

Communicative constructions of person-centred and non-person-centred caring in nurse-led consultations

Introduction

Over the last few years, the development of person-centred care has been enhanced by care providers, researchers and politicians. These groups of people talk publically about providing person-centred, rather than patient-centred, care (Swedish Code of Statutes 2014: 821; Högberg et al., 2015, 2018; Siouta, 2016). According to McCance et al. (2010), person-centred care means that the patient's perceptions and experiences should be in focus. Whereas the concept of 'patient' can be identified on the basis of medical or biological markers and diagnoses, the concept of 'person' is linked to a life story (Kristensson Uggla, 2014). In the present study, when addressing the medical or biological model, we use the concept of the non-person-centred model or discourse. According to the person-centred model or discourse, care providers should base the planning and implementation of care on the individual's resources and needs, with the patient treated an active party. Care and treatment should not be based solely on biological markers and measurement methods but should rather be integrated into a larger context where the patient's perception of his or her health and disease is in focus. The relationship between care providers and patients should be characterised by partnership (Duffin & Sarangi, 2017; Eldh, 2006; Ishikawa, 2013; McCance et al., 2010; Ekman et al., 2011; Lines, et al., 2015).

Previous research has shown that person-centred nursing is closely intertwined with the nursing relationship (Ekman et al., 2011; Chan et al., 2013). A nursing relationship enables the expression of needs, thoughts and wishes. A subject-to-subject relationship should be pursued, in which the balance of power is as equal as possible. A partnership needs to be created in an engaged and empathetic way, where the patient is invited to participate in decisions and autonomy is promoted (Siouta, 2016). It is important to listen actively to what the patient expresses and to what is expressed 'between the lines', as well as to have the ability to provide respectful nursing with regard to the patient's values and beliefs (McCance et al., 2010; Swedish Nursing Association, 2016). There is little research evidence regarding the care provided in nurse-led chemotherapy clinics. Farrell and Lennan (2003) evaluated nurses' roles/operational practices, but more research is needed to evaluate the person-centred communicative constructions in nurses' consultations.

Previous research has also shown that the dominant discourse is still a non-person-centred discourse framed by the biomedical model. Thus, the change to a person-centred form of care has not yet become an obvious element of consultations with nurses (McCance et al., 2010; Ekman et al., 2011; Ishikawa, 2013; Siouta, 2016). Against this background, the aim of this study was to explore whether and how the participants in consultations verbally construct person-centred care for patients with cancer at nurse-led chemotherapy outpatient clinics.

The theoretical basis of the study is in social constructionism, in which social reality is understood to be constructed in constant, everyday social and linguistic interactions among people, particularly through communication and language (Berger & Luckmann, 1991; Burr, 2003). According to social constructionism, we use language as a means to construct the world around us, as well as participants' roles and relationships, responsibilities and decision making during consultations (Duffin & Sarangi, 2017; Berger & Luckmann, 1991; Siouta, 2016). This means that language is used to construct ways of understanding the world and the objects and subjects that are included in our different, often conflicting, discourses. Discourses relate to what can be said and what can be thought concerning, for example, health care consultation. Discourses embody values, interests, meanings and social relationships (Olsson et al., 2011; Howarth, 2007). Discourses are practices that form and constitute the objects about which they speak. Thus, discourses do not discover objects; they construct them (Olsson et al., 2011). For instance, discourses construct the roles of the participants in consultations, as well as their responsibilities and power relationships.

When one discourse dominates, it does so at the expense of other discourses (Howarth, 2007; Olsson et al., 2011). A descriptive analysis of discursive spaces in nurse's consultations conducted by Siouta et al., (2013) has shown that the medical-driven agenda dominated over the patient-driven agenda in consultations between health care professionals and patients, even when patients were more talkative during conversations in nurse consultations. An exploration of communicative patterns of consultations in palliative cancer care by Ohlén et al., 2008 has also shown the frequency of the medicine voices in nursing care. According to Siouta (2016), Uitterhoeve et al., (2009) and Mishler (1984), this is traditionally evident in the healthcare system as a medical discourse or 'medicine voice' that is built on a technical, biomedical model and that dominates the way of organising, talking and thinking at the expense of a 'lifeworld discourse or lifeworld voice', which localises health problems within the patient's personal and sociocultural context.

The aim of this study was to examine whether and how person-centred caring is constructed verbally in the ongoing communication in consultations between patients with cancer and nurses at nurse-led chemotherapy outpatient clinics. To achieve this aim, we used the concept of cue-responding behaviour as a means to study how the participants responded to each other. Studies on how nurses address patients' psychosocial needs in communication have been based on this concept (Lin et al., 2017; Uitterhoeve et al., 2009). However, the present study had a different focus: We used the concept to study the construction of person-centred care.

Methods

Design, setting and selection criteria

A qualitative design was used to explore audio-recorded observations in consultations between patients with cancer and nurses at nurse-led chemotherapy clinics in the UK as setting. The current study was an additional analysis of data from an existing qualitative ethnographic study (Farrell et al., 2017) (Ethical approval reference 11/NW/0240) that aimed to explore the roles and autonomy of nurses within nurse-led chemotherapy clinics. The research setting encompassed the nurse-led chemotherapy clinics of four hospitals in different regions in the United Kingdom. Given the complexities of nurses' roles within nurse-led

chemotherapy clinics, observations were essential to achieve the required depth of understanding. Since its core focus is describing cultural behaviour which provides increased understanding of people's experiences within their local context, ethnography was chosen (Sacks, 1995). This has particular merits for nurse researchers who aim to focus on nursing as inter-professional relationships and issues within their workplace environment (Priest and Roberts, 2010), and therefore seemed like a good approach for this study. A key advantage of observing nurses within their clinical environment is the opportunity to gain a greater understanding of the context for each nurse-led chemotherapy clinic and operational aspects of nurses' roles, and to observe nurses' interactions with patients. This valuable information could not be obtained from interviews alone (Heath et al., 2010).

Purposive sampling strategies were used to target participants with specific knowledge of/experience with the chosen topic (Polit and Beck, 2010). The five clinics were chosen based on their geographical location and also because of their specific knowledge of and experience with the studied topic. The nurse-led chemotherapy clinics of the four selected hospitals were chosen because they represented a 'characteristic day' in terms of the number of patients seen and the types of chemotherapy regimens and other systemic infusions given. Some hospitals had clinics for specific cancer groups on certain days, which the observations covered; other nurse-led clinics had two or three sessions per week. Therefore, observations covered several sessions/clinics on different days, which resulted in approximately 12 days of observation across the four sites over six months (Table 1). The sample consisted five nurses who participated in the study. Of these five nurses, two were nurse consultants, three were advanced nurse practitioners and two were chemotherapy nurses. All of the nurses had received training in clinical examination skills and non-medical prescribing. All of the patients had cancer and were receiving chemotherapy, but, except sex, no other patient demographic data were collected.

Procedures

The study has been carried out in accordance with The Code of Ethics of the World Medical Association (World Medical Association, WMA, 2008). Ethical approval was obtained from the NHS Research Ethics Committee, REC: reference 11/NW/0240, and from the local Research and Development approvals from the four hospitals in England to conduct this multicentre study in the hospitals of different locations. University ethics approval was also granted by the University of Manchester. The setting encompassed the nurse-led chemotherapy clinics of four hospitals across different regions in the United Kingdom, to replicate the norm of nurse-led models in terms of capacity and types of chemotherapy regimens. Nurses employed in nurse-led chemotherapy clinics at the four hospitals were invited to participate in the study. Written informed consent was obtained from all nurse participants prior to the study requesting permission to observe their nurse-led chemotherapy clinics for two days and be interviewed by a researcher. Patients received written information about the study on arrival at the chemotherapy unit, and information posters were also displayed. Patients gave verbal and written consent before their consultation in the nurse-led clinic and researcher observation; they were informed that they could decline observation or ask the researcher to leave at any point. Numerical codes were assigned to each patient/nurse to maintain confidentiality/anonymity throughout.

Data collection

The current study is an additional analysis of data from a qualitative ethnographic study (Farrell et al., 2017) aimed at exploring the roles and autonomy of nurses within nurse-led chemotherapy clinics. The setting encompassed the nurse-led chemotherapy clinics of four hospitals across different regions in the United Kingdom. The qualitative data came from audio-recorded transcripts of non-participant observations (Cruz and Higginbottom, 2013) of nurses' consultations. This study included observation of nurse-patient consultations, which were audio-recorded. An observation guide was created to facilitate non-verbal data collection. Forty-five patients attending the nurse-led chemotherapy clinics participated in the study, and one patient declined. The qualitative method used does not focus on quantification, and 45 consultations were expected to allow for substantial and meaningful insight into the central issues of the study. All patients received an information sheet when they arrived at the clinic. The nurses discussed the study with each patient and obtained verbal consent before introducing them to the researcher, who obtained verbal consent to observe and audio-record the consultation. Three accompanying spouses were present during their partner's consultation. Thirteen nurse participants were observed within nurse-led chemotherapy clinics. Non-participant observations were made in all five clinics over six months on a total of 45 nurse consultations. The consultations ranged in length from 3 to 56 minutes (Mean = 15,18). Identifiable data recorded during the observed consultation were assigned with to each patient/nurse to maintain confidentiality/anonymity throughout. Semi-structured interviews with nurses were used to validate observations, clarify aspects of practice and understand nurses' perceptions (Heritage, 2010; Hydén and Mishler, 1999). An interview guide was used; questions included setting up nurse-led clinics, operational aspects, managerial support and training. The interviews have been used in another study, in Farrell et al., (2017), by the second author.

Data analysis

The transcripts were analysed from a discourse-analytical perspective (Horwarth, 2007). The transcriptions were read through several times. The reading continued until the themes within the data in relation to the research question appeared. Sequences were compared and sorted into themes as part of an ongoing process until the focused themes became solid (Sarangi and Roberts, 1999; Sarangi and Slembrouck, 2014). Five themes that emerged from the data analysis are displayed in Table 1. The analysis was performed by ES, with frequent discussions with her co-authors, until agreement was reached. The discussion between authors were that the data presented, and findings were consistent. The authors provide the manuscript many times. Questions to authors: Were participant quotations presented to illustrate the themes? Was each quotation identified? Was there consistency between the data presented and the findings? Were the themes clearly presented in the findings? Further discussion took place and the first author revisited her notes. This process was repeated until agreement was reached. The selected excerpts symbolise the overall view of the nurse-based consultations and therefore, in order to illustrate how the selected excerpts are representative of the total material, examples will be presented at the end of each discourse dimension. The content can clarify how Non-person-centred and person-centred care can be constructed and will therefore be discussed in the discussion section.

Findings

In the analysis of the communicative patterns in the empirical data, both the person-oriented and non-person-oriented discourse was found, hence both the construction of human beings as patients and the construction of human beings as persons. The dominant discourse was the non-person-oriented discourse framed by a biomedical model. However, in the data it was also possible to identify fragments of an alternative discourse, a person-oriented discourse, a 'lifeworld discourse or lifeworld voice' localising health problems within the patient's personal and sociocultural context. Below, the collected material is presented using five themes which were identified in the analysis (Table 2). The following analysis shows how each of these themes can be discussed during a consultation based on a non-person-centred or person-centred approach respectively. The chosen quotes aim to visualise the differences between non-person-centred and person-centred communication.

Theme 1: Discursive approaches to the start of the consultation

Patient-oriented discourse

In the patient-oriented discourse, the focus from the very beginning of the consultation is on a physiological and medical theme concerning chemotherapy, blood tests and physical side effects. The communication pattern is that the patient is rather restrained and silent and the nurse is doing the talking. A common pattern is exemplified by nurse 4 (N=Nurse). She takes the initiative and begins in the medicine voice by directly moving onto the subject of the chemotherapy. In this example the conversation with the patient (P=Patient). starts with a discussion about how the participants can best be seated in the cramped room they are in.

Nurse-led chemotherapy clinic 4. N 4. P 37. Consultation time: 28.39 minutes

P: Am I okay here?

N: Yes, just take a seat there.

P: Do you want me to move?

N: No, you're okay, that's fine.

Both the woman and her husband are asking questions about where to sit and the nurse just confirms that they are okay. The nurse then asks a question which has to do with whether the patient understands why she is at the hospital. The patient answers yes to the question, but the nurse continues to ask the patient to provide further explanation. "Can you tell me?"

Nurse-led chemotherapy clinic 4. N 4. P 37. Consultation time: 28.39 minutes

N: So, do you understand why you've come here today?

P: Yes.

N: Can you tell me?

P: [laughs] I've chosen to come here. I don't know if I've done the right thing, but I would like to live a little bit longer

N: Yes....

Thus, allowing the patient to express the reason for the consultation. However, in her response the woman expands on her answer with a laugh and says that she has chosen to come because she “would like to live a little bit longer.” Instead of following up on the existential response...to live a little bit longer, the nurse cuts off the patient with a short “yes” followed by a continuation of the medical theme, asking if the woman knows the name of the chemotherapy.

Nurse-led chemotherapy clinic 4. N 4. P 37. Consultation time: 28.39 minutes

N: And what ...do you know the name of the chemotherapy that you’re going to be receiving?

P: Gem.... Something or other...I wouldn’t remember but I....

N: Gemcitabine (name of the chemotherapy), that’s right

P: Gemcitabine. The other I had with something else, it was...

N: It was carboplatin last time

P: Carboplatin

N: How were you whilst you were on it?

The nurse thus continues with the medical discourse’s patient orientation, and in doing so misses the opportunity to expand on the patient’s lifeworld theme, which would have made it possible to shift the conversation from patient orientation to person orientation, for instance by giving feedback to the comment “live a little bit longer”.

Person-oriented discourse

The person-oriented conversations often begin with a discussion about how things have been for the patient lately, or how the patient is feeling just now. An example of this is provided by nurse 1. She takes the patient by the hand and welcomes her warmly, looking her in the eyes and saying:

Nurse-led chemotherapy clinic 1. N 1. P 1. Consultation time: 11.55 minutes

N: “I saw you this Monday. How have you been since then?”

P: "I've been okay"

N: "Any new problems?"

Another example is nurse 3, who also takes the patient by the hand and welcomes him warmly and then sits face-to-face with him and asks how he is feeling.

Nurse-led chemotherapy clinic 3. N 3. P 29. Consultation time: 06.27 minutes

N: How are you doing?

P: I’m all right, no problem

N: Okay

P: Yeah, what?

N: Well I just want to make sure how you’re feeling

P: I’m alright. I’ve had no problems

Thus, only after first having shown an interest in and welcoming the patient warmly, taking the patient's hand and asking how the patient is feeling, do the two nurses, nurse 1 and 3, start to ask questions about medical issues. In this person-centred atmosphere which is created, the consultation continues by talking about the patient's pain. The excerpts below show how it affects the ability of the patient to lie on his side in bed.

Nurse-led chemotherapy clinic 3. N 3. P 29. Consultation time: 06.27 minutes

N: When you came on

P: You know during the night when I said...no pain

N: That's good. Have you managed to come down your painkillers at all?

P: What painkillers?

N: You aren't on any?

P: No

N: Excellent. So, the pain's gone?

P: Yeah

N: Are you able to lie on that side now?

And at the end of this sequence in the consultation the nurse 3 once again shows that she is interested in the patient as a person and not only as a patient by saying in an encouraging way; "Very good...you look happy".

Nurse-led chemotherapy clinic 3. N 3. P 29. Consultation time: 06.27 minutes

P: Oh yeah

N: Excellent

P: And I'm sleeping well

N: Very good...you look happy

In summary: The first of the three conversations analysed above is an example of when the patient-oriented discourse is dominant. The dominant aspect of this discourse is that the medical issues are brought to the foreground from the very beginning, for example by asking questions about chemotherapy, blood tests and physical side effects. Another aspect of this discourse is that the nurse does not accept the patient's invitation to move the conversation over to issues which have to do with the person's lifeworld and concerns. The two person-oriented conversations analysed above go against this patient-oriented pattern. The nurses 1 and 3 are showing an interest in the patient's wellbeing at the beginning of the conversation by asking questions about how the patient is feeling. In these conversations, scope is created for the lifeworld voice and for localising the health problem within a personal and sociocultural context.

Theme 2: Discursive approaches to talking about side-effects

Patient-oriented discourse

Even the way side-effects are discussed is different depending on the discursive approach taken. In the conversation below the nurse begins the conversation by asking a question about nausea and vomiting, and whether the woman has had any upset from the chemotherapy. When the woman says no, the nurse continues on the medical track by asking questions about other types of side-effects, for instance diarrhoea. In this sequence the patient's husband (H=Husband) joins in and answers that his wife has had a bit of constipation, while at the same time seeking her confirmation ("didn't you?"). The wife confirms this and then further develops the answer that she has had a lot of constipation with the (medicine) codeine.

Nurse-led chemotherapy clinic 2. N 2. P 9. Consultation time: 21.39 minutes

N: Did you have any upset from the chemo apart from all this?

P: Apart from that no. No

N: No sickness or anything? No diarrhoea?

P: Erm....

H: Yes, a bit of constipation... didn't you?

P: Yeah. That was with the codeine I had a lot of constipation... before the insides started up

The discussion continues regarding side-effects and blood test, with no reference at all to the way in which these might influence the patient's everyday life or family life as a whole.

Nurse-led chemotherapy clinic 2. N 2. P 9. Consultation time: 21.39 minutes

N: Yeah... I mean sometimes we get this sort of discharge and it's just all the tumour sort of breaking down

P: Well this is last February...inside my ear, not outside

N: This bleeding and everything that you had erm... but sometimes it's due to infections. You need to be careful

P: Yes, I know

N: So, I think we need to see what your blood tests are like and I'll give (consultant) a ring and just see what he thinks about it as well

P: Fine

N: Okay?

In this conversation the woman is constructed entirely as a patient, as a bearer of various side-effects like diarrhoea, nausea, vomiting and bleeding, rather than as a whole person.

Person-oriented discourse

In the conversation between nurse 2 and patient 10, the same side-effects are discussed but in an entirely different way, which enables the man to represent himself as a whole person

who lives a normal everyday life, not solely as a patient. When the nurse asks the patient if he has had any problems with diarrhoea, he replies that he hasn't, apart from on the Tuesday when they had planned to go out to a pub. He says that after spending most of the day in bed he could go to the bar after teatime, drinking two beers.

Nurse-led chemotherapy clinic 2. N 2. P 10. Consultation time: 07.12 minutes

N: No diarrhoea?

P: No nothing. As I say apart from Tuesday Tuesday evening anyway

W: He wanted to go

P: So, I spent most of the day in bed....and about teatime I got up.... then we went to (name of pub)I had about 2 pints

N: Did you enjoy it?

P: Drinking it were alright but by the time I got back to the car I fetched it back up so...

N: Oh right

In the above sequence, the side-effects are related to the man's possibilities of living a normal everyday life, by being able to go out and enjoy a beer and the wife emphasized that it was really the man's own desire to go out. The nurse immediately latches onto this theme and asks did he "enjoy it?". The man replies that it was fine actually drinking, but that he had problems afterwards when he came back to the car. In this consultation the conversation moves onto the man's everyday life, and the side-effect (the vomiting) is related to something which the man appreciates being able to do, namely visiting the pub. The nurse confirms the man as a person who lives a normal everyday life by looking at the man sympathetically and answering: "Oh, right".

Another example of how the conversation about side-effects can be put in the context of normal everyday life and thus construct the "patient" as a whole person rather than as a medically framed patient, is apparent in the conversation between nurse 9 and patient 44. Here we can see how the nurse connects the patient's symptom of tiredness to the lifeworld.

Nurse-led chemotherapy clinic 5. N 5. P 44. Consultation time: 12.22 minutes

N: Tiredness. How have you been this week?

P: Tired

N: Tired?

P: Just the same, yeah

N: Are you getting up and about doing things?

The nurse first steers the conversation towards the lifeworld by asking about the consequences of the man's tiredness in everyday life, in this case in relation to getting up (out of bed) and being active. The man turns and asks his wife about his daily activity.

Nurse-led chemotherapy clinic 5. N 5. P 44. Consultation time: 12.22 minutes

- P: Oh yeah. She had me working. How many days did you make me work this week?
 W: He's been assembling furniture
 N: Has he?
 W: Hmm.... we've gone out a few days somewhere
 N: Right. She's keeping you on your toes, isn't she?
 P: Oh definitely

When the man then brings his wife into the discussion by suggesting that she is the one who has had him working with the assembling of furniture, the nurse immediately joins in on the theme by saying that his wife is keeping him on his toes. When the conversation then moves onto bedtimes, the nurse continues to joke about the way in which the wife influences the man in his everyday life. The nurse says that it is probably not just whether or not there is something worth watching on TV that determines when the man goes to bed. The nurse says jokingly that this probably has something to do with the wife, when the wife stops giving him jobs to do.

Nurse-led chemotherapy clinic 5. N 5. P 44. Consultation time: 12.22 minutes

- N: Do you have a little rest in the afternoon or do you go to bed early?
 P: No, no just go to bed early. I give up and go to bed when there's nothing else on the television
 N: And when she's stopped giving you jobs to do
 P: Well probably because she's got the remote of course
 W: Oh...well that's not so in our house

In summary: In the first sequence, the patient-oriented conversation, the side-effects are discussed without any connection being made to how these might affect the patient's everyday life and family life. The conversation is thus characterised by a patient-oriented medical discourse. On the other hand, in the two following person-oriented conversations, the side-effects are in a clear manner related to the context of the patient's normal everyday life, with activities like going to the pub and drinking beer, or being active around the house. These latter two sequences thus demonstrate how it is fully possible to create scope for the lifeworld discourse or lifeworld voice, and thereby localise health problems within a personal and sociocultural context.

Theme 3: Discursive approaches to patient education

Patient-oriented discourse

In the following excerpt the nurse primarily wants to check how well-informed the patient is about the upcoming treatment and whether the patient has signed the type of consent forms that are required for such treatment. The nurse asks control questions about various side-

effects, for example the increased risk of infection and whether the doctor has talked to the patient about the side-effects. One issue that is dealt with is pain and analgesia.

Nurse-led chemotherapy clinic 4. N 4. P 37 Consultation time: 28.39 minutes

P: Because it's not strong is it, paracetamol?

N: Well.... I must say I find paracetamol very good

P: Oh good. Well you're a healthy young lady. Alright

P: So, if you don't find it effective then something else is more appropriate

P: Yes, I'll try some

N: But most people find this treatment... tolerate this treatment really well... So, they don't often need their pain-killers for aches and pains in their joints.... but it is....

P: It's possible, so you've got to know

N: Exactly. So, you're fully informed

The nurse's primary aim is thus to check how well-informed the patient is in order to be able to fill in the gaps in the patient's knowledge that she believes to exist. She summarises this intention by saying: "So you're fully informed". The discussion about medical issues, pain and analgesia thus does not have to do with her taking the opportunity to teach and for the man to learn more about relevant medical issues.

Another example of how a low level of educational ambition appears in the voice of medicine is when nurse 10 is talking about putting up the patient's chemotherapy. The patient's relative wonders if it is just one bag that will be given and alludes to the chemotherapy with the question: "Is it just one bag?", and the nurse answers the relative's question directly by saying: No that's just the flush. The nurse continues with relevant questions from the chemotherapy point of view, but she misses an opportunity to teach the relative more about the issues.

Nurse-led chemotherapy clinic 4. N 4. P 38 Consultation time: 12.48 minutes

H: Is it just the one bag?

N: No that's just the flush. What I'm going to do I'm going to put up her chemo in a minute.....That's okay now

N: Do you feel okay? Are you feeling fine? Is it sore or anything? No? Okay

N: If you feel any sore or pain or stinging at any time you need to let me know straight away, alright?

N: Okay, so I'm going to put the chemo up...if you feel any different, any abnormal you let us know straight away alright? Okay date of birth again please

P: ...[dob]

N: Thank you okay I'm going to put the chemo up now. It takes about an hour.

She doesn't take the chance to go into a more detailed explanation of what is happening with the treatment in order for the relative and the patient to learn about what is happening with the blood vessel and the medicine and what is required for the blood vessel to be free so that the chemotherapy will flow freely in the blood vessel.

Person-oriented discourse

In the conversation between nurse 2 and patient 11, a person-oriented conversation appears. The nurse gives the woman an opportunity to learn more about her complex pain pattern when the woman starts to talk about her problems with pain. When she says “I get this pain...complete tingling in here ...and up into my ear”, she points to her throat, then coughs lightly to clear her throat. She has obviously found out that there is some connection between her throat and her ears.

Nurse-led chemotherapy clinic 2. N 2. P 11. Consultation time: 21.02 minutes

P: I've already taken some today because when I woke up it was like this then...a sort of connection between here and the ear. A sort of big tingling in the back...and it slightly gives me a headache...like a vague migraine...but not that bad. It's just all interconnected probably

N: Yeah

P: And my ears go pop sometimes as well

N: Right

P: I think that's all I can report really

N: Right

The nurse confirms the woman's story with a "Yeah" and a "Right". When she then asks about whether the pain is going to get worse before it gets better, the nurse explains why she thinks it will get better.

Nurse-led chemotherapy clinic 2. N 2. P 11. Consultation time: 21.02 minutes

P: Is this going to happen? Is it going to get worse before it gets better?

N: I think some of it will get better.... I think the pain in your ear will go because that's You've probably been told there's a nerve that supplies the back of your tongue that also has a branch to your ear, so you get pain in your ear and your tongue. It's nothing to do with anything spreading anywhere it's just the signalling of that nerve. I think as the tumour gets smaller the ear thing will go. Unfortunately, the downside is that you will get sore in a different way ... your throat will get more sore. But that's a little way in the future yet.

She then develops her answer as to why she thinks that the pain in the ear will go away by explaining that there is a nerve that supplies the back of the tongue that also has a branch to the ear. That is why the pain appears in both the ear and the tongue. She also says that it just has to do with the nerve connecting the ear and the tongue, and not at all with anything spreading. So that is why she thinks that when the “tumour gets smaller the ear thing will go”. However, she continues, it will also have the downside that her throat will get sorer. Thus, what is going on in this conversation is that when the “patient” is asking about her pain in both the tongue and the ear, the nurse takes the chance to teach the patient more about these very relevant medical issues.

In summary: The educational ambition in the patient-oriented conversation was a fully informed patient prepared for the treatment. To guarantee this the nurse was asking control questions about various side-effects. In the two following person-oriented conversations, this ambition was superseded by the nurse trying to give the man a possibility to learn more about how there is a connection between different forms of pain in the body. In the patient-oriented conversation, the ambition is thus about informing, while in the person-oriented conversation it has more to do with an ambition to educate, with focus on the man as a learning person rather than as an informed patient.

Theme 4: Discursive approaches to feelings, worries and concerns

Patient-oriented discourse

The two following conversations are examples of two completely different approaches to addressing the feelings that serious diseases awaken in people. The first consultation begins with the nurse asking the patient if everything has gone well since the last examination. When the patient answers, she looks anxious and turns to her husband, who shakes his head and replies that it has not gone well.

Nurse-led chemotherapy clinic 1. N 1. P 2. Consultation time: 20.27 minutes

N: "So we met last Friday didn't we, before your planning scan...did that go okay?"

P: "No, it didn't really, did it?" [Patient looks anxious, turns to her husband who shakes his head]

N: "I know by the time I phoned you Friday afternoon you'd had enough about all of these appointments being changed around?"

P: "You'd thingy'd it off didn't ya?....I'm supposed t'start tomorrow"

The nurse doesn't address the woman's and her husband's feeling of concern, instead she continues on the medical path by proceeding with her own medical agenda. Instead, she tells them what she wants to do and that she wants to go through everything face-to-face and not over the telephone. "Well we need to...what I want to do today is go through everything with you because it's much easier to do it with you when we're sitting here than try to do it over the phone". The conversation then continues with the nurse bringing up various medical issues, like blood tests.

Nurse-led chemotherapy clinic 1. N 1. P 2. Consultation time: 20.27 minutes

N: Well we need to...what I want to do today is go through everything with you because it's much easier to do it with you when we're sitting here than try to do it over the phone

P: Yeah cos we're over there...

H: at that nuclear medicine...

P: at 20 past 12 I have to be back

N: We'll be finished here by 20 past 12...okay is that for your first blood test?

P: I've had one
 H: had one...
 N: You've had one?
 P: Yeah I've had one and I have to go back.
 N: And is that your last one... or have you got one more after that?
 P: Wait a minute...Have I got one more after that?
 H: No you've only 2 to do I think
 P: Oh I can't remember..."
 N: Well they'll tell you when you get back

From the discussion it is apparent that the matter of the blood test is not entirely clear to any of the parties involved, which seems to worry the patient further. She turns to her husband looking puzzled, then starts to look flustered and unsure and laughs nervously. However, the nurse continues to ignore the patient's signals of worry and instead proceeds on the medical path.

The conversation as a whole is characterised at an overall level by the parties involved, the nurse, the woman and her husband, interrupting each other over and over again or putting words in each other's mouth, which can be seen as an expression of the worries that seem to be present during the greater part of the conversation. However, the woman's and her husband's replies and body languages could have provided a path to transition into a more person-centred conversation. But the nurse does not accept this invitation, or perhaps she doesn't even understand it to be an invitation, and instead she quickly steers the conversation back to the Non-person-centred parlance of the medical discourse.

Person-oriented discourse

However, the fact that it is completely possible to address the feelings that appear during a consultation is demonstrated by the conversation between nurse 7 and patient 45. In this conversation the nurse responds to the man's invitation to also discuss emotional phenomena. When the man talks about how several members of his family had taken part in a charity race, his eyes fill with tears, in particular when he describes how his daughter had said that she was doing it for her daddy. The man continues by saying that he could become a bit emotional, and starts to cry sometimes.

Nurse-led chemotherapy clinic 5. N 5. P 45. Consultation time: 46.57 minutes

P: I do find I get a bit emotional and can't talk...I cry...I don't know why...but sometimes....
 N: Yeah...do you find you lack concentration sometimes with the chemo?
 P: I'm not going senile! [laughs]
 N: No I don't mean that. You could be watching something on tele and then suddenly....and think I don't understand that

The nurse latches onto the man's expressions of emotion and says that this is quite common, for example that one's emotions can be stirred if you see something on TV. The patient replies that when he is feeling a bit rough he usually says that he doesn't want to watch any more.

Nurse-led chemotherapy clinic 5. N 5. P 45. Consultation time: 46.57 minutes

P: If I'm feeling a bit rough I just say I don't want to watch anything

W: Yeah you do get all tearful when watching emotional things

P: I don't know why... it doesn't make sense..... I'll put it down to the chemo anyway

N: Yeah it does

P: If anything goes wrong it's the chemo's fault

N: It is ...blame everything...chemo mush brain

P: I don't know how [consultant] keeps his up [laughs]...I get on with him very well. He's a nice man

W: He is... he's so nice

P: But he kept me going for another 4 years so that ain't bad is it? ...another 4 years would do me. I'm not greedy

W: I think we've all got to take each day as it comes sometimes haven't we?

In this sequence both the man's wife and the nurse go in and confirm the man's feelings in different ways; the wife by saying that he becomes "tearful when watching emotional things", and the nurse by saying "Yeah it does" when the man suggests a connection between his tears and feelings and the chemotherapy. The nurse attempts to be with the patient and allow the patient to lead the conversation.

In summary: In the first sequence the concern shown by the man and his wife, both verbally and non-verbally, is ignored. The fact that the participants often interrupt one another suggests that the concern remains under the surface during large parts of the conversation. In the second sequence the man's emotions are confirmed by both the nurse and his wife, which means that the man is confirmed as a person with a family life, and not just as a patient with a life at the hospital.

Theme 5: Discursive approaches to decision making

Patient-oriented discourse

The most common and frequent decision-making pattern that appears in the material as a whole is that the "patient" just accepts the suggestions without any comments. One example is the consultation between nurse 1 and patient 2.

Nurse-led chemotherapy clinic 1. N 1. P 2. Consultation time: 20.27 minutes

N: "What I've been told and what the consultant wants...and she's planned all your treatments...is she wants you to start your radiotherapy on Tuesday...okay?....because that would be a better treatment for you"

P: "Yeah...so what about tomorrow?"

N: "Tomorrow we still want you here, because we could do your blood transfusion tomorrow..."
 P: "Oh...right"
 N: "Okay?"
 P: "Yeah"

The only comments that the "patient" seems to have are "Yeah...", "Oh...right" and "Yeah". This is a pattern that appears in most conversations in Non-person- centred consultations.

Person-oriented discourse

However, on rare occasions another approach to decision-making appears in the data, a pattern which is most obvious in the following consultation. When the nurse (N5), the patient (P45) and his wife (W) are discussing the chemotherapy, the nurse and the wife initially take it for granted that the man wants to continue with the chemotherapy.

Nurse-led chemotherapy clinic 5. N 5. P 45. Consultation time: 46.57 minutes

N: Right let me just see your clinical plan.... Well according to this ...
 W: This is our last one, wouldn't it...at the moment?
 N: You've got ...so he's prescribed you ...
 P: He told me to keep taking the chemo tablets till tomorrow. I've still got a day's chemo to take...21 days
 N: You've done 21 days?
 P: Yeah. Before that I had it for 14 then a break for 7 days
 W: That's 4 years back isn't it?
 P: Yeah
 N: Okay let me just bring your last one....let's just sort this out because there's nothing worse than being a little bit confused about things is there?
 W: That's right. That's what we wanted to sort out was whether he had to have another one or whatever
 N: Right. Usually you have ...he'll do 4 cycles and then do a CT scan
 P: Right
 N: Right? And see how the chemotherapy has worked
 W: Responded?
 N: Yeah. If the chemotherapy has responded and things have shrunk down then they would go on for another four. Alright?

Hence, both the nurse and the wife assume that the man wants to continue the treatment if he responds well to it. However, for the man this issue is not as clear-cut. He may answer yes, but he does so with a strong reservation by saying that it depends on how he responds to the treatment.

Nurse-led chemotherapy clinic 5. N 5. P 45. Consultation time: 46.57 minutes

P: Yeah. But if it aint I won't be having no more anyway?

W: Well you don't know

P: I won't. I'm telling you. It's my decision

N: He's decided, yeah?

W: Okay, that's fine yeah...whatever

P: I done it this time and I aint doing it a second or 3rd time, as far as I'm concerned... and if it only keeps me alive for a month or maybe two

W: Well you don't know. It's one of those things

When the wife tries to question what the man is saying, he replies firmly "I won't. I'm telling you. It's my decision". That it is his decision is then confirmed in a different manner by both the nurse and the wife. The man responds to this confirmation by expressing even more clearly that he is not doing it a second or third time, as far as he is concerned if it will only keep him alive for a month or two. However, both the nurse and the wife try to soften the man's resolve by expressing in different ways that the man perhaps cannot really know right now. The nurse proposes that the man should at least wait until the next treatment results, since it is such a complicated matter about which to decide.

Nurse-led chemotherapy clinic 5. N 5. P 45. Consultation time: 46.57 minutes

N: Let's do the 4 cycles and then look at your CT scan and see how things are

P: Right we'll do that

N: We have to you know there's no point in jumping the gun and saying right I'm not having anything else because we don't know what the scan's going to show. Also erm...you know you're saying that now but if there was something like it may have a bit of mixed... it might have mixed the CT scan, you might have some things that have shrunk and something might have got a little bit bigger so it might mean we might have to shift chemotherapy to a different one to see if we can make things even better.

P: Right. Re-tuning?

"Right we'll do that" the man says, thus showing that he can follow the nurse's line of thinking and suggestion to wait until after the next round of treatment before making a final decision.

Nurse-led chemotherapy clinic 5. N 5. P 45. Consultation time: 46.57 minutes

N: Yeah, but it is your choice ultimately though

W: Of course

N: Because the side-effects can sometimes outweigh the cancer itself, alright...

Both the nurse and the wife once again confirm that the final decision is the man's to make, and the nurse also says that she truly understands that one can sometimes feel so down that "you just want to stuff it".

Nurse-led chemotherapy clinic 5. N 5. P 45. Consultation time: 46.57 minutes

P: And sometimes you feel that bad you think ‘stuff it’

N: Yeah I can understand that, I really can

In summary: An important component of person-centred care is shared decision-making whereby the patient to whom the decision applies has the final word. This process is not particularly apparent in the material in its entirety, although a clear exception is the second sequence above, where the man who is being treated for cancer “fights” to ensure that the decision about whether or not the treatment shall continue is ultimately up to him. In the discussion between the man, his wife and the nurse, the man comes across as a fully entitled person with the power to make his own treatment decision.

Discussion

The analysis of the empirical data showed that the dominant discourse was the non-person-centred discourse framed by the biomedical model. Thus, our findings were comparable to those of other similar studies in cancer care and other fields. The change to a person-centred form of care, which is considered necessary, has not yet become an obvious element of consultations with nurses (McCance et al., 2010; Ekman et al., 2011; Ishikawa, 2013; Siouta, 2016). However, in our data, it was also possible to identify examples or fragments of the person-oriented discourse that localised health problems within the patient’s personal and sociocultural context. This was found in all of the themes identified in this study. As was demonstrated in our description of Theme 1, showing an interest in the patient’s wellbeing at the beginning of the conversation by asking questions about the patient’s feelings and personal context was a means of making person-centeredness possible by avoiding bringing medical issues to the foreground at the very beginning of the consultation. The examples presented for Theme 2 showed that discussing medical side effects in relation to the patient’s normal everyday life, such as going to the pub, and thus treating the issue as a social personal problem instead of only as a medical issue was another possibility. The examples presented for Theme 3 showed that, to make person-centeredness possible, it was also crucial to raise the educational ambitions of the consultations, giving the patient opportunities to learn more about his or her disease, with a focus on the patient as a learning person rather than only an informed one. In Theme 4, the importance of how to address the patient’s feelings of worry and concern—feelings that serious diseases awaken in people—became evident. A means of making person-centeredness possible was to confirm, rather than neglect, the emotions that appeared in the consultations. In Theme 5, the importance of shared decision making became evident. When it was clear that patients had the final word, they were able to come across as fully entitled persons with the power to make their own treatment decisions.

The findings indicated that the nurses in this study did not see the person behind the illness/perceived health problem and instead focused to far too great an extent on biological markers, with a result that contradicts the desired discursive shift to person-centeredness. Ordinarily, health care communications focus on the delivery of information. This monological

perspective on communication is based on a dualistic-reductionist paradigm that attempts to reduce the experience of illness to a system of diagnoses (McCabe and Timmins, 2013; Ijäs-Kallio et al., 2010; Peräkylä et al., 2007; Linell, 2014; Linell, 2011). This kind of interaction, which occurred between patients and nurses in consultations, is considered to be rooted in a power relationship (Mishler, 1984; Siouta, 2016). The premise is that communication through the ‘medicine voice’ leads to the non-involvement of patients. In contrast to traditional medicine as the dominant starting point in the biological model, in a person-centred perspective, medical issues provide a complement to the narrative of the patient’s experience of his or her situation (Kristensson Uggla, 2014; Ekman et al., 2011). By listening actively to the patient’s ideas, being open to the patient’s thoughts and encouraging reflection, the person’s strengths can be identified and used as a resource and asset in the consultation (Siouta et al., 2016). Our results showed that it was possible to identify fragments of this kind of discourse—a person-oriented discourse, or the ‘lifeworld discourse or lifeworld voice’ that Mishler (1984) and Uitterhoeve et al. (2009) advocate. Taken together, all of these fragments showed that it was possible for nurses to allow a person-centred approach to permeate different parts of the consultation and hence the consultation as a whole. For instance, in some conversations, the nurse started by posing questions about how the patient was feeling in the foreground of the interaction, thus showing an interest in the person as a whole human being. Beginning the consultation in this way creates a good basis for a person-centred discussion of various relevant medical issues. In one conversation, the nurse steered the conversation towards the lifeworld context by asking about how side effects such as tiredness in everyday life were affecting the person’s activities during the rest of a day. This is in harmony with Mishler’s (1984) and Uitterhoeve et al.’s (2009) consideration that placing patients’ experiences of illness into the lifeworld or everyday life is important.

In another consultation, side effects were discussed in relation to possibilities for living a normal everyday life, with activities like going to the pub and having a beer or two. Thus, the side effects were localised within the personal and sociocultural context. This created a certain health-promoting atmosphere and opened a space for the person’s will, resources, motivation, emotions and possibilities to participate, thus toning down the aspects of sickness and the ideas of illness and of being weak and perhaps depressed (McCance et al., 2010; Ekman et al., 2011; Han, 2013). In this atmosphere, it also became natural to confirm the person’s worries and negative and positive emotions—for example, when a man’s eyes filled with tears as he told the nurse that his daughter had said that she had taken part in a charity race for her daddy. When the nurse confirmed the man’s emotions about the situation, she was also confirming him as a whole person with a family life. When the patient’s daily life became an obvious dimension in the conversation about the disease in this manner, his daughter was also given the opportunity to be involved and become an active participant. The participation of relatives gave nurses increased insight and hopefully a heightened interest in the lifeworld of the patient. This made it possible to discuss the relative’s ability to provide support and to contribute to care.

One crucial element of person-centred care is giving the person a chance to be a learning person, rather than just an informed patient (Ekman et al., 2011). One example of how the person was constructed as a learning person was when a nurse explained how pain in the ears can be connected to pain in the tongue. This gave the person a chance to have a deeper understanding, not only of the pain but also of the treatment as a whole (Brink and Skott, 2013; Salmon et al., 2007; Epstein and Street, 2011; Starfield, 2011; Sainio and Lauri, 2003; Sainio et al., 2001). Another crucial element of person-centred care—probably the ultimate one—is confirming that the ultimate decision about whether to continue or stop the treatment is in the hands of the person him- or herself. The processes in decision making about treatment were not

particularly apparent in the consultations. However, there was one clear exception, where a man who was being treated for cancer ‘fought’ to ensure that the decision about whether or not the treatment would continue was ultimately up to him. In the discussion among the man, his wife and the nurse, the man came across as a fully entitled person with the power to make his own treatment decisions. Thus, even if the paradigm shift to person-centred caring is still yet to come, we can see in the consultations studied that many possibilities appear for health personnel to implement the desired paradigm shift. It was always possible for the participants in the consultations to verbally construct the person-centred discourse.

It was also always possible for nurses to create the scope for the lifeworld voice and for localising the health problem within a personal and sociocultural context. Nurses could use communication to socially construct the consultations as a person-centred discourse and, hence, as a meeting between persons. The consultation as a social practice or reality was constructed through constant social interaction and communication between the nurses and the patients (Berger & Luckmann, 1991; Burr, 2003). As shown in all of the examples of person-centred communication presented here, the crucial issue in the consultations was the participant’s cue-responding behaviour. When the nurse showed an interest in the patient’s wellbeing at the beginning of the conversation, his or her words became a cue that made it possible for the patient to respond in a personal way. Likewise, the patient’s response became a cue for the nurse that made it possible to continue with person-centred questions, or, when the patient started to talk about going to the pub, became a cue for the nurse to ask personal questions, which, in turn, became a cue for the patient to continue to talk about his or her family life. Thus, the participants’ questions and answers created circles of cue-responding behaviour. These circles, in turn, created the desired shift to a person-centred discourse and space.

Importantly, this desired shift does not mean the exclusion of important medical and biological indicators. Person-centeredness is an inclusive process, which means that both biological and lifeworld markers need to co-exist in interactions among nurses, patients and their relatives. However, the relevant medical questions need to be framed within the patient’s lifeworld as part of the person’s identity. In a person-centred perspective, the important biological indications should provide a complement to the narrative configuration of the patient’s experience of his or her situation (Mishler, 1984; Kristensson Uggla, 2014; Ekman et al., 2011). Because patients often prefer to express their emotional concerns to nurses rather than to general practitioners (Heyn et al., 2012), nurses in nurse-led chemotherapy clinics can focus on person-centred care. Despite similarities in clinical skills, training and prescribing, there were large differences between clinics run by chemotherapy nurses and those run by advanced nurse practitioners. These include differences in the number of patients seen in the clinics, operational aspects, nurses’ autonomy, the scope of practice and clinical decision-making abilities. However, these factors were heavily influenced by medical consultants. Several nurses expressed the perception that they were undertaking holistic assessments; however, they were using medical models/consultation styles, indicating the medicalisation of nurses’ roles (Farrell et al., 2017).

In the present study, we did not focus on how the clinical environment might have affected nurses’ and patients’ possibilities for constructing a person-centred discourse. However, other studies of nurse–patient communication have revealed that the contextual factor of a packed schedule with the related time constraints could hamper the quality of the psychosocial care provided by nurses in nurse-led chemotherapy clinics (Northouse et al., 2012). Therefore, it is likely that time factors may have played a role also in the consultations studied here. However, because the consultations in the present study lasted between from 3 to

56 minutes, it is nevertheless reasonable to assume that there was enough time and sufficient opportunity to hold person-centred conversations. The presence of a family member influenced the construction of discourses in the consultations, sometimes supporting the construction of a non-person-centred discourse and sometimes supporting the construction of a person-centred discourse. For instance, in one conversation, both the nurse and the patient's wife confirmed a man's emotions and thus his status as a person with a family life, rather than just a patient with a life at the hospital. Despite the fact that the role of patients' relatives was not a focus in our analysis, our findings indicated that relatives can play an important role in the formation of consultations. We agree with De Leeuw et al. (2014) that more research is needed to further the understanding of the complexity of family dynamics and the three-way communication in these consultations.

Conclusions

The change to a person-centred form of care that is considered necessary has not yet become an obvious element of nurses' caring practice; in fact, the analysis showed the opposite. The dominant discourse was still the non-person-centred discourse framed by the biomedical model. Furthermore, the prominent use of the non-person-oriented discourse in a patient's assessment/evaluation in consultations may also make it difficult for patients to raise questions and concerns from their daily lives during the consultations. However, fragments of a person-oriented discourse show that it is possible for nurses to develop a person-centred approach to consultation, thus using their time to offer person-centred care instead of replicating the traditional biomedical model. One crucial aspect of person-centred care is giving the person the chance to become a learning person and a person who is competent to make his or her own decisions—not just an informed and obedient patient. To make this possible, the nurse must become a learning nurse. Thus, the development of life-long learning patients and life-long learning nurses go hand in hand because these are two mutually dependent processes.

Implications for practice

The present study indicates that it is important to make changes in communication training modules so that nurses can learn how to incorporate lifeworld elements such as the patient's wishes, worries and concerns into their consultations. This kind of pedagogical implication is related to raising nursing students' and practicing nurses' awareness of the role of evaluative language in enhancing person-centred communication with patients in clinical interactions. It is also related to the nurse's ability to respond to the patient's person-centred cues. Nurses must learn how to become not only cue-responding but also cue-seeking for patients and their family members in nurse-led chemotherapy clinics. Transcript excerpts of examples of person-centred and non-person-centred approaches presented in this article can be used in the learning process in basic education for nurses and for further education among nurses in cancer care.

Study limitations

There are several limitations to our study. Reflexivity is important because the researchers' own experiences and assumptions might have influenced the data collected. The

patients and nurses were aware that studies about the roles and autonomy of nurses within nurse-led chemotherapy clinics, Farrell et al., (2017), were being conducted, and this may have caused them to alter their communication (Priest and Roberts, 2010). Future studies should ask participants to comment on this aspect after they have been shown the transcripts. The participants in this study were not screened regarding their expertise as person-centred nurses; therefore, the study would benefit from a comparison of participants' perceptions of how they communicate person-centredness with how they enact these views, particularly with regard to evaluation as conceptualised in this study. We did not attend to the distribution or quantity of evaluations across the study settings, investigate differences between more and less experienced nurses, or take into account nurse or patient gender as a variable. However, the detailed nature of the results makes them ideal for transferability. The transferability of the findings invites readers to make connections between the study findings and their own contexts and experiences. In doing so, readers must of course consider differences between the context outlined here and their own contexts.

Acknowledgements

We are grateful to the participating nurses and patients. We are also grateful to associate professor Ulf Olsson, Stockholm University, Sweden, for the help with the reading of the manuscript. The study has not received any funding.

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