course of conversation. What an individual chooses to say in an interaction grows out of multiple knowledge schemas (Tannen & Wallat, 1993). A shift in frames can assist in the communication process when there is a mismatch of knowledge schemas. For example, a shift of frames can occur by an RN (who has a knowledge schema involving the side effects of opiate medication) during an assessment of bowel function of an immobile patient on opiate analgesics (whose knowledge schema does not include such side effects). Here, the nurse may shift from an 'assessment/examination' frame to an 'educational' frame to explain the constipating side effects of opiate medication and immobility. Some of these experiences are built up through interacting in a particular socio-cultural environment, for example,

professional knowledge and ways of speaking are gained through experience working as a health professional (Candlin & Roger, 2013).

Communication problems can occur when health professionals (with their experience and training) and patients (with their lay knowledge, personal involvement and experience of their condition) have divergent and clashing frames, knowledge schemas and therefore expectations. Conflicts can arise when participants are oriented towards different interactive frames which results in talking at cross purposes (Tannen & Wallat, 1993). O'Neill (2011, p. 1123) describes the misunderstanding between a CALD nurse and her patient through a clash of interactive frames when it came to a night-time settling routine. The particular patient's routine was quite different from what the nurse had experienced previously, both from other patients and from her experience in her home country, thereby contributing to her confusion.

> I tried to be caring because it's night time… I think his daily routine is a little bit different from the other patients… Always we will leave the curtain open just towards the door, but he want this half to be closed and this half to be open. You get, what's that, what's that? He talks very fast, so I like open the curtain and he's like, "no, no, no…" I don't know what to do, which order, it's weird, it's not commonsense… And he explained it very fast, I didn't get it… He got furious, started to yell at me…I forgot what he wanted me to do, I draw the curtain, turn off the lights, close the door and just escape…

Ideally such misunderstandings are resolved through a shift in frame, where patient and nurse shift their interaction together from a 'preparing for sleep' frame to an 'agreeing on the routine' frame. In this instance, however, the exchange became emotionally intense, leading to total communication paralysis which is both debilitating and isolating

for those concerned. The analysis of frames of reference provides a deeper understanding of interactions, particularly when combined with other linguistic analyses tools such as Gumperz' (1982) theory of 'conversational inference'. The work of Gumperz sheds light on how shifts in frame are signalled in routine interactions. Speakers' tacit shifts in frame show communication is impaired when these signals are not shared between participants, resulting in a loss of synchrony in the conversational exchanges.

Gumperz (1982) drew on Goffman's (1974) work to argue that people make decisions about how to interpret a given utterance based on frames and what is happening at the time. However, in modern society social boundaries are diffuse and speakers of differing backgrounds are the rule rather than the exception, therefore signalling conventions may vary from situation to situation. Conversationalists 'rely on their knowledge and stereotypes to categorize events, infer intent and derive expectations about what is likely to ensue' (Gumperz, 1982, p. 130). Gumperz' theory of conversational inference highlights the role of linguistic features or signals termed 'contextualisation cues', which are a means of accomplishing framing in social interactions, and which require sociocultural background knowledge to infer meaning in conversations (Wodak, Johnstone & Kerswill, 2011).

Gumperz (1982; 1999) defines a contextualisation cue as any verbal signal which serves to construct the context for interpretation of symbolic grammatical and lexical signs that affects how the message is understood. They are 'features by which speakers signal and listeners interpret what the activity is' (Holmes, 2013, p. 381), and mark how each sentence relates to what precedes and follows. Contextualisation cues are, for the most part, implicit, habitually used and perceived but rarely consciously noted. No utterance can occur without such signs; hence contextualisation cues are ever present in

talk. There are conventional expectations of what counts as normal rhythm, loudness, intonation and speech style hence misinterpretations and misunderstandings may occur when a listener does not react to a cue, or is unaware of its function. Examples of contextualisation cues include signs such as intonation and word stress, rhythm evident in accents, speed of speech, formulaic expressions (such as, 'how are you going' when it serves more as a function of a greeting than a genuine enquiry after one's health), how one opens and closes conversations, and how turn taking occurs in conversational exchanges (who controls the topic and topic exchange).

A study of primary care consultations in a multilingual setting (Roberts et al, 2005) highlights the importance of contextualisation cues. It was found that pronunciation, word stress, intonation and speech delivery as well as grammar, vocabulary and style of self-presentation were major causes of misunderstandings. Rhythm, intonation and word stress help to chunk information into units to distinguish what is important or to contrast information. Intonation and word stress is central to understanding communication, for example, Roberts et al (2005) cite a misunderstanding between a GP and a Nigerian man who was bitten by a dog due to differing word stress patterns. When enquiring whether the patient would need a vaccination, the patient reported he knew the dog owner and that the dog was seen regularly by the vet. The GP understood this to mean a vaccination would not be necessary. However, the patient implied he wasn't convinced the dog was free from rabies: 'they told me the dog go to the vet regular but that's what they said' (p. 470). Native English speakers would stress the verbs 'told' and 'said': 'they told me the dog go to the vet regular but that's what they said', thereby implying doubt in the owner's actions. The difference between the patient's and GP's intonation systems meant the

patient's hint was not picked up by the GP and the question regarding the need for the vaccine was not resolved.

Other forms of contextualisation cues include conversational openings and closings, and formulaic expressions which are particularly problematic for non-native speakers as they would not be familiar with colloquial forms of English such as 'she'll be right'. Difficulties with these cues are highlighted by an international RN interviewed by O'Neill (2011, p. 1124):

> I really felt embarrassed the first time I went to the wards…the RN always spoke to the patients freely, and no problems with conversation. They know how to start it and I couldn't adjust to the situation with the patient, how to greet them and I don't know whether I need to say some polite sentence, or "Hello how are you?".

What we learned in the course of previous interactive experiences forms part of our habitual and instinctive linguistic knowledge. Contextualisation cues serve to maintain coherence and synchrony in interaction; however, they are more complex for non-native speakers to learn.

The process of conversational inference requires listening to speech, forming a hypothesis about what is being enacted, relying on social background knowledge, the perception of contextualisation cues and expectations to evaluate what is intended and what attitudes are conveyed which makes sense in terms of what we know from past experience (Gumperz, 1982). Conversational inference is important for communication but is also a major source of miscommunication if one does not have the appropriate social and cultural background knowledge required to infer meaning in what is being said.

Conclusion

Given that the ability to maintain, control and evaluate conversation is a function of communicative and ethnic background, it is not surprising that problems arise when different background expectations are employed in the interpretation of a single message. Analysis of the discourse between RNs of CALD backgrounds and their patients within these theoretical frameworks will assist in understanding the process of communication better and make unconscious practices explicit. Careful examination of discourse informed by frame analysis and knowledge schemas, contextualisation cues and signalling mechanisms can isolate cues, symbolic conventions and social assumptions through which messages are interpreted and communicated. Knowing how and where misinterpretations occur will help to raise awareness of underlying causes and potentially lead to the development of a framework forming the basis for interventions and tools to develop stronger communication skills. These skills will help to empower nurses and enable more effective communication, therapeutic relationships and therefore patient satisfaction and safety.

Interlude

Chapter Two discussed how linguistics frameworks and analyses can help to understand communication processes and problems, especially when interlocutors from diverse cultural and linguistic backgrounds are interacting. It then set out the theoretical underpinnings of this research project by describing the theoretical frameworks that will inform the analysis of interactions between RNs from CALD backgrounds. However, before the collection and analysis of interactional data could occur, I needed to understand how the participating RNs viewed their experiences of working and communicating in Australia, what they found helped and hindered communication, and what strategies they used when communicating with their patients. This first phase of the project also helped to establish rapport with the participants which then supported the implementation of the potentially threatening second phase that involved participant observations and audio-recordings of the RNs interactions with their patients. Chapter Three discusses this foundational phase which employed unstructured interviews of the participants which were analysed thematically. The themes that were derived empirically from the data provided an understanding of the RNs' experiences of adjustment to work in the Australian healthcare setting, how their cultural background informed their approaches to communication with their patients, and how they viewed their communicative competence.

Chapter 3

"Are we on the same wavelength?" International nurses and the process of confronting and adjusting to clinical communication in Australia

Abstract

Effective communication skills are important in the health care setting to develop rapport and trust with patients, provide reassurance, assess patients effectively and provide education related to their health condition in a way that patients easily understand. However, with many nurses from culturally and linguistically diverse (CALD) backgrounds being recruited to fill the workforce shortfall in Australia, topics such as communication across cultures with increased potential for miscommunication and ensuing risks to patient safety have gained increasing focus in recent years. This paper reports on the first phase of a study that examines intercultural nurse patient communication from the perspective of four Registered Nurses (RNs) from CALD backgrounds working in Australia. Five interrelating themes that were derived from thematic analysis of semi-structured interviews are discussed. The central theme of 'adjustment' was identified as fundamental to the experiences of the RNs and this theme interrelated with each of the other themes that emerged: professional experiences with communication, ways of showing respect, displaying empathy, and vulnerability.

1. Introduction

Communication has long been considered to be a cornerstone of therapeutic care with many textbooks stressing the importance of good communication skills (Major and Holmes 2008). Effective communication skills are important in the healthcare

setting in order to develop rapport and trust with patients, provide reassurance, assess patients effectively, and provide easily understood health related education (Candlin and Candlin 2003). Major and Holmes (2008) argue that one key skill that has been highlighted for nurses in particular is the ability to respond flexibly and with empathy to patient anxiety. However, with migration of both patients and healthcare workers from culturally and linguistically diverse (CALD) backgrounds to Australia, the management of clinical communication and the intercultural competence of healthcare workers from CALD backgrounds with increased potential for miscommunication and ensuing risks to patient safety, has been an area of concern for many years (Shakya and Horsefall 2000; Chiang and Crickmore 2009; O'Neill 2011; Shen *et al* 2012).

This paper reports on the first phase of a study that examines intercultural nurse patient encounters. Firstly, literature related to intercultural healthcare communication is reviewed, followed by a discussion of the methods used in this study. The findings from thematic analysis of semi structured interviews of four Registered Nurses (RNs) from CALD backgrounds will then be discussed.

2. Literature review

There have been increasing numbers of overseas trained health professionals working in Australia with one in three born outside of Australia in 2011. The proportion of recent arrivals of nurses to Australia increased from 9% in 2001 to 19% in 2011, 75% of those from CALD backgrounds (Australian Burea of Statistics 2013). Currently in Australia, international nurses must meet English language skills stipulated in the registration standards in preparation for integration into the workforce. A minimum score of 7 out of 9 for each macro skill (writing, listening, speaking and reading) of the International English Language Testing

System (IELTS) academic module, or a 'B' score in the Occupational English Test (OET) is required in order to gain registration (Australian Health Practitioner Regulation Agency 2015). However, despite often having learned English at school in their home countries, and attaining the English language requirement for registration, a number of obstacles and challenges are often faced by nurses from CALD backgrounds once they start working in Australia. These include the Australian accent, use of colloquialisms, cultural aspects of communication and different expectations of nurses by colleagues and patients (Walters 2008; O'Neill 2011).

Communication in the healthcare setting is often already difficult due to differences such as gender, socio-economic status and education. Diverse cultural patterns and behavioural differences between nurses from CALD backgrounds and their patients, who often also come from diverse backgrounds, add another dimension to this already complex situation (Ulrey and Amason 2001; S. Candlin 2002). Language and communication barriers have been cited as top concerns among both hospital administrators and international nurses, with 20% of health consultations resulting in major and extended miscommunication (Roberts, Moss, Wass, Sarangi, and Jones 2005; Shen *et al.* 2012).

Effective communication is critical to safe and competent patient care, and problems with communication skills can cause serious misunderstandings which can result in poorer health outcomes (Hamilton and Woodward-Kron 2010; Xu, Shen, Bolstad, Covelli, and Torpey 2010). While intercultural health communication has received ample attention in recent years, research has mainly focused on the medical profession, particularly in contexts where doctors are native English speakers and their patients come from CALD backgrounds. There has also

been recent research focusing on 'international medical graduates' who are not native English speakers but are working in countries such as the UK, the USA and Australia (Couser 2007; Hoekje 2007; Cordella and Musgrave 2009; O'Grady 2011). There is limited research focusing on nurse-patient communication (Major and Holmes 2008), particularly where nurses come from CALD backgrounds (O'Neill 2011) focusing on how cultural differences impact on their everyday practice (Grant and Luxford 2011).

In view of the findings from the literature, the question that is raised is: how do language and cultural differences influence therapeutic communication between nurses from CALD backgrounds and their patients? This study seeks to understand and describe the interpretation of meaning in interactions between international nurses and their patients in the Australian healthcare context over two phases. Results from the first phase of this research project, involving in-depth interviews with nurses from CALD backgrounds working in the Australian health system, will be discussed in this paper. Its contribution to the existing literature is novel in two respects. Firstly, by interviewing nurses who have worked in Australia for 3-10 years, the study reported here takes a 'long view' of the process of adjustment to the challenges of clinical practice in a new environment. Secondly, it seeks to map the clinical communication issues reported by participants onto the broader elements of cultural adjustment.

3. Method

3.1 Research design

The aim of the first phase of this study was to explore the experiences and perceptions of RNs from CALD backgrounds regarding communication with their patients in order to identify issues to be explored in greater depth in the second

phase of the study. This phase involved interviews with each participant in a private 183 bed acute care/surgical hospital in Sydney, Australia. The hospital provides services across a range of specialties, as well as radiotherapy and oncology services. The research site has a significant proportion of RNs from CALD backgrounds who work in relatively small nursing teams.

Approval for the study was given by the research site, and ethics approval (reference number 5201400783) was obtained from Macquarie University Human Research Ethics Committee prior to recruitment and data collection. Participants were informed about the study both verbally and in writing prior to giving their written consent to participate. It was clearly specified that that they were free to withdraw from the study without consequence if they wished to do so at any time.

3.2 Participants

Participants were recruited through advertisements placed in the clinical areas around the hospital and through professional contacts. Despite advertising over several months (2015), only four RNs from various backgrounds volunteered to participate in the study – see Table 1. Pseudonyms are used to protect the identity of the participants.

Name (pseudonym)	***Gender***	***Age***	***Country of origin***	***Years of employ-ment in Australia***	***Highest level of Education***	***IELTS score***	***Hospital department***
Andrea	Female	mid 40s	Philippines	3	Certificate and bridging course to work in Australia	7	Neurology unit
Betty	Female	mid 40s	Zimbabwe	10	Masters degree	7	Neurology unit

Jenny	Female	mid 20s	China	3	Bachelor degree	7	Day surgery
Elaine	Female	mid 30s	Iran	6	Certificate - RN for 6 years in Iran, studying for a Bachelor degree	6.5	Various surgical units

Table 1: Participant details

3.3 Data collection and analysis

Qualitative methods were chosen for this study as the varied and changing situations in hospitals are too complex to be viewed from a single perspective, and attempts to isolate variables (required in quantitative data collection and analysis) may result in limited, decontextualised and reductionist data with little practical applicability. The in-depth reporting of the data and rich descriptions afforded by qualitative methods (as opposed to measurable, quantifiable data) are useful for gaining an understanding of social contexts and processes, for examining phenomena holistically, and for assessing participants' interpretation of events (Popay, Rogers, and Williams 1998). The inductive nature of qualitative analysis is amenable to the changing nature of human interaction and communication in healthcare, and is sensitive to subjective aspects of life such as meaning, perceptions and reasons for particular observations that cannot be easily captured using quantitative methods (Burns 2000; Roper 2000; Dörnyei 2007).

Semi-structured interviews lasting between 30 and 60 minutes were conducted by the first author which focused on eliciting the participants' critical reflections on clinical encounters that they had experienced in Australia. Specifically, the participants were asked to recall and comment on instances where

they had experienced either effective or problematic encounters, as well as identifying factors that hindered, and strategies that they used to support the communication process. According to Dörnyei (2007), interviews are appropriate for obtaining deep meaning of a particular phenomenon or personal historical account. Interviews were therefore included in this phase in order to elicit the participants' perceptions regarding their clinical encounters in the Australian healthcare setting. This phase also had the purpose of building trust between the researcher and the participants to support the implementation of the second phase of the research (not reported here) which involved ethnographic approaches of participant observation and audio recording of interactions and conversations between the participant RNs and their patients.

The researcher also maintained a research journal during the project containing 'metadata' – insights, real-time comments, annotations and field notes – which forms an audit trail and becomes part of the dataset (Dörnyei 2007). In this journal, the researcher documented the development of thinking, reflections on the potential influence of personal values and beliefs on the data collection process, and accounted for each step of the project, thus strengthening the validity and reliability of the research. This data contributed to the analysis and interpretation process.

The interviews were audio-recorded, transcribed verbatim using transcription conventions outlined in appendix 1, and listened to repeatedly by the first author to immerse deeply in the data and to identify initial key descriptive aspects. These descriptive aspects were reviewed with the second author to confirm the findings. Analysis involved careful reading and re-reading of the transcripts to decide what is going on and what people are saying; asking questions such as who, when, what, why, how and so on to alert the researcher to deeper

theoretical levels underlying the text (Gibbs 2007). While the sequential coding system utilized in this analysis is similar to that used in grounded theory (Strauss and Corbin 1998), the analysis does not produce a theory as an outcome of the study, but is used as a tool to provide an in-depth analysis of the data (Dörnyei 2007). Analysis was an iterative process of moving back and forth between emerging aspects of the data and identification of themes, review of participant interviews, the researcher journal and earlier key aspects.

Initial codes were categorised and sub-codes were identified and reviewed with the second author, with subsequent redefining and renaming of some codes. These codes were tabulated and analysed with a constant comparison of the themes to bring out what lay behind the text, 'comparing similarly coded passages with each other, different codes with each other and coding in one case with other cases' (Gibbs 2007: 55). The case by case comparisons allowed an understanding of the relationships between the themes and identification of causal influences of one theme on the other. Selective coding identified the theme that is central to the phenomena being studied as it was linked to all the other themes (Gibbs 2007). The participants had the opportunity to check the transcripts and analysis for accuracy, thereby enhancing validity. Not all participants responded; however, those who did had only minor adjustments to the transcripts and confirmed the analysis.

4. Findings

4.1 Five interrelating themes

The central theme of 'adjustment' was identified as fundamental to the experiences of the RNs and this theme interrelated with each of the other themes that emerged: professional experiences with communication, ways of showing respect, displaying

empathy, and vulnerability as described below and illustrated in figure 3. These primary themes are explained below followed by an explanation of the secondary themes. Despite the small number of participants, a saturation of themes emerged.

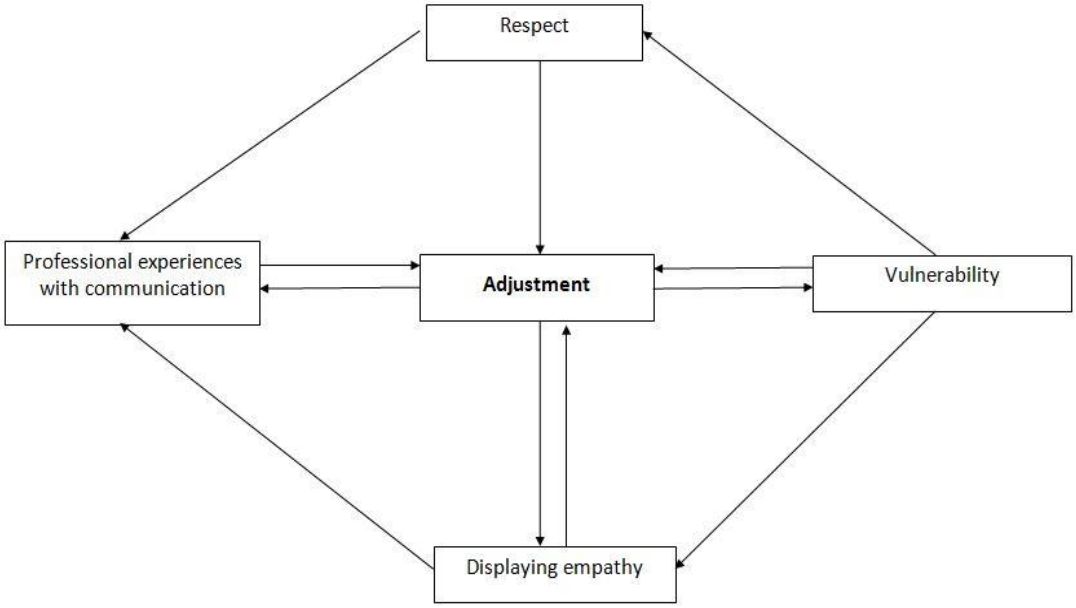


Figure 3: Primary themes of CALD nurses' experiences working in Australia

Adjustment was identified as the central theme as it influenced every other theme that emerged and was discussed by all the participants at length. The participants were not only adjusting to the Australian culture but also to the culture and systems of the healthcare institution in which they were employed, as well as to the language and approaches to communication that are quite different from their home countries. Adjustment was enhanced through the RNs' professional experience and training (both from their home countries and in Australia) and the participants discussed how the experience of working in other countries, or their knowledge of communication skills influenced how they approached communication with patients and colleagues.

Conversely, in situations where they did not feel well adjusted, they commented that their approach to communication was affected, which was demonstrated by the other themes. For example, difficulty with adjustment increased the nurses' feelings of vulnerability, which then played out in how they showed respect to patients and colleagues, and in their capacity to display empathy. Culturally informed ways of showing respect influenced how quickly nurses adjusted to working in Australia. Some ways of showing respect that were informed by cultural backgrounds, such as the use of eye contact, influenced the participants' approaches to communication with patients and colleagues, and sometimes led to misunderstandings which will be discussed later in this paper.

Learning ways of showing respect that aligned with common practice in the Australian context increased adjustment. This then enhanced their ability to attend to the psychosocial dimensions of patient care. How adjusted the nurses felt also had an impact on their ability to adopt an empathic stance, as feeling overwhelmed or stressed limited their emotional capacity to provide or display empathy. When participants were struggling to cope, they were at times too emotionally drained to provide psychosocial care.

> Sometimes you have to deal too much with this stuff… You more like (..) not just from the medical things, from the mental things yes, you have to caring a lot to the patient yeah so…I don't know what nurse do but sometimes I feel like quite pressure you know. (Jenny)

However, when the nurses had the capacity to provide empathy, they utilized a number of successful approaches to communication (described later in section 4.5) which then enhanced the connection with patients and therefore feelings of adjustment, thus reducing vulnerability. Further analysis of these five primary

themes led to several secondary themes that further explain these interrelationships. These are illustrated in Figure 4, and discussed in detail below.

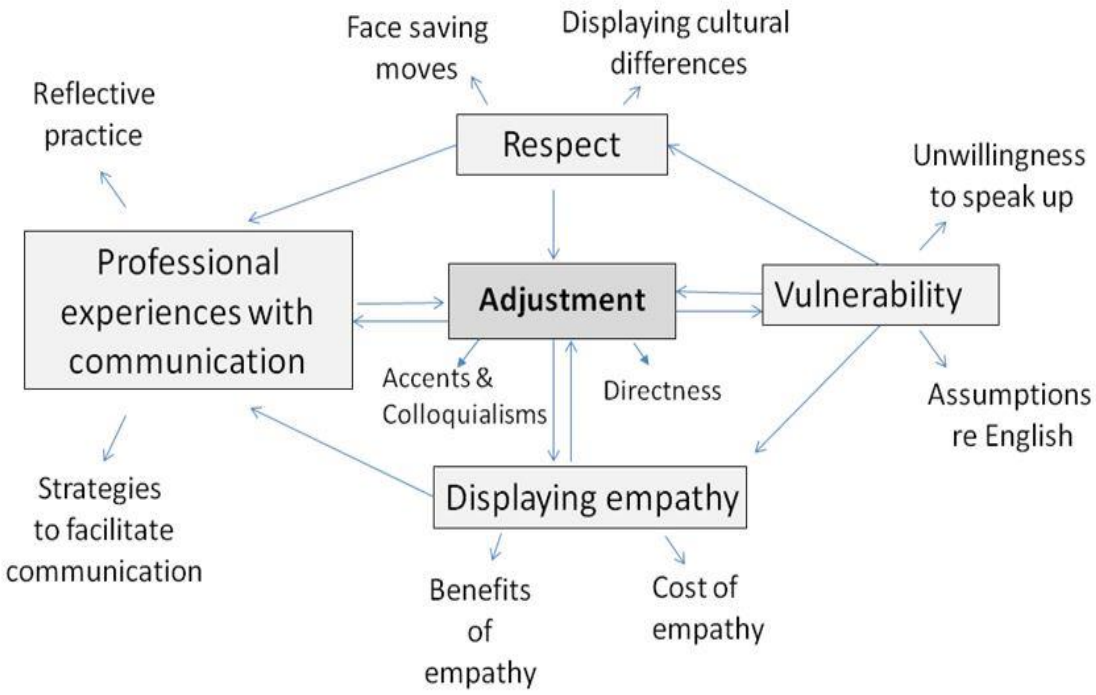


Figure 4: Secondary themes of CALD nurses' experiences working in Australia

4.2 Adjustment

Adjustment to accents and colloquialisms in culturally diverse health settings is a well-known theme that has been widely documented (Hearnden 2008; Kingma 2008; Deegan and Simkin 2010; O'Neill 2011). All RNs talked at length about the adjustment to not only the Australian accent but also accents from the many different nationalities that work in Australia.

> That is the problem in Australia because Australia got so many um cultural backgrounds, you know the people from India, Middle East, or the Europe (.) they all got their own accent so it's very interesting… Um I find the hardest thing to understand the Australian slang sometimes *(laughs)*

> …You've got oh oh … 'what you talking about' sometimes you have to, you know'. (Jenny)

The features of Australian English that were quite different to what they had learned in their home countries, as well as the use of colloquialisms, were also discussed by all the participants. Despite 'adjustment' being a previously reported theme, this data differs in terms of adjustment to the directness of communication in Australia and how the other themes interact with adjustment.

All of the RNs also talked about having to adjust to what they perceived as the 'direct' way in which Australians approach communication and how they found it confronting and sometimes rude. They also reported that with the direct approach they often felt they were in trouble, but subsequently learned not to take it personally, as it was just how people approached communication. Some participants eventually saw benefits to this directness, for example, being good for patient care and saving time.

> '…the (.) culture I think (.) because in most Western people, they very direct, they just straight to the point. but in Asia we very indirect, we probably ask many question and then get to the point' (Jenny). 'So, I've learnt when my boss says 'Betty' I say 'am I in trouble?' She says no, then you know it's not, it's just directness. (Betty).

Challenges posed by cultural difference and language difficulties impact on how a nurse adjusts to working in the new environment (Deegan and Simkin 2010). Conversely, the participants' sense of adjustment was also enhanced through their communication skills that they had either been trained with, or had learned from experience through their professional lives.

4.3 Professional experiences with communication

While all of the RNs were professionally experienced, two of them (Andrea and Elaine) demonstrated critical reflection on their professional practice. This critical reflection guided the way in which they approached a patient, with further reflection on what they were doing and whether it was effective or not. These RNs felt that they were competent in their communication skills and confidently gave examples:

> You gauge, you tend to gauge otherwise you would be lost. 'Ok what is happening, are we on the right track. Are we on the same wavelength about communication, are we getting somewhere …Yes I think about how you saying, what it is you saying, and how you sort of like voice your sound, your position to the patient. It all comes in. (Andrea)
>
> Mmm as soon as you see the person of course, some person you will think 'oh, this person might be like this' and then regarding to whatever you know, you can predict 'with that one I have to do it this way' and sometimes it doesn't work so you have to do the other option. You have to struggle to see which option better for the patient. (Elaine)

Reflective practice is a cornerstone of nursing practice and is taught in undergraduate and postgraduate nursing degrees (Turner and Beddoes 2007), but such reflectivity develops through experience. Reflection on behaviours and interpretation of meanings informs future decision making (Howard 2003) which then influences the strategies and approaches nurses take in their patient care. Connection with patients is enhanced through reflective practice and effective communication strategies, which then impacts on one's adjustment to a new setting. The participants were

explicit in how they used well-known communication strategies such as the use of body language, smiling, use of clarification and paraphrasing to aid in understanding, and explanations in everyday language. Clarification and paraphrasing was the most frequently mentioned strategy; however, many more were used, with reflection regarding the rationale or effectiveness of the strategy employed.

> Clarifying. It's like I ask them (.) to repeat it again, or I'd ask another question (..) and the same content like like say what is it you told me but… Just to clarify (.) where they are at… So so are we understanding each other properly… Yeah 'cause it is difficult to care for a patient if you are not understand each other, sort of like (.) not seeing eye to eye. (Andrea)

> First the thing smile. I find smile the best way settle people down yes, and they are, (.) people are willing to talk to you so that a good yes…with them just explain a lot before I do anything just because if you go straight to the patient ahh you don't talk or (.) do any kind of practice, the patient just feel very unsafe, they feel 'what you doing on me?' yeah so if you explained and they understand they are happy, you know, to help with you and cooperate with you to finish this skills…Um, I don't really speak terminology to them cause most of them don't understand, if like you say like laparoscopy, they will ask 'what's the laparoscopy?'. Then if you say 'keyhole surgery' they will fully understand. (Jenny)

As demonstrated in the extracts above, the RNs were very conscious of the importance of effective communication and were explicit in how they attempted to establish clear understanding with their patients. One of the participants noted: 'I

think that the communication helps a lot that you know not only how to speak the words like um, the English language correctly, but how you say it, like the sign, the framing of it you, the approach' (Andrea). They all reported that they felt they were successful in this, which assisted their adjustment to working in Australia. Despite this success, however, culturally informed ways of showing respect sometimes resulted in occasions of misunderstanding.

4.4 Respect

Showing respect impacted on how the nurses adjusted to clinical practice in Australia, as showing respect in ways that were culturally informed was easily misinterpreted. Cultural differences were discussed by three of the RNs, Elaine and Betty in particular, in terms of respect for older people, not speaking up to people in authority, and in terms of eye contact. Betty cited how she had to learn to look people in the eye, for in her culture to do so was actually showing disrespect, especially if they were older. She had found that averting her gaze in an attempt to show respect was misinterpreted as being evasive and not engaging in the conversation by some people.

> My background, you don't look at people, especially elderly people directly. It's actually a sign of disrespect. So I know when somebody says 'you are not even looking at me' they have found that very rude and some people might not say it, but you get that feeling, so it's something. Actually, that's one main thing about communication here. If you don't look at an elderly person's face that's respect but that's not (.) I've learnt to stand looking at people in the eye big time. Yeah that's one of the main things I have learnt because if they are talking to you and you are looking elsewhere… I'm

> respecting you. I'm not because if you hold a stare you are challenging them. But I've learnt that in 10 years here… (Betty)

> Age is very important for our culture. People respect older people no matter what. Even if they are wrong (.) um (.) you got another way to tell them, not straight forward or you bound them. (Elaine)

Elaine and Betty also reported showing respect through strategies that were sometimes employed to save face for people in higher positions, such as the nursing unit manager: just listening before engaging in conversation, not defending yourself or 'answering back', and framing yourself as being slow so that the person would repeat what they had said without personal embarrassment.

> And if your boss says (.) because we had the structure of British trained nursing where the boss is up there and you don't just answer back the boss. So I found that people think you are failing to defend yourself but its more for respect, you don't want to put the boss on the spot. (Betty)

> But if it going to be like a colleague or even supervisor or someone, I just trying to (.) paraphrase the thing that they saying then I just 'um you know I'm just slow, did you say that?' because I don't want to put them like they don't talk about or they don't know how to say it. (Elaine)

By not speaking up, not maintaining eye contact and attempting to 'save face' for those in authority, the participants were increasing their vulnerability and therefore reducing their capacity for providing psychosocial care and adopting an empathic stance.

4.5 Displaying empathy

All of the RNs felt competent and demonstrated knowledge of the importance of conveying empathy in the healthcare setting and how doing so can assist in recovery and development of rapport with patients.

> .. if I'm in their shoes I'd say … 'how should I approach this, should I feel'... and so I feel that communicating properly, verbally telling him what to do in a in a, in a non-confronting way, 'cause … helps like…they have been independent most of their lives, and if you sort of like push them into doing things, they sort of like resent you *(laughs)*. ...Sometimes at the end of the shift, you know it's true if a patient um forgets your name, they would never forget how you made them feel. I think that's how it is, so it's satisfying with the communication. (Andrea)

> They in hospital, they in pain, they already hurt, well if you try to help them, even just to be nice to them and try to do medical thing for them. If you trying to showing them you that you care about them, that really helps. Like as soon as you come into the room and you smile, how you going, stuff like that. (Elaine)

Despite this knowledge, Betty and Jenny also found it difficult to respond to patients in ways that conveyed empathy and found doing so taxing. As a result, they reported that they were sometimes unable to focus on getting their work done, or experienced personal discomfort and pressure when attempting to provide emotional care.

> I **try** to be good you know, to be the be best to the patient, but sometimes you handling this too much you feel like 'mmm I'm not your (..) like your emotional rubbish **dump'**, this to me you know, yes yes (Jenny).

The RNs expressed stress and tension between the need to provide empathy and emotional care to patients that need it, as well as conflicting priorities with the needs of other patients, combined with ringing buzzers on the ward. Betty talked about having an 'indifferent face' as a protective mechanism and one way of dealing with her own emotional vulnerability:

> You might be looking after 10 people all night and their stories and you will be crying the whole shift if you…they read as being indifferent… I know a patient one time; I think he had lost his wife two weeks before. He wanted to talk but (*) you also had to answer buzzers, you have handover coming up and somebody wants to talk to you, you need to sit down and at least show like you are caring. You can't stand there when someone is telling you they lost someone but then there is this ringing buzzer. 'Cause sometimes I think they find it difficult to read my facial expressions so they think indifferent. They think probably you are indifferent, you know what I'm saying? But sometimes to get the work you need to, and sometimes you do genuinely care … (Betty).

4.6 Vulnerability

Despite the interviewees demonstrating how they had adjusted and communicated successfully in Australia, three of the RNs discussed times when they felt periods of vulnerability, particularly when patients or colleagues made assumptions about their ability to communicate effectively, or their ability with English: '…some of

the people don't trust you because…you are speaking English and (..) but they think you not fully understand them' (Jenny).

> I think sometimes it's an issue with people, especially new people who don't know you, maybe a new member of staff, may be a new boss coming into the department, they don't understand how much English you have so they thinking 'I need to hammer this in case she doesn't get it' and I find that very confronting… And sometimes with other patients, they start talking with sign language and you like, so normally I just look away when they start sign language you know. Yeah you get that, patients will start (*demonstrating with hands, pointing)* yeah, I understand. I think it's just sort of them thinking my English is limited… Yeah I think normally the **initial** first, you know, first point of situation can be a bit (.) challenging but as I said they sort of test you, ask some questions and once they are confident in you they sort of opposite, yes, but some people won't be confident with you so whatever you do, they will always be double check you know, but some people you win them over. (Betty)

Here Betty felt frustrated by assumptions people made regarding her English language skills but rather than speaking up, she would reject their attempts at 'sign language' by turning away, a way of sending a message in a respectful manner. These assumptions by colleagues and patients, and their lack of confidence in her, increased her sense of vulnerability, which in turn restricted her adjustment and impacted negatively on her ability to display empathy.

Jenny talked about reluctance to communicate with families as they tended to ask more questions.

> You need to be very careful where you say the words, talk to them yeah so, especially some of the family, better not to let, better not to let family (.) around you…I find it a bit hard to (..) explain to them if the family is here. I will get more questions and the patient will get more nervous… (Jenny)

Jenny also expressed not wanting to talk too much because she felt she would get into trouble, especially when being reprimanded by a colleague.

> If they don't like it they just speak loud all right, if they think you doing wrong, they just speak loud. Sometimes some of the staff not do professionally...but…I didn't say anything…probably I should talk to her regarding this but …undermine you in front of the patient which is very embarrassing, especially in front of the patient…
>
> so in this kind of situation I don't want to speak too much because the more you speak the more trouble you will get so… (Jenny)

Elaine found it difficult to stand up for herself when overloaded with work. '…they trying to put so many things on me and I found it hard but at the same time I didn't have that much power to complain or, do you know, do something about it so I just go ahead…' (Elaine).

Vulnerability was demonstrated as apparent quietness and passivity; however, as mentioned earlier, unwillingness to speak up was also a way of showing respect to hierarchy. Here the nurses are caught between two different linguistic and cultural worlds (O'Neill 2011).

5. Discussion

Earlier research has documented the difficulties that CALD nurses face when adjusting to work in Australia with themes of otherness and marginalisation, silencing and difficulties with language and communication, and risks to

professional identity (Omeri and Atkins 2002; Kingma 2008; Deegan and Simkin 2010; O'Neil 2011). Results from these studies generally come from RNs who had recently commenced work in the host country and were currently enrolled in, or had recently completed courses to satisfy language and clinical competency requirements for registration. The participants in this research had worked a number of years in Australia and are therefore able to offer longitudinal perspectives on the processes of adjustment, reporting adjustment from a retrospective stance. This first phase data provides rich insights into the experiences of the participants and their perceptions of communication processes with patients who might either be native English speakers or also from CALD backgrounds. Through their responses, they demonstrated that they were successfully adjusting to work in Australia over time. While they did not use the term 'reflective practice', their answers revealed approaches that demonstrate critical reflection on their professional practice. In response to the adjustment hurdles that they identified, they articulated and utilised a variety of communication strategies to support the communication process with their patients and colleagues. These nurses also reflected on the benefits and costs of empathy and were able to describe various communication strategies used to convey empathy to their patients which subsequently enhanced their sense of adjustment and reduced vulnerability. Reduced feelings of vulnerability enabled them to demonstrate forms of showing respect that are more in line with contemporary institutional practice in Australia, rather than doing so in ways that are informed by their background culture and which have the potential to cause misunderstandings in the Australian context. This enhances their sense of adjustment and gives them the emotional capacity to

display empathy, which then impacts on the strategies that they use to facilitate communication with patients and colleagues.

While problems with intercultural communication are well documented, these participants felt that they were largely successful. The participants did not say whether they had received specific mentoring to assist in their adjustment; however, the themes of vulnerability and difficulties displaying empathy suggest that mentorship and an inclusive culture within the healthcare setting that also recognises the professionalism and skills of CALD nurses would reduce the incidence of this occurring. Sarangi (in press) discusses the notion of 'communicative vulnerability', a continuum of communicative competence which is inevitable in super-diverse societies. Communicative deficits are a form of 'discursive poverty' which have negative consequences on healthcare encounters. Therefore, the overall goal in diverse societies must be to 'minimise the occurrence of adverse events in spite of linguistic and cultural diversity' (Sarangi in press: 15). As Kingma (2008) points out, marginalisation will impact negatively on competence, which then creates threats to patient safety.

6. Conclusion

The first phase of this research project has examined intercultural communication from the perspective of four participants from various backgrounds focusing on their experience and perception regarding successes and problems in communicating with patients in an Australian hospital. All participants reported difficulty in adjusting to working with different accents and Australian colloquialisms and initially found what they perceived as 'direct' approaches to communication confrontational. However, over time they were able to use their

professional experience and training to implement successful communication. They demonstrated reflective practice and implemented a variety of communication strategies such as clarification, paraphrasing, use of non-technical language and non-verbal communication skills which included their positioning in relation to the patient. These skills enhanced adjustment which then supported their ability to provide psychosocial care and display empathy. Adjustment however was restricted by feelings of vulnerability at times when they felt silenced or when assumptions were made by both patients and colleagues regarding their English language skills. Vulnerability was also displayed through culturally informed ways of showing respect, such as not speaking up or not maintaining eye contact to people in positions of higher authority. Some of these culturally diverse ways of showing respect impacted on how the nurses approached communication and were a source of misunderstanding.

This data is self-reported communication behaviour; consequently, the second phase of this study builds on the findings reported here, and involves participant observation and audio recording of interactions between the participants and their patients, using interactional sociolinguistic analysis to further examine the communication process between the RNs and their patients. Results from both phases will raise awareness and potentially form the basis for interventions and tools to assist adjustment and the development of socio-pragmatic skills for other nurses from CALD backgrounds, enabling more effective therapeutic communication. This research is limited by the small number of participants; therefore, the results cannot be generalised. Further research drawing from larger numbers of participants would build on these results. Furthermore, research exploring the nurses' reflection on their practice is required to draw out more in-

depth critique of the situation; to identify their perceptions regarding what they feel would be useful in terms of content and method that may assist other RNs from diverse backgrounds who are still adjusting to work in Australia.

Acknowledgement: This research was carried out with the financial assistance of an Australian Postgraduate Award.

Appendix 1: Transcription notes:

(.) seconds of silence

(*) seconds of indecipherable talk

(?) an indecipherable syllable

Bold indicates the emphasis to the works given by the speaker

Interlude

Chapter Three set out the participants' perspectives regarding their adjustment to working in Australia, their communicative competence and strategies they use to communicate with their patients. This set the foundation for the second phase of the project as well as serving to establish rapport with the participants. Rapport was important for the project as the second phase was potentially intimidating for the participants. Ethnographic techniques that included participant observations and audio-recordings of their interactions with patients were carried out with in the hospital setting during the course of their work which could have been intimidating, particularly if they were feeling vulnerable. I documented my overall impressions of the interactions in field notes, noting any significant nonverbal communication that might have impacted on the interaction but was not recordable. Contextual details such as the ward setting, type of surgical intervention and procedures being carried out by the RNs were also recorded. Focal themes of empathy, rapport and empowering patient education were empirically derived using interactional sociolinguistic analysis combined with theme-oriented discourse analysis. These themes underpin therapeutic patient care and impact on health outcomes (Hamilton & Woodward-Kron, 2010). How each of these themes are displayed are discussed in Chapters Four to Seven. Chapter Four discusses the first of these focal themes, empathy, demonstrating the consequences to the interaction that diverse empathic responses create.

Chapter 4

The consequences of diverse empathic responses in intercultural nurse-patient interactions: a discourse analysis

Abstract

Background: Empathy in healthcare interactions has been a focus of considerable research since the 1980s, and discourse analysis has been used more recently to identify *how* empathy is accomplished in interactions between healthcare professionals and their patients. However, there has been little research using *naturally occurring* nurse/patient interactions.

Method: A case study exploration of interactions using discourse analysis from an interactional sociolinguistic approach to examine and describe the interactional consequences of empathy by two nurses using a schema of professional responses.

Results: The consequence of the display of empathy was an extended interaction with numerous affiliative responses by both parties, showing evidence of good rapport and a therapeutic relationship. This is compared to interactions where minimal affiliative responses are evident. The interaction with the patient is cut short with a quick return to the clinical agenda after a momentary acknowledgement of the patient's concern. Where empathy is not displayed, the patient does not elaborate on concerns, thereby limiting the building of rapport and trust. The display of empathy has been linked to patient satisfaction and improved patient outcomes.

Conclusions: Examining natural nurse-patient interactions allows for a greater understanding of the consequences of various communicative approaches and levels of engagement. This awareness can enable the development of stronger

communicative competence of health professionals, enhancing professional practice and patient satisfaction.

Introduction

Empathy in healthcare interactions has been the focus of considerable research since the 1980s. It is a powerful therapeutic technique that has been linked with improved outcomes of care and health status, patient satisfaction, enhanced doctor-patient trust and concordance with treatment plans (Frankel, 1995; Roter, Frankel, Hall, & Sluyter, 2006; Stewart, 1995; Stewart et al., 2000). The concept of empathy is difficult to describe, and there are a number of different conceptualisations of what it means. For instance, empathy is considered a human trait or disposition, a professional state, a communication process or interaction, a way of caring, and evidence of a special relationship (Kunyk & Olson, 2001; O'Grady, 2011). According to Frankel (1995) empathy involves recognising a concern or negative feeling, and then providing support and legitimacy by acknowledging the concern and giving it a name. Empathy is also considered a multidimensional triad that involves 'cognitive (the ability to understand another person's feelings and perspectives), affective (feelings of compassion and sympathy for the other person, as well as concern with his or her wellbeing), and behavioural (transmission of other person's feelings and perspective so that he or she feels profoundly understood) components' (Trevizan et al., 2014, p. 368). Empathy is distinct from sympathy, which is described as awareness of another person's feelings, provoking sadness or concern, but without internalising this sadness. According to Trevizan et al (2014), sympathy precedes empathy.

There have been numerous studies using various instruments and methodologies over the years (Baillie, 1996; Bramley & Matiti, 2014; Cunico, Sartori, Marognolli, & Meneghini, 2012; Kunyk & Olson, 2001; McCabe, 2004; Mishler, 1984; Roter et al., 2006; Trevizan et al., 2015). These studies explored the display of empathy during relational talk in institutional settings, employing varying conceptualisations of empathy. Other studies focus on how physicians respond to affective displays of patients and provide opportunities to debrief their concerns (Frankel, 1995; Suchman, Markakis, Beckman & Frankel, 1997). Discourse analysis has been used more recently to identify *how* empathy is accomplished in interactions between healthcare professionals and their patients, as well as tracing the interactional consequences of different empathy display strategies (Chang, Park, & Kim, 2013; Jansson, 2014; O'Grady, 2011; Ruusuvuori, 2007). However, the majority of the studies have examined doctor/patient interactions. There has been little research using naturally occurring *nurse/patient* interactions (Major & Holmes, 2008), with nurses from culturally and linguistically diverse (CALD) backgrounds in particular (O'Neill, 2011), where communication in English adds another level of difficulty to what is already a complex process. In this paper, we attempt to address this gap, using discourse analysis to trace the interactional consequences of displays of empathy by two nurses from CALD backgrounds in the Australian healthcare setting.

Background

Empathy is an important aspect of therapeutic intervention as it enables the clinician and patient to co-construct an understanding of the patient's lived experience, enable acceptance of the patient's concerns and feelings, and therefore engender trust (Frankel, 1995; O'Grady, 2011; Trevizan et al., 2014). Some have

argued that empathy leads to the development of rapport between health professionals and patients (Norfolk, Birdi, & Walsh, 2007), which is important for subsequently building a sense of mutual trust (Seccareccia et al., 2015). Other researchers have argued that nursing students and registered nurses (RNs) can and should be taught empathy (Baillie, 1996; Bramley & Matiti, 2014; Cunico et al., 2012; Shield, Tong, Tomas, & Besdine, 2011; Trevizan et al., 2015); however a focus on patient centred care by individual nurses, and support from healthcare managers is needed in order to incorporate empathy into patient care (McCabe, 2004). Displaying empathy requires effective communication to demonstrate understanding and acceptance of a person's situation, but how do nurses from CALD backgrounds accomplish this co-constructed, dynamic and interactive process when there might be varying degrees of proficiency when speaking English? This complex situation is compounded when both patients and nurses come from diverse linguistic and cultural backgrounds, an increasingly familiar situation in today's globalising world.

There has been increasing cultural and linguistic diversity among Australia's health workforce and patient population, and the migration of nurses from CALD backgrounds has been important for meeting workforce shortages (Ohr, Parker, Jeong, & Joyce, 2010). However, an emerging body of research examining the experiences of CALD nurses (Deegan & Simkin, 2010; Hearnden, 2008; O'Neill, 2011; Omeri & Atkins, 2002; Walters, 2008) has found adjustment to communication a major theme. It has been recognised that adaptation to social, cultural and communication approaches in a new country is more difficult than originally acknowledged (Lum, Dowedoff, Bradley, Kerekes, & Valeo, 2015). Furthermore, managing clinical communication in a second language and intercultural competence were found to be problematic for RNs of CALD

backgrounds (Chiang & Crickmore, 2009). In the present study, these themes were explored during interviews with four RNs from CALD backgrounds, undertaken by the first author as part of a larger project examining intercultural communication in the Australian healthcare setting. Several themes emerged, one of which was empathy. The RNs acknowledged the importance of empathy in assisting the patient's recovery, and described how they empathised with patients. However, as experienced personally, they also reported difficulty in responding to patients in ways that convey empathy when they were busy, or in situations where they felt uncomfortable about providing the kind of emotional care that patients appeared to need. This paper focuses on the actions that characterise an effective empathic response that resonates with how the patient is feeling at that point in time. It reports on the display of empathy by two of these nurses, albeit with different levels of affiliation or connection with the patient, using a schema of professional responses described by Ruusuvuori (2007) which is outlined in detail later in this paper.

Methodology

Methods. Ethnographic techniques of participant observation and audio recordings were used, in conjunction with field notes that were made directly following the observations which documented the context and background of the interaction, for example the type of ward setting, surgery the patient had undergone, the procedure being conducted. The first author's experience as a registered nurse with knowledge of hospital routines and procedures supported the ethnographic knowledge that was collected, and this helped to comprehend the socio-pragmatic meanings of the conversations in this workplace (Major & Holmes, 2008). Data were drawn from naturally occurring interactions between patients and nurses from CALD backgrounds in an acute care hospital in Sydney, Australia.

Participants. Four RNs from differing cultural and linguistic backgrounds (China, Philippines, Iran and Zimbabwe) participated voluntarily in the project, with between three and ten years' experience working in Australia. All had experienced working as RNs in their home, and other countries, using English and their native languages prior to working in Australia. They had all achieved the mandatory English requirements in order to be registered, with either an Occupational English Test (OET) B or International English Language Testing System (IELTS) 7 (out of a maximum of 9) score, thereby considered sufficiently proficient in English to work in the Australian healthcare settings.

Data analysis. The audio recordings were transcribed verbatim and analysed using Interactional Sociolinguist (IS) and theme-oriented discourse analytic approaches (Gumperz, 1982; Roberts & Sarangi, 2005). Both approaches offer comprehensive ways of closely analysing the intercultural nurse-patient interactions in the workplace, thereby allowing for a better understanding of the social and cultural mechanisms underpinning the interactions. According to Gumperz (1999), people draw on lived experience and background knowledge to frame moments in interaction in order to deduce meaning from the interaction with what he called 'contextualisation cues' (intonation, word stress, rhythm evident in accents, speed of speech, and formulaic expressions used to interpret events and make inferences). This background contextual knowledge is integrated into IS analysis. Roberts and Sarangi (2005) drew on Gumperz (1999) and Goffman (1974) to describe theme-oriented discourse analysis which examines interactions and language used in healthcare settings. Such an analysis focuses on the way talk is structured, how relationships are sustained, and health content itself in order to shed light on how meaning is negotiated within institutional settings. Features that are analysed include

lexical choices, topic control, intonation, pronunciation and inferences that are made about 'what is going on' (Goffman, 1974). By understanding interpretive processes and overall patterns of communication, we can gain a better understanding of professional and intercultural communication (Roberts & Sarangi, 2005).

The transcriptions and audio-recordings were examined repeatedly for prosodic cues such as pauses, word stress and intonation, with the transcripts marked using the conventions outlined in the appendix. 'Focal' or professional themes were identified along with 'analytic themes' that are informed by linguistic and socio-cultural concepts. These include contextualisation cues used to interpret events and inferences, face and face-work, social identity, interactive frames and footings (Roberts & Sarangi, 2005). Goffman (1974) described a person's 'face' as the positive social value that a person claims for themselves; how they present themselves in everyday interactions. A 'frame' refers to a frame of reference, providing the foundation for interpreting 'what is going on' in relation to earlier experiences, thereby helping the understanding of new experiences. 'Footing' refers to the alignment that participants take up to each other (Goffman, 1974); for example a friendly interaction where rapport is evident would be viewed as being on a positive footing.

The 'display of empathy' along with 'rapport building' and 'patient education' are focal themes that were identified (each theme is discussed in separate papers). The present paper focuses on the display of empathy in the nurse-patient interactions, and analytic themes are used to examine the interactional consequences of the different approaches used. Interactions from two of the participants were chosen for discussion in this paper as they provide good examples of diverse empathic responses.

Ethical considerations. The study was approved by the Macquarie University Human Research Ethics Committee and the hospital concerned. RNs and patients participated voluntarily in the research, signed consents (see appendix 3 and 4) and were informed that they could withdraw at any time without consequence. Pseudonyms are used to protect the identity of the participants.

Findings and discussion

Both RNs displayed empathy at various stages throughout their patient care, however with different approaches, resulting in different responses in the ensuing interaction. These approaches will be compared and explained in terms of 'professional responses' outlined by Ruusuvuori (2007). Conversation analysis was used by Ruusuvuori (2007) to analyse ways in which general medical and homeopathic practitioners affiliate or empathise with patients' emotional disclosures, including how patients received those responses. She described two categories of professional responses: minimal and extended.

The *minimal response* category includes minimal affiliative responses from health professionals that include 'I see what you mean', however they do not exhibit understanding by talking about similar circumstances. Furthermore, they do not encourage the patient to elaborate, but return to the task or clinical agenda at hand. The 'troubles-telling' (Coupland, Robinson, & Coupland, 1994) by the patient is acknowledged, but more as a side issue, and is therefore not integrated into the ongoing activity of problem solving. Minimal non-affiliative responses include examples such as 'yeah' with a falling intonation that discourages further disclosure (Ruusuvuori, 2007).

Practitioners providing *extended responses* range from expressions such as 'that's a pity', to elaborations of similar circumstances to show understanding of the

patient's feelings. They extend the conversation, requesting confirmation that the practitioner's responses resonate with the patient, subsequently encouraging further discussion. Extended responses may also include evaluations or descriptions of possible outcomes of the patient's situation thus giving legitimacy to the patient's concerns. With extended affiliative responses, the patient's concerns are integrated into the clinical agenda rather than being treated as a side issue (Ruusuvuori, 2007).

Empathy in action with extended affiliative responses. According to Cunico et al. (2012), empathic caring means giving attention to, and understanding the health problems of the patient and their family, trying to improve the patient's physical, psychological and social comfort, and communicating this effectively in order to build a supportive and therapeutic relationship. This is demonstrated by Betty as she was caring for a patient postoperatively, who was to be discharged the same day as her surgery, but had been vomiting repeatedly and had remained in hospital overnight. The excerpt begins with Betty, who has come into the room to give the patient an antiemetic injection (medication to reduce nausea and stop vomiting) but delays the task in order to support the patient who is in the act of vomiting and is despairing about its persistence.

2	Patient:	I don't know why it's doing this.
3	Betty:	Yeah that's why you need these things (…....) there we go. *((Betty hands the patient an emesis/vomit bag, who proceeds to use it))*
4	P:	Excuse me. Oh dear.
5	B:	Yeah *((inaudible))* tells me she doesn't come out of anaesthetics too well. *((Patient vomiting))*
6	Husband:	I was pretty surprised last night. She was feeling, she was pretty, no sign of nausea.
7	B:	=She was pretty good then. Yeah night staff tell me she was pretty terrible overnight. ((*Patient vomiting continues several seconds with silence))* I will get more sick bags. I will be back because I think that is the last one.

8	P:	Oh dear. (…..) There shouldn't be anything left to come. *((Vomiting continues after Betty has left the room. Small talk by husband. Betty returns shortly with more bags.))*
9	B:	Do you want more tissues? *((Patient blows nose))* (……) You might have to stay with us! ((*Laughing))* Yeah.
10	P:	//Forever? Oh No! ((*Laughing))*
11	B:	Don't want to go home and//
12	Husband:	//No it usually takes a while (.) and she wouldn't feel comfortable at home.
13	B:	//and you not too great as well to look after her yourself!
14	Husband:	**No.** That's right!

In this excerpt, Betty is displaying empathy through her presence, sitting with the patient as she is vomiting, handing her the emesis bags and tissues, and making small talk with both the patient and her husband to demonstrate that she is comfortable being with them (Coupland et al. 1994) despite the unpleasantness of the vomiting. In this way, Betty is displaying the behavioural dimension of empathy (Trevizan et al., 2014). When Betty links the vomiting to the anaesthetic, the patient's husband comments that there was no vomiting initially; a surprise, implying that the patient has had this reaction following anaesthetic on previous occasions. Betty's latched response aligns with the husband's responses as she then explains that the night staff reported 'terrible' vomiting overnight. This communicates Betty's understanding of the patient's discomfort, demonstrating cognitive and affective dimensions of empathy, followed up with the offer of more tissues; the behavioural dimension. Betty attempts to ease the situation with humour and laughter in a joking frame (as explained above) that the patient extends with a latched and unlikely scenario of 'forever', followed by a dismayed 'oh no!' This exchange indicates the achievement of affiliation and rapport between the patient and Betty, a core tenet of quality patient care. This sequence also constitutes a 'critical moment' (Candlin, 1987) in the interaction where the direction of the relations could turn. An insensitive response on

Betty's part, such as a look of disgust or discomfort with the vomiting, not returning with emesis bags, or minimising the patient's discomfort could result in the patient feeling embarrassed and belittled, resulting in damage to the rapport that is evident in turn 10.

Betty's empathic approach continues as she extends the conversation by starting to point out the pitfalls of going home before the nausea and vomiting has resolved. This idea is quickly taken up, with the husband's quick elaboration that she wouldn't feel comfortable at home in this state. Betty again demonstrates understanding of the patient and her husband's situation (turn 13) as the husband has a cold, and he quickly agrees with her that he would not be well enough to care for the patient. By including the husband while caring for the patient, using small talk and considering his health and ability to help his wife, Betty is conveying an empathic and inclusive approach to her patient care. As the vomiting appears to have eased, Betty proceeds to attend to the task of giving the antiemetic drug that she had intended to give when first entering the room.

15	Betty:	All right, think we can do the injection? (…) So do this undone. *((Unscrews an injection port on the patient's IV line)).*
16	Patient:	That's the nausea one is it?
17	B:	Yeah that's another nausea one; no it's not the pain one. (...) So this one is just the saline, just to make sure this one is working, and then the actual injection (…..) If it hurts let me know (…..) that's the injection there. Hopefully this works. *((chuckling))* You've just had a nasty morning.
18	P:	Yeah (…) I was feeling good last night thinking, 'oh this is great'.
19	B:	//Yeah that's what your *((chuckling))* husband just says, you had a good day.
20	P:	//Two am or whatever the time was that (..) it started.
21	B:	//Yep *((chuckling))* the anaesthetist probably gave you something that must have probably worn off at night and//
22	P:	//yeah well he said he was giving the one that was the least whatever.

23 B: Mmmm

24 P: He said if that doesn't work he doesn't know if it would or//

25 B: //Mmmm. At least the good thing, the surgeon is here, we'll see what he thinks about it. He is coming (…) You are right, Ill let you to (..) just leave it, let it work (….) Good, just keep with the chips going. Just keep your dehydr//

26 P: //chips?

27 B: Yeah, the (.) **ice** chips//

28 P: //Oh yeah yeah (..)

29 B: Good thing your blood pressure is fine.

30 P: Thank you *((inaudible small talk from husband))*

31 B: All right. *** *((B leaves room))*

While Betty is injecting the medication via the intravenous line (IV), provides information about what she is doing, followed by an empathic statement using a friendly tone of voice with the patient in turn 17, an important element of building and maintaining rapport (Woodward-Kron, Hamilton, & Rischin, 2007). Small talk, used here while attending to clinical goals, maintains the interaction on a positive relational footing by promoting goodwill (Coupland et al., 1994; O'Grady, Dahm, Roger, & Yates, 2013). Betty explains that she is injecting normal saline first to make sure the IV cannula is flushed and clear, allowing the medication to be administered easily into the vein. Betty then asks the patient to inform her if she feels discomfort while she is injecting the antiemetic – an indicator of problems such as the cannula having pierced the wall of the vein causing the drug to infiltrate the surrounding tissue.

After indicating that she has completed the task, Betty affiliates with the patient by stating she hopes the medication works successfully to ease the nausea and vomiting, chuckling and using a friendly tone of voice to reintroduce the light-hearted frame. She conveys understanding and empathy in turn 17 through the statement 'You've just had a nasty morning'. This empathic expression supports, validates and

enables the patient to make meaning from the event, and she acknowledges receipt with the agreement token 'Yeah', elaborating that she had felt good the previous evening. Betty responds by reflecting what the husband had said, continuing in turn 21, chuckling, and explaining that it might be due to another drug having lost effect. The patient continues the conversation, drawing agreement tokens from Betty.

With the completion of the medication administration and the apparent easing of the nausea, Betty then indicates closure by changing the topic to the surgeon's imminent visit as a way of getting further explanation for the vomiting. Betty then changes frame from that of 'small talk' to 'instruction giving' by advising the patient to relax, let the drug take effect and to suck on ice chips to maintain her hydration. The overlapping speech from turns 20 to 28 demonstrate collaborative interruptions rather than interference which serves to enhance rapport between nurse and patient, thus demonstrating solidarity (Goldberg, 1990). Betty closes the interaction on a positive and reassuring note, referring to the patient's blood pressure that is within normal limits despite the vomiting (which can cause dehydration and therefore reduce blood volume and blood pressure), and prepares to leave the room in turn 31 with the words 'all right' spoken with falling intonation to close the interaction.

Despite concerns regarding CALD nurses' competence with clinical communication and developing therapeutic relationships (Chiang & Crickmore, 2009), the contextualisation cues evident in the exchange, as well as the way in which the talk is structured and rapport maintained demonstrates Betty's expertise with communication that conveys empathy through an extended response (Ruusuvuori, 2007). Betty does this by not only using verbal statements acknowledging the patient's 'nasty morning', but being present while the patient is vomiting, sitting at the patient's eye level, handing her tissues and emesis bags, and giving the patient's

condition legitimacy by describing the outcome of continued vomiting (a delayed discharge), albeit in a light-hearted frame. Betty remains with the patient despite the unpleasant situation and includes the patient's husband in conversation while invoking a joking frame to keep the interaction on a positive footing. This demonstrates an 'in feeling' rather than a 'with feeling' approach (Trevizan et al., 2014), communicating acceptance of the patient and empathy towards her situation. According to O'Grady (2011), the articulation of a patient's emotions by the health professional that they are unable to explicitly express, together with the 'interactional consequences' of such empathic formulations, maintains the interaction on a positive footing that enables further elucidation of the patient's emotional concerns. The patient's concerns are integrated into the clinical agenda rather than being treated as a side issue. The patient in this excerpt acknowledges receipt of this by extending the humour with an exaggerated response. The consequence of Betty's empathy was an extended interaction with numerous affiliative responses by both parties, showing evidence of good rapport and therapeutic relationship. This interaction will be compared with the outcomes of an interaction where empathy is given with minimal responses.

Empathy in action with minimal affiliative responses. According to Ruusuvuori (2007), where empathy is given with minimal affiliative responses, there may be compassionate expressions or short verbal responses indicating an understanding of the patient's troublesome experience, however there is little attempt to draw out the experience, and the professional then returns to the clinical agenda with the conversation falling flat or changing course. Alternatively, the patient may pursue a description of the problem by upgrading their experience with 'extreme case formulations' (Ruusuvuori, 2007, p. 601); elaborate descriptions of events to invite

the professional's compassion. This is demonstrated in an interaction between Jenny and a patient as she documents reactions to numerous allergies in preparation for the patient's upcoming surgery.

30 Jenny And also you allergic to NSAIDS medication, which is non-steroidal anti-inflammatory medication?

31 Patient: Correct.

32 J: What sort of reaction?

33 P: Oh I haemorrhage

34 J: Haemorrhage, you mean bleeding?

35 P: Yep, first time was from the nose, first and last time was from the nose. I had life threatening epistaxis for 18 days. I was really sick. 4 units of blood and they resuscitated me several times! Awful. (…) I don't want that again! *((Jenny clicking on computer throughout the patient's response))*

36 J: Penicillin, what sort of reaction brought by the penicillin?

The patient responds to Jenny's probe regarding the type of reaction brought on by non-steroidal anti-inflammatory (NSAID) medication with an elaboration about 'life threatening epistaxis', the need to be transfused with a significant volume of blood and several resuscitation attempts, indicating the severity of the response. Silence ensues except for Jenny clicking on the computer. The patient allows time for Jenny to respond, and when she doesn't, the patient continues, saying she doesn't want to repeat the experience. Rather than responding empathically, Jenny then proceeds with the questioning; in this instance letting the opportunity to build a therapeutic relationship to pass. Turn 36 constitutes a 'critical moment' (Candlin, 1987), where there is an opportunity for Jenny to follow up on the patient's 'troubles telling' and engage empathically with the patient by acknowledging the significant allergic reaction and emotional consequences of the experience. However, Jenny misses this opportunity and proceeds with the task at hand.

37 P: Um (..) severe urticaria.

38 J: All right (.) like hives stuff?

39 P: Yeah, like more than hives, **hug**e welts like this. ..

40 J: Wow.

41 P: All over.

42 J: Sounds terrible. *((Spoken with even/flat intonation))*

43 P: And inside your brain. Inside your head, you know that feeling? I don't know if you know that feeling.

44 J: //And you also allergic to ad, ad, ad, sorry adrenalin?

45 P: I'm sensitive.

46 J: //Sensitive. What sort of sensitive?

47 P: I have heart palpitations.

48 J: All right, heart palpitations.

49 P: And I have giddiness and I have black out (..) and I think I'm going to die! Not pleasant! *((Laughs))* I'm very careful!

50 J: Yeah. *((clicks on computer a couple minutes))* And how about ephedrine?

After the patient demonstrates the size of welts experienced after taking penicillin, Jenny does acknowledge the patient in turns 40 and 42 with short empathic statements. The patient receives these statements and elaborates in turn 43, however when Jenny fails to respond, she resorts to a statement that refers to her previous question. Once again, Jenny is focusing on the list of allergies and the clinical task at hand, misses the cue for empathy and proceeds to ask the patient how she responds to adrenalin. Once again, the patient provides an 'extreme case formulation' (Ruusuvuori, 2007, p. 601), pursuing a stronger response in an attempt to invite compassion from Jenny. She describes giddiness, fainting, and the extreme thought (albeit told in a joking frame) that she is going to die. Jenny continues to focus on the computer screen and the clinical task of confirming allergies, and again misses this cue and fails to respond empathically, continuing to the next question.

Another form of minimal response is illustrated in an interaction with a different patient who is about to go to theatre for an excision of a lung tumour. Jenny

responds when the patient says she is feeling scared, however while she acknowledges the patient's fear, her response fails to invite the patient to elaborate on her feelings and the reasons for her fear; an important aspect of providing emotional care. Rather, she treats the fear as a side issue and suggests listening to music. The excerpt begins after Jenny has been educating the patient about what to expect after surgery and when her family will be able to visit her.

65 Jenny: Do you have any question for me *((name))*?

66 Patient: No, I'm too scared!

67 J: Too scared! *((laughs))* Do you want, have some music for you? Turn on some music or TV?

68 Daugher in law: You have to talk to her! That doesn't help.

69 J: It's all right, once you in anaesthetic bay, it knock you down. You won't know anything, no time to worry all right yes. Just leave everything to the doctor, even you worry, still can't help, all right. Can't do anything, the worry didn't help the surgery, yes, just make it worse. All right, yes. Take deep breaths, have lovely family here, yes. Your daughter-in-law really impress me, I thought she was the daughter! *((laughter from all present))*

70 P: She like my daughter. *** *((inaudible – over talking by family members and laughter))*

71 J: She like your daughter, yes that's right! *** All right good. I'm going to level the bed for her (……) Good (….) I'll be back.

72 DIL: No worries.

After Jenny suggests listening to music, the patient's daughter-in-law suggests talking as a more effective way of helping the patient manage her fear. Jenny responds in turn 69 in a light-hearted frame by trying to reassure the patient, encouraging her not to worry, take deep breaths and focus on her family. Diverting the patient's attention away from the impending surgery may help her to manage her nervousness in the short term; however, it also limits the conversation and closes important therapeutic opportunities, as explained in the following paragraph.

This sequence, and turn 67 in particular, constitutes a 'critical moment' (Candlin, 1987) where there is the opportunity to engage both cognitive and affective dimensions (Trevizan et al., 2014), acknowledge the patient's fear of the upcoming surgery, and provide empathic responses that allow the patient to diffuse or manage her fear. This moment, however, is missed as Jenny instead recommends listening to music or watching television. The daughter-in-law provides another opportunity to engage empathically in turn 68, stating 'you have to talk to her', but this opportunity is also missed. O'Grady (2011) argues that ongoing monitoring of the implicit cues to the patient's emotional state, and responding with empathic responses that resonate accurately with how the patient is feeling, allows the patient to feel understood and provides an opportunity to extend the 'troubles telling' if they so desire. Effective empathy is thus consequential, and as O'Grady (2011, p. 50) explains, "has clinical work to do". Despite the missed opportunity to engage with the patient's fear, the light-hearted frame and laughter from all parties indicates rapport in this interaction, although more limited when compared to extended interactions such as that discussed earlier.

Both types of minimally affiliative responses illustrated here were followed by a quick return to the clinical agenda after a momentary acknowledgement of the patient's concern. The 'troubles telling' by the patient is cut short despite occasional attempts by the patient or relative to invite compassion from the RN. While Jenny communicated with her patient with a friendly tone and a light hearted frame that established a therapeutic relationship, her minimally affiliative responses did not allow the patient to elaborate on her concerns, thereby limiting the building of rapport and trust, patient satisfaction and improved patient outcomes that have been linked to empathy (Frankel, 1995; Roter et al., 2006; Stewart, 1995; Stewart et al., 2000).

Conclusion

Discourse analysis has been used to examine and describe different ways of managing patients' emotional responses by two RNs from CALD backgrounds in naturally occurring institutional interactions. While the cultural and language backgrounds between the nurses and patients differ, therefore raising the potential for communication breakdown, the RNs demonstrate an ability to communicate with their patients. However, the 'interactional consequences' (O'Grady, 2011) of extended responses and minimal affiliative responses respectively were demonstrated. An extended response invited the patient to elaborate on their 'troubles telling', and management of the patient's emotional state was integrated into the clinical agenda and care for the patient. This had a clear result of building rapport and trust between the RN and the patient. Analysis of this encounter demonstrates that empathy is both a consequential and cumulative activity. By contrast, while some empathic statements were made by Jenny, her minimal responses had the effect of limiting ongoing conversation about the patient's concerns, with attention paid primarily to the clinical agenda and the patient's concern being treated as a side issue. Rapport was less evident as a result. Decisions regarding how deeply to engage with patients are made daily by RNs, however constraining factors that limit this engagement include time pressures and competing priorities (discussed by the participants during interviews undertaken as part of this project).

The examination of natural nurse-patient interactions using discourse analysis allows for a greater understanding of the consequences to various communicative approaches and levels of engagement. Through highlighting the consequences of these different approaches, and the strategic interactional work that builds therapeutic relationships, we can strengthen the communicative competence of health

professionals. Education related to these approaches and their consequences can be included in communication training for not only nurses from CALD backgrounds, but health professionals generally. For this reason, discourse analysis has much to offer professional development and practice, resulting in improved patient satisfaction and safety.

Funding: This project was conducted with the financial support of an Australian Postgraduate Award.

Acknowledgements: The authors would like to thank the participants and patients who took part in this project, as well as the hospital managers who allowed the project to go ahead.

Appendix 1: Transcription symbols used

(.)	seconds of silence.
Bold	indicates the emphasis to the words given by the speaker.
//	indicates overlapping speech.
=	latching of one speaker's utterance with the next speaker's utterance with no discernible silence between them.
(( ))	double parentheses mark descriptions of events or what is happening during a period of silence.
***	Inaudible

Interlude

The exploration of the communication between the RNs of CALD backgrounds and their patients identified empathy as one of three focal themes. Chapter Four outlined the interactional consequences of diverse approaches to the provision of empathic care using Ruusuvuori's (2007) model of professional responses. The consequences of extended affiliative responses were contrasted against the consequences of minimal affiliative responses in terms rapport-building in the nurse-patient relationship. Rapport is the second focal theme that will be discussed in Chapter Five. The development of rapport is an important underlying factor in the provision of quality nursing care, impacting on the health outcomes for the patient. This chapter traces the interactional accomplishment of rapport by the RNs, albeit with varying degrees of expertise, demonstrating the strategies that are used.

Chapter 5

Tracing the discursive development of rapport in intercultural nurse-patient interactions

Abstract

Good rapport underpins effective patient care; however communication barriers can undermine the building of rapport and the development of a therapeutic relationship, potentially resulting in poorer health outcomes (Hamilton & Woodward-Kron, 2010). This paper examines the development of rapport by Registered Nurses (RNs) from a variety of cultural and linguistic backgrounds. Discourse analytical techniques are used to trace rapport-building in naturally occurring interactions through the course of the participants' nursing care. Ethnographic techniques including participant observations and audio-recordings of interactions were conducted in Sydney, Australia, and analysed using interactional sociolinguistic (IS) and theme oriented discourse analytic approaches (Gumperz, 1982; Roberts & Sarangi, 2005). This paper demonstrates how rapport is accomplished by the RNs through strategies such as humour, reassurance, small talk and use of colloquial language.

Introduction

Communication is well recognised as an essential skill in nursing and important in the provision of quality nursing care. Good communication skills form a platform for building good nurse-patient relationships, with rapport being a core tenet that underpins effective and compassionate nursing care (Candlin, 1995; SmithBattle, Leander, Westhus, Freed, & McLaughlin, 2010). Rapport is defined

as the interpersonal experience of harmony, warmth and "feeling comfortable with one another" (Belcher & Jones, 2009, p. 146; O'Grady, Dahm, Roger, & Yates, 2013). It is distinct from trust which is "confidence that the other party will act in one's best interests" (O'Grady et al., 2013, p. 9), although the two terms are often used interchangeably. O'Grady et al. (2013) suggest that once rapport has been accomplished, a trusting and cooperative therapeutic relationship between patient and health professional is more likely to be achieved. However, if a nurse is having difficulty communicating with a patient, then rapport building and the development of a therapeutic relationship is undermined, potentially resulting in poorer health outcomes (Hamilton & Woodward-Kron, 2010).

Communication barriers might be created by differences in gender, cultural and language backgrounds, education and socio-economic status (Candlin, 1999, 2002), compounded by the stressful situations inherent in the healthcare situation with busy health professionals and patients who are unfamiliar with medical jargon, procedures and routines. There have been growing concerns from employers, regulatory agencies, as well as nurses themselves, regarding the English language and clinical communication skills of nurses from culturally and linguistically diverse (CALD) backgrounds (Chiang & Crickmore, 2009; Shen et al., 2012). This is due to risks to patient safety when there are deficiencies with communication which may result in misunderstandings (Xu, Shen, Bolstad, Covelli, & Torpey, 2010).

Globalisation of the health workforce has resulted in increasing numbers of nurses from CALD backgrounds migrating to countries such as Australia. Australia has been actively recruiting nurses from overseas to address workforce shortages through skilled migration and employer sponsorship programmes (Ohr, Parker,

Jeong, & Joyce, 2010); however, achieving English language proficiency and adapting to social and cultural aspects of their new country has been more difficult than previously recognised (Lum, Dowedoff, Bradley, Kerekes, & Valeo, 2015). There has been an emerging body of research examining the experiences of CALD nurses which have identified recurrent themes of having to adjust to communication approaches that differ from their home countries (Deegan & Simkin, 2010; Hearnden, 2008; O'Neill, 2011; Omeri & Atkins, 2002; Walters, 2008). Yet there is little research involving the analysis of nurse-patient communication using naturally occurring interactions (Major & Holmes, 2008), particularly by nurses from CALD backgrounds (O'Neill, 2011).

This paper discusses the interactional accomplishment of rapport by Registered Nurses (RNs) from a variety of cultural and linguistic backgrounds. The theme of rapport was identified as part of a study examining intercultural communication among four nurses from CALD backgrounds (China, Iran, Philippines and Zimbabwe) and their patients in the Australian healthcare setting. Other themes that were identified in the study are discussed in separate papers which are currently under review or in press (Crawford, Roger, & Candlin, in press). Discourse analytical techniques are used to trace rapport-building in naturally occurring interactions through the course of the participants' nursing care.

Background

Research focusing on rapport in health settings has focused to a large extent on the medical profession. Some have argued that rapport is a consequence of empathy (Norfolk, Birdi, & Walsh, 2007). Others have suggested that while rapport can result from an empathic interaction, it is also developed, maintained or diminished through various interactions, and thus permeates clinical

communication (Leahy & Walsh, 2008; O'Grady, 2011). Seccareccia et al (2015) investigated communication in healthcare settings and found that building rapport was considered essential by both health professionals and patients, and that health professionals set the tone and started to build rapport by initiating dialogue with patients. Patients reported that this helped their sense of belonging and that they subsequently felt that the care was genuine, thus building a sense of mutual trust (Seccareccia et al., 2015).

Rapport, and subsequently trust, are developed through a co-constructed, dynamic and interactive process that emerges out of mutual understanding and regard, where the clinician respects the patient's needs and concerns (O'Grady et al., 2013). O'Grady et al. (2013) also found that rapport and therefore trust are never an absolute accomplishment but rather a "gradual, iterative and delicate process that is often diverted by patient wariness and dissent" (p. 15). Belcher and Jones (2009) found that rapport was built by nurses primarily through active listening and having social conversations with the patients. Research has found that a large proportion (60%) of nurse-patient interaction consisted of informal 'small talk', including amusing anecdotes, intentionally and strategically positioned alongside medical talk that was intended to build rapport and help patients to feel comfortable in the medical environment (Holmes & Major, 2003). Small talk is a strategy commonly used by health professionals to establish rapport with patients in order for the health professional to gain an understanding of the patient's psychosocial health (Woodward-Kron, Hamilton, & Rischin, 2007). In fact, talk is the only avenue to understanding a patient's socio-environmental circumstances, point of view or their understanding of events, in other words their '*life world*'

(Mishler, 1984), and therefore socio-relational talk is often interwoven with medical talk (Coupland, Robinson, & Coupland, 1994).

Despite small talk being frequently used to build rapport, nurses from diverse backgrounds may have difficulty recognising the importance of 'small talk' as a core component of practice. Discomfort engaging in small talk with patients can result in these nurses appearing unfriendly (Lum et al., 2015; Philip, Manias, & Woodward-Kron, 2015; Woodward-Kron et al., 2007) which can impact negatively on building rapport with patients. This in turn can result in reduced clinical outcomes; for example, a lack of engagement in a prescribed treatment regime can result in limited adherence, and lead to complications, exacerbation of the patient's condition and lower patient satisfaction. A lack of rapport can also lead to an unwillingness to reveal sensitive information which may result in a limited assessment and therefore inadequate intervention or treatment (Flickinger et al., 2015; Hall, 2001). Flickinger et al. (2015) found that when clinicians reported respect for patients, both clinicians and patients reported more rapport-building, associated with social chitchat and small talk, resulting in the development of trust. Patients subsequently divulged more psychosocial information, and consequently, there was less clinician-dominated talk. Given the importance of small talk, and the apparent struggle to build rapport and trust with patients if small talk is found to be difficult, how do registered nurses (RNs) from culturally and linguistically diverse (CALD) backgrounds go about achieving this?

Methodology

Ethnographic techniques including participant observations and audio-recordings of interactions were conducted to collect data totalling over 370 minutes of natural discourse in a day surgery unit and two surgical wards of an acute care

hospital in Sydney, Australia. The ethnographic knowledge of the hospital setting and nursing procedures was informed by the first author's experience as a registered nurse, as well as observations of the participants as they recorded conversations and interactions with their patients. Field notes were made immediately following periods of observations providing contextual information such as the type of surgery the patient had, what procedure the nurse was conducting, and non-verbal communication that occurred which helped to comprehend the socio-pragmatic meanings of the conversations in this workplace (Major& Holmes, 2008).

Audio-recordings were transcribed verbatim and relevant sections were analysed using interactional sociolinguistic (IS) and theme oriented discourse analytic approaches (Gumperz, 1982; Roberts & Sarangi, 2005), both offering comprehensive methods for analysing how rapport is accomplished in nurse-patient interactions. IS incorporates background knowledge and lived experience that people invoke to frame moments in interactions, and draw from to infer meaning from the interaction (Gumperz, 1999). According to Roberts and Sarangi (2005), theme orientated discourse analysis is the study of language-in-action which is connected to broader themes of health and inequality; it considers both the health content, as well as the way talk is structured, and how relationships are sustained. Analysis of detailed features of talk such as lexical choices, intonation, what gets talked about, topic control, and inferences that are made about '*what is going on*' (Goffman, 1974), shed light on how meaning is negotiated in interactions within institutional settings. This highlights interpretive processes and overall patterns that emerge across an activity, allowing for a better understanding of professional and intercultural communication (Roberts & Sarangi, 2005).

The first stage of analysis involved repeated listening to the audio-recordings to identify phases of the interaction, to examine the content and look for prosodic cues such as intonation, pauses, and word stress. This was followed by transcribing the data using transcription conventions outlined in the appendix. The whole interactions were then read and re-read to examine outcomes and identify focal themes (professional concerns) and analytic themes (interactive frames and footings, contextualisation cues and inferences, face and face-work, social identity and rhetorical devices) informed by linguistic and socio-cultural concepts (Roberts & Sarangi, 2005). Focal themes that were identified include rapport building, displaying empathy and provision of patient education. The theme of rapport building will be described in this paper using analytic themes to map what is happening in the interaction and explain how meaning is made.

Ethical considerations

The study was approved by both the hospital involved and by the Macquarie University Human Research Ethics Committee. Written consent was gained from both the RN participants and the patients involved in the interactions. Pseudonyms are used to protect confidentiality and participant identity. Participants were informed that they could withdraw at any time without consequence.

Findings and discussion

The ability of a health professional to build and sustain rapport in a clinical encounter is a hallmark of communicative expertise, and it is thus relevant to incorporate into the analysis theories of professional expertise. Schön (1983) describes a continuum of expertise ranging from '*technical rationality*' at one end of the continuum where inexperienced practitioners see problems in clear-cut terms, and there is focus on rules and protocols guiding practice. The other end of the

continuum is what Schön (1983) describes as '*reflection-in-action*' where experienced practitioners are flexible and open to experimentation. They draw on previous experiences to improvise or implement new practice while working with the patient towards solving complex problems. Schön (1983) cautions, however, that greater experience is not always accompanied by higher levels of expertise. He describes the phenomenon of '*selective inattention*' where experienced practitioners can become routine and rigid in their approach if they fail to engage in critical reflection.

The novice to expert model developed by Benner (1984), while developed to explain the development of clinical reasoning and skills, can also be used to explain degrees of skill in communicative competence. According to Benner (1984) there are five stages of the development of a nurse's skill from that of '*novice*' where beginners learn through instruction and have limited application of knowledge and see interventions bound by rules. With time, the novice becomes an '*advanced beginner*' where experience can be drawn on to understand and apply rules to suit the nuances of varying situations. Further experience leads to '*competence*' where planning is still deliberate and analytic but more efficient, and actions are prioritised hierarchically. With further experience, the professional becomes '*proficient*' where unconnected aspects are seen as a whole, problem situations are understood more intuitively, but actions still require analytical thinking. Finally, the professional becomes an '*expert*' where understanding of routine situations is deep and actions are intuitive without the need for explicit decision-making to solve problems.

Benner's theory has been criticized as having weak evidence to support each stage, and that each stage is poorly documented in the literature (Gobet & Chassy,

2008). It also fails to account for differences in personality, other people's ability to communicate effectively, or simply having a day where communication is difficult for various reasons. Despite these shortcomings and risks, it does help to explain differences in the smooth integration of various discursive tasks and the development of conversational synchrony (the smooth and automatic exchanges between participants that indicates successful communication [Gumperz, 1982]) in relation to the length of time spent working in Australia, and the ease at which colloquial forms of English are used to build rapport.

Rapport demonstrated by experienced nurses.

All participants in this study demonstrated the ability to develop rapport with their patients with varying degrees of skill. Building rapport is a core ingredient in developing a therapeutic relationship between nurses and patients, and research examining social aspects of nurse-patient interactions found that small talk and humour is skilfully integrated with the clinical aspects of patient care by effective nurses (Holmes & Major, 2002). O'Grady et al (2013, p. 9) also found that small talk was "purposeful and closely intertwined with the pursuit of clinical goals." Similarly, the RNs who participated in this research used humour and small talk in the interactions with their patients. This is illustrated in interactions by Betty, a very experienced RN who has worked in Australia for 10 years. A smooth interweaving of small talk, humour, education and reassurance is demonstrated while removing a pump that provides the patient with pain relief, and preparing to assist her transfer to the shower. The conversation starts with Betty asking where the patient's toiletries are kept.

1 Patient: I think on top of the drawers next to the bed there, in a grey bag.

2 Betty: Grey bag? Oh yeah. ((*collecting toiletries)*) that's all right ((*inaudible several seconds*)) …do you want to have one more shot before I disconnect?=

3 P: =might may might do that, yeah=.

4 B: =Just one for the road! ((*laughs*))

5 P: Might be a good idea! Ta.

Betty demonstrates her familiarity with everyday language and uses it to affiliate or relate socially to the patient through use of colloquial expressions such as "one more shot". She is referring to the patient controlled analgesia (PCA) where the patient presses a button to receive a pre-set micro dose of pain relieving drug (analgesia) to make sure the patient is kept comfortable and pain free. The reference to "one more for the road" is a humorous take on a colloquial saying used in hospitable situations where food or drink is offered before the guest takes their leave. In this exchange, Betty is relating to the patient using everyday language and foregrounding her 'personal' rather than her 'professional' identity (Mishler, 1984) while offering a last chance for the patient to receive a dose of medication before she removes the pump. According to Roberts and Sarangi (2005) shared ways of speaking or finding common ground affects the way in which interactants get along in an encounter; commonality can create a positive assessment of each other and "oil the wheels of the interaction" (p. 634).

6 B: Ok. So after this comes off its um .endone (.) but you just have to ask for it. Might not offer it, you just//

7 P: //ok

8 B: (. . .) and the targin that I gave you, earlier, that will continue probably until you are discharged.

9 P: Ok. ((*Several seconds of silence while PCA is disconnected*))

10 B: They might want you to continue with the drip since your blood pressure is a bit low isn't it?

11 P: Yeah

Here Betty continues the rapport building by reassuring the patient; she explains that oral analgesia (Endone) will be provided, but reminds her that she will have to request it as it written as an 'as required' order and will therefore not be given routinely. Betty continues the reassurance by explaining that another analgesia (Targin) will continue to be routinely provided as it had been while the PCA was in place. Betty also explains that the intravenous therapy 'drip' won't be removed due to low blood pressure which is also used to increase blood volume and therefore help to maintain or increase blood pressure. While the PCA is being removed, Betty shifts from reassuring the patient to using small talk and planning the activities for the rest of the morning. Small talk, which has been shown to engender goodwill and to maintain the interaction on a positive relational '*footing*' (Coupland et al, 1994; O'Grady et al, 2013), is used here while attending to clinical goals. '*Footing*' refers to the way that participants frame events, and how they negotiate and align relationships within those events (Goffman, 1974).

12	B:	*((disconnecting PCA several seconds))* And did they say how long they want you to sit up for?
13	P:	Umm (.) I think it is about 20 minutes
14	B:	20 minutes?
15	P:	=Yeah, they have to check that one, I think it was 20 (…)
16	B:	Oh well, so we'll do this and then I'll try and sit you up for lunch, I think it will be easier.
17	P:	=Ok (..) sounds good (…)
18	B:	Are you having visitors?
19	P:	No, no, everyone is still in *((patient's town))*//
20	B:	// *((patient's town))*.
21	P:	=Yeah. My mum is coming next month to help.

After talking for a few turns about not going to rehabilitation but returning to her home with her mother's help, Betty completes the PCA removal and indicates a

change in frame from 'rapport building' to 'instruction' using the marker "all right". A '*frame*' refers to a frame of reference that provides the basis for interpreting '*what is going on*' in relation to previous experience – it helps interpretation of new experiences (Goffman, 1974). Betty helps the patient transfer to the bathroom after applying a supportive corset around that patient's waist that is used in spinal surgery to provide stability to the spine.

27	B:	All right (..) do you think you can, get you to stand up with the corset?
28	P:	Ok (..) can I borrow a (.) face washer as well? *((inaudible/over-talking))*
29	B:	I've got all that//
30	P:	//oh good
31	B:	((*silent several seconds while corset is applied))* This might be old fashioned!
32	P:	I need one! *((laughs))*
33	B:	=tummy tuck!
34	P	badly!
35	B:	(….) Get a seat *((inaudible))* (…) so that you can reach the buzzer if you need me *((moving shower chair into position))*

In this interaction, Betty skilfully draws on humour to save *'face*' on what might be a potentially embarrassing situation for the patient while a corset is applied to her rather generously proportioned abdomen. A person's '*face*' is how they present themselves in everyday interactions; the positive social value that a person claims for themselves (Goffman, 1974). Rapport has been established as indicated by the sequences of mutual affiliation or friendly inter-relating in lines 32 to 34. Without pursuing the topic of the patient's perceived need for a tummy tuck, Betty returns to the formality of a 'professional' voice (Mishler, 1984) after a few seconds of silence while supporting the patient to walk to the bathroom, where a shower chair is positioned for the patient with easy access of the call bell if help is required.

This interaction demonstrates effective rapport-building using colloquial language, small talk, humour and reassurance while achieving the clinical goal of removing a PCA, application of a corset and transfer to the bathroom. There is clear understanding with synchronous exchanges in the conversation (Coupland et al., 1994). Mutual affiliation occurs, rather than an awkward embarrassment that might otherwise have occurred during the application of the corset. A potential face threat is thus successfully mitigated.

Another experienced RN, Andrea, also demonstrates the accomplishment of rapport through sequences that involve a friendly conversation during a procedure where eye medication is instilled. A high degree of '*cohesive fit*' (Goldberg, 1990) is demonstrated in mutual understanding despite a complex process of providing education, using small talk and humour, while clinical discourse is interwoven. The patient in this excerpt has had bilateral cranial surgery, with each side having been operated on in separate occasions. She has swollen eyes as a result of post-operative oedema. This RN has cared for the patient several times, knows her quite well and has a good relationship as demonstrated by the easy-going and light hearted interaction to which both interlocutors contribute.

The interaction begins with the RN looking for the eye ointment medication she is to instil in both eyes. Once Andrea has located the medication, she immediately begins small talk discussing a visit from a rehabilitation nurse in preparation for the patient to transfer to a rehabilitation hospital. However, the conversation diverts back to task related discourse in turn 19, balancing socio-relational and clinical goals related to instillation of the eye ointment.

10 Patient: Oh, the eye drop, it's a little red um box and it's got like a bird on it or something.

11 Andrea: Yes, I see.

12 P: That's the one for the eye.

13 A: Ok *((silence while washes hands and puts gloves on to instil eye ointment to commence the procedure))* Well (….) this one, because we have a good um good news for you today for your transfer to *((name given))* rehab//.

14 P: //I know.

15 A: The rehab *((name))* assessor, the rehab

16 P: //Jean um Theresa

17 A: Theresa, so she just came here this morning.

18 P: =Yeah *((silence while medication is instilled))*

19 A: One there, let's go for the other eye. That's the eye drop. (..) Tissue?

20 P: Thank you

21 A: (…) And *((reaching for tissues))*

22 P: Which end do you want to start?

23 A: (…) Which ever you are comfortable with. Right side is OK? I think I banged that head with my head so *((inaudible/laughs))*. I hope its not bleeding or anything or I won't be able to get to sleep tonight!

24 P: Oh, God don't, don't think like that! You tonight go to bed and think how much I love you! *((laughs))*

25 A: =Yes, thank you! All right! *((Silent a few minutes while instilling eye drops*))

Rapport between Andrea and her patient is demonstrated in turns 23 to 25 in a humorous interchange about Andrea hitting her head on the bed head, and the patient subsequently providing reassurance in a reversal of roles that evokes laughter from both parties. The RN returns to a 'professional' voice (Mishler, 1984) with the marker "all right" and changes to an 'instruction giving' frame requesting the patient to turn her head, interweaving clinical discourse with small talk.

26 P: Where are we? *((silence a few seconds))*

27 A: (….) just comes up to here (….) All right, now turn the other side, have a look on this side. *((silence a few seconds))* So the removal of your clips, we will have to verify with the neuro doctors if they

are quite happy for all of these to be removed tomorrow. They said Friday.

28 P: Mmm. But apparently they are going to do the left ones first, because the right one hasn't had the full (..) whatever days it is, 10 days or something I don't know.

29 A: It's quite an extensive operation//

30 P: //Actually it was 7 days (.) yesterday. Yesterday was Wednesday, was it?

31 A: Yes

32 P: 7, so 7, 8, 9, 10, see 10 is not till Saturday (...) Something like that anyway.

33 A: *((silence a few seconds while competing procedure))* Perfecto!

34 P: Perfecto!

Andrea engages in small talk regarding skin closure clips from the left sided suture line to be removed the following day. The procedure is completed as announced by "perfecto" in turn 33 mimicking an Italian accent. Affiliation or a friendly relationship between Andrea and the patient is again demonstrated by the light-hearted mirroring of "perfecto" by the patient, again mimicking the Italian accent. Having completed the procedure, the RN continues with small talk within a socio-relational frame, turning the conversation to the patient's sister and the likelihood of a visit. However, there is a momentary threat to the positive footing of the interaction with the patient's immediate rebuttal of Andrea's comparison of her appearance to that of her sister in turn 38. This results in Andrea's quick, if flustered attempt at repair, restoring or saving a positive face for both herself and the patient in turn 39.

35 A: Ok. I haven't seen, did your sister (.) come for a visit again.

36 P: Not today. Yesterday she came. You saw her yesterday!

37 A: Saw her..That's why I did a double take like, 'was that her'?

38 P: //I don't look like **her**!

39 A: **No,** the the..I think it's the height, I don't know but=

40 P: =she is taller than me. I'm older than her.

41 A: //she's your sister, ((*laughs)*) you look alike but not really, you know, like twins look alike! Ok let's have a look at this sertraline, if it's charted in the med chart.

In turn 41 Andrea further attempts to repair the relationship by qualifying her comments about likeness in appearance between the patient and her sister before returning to a 'professional' voice (Mishler, 1984) and changing the frame using the marker "ok" to answer an earlier question regarding a drug that the patient was inquiring about. While Andrea is consulting the medication chart, the patient examines her eyes and the suture lines in a mirror and shows concern about the swelling. This draws Andrea's concern in turn 43, who assesses the situation and considers it in light of previous conversations and education about an exercise referred to as 'apple biting' to mobilise the jaw and strengthen facial muscles left immobile by the surgery and subsequent bandaging.

42 P: I wish there was something you could put in the eye.

43 A: What, what? like um

44 P: =see how it's all=

45 A: =Puffed up? Puffed out? (..) **Don't worry**. The swelling has really gone down a lot today.

46 P: Yeah. That's still there.

47 A: (..) which one? Which (…)

48 P: Down there see?(…)

49 A: Yes the swelling this side. (..) Mmm. (..) But have you been (.) um you know with the the apple biting?

50 P: //Yeah yeah

51 A: Jaw not anymore stiff?

52 P: //Not really

53 A: Not anymore painful when you want to chew?

54 P: //not really, no.

55 A: That's good. What about the left side?

56 P: //Yeah

57 A: Ok that's all good. Because um the last time I remember you saying

58 P: //that I can't put 2 fingers in my mouth

59 A: //too painful (.) because of that left side surgery. But now it's, (.) your right side is done as well now so (.) Im hoping that you're able to eat well, not just//

60 P: //Yeah, oh no I'm fine, don't have any trouble. Just too much food! Foods in the bed! **Food food**! *((laughs))*

61 A: I'll just clear out this table for you.

When Andrea is satisfied that there is no deterioration in the strength and mobility of the jaw, she moves to reassure the patient in turn 57 by recalling the previous conversation to which the patient confers and goes on to admit that she was fine, subsequently returning to a light-hearted frame by joking about food and invoking laughter from both parties. The collaborative interruptions indicated by the overlapping speech in this interchange serve to demonstrate solidarity (Goldberg, 1990), rather than interference, which enhances rapport between nurse and patient. Rapport is also strengthened by reassurance from the RN. Andrea then marks the end of that interchange in turn 61 using a falling tone, returning to a clinical frame, clearing up the tissues and medication left on the patient's bedside table from the procedure.

The smooth interweaving of rapport building strategies with clinical related discourse demonstrated by these experienced RNs, can be compared to interactions by a less experienced RN, where less conversational synchrony is evident.

Rapport by a less experienced nurse. According to Benner's (1984) theory, nurses with less experience (as compared to expert nurses) have a smaller repertoire of emotional responses and intuition that act as informative and guiding cues, shaping not only clinical know-how, but emotional involvement with patients and

their families. Analysis of authentic interactions by the nurse with three years' postgraduate experience (Jenny) demonstrates efforts at rapport building through the use of humour and reassurance; however, this occurs less frequently with much less small talk as compared to the experienced nurses. Jenny does engage in light hearted banter with her patients but at times misses their humour, as understanding requires shared cultural background knowledge and lived experience (Gumperz, 1999). This is demonstrated in this extract where Jenny is admitting a patient and preparing them for surgery. The admission process is conducted using a computer where data is entered directly and the RN adheres closely to the admission questionnaire. Consequently, there is a tendency to attend more to the computer and less to the patient. Here Jenny commences the admission process and is working her way through the admission questions, confirming the patients name, correct spelling and date of birth.

1	Jenny:	All right *((name spoken))* can you tell me you full name please?
2	Patient:	*((full name given))*
3	J:	Your date of birth?
4	P	*((date of birth given))*
5	J:	Very good! Have a read the spelling right with the name, can you read it? Spelling, right? And your date of birth, good?
6	P:	Yes, same as New Zealand, Elvis Presley, *(inaudible)* and Pavlova! Some useless information for you!
7	J:	Sorry I can't get this kind of sense of humour! *((laughs))* All right and is the address correct?
8	P:	Yes *((inaudible))*

The patient's attempt at humour, stating that he was born the same year as the declaration of independence by New Zealand (although 100 years later), the same year that Elvis Presley was born and the year the Pavlova dessert was first created, fell flat. Jenny, being from a CALD background, did not know this cultural history

and therefore could not understand the humour. She saved face by admitting this and laughing, therefore keeping the interaction light hearted, but then immediately returned to the clinical task at hand. Jenny attempts to build rapport when the patient affirms the right address with the agreement tokens "good, very good", however it is not quite appropriate given that it is the type of response used for correct answers in a quiz, rather than the routine procedure of confirming the correctness of personal details.

9	J:	Good, very good! All right, and can you tell me what you having done today, just use your own words, explain to me.
10.	P:	I'm getting the left knee replacement. I had the right one done 2 May 2014 and I'm having the other one done today.
11	J:	**All right**! Did you have the last surgery done here or other hospital?
12	P:	Here.
13	J:	Good and have a look at the spelling right of the name. And you having left total knee replacement, right? And this your signature? And this signed by Dr *((surgeon's name))*? Alright, cool. And your other leg is good now? *((patient nodding to the affirmative in response to the questions))*
14	P:	Good, excellent.
15	J:	Fantastic all right, good. I've seen your blood test result all right, it's all in the normal range, all right, all good. And your ECG also very nice, all right.
16	P:	The ECG was what, OK?
17	J:	Everything was good alright, its normal, ECG. You can go home now!
18	P:	//For my aging condition! *((laughs))* Can I go home now?! *((laughs))*
19	J:	Let me go through all these questions with you all right.

In this excerpt Jenny is affiliating with the patient in turn 11, 13 and 15 by the agreement tokens "all right", "good" and so on by foregrounding her 'personal' voice (Mishler, 1984). By speaking in idiomatic and '*life-world'* (Mishler, 1984)

vernacular, affiliation is encouraged (O'Grady et al, 2013) and thereby Jenny is attempting to build rapport with the patient. She also reassures the patient in turns 15 and 17 by informing the patient that his blood tests and echocardiogram (ECG) are within healthy limits. Jenny extends this interchange by invoking a joking frame in turn 17 by telling the patient that he can now go home and therefore miss his surgery, which elicits laughter from both parties. The interaction appears to be on a positive footing despite Jenny not understanding the patient's earlier humour. Jenny returns immediately to her clinical goals with "all right" in turn 19 spoken with a downward inflection to reflect her intent as a statement rather than a question requiring the patient's consent. The admission process continues with Jenny inquiring if anything had caused the knee problem. The patient responds in a humorous frame to which Jenny responded, relating to the patient by extending the humour, taking a position opposing that typically taken by health professionals where more exercise is usually encouraged.

21	P:	Oh, well I've played a lot of golf in my time, done a lot of walking!
22	J:	All right. Too much exercise! (….) First question, are you allergic to anything?

Again, a quick return to clinical goals occurs with the primary focus being on the questionnaire and admission of the patient in a question and answer format. Although there is little interweaving of clinical and socio-relational discourse as evident with more experienced RNs, the limited use of humour does build rapport, allowing clinical goals to be pursued.

In another interchange between Jenny, an 11-year-old patient and her mother, the development of rapport and therefore the therapeutic relationship is placed in jeopardy. Jenny has a smaller repertoire of responses (as compared to the

more experienced participants) to deal with a potential disagreement between her opinion and that of the patient's mother, and in the process, prioritises the institution's protocol regarding allergy bands over the situation at hand. As Jenny is preparing the patient for the operating theatre, a difference develops about the need for an allergy band. The mother, who is a health professional and has strong health literacy, does not think that an allergy band is required for her daughter; however, Jenny is adamant that she should apply one all the same. The extract begins with Jenny's attempts to affiliate with the patient by reassuring her that she won't feel any pain when the anaesthetist cannulates her with the intravenous needle, and that her veins are very good, meaning that the anaesthetist will be able to insert the needle quickly and with no problem. By using idiomatic and young people's vernacular in turn 4, "cool, cool", Jenny is again attempting to relate to the patient; however, the patient is more interested in the television program she is watching and the attempts at rapport fall flat. Furthermore, Jenny's exclamation of "very good girl" (when the child gives her date of birth) is more appropriate for a very young girl than an 11-year-old. Jenny alternates between talking directly to the patient and her mother, who is attentive.

1	Jenny:	All right the Dr ordered emla patch for her all right. This going to numb your skin and when the doctor put a needle in you won't feel anything all right, yes. So, can I have a look at your hand please? Yes, your veins **very good,** yeah, good! Can you just tell me your full name please? *((girl tells name))* Can you tell me your date of birth please *((girl gives DOB))* Good! Very good girl! Are you allergic to anything?
2	Patient:	latex
3	Mum:	**No**, just say no. She is not anaphylactic to anything.
4	J:	All right cool, cool, great all right (….) so the latex cause...?
5	M:	It causes dermatitis.

6 J: Just a little bit dermatitis. Might just put an allergy for her just in case, yes and notify the theatre about this latex. It's better just in case.

7 Mum: *((anaesthetist's first name))* knows about it. Last time it caused her problems but *((anaesthetist's first name))* and I discussed it//

Jenny's initial response is reminiscent of Schön's (1983) '*technical rationality*' in that she focuses on the protocol for allergies, (an allergy band on the patient and notification of the operating theatre) despite the additional qualifying information that the mother provides. Jenny does acknowledge the minimal reaction in turn 6 by hedging "just a little dermatitis" and "might" in reference to applying the allergy band; however, in line with Benner's theory, she tends to focus on rules and protocols and prioritises the biomedical agenda over the patient's situation. The mother re-emphasises that there is no need for this, referring to the anaesthetist's first name, thus indicating a close personal relationship, stating they had discussed it and they had concluded there was no concern regarding latex exposure. The RN's 'face' is threatened and she moves to regain control by interrupting the mother. She emphasises her reasoning with a loud voice, "**because"**, to explain her reasoning in relation to theatre equipment containing latex, albeit with a flustered response. Jenny's and the mother's abilities, position and 'face' are threatened, as is the rapport-building process. The mother's immediate rebuttal maintains her position that she does not think an allergy band is necessary.

8 J: //**because** some of the (.) you know the theatre equipment like like stuff contains latex and when doctor touch you don't want this, you know, rash stuff so better contact theatre…change ID band.

9 Mum: We will watch the emla gel because she had it once before and it caused the reaction but *((anaesthetist's first name))* and I discussed it, you know the anaesthetist, and we agreed that we will try it again, yeah//

10 J: //All right the patch, yeah all right this one not sure, it's the sticky stuff or the contains the latex//

Jenny again interrupts the mother but this time is starting to repair and reposition her argument and save 'face' in turn 10 using agreement tokens "all right" and "yeah", surmising that any reaction to the emla patch could be due either to the adhesive or latex. The mother also moves to save '*face*', and like Jenny, acknowledges that they do not know what the cause of any skin reaction might be.

11	Mum:	//no no no, not too sure what caused it.
12	J:	//yeah sometimes the sticky stuff cause irritation if on too long you know can cause the skin irritation but yes just let us know if anything happen, if you feel itchy or stuff just let us know all right? The other hand dear? *((silent a few seconds while putting the patch on)) I've* got contact dermatitis so it's *((inaudible))* the lifestyle.
13	Mum:	It's annoying.
14	J:	It is, especially for the hospital staff. Ok I'll come back, might sneak into the theatre, steal some pillow for you all right! *((laughs))*

Rapport building with the mother is re-established as Jenny continues to support their now aligned belief that adhesive can sometimes cause skin reactions if left on too long. This way she is attempting to relate to the mother through mutual agreement. Jenny then moves to align their respective 'life worlds' (Mishler, 1984) by acknowledging that she also gets contact dermatitis which has an impact on her role as a nurse with the need to wear gloves. Despite the indications of technical rationality identified earlier, these moves by Jenny indicate a capacity to '*reflect-in-action*' (Schön, 1983) therefore indicating that she is not entirely rigid in her approach. A positive footing (Goffman, 1974) is re-established with the mother's acknowledgement that this must be annoying. Jenny extends on this and attempts to affiliate with the mother using a final humorous and light hearted comment before she leaves the room that she might "sneak in" and "steal" a pillow for the patient (acknowledging an earlier observation that a pillow is missing off the bed).

The use of a 'personal' voice (Mishler, 1984) and everyday language helps to re-establish the tentative rapport building.

Conclusion

Discourse analysis of naturally occurring interactions between CALD RNs and their patients makes evident the strategic interactional work that builds rapport with patients. It provides evidence of how rapport is built. The hallmarks of a higher level of communicative expertise demonstrated by more experienced RNs include the ability to smoothly and expertly interweave between different frames to achieve clinical and rapport building goals during patient care, foregrounding their personal identity over their professional identity, maintaining the patient's positive face, therefore maintaining the relationship on a positive footing. Rapport is successfully built and clearly demonstrated in synchronous conversation and the exchange of humour from both parties. Strategies that are used include humour, small talk, reassurance and the use of colloquial forms of English to affiliate with the patient's 'life world' through a 'personal' voice (Mishler, 1984) as illustrated in Figure 5.

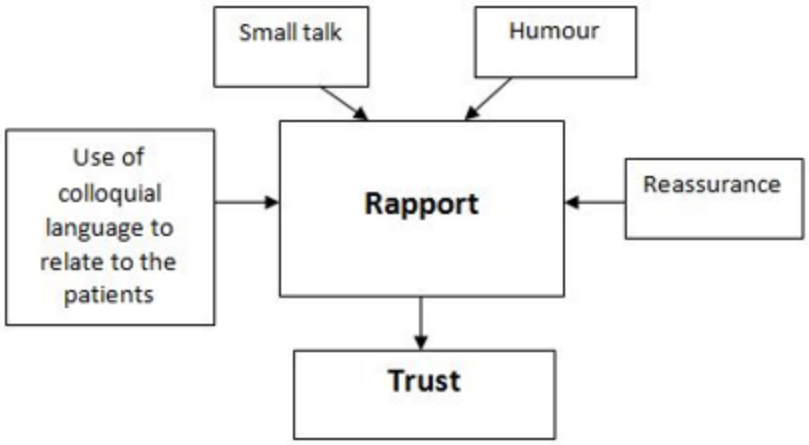


Figure 5: Strategies that build rapport

These strategies are used less frequently with less experience, and there is more focus on achieving clinical goals. It must also be acknowledged that while a comparison is made in this paper to demonstrate the consequences of rapport on an interaction, the less experienced RN (Jenny) is at a disadvantage when compared to the other RNs. Not only does she have less experience as an RN, she has also been working in Australia for a shorter length of time and her communication and language skills are therefore less 'socialized'. Furthermore, the setting in which she is working does not provide the opportunity and benefit of getting to know patients over several shifts that a ward setting allows. This lack of history and familiarity with patients would therefore limit the capacity to build rapport.

The communicative competence of less experienced RNs may be enhanced through education, highlighting the strategies and ways expert RNs build rapport with their patients by showing how these strategies are interwoven and how socio-relational and clinical goals are achieved. This way, discourse analysis has much to offer professional development and practice. Through discussing and reflecting on discourse analytical findings, education programmes can be developed to support novice CALD RNs by expanding their repertoire of communicative resources that can be used in practice. Enhancing communication skills strengthens professional practice, and therefore the provision of safer patient care.

Acknowledgements

The authors would like to thank the participants and patients who took part in this project, as well as the hospital managers who allowed the project to go ahead.

Funding

This project was conducted with the financial support of an Australian Postgraduate Award.

Appendix 1: Transcription symbols used

(.) seconds of silence.

Bold indicates the emphasis to the words given by the speaker.
// indicates overlapping speech.
= latching of one speaker's utterance with the next speaker's utterance with not. discernible silence between them.
(( )) double parentheses mark descriptions of events or what is happening during a period of silence.

Interlude

The accomplishment of rapport and the strategies used by each of the RNs were discussed in Chapter Five. Varying levels of expertise demonstrated in the data were explained by Benner's (1984) and Schön's (1983) theoretical models. Both focal themes of empathy and rapport are important elements of quality nursing care which impact on patient satisfaction and health outcomes (Hamilton & Woodward-Kron, 2010). These themes are also important elements in delivering patient education that results in greater patient self-efficacy (Virtanen, Leino-Kilpi, Salantera, 2007). Patient education is the third focal theme that emerged from discourse analysis of communication between the participating RNs and their patients, and has important implications for patient safety, self-management of clinical symptoms and quality of life. Chapter Six provides a case study that demonstrates patient education that incorporates empowering discourse while clinical tasks are being attended to. An empowering approach to patient education includes the patient as an active partner and promotes self-efficacy in the management of their health condition.

Note: the reference list has been included with this chapter as the journal that published this paper (Patient Education and Counselling) had a numbered reference style.

Chapter 6

The interactional consequences of 'empowering discourse' in intercultural patient education

Abstract

Objective: Patient education is an important part of nurses' roles; however the inconsistent quality of communication skills, including those of registered nurses (RNs) from culturally and linguistically diverse (CALD) backgrounds, risk patient safety. Empowerment in patient education has been found to influence patients' self-efficacy and participation in decision-making. Discourse analysis of a whole interaction is used in this paper to trace the consequences of patient education where empowering discourse is displayed by an RN from a CALD background.

Methods: Ethnographic techniques of participant observation and audio recordings of naturally occurring interactions between nurses from CALD backgrounds and their patients were conducted and analysed using interactional sociolinguistic (IS) and theme oriented discourse analytic approaches.

Results: The interactional consequences of the nurse's empowering approach are readily observable in the data. The RN addresses the patient's education needs through a respectful encounter that illustrates the patient's active involvement.

Conclusion: Examining the interactional consequences of empowering discourse demonstrates its effectiveness, and illustrates how empowering behaviour can be integrated into patient education, thus offering an alternative to traditional approaches.

Practical implications: Greater awareness of how to use empowering discourse will offer an alternative and consistent approach that enables nurses to facilitate patient-centred education.

Introduction

Patient education has long been recognised as an important part of a nurse's role, and this is increasingly so with an aging population, shorter hospital stays, and an increasing prevalence of chronic disease and complex health problems [1]. Patient education is a term that includes patient teaching, advice and information-giving, behaviour modification techniques, and involves two-way communication between the nurse and the patient aimed at maintaining or improving health or learning to cope with their condition [2, 3]. Whitehead [4] argues that the term 'health education' can be confusing because it refers both to formal health education programmes and the most predominant activity used in nursing practice: the provision of health-related information. Positive outcomes of patient education include an increase in knowledge, adherence to treatment plans, involvement in care, perceived control over health and illness, and behaviour change that enhances health related quality of life, therefore it is critical that health professionals have proficient communication skills to influence and enable this change [5].

While there has been significant research focusing on patient education since the 1980s, it remains very much on the agenda [1]. Evolving societal demands have seen a shift in perspective from disease orientated to health orientated education, and an expectation that patients participate in conversations about illnesses and treatments, and be more active in their healthcare, indicating that specific pedagogical competencies are necessary to provide effective patient

education [2]. However, a key finding from review of 32 articles focusing on conditional factors underpinning patient education [1] revealed that while nurses regarded patient education as a significant part of everyday practice, they did not necessarily know how to teach. The same review found that patient education was implemented on a random basis, and the quality of the patient education work was variable as it was guided more by personal knowledge and experience than based on research findings. Communication difficulties due to the patient's spoken language [6], or a lack of communication skills [3] were included among challenges to the provision of patient education, as well as heavy workloads and limited time, variable factual and pedagogical knowledge and experience of individual nurses, a lack of resources or managerial support, and uncertainty regarding role boundaries with other health professionals [7, 1, 8, 6].

The migration of health professionals from diverse cultural and linguistic backgrounds (CALD) have been important in meeting Australia's workforce shortage [9], however there have also been concerns regarding the management of clinical communication skills, as adaptation to communication, cultural and social approaches of a new country have been found to be difficult for many registered nurses (RNs) from CALD backgrounds [10, 11]. There may be safety risks for patients who are not educated effectively about self-care and management of health problems and the prevention of complications [3], and effective communication skills are therefore important for maintaining patient safety. Empowerment in patient education [12] is a model that has been used increasingly in recent years as education offered with this approach has been found to influence patients' self-efficacy, quality of life and participation in decision-making [13].

Funnel et al. [12, p. 38] conceptualize 'empowerment' in patient education as an approach that enables patients to 'take charge of their health through recognition and promotion of individual strengths, informed choices, and personal goals'. This approach views patients as experts on their own lives, and as equal and active partners in their healthcare. It differs significantly from traditional and didactic forms of patient education where health professionals are represented as the expert, the patient as a passive recipient, failing to account for the person in their social context [12]. The concept of empowerment was further developed into a model for patient education, made up of seven dimensions [14, 15]:

- *Bio-physiological* – patients have sufficient knowledge of the physiological signs and symptoms and feel they can control these symptoms;
- *Functional* - patients are able to take control of their situation and daily activities, and function in a manner they wish;
- *Cognitive* – patients have sufficient knowledge of the health problem and can use that knowledge to improve their health, or have the ability to access and evaluate new knowledge;
- *Social* – meaningful social contacts and interactions are maintained despite the health problem, and patients feel support when attempting to control their problem;
- *Experiential* – patients are able to use their past experiences to control their health problem;
- *Ethical* – patients feel unique, respected, and valued and believes that the care they are receiving ensures their wellbeing;
- *Economic* – patients are able to manage their care financially, and are able to afford technical aids and other support.

A metasummary of 'empowering discourse' in patient education found very few studies dealing with methods of empowerment in nurse-patient discourse, therefore more research examining discourse in whole interactions is needed [16] in order to analyse situated language. Observing sequential patterns and social actions within sequences in everyday nurse-patient interactions explicates the consequences to various approaches used. Furthermore, minimal research on naturally occurring nurse/patient interactions with nurses from CALD backgrounds has been conducted [17, 18]. In this paper, discourse analysis of an entire interaction is used to trace the consequences of patient education where empowering discourse is displayed by an RN from a CALD background. Greater awareness of how to use empowering discourse will offer alternative approaches to the more prescriptive and didactic methods often used in patient education.

Methods

Ethnographic techniques of participant observation and audio recordings of naturally occurring interactions between nurses from CALD backgrounds and their patients were conducted in an acute care hospital in Sydney, Australia. Field notes were made directly following the observations to document the contextual background of the interactions, for example, the ward setting, type of surgery, procedures the nurses were conducting and non-verbal communication that occurred. These notes, as well as the first author's experience as a registered nurse, assisted the understanding of the conversations [17] that were conducted as part of routine nursing care.

The focus on patient education in this paper is part of a larger project examining intercultural communication between nurses from CALD backgrounds and their patients. Four RNs from various cultural and linguistic backgrounds

(China, Philippines, Iran and Zimbabwe) volunteered to participate in the project; however, the interactions from only one of the RNs are used in this paper as clear examples of empowering discourse are displayed.

Approval for the study was given by the Macquarie University Human Research Ethics Committee and the hospital concerned, and written consent was provided by the RNs and patients who participated voluntarily in the research. Participants were informed that they could withdraw at any time without consequence. Pseudonyms are used to protect participant identities.

Audio-recordings of the nurse-patient conversations were transcribed verbatim and relevant sections of these transcripts were analysed using interactional sociolinguistic (IS) and theme oriented discourse analytic approaches [19, 20]. Both of these approaches offer comprehensive ways of analysing workplace interactions, enabling a better understanding of sociocultural influences that underpin intercultural nurse-patient interactions. People draw on background knowledge and lived experience to frame interactions, thus enabling them to deduce meaning from the interactions [21]. Theme orientated discourse analysis [20] is the study of language-in-action in healthcare settings, and focuses on health content, how relationships are sustained, and the way talk is structured is examined. Furthermore, detailed features of talk that include lexical choice, intonation, topic control, and inferences made about 'what is going on' [22], shed light on interpretive processes and overall patterns of communication that emerge across a complete interaction. This enables a nuanced understanding of professional and intercultural communication [21].

The analysis required repeated listening of the audio-recordings and reviewing of the transcriptions to examine the content and look for prosodic cues

such as intonation, pauses, and word stress. This was followed by marking the transcripts using the conventions outlined in the appendix. The transcripts were then examined for 'focal' themes or professional concerns as well as 'analytic' themes that are informed by linguistic and sociocultural concepts [22]. Examples include 'contextualisation cues' (intonation, word stress, rhythm, accents, speed of speech) [21]; social identity and 'face' (how a person presents themselves in everyday interactions) [22]. Focal themes that were identified include 'rapport building', 'displaying empathy' and 'patient education', each discussed elsewhere. Analytic themes are used in this paper to examine a complete interaction and trace the interactional consequences of patient education that displays empowering discourse.

Results

A number of dimensions of empowering discourse [14, 15] are displayed throughout the following interaction which serves to enhance the patient's problem-solving abilities and demonstrates rapport and effective communication between the RN and the patient. While Betty has a CALD background, she has worked in Australia for 10 years and demonstrates effective communication skills, integrating rapport building and empathic statements while giving information to a patient who has had a cholecystectomy prior to her discharge. The excerpt begins with Betty indicating her plan to remove the patient's intravenous cannula that had been used to maintain the patient's hydration during surgery. While she does this, Betty engages in small talk with the patient, inquiring about the time of day the patient's friend will collect her and the logistics involved. Small talk serves to build/maintain rapport with the patient [23], and also distracts them from the procedure at hand. The conversation then moves on to the recent conversation the

patient had with the surgeon regarding her medication and instructions related to her wound dressing.

1	Betty:	Ok. All right, so what I'll do is just take off the cannula. Just take off the cannula. And what time is your friend?
2	Patient:	She's on the way. She said, I said, she said *((patient's name))*, when I get here I'll//
3	B:	//Oh OK, she can come up to the ward.
4	Pt:	//Yeah, I told her that. =
5	B:	=and parking is not too bad on the weekend.
6	Pt:	Oh, that's good. *((Seconds of silence while Betty sets up to remove the cannula))*
7	B:	Are you going home on antibiotics?
8	Pt:	No, he said just take pain killers.
9	B:	Ok. What pain killers have you got, he said//
10	Pt:	//Well just Panadol. **
11	B:	Yeah, and he doesn't want us to touch the bandages, just to leave those on?
12	Pt:	Till Friday.
13	B:	Till Friday, OK.
14	Pt:	=and then he said to take them off on Friday.
15	B:	Ok, and just wash normally?
16	Pt:	Yeah, I guess so, that's right.
17	B:	Your pillow?
18	Pt:	I know, sometimes they don't tell you much!
19	B:	((*laughing))* That's all right. So, I'll take this off. It doesn't hurt, but the sticky bits hurt more than the actually.

In this excerpt the patient displays *bio-physiological* and *functional* dimensions of empowering behaviour in relation to understanding her medication and wound management by paraphrasing the conversation with the doctor, as well as implying limitations in the doctor's information-giving. It is not clear whether Betty has not had the opportunity to read the surgeon's discharge instructions for the patient, or is checking whether the patient understands her post-discharge management. According to Kelo et al. [14], nurses who demonstrate empowering behaviour verify patient learning and encourage patient participation through asking questions, as exemplified by Betty in turns 10, 12 and 16.

In noting the limited nature of her doctor's instructions, the patient moves to show solidarity and alignment with the RN in turn 18 by using the pronoun 'they'

to refer collectively to doctors. Betty supports this relationship-building with laughter, however she also demonstrates her professionalism by not extending the conversation, rather directing the topic back to the task at hand.

20 Pt: //yes, I know, that's right, I can imagine.
21 B: Because you have stickies up here.
22 Pt: Yeah OK ((….))
23 B: and no nausea since the?
24 Pt: =**No**, which is great, thank you. So they did the job those, which is good.
25 B: //yeah, those tablets//
26 Pt: //Were they Stemetil?=
27 B: =No not Stemetil. It's called Ondansetron.
28 Pt: Right, great//.
29 B: //for nausea
30 Pt: Ok it's a good one.
31 B: //very good stuff. They normally give it to people on chemo because of the nausea they get.
32 Pt: //Oh of course. Yeah. It's horrible.
33 B: Also after anaesthetic you tend to get similar bad nausea.

Again, Betty engages with the patient while she is removing the dressing, asking about the effectiveness of an antiemetic medication (to reduce nausea) given earlier. When the patient inquires about the name of the medication, Betty provides an explanation that links severe nausea after anaesthetic with that experienced by people on chemotherapy; this incidental education acknowledges the discomfort the patient had been in, attending to the *bio-physiological* dimension. The overlapping speech or collaborative interruptions evident in this interchange demonstrate solidarity rather than interference [24], and together with the agreement tokens from both parties (yeah, OK, right, great, of course), exhibit rapport between the RN and patient; the *social* dimension of empowering discourse. The patient acknowledges receipt of the education with further agreement tokens in turn 34. The patient clearly feels empowered to question further and reinforce her knowledge as evidenced by her follow-up 'why' questions below:

34 Pt: //right right. **Why** do they ask always, you know last night the doctor always asked me, did you pass wind, did you pass wind? (*((laughing))//*I was wondering **why**?

35 B: And in (.) because after you have had ahh (.) anaesthesia, it sort of paralyses the bowel movement.

36 Pt: //Ooh I see.

37 B: //The bowel you know, stops everything.

38 Pt: //Right.

39 B: //So if you have bowel motion you are passing wind.

40 Pt: //Right.

41 B: And you know, so that is one of the signs to see that everything is back to normal, the anaesthesia is off your system.

42 Pt: //Oh, ok that's good to know!

43 B: Yeah, I know it's a bit embarrassing, everyone asking about wind and ((*laughing*))

44 Pt: //I know, I know, that's right!

45 B: Normally if you are staying longer, they will be asking like have you opened your bowels today.

46 Pt: //That's right, exactly!

47 B: //because you are going home today so wind will be good enough, just to know there is some movement in the bowels.

48 Pt: //That's right, exactly.

49 B: Yeah, I know with some elderly people, they find it rather intrusive! *((Laughing))*

50 Pt Right, it **is** a bit em**barrassing**, but anyway I said, they have a purpose for asking, that's right but they hadn't told me the purpose.

51 B: =and some surgeons are strict, like if you haven't passed wind, they won't allow you to start eating=

52 Pt: =Oh right right.

53 B //Because sometimes you need to go back to theatre so they say don't eat until you have actually passed wind so that's why.

54 Pt: //Oh right right, ok right

The personal topics covered in this interaction, 'bowel motions' and 'passing wind', demonstrate the patient's ease with discussing bodily functions with Betty. It highlights the often taken-for-granted role that nurses have when it comes to discussing topics that are embarrassing, a sentiment that is recognized by Betty in turn 43 in an empathic display, and subsequently acknowledged by the patient in turn 50. Providing information about bodily functions in a way that treats the patient as valued and equal attends to the *bio-physiological, cognitive* and *ethical* dimensions. Betty is providing knowledge about physiological signs, enabling the patient to use that knowledge to understand her recovery. She is treating the patient

with respect and identifying her individual needs. The empowerment model however does not account for the psycho-emotional dimension of patient education where emotion is acknowledged and included in the discourse, as Betty does in turns 43 and 49 when she raises the topic of embarrassment.

Betty continues the education, turning the topic to the necessity to monitor passing of urine following an anaesthetic. At this point, the patient refers to numerous trips to the toilet overnight.

55	B:	//and then some worry about passing urine, if you have passed water because//** *((over talking and laughter))*
56	Pt:	I don't know why.
57	B:	=Did you have a drip though?
58	Pt:	Um I did, um no, did I?
59	B:	//I think you must have because you still have the cannula in, that's probably why.
60	Pt:	=Right.
61	B:	Yeah, it's just to make sure all systems are working before you go.
62	Pt:	//Oh fair enough. And um (.) I had um (.) what else? The drip and (.) what else did he say? Oh, and I had a cup of tea too.
63	B:	//yeah, a cup of tea and eating.
64	Pt:	//Because I had a cup of tea, normally I don't before I go to bed so sometimes that makes you go to the toilet too, but **50** times ** *((laughing))*
65:	B:	//well at least you got your exercise, 'cause it's good to keep moving!
66	Pt:	//that's right exactly! You are right, true.

The patient and Betty explore a number of reasons for the frequent toilet visits, the potential embarrassment allayed by the light-hearted nature of the interaction with the patient exaggerating the number of times in turn 64, and Betty pointing out the benefit of exercise in turn 65. Again, the *social* and *ethical* dimensions of empowerment are being attended to through light hearted talk and treating the patient as a valued individual. Providing information that links to daily function attends to the *cognitive* and *functional* dimensions of empowering discourse, enabling the patient to make sense of the experience. Betty attempts to return to the task at hand in turn 67, however the patient begins to talk about the referred pain

she has been experiencing in her shoulder and draws on the surgeon's explanation and her own reading; information that is new to Betty.

67	B:	That's all right. So, what I'll do is//
68	Pt:	//And he said the shoulder. It's still very painful, it's even more painful than **this**. He said it takes about 36 hours to settle down.
69	B:	//Oh.
70	Pt:	It's the gas that they put in.
71	B:	//Oh ok.
72	Pt:	He said it kind of goes around and that's what causes the pain, so it takes about 36 hours.
73	B:	=I didn't know about that, so I've learnt something there. 'Cause//
74	Pt:	//So this one too but this is not as bad as this one. *((referring to the suture line))*
75	B:	=Oh there you go. Because I have heard a few people complaining about that, what is the relationship between ** and//
76	Pt:	//That's right, I read about it, because I did my research before I came, on the internet, gall bladder search, and that was one of the things, you will be left with, a very very severe kind of painful shoulder.
77	B:	=Oh there you go.
78	Pt:	That's right. And at the moment because you can't kind of laugh, its very hurt, reminded me of when you have your appendectomy, you can't laugh either! *((laughs))*
79	B:	=Yes that's the same thing. So, that's //all good.
80	Pt:	//all good!
81	B:	So, you're all set, just print your discharge letter and you are done!

This interaction illustrates the *cognitive* and *experiential* dimensions as the patient draws on her reading and experience of pain from a previous surgery and uses it to make sense of her current pain experience. Empowering discourse is demonstrated again with the patient's confident interaction with the RN on a balanced and equal basis and is 'characterised by an appreciation of each other's expertise' [16, p. 144]. Betty openly acknowledges several times, learning something from the patient's explanations without defensiveness. Betty then signals completion of her task in turn 79, having removed the cannula while the discussion was taking place.

Discussion and Conclusion

Discussion. A review of studies of 'empowering discourse' involving RNs and patients by Virtanen et al. [16] found that both patients and RNs were active participants in selecting discourse topics aimed at exchanging information to help patients cope better with their situations. The patient's ability to self-manage is enhanced by the RN placing her expertise at the patient's disposal, thereby attending to bio-*physiological*, *functional* and *cognitive* dimensions. This interaction demonstrates parity in turn taking, topic control, and collaborative interruptions [22] indicating good rapport, thereby attending to the *social*, *experiential* and *ethical* dimensions of the empowerment model [14, 15]. While nurses frequently provide emotional support and empathy, this model does not include this psycho-emotional dimension. Analysis of this interaction suggests that a psycho-emotional dimension could be added to the empowering discourse model to describe moves by the RN to attend to emotional aspects of patient education (see turns 43, 49). Discourse analysis of this entire interaction has identified and demonstrated how elements of 'empowering discourse' are achieved. The consequences of this approach are evidenced by good rapport and the confident participation of the patient, who is clearly comfortable both to ask questions and discuss her prior knowledge.

All elements of 'empowering discourse' are displayed in this interaction with the exception of the economic element. The fact that the patient is attending a private hospital and therefore holds private insurance may mean that this element requires less attention than it would in other healthcare contexts.

Conclusion. Discourse analysis is used to examine the provision of patient education through a complete interaction between a patient and an RN from a

CALD background. While there have been concerns regarding the communicative competence of some RNs from CALD backgrounds, this analysis balances these concerns by demonstrating the effective communication skills used by this RN in achieving rapport and providing information.

Discourse analysis is limited by reliance on interpretive analytic procedures to deduce speakers' intent and listeners' interpretation [25]; however, this is mitigated through ethnographic techniques of participant observation, field notes and discussions with the participants to validate observations. Audio-recordings also enable repeated listening of the interactions to check interpretation of the transcripts.

The interactional consequences of the nurse's empowering approach are readily observable in the data, with the patient taking a very active role throughout the encounter. The patient demonstrates engagement with information offered by the nurse, and her moves to share medical details that she has researched herself are supported and acknowledged positively by the RN.

Examining the interactional consequences of 'empowering discourse' illustrates how empowering behaviour can be integrated into patient education, thus offering an alternative to traditional approaches. However, as Virtanen et al. [16] argue, it must be acknowledged that it is patients themselves who decide how empowered they are and what support they need. To use empowering discourse, nurses must take patients' levels of knowledge, abilities and values into account, but this is demanding of time and energy, and can be difficult in busy working environments. A tool that might be useful in achieving this form of patient education is a mnemonic that provides prompts to the various dimensions of

empowering discourse. This also accounts for the psycho-emotional aspects of patient education – BESt EFfECt:

Bio-physiological
Ethical
Social
t

Economic
Functional
f
Emotional
Cognitive
t

Demonstrating the interactional consequences of an empowering approach using this mnemonic may also be useful in nurse education generally, both to strengthen the communication awareness of RNs but also their skills in providing patient-centred education. It would be useful to evaluate this approach with further research.

Practice implications.

Encapsulating the key elements of 'empowering discourse' using a mnemonic such as BESt EFfECt provides a consistent approach to patient-centred education. Effective educators foster rapport with patients through empathic and respectful interactions, are knowledgeable and competent in answering questions and provide explanations regarding treatments that relate to their symptoms and experience. Empowering behaviour builds trusting nurse-patient relationships which underpins good patient education [5, 16].

I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

Acknowledgements: The authors would like to thank the participants and patients who took part in this project, as well as the hospital managers who allowed the project to go ahead.

Conflict of interest: None declared.

Funding: This project was conducted with the financial support of an Australian Postgraduate Award.

Appendix 1: Transcription symbols used

(.) seconds of silence.
Bold indicates the emphasis to the words given by the speaker.
// indicates overlapping speech.
= latching of one speaker's utterance with the next speaker's utterance with no discernible silence between them.
(( )) double parentheses mark descriptions of events or what is happening during a period of silence.
** Inaudible

References

[1] F. Friberg, G. Vigdis, A-L. Bergh, Nurses' patient-education work: conditional factors - an integrative review, J Nurs Manag. 20 (2012) 170-6. doi:10.1111/j.1365-2834.2011.01367.x

[2] A-L. Bergh, E. Persson, J. Karlsson, F. Friberg, Registered nurses' perceptions of conditions for patient education - focusing on aspects of competence, Scandinavian J Caring Sci. 28 (2013) 523-6. doi:10.111/scs.12077

[3] F. Golaghaie, F. Bastani, Cross-cultural adaptation of a patient-based tool for evaluating the implementation of patient education in acute care settings, Patient Educ Couns. 96 (2014) 210-5. doi:10.1016/j.pec.2014.05.017

[4] D. Whitehead, Health education, behaviour change and social psychology: Nursing's contribution to health promotion? J Adv Nurs. 34 (2001) 632-0.

[5] M. Svavarsdóttir, A. Sigurdardottir, A. Steinsbekk, What is a good educator? A qualitative study on the perspective of individuals with coronary heart disease. European J Card Nurs. (2015) 1-9. doi:10.1177/1474515115618569

[6] C.K. Lee, I.F.K. Lee, Preoperative patient teaching: the practice and perceptions among surgical ward nurses, J Clin Nurs. 22 (2012) 2551–1. doi:10.1111/j.1365-2702.2012.04345.x

[7] A-L. Bergh, J. Karlsson, E. Persson, F. Friberg, Registered nurses' perceptions of conditions for patient education – focusing on organisational, environmental and professional cooperation aspects, J Nurs Manag. 20 (2012) 758-0. doi:10.1111/j.1365-2834.2012.01460.x

[8] R. Ghorbani, M. Soleimani, M-R. Zeinali, M. Davaji, Iranian nurses and nursing students' attitudes on barriers and facilitators to patient education: A survey study, Nurs Ed in Prac. 14 (2014) 551-6. doi:http://dx.doi.org/10.1016/j.nepr.2014.06.003

[9] S.O. Ohr. V. Parker, S. Jeong, T. Joyce, Migration of nurses in Australia: Where and why? Australian J Primary Health. 16 (2010) 17-4.

[10] V. Chiang, B.L. Crickmore, Improving English proficiency of post-graduate international nursing students seeking further qualifications and continuing education in foreign countries, The J Cont Educ in Nurs. 40 (2009) 329-6.

[11] L. Lum, P. Dowedoff, P. Bradley, J. Kerekes, J. Valeo, Challenges in Oral Communication for Internationally Educated Nurses, J transcult nurs. 26 (2015) 83–1. doi:10.1177/1043659614524792

[12] M. Funnell, R. Anderson, M. Arnold, P. Barr, M. Donnelly, P. Johnson, ... N. White, Empowerment: An idea whose time has come in diabetes education, The Diabetes Educ. 17 (1991) 37-1. doi:10.1177/014572179101700108

[13] H. Virtanen, H. Leino-Kilpi, S. Salantera, Empowering discourse in patient education, Patient Educ Couns, 66 (2007). 140-6. doi:10.1016/j.pec.2006.12.010

[14] M. Kelo, M. Martikainen, E. Eriksson, Patient education of children and their families: nurses' experiences, Pediatric Nurs, 39 (2013) 71-9.

[15] H. Leino-Kilpi, E. Luoto, J. Katajisto, Elements of empowerment and MS patients, J Neurosci Nurs. 30 (1998) 116-3.

[16] H. Virtanen, H. Leino-Kilpi, S. Salantera, Empowering discourse in patient education, Patient Educ Couns. 66 (2007) 140-6. doi:10.1016/j.pec.2006.12.010

[17] G. Major, J. Holmes, How Do Nurses Describe Health Care Procedures?: Analysing Nurse-patient Interaction in a Hospital Ward, The Australian J Adv Nurs. 25 (2008) 58-70.

[18] F. O'Neill, From language classroom to clinical context: The role of language and culture in communication for nurses using English as a second language, Intern J Nurs Stud. 48 (2011) 1120-8.

[19] J. J. Gumperz, Discourse Strategies, Cambridge University Press, New York, 1982.

[20] C. Roberts, S. Sarangi, Theme-orientated discourse analysis of medical encounters, Med Educ. 39 (2005) 632-40.

[21] J. J. Gumperz, On interctional sociolinguistic method, in S. Sarangi & C. Roberts (Eds.), Talk, Work & Institutional Order: Discourse in medical, mediation & management settings, Mouton de Gruyter, Berlin, 1999, pp.453-71.

[22] E. Goffman, Frame analysis: An essay on the organisation of experience, Blackwell, Oxford, 1974.

[23] R. Woodward-Kron,J. Hamilton, I. Rischin, Managing cultural differences, diversity and the dodgy: Overseas-born students' perspectives of clinical communication in Australia, Focus on Health Prof Educ. 9 (2007) 30-3.

[24] J. Goldberg, Interrupting the discourse on interruptions: An analysis in terms of relationally neutral, power and rapport oriented acts, J Pragmatics. 14 (1990) 883-3.

[25] C. Gordon, Gumperz and Interactional Sociolinguistics, in R. Wodak, B. Jonstone, P. Kerswill (Eds.), The SAGE Handbook of Sociolinguistics, London, Sage, 2011, pp. 67-84.

Interlude

The case study provided in Chapter Six demonstrated the consequences of empowering discourse in an interaction between Betty and her patient while clinical tasks were being attended to. Empathy and rapport were demonstrated throughout the interaction and the patient was engaged and involved in the management of her condition. The elements of empowering discourse foster a therapeutic relationship that underpins good patient education, resulting in greater patient self-efficacy and health outcomes. However, while patient education has long been considered to be an important part of nurses' roles, there are a number of difficulties with providing education to patients, for example, nurses having low levels of pedagogical training, resulting in a random provision of education with variable quality. When an empowering approach is taken by the RN, the patient is more engaged and interactive in the educational encounter. Chapter Seven examines various health information encounters that are mapped against cognitive learning theories. When elements drawn from these theories are implemented, the consequences on the interaction are observable in the data.

Chapter 7

Supporting patient education using schema theory: a discourse analysis

Abstract

Background: While patient education has long been an important part nurses' roles in patient care, research has found difficulties providing patient education. Sound subject matter knowledge is not enough to give effective and meaningful instruction; pedagogical knowledge is also needed, with an understanding of different aspects of learning processes to inform our teaching methods. Despite the importance of patient education, many nurses do not necessarily have pedagogical knowledge regarding how to teach, how to support patient's learning and how to consciously implement strategies into patient education.

Aim: By understanding theories that explain how people learn better, and awareness of the consequences of different approaches to giving patient education, nurses can be better informed about how to structure their information-giving that will support patient learning.

Methods: Discourse analysis from an interactional sociolinguistic perspective is used to examine authentic nurse-patient health information encounters, mapped against cognitive learning theories, schema theory in particular.

Findings: The interactional consequences, when elements drawn from learning theories are implemented, are observable in the data.

Discussion: Strategies that support patients' learning include linking information to the patients' prior experience/knowledge, providing information that is relevant to them, and chunking information into unified themes while encouraging patients' active involvement through questioning and clarification of information.

Conclusion: Awareness of learning theories and strategies outlined in this paper can strengthen communication skills and assist health professionals to structure patient education that supports patients' learning, thereby enhancing patient safety.

Introduction and background

Patient education has long been considered by nurses as an important part of their role in patient care, and despite being the focus of many research studies over the last thirty years, it continues to attract attention (Friberg, Vigdis, & Bergh, 2012). Much of the research has focused on what nurses and doctors expected patients to know about their health, with the effectiveness of professionals' explanations regarding symptoms, interventions and management studied to a minor degree (Bergh, Persson, Karlsson, & Friberg, 2013). 'Patient education' is broadly defined as health related educational activities directed to patients (Friberg et al., 2012). Whitehead (2001) argues, however, that there is confusion regarding terminology as the term 'health education' may be used to refer to any educational activity including formal health education programmes and health promotion, but the most predominant activity used in nursing practice is the provision of health-related information. Bergh et al. (2013) define 'patient information' as one-way communication in conveying information, and suggest 'patient teaching' as a term to describe a two-way communication process. The term 'patient education' in this paper therefore refers to both these approaches (this distinction will be returned to later in this paper to explain the consequences of the different approaches taken) and is taken to mean the process of empowering, encouraging involvement in decision-making, and assisting the patient to gain knowledge, skills, attitudes and

behaviours related to their health problem through either informal information-giving or formal education programmes.

A review of 32 studies (Friberg et al., 2012) focusing on conditional factors that influence nurses' patient education work found the provision of patient education is impeded by limited pedagogical competence and uncertainty relating to the educational task. Many of the studies revealed that patient education was underpinned by an 'authority' model influenced by medical science which meant passing on information to patients, rather than a 'partnership' model where patient understanding is used as a starting point. Bergh et al. (2013) surveyed 842 nurses in Sweden across primary care, community care and hospital care settings and found that despite regarding patient education as important in daily work, nurses had low levels of pedagogical training, did not follow research in patient education, and few reported that they identified individual patients' need for knowledge and understanding of their health condition prior to providing education. Furthermore, nurses had difficulty knowing *how* to teach, the quality was variable and the provision of education was random and guided more by tacit knowledge than by research evidence (Bergh et al., 2013). Other research has found difficulties with patient education relating to communication difficulties and the language spoken (Golaghaie & Bastani, 2014; Lee & Lee, 2012), organisational factors such as limited time and a lack of managerial support, and uncertainty regarding role boundaries with other health professionals (Fitzpatrick & Hyde, 2005; Friberg et al., 2012; Ghorbani, Soleimani, Zeinali, & Davaji, 2014).

Educating patients about self-management of their condition and how to prevent complications is important for promoting patient safety (Golaghaie & Bastani, 2014), but effective communication skills are necessary to achieve this

(Xu, Shen, Bolstad, Covelli, & Torpey, 2010). The picture has become more complex with increasing cultural and linguistic (CALD) diversity of nurses in Australia (Ohr, Parker, Jeong, & Joyce, 2010) and the implications that this has for clinical communication skills (Chiang & Crickmore, 2009). Adaptation to sociocultural and communication approaches to a new country have been found to be more difficult for many registered nurses (RNs) than previously acknowledged (Lum, Dowedoff, Bradley, Kerekes, & Valeo, 2015), and differences in language and culture can cause misunderstandings that result in serious impacts on patient safety and health outcomes (Hamilton & Woodward-Kron, 2010).

Patient education is not a straight forward activity. As Yilmaz (2011) points out, sound subject matter knowledge is not enough to give effective and meaningful instruction; we also need pedagogical knowledge and an understanding of different aspects of learning processes, explained by theoretical perspectives to inform our teaching methods. There is a growing acknowledgement that patient education does not necessarily result in any modification to a patient's health related behaviour (Whitehead, 2001), however knowing how to provide education that is appropriate to the patient's needs, values and beliefs would encourage behaviour that manages or minimises their health problem. Bergh et al (2013) argue there is little research regarding *how* to determine what patients need to know, understanding *how* to support their learning and *how* to consciously implement strategies into patient education. Training and support in pedagogy and learning theories for nurses is required in primary care (Macdonald, Rogers, Blakeman, & Bower, 2008), and the same could be said for other areas or specialties in nursing. Education that is patient centred requires that nurses understand patients' reasoning and preferences to be able to support them in learning about their health/illness

(Bergh et al., 2013). For this reason, a better understanding of learning theories on the part of nurses, enhanced through the mapping of these theories to authentic interactions, might support more effective patient teaching and learning.

Discourse analysis can enable an understanding of what is happening within the communication process, particularly where people from various cultures are interacting, as it examines not only the practical aspects of communication such as speakers' choices of vocabulary, grammar, and intonation, but also how interactions are sequenced and how the content at each turn of talk is managed. Awareness of these factors can inform nursing practice and enhance communication skills. In this paper we use discourse analysis from an interactional sociolinguistic perspective to examine intercultural nurse-patient health information encounters mapped against cognitive learning theories.

Cognitive learning theories

There are a number of theories regarding orientations to learning, with behaviourism as a teacher centred instructional framework, to cognitive learning theories and constructivism where the locus of control is with the learner. Cognitive learning theories argue that learning involves a reorganisation of experiences that help the learner to make sense of the environment (Merriam & Caffarella, 1999; Yilmaz, 2011). Cognitive learning (also known as human information processing theory) and constructivism embrace learning as an active process; the learner is an active participant in the process of knowledge acquisition. The cognitive approach focuses on making new knowledge meaningful, helping learners to understand by structuring the content of the learning activity and linking new information to prior and current knowledge structures, therefore enabling the learner to make sense out of their experience (Merriam & Caffarella, 1999;

Ormrod, 1995; Yilmaz, 2011). Ausubel (1967, cited in Merriam & Caffarella, 1999, p.254) argued that 'learning is meaningful only when it can be related to concepts that already exist in a person's cognitive structure'. He proposed 'advance organisers' that prepare a person for learning through the structuring of new knowledge by linking it to the current cognitive structures (or schemata) of the learner. Examples of advance organisers include overviews, outlines, examples, analogies and thought-provoking questions (Ormrod, 1995).

Ausubel's work is an antecedent to more current research on schema theory (Merriam & Caffarella, 1999; Ormrod, 1995; Wilson & Anderson, 1986). This theory proposes that learners use prior knowledge or 'schemas' to organise, process and apply new information and experiences to those previously learned and experienced. Therefore, it is argued that instruction should be based on these schemas to be effective (Merriam & Caffarella, 1999; Ormrod, 1995; Wilson & Anderson, 1986; Yilmaz, 2011). Instruction is more effective when it begins with what a learner already knows, and teachers can assist by making connections between new and older knowledge (Ormrod, 1995). Discourse analysts also refer to the concept of 'knowledge schemas'; how expectations and interpretations about people, objects, events and settings in everyday life are informed by peoples' prior knowledge and past experience (Tannen & Wallat, 1993). While there are many learning theories that can be drawn from, cognitive learning theory (using schema theory in particular) is adopted in this paper as it fits closely with the concept of 'knowledge schemas' and the way in which patients make sense of their illness experience through the linking of new to prior knowledge and experience. By understanding theories that explain how people learn better, nurses can be better informed about how to structure their information-giving that will support patient

learning. This could be particularly useful to nurses from CALD backgrounds given their additional adjustment to new healthcare settings, and differences between new and old knowledge, values and beliefs.

The application of schema theory to patient education involves tailoring patient teaching to the needs, interest and experience of the patient in order for them to form links with prior knowledge, enabling them to form a bridge to learning the new information. Providing information that is *relevant* to their context and using a *unifying theme* to link new information to what is already known supports this 'bridge building' (for example linking times that new medication is to be taken with the schedule that current medication is taken). Furthermore, attending to the limits of attention by *emphasising important points* to be learned and *'chunking'* or organising information with similar themes together, enables a more coherent and unified presentation of subject matter that supports learning. If new knowledge cannot be linked easily to prior knowledge, then *using visual aids* (physical objects/models, diagrams, pictures) and *analogies* to familiar concepts and situations (taking out stiches is like unpicking a hem) can provide an alternative strategy (Ormrod, 1995). Encouraging patients to *ask questions* and *summarize* new information back to the educator assists them to become more active in their learning (Yilmaz, 2011). In the present study, excerpts of authentic interactions between RNs from CALD backgrounds and their patients are examined and mapped to schema theory to highlight how some of these strategies are used.

Methodology

Data collection. Data was drawn from naturally occurring interactions in an acute care hospital in Sydney, Australia, with ethnographic techniques that include participant observation and audio-recordings. Field notes were also taken to

describe the context of the interactions, for example the ward setting and type of surgery, the procedure being undertaken by the RN and any notable non-verbal interactions. Understanding of the socio-pragmatic meanings of the workplace (Major & Holmes, 2008) and knowledge of the hospital setting and nursing procedures were supported by the authors' experiences as health professionals.

The focus on patient education in this paper is part of a larger project examining intercultural communication between nurses from CALD backgrounds and their patients. Four RNs from CALD backgrounds (China, Zimbabwe, Iran and the Philippines) participated voluntarily. Their experience working in Australia range between 3 and 10 years, however all had worked as RNs in their home, and other countries, using English and their native languages prior to working in Australia. They had achieved the mandatory English language requirements to be registered in Australia.

Approval for the study was given by the Macquarie University Human Research Ethics Committee and the hospital concerned. Written consent was provided by the RNs and patients who participated voluntarily in the research. Participants were informed that they could withdraw at any time without consequence. Pseudonyms are used to protect participant identities.

Analysis. Interactional sociolinguistic (IS) and theme oriented discourse analytic approaches (Gumperz, 1982; Roberts & Sarangi, 2005) were used to analyse audio-recordings of nurse-patient conversations that had been transcribed verbatim; both approaches offering comprehensive methods for analysing nurse-patient interactions. Similarly to cognitive learning theories, IS incorporates background knowledge and lived experience that people invoke to frame moments in interaction, and draw from to infer meaning from the interaction (Gumperz, 1999).

Theme orientated discourse analysis (Roberts & Sarangi, 2005) builds on IS to examine interactions and language-in-action in healthcare settings. Consideration is given to health content as well as the way talk is structured (lexical choices, intonation, topic choice and control, and inferences that are made). These facilitate how meaning is negotiated and relationships are sustained. This highlights interpretive processes and overall patterns that emerge across an activity, allowing for a better understanding of professional and intercultural communication (Roberts & Sarangi, 2005).

The initial analysis involved repeated listening to the audio-recordings to examine the content, identify phases of the interaction, and look for 'contextualisation cues' such as intonation, pauses, word stress and expressions used to interpret events (Gumperz, 1999). The data was then transcribed using the transcription conventions outlined in the appendix. The whole interactions were then read and re-read to examine outcomes and identify focal themes (professional concerns) and analytic themes informed by linguistic and socio-cultural concepts, such as 'face' and how individuals present themselves in social interactions, and how talk is managed (Gumperz, 1999; Roberts & Sarangi, 2005). Focal themes that were identified, and discussed in separate papers, include 'rapport building' (in press), 'displaying empathy' (in press) and provision of empowering 'patient education' (Crawford, Roger & Candlin, 2017). Patient education is examined in this paper using discourse analysis of three different interactions from RNs of CALD backgrounds, with reference to cognitive learning theories and schemas in particular.

Findings and discussion

The first excerpt begins with RN Andrea providing discharge information for a patient who has had eye surgery. Andrea had been discussing the follow-up appointment with the surgeon and confirming the details on the discharge letter for the General Practitioner. Andrea then steers the conversation to the eye medication the patient is to apply at home. Patient teaching is evident as there is two way communication in the interaction (Bergh et al., 2013). The content is relevant to the patient as she is about to be discharged and will need to administer the medication herself.

28	Andrea	And then we've got a list of medications here//
29	Patient	=uh ha
30	A	//that you should put on like for example, Chloramphenicol ointment
31	Pt	//yes
32	A	//you apply on the right eye twice a day
33	Pt	=uh ha
34	A	=so has you know, Dr *** wants the eye ointment near the eye lid
35	Pt	//under the bottom
36	A	//under the bottom and a little bit inside the eye
37	Pt	OK.
38	A	=same as what I did last night when I removed the sutures and the eye patch,
39	Pt	=yes
40	A	if you remember.
41	Pt	//uh ha.

Key elements of schema theory are evident in this interaction. The patient's *active involvement* is evident with agreement tokens (yes, uh ha) and backchannel cues. The patient demonstrates *prior knowledge* of what Andrea is saying in turn 35 by completing the RNs instruction of where to apply eye ointment. Andrea builds on

this and supports the patient's learning by *linking her instruction to the patient's prior knowledge*: application of ointment she had done the previous night (turns 38 and 40) to which the patient readily acknowledges. Andrea then emphasises the word 'so' in turn 42 as a signal which serves to '*chunk' the information into a similar theme*: eye medication, but this time instructing her about eye drops.

42	A	**So** (.) this one is the prednisolone forte eye drop, this is an eye drop, not an ointment.
43	Pt	No
44	A	It's a steroid.
45	Pt	=Yep
46	A	You have to put it in your right eye, four times day.
47	Pt	//Uh ha
48	A	**So** I've given you at 7.30
49	Pt	=yep
50	A	=and you have to count 6 hours after that
51	Pt	=yep
52	A	and another 6 hours.
53	Pt	//every 6 hours.
54	A	Yes. **Now**, for you to be able to remember its easier when you go home, say (.) in the morning when you wake up
55	Pt	//take it with my Oxycontin
56	A	//yes take with your Oxycontin.
57	Pt	//I take that early in the morning
58	A	Yeah, together with your Predneferin you have it at say at 7, then again at 1, then have it again at 7 (.) at night and maybe about 11ish
59	Pt	//or earlier at 10 o'clock, yeah.
60	A	//yeah as long as you have 4 (.) 4 drops
61	Pt	//drops in my eye

Again, the patient's latched responses and agreement tokens indicate *active involvement* with the instruction and the *relevance of the content*. Similarly,

Andrea's agreement tokens and reiterating the patient's statements encourage the patient's active involvement in the conversation. Once again Andrea *links the education to the patient's prior learning* in turn 54, to which the patient quickly elaborates by connecting the application of eye drops to the times she has to take other medication. Andrea confirms this link and continues by outlining times when she recommends the patient apply the eye drops before reiterating and showing the patient the medication she had been talking about while using the full name.

62	A	//in your eye, and that is this one Predneferin forte.
63	Pt	//yeah, red corner on that one. And blue.
64	A	//and this is Chlorsig, blue one, this is the ointment.
65	Pt	//I've used Chlorsig a lot of times for my eye.
66	A	//Yes. This is only twice a day.
67	Pt	=Yeah
68	A	The ointment under the eye lid
69	Pt	//under the eye and a tiny bit in, yes.

Andrea clarifies the colour of the ointment she had discussed initially in turn 64 and shows it to the patient, reiterating the frequency of application in turn 66 to make sure the patient understands the medication regime. The patient demonstrates comprehension through agreement tokens, and makes links to prior knowledge by stating she is familiar with this ointment in turn 65, reiterating and elaborating Andrea's instruction by adding 'a tiny bit in' in turn 69. The elements of schema theory (tailoring relevant teaching to the patient's need, making links to prior knowledge, chunking or combining information with similar themes together and encouraging the patient's active involvement) are demonstrated with what appears to be a successful educational interaction, evidenced by the patient's ready acknowledgement and agreement tokens. These elements help to develop a plan/ memory based device that assist the patient to remember her medications.

In a different form of patient education, another RN (Betty) provides incidental education regarding the degree of mobility and length of time the patient has her catheter insitu, while fulfilling another patient care task; removing Patient Controlled Analgesia (PCA), a device often given to post-operative patients that allows them to inject small doses of pain relieving medication (analgesia) for the first day or two after surgery. The excerpt begins with Betty inviting the patient to take a final dose of medication before she disconnects the device. Betty uses 'every day' vernacular as a way of relating to the patient and building rapport. She continues to explain that along with disconnecting the PCA, the intravenous therapy (IV) line and oxygen is also disconnected.

1 Betty: You just want one more for the road (.) before I take it off? (…) All right? (...) And the good thing, the drip comes off and the oxygen comes off when that comes out.

2 Patient: Good.

Betty and the patient then discuss the overlap of oral analgesia she had been given with the removal of the PCA. Betty reassures the patient that she does not want to leave her without any pain relief and that Endone (oral analgesia) may be due after the physiotherapist's visit in turn 9.

9 B: Yeah, they will write you up for Endone and when I take this off the **physio** will come in (.) and then take you for a walk, give you a shower. And then maybe your endone will be due then **

10 Pt: Walk ** business but shower's all right ((*laughs nervously*))

11 B: I don't think he will take you walking too far 'cause you really haven't been up for long. Maybe just sitting up on your bed and

12 Pt: //cause remember my legs were very weak when he had me up before. First time wasn't too bad but the second time wasn't too good.

13 B: Mmm OK, all right. See how it goes. Let me take this off so it's easier to walk around. *((Silence while Betty disconnects device and tubing))*

14 Pt: Catheter?

15 B: Now the catheter stays in because you haven't been walking. So we keep the catheter in until you are sort of good on your feet then we can take that out.

16 Pt: Thought you said that was coming out today?

17 B: No not today. *((silence while removes PCA and IV pole))*

18 P: ** feel so weak

19 B: Yeah that's because you have been lying down for long, yeah. It will be good to sit up. If you walk then sit up for lunch (.) be good (.) then get back to bed.

20 Pt: //what time is it?

21 B: Just before 11 (.) 20 to 11. So, by the time you are done with the shower and everything should be near lunchtime

22 Pt: //don't want to sit up too long!

23 B: //No no no, 20 or 30 minutes

24 Pt: Yeah, its amazing how time**. Been lying all day.

25: B: Bit by bit they come out. And after your shower you can put on your own nightie, you might feel better with own clothes.

This interaction is a two-way communication that demonstrates some elements of schema theory with discussion that is *relevant and meaningful* to the patient. Furthermore, the patient demonstrates *active engagement* as evident through the frequent questions and comments; however, there is no linking to prior knowledge, a key aspect of schema theory. Nevertheless, the patient clearly feels comfortable asking questions and clarifying her understanding, evidenced by the relatively even turn-taking between Betty and the patient. However, Betty takes longer turns to address the patient's needs; answering her questions directly, providing reassurance and explaining as to why the patient is feeling the way she does, thereby demonstrating active listening.

By way of comparison, the following excerpt is an example of didactic information-giving that demonstrates a largely one-way communication without any of the elements of schema theory. In this interaction, RN Jenny is providing

discharge information to a patient who has had a colonoscopy, and commences with the medications the patient is to take.

1	Jenny:	First (..) we got medication, the Augmentin and Ciproxin, this antibiotics. So have you (…) Can I get the box?
2	Patient:	I've only got the script.
3	J:	Oh, the script. Yep yep so there is a pharmacy on the ground floor. Ah the Metopozil is 3 times a day for 7 days all right? And also the Targin, that's 2 times a day, it's a kind of slow release pain relief medication. So you can take in the morning and again in the afternoon and you can take Targin any time from now; I don't think they give you in the theatre
4	Pt:	=So that's just purely pain relief that one?
5	J:	=Yes slow release pain relief, just long lasting one all right. Just and also, I suggest you can use Panadol with them together, brings a good effect with you all right. And ah (..)
6	Pt:	//So if there is no pain I don't have to take it?
7	J:	=I suggest, I suggest with you today when you don't have any pain still I would take it, because the anaesthetic still works on you, all right. You don't feel anything but after anaesthetic wear off, pain will come back and this medication will kick in timely, all right. And (.) because of this surgery, I would say could be painful so better to follow the doctors so, especially the targin 2 times a day just for * otherwise you discomfort all right. And you going to see the surgeon in the rooms 6 weeks. Have you booked appointment with him yet?
8	Pt:	//Not yet no, I believe he was coming here to see me today.
9	J:	=Yes so yeah book the time and he will tell you what he find all right all this stuff so we just waiting. You had a colonoscopy *** this stuff so with this surgery you could have a problem with the bowel movement, could be a little bit painful yes so you need to increase like a fibre diet, drink more water you know, help you have a good bowel movement.
10	Pt:	//I don't have any formed stool anyway!
11	J:	//Oh you don't have like a formed stool anyway, always like a very loose one, oh that's fine, not big issue I'm just worried. Actually, I'm sorry about that, yeah sometime formed one could be a bit painful when you push it but its fine for you. So, um you might expect like difficult to concentrate because you had a general anaesthetic so just drink plenty of fluids, all right help you flush it out. And um it is expected the bleeding all right you will see when you open the bowel or in the urinate you probably see some drips in the toilet all right it is expected but should be small

amount, not like a big bleed yeah yeah. If you see big bleeding stuff call the doctor, let him aware and go to emergency, can't do anything about this all right yes if it happen. Eat and drink as normal no restriction on eating but do not eat too heavy today because you had the general anaesthetic. Might make you sick or stuff, make you discomfort, and don't eat too spicy stuff all right, might affect your bowel, make it a bit painful. And ah just need you in the next 24 hours, no driving all right because general anaesthetic might affect your judgement during the driving, put your life at risk. And also, do not carry carry or lifting any heavy things because put more pressure over your tummy and increase the chance of the bleeding all right and no alcohol in the next 24 hours

12 Pt: //I don't drink anyway!

13 J: All right, good girl you! And tonight, if you have any problem you can call us. Before 8 o'clock you can ring the first number, after 8 o'clock you can ring the second number all right yes. If you have any question? ((*patient nodding and saying 'mmm' throughout*))

Through this interaction, Jenny 'holds the floor' in terms of conversation exchange, demonstrated through her extended turns of talk which provide little opportunity for the patient to be actively engaged, to ask questions or to clarify the information. While it might be expected that an RN would take extended turns while educating a patient, particularly prior to discharge, in this case the education was provided in a hurried manner with little opportunity for involvement as demonstrated by the brevity of her turns. The patient does ask occasional questions, make some comments, and acknowledge receipt with agreement tokens (nodding and saying 'mmm'), however, there is no checking the patient's understanding by the RN. There is no evidence of linking to prior knowledge; finding out and using the patient's knowledge as a starting point for the education as demonstrated in turns 9 to 11 and again in turn 12. Rather, Jenny is focusing on the discharge papers which contain a list of items to be discussed with the patient, and adopts a 'tick sheet' approach to the education which is far from being patient centred. While the content might be relevant to the patient, the limits of attention are not attended to

and the information with similar themes are not 'chunked' together or presented in a meaningful way. For example, emphasising key words to such as antibiotic medication, pain medication, and dietary advice would 'chunk' that information together to enable easier comprehension. Rather, it is a running commentary that would be difficult to follow and absorb, with no efforts to check the patients understands throughout the interaction. While the offer of asking questions was made on completion of the 'list', the conversation continued with small talk while Jenny took the patient's vital signs. The patient's comments and non-verbal agreement tokens indicate that she was able to follow the flow of the conversation; however, how well she would be able to recall the points made regarding postoperative recovery is questionable. By understanding and utilising strategies such as linking new information to the patient's prior knowledge and experience, chunking information into more comprehendible sub-themes and encouraging the patient's active involvement, the RN would have been able to support this patient's learning more effectively.

Conclusion

Discourse analysis was used to examine patient education provided through authentic nurse-patient interactions. Different approaches to patient education were mapped against cognitive learning theories and schemas in particular. The interactional consequences, when elements drawn from these theories are implemented, are clearly observable in the data. While cognitive learning theory is not the only learning theory that may be used, its key tenets such as linking information to the patients' experience/knowledge, providing information that is relevant, chunking information into unified themes while encouraging patients' active involvement through questioning and clarification of information, are all

strategies that support learning. Analysis of authentic interactions by RNs from CALD backgrounds demonstrates application of these strategies across a spectrum of proficiency that might be representative of the capability of RNs for whom English is their original language. This may counter blanket assumptions that are sometimes made regarding the communication skills of RNs from CALD backgrounds. Awareness of learning theories and strategies outlined in this paper can strengthen communication skills and assist health professionals', particularly those from CALD backgrounds, to structure patient education that supports patients' learning, thereby enhancing patient safety and health outcomes.

Acknowledgements: The authors would like to thank the participants and patients who took part in this project, as well as the hospital managers who allowed the project to go ahead.

Conflict of interest: None declared.

Funding: This project was conducted with the financial support of an Australian Postgraduate Award.

Appendix 1: Transcription symbols used

(.)	seconds of silence.
Bold	indicates the emphasis to the words given by the speaker.
//	indicates overlapping speech.
=	latching of one speaker's utterance with the next speaker's utterance with no discernible silence between them.
(( ))	double parentheses mark descriptions of events or what is happening during a period of silence.
**	Inaudible

Chapter 8

Conclusion

This chapter draws this thesis to a close and argues for the practical relevance of the findings in suggesting how discourse analysis might complement current forms of clinical communication training for nurses, those from CALD backgrounds in particular. The results of this study, an exploration of interactions between RNs of CALD backgrounds and their patients, demonstrates approaches and strategies that display empathy, develop rapport and provide empowering patient education. This thesis demonstrates the degrees of communicative competence of the participating RNs, serving to counter blanket assumptions that all RNs from CALD backgrounds may have communication difficulties related to their use of English.

The approaches and strategies identified in this study could be used as central elements of evidence-based communication training programmes. This chapter draws from these results to outline a training workshop that incorporates discourse analytical skills and may be used for professional development programmes, undergraduate nursing programmes and English language workshops for health professionals. By explicating the consequences of different approaches to communication, and highlighting various strategies that develop therapeutic relationships, we can build on nurses' knowledge about how to approach various communication encounters. For example, by being aware of, and knowing how to use strategies that build rapport with a new patient, the RN will know to use small talk, colloquialisms and seek to find commonalities with the patient that foregrounds the nurse's 'life world' (Mishler, 1984) over their status as a health

professional, and thereby identify on an equal level with the patient. The focal themes of empathy, rapport and patient education were derived empirically from the data through theme-oriented discourse analysis of transcripts of naturally occurring interactions, and form the basis of the proposed model. The connections between these focal themes are explained below.

Focal themes of the study

Empathy, an important aspect of therapeutic interventions, underpins the development of rapport. Rapport is developed, maintained or diminished by communication through processes that are interactive, co-constructed and iterative. Empathy and rapport-building permeate therapeutic clinical communication (Leahy & Walsh, 2008; Norfolk, Birdi, & Walsh, 2007; O'Grady, 2011; Seccareccia et al., 2015), as they have a direct impact on patients' health outcomes and are considered important by both patients and health professionals (Hamilton & Woodward-Kron, 2010). Patients' health outcomes are also impacted by the quality of patient education as an increase in knowledge leads to increased involvement in care, an increased sense of control over health and illness, increased adherence to treatment plans and behaviour change that enhances the patient's quality of life (Svavarsdottir, Sigurdardottir, & Steinsbekk, 2015). Empathy and rapport facilitate the provision of empowering patient education that supports the active involvement and self-efficacy of patients in managing their health condition (Virtanen, Leino-Kilpi, & Salantera, 2007). However, analysis of participant interviews in phase one of this study found that the provision of empathic care and the development of rapport was difficult if the nurse participants were feeling vulnerable and experiencing difficult adjustment to the workplace. These focal themes therefore

form the basis of the proposed clinical communication training workshops that incorporate discourse analysis. By analysing the discourse of authentic interactions, we can highlight the consequences of various communication approaches, and provide strategies that enhance therapeutic communication (Roberts & Sarangi, 2005), thereby assisting adjustment to new work settings. This in turn will support the provision of empathic care, the development of rapport, and the provision of empowering patient education that underpins the provision of patient-centred care, and enhances patient safety.

A review of current communication training programmes

It was argued in the introductory chapter of this thesis that communication training of nurses often relies on skills and competency based approaches, with little focus on socio-cultural or historical contexts of many healthcare encounters. Often this form of communication training occurs through the discussion of abstract issues such as non-verbal communication, or using a scenario that is based on common encounters in the health-care setting such as assessing a patient or dealing with aggressive behaviour by a patient. Role plays are commonly utilised and focus on situations such as giving bad news or dealing with aggressive behaviour, using exemplar statements that are provided by the educators, for example, 'I can see you are upset' which may not suit all situations. Phrases and responses given as exemplars can be useful for responding to some situations; however, they can also be reductionist and not be applicable to a variety of contexts, or suit the complexity of many nurse-patient interactions in a stressful health environment. While role play is recognised as a successful form of experiential learning, this thesis argues that discourse analysis of authentic interactions that accounts for contextual factors

can complement, or provide an alternative to this form of learning, and broaden the perspective and awareness of the learners. It is proposed that learners themselves analyse the transcripts of authentic interactions following an introduction to discourse analytical techniques.

Understanding the consequences to diverse communication approaches, and knowing techniques and strategies that impact positively on interactions, strengthens the ability of nurses to communicate in a wider range of circumstances. Furthermore, access to transcribed interactions enables detailed analysis and close observations through the slowing down of talk (Roberts & Sarangi, 2005); not possible with real-time observation of role-play. Therefore, it is suggested that the application of discourse analytical techniques can deepen learners' understanding of clinical communication and sharpen their reflective skills. Incorporation of discourse analysis in the teaching of clinical communication in various heath disciplines has been suggested and utilised in the past as outlined below.

Precedents for discourse analysis in clinical communication training

A nursing curriculum that integrated discourse analysis of transcribed interactions for pre-registration and professional development programmes was developed by Candlin (1995) to highlight important aspects of communicative expertise in the context of health assessment. It was proposed that this comprehensive curriculum should span three semesters and start broadly by introducing the students to values, beliefs and legal/ethical issues in a multicultural society. In subsequent semesters, students could be introduced to communication practices drawn from authentic data before they be required to collect their own

data from clinical placements, enabling them to analyse and reflect on their own practice.

A model that includes discourse analysis of expert communication in challenging interactions between General Practitioners (GPs) and their patients was developed by O'Grady (2011) for the teaching curriculum of clinical communication for GPs. The model incorporated joint analysis by both the educators and trainees. Discourse analytic techniques were used to analyse authentic video-recorded consultations that had been submitted to the Royal Australian College of General Practitioners. The communication of empathy was used as an example in the model, which incorporated a transcribed interaction that illustrated empathy in action with outcomes of a therapeutic relationship. In this interaction, the GP's 'empathic responses go beyond the stocks of pre-conceptualised phrases that circulate in discussions and appear in training texts' (O'Grady, 2011, pp. 309,310). This serves to highlight the complexity of interactions in real world settings, but also increases awareness of strategies that may be utilized to enhance therapeutic relationships in GP consultations.

Leahy and Walsh (2008) introduced discourse analysis into the undergraduate training for speech-language pathology students, as well as continuing professional development programmes for practicing speech-language pathologists. This curriculum enabled students to examine their own and others' interactions, and the impacts of diverse communication styles on the interaction. During tutorial sessions, students examined transcriptions of therapy sessions to identify how rapport is built with the client, how power is manifest between the professional and the client, and the subsequent impact this has on the interaction.

The analysis of transcribed interactional data complemented case discussions and role play to enhance the problem-solving of professional issues.

Finally, discourse analysis using conversation analytic (CA) techniques was incorporated in an undergraduate dietician programme to exhibit expert history taking practice (Tapsell, 2000). Analysts using CA focus on participants' overtly lexicalised conversational strategies, rather than how interlocutors interpret indirect inferences, assuming shared inferences are taken for granted (Roberts & Sarangi, 1999). The context is not considered in the analysis, thereby differentiating CA from IS. Tapsell (2000) developed a communication curriculum that drew on results of a study that analysed the discourse of expert consultations within the profession of dieticians. He focused on the history-taking phase and provided transcripts to students that illustrated a co-constructed interview structure that enabled a comprehensive assessment of the patient's dietary history. By highlighting an approach to questioning that was integrated into a co-constructed, responsive and collaborative narrative, Tapsell was able to represent an alternative to the skills approach to teaching history-taking that used a fixed and inflexible questioning style. An evaluation of these methods found that students were subsequently able to co-construct history-taking that modelled this narrative structure, thereby hastening the learning process that would normally occur through a developing expertise in the profession.

With these earlier models in mind, I propose a model that complements the more traditional approaches to clinical communication training for nurses, those from CALD backgrounds in particular. This model may be used in undergraduate nursing programmes or for continuing professional development.

A proposed model for integrating discourse analysis into communication training for nurses.

This model is developed in consideration of cognitive learning theories that were described in Chapter Seven, and utilises reflective practice discussed in Chapter Five. Cognitive learning theories embrace the learner as an active participant in the learning experience, helping them understand the content of the activity by structuring and linking new information to prior knowledge structures, also known as 'knowledge schemas' (Merriam & Caffarella, 1999; Ormrod, 1995). This approach emphasizes both independent mental activity and socially interactive inquiry, where learners participate in experiential learning and reflective practice to construct new meaning that is personally relevant (Merriam & Caffarella, 1999). Prior knowledge and spontaneous, intuitive performance of communication can be brought to bear on case scenarios that are commonly experienced in the clinical setting, but often it is with discourse analysis that the tacit knowledge of communication is explicated and we become aware of strategies that we use.

Schön (1983) described reflection-in-action where professionals demonstrate the 'art' by which intuitive processes are used to manage situations where there might be conflict, instability or uncertainty. When there are difficult circumstances that a professional is trying to make sense of, they reflect on the understandings which surface as a result of the interaction, critique, restructure, and then embody the new understanding of the phenomena and change in the situation (Schön, 1983). The principles of cognitive learning theories and reflection underpin the training workshop that is proposed as an alternative or supplement to the skills-based approach commonly used in communication training. This

workshop uses the focal theme of rapport as an example; however, the same structure may be applied to other themes.

Rapport, as discussed in Chapter Five, is an important underpinning requirement of patient-centred care that is mutually accomplished by both the patient and the nurse. Discourse analysis provides evidence of how rapport is built by showing how the nurse's lexical choices, tone of voice, and topic control contribute to rapport-building. It also shows how these strategic choices foreground the nurse's identity in a way that aligns with the life world (Mishler, 1984) of the patient, thus serving to build rapport with them. By analysing the discourse of authentic interactions to focus on rapport-building, both educators and students are able to examine the complexity of clinical interactions and move beyond exemplar phrases that are often used. For example, by slowing down the talk in the interaction, students will be able to see the responses the RN has made to various situations, and observe the consequences to those responses (in terms of extending or limiting the interaction and the subsequent impact on rapport). These interactions therefore enable nurses to evaluate the effectiveness of strategies that are used, enhancing their understanding of the consequential nature of intercultural nurse-patient communication. Understanding discourse analytical techniques will also enable nurses to reflect-on-action and critically evaluate their own communicative practice.

While rapport is used in this example, educators might also follow a similar format and draw on transcriptions to focus on other communicative themes such as the accomplishment of empathy or the provision of patient education. This workshop addresses the shortcomings in the skills-based approach to communication training by including transcripts of authentic interactions that

students will be able to analyse following an introduction to discourse analytic techniques.

Teaching /learning focus: Accomplishment of rapport.

1. **Introduction.** Elicit students' ideas about rapport and what they do to accomplish this in their interactions. Reflect on their clinical practice and on situations where rapport had or had not been accomplished, both with people of similar and diverse cultural and language backgrounds.
2. **Theory.** Introduce and discuss basic analytical themes drawn from IS with examples from transcribed interactions. Encourage reflection regarding how the students use each of these themes in their own interactions, both socially with family and friends, and in their clinical practice. Discuss how communicative goals may be realised differently depending upon the cultural experiences/expectations of the interlocutors.
    - Face and facework (social relations and 'saving face' – both our own and the patients' through how direct or indirect to be, adjusting levels of formality/informality with terms used that indicate relative closeness, politeness strategies such as 'I think' when disagreeing, and use of modal verbs such as 'could' and 'would').
    - Social identity and shared ways of speaking or finding something in common (life world and connection as fellow human beings versus professional world that upholds the balance of power and knowledge with the health professional).
    - Interactive frames and footings that act as filters to trigger inferences about the context of the interaction (for example, an interaction may

shift between frames of 'having a chat', 'giving medical advice', or 'completing a procedure'. Footings describe the way relationships or alignments during an interaction can change, for example, having a chat may shift an interaction from a strained to a positive footing).

- Contextualisation cues that invoke the context that gives meaning to the conversation but are often culturally informed and can cause miscommunication.
    i. Intonation - explore intonation patterns in the authentic extracts being analysed and compare the contextualising functions (if any) that the students would associate with them. This highlights potential differences in interpretation that might otherwise be invisible and cause miscommunication.
    ii. Word stress and rhythm that might indicate the importance of a statement,
    iii. Pausing and linguistic cues such as 'so' (e.g. to indicate that the speaker might summarise the preceding discussion), 'well' and 'um' that might indicate a shift in topic or hesitation to find the right words.
- Turn taking and topic control (who 'holds the floor' in the conversation and controls the topics that are talked about – often by the dominant culture).

3. **Practical application.** Form students into groups to examine texts of transcribed authentic interactions and identify analytical themes that have

been introduced, focusing on the consequences of the interaction and the development of rapport in particular. One such example is provided below.

Example 1: Removal of a pump that provides the patient with pain relief, and preparing to assist the patient to transfer to the shower. The conversation starts with Betty asking where the patient's toiletries are kept.

1 Patient: I think on top of the drawers next to the bed there, in a grey bag.

2 Betty: Grey bag? Oh yeah. ((*collecting toiletries)*) that's all right ((*inaudible several seconds*))…do you want to have one more shot before I disconnect?=

3 P: =might may might do that, yeah=.

4 B: =Just one for the road! ((*laughs*))

5 P: Might be a good idea! Ta.

6 B: Ok. So after this comes off its um .endone (.) but you just have to ask for it. Might not offer it, you just//

7 P: //ok

8 B: (. . .) and the targin that I gave you, earlier, that will continue probably until you are discharged.

9 P: Ok. ((*Several seconds of silence while PCA is disconnected*))

10 B: They might want you to continue with the drip since your blood pressure is a bit low, isn't it?

11 P: Yeah

12 B: *((disconnecting PCA several seconds))* And did they say how long they want you to sit up for?

13 P: Umm (.) I think it is about 20 minutes

14 B: 20 minutes?

15 P: =Yeah, they have to check that one, I think it was 20 (…)

16 B: Oh well, so we'll do this and then I'll try and sit you up for lunch, I think it will be easier.

17 P: =Ok (..) sounds good (…)

18 B: Are you having visitors?

19 P: No, no, everyone is still in *((patient's town))*//

20 B: //*((patient's town))*.

21 P: =Yeah. My mum is coming next month to help.

27 B: All right (..) do you think you can, get you to stand up with the corset?

28 P: Ok (..) can I borrow a (.) face washer as well? *((inaudible/overtalking))*

29 B: I've got all that//

30 P: //oh good

31 B: ((*silent several seconds while corset is applied))* This might be old fashioned!

32 P: I need one!*((laughs))*

33 B: =tummy tuck!

34 P badly!

35 B: (….) Get a seat *((inaudible))* (…) so that you can reach the buzzer if you need me *((moving shower chair into position))*

After working through the transcript, each group is to present their analysis to the whole group, highlighting consequences in terms of the development of rapport. The tutor is to notice whether the group identifies analytical themes and the important role of small talk, humour, reassurance, as well as the ability to multitask by the RN as she accomplishes the development of rapport as well as the clinical task at hand. They might notice the turn of conversation and who controls the conversation, and contextualisation cues that are informed by the local sociocultural context. (For instance, in this case discuss the light-hearted joking frame that is invoked here, and who initiates the move into this frame. This patient is born and raised in Australia and seems happy to make a joke of her weight, which Betty picks up on and uses as a way of lessening what might otherwise be an awkward or embarrassing encounter. Note Betty's skill and familiarity with the Australian sociocultural context – an important point as nurses new to Australia might go away with the general conclusion that "it's fine to joke with patients about their weight". The use of the whole encounter helps us

to see how Betty picks up on cues that help her to gauge that a reference to 'tummy tuck' will be all right here where it might be disastrous in other contexts).

4. **Review and debrief.** Tutor to recap on analytical themes in the exemplar, and highlight strategies that are evident in the interactions, for example, use of small talk, humour, reassurance, and turn-taking. Bring attention to face, frames and contextualisation cues that might be culturally informed and raise the potential for misunderstandings. Discuss with the group as to how they found the exercise, what aspects most informed their awareness of communication and what they might include in their communicative repertoire.
5. **Reflection in action** – provide a case scenario for the students to role play, trying to enact strategies that had been highlighted in the previous exercise. Afterwards, reflect on tacit knowledge and what the students feel they already do in their communication.
6. **Reflection on action** – facilitate a discussion on the effectiveness of the strategies that were used and the consequences to the ensuing interaction. Reflect on strategies that might be adopted and how they might implement them in their work environments, particularly where diverse cultural groups are interacting.

By incorporating discourse analytic techniques and transcripts of authentic nurse-patient interactions into communication training for nurses, particularly for those from CALD backgrounds, we can support the adjustment process and socialisation to communication approaches in the Australian health-care setting.

Through engaging with transcripts from real-world practice, the nurses can observe the consequences to different approaches to communication, critique what others do, reflect in and on action and augment their repertoire of communicative approaches that they can then implement in various complex situations. The transcripts and analyses provided in the various chapters of this thesis provide a resource that might be drawn upon to conduct communication workshops that focus on themes that underpin therapeutic communication.

Conclusion

This project has set out to explore interactions in intercultural nurse-patient encounters in the Australian health-care setting. Chapter One sets the scene of this thesis, discussing and critiquing conceptions of culture, intercultural health communication and the traditional skills based approaches to clinical communication training. Chapter Two provided a broad introduction to linguistics frameworks and tools that provide an alternative way of analysing communication problems in nursing. The questions that were explored through two phases of data collection that are discussed in Chapters Three to Seven included:

- The approach that RNs from CALD backgrounds take to manage communicative encounters with their patients, and how these approaches align with the broad societal expectations from an Australian perspective.
- The forms of discourse or communication that are called upon to accomplish nursing tasks or actions and the accomplishment of therapeutic relationships with patients.

- The role that culture, discourse systems or membership in particular 'communities of practice' (Lave & Wenger, 1991) play for nurses from CALD backgrounds.

The participants in this study had been working in Australia for several years and consequently the forms of discourse and communication they displayed reflected the community of practice of the nursing profession in Australia more than what might be perceived as communication that is influenced by their country of origin. In the main, their approaches to communication with their patients were aligned with broad societal expectations from an Australian perspective. Most of the patients in this research site had grown up in Australia, reflecting the patient demographics of the hospital. Consequently, aligning with the broader societal expectations from an Australian perspective is effective. Had the patients been from other cultural backgrounds, there would still have been the expectation that communication adheres to the core 'values' of the Australian healthcare system (for example patient-centeredness), but there would have been other strategic adjustments necessary to achieve effective intercultural communication on an individual level.

To achieve the general alignment with Australian communication approaches demonstrated by the participants, a period of adjustment was required. The first phase of data collection (discussed in Chapter Three) involved interviews of the participant RNs where the central theme of adjustment was identified and was fundamental to the experiences of all the RNs. This theme interrelated with each of the other themes that emerged: professional experiences with communication, culturally informed ways of showing respect, displaying empathy,

and vulnerability. All the participants had discussed their adjustment to the Australian health-care setting, and how this impacted on the other interrelating themes. The participants also perceived that they had become successful in their communication with their patients. Understanding the experiences of the participants assisted with the second, ethnographic phase of the research as rapport with the participants had been established.

IS and theme-oriented discourse analysis of the participants' interactions with their patients in the second phase of the study produced three focal themes that underpin therapeutic relationships and promote patient-centred care and patient safety. The interactional consequences of diverse approaches to providing empathic care (Chapter Four), building of rapport (Chapter Five), and provision of empowering patient education (Chapter Six) that is informed by educational theory (Chapter Seven) has been shown in the data. These themes form the basis for the proposed evidence-based communication training workshop that aims to address the shortcomings, and provide an alternative to the skills-based approach to communication training that has been critiqued in Chapter One of this thesis. Different theories have been used for each theme/chapter to help explain what is going on in the interaction; each providing a spectrum of responses or framework that helps to identify the degree each theme is being played out. Ruusuvuori (2007), Shön (1983) and Benner (1984) described a spectrum of responses that demonstrated the degree of empathy and rapport-building occurring in the interactions discussed. Virtanen et al. (2007) and Ormrod (1995) described various dimensions/strategies that support patient education, which could be identified to varying degrees in interactions where patient education and information-giving

occur. The interactional consequences of the extent each theme is played out in the interaction could then be identified.

This study has made visible the effective communication approaches and strategies of experienced RNs from CALD backgrounds, as well as the consequences of less effective communication. Discourse analysis of this interactional data has made available for discussion the strategic, discursive choices that these RNs make, thus enabling resources for training workshops that support the development of the communicative competence of RNs who are new to the Australian health-care environment. In this way, discourse analysis makes a valuable contribution to nursing practice. This thesis has provided a resource that is of practical relevance for educators of communication training, which may be used not only for RNs of CALD backgrounds, but potentially for undergraduate and continuing professional development training of clinical communication.

Limitations and future research

Many of the limitations of this study have been discussed in the previous chapters, however I will reconsider some limitations in view of how they might be addressed in future research. The most apparent limitation is the small number of participants. The research site has a very culturally diverse workforce, however, prolonged advertising and attempts at snowballing to increase recruitment failed to attract more RNs to the study. Furthermore, two of the participants left the project prematurely thus limiting the data set further. While the methods used in this study do not allow for generalisations regarding the communicative competence of RNs from CALD backgrounds, a larger cohort of participants would have led to a greater diversity participants with a greater variety of interactions from different

areas of the hospital, providing a richer resource from which to analyse their interactions. A future research project might consider more hospital and/or community health sites thereby broadening the base from which to recruit participants.

As discussed earlier, the participants had lived and worked in Australia for an extended period. Had RNs who were relatively new to work in Australia elected to participate, the data might have demonstrated a greater range of communicative competence and led to quite different results. It is possible that RNs who are new to Australia feel vulnerable, and the research methods that involve participant observations for extended periods of time that focus on communication in the workplace, might have been considered too daunting. Naturally occurring data may not be readily accessible from this population, and future research may consider self-reported evidence gained from interviews and focus groups that may be considered less threatening. These qualitative findings may still offer some additional insights into how these participants go about developing therapeutic relationships with their patients. Despite the disadvantages associated with the lack of participants who were earlier in the stages of 'socialisation' into the new practice environment, the advantage is that these participants had years of experience and could therefore share their insights and experiences of their adjustment journey from a retrospective stance.

Given that one of the focal themes (and two of the chapters) report on patient education, a further limitation is the private hospital setting situated in a more affluent area of Sydney. The ability to afford private health care implies a generally higher socioeconomic status that might mean a higher level of health literacy and therefore empowerment to engage in patient education on a more equal

footing with the RNs. Had the research occurred in a public hospital setting with patients from lower socioeconomic backgrounds, the interactions in relation to patient education might have looked quite different.

The findings in this study are exploratory in nature, however they offer insights that may be explored in future research using alternative data collection methods and analyses, for example multimodal analysis of video recorded interactions may be less intrusive than participant observations. It may also enable analysis of elements of non-verbal communication easily missed if there is no opportunity to review the interaction from a visual standpoint. Alternative settings such as community health may enable interviewing of patients, particularly from CALD backgrounds, to gain their perception of what they find enhances therapeutic relationships and aids communication with health professionals.

References

Alexis, O., & Vydelingum, V. (2005). The experiences of overseas black and minority ethnic registered nurses in an English hospital. *Journal of Research in Nursing, 10*(4), 459-472.

Australian Bureau of Statistics. (2012). Australia's population by country of birth. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Products/84074889D69E738CCA257A5A00120A69?opendocument

Australian Burea of Statistics. (2013) 4102.0 - Australians ocial trends: Doctors and nurses. Retrieved 20 June, 2015, from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features20April+2013#p7

Australian Health Practitioner Regulation Agency. (2015) Registration process. Retrieved 17 June 2015, from http://www.ahpra.gov.au/Registration/Registration-Process/Overseas-Practitioners.aspx

Australian Institute of Health and Welfare. (2012). Australia's health 2012. Retrieved from http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422169

Australian Nursing and Midwifery Council. (2006). National competency standards. Retrieved from www.anmc.org.au

Baillie, L. (1996). A phenomenological study of the nature of empathy. *Journal of Advanced Nursing, 24*(6), 1300-1308. doi:10.1111/j.1365-2648.1996.tb01038.x

Bateson, G. (1955). A theory of play and fantasy. *Psychiatric Research Reports, 2,* 39-51.

Bell, K. (2009). 'If it almost kills you that means it's working? Cultual models of chemotherapy expressed in a cancer support group. *Social science and medicine, 68,* 169-176.

Belcher, M. and L. K. Jones (2009) Graduate nurses' experience of developing trust in the nurse-patient relationship. *Contemporary nurse, 31*(2), 142-152.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park: Addison Wesley.

Bergh, A. l., Karlsson, J., Persson, E., & Friberg, F. (2012). Registered nurses' perceptions of conditions for patient education – focusing on organisational, environmental and professional cooperation aspects. *Journal of Nursing Management, 20*(6), 758-770. doi:10.1111/j.1365-2834.2012.01460.x

Bergh, A. l., Persson, E., Karlsson, J., & Friberg, F. (2013). Registered nurses' perceptions of conditions for patient education - focusing on aspects of competence. *Scandinavian Journal of Caring Sciences, 28*, 523-536. doi:10.111/scs.12077

Blommaert, J. (2010). *The sociolinguistics of globalisation*. Cambridge: Cambridge University Press.

Bramley, L., & Matiti, M. (2014). How does it really feel to be in my shoes? Patients' experiences of compassion within nursing care and their perceptions of developing compassionate nurses. *Journal of Clinical Nursing, 23*(19-20), 2790-2799. doi:10.1111/jocn.12537

Burns, R. B. (2000). *Introduction to research methods* (4th ed.). Frenchs Forest, NSW: Longman/Pearson Education.

Candlin, S. (1995a). *Towards excellence in nursing: An analysis of the discourse of nurses and patients in the context of health assessments.* (Doctor of Philosophy), Lancaster University, Lancaster, UK.

Candlin, S. (1995b). Transcultural issues in nurse patient communication. *Geriaction, 13*(7), 28-33.

Candlin, S. (1999). *Discourse and behaviour change.* Paper presented at the AILA Congress, Tokyo.

Candlin, S. (2002). *Making meaning out of experience: the nursing perspective*. Paper presented at the BAAL Conference: Colloquium on health communication.

Candlin, C. N., & Candlin, S. (2003) Healthcare communication: A problematic site for applied linguistics research. *Annual Review of Applied Linguistics, 23*, 134-154. DOI: 10.1017/S0267190503000230

Candlin, S. & Roger, P. (2013). *Communication and professional relationships in healthcare practice.* Bristol, UK: Equinox.

Chang, C. L., Park, B. K., & Kim, S. S. (2013). Conversational analysis of medical discourse in rehabilitation: A study in Korea. *The Journal of Spinal Cord Medicine, 36*(1), 24-30. doi:10.1179/2045772312Y.0000000051

Chiang, V., & Crickmore, B. L. (2009). Improving English proficiency of post-graduate international nursing students seeking further qualifications and continuing education in foreign countries. *The Journal of Continuing Education in Nursing, 40*(7), 329-336.

Cioffi, R. N. J. (2003). Communicating with culturally and linguistically diverse patients in an acute care setting: nurses' experiences. *International Journal of Nursing Studies, 40*(3), 299-306.

Coffin, C., Lillis, T., & O'Halloran, K. (Eds.). (2010). *Applied linguistics methods: A reader*. Milton Keynes, UK: The Open University/Routledge.

Collins, S., Peters, S., & Watt, I. (2011). Medical communication. In J. Simpson (Ed.), *The Routledge Handbook of Applied Linguistics* (pp. 96-110). Abington, UK: Rougledge.

Cordella, M., & Musgrave, S. (2009) Oral communication skills of international medical graduates: Assessing empathy in discourse. *Communication and Medicine, 6*(2), 129-142.

Coupland, J., J. Robinson and N. Coupland, N (1994) Frame negotiation in doctor-elderly patient consulations. *Discourse and Society, 5*(1), 89-124.

Couser, G. (2007) Twelve tips for developing training progrms for international medical graduates. *Medical Teacher, 29*(5), 427-430. DOI: 10.1080/01421590701317843

Crawford, T. (2011). *What are the language needs of nursing students for whom English is a second language, so that appropriate teaching/learning strategies can be identified which will assist them to successfully complete the Bachelor of Nursing programme and become effective and safe practitioners?* Unpublished postgraduate certificate dissertation, Macquarie University, Australia.

Crawford, T. & Candlin, S. (2012). Investigating the language needs of culturally and linguistically diverse nursing students to assist their completion of the bachelor of nursing programme to become safe and effective practitioners. *Nurse Education Today, 33*, 796-801.

Crawford, T., & Candlin, S. (2013). Investigating the language needs of culturally and linguistically diverse nursing students to assist their completion of the

bachelor of nursing programme to become safe and effective practitioners. *Nurse Education Today, 33*(8), 796-801. doi:10.1016/j.nedt.2012.03.005

Crawford, T., Roger, P. & Candlin, S. (2017). The interactional consequences of 'empowering discourse' in intercultural patient education. *Patient Education and Counselling, 100*(3) 495-500. **doi:** 10.1016/j.pec.2016.09.017

Croker, R. A. (2009). An introduction to qualitative research. In J. Heigham & R. A. Croker (Eds.), *Qualitative research in applied linguistics: A practical introduction*. Houndmills, UK: Palgrave Macmillan.

Cunico, L., Sartori, R., Marognolli, O., & Meneghini, A. M. (2012). Developing empathy in nursing students: a cohort longitudinal study. *Journal of Clinical Nursing, 21*(13,14), 2016-2025. doi:10.1111/j.1365-2702.2012.04105.x

Dahm, M. & Yates, L. (2014). English in the workplace: Doing patient-centred care in medical communication. *TESOL Canada Journal, 30*(7), 21.

Dahm, M., Yates, L., Ogden, K., Rooney, K. & Sheldon, B. (2015). Enhancing international medical graduates' communication: The contribution of applied linguistics. *Medical Education, 49*,828-237.

Deegan, J., & Simkin, K. (2010). Expert to novice: experiences of professional adaptation reported by non-English speaking nurses in Australia. *Australian Journal of Advanced Nursing, 27*(3), 31-37.

Denzin, N., & Lincoln, Y. (2005). Introduction: The discipline and practice of qualitative research. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 1-32). Thousand Oaks, CA: Sage.

Dörnyei, Z. (2007). *Research Methods in Applied Linguistics*. Oxford: Oxford University Press.

Fiscella, K. & Frankel, R. (2000). Overcoming cultural barriers: International medical graduates in the United States. *Journal of the American Medical Association, 284*(13), 1751.

Fitzpatrick, E., & Hyde, A. (2005). What characterizes the 'usual' preoperative education in clinical contexts? *Nurse Health Science, 7,* 251-258.

Flickinger, T. E., S. Saha, D. Roter, P.T. Korthuis, V. Sharp, J.Cohn . . . M.C. Beach (2015) Respecting patients is associated with more patient-centered communication behaviors in clinical encounters. *Patient education and counseling, 99,* 250-255. doi:http://dx.doi.org/10.1016/j.pec.2015.08.020

Frankel, R. M. (1995). Emotion and the physician-patient relationship. *Motivation and Emotion, 19*(3), 163-173.

Friberg, F., Vigdis, G., & Bergh, A.-L. (2012). Nurses' patient-education work: conditional factors - an integrative review. *Journal of Nursing Management, 20,* 170-186. doi:10.1111/j.1365-2834.2011.01367.x

Funnell, M., Anderson, R., Arnold, M., Barr, P., Donnelly, M., Johnson, P., . . . White, N. (1991). Empowerment: An idea whose time has come in diabetes education. *The Diabetes Educator, 17,* 37-41. doi:10.1177/014572179101700108

Gallois, C. (2003). Reconciliation through communication in intercultural encounters: potential or peril? *Journal of Communication, 53,* 5-15.

Gee, J. P. (2011). *An introduction to discourse analysis: theory and method* (3rd ed.). New York: Routledge.

Gerrish, K. (2001). The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers. *Journal of Advanced Nursing, 33*(5), 566-574.

Gerrish, K. (2011). Methodological challenges in qualitative research. *Nurse Researcher, 19*(1), 4-5.

Ghorbani, R., Soleimani, M., Zeinali, M.-R., & Davaji, M. (2014). Iranian nurses and nursing students' attitudes on barriers and facilitators to patient education: A survey study. *Nurse education in practice, 14*(5), 551-556. doi:http://dx.doi.org/10.1016/j.nepr.2014.06.003

Gibbs, G. (2007). *Analyzing Qualitative Data*. London: Sage.

Gobet, F. and P. Chassy (2008) Towards an alternative to Benner's theory of expert intuition in nursing: A discussion paper. *International Journal of Nursing Studies, 45*, 129-139.

Goffman, E. (1974). *Frame analysis: An essay on the organisation of experience.* Oxford:Blackwell.

Golaghaie, F., & Bastani, F. (2014). Cross-cultural adaptation of a patient-based tool for evaluating the implementation of patient education in acute care settings. *Patient education and counseling, 96*, 210-215. doi:10.1016/j.pec.2014.05.017

Goldberg, J. (1990) Interrupting the discourse on interruptions: An analysis in terms of relationally neutral, power and rapport oriented acts. *Journal of Pragmatics, 14*, 883-903.

Gordon, C. (2011). Gumperz and interactional sociolinguistics. In R. Wodak, B. Jonstone, & P. Kerswill (Eds.), *The SAGE Handbook of Sociolinguistics* (pp. 67-84). London: Sage.

Grant, J., & Luxford, Y. (2011). 'Culture is a big term isn't it?': An analysis of child and family health nurses' understanding of culture and intercultural understanding. *Health Sociology Review, 20*(1), 16-27.

1Press.

Gumperz, J. J. (1999). On interctional sociolinguistic method. In S. Sarangi & C. Roberts (Eds.), *Talk, Work & Institutional Order: Discourse in medical, mediation & management settings.* Berlin: Mouton de Gruyter.

Guttman, M. S. (2004). Increasing the linguistic competence of the nurse with limited English proficiency. *The Journal of Continuing Education in Nursing, 35*(6), 264-269.

Hall, M. (2001) Trust in physicians and medical institutions: What is it, can it be measured, and does it matter? *Milbank Quarterly, 79*(4), 613-639.

Hall, P., Keely, E., Dojeiji, S., Buszewski, A. & Marks, M. (2009). Communication skills, cultural challenges and individual support: Challenges of international medical graduates in a Canadian healthcare environment. *Medical Teacher, 26*(2), 120-125.

Hamilton, J., & Woodward-Kron, R. (2010). Developing cultural awareness and intercultural communication through multimedia: A case study from medicine and the health sciences. *System, 38*(4), 560-568.

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.). London: Routledge.

Harvey, K. J., Brown, B., Crawford, P., Macfarlane, A., & McPerson, A. (2007). 'Am I normal?': Teenagers, sexual health and the internet. *Social science and medicine, 65,* 771-781.

Hearnden, M. (2008). Coping with differences in culture and communication in healthcare. *Nursing Standard, 23*(11), 49-58.

Heritage, J., & Maynard, D. W. (Eds.). (2006). *Communication in medical care: Interaction between primary medical care and patients*. Cambridge: Cambridge University Press.

Heritage, J., Robinson, J., Elliott, M., Bechett, M., & Wilkes, M. (2007). 'Reducing patients' unmet concerns in primary care: the difference one word can make. *Journal of General Inerntal Medicine, 22*(10), 1429-1433.

Hoekje, B. J. (2007) Medical discourse and ESP courses for international medical graduates (IMGS). *English for Specific Purposes 26,* 327-343. DOI: 10.1016/j.esp.2006.09.002

Holliday, A. (2010). Analysing qualitative data. In B. Paltridge & A. Phakiti (Eds.), *Continuum companion to rsearch methods in applied linguistics*. London: Continuum.

Holliday, A. (2012). Culture, communication, context and power. In J. Jackson (Ed.), *The Routledge handbook of language and intercultural communication* (pp. 37-51). Milton Park, UK: Routledge.

Holmes, J. (2000). Talking English from 9 to 5: challenges for ESL learners at work. *International Journal of Applied Linguistics, 10*(1), 125-140.

Holmes, J. (2013). *An introduction to sociolinguists* (4th Ed.). Harlow, UK: Pearson Education.

Holmes, J. and G. Major (2002) Nurses communicating on the wards: the human face of hospitals. *Kai Tiaki, Nursing New Zealand 8*(1),1 4-16.

Holmes, J., & Major, G. (2003). Talking to patients: The complexity of communication on the ward. *Vision—A Journal of Nursing, 11*(7), 4–9.

Holmes, J., Stubbe, M., & Vine, B. (1999). Constructing professional identity. In S. Sarangi & C. Roberts (Eds.), *Talk, work & institutional order: Discourse in medical, mediation & management settings*. Berlin: Mouton de Gruyter.

Holmes, J., Joe, A., Marra, M., Newton, J., Riddiford, N. & Vine, B. (2011). Applying linguistic research to real world problems: The social meaning of talk in workplace interaction. In C. Candlin & S. Sarangi (eds.), *Handbook of communication in organisations and professions* (pp.533-549). Berlin, Germany:De Gruyter Mouton.

Howard, T. C. (2003) Culturally relevant pedagogy: Ingredients for critical teacher reflection. *Theory into Practice, 42*(3), 195-202.

Jackson, J. (2014). *Introducing language and intercultural communication*. Oxon, UK: Routledge.

Jansson, G. (2014). Bridging language barriers in multilingual care encounters. *Multilingua, 33*(1-2), 210-232.

Kelo, M., Martikainen, M., & Eriksson, E. (2013). Patient education of children and their families: nurses' experiences.(CNE: Continuing Nursing Education). *Pediatric Nursing, 39*(2), 71.

Kingma, M. (2008) Nurses on the move: diversity and the work environment. *Contemporary nurse: A journal for the Australian nursing profession, 28*(1-2), 198-206. Doi: 10.5172/conu.673.28.1-2.198

Kramsch, C. (1998). *Language and culture*. Oxford: Oxford University Press.

Kumaravadivelu, B. (2007). *Cultural globalization and language education*. Yale: Yale Unversity Press.

Kunyk, D., & Olson, J. K. (2001). Clarification of conceptualizations of empathy. *Journal of Advanced Nursing, 35*(3), 317-325. doi:10.1046/j.1365-2648.2001.01848.x

Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge: Cambridge University Press.

Leahy, M., & Walsh, I. (2008). Talk in interaction in the speech-language pathology clinic. Bringing theory to practice through discourse. *Topics in language disorders, 28*(3), 229-241.

Lee, C. k., & Lee, I. F. k. (2012). Preoperative patient teaching: the practice and perceptions among surgical ward nurses. *Journal of Clinical Nursing, 22*, 2551–2561. doi:10.1111/j.1365-2702.2012.04345.x

Leino-Kilpi, H., Luoto, E., & Katajisto, J. (1998). Elements of empowerment and MS patients. *Journal of Neuroscience Nursing, 30*, 116-123.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., & others, C. G. a. (2001). Preferences of patients for patient centred approach to consultaiton in primary care: observational study. *British Medical Journal, 322*, 1-7.

Lum, L., Dowedoff, P., Bradley, P., Kerekes, J., & Valeo, J. (2015). Challenges in oral communication for internationally educated nurses. *Journal of transcultural nursing : official journal of the Transcultural Nursing Society / Transcultural Nursing Society, 26*(1), 83–91. doi:10.1177/1043659614524792

Macdonald, W., Rogers, A., Blakeman, T., & Bower, P. (2008). Practice nurses and the facilitaiton of self-management in primary care. *Journal of Advanced Nursing, 62*, 191-199.

Major, G., & Holmes, J. (2008) How do nurses describe healthcare procedures?: Analysing nurse-patient interaction in a hospital ward. *Australian Journal of Advanced Nursing, 25*(4), 58-70.

Martin, J. N., Nakayama, T. K., & Carbaugh, D. (2012). The history and developmentof the study of intercultural communication and applied linguistics. In J. Jackson (Ed.), *The Routledge handbook of language and intercultural communication* (pp. 17-36). Milton Park, UK: Routledge.

McCabe, C. (2004). Nurse–patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing, 13*(1), 41-49. doi:10.1111/j.1365-2702.2004.00817.x

Merriam, S. B., & Caffarella, R. S. (1999). *Learning in adulthood: A comprehensive guide* (2nd ed.). San Fransisco: Jossey-Bass.

Mishler, E. (1984). *The discourse of medicine: Dialectics of medical interviews.* New Jersey: Ablex.

Norfolk, T., Birdi, K., & Walsh, D. (2007). The role of empathy in establishing rapport in the consultation: a new model. *Medical Education, 41*, 6900-6697.

O'Grady, C. (2011a). *The nature of expert communication as required for the General Practice of medicine - A discourse analytical study.* (Doctor or Philosophy), Macquarie University, Sydney, Australia.

O'Grady, C. (2011b). Teaching the communication of empathy in patient-centered medicine. *English language and the medical professions: instructing and assessing the communication skills of international physicians*. London: Emerald Group Publishing.

O'Grady, C., M.R. Dahm, P. Roger, and L. Yates (2013) Trust, talk and the dicatophone: Tracing the discursive accomplishment of trust in a surgical consultation. *Discourse and Society* 5(1) 65 –83.

Ormrod, J. (1995). *Human Learning* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

O'Neill, F. (2011). From language classroom to clinical context: The role of language and culture in communication for nurses using English as a second language. *International Journal of Nursing Studies, 48*(9), 1120-1128.

Ohr, S. O., Parker, V., Jeong, S., & Joyce, T. (2010). Migration of nurses in Australia: Where and why? *Australian Journal of Primary Health, 16*, 17-24.

Omeri, A., & Atkins, K. (2002). Lived experience of immigrant nurses in New South Wales, Australia: searching for meaning. *International Journal of Nursing Studies, 39*, 495-505.

Ormrod, J. (1995). *Human Learning* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Paltridge, B. (2012). *Discourse Analysis* (2nd ed.). London: Bloomsbury.

Paltridge, B., & Wang, W. (2010). Researching discourse. In B. Paltridge & A. Phakiti (Eds.), *Continuum companion to research methods in applied linguistics* (pp. 256-273). London: Continuum.

Pennycook, A. (2001). *Critical applied linguistics: a critical introduction*. New Jersey, USA: Lawrence Erlbaum Associates.

Philip, S., Manias, E., & Woodward-Kron, R. (2015). Nursing educator perspectives of overseas qualified nurses' intercultural clinical

communication: barriers, enablers and engagement strategies. *Journal of Clinical Nursing, 24*, 2628–2637. doi:10.1111/jocn.12879

Pilotto, L., Duncan, G. & Anderson-Wurf, J. (2007). Issues for clinicians training international medical graduates: A systematic review. *The Medical Journal of Australia, 187*(4), 225-228.

Piller, I. (2011). *Intercultural communication: A critical introduction*. Edinburgh: Edinburgh University Press.

Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

Popay, J., Rogers, A., & Williams, G. (1998) Rationale and standards for the systematic review of qualitative literature in health services research. *Qualitative Health Research, 8*(3), 341-351.

Roberts, C., & Sarangi, S. (1999). Introduction: Revising different analytic frameworks. In S. Sarangi & C. Roberts (Eds.), *Talk, work and institutional order: Discourse in medical, mediation and management settings*. Berlin: Mouton de Gruyter.

Roberts, C., & Sarangi, S. (2005). Theme-orientated discourse analysis of medical encounters. *Medical Education, 39*, 632-640.

Roberts, C., Moss, B., Wass, V., Sarangi, S., & Jones, R. (2005). Misunderstanding: a qualitative study of primary care consultations in multilingual settings, and educational implications. *Medical Education, 39*, 465-475.

Roberts, C., Wass, V., Jones, R., Sarangi, S. & Gillett, A. (2003). A discourse analysis study of 'good' and 'poor' communication in an OSCE: A

proposed new framework for teaching students. *Medical Education, 37,* 192-201.

Robinson, G. L. N. (1988). *Crosscultural understanding*. New York: Prentice Hall.

Robinson, M., & Gilmartin, J. (2002). Barriers to communication between health practitioners and service users who are not fluent in English. *Nurse Education Today, 22*, 457-465. doi:10.1054/nedt.2002.0758

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, California: Sage.

Roter, D. L., Frankel, R. M., Hall, J. A., & Sluyter, D. (2006). The expression of emotion through nonverbal behavior in medical visits. Mechanisms and outcomes. *Journal of general internal medicine, 21 Suppl 1*, S28.

Roter, D., & Larson, S. (2002). The Roter Ineraction Analysis System (RIAS): utility and flexibility for analysis of medical interactions. *Patient education and counseling, 46*(4), 243-251.

Ruusuvuori, J. (2007). Managing affect: integration of empathy and problem-solving in healthcare encounters. *Discourse Studies, 9*(5), 597-622.

Sarangi, S. (in press). Mind the gap: 'Communicative vulnerability' and the mediation of linguistic/cultural diversity in healthcare settings. In H. Coleman (Ed.), *Multilingualism and Development*.

Sarangi, S., & Roberts, C. (1999). The dynamics of interactionals and institutional orders in work-related settings. In S. Sarangi & C. Roberts (Eds.), *Talk, work, and institutional order* (pp. 1-43). Berlin: Mouton de Gruyter.

Schön, D. (1983). *The reflective practitioner: how professionals think in action*. New York: Basic Books.

Scollon, R., & Scollon, S. W. (2001). *Intercultural communication* (2 ed.). Malden, MA: Blackwell Publishing.

Seccareccia, D., Wentlandt, K., Kevork, N., Workentin, K., Blacker, S., Gagliese, L., . . . Zimmermann, C. (2015). Communication and quality of care on palliative care units: A qualitative study. *Journal of Palliative Care Medicine, 18* (9), 758-764. doi:10.1089/jpm.2014.0408

Shakya, A., & Horsefall, J. M. (2000). ESL undergraduate nursing students in Australia: Some experiences. *Nursing and Health Sciences, 2*, 163-171.

Shaw, S., & Greenhalgh, T. (2008). Best research - for what? Best health - for whom? A critical exploration of primary care research using discourse analysis. *Social science and medicine, 66*, 2506-2519.

Shen, J. J., Xu, Y., Bolstad, A. L., Covelli, M., Torpey, M., & Colosimo, R. (2012). Effects of a short-term linguistic class on communication competence of international nurses: Implications for practice, policy, and research. *Nursing economic$, 30*(1), 21-28.

Shield, R. R., Tong, I., Tomas, M., & Besdine, R. W. (2011). Teaching communication and compassionate care skills: An innovative curriculum for pre-clerkship medical students. *Medical Teacher, 2011, Vol.33(8), p.e408-e416, 33*(8), e408-e416. doi:10.3109/0142159X.2011.586748

SmithBattle, L., S. Leander, N. Westhus, P.E. Freed, and D.E. McLaughlin (2010) Writing therapeutic letters in undergraduate nursing education: Promoting relational skill development. *Qualitative Health Research, 20*(5), 707–716. doi:10.1177/1049732309354095

Starfield, S. (2010). Ethnographies. In B. Paltridge & A. Phakiti (Eds.), *Continuum companion to research methods in applied linguistics* (pp. 50-65). London: Continuum.

Stewart, M. (1995). Effective physician-patient communication and health outcomes: a review. *CMAJ, 152*(9), 1423-1433.

Stewart, M., Brown, J., Donner, A., McWhinney, I., Oates, J., & Weston, W. (2000). The impact of patient-centred care on outcomes. *Journal of family practice, 49*(9), 796-804.

Strauss, A.L. and Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory* (2nd ed.).Thousand Oaks, California: Sage.

Suchman, A., Markakis, K., Beckman, H, & Frankel, R. (1997). A mode of empathic communication in the medical interview. *Journal of the American Medical Association, 4*(277), 1680-1.

Svavarsdottir, M., Sigurdardottir, A., & Steinsbekk, A. (2015). What is a good educator? A qualitative study on the perspective of individuals with coronary heart disease. *European Journal of Cardiac Nursing*, 1-9. doi:10.1177/1474515115618569

Szalay, L. B. (1981). Intercultural communication - A process model. *International Journal of Intercultural Relations, 2*, 133-146.

Tannen, D. (2009). Framing and Face: The relevance of the presentation of self to linguistic discourse analysis. *Social Psychology Quarterly, 72*(4), 300-305.

Tannen, D. (Ed.) (1993). *Framing in discourse*. New York: Oxford University Press.

Tannen, D., & Wallat, C. (1993). Interactive frames and knowledge schemas in interaction: Examples from a medical examination/interview. In D. Tannen (Ed.), *Framing in Discourse*. New York: Oxford University Press.

Tapsell, L. (2000). Using applied canversation analysis to teach novice dieticians history taking skills. *Human Studies, 23*, 281-307.

Trevizan, M. A., Almeida, R. G. e. d. S., Souza, M. C., Mazzo, A., Mendes, I. A. l. C., & Martins, J. C. A. (2015). Empathy in Brazilian nursing professionals. *Nursing Ethics, 22*(3), 367-376. doi:10.1177/0969733014534872

Turner, d. S., & Beddoes, L. (2007) Using reflective models to enhance learning: Experiences of staff and students. *Nurse education in practice 7*, 135-140. DOI: 10.1016/j.nepr.2006.04.011

Ulrey, K. L., & Amason, P. (2001). Intercultural communication between patients and healthcare providers: An exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety. *Health Communication, 13*(4), 449-463.

Virtanen, H., Leino-Kilpi, H., & Salantera, S. (2007). Empowering discourse in patient education. *Patient education and counseling, 66*, 140-146. doi:10.1016/j.pec.2006.12.010

Wallace, C. (2003). *Critical reading in language education*. Basingstoke: Palgrave Macmillan.

Walters, H. (2008) The experiences, challenges and rewards of nurses from South Asia in the process of entering the Australian nursing system. *Australian Journal of Advanced Nursing, 25*(3), 95-105.

Watson, B., Gallois, C., Hewett, D. G., & Jones, L. (2012). Culture and healthcare: Intergroup communication and its consequences. In J. Jackson (Ed.), *The*

Routledge handbook of language and intercultural communication (pp. 510-522). Milton Park, UK: Routledge.

Wilson, P. S., & Anderson, R. C. (1986). What they don't know will hurt them: The role of prior knowledge in comprehension. In J. Orasanu (Ed.), *Reading comprehension*. Hillsdale NJ: Erlbaum.

Whitehead, D. (2001). Health education, behaviour change and social psychology: nursing's contribution to health promotion? *Journal of Advanced Nursing, 34*(6), 822-832.

Wilson, P. S., & Anderson, R. C. (1986). What they don't know will hurt them: The role of prior knowledge in comprehension. In J. Orasanu (Ed.), *Reading comprehension*. Hillsdale NJ: Erlbaum.

Wodak, R., Jonstone, B., & Kerswill, P. (Eds.). (2011). *The SAGE Handbook of Sociolinguistics*. London: Sage.

Woodward-Kron, R., J. Hamilton and I. Rischin (2007) Managing cultural differences, diversity and the dodgy: Overseas-born students' perspectives of clinical communication in Australia. *Focus on Health Professional Education: A Multidisciplinary Journal, 9*(3), 30-43.

Woodward-Kron, R., Stevens, M. & Flynn, E. (2011). The medical educator, the discourse analyst, and the phonetician: A collaborative feedback methodology for clinical communication. *Academic Medicine, 86*(5), 565-570.

Xu, Y., Shen, J., Bolstad, A. L., Covelli, M., & Torpey, M. (2010). Evaluation of an intervention on socio-cultural communication skills of international nurses. *Nursing economic$, 28*(6), 386- 408.

Yahes, E. & Dunn, A.K. (1996). Enculturation of foreign nurse graduates: An integrated model. *The Journal of Continuing Education in Nursing*, 27, 120-123.

Yilmaz, K. (2011). The cognitive perspective on learning: Its theoretical underpinnings and implications for classroom practices. *The Clearing House: A journal of educational strategies, issues and ideas, 84*(5), 204-212. doi:10.1080/00098655.2011.568989

Zizzo, K. & Xu, Y. (2009). Transitional programs for internationally educated nurses: A systematic review. *The Journal of Continuing Education for Nurses, 40*(2), 57-64

Appendices

Appendix 1: Questions for unstructured interviews

- Ice breaker to establish rapport/relax participants: ask personal/factual information e.g.

  1. How long have you been working in Australia?
  2. How long since you started learning English (if appropriate)?

- What have been your experiences with communicating in relation to:
  1. Understanding what patients are saying to you?
  2. Speaking to patients and having them understand you?

- Have there been occasions where you have misinterpreted what the patient is saying?
- Have there been occasions where the patients have misinterpreted what you were saying?
- What has helped you communicate with patients both in speaking and listening?
- What has hindered your communication with patients?
- Is there anything about the health system here that you think may contribute to occasions of miscommunication?

Probe to elaborate on salient points and to elaborate on contrast/comparison of experience/feelings (Potential issues that may arise: Stress associated with past negative experiences e.g. miscommunication with patients, prejudice due to accents, confusion with listening but reluctance to admit it).

- What should I have asked you that I didn't think to ask?

Closing: summarise or recap main points of discussion and thanks for participation.

Appendix 2: Ethics approval form

Office of the Deputy Vice-Chancellor (Research)

Research Office
C5C Research
HUB East, Level 3, Room 324
MACQUARIE UNIVERSITY NSW 2109 AUSTRALIA
Phone +61 (0)2 9850 4194
Fax +61 (0)2 9850 4465
Email ethics.secretariat@mq.edu.au

19 November 2014
Dr Peter Roger
Department of Linguistics
Faculty of Human Sciences
Macquarie University NSW 2109

Dear Dr Roger

Reference No: 5201400783

Title: Misinterpretations: an exploration of intercultural nurse-patient health communication

Thank you for submitting the above application for ethical and scientific review. Your application was considered by the Macquarie University Human Research Ethics Committee (HREC (Medical Sciences)) at its meeting on 28 August 2014 at which further information was requested to be reviewed by the HREC (Medical Sciences) Executive.

The requested information was received with correspondence on 17 September 2014 & 27 October 2014.

The HREC (Medical Sciences) Executive considered your responses at its meeting held on 17 November 2014.

I am pleased to advise that ethical and scientific approval has been granted for this project to be conducted at:

- Macquarie University

This research meets the requirements set out in the *National Statement on Ethical Conduct in Human Research* (2007 – Updated March 2014) (the *National Statement*).

Details of this approval are as follows:

Approval Date: 17 November 2014

The following documentation has been reviewed and approved by the HREC (Medical Sciences):

Documents reviewed	Version no.	Date
Macquarie University ethics Application Form	2.3	July 2013
Correspondence from Dr Roger & Ms Crawford responding to the issues raised by the HREC (Medical Sciences)		Received 17 Sep & 27 Oct 2014
Research Protocol	2	17 Sep 2014
MQ Participant Information and Consent Form (PICF): RN	3	24 Oct 2014

This letter constitutes ethical and scientific approval only.

Standard Conditions of Approval:

1. Continuing compliance with the requirements of the *National Statement,* which is available at the following website: http://www.nhmrc.gov.au/book/national-statement-ethical-conduct-human-research

2. This approval is valid for five (5) years, subject to the submission of annual reports. Please submit your reports on the anniversary of the approval for this protocol.

3. All adverse events, including events which might affect the continued ethical and scientific acceptability of the project, must be reported to the HREC within 72 hours.

4. Proposed changes to the protocol must be submitted to the Committee for approval before implementation.

It is the responsibility of the Chief investigator to retain a copy of all documentation related to this project and to forward a copy of this approval letter to all personnel listed on the project.

Should you have any queries regarding your project, please contact the Ethics Secretariat on 9850 4194 or by email ethics.secretariat@mq.edu.au

The HREC (Medical Sciences) Terms of Reference and Standard Operating Procedures are available from the Research Office website at: http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics

The HREC (Medical Sciences) wishes you every success in your research.

Yours sincerely

Professor Tony Eyers
Chair, Macquarie University Human Research Ethics Committee (Medical Sciences)

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research* (2007) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.

Appendix 3: RN information sheet and consent form

Name of Project:

An exploration of intercultural nurse-patient health communication.

You are invited to participate in a study to understand and describe how language and cultural differences affect interpretation of meaning in interactions between nurses and their patients in the Australian healthcare context.

'Real life' communication will be examined in order to understand the process of communication better which will raise awareness of what contributes to both successful and problematic occasions of communication with your patients. Strategies used are often taken for granted and this research aims to examine and identify what you use to communicate in a culturally diverse healthcare setting. Understanding and raising awareness of strategies that contribute to successful communication will ultimately improve patient care and safety.

The study is being conducted by Tonia Crawford (Ph: 0431 921 664, email: tonia.crawford@students.mq.edu.au) to meet the requirements of a PhD in Linguistics Research under the supervision of by Dr Peter Roger (Ph: 9850 9650; email: Peter.Roger@mq.edu.au and Dr Sally Candlin (Ph: 9850 8744, email: sallycandlin@gmail.com) of the Department of Linguistics, Macquarie University, Sydney.

If you decide to participate, you will be asked to participate in two phases of the project. Phase 1 will involve an individual interview regarding your experiences communicating in English with your patients. Time taken to participate in the interview is approximately 30-60 minutes, plus the time taken to check interview transcripts and analysis for accuracy later in the project. The interview will be audio recorded to allow for more accurate data collection and analysis. The recordings will be destroyed once transcriptions have occurred.

Phase 2 will involve you audio-recording some of your interactions/conversations with your patients (with their informed written consent given to the researcher), for example, while you are admitting and assessing your patients, giving medication, preparing for surgery or giving patient education. You will be supplied with a small audio recorder which may be placed on the patients locker so either of you may turn on and off as you see fit. Do not record conversations which might be sensitive or embarrassing to the patient, or where you might be counselling the patient after they have received bad news. If you are comfortable, this phase would include observation of some of your interactions to view the aspects of communication that are not recorded, for example, non verbal communication skills.

There may be some difficulty taking the time to participate in the interviews due to other commitments and the interview may elicit some feelings of frustration relating to communicating in English. On the other hand, you may also find that it is a positive experience to share your experiences, contribute to a greater understanding of what strategies contribute to communication in a culturally diverse healthcare setting. You will be offered a $100 gift card as thanks for your time and contribution to the project.

Any information or personal details gathered in the course of the study are confidential. No individual will be identified in any recording or publication of the interviews or results, as pseudonyms will be used. All identifying information will be removed and care will be taken that participants are not identifiable by the information they provide, unless they have agreed to be identified. In the unlikely event whereby patient safety had been compromised, there is a duty to report any legal/ethical issues to the relevant authorities.

Only the researcher and supervisors will have access to the data, which will be stored in a locked filing cabinet in the researcher's university office. A summary of the results of the data can be made available to you on request and will be available after completion of the analysis. Publication of results will be submitted to peer reviewed professional and academic nursing and linguistic journals, and presentation at appropriate linguistic and nursing conferences.

Participation in this study is entirely voluntary: you are not obliged to participate and if you decide to participate, you are free to withdraw at any time without having to give a reason and without consequence.

I, _____ have read *(or, where appropriate, have had read to me)* and understand the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this research, knowing that I can withdraw from further participation in the research at any time without consequence. I have been given a copy of this form to keep.

Participant's Name:

(block letters)

Participant's Signature: _____Date:

Investigator's Name:

(block letters)

Investigator's Signature: _____ Date:

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics (telephone (02) 9850 7854; email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

Appendix 4: Patient information sheet and consent form

Name of Project:

An exploration of multicultural nurse-patient health communication.

You are invited to participate in a study with an interest in communication between patients and staff in the Australian healthcare context.

'Real life' communication problems will be examined in order to understand the process of communication better which will raise awareness of causes of any occasions of miscommunication and enable the development of a framework from which interventions and tools may be developed to strengthen communication skills.

The study is being conducted by Tonia Crawford (Ph: 0431 921 664, email: tonia.crawford@students.mq.edu.au) to meet the requirements of a PhD in Linguistics Research under the supervision of by Dr Peter Roger (Ph: 9850 9650; email: Peter.Roger@mq.edu.au and Dr Sally Candlin (Ph: 9850 8744, email: sallycandlin@gmail. com) of the Department of Linguistics, Macquarie University, Sydney.

If you decide to participate, some of your conversations will be audio-recorded by your nurse, for example, while you are being admitted and assessed, being given medication, prepared for surgery or given patient education. The nurse will have a small audio-recorder which may be placed on the locker or table so either of you may turn it on and off as you see fit. Conversations which might be sensitive or embarrassing to you need not be recorded. If you are comfortable, the researcher may also observe of some of your interactions to view the aspects of communication that are not recorded, for example, non verbal communication.

Any information or personal details gathered in the course of the study are confidential. No individual will be identified in any recording or publication of the interviews or results, as pseudonyms will be used. All identifying information will be removed and care will be taken that you are not identifiable by the information you provide.

Only the researcher and supervisors will have access to the data, which will be stored in a locked filing cabinet in the researcher's university office. Publication of results will be submitted to peer reviewed professional and academic nursing and linguistic journals, and presentation at appropriate linguistic and nursing conferences.

Participation in this study is entirely voluntary: you are not obliged to participate and if you decide to participate, you are free to withdraw at any time without having to give a reason and without consequence.

I, _____ have read *(or, where appropriate, have had read to me)* and understand the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this research, knowing that I can withdraw from further participation in the research at any time without consequence. I have been given a copy of this form to keep.

Participant's Name:

(block letters)

Participant's Signature: _____Date:

Investigator's Name:

(block letters)

Investigator's Signature: _____ Date:

The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Director, Research Ethics (telephone (02) 9850 7854; email ethics@mq.edu.au). Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.