University of San Diego

Digital USD

Dissertations

Theses and Dissertations

1992-12-01

# Sociolinguistic Dimensions of Nurse Practitioner Practice: A Question of Power

Merrily J. Allen DNSc, MN, RN
*University of San Diego*

Follow this and additional works at: https://digital.sandiego.edu/dissertations

Part of the Nursing Commons

## Digital USD Citation

Allen, Merrily J. DNSc, MN, RN, "Sociolinguistic Dimensions of Nurse Practitioner Practice: A Question of Power" (1992). *Dissertations*. 241.
https://digital.sandiego.edu/dissertations/241

This Dissertation: Open Access is brought to you for free and open access by the Theses and Dissertations at Digital USD. It has been accepted for inclusion in Dissertations by an authorized administrator of Digital USD. For more information, please contact digital@sandiego.edu.

# SOCIOLINGUISTIC DIMENSIONS OF NURSE PRACTITIONER PRACTICE

# A QUESTION OF POWER

by

Merrily J. Allen, MN, RN

A dissertation presented to the

FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING

UNIVERSITY OF SAN DIEGO

In partial fulfillment of the

requirements for the degree

DOCTOR OF NURSING SCIENCE

December 1992

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

## Abstract

Ethnographic methods were used to examine the sociolinguistic dimensions of female nurse practitioner interactions with female patients. The purpose was to provide a contextual account of the discursive practices used by the nurse practitioners during routine office visits with female patients. Direction for this research was provided by my concern about power inherent in professional-client dyadic relationships. Data collection methods included formal and informal interviews, participant observation and audio taping nurse-patient encounters. Nine nurse practitioners and 26 patients participated in the study in both private and public ambulatory care settings.

Data analysis yielded two concurrent story lines which I labeled "language as process" and "patterns of language". These two story lines eventually converged on the question of power in nurse practitioner encounters with patients.

The language process that characterized the encounters consisted of five action oriented linguistic steps or phases that served to establish the ambiance, as well as control the pace, and direction of the office visit The steps or phases were identified as: openings, transitions to business, the business at hand, transitions to closure, and closures.

The four major linguistic patterns that seemed to characterize the talk of the nurse practitioners as they interacted with female patients were as follows: Supporting, informing, controlling and professional jargon.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Instances of sociolinguistic power were identified in the processes that controlled the pace and direction of the office visits and potentially truncated data gathering. Controlling language, including warning and command statements, and the use of professional jargon were also examples of power embedded in the language of nurse practitioners identified in the verbatim transcripts.

Some implications for this study relate to educating nurse practitioners about the transparent power of language, and the potential for untoward outcomes for patients when that power is not recognized.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# DEDICATION

This work is dedicated to the memory of my husband, Erik David Allen, who never failed to remind me "you can do it kid!" when ever I felt overwhelmed by a difficult task. Well dear David the kid finally did it!

I also dedicate this work to my family who were wonderfully supportive. To Erik Jr. and Elizabeth Burton Allen, oldest son and daughter-in-law, daughter Merry J. Allen and son Neal A. Allen, to youngest daughter Angela Allen Garcia and son-in-law Jim Garcia, and to my mother-in-law Althea Allen, who has waited a long time to celebrate this occasion with me.

Finally, to grandson David who watched so intently, if not so patiently, as I worked on this project, and to granddaughter Alissa Merrily, now we can play!



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

## Preface

While this was often a lonely process, I never-the-less had a great deal of assistance from a number of individuals. I wish to acknowledge them in this section. I begin with the faculty and support staff of Philip Y. Hahn School of Nursing. In particular, I wish to acknowledge and thank the members of my dissertation committee, Mary Ann Hautmann, PhD, RN, chair, and Kathleen Heinrich, EdD RN, from the University of San Diego, and Janice Thompson, PhD, RN, from the University of Southern Maine.

I also wish to acknowledge the participants in this study who were willing to have their conversations and interactions observed and recorded as part of the research process, there would not be a dissertation report without them. I thank Susan Harris, DNSc. colleague and friend for her contribution to data analysis, her never failing sense of humor, and her understanding of what works. I am grateful for the reassurance that this work would be finished provided by Dr. June Lowenberg. I thank my niece, Annette I. Kostenko for her editorial and word processing assistance, as well as her gourmet cooking and good company over the summer of '92.

Finally, I wish to acknowledge and thank the women of the summer of '85 who came together to learn under the "womentoring" of Dr. Jacqueline Fawcett and Dr. Janice Thompson, and came away for ever changed. Thank you all.



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

TABLE OF CONTENTS

Page

Abstract ........................................

Dedication ...................................... ii

Acknowledgements................................. iii

List of Appendices .............................. vii

CHAPTER 1

INTRODUCTION................................ 1

Nursing and communication............... 4

Power Relations in Medicine............. 6

Nurse Practitioners:
Relations of Power or Empowerment........ 8

Purpose ................................. 11

Assumptions ............................. 12

Significance of Study.................... 13

CHAPTER 2

Selected Literature Review .................. 15

Philosophical Perspectives on Language.. 15

Pragmatics.............................. 17

The Power and Language Connection ...... 22

Post-Structural/Post-Modern Perspectives 24

Feminist Perspectives on Language and Power 27

Nursing as Interpersonal/Linguistic Process 31

Empirical Literature.................... 37

Language and Power:
Micro-sociological Processes in Medicine 45



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER 3

Research Methodology and Method.............. 55

Research Method ........................ 56

Ethical Considerations and the Protection of Human Participants .................... 60

The Setting ............................. 62

Entree to the Setting and Access to Participants.......................... 63

The Sample.............................. 65

Data Collection.......................... 66

Data Recording........................... 69

Data Analysis ........................... 73

Trustworthiness and Qualitative Methods.. 76

CHAPTER 4

Language as Process ......................... 81

Openings................................ 82

Transitions ............................. 90

The Business at Hand .................... 97

Closure ................................. 104

Summary ................................. 106

CHAPTER 5

Patterns of Language ......................... 110

Supporting .............................. 111

Informing ............................... 136



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Controlling.............................. 144

Professional Jargon ..................... 152

Summary ................................. 160

CHAPTER 6

A Question of Power.......................... 162

CHAPTER 7

Reflections and Summation.................... 173

REFERENCES................................... 183

APPENDICES

Appendix A Information Letter ................ 196

Appendix B Nurse practitioner consent form.... 198

Appendix C Patient consent form............... 199

Appendix D Demographic Profile................ 200

Appendix E Interview Probes................... 201

Appendix F Protection of Human Subjects ...... 203

Appendix G Experimental Bill of Rights......... 204



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# CHAPTER 1

## Introduction

> What I shall have to say here is neither difficult nor contentious; the only merit I should like to claim for it is that of being true, at least in parts. The phenomenon to be discussed is very widespread and obvious, and it cannot fail to have been already noticed, at least here and there, by others. Yet I have not found attention paid to it specifically.
>
> How To Do Things With Words
> John Austin, 1962, p. 1

Language is defined as a rule governed system of conventional signs, sounds, gestures, or marks having understood meaning for a community of speakers and writers. Language is the principle medium by which we share ideas, feelings, and information. However, language scholars such as John Austin (1962), suggested that through language we do more than simply inform or report. Language is also a powerful medium through which we control or regulate our environment, including the people with whom we interact. Sociologist Pierre Bourdieu (1977, p. 648) further posited that "Language is not only an instrument of communication or even of knowledge, but also an instrument of power."

My interest in the relation between power and language developed after observing nurses and other health care workers, in a variety of settings, talking with their peers, students, supervisors, and patients. The observed encounters contributed to the troubling perception that nurses used



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

controlling language behaviors (ie. commands, warnings, interruptions and silences) with less powerful others such as patients and students as frequently as they used language to inform, comfort or empower them. In diverse situations and settings, language was the medium that dichotomized the interactional environment, creating conflict or consensus, enhancing or repressing the learning process, and controlling the autonomy of one type of health care worker while legitimating the claims of another to a position of authority. Language also regulated patient access to information about their health status, as well as empowered them to make informed decisions about their care. These are powerful uses of an otherwise ubiquitous and often taken for granted system of signs and sounds.

Philosophy and the social sciences have a rich and varied tradition of scholarship related to language. The diverse perspectives within the philosophy of language may be reduced analytically to two which present language as an entity to be intellectually understood versus those which view language as praxis (McCarthy,1979). For example, some early linguistic scholars examined language as a formal, logical abstraction, ignoring the social and political context of its formation and use (Thompson, 1984). Others theorized about such things as rules of syntax (Carnap, 1937), the formal structures of language which specify truth and meaning (Tarsky, 1944)), and communicative competence in idealized language situations (Chomsky, 1975).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The ordinary language philosophers, on the other hand, viewed language as inexorably enmeshed with the every day affairs of those who use it. Following Ludwig Wittgenstein (1953,1968), the ordinary language scholars developed arguments which illuminated both the social, and action character of language. Wittgenstein (1968) theorized about language games as a form of life; Austin (1962, 1970) focused on how to do things with words in the development of speech act theory; Searle (1967), among others, critiqued and expanded on Austin's work; and Habermas (1981/87) took speech act theory as the point of departure for a theory of communicative action. In sociology, Bourdieu (1977) theorized about power relations manifested in language, particularly related to issues of race and class, as a type of symbolic violence. These perspectives contributed significantly to the emerging discipline of sociolinguistics.

Sociolinguistic inquiry has focused on the structural, organizational and interactional aspects of language in social situations (Gumperz & Hymes, 1986). For example, studies of conversation have demonstrated that linguistic exchange is a matter of negotiation between the participants. There must be some implicit and/or explicit agreement on the rules for the interaction in order to initiate and sustain it (Gumperz, 1981). Power relationships embedded in professional - client encounters has been one of the major areas of sociolinguistic inquiry; the physician - patient encounter being the focus of study more than any other

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

professional - client dyad (Fisher, 1978; Fisher & Todd, 1983; Stoeckle, 1987).

Finally, feminist scholarship across disciplines has contributed to more than a decade of sociolinguistic inquiry focused on the relationship between gender and language particularly as sources of power and control in a variety of interactional contexts (Thorne, Henley & Kramarae, 1986). For example, Hellinger (1988) explored issues of sex discrimination through languages which fostered generic man as the appropriate reference for all humans. Semantic changes which occur in language overtime and which tend to derogate women was the focus of work by Schulz (1975). Language behaviors that characterized talk between women, was the focus of studies by Aries (1976), and Goodwin (1980). They suggested active listening, flexibility, and collaboration as dominant patterns of communication between women. In contrast however, relations of power and dominance were characteristic of talk between male physicians and female patients in work by Fisher (1986), Richards (1988), and Todd (1989). If language is central to the dynamics of human interaction, as these various scholars suggest, then inquiry regarding sociolinguistics in nursing can be an important and useful endeavor.

Nursing and Communication

Much of the theoretical and empirical inquiry in nursing related to language has derived from the broad scope of communication literature. For example, Pluckhan (1978),

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

described communication as central to all that is essential for competent nursing practice and further identified it as integral to theories of interpersonal relationships in nursing developed by King (1971,1981), Orlando (1961), Peplau (1952; 1992) and Travelbee (1971), among others.

Peplau (1952; 1992) addressed the issue of patient's "felt needs" and the use of the nursing process, within the context of the dyadic relationship to educate and facilitate personality development. Nurse as teacher, resource person and counselor were all roles with an assumed communicative component. Orlando (1961) defined the patient as an individual with needs expressed by verbal and nonverbal behaviors, postulating that unmet needs increased patient distress which interfered with recovery. Within the context of the nurse - patient interaction the nurse acted to alleviate patient distress by attending to communicative components of care as well as the physiological. King (1971) described patients and nurses as interactants in interpersonal systems subsumed by larger social systems. Therapeutic nurse-patient relationships require that nurses understand the interactive nature of the health care system, as well as the status, power, and authority structures inherent in the system. Communication skills were described as central to King's theory since the nurse and patient engage in a process of action, reaction and transaction to arrive at mutually negotiated goals for regaining and maintaining patient health.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Very few nursing studies have focused on language per se, spoken or written, as a medium for accomplishing specific nursing goals ( Henry & LeClair,1987; Kasch & Dine,1988). To date only Kliewer (1986) and Taylor, Pickens and Gedens, (1989) have addressed language in relation to the issue of power embedded in nurses talk with patients. This is in contrast to a large body of research literature that has focused on physicians communication with patients.

Power Relations in Medicine

Empirical research focusing on medicine has revealed sociolinguistic dimensions of power or control in dyadic encounters which may have implications for nursing practice, given an overlapping interest in meeting patient health and illness care needs. Furthermore, nurses are educated in the health sciences in ways that are somewhat similar to physicians. Nurses serve as resources for health information, provide direct care and act as gate keepers in the distribution of health services. These functions tend to invest nurses (as well as physicians) with expert authority and power in relations with patients. As a result, a power differential may exist between the nurse or physician and the patient which is manifest in a variety of ways. For example, the use of professional jargon in medicine was demonstrated to limit patient access to needed information for making informed health care decisions, as well as to generally display a kind of social one-upmanship by insiders (Shuy, 1983).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Another aspect of medical jargon can be reasoned from Bourdieu's notion of language as symbolic asset or capital (1977). In the health care setting medical jargon carries a high value. It is invested with value and power because of the authority of those who speak it, and like wise, its very use reinforces the insider status and authority of its' speakers. The synergy between language and the perceived authority of the speaker produces a type of linguistic power.

West (1984) identified another perspective on linguistic power in the structure of physician-patient discourse. Male physicians in West's study, dominated medical encounters with female patients by routinely interrupting the patient and by controlling the topics to be considered throughout the medical interview. Linguistic behaviors of this sort truncate the data gathering process and ultimately decrease patient satisfaction and adherence with treatment regimens (Cartwright, 1964; Palmer, 1989). West's study clearly demonstrated that some male physicians routinely engaged in oppressive behaviors with women patients, a concern for all women, as well as feminist scholars.

Fisher (1979) and Richards (1988) found that male physicians employed the strategic use of language to persuade patients to accept treatment decisions which often met physician goals, rather than patient goals. This was particularly true in public or government sponsored settings as opposed to private practice settings. These decisions may have been based on social, cultural, gender, or economic

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

biases, or the more pragmatic organizational need for the physician (in the case of medical students and residents) to gain experience doing particular surgical procedures. Regardless of the basis for the physician's decision, it is clear that asymmetry exists in the physician-patient relationship, given the physician's greater knowledge and status as care giver and reservoir of medical information. Furthermore, asymmetry can be demonstrated through language that places the patient (particularly the female patient) at a disadvantage in encounters with physicians. These examples of controlling language behaviors are consistent with domains of speech action identified and termed strategic by Habermas (1979), instrumental by Bourdieu (1977) or regulative or persuasive by Yoos (1984). From a feminist perspective these behaviors are clearly expressions of domination within capitalist patriarchy.

The foregoing studies introduced the problematic nature of powerful language processes and behaviors used by physicians in patient encounters to manage or control the interaction and the outcomes. They have also provided a framework for discovering those sociolinguistic structures or behaviors which characterize the actual practice of nurse practitioners.

## Nurse Practitioners: Relations of Power or Empowerment?

As suggested earlier in this chapter, nursing shares with medicine an interest in, and concern for the health needs of patients, as well as a potential for power in

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

relations with patients. In ambulatory care settings, where nurse practitioners typically function as primary health care providers, they share similar case loads with physician co-workers. Depending on nursing background and nurse practitioner preparation, and work environment (medical versus nursing model) nurse practitioners may also share similar diagnostic, intervention, and evaluation processes, including ways to manage or control the patient interaction. Additionally, productivity requirements established by some employers limit the amount of time that can be spent with patients, a practice which reinforces the perceived need to control the encounter.

Sociological studies directed toward physician-patient interactions have clearly demonstrated that physicians control the patient encounter primarily by linguistic means (Shuy, 1983; Todd, 1989; West,1984). Although linguistic strategies of hospital nurses have been studied (Fosbinder, 1990; Kliewer, 1986; Mathews, 1962), little research has been directed toward the dimensions of language and power in nurse practitioner-patient interactions. We can only speculate about linguistic strategies or behaviors used by female nurse practitioners in patient encounters, and wonder if they are similar to those identified with physicians, or if they reflect the mutuality, and intersubjectivity, attributed to women's ways of talking.

Most research on nurse practitioners has focused on performance, interventions, and outcomes in comparison with

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

physicians (Prescott & Drescoll,1979; Sullivan, 1982). This body of literature indicated that, within their scope of practice, outcomes are equal to and in some cases better than outcomes for patients managed by physicians. Sullivan (1982, p. 8) noted that nurse practitioners "continue to show an uncanny ability to not only provide primary care equivalent to that of physicians, but also to offer something special that increases adherence or decreases symptoms." Although a number of variables ( age, length of visit, treatment protocol, follow up patterns) have been explored to account for these outcomes (Ramsay, McKenzie, & Fish, 1982; Sullivan & Armignacco, 1979; Watkins & Wagner, 1982), that something special that nurse practitioners possess, may be what Sullivan (1982) called soft variables derived from the social-behavioral sciences. These variables focused on interpersonal skills, communication, and teaching and learning theory that are integral to the education and socialization of nurses. Nurse practitioners may simply be building their expanded practice repertoires on the bedrock of interpersonal and interactional processes historically central to the discipline of nursing and women's discourse. This perspective is supported by Brykczynski's (1989) naturalistic study that provided evidence that holistic, personalized, participatory, and supportive behaviors and interventions characterized the practice of nurse practitioners. An alternative view was suggested by Ramsay, et al.(1982), who suggested that in the final analysis,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

rather than something special that characterized their practice, nurse practitioners, may just try harder in their encounters with patients in an attempt to prove their worth.

In reviewing this literature I was reminded of the arguments of Benner (1983) and Gortner (1984) who emphasized the need to identify the knowledge embedded in the practice of nurses. Molde & Diers (1985) also reviewed the nurse practitioner literature and research agendas and specified the need for research to identify that "special something" embedded in nurse practitioner practice as suggested by Sullivan. Expressions of power and control demonstrated in physician-patient interactions have already been identified as problematic. It seemed to me then that inquiry focused on the actual speech acts that nurse practitioners engage in with patients would provide some answers about language behaviors found in these encounters. I hoped to discover that the "something special" in nurse practitioner practice was related to sociolinguistic behaviors that empower and affirm patients, rather than control them.

## Purpose

The purpose of this study was to provide a contextual account of the language that characterizes nurse practitioner- patient encounters, using ethnographic methods. The focus was on dimensions of language embedded in those interactions which may reveal relations of power. The broad, organizing question that guided the inquiry was:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

What language behaviors or speech acts characterize the discourse of female nurse practitioners with female patients?

Assumptions

I brought eight assumptions into this inquiry. The first assumption was that language is ubiquitous, powerful, and an often taken for granted medium affecting social relations. The second assumption was that, not enough is known about women's discourse,.particularly language behaviors used by women professionals, such as nurse practitioners, when talking with women clients. The third assumption was that nurse practitioners, although varying in educational preparation, typically practice with enhanced professional autonomy in managing ambulatory health care problems for patients. In many situations, nurse practitioners provide health care services equal to or better than physicians and typically have positive relationships with their patients. A fourth assumption was that qualitative methods are best suited to uncovering and describing the language that characterizes nurse practitioner-patient encounters in the natural setting of routine office visits. Furthermore, the analysis of the resulting qualitative data may reveal "that something special" referred to by Sullivan (1982, p.8) which enhances positive outcomes for patients. The fifth assumption was that female nurse practitioners who identify their practice with nursing tend to use language in ways thought to be more typical of women. The sixth assumption was that those nurse

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

practitioners who more closely identify their practice with medicine tend to use controlling language behaviors more typical of physicians. The seventh assumption was that in certain situations, most nurse practitioners resort to some controlling language to expedite office visits when pressed for time. The eighth assumption was that the majority of nurse practitioners are women and the majority of all ambulatory health care visits are made by women patients, therefore, female nurse practitioner-patient dyads will predominate in the real world of ambulatory office visits. A study limited to discovering the behaviors and structures that characterize the talk of female nurse practitioners with female patients has significance for both nursing and feminist scholarship.

Significance of the study

Language is the primary medium for communication and social interaction. It can be argued that language frames and transmits what we may know. The synergy between a language and those who speak it with authority produces what has been termed linguistic capital by Bourdieu (1977). I argue that linguistic capital may also be conceptualized as linguistic power.

Nursing, as a profession, is grounded in interactional and interpersonal concepts yet nursing has produced little research devoted to linguistic inquiry, particularly focused on power relations in nurse-patient encounters. Furthermore, the majority of language studies coming out of the social

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

sciences, particularly sociolinguistics, has focused on medicine, with little, if any, attention to nursing. This study will make a contribution to nursing knowledge by uncovering sociolinguistic dimensions that characterize nurse practitioner-patient encounters. In addition, it will increase nursing's awareness about language as a sometimes unrecognized yet powerful medium of interaction with patients and contribute to the education and socialization of nurse practitioners about their own language practices.

Since information exchange occurs primarily through language, those linguistic means that enhance patient understanding of health information will also empower the patient to make informed decisions about their health practices. There is also potential for specifying sociolinguistic behaviors that affirm the personhood of patients and allow for negotiated agreement on treatment goals and regimens, thereby enhancing health care outcomes. Finally, this study will contribute to our knowledge about discourse and potential relations of power between women, particularly women who may be separated by such things as professional, social and economic status, as well as race and ethnicity.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# CHAPTER 2

## SELECTED LITERATURE REVIEW

"I decided to take refuge in language,
and study the truth of things by means of it.

Socrates, Phaedo 99E

This chapter is devoted to a review of selected theoretical and empirical literature which address speech actiivities between healthcare providers and patients. Grounding for the focus on nurse practitioner-client interactions within the context of the routine office visit will be also be developed.

### Philosophical Perspectives on Language

As noted in chapter one, the study of language has evolved from a variety of disciplines and philosophical perspectives. The system of signs, sounds, gestures and symbols allows for the construction of an infinitely large number of expressions. Furthermore, the various components of the system are open to interpretation and negotiation as to meaning and intent by participants in the linguistic exchange. Some language scholars such as Martinich (1985) believe it is those interpretive and negotiable aspects of spoken language that make it unique and distinguishes it from other communicative systems.

The central position of language in relation to all human experience has been the focus of study of philosophers



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

from the time of Socrates to the present. For example, Socrates linked language with reality, positing that language was a kind of mirror of reality and if the structure of language could be understood then it was logical that the structure of reality could be understood. The argument was that if language was an expression of human thought and human thought reflected knowledge about the world, then thought would seem to be a reflection of reality. Ergo, language is a reflection of reality (Martinich, 1985).

The language and reality connection has continued into the twentieth century as a dominant philosophical theme with the emergence of Wittgenstein's earliest theory of language as a picture of reality, and the works of linguist Ferdinand de Saussure, anthropologists Benjamin Whorf, Edward Sapir, Shirley and Edward Ardener, and feminist scholar Dale Spender, among others concerned with the idea of linguistic determinism (Cameron, 1985). Simply put, determinism assumes that language plays a part in creating reality, however the questions for debate within linguistic determinism has to do with just what that part is. On one hand there is the possibility of language as a tool to serve our thought processes; a medium that simply "encodes or expresses perceived reality." (Cameron, 1985, p. 94). On the other hand is the possibility "that language acts like a straitjacket, a ready-made classification which our experience must be forced into." (Cameron, 1985, p. 94). Language therefore filters our perceptions of the real world,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

giving rise to the possibilities of distortion and oppression by powerful groups who control it.

Pragmatics

Taken broadly, the study of language includes not only the specified rules for selecting, sequencing and linking words and sentences, but also the function of words, spoken or written. That is, how language frames realities, influences interaction in everyday social life, and perhaps, determines what we may know (Pearson, 1985; Clegg, 1989). Pragmatics refers to the study of language as social action, which includes the study of what speakers do with language in a social situation (Gorman,1958). Given the emphasis on the contextual interpretation of discourse, pragmatics appears to provide a useful backdrop against which encounters between nurse practitioners and patients may be examined.

The origins of pragmatics have been traced from the pragmatism of Charles Sanders Peirce (1934), through the ordinary language philosophy of the later Wittgenstein (1968), to the speech acts and communicative action theorists (Habermas,1979; 1981/1987, p.3-4). For Peirce and his followers, pragmatism was a philosophical doctrine which emphasized action, practice, society, and a concern for what works (Scheffler, 1974). Notions about the lived experience as a measure of the truth of things, and the role of language in constituting human consciousness were pragmatic theories which grounded modern sociological and educational thought (Scheffler, 1974).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Ludwig Wittgenstein, in his Philosophical Investigations (1968), sought to remedy his earlier pictorial representation of language, in which he suggested that language makes pictures of facts which are then compared to facts. Simply put, his revised theory stated that communicative interaction is the real function of language. Rather than elements of a picture, words are more like tools in a tool box with diverse uses and rules for their use (Cornforth, 1965). Using the metaphor of language game, Wittgenstein (1968) compared using language with playing games, which also involved following rules. The skills of understanding and speaking a language are learned in an interactive process (like playing a game) and one can assume mastery of the language game when one has learned to use these skills by following agreed upon rules with others in a community of speakers (McCarthy, 1979). That is, how to use certain words in certain contexts to do certain things. Furthermore, notions of the right or proper uses of words are found in their actual application in ordinary language. The influence of Wittgenstein's rather instrumental perspective of language is reflected most notably in the work of John Austin on speech act theory.

Austin (1962, 1970) continued to explore the role of ordinary language, for accomplishing specified action in social situations. He first developed and refined the notion of performative utterances, which asserted that to say something was also to do something beyond simply reporting or describing. This work provided the basis for conceptualizing

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

language as action and recognized the performative nature of all language in communication (Austin, 1962, p.6-7). Along with the notion of language performing action, Austin suggested the notion of force as it pertains to a particular utterance. Thus we can have the performative utterance "I command!" as a demonstration of the intensity or force embedded in language. Eventually, Austin replaced the performative utterance with the speech act as the basic concept of his theory of language action (de Souza Filho, 1984).

The speech act incorporated ideas about performance or action, and force, as well as the social context of the total speech situation. Furthermore, it was subdivided into three domains which were different aspects of the same speech event. For example, the locutionary domain refers to the act of uttering a certain sentence of a language with more or less definite sense and reference. The ilocutionary domain refers to the effect of uttering a sentence such that some level of force is conveyed as in "I command you to stop!" The perlocutionary domain refers to the non-conventional effect the utterance has on the hearer. For example, the illocutionary act of saying "I command you to stop!" may have the perlocutionary effect of making the recipient of that command very angry.

These three components serve to establish the internal connection between speaking and acting. At the heart of Austin's notion of speech act theory, is an explanation of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the speaker's power to create intended interpersonal relations (McCarthy, 1979).

Habermas's (1979; 1981/1987) communicative action theory evolved, in part from the theory of speech acts, which provided direction and motivation for his future work. Habermas proposed two major forms of communication, communicative action and argumentive discourse. Argumentive discourse addressed theoretical and ideal speech situations where exact parity existed between both parties to the interaction in achieving a rationally grounded understanding. In a similar vein, universal pragmatics seeks to examine general structures in speech acts that contextualize expressions generated by linguistically competent speakers (McCarthy, 1979).

Communicative action theory however, is more useful for informing an inquiry of actual interactions in the social world. In communicative action, language is viewed as a medium or vehicle through which action (interaction) occurs. Communicative action is further subdivided into strategic and non-strategic forms.

In Habermas's view strategic communicative action is defined as "oriented to success", that is, the successful achievement of one's intended ends. Strategic forms of communication may include lying, misleading, deceiving, and manipulation among others. The suspension of certain validity claims, particularly truthfulness may also be involved(McCarthy, 1979, p.).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Non-strategic communicative action was defined as "oriented to understanding" and takes the form of being either consensual, or understanding oriented. Consensual communicative action takes place against the unproblematic background of an already achieved common definition of the situation or event and includes consensus on the validity claims raised by the parties involved (McCarthy, 1979).

Understanding oriented action is aimed at achieving an agreement where the common definition of the situation is in the process of being negotiated. Again, the truthfulness of the claims are recognized by the communicating parties, and understanding is sought within the framework of the interaction. In both situations, if claims of validity are not met, the parties have no recourse other than breaking off communication altogether, switching over to strategic forms of communication or raising communication to the level of argumentive discourse (McCarthy, 1979).

While philosophical perspectives which espouse instrumental, strategic, and mediating notions of language have dominated linguistic inquiry, they are not the only view of language. For example, Hans-Georg Gadamer (1985, p. 275) recognized the centrality of language for all human experience in his deliniation of the universal linguistic character of our relationship to the social world. However, Gadamer argued that our relationship to language is such that we can not stand out side of it, because we are historically bound to it by preconceptions or prejudices which are

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

themselves framed linguistically. We can not, in Gadamer's view, wield language at will, like some kind of tool or weapon. Rather, we are held in the horizons of language because of the limited vision of our standpoint. We are unconscious of its' historical and cultural hold on us (Gadamer, 1985). This perspective generated critical debate for pragmatics and contextualized the notion of speech acts.

The Power and Language Connection

Scholars have suggested that power is the capacity of some individuals or groups to achieve intended or foreseen effects on others (Wrong, 1979), or the possibility of forcing one's own will on the behavior of others. When the intended effect is the control of behavior on the macro societal level, where one interest group attempts to control another, the power issue is one of social control (Freund, 1982). Whether on the individual or societal level, the focus is on holding power over some one or some group (Lukes,1986).

Another view of power is "the ability to act in pursuit of one's own aims and interests, to intervene in a sequence of events and to alter their course" (Thompson, 1987, p. 519). In this perspective power is seen as action, or the production of intended effects without necessarily having power over others. This view of power attempts to be more value neutral in its focus on the ability to get things done. These various definitions comprise a view of power which is derived from metaphors of physical momentum, electrical

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

force, or military models of command and discipline. Lukes referred to this view of power as "getting what one wants" (Lukes, 1986, p.8). There is a cogent link between Luke's analysis of power, (getting what one wants) and instrumental perspectives of language based on pragmatic considerations of action and practice. Similarly, the discussion by Austin (1970) and Searle (1985) of action and illocutionary force as dimensions of language to get things done from the focused perspective of the speaker strengthens this tie.

Pierre Bourdieu

Situated between the wholely instrumental perspectives of the pragmatists and the shifting perspectives of the post-structuralist/post-modern scholars is the work of Bourdieu (1977). Bourdieu, coming from a Marxian stance, recognized language as both a medium of social reproduction and a source of power. Power is suggested in the symbolic representation of violence resident in everyday language, although it may be unrecognized by both speaker and hearer. This conception is tied to authority embedded in the language of privileged individuals and groups. The link to elite languages used by professionals such as physicians and nurse practitioners is not difficult to make. Bourdieu used the analogy of market capital or asset in further examining language with fairly explicit connections to power. After all, the privileged languages of the professions can control access to information, and autonomous decision making by

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

patients/clients in much the same way that financial assets control access to material resources.

Post-structural / post-modern perspectives

For the last two decades Euopean post-structuralism, and its North American counter-part, post-modernism, has reflected the varying philosophical perspectives of critical thinkers who seek to break down and make explicit (deconstruct) features that characterize the dominant institutuionalized structures in society (Lather, 1991). The targets for deconstruction include ideas and social systems that promote injustice and unequal access to knowlege and resouces, as well as the language used to articulate and maintain them (Tong, 1989).

Post-modernist thought such as that represented by Jacques Lacan and Jacques Derrida has moved even farther from the idea of linguistic determinism, negating its central claim that a transparent language is a reflection of reality. These scholars suggest that language can neither be pinioned nor limited by reality and conversely, reality cannot be fully captured by language (Tong, 1989, p. 220). Rather, taking a psycho-analytic turn, Lacan attaches power to language as the medium by which individuals assimilate their culture. That is, the signs, roles and rituals, (the internalized Symbolic Order of linguistic rules) that are neccessary for individuals to function in society (Tong, 1989). Although perspectives on language are shifting, taken

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

as a whole, they continue to underscore the importance of language in shaping human experience.

As opposed to the mechanistic, instrumental views of power proposed by Wrong (1979) or Lukes (1986), post-structuralist Michel Foucault (1984, p.92), has posited that power is not an entitiy to be seized but rather a shifting network or alliance of "force relations". Although Foucault (1982, p. 217) makes a distinction between power relations and relationships of communication which transmit meaning through language, he allows for language to have as objective or consequence "certain results in the realm of power." Furthermore, Foucault may be said to make the connection between power and language in his concern for discourses that in fact define "what is or is not normal, or what is or is not available for individuals to do, think, say and be" (Clegg, 1989, p.155). Foucault's perspective brings into focus the "professional discourses " of medicine, law, and social work, among others, that constitute, limit, and normalize ways of thinking and doing that are "institutionalized and incorporated into everyday life "(Clegg, 1989, p. 156). The effect of these discourses is to solidify certain views of what counts for truth while marginalzing or eliminating others (Clegg, 1989). Foucualt may be said to reinforce Bourdieu's (1977) notion of linguistic captial as an essential asset for the professions in maintaining control over clients/patients.

Post-structural/post-modern scholars have identified language as central to the expression of power, including the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

role of language in defining the possibilities of meaningful existence, constituting notions of human subjectivity, and determining how we see possibilities for change (Clegg, 1989; Weedon, 1987). Furthermore they have illuminated linguistic behaviors (discursive practices) such as talking, writing, and argumentation as "constant sites of struggle over power" (Clegg, 1989, p. 151). As suggested by Lather (1991, p. 25) post-modernism is useful in foregrounding how "discourses shape our experience of the 'real' in its proposal that the way we speak and write reflects the structures of power in our society."

Clegg (1989) reminds us that our sense of who we are as distinct subjectivities is constituted through language. As humans we have engaged in an on going struggle to define and locate one another as subjective members of the social world. It is precisely in the process of defining and locating these various meanings and memberships that we see the intersection of language and power. Furthermore, in opposition to structuralist theories of language which fixed terms of signification and reference by appealing to set rules or conventions of speech (Saussure,1974), post-structuralists see the possibility of both fixing and shifting linguistic conventions and meanings. The connection between language and power is demonstrated in the attempts to fix or shift particular historical representations and relations of meaning within a community of speakers (Clegg, 1989).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Feminist perspectives on language and power

Feminists bring a variety of philosophical perspectives to bear on the issue of power and language. Although it is difficult and, perphaps, unwise to definitively categorize these various perspectives, two diverging models of language can be identified in current feminist scholarship. The first focuses on aspects of language which have historically silenced, alienated and oppressed women (Cameron 1985). Feminist scholars who have been influenced by the linguistic determinism of Saussure and Whorf, and a pragmatics that stresses the strategic and instrumental use of language come under this model. They find no neutral ground in language since it is a system wholly constructed (man made) and controlled by men. Following Habermas's (1979;1981/1987) idea of strategic communicative action, language in their view has been strategically employed to exclude or make women invisable, and /or has muted womens voices in our social world.

Radical feminism, given its focus on power existing in the discourses which historically constitute and reconstitute aspects of gender and subjectivity fits well here. Specifically, the concern has been about the reproduction of social relations which privilege male subjectivity, and subordinate female subjectivity (Clegg, 1989). Language practices which fix and reproduce what is considered normal in social interactions are cogently linked to power. For example, scholars such as Adrienne Rich (1979), Dale Spender

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(1980) and Muriel Schulz, (1975), among others, have critically addressed dimensions of power embedded in patriarchical structures of language. According to Cameron (1985, p. 93) "the radical feminist view is of women who live and speak within the confines of a man-made symbolic universe . . . where women may be alienated not only from language but also from the female experience it fails to encode." Language is not neutral, since it springs from a social organization in which all men have power over all women. Although power does not magically reside in the words we speak or write, there is latent power in the way they are used to create and reproduce social relations, particularly relations of power (Bolinger, 1980).

The second model of language and power is one that is emerging from post-modern philosophical perspectives which displace ideas about universal or totalizing "grand social theories which by definition attempt to speak for all women" (Lather, 1991, p. 27). Some feminist scholars believe that the pursuit of master paradigms, and the adoption of deterministic notions about language by earlier feminisms has not been productive in liberating women, nor has it been truly reflective of womens lived experience. These critics suggest that radical feminist theory for example, has only mystified and demoralized women by proposing solutions that

> had the effect of making large numbers of women feel inadequate,stupid, or angry . . . the process we identify in education as a process of socialization

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

which often makes women, blacks, working-class people unconfident and suspicious of intellectual work and makes them doubt the strength and potential of their own language (Cameron, 1985, p. 135).

Fox-Genovese (1991), hooks (1990), Ramazanoglu (1989), and Spelman (1988) among other scholars have added to the critique of any feminism that fails to recognize that women's experiences have varied greatly across cultures and across time. Therefore any attempts to forge a common perspective on such issues as politics, class, race, male oppression, sexual preference, or sexuality for that matter, is very problematic. Ramazanoglu suggested that the "Gulfs between privileged women who exercise considerable choice over the course of their lives and women who have to struggle alongside men for their subsistence, let alone any further rights, are enormous"(1989, p 18). The nature and extent of the gulfs (including relations of power) which separate professional women of privilege and women of color and/or poverty, may be further revealed and illuminated in the language structures and behaviors which characterize their interactions.

This second model of language and power therefore seeks to dislodge notions of singularly masculine and feminine languages and suggest in their place the idea of discourse competence (Mills, 1992). That is, rather than perseverate on the various tenets of those feminisms that stereoptype women's language as essentially " powerless or over-polite"

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(Mills, 1992, p. 4) and men's language as assertive and powerful, it is time to focus on "how it is possible for women to be strong, competent speakers despite social and discursive constraints" (Mills, 1992, p. 4). While Mills (1992) acknowledges that social and economic power relations are often enacted/reflected in language, never the less a host of other factors such as education, age, race, general self confidence, past experience, as well as gender, can prepare a person to be interactionally powerful. Just as it is no longer possible to suggest a single grand theory that applies to all women, it is likewise unwise to suggest a monolithic analytic approach to women's language. Women have a variety of speech styles which they use selectively depending on the participants and the setting. Rather than describing strong women speakers as masculine, and thinking of them as some how deviant, it is time to describe their language style as simply "discursively competent" (Mills, 1992, p. 10 ). That is, discursive competence reflects the woman's ability to select the type of language behavior that is appropriate to the setting, the participants and the goals of the interactants.

In summary, whether power is viewed as intrumental or relational the common ground for the various perspectives is the notion of bringing about certain consequences. Furthermore, language is ultimately linked to its manifestation. According to Kramarae, Schutz, and O'Barr (1984, p. 11) "The resources available to exert or resist

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

power are recurrent, similar, and in societies at peace, chiefly linguistic." These authors further posit that the link between language and power requires that the consideration of either one typically involves the other. The literature reviewed in the following section will address issues of language and power embedded in nurse-patient interactions.

## Nursing as Interpersonal and Linguistic Process

The theoretical and empirical literature in this section focuses on the interpersonal aspects of nursing and identifies linguistic dimensions embedded in the interactional process.

### Theoretical literature.

Kasch and Knutson (1985), building earlier communication theory in nursing (Kasch & Lisnek, 1984), explored notions of "patient compliance" and interpersonal style and posited some implications for research. Kasch and Knutson suggested that caregiver-patient interactions would be an appropriate focus for research because it is one important means by which nurses can influence patient adherence to treatment regimens and it is one of the few areas within the power of the nurse to effect change. They further asserted that the relationship between a nurse practitioner's interpersonal behavior and patient compliance has not been studied sufficiently. Communication, as a tool for social influence, and speech, at the interpersonal level, was viewed as a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

strategic force to advance instrumental objectives in nurse-patient relationships.

Functional language behaviors identified as central to nursing action included: regulative/persuasive; comforting; relationship maintenance and development; enhancing patient self-concept; and transmitting information. The authors suggested that skillful use of all these identified linguistic behaviors is central to interpersonal competence. However, they chose to focus on the regulative/persuasive behaviors in relation to compliance gaining strategies in the nurse-patient interaction. Intended or unintended, power relations between nurses and patients are exemplified in the term compliance which was used throughout the paper. Perhaps negotiated would be a more enlightened term, since it implies mutuality in decisions about treatment and care.

In the same paper Kasch and Knutson (1985) addressed position centered versus person centered interpersonal styles of speaking, and credited Mathews' (1962) study which addressed these psychological dimensions of the nurse-patient relationship. A position centered perspective focused on the role of nurse as expert authority, and on the patient as passive recipient of care. Nurses who used position centered strategies to control interactions were thought to use more verbal commands, and directives which state what it is that patients must do, or should do (Kasch and Knutson,1985). Furthermore, it was suggested that nurses who use this approach assume that the authority inherent in their role

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

gives them the right to control patient behavior. The authors pointed out that position-centered caregivers are not necessarily less caring or sensitive about patient needs. They simply see this approach as most expedient in accomplishing the objectives of the healthcare regimen.

A person centered approach recognizes the patient as an individual when considering communication strategies. Persuasion rather than control is emphasized. The logic or rationale behind a treatment regimen is given, and attention is focused on the needs and feelings of the patient as well as acknowledging the patients perspective in the situation.

It should be noted that both person and position centered language styles, as developed by these authors, were seen as useful approaches in gaining compliance. Neither approach appeared to consider negotiation and consensus in the interpersonal process. Language was identified as a tool to accomplish the aims and objectives of the healthcare provider, the assumption being that the nurses goals would always be in the patient's best interest. The separate personal goals of the patient were not explored or considered. The communicative control strategies discussed by Kash and Knutson appear to be conceptually linked to Habermas's notion of communicative action oriented to the successful management of interactions as opposed to communicative action oriented to gaining mutual understanding. Relations of power between nurses and patients were demonstrated in the assumption of a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

professional right to control patient behavior. Such assumptions are clearly paternalistic in nature and out of sync with traditional principles of nursing communication.

Three other papers by Kasch (1986), Kasch, Kasch & Lisnek (1987), and Kasch & Dine (1988) take the same general perspective of a need for communicative and interpersonal competence in nurse-patient interactions. Kasch (1986) suggested that nursing action may be described as functional, strategic and goal directed. Strategic action is again cast in terms of communicative behaviors which allow the nurse to pursue nursing objectives. Once more, although the author makes no reference to Habermas's communicative theory, a link may be made to his definition of strategic communication as being oriented to the successful attainment of the speakers goals. The nurse functions as a communication strategist, controlling interpersonal behaviors in ways designed to enhance the chances of accomplishing specific goals. The author allows that patients and nurses bring common as well a divergent goals into the interaction, as well as competing or conflicting perspective of the situation calling for nursing action (Kasch,1986). In this paper, Kasch acknowledged the need for the negotiation of mutually acceptable agreement on the goals of the healthcare encounter, however the nurse is still cast in the role of manipulating and controlling the interaction. An instrumental form of power is demonstrated in the continued reference to strategic language behaviors by which nurses maintain control over the interaction. Further

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

research is recommended to reveal the nature of behavioral and linguistic competencies of nurses in interactions with patients.

The Kasch and Dine paper (1988) is not conceptually different from Kasch and Knutson (1985) with the exception of adding the notion of "perspective taking" as an antecedent to person-centered communication. Perspective taking is defined as a range of cognitive processes and capacities that allow one to understand the view point of others. The authors suggest that perspective taking is not an ability that is possessed equally, so differences are likely to occur in how nurses can use "person-knowledge" in constructing person-centered communication strategies.

Finally, Kasch, Kasch and Lisnek (1987) discussed the connection between women's communicative style and nurse-client interpersonal skills. Criteria for assessing interpersonal competence were suggested. Borrowing from Spitzberg and Cupach (1984), interpersonal competence was defined as the extent to which the goals of the client and caregiver, related to communication are effectively fulfilled through cooperative interaction. The interpersonal goals of the caregiver and the client are seen to be both overlapping and divergent. Interpersonal competence is judged on both effectiveness and appropriateness as defined by Spitzberg and Cupach (1984). The authors suggested that the nurse-client encounter involved five phases:

1 Establishing an interpersonal bond

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

2 Eliciting information from the client

3 Engaging in collaboration

4 Undertaking strategic action

5 Terminating the encounter

A review of gender linked language studies was well developed by the authors. Issues such as turn taking, active listening, acknowledging, and the connecting work in conversations typical of women were elaborated. It was suggested that all phases of the nurse-client encounter can be facilitated by adopting traditional patterns of interaction associated with women's language behaviors. Fairly explicit direction was provided for assessing the use of language in nurse-client interactions and a research focus on the communicative aspects of interpersonal processes.was suggested. It is interesting to note the evolutionary change in perspective and language that ocurred over the course of these four papers. For example, the emphasis on language behaviors used to strategically gain compliance in treatment regimens, shifted to behaviors for increasing adherence by establishing mutually acceptable goals in the encounter. In like fashion the signifier nurse changed to care giver and patient became client. Over all, these shifts appear to reflect in part, the influence of literature on women's discourse and the work of Spitsberg and Cupach (1984). All of the literature presented in this section posited a substantive role for language in interactions between nurses and patients. The language and power connection was also

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

effectively illustrated. Although four papers were presented in this section, I tend to view them collectively, given the redundant focus and authorship, with limited substantive changes.

Empirical literature

Empirical studies which addressed language in the nurse-patient encounter will be reviewed for relevance to the proposed study. Hays (1966) studied one hundred verbatim discussions between patients and nursing students at the University of Pennsylvania. The data were collected from student nurse interaction notes over a one year period. Content analysis identified the dominant patterns of communication which were judged to be either therapeutic or nontherapeutic by the researcher. Nine therapeutic behaviors were elicited as follows: Giving broad openings; encouraging descriptions; using silence; making observations; suggesting collaboration; giving information; reflecting; encouraging evaluation; seeking consensual validation. Interactions reflecting nontherapeutic language behaviors included requesting explanations, introducing unrelated topics, reassuring inappropriately, probing, making stereotyped comments, offering advice, showing disapproval, and introducing personal data. The findings demonstrated that students used a significant number of nontherapeutic language behaviors which were thought to block interaction, and to be problematic for patient well being. Although there were many drawbacks to this paper such as limited description of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

methodology and analysis, it represents an early example of nursing research on language in nursing and was included for its historical perspective on the topic.

In a study designed to elicit reasons for clinic visits to nurse practitioners, Molde and Baker (1985) discovered that, although nearly all of the 125 patients in the study cited physical symptoms as the reason for seeing the practitioner, approximately 48% of the patient requests were for advice, reassurance, administrative intervention or questions about medicines. Furthermore, 30% of the sample had hidden agendas that were not predictable from initial clinic interviews about the purpose of the visit, that is, they were not related to "chief complaint" or presenting problem. Analysis of the verbatim responses to the question "How did you hope I could help you today?" indicated that those patients with hidden agendas tended to ask more questions related to specific causes for their symptoms and to have definite ideas about how symptoms should be evaluated and treated. In addition, 98% of the sample responded to the question with one or more requests. Only nine patients out of 125 in the sample, spontaneously offered how they had hoped to be helped by the practitioner during the clinic visit. The authors suggested that the findings demonstrated that a substantial proportion of clinic visits are motivated by requests for informational and validation purposes. Furthermore, the patients needed to feel "invited" to verbalize their requests for information. The findings

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

suggest that language use which facilitates patient disclosure will add significantly to the health history and diagnostic data base, as well as contribute to patient satisfaction. Further research focused on linguistic behaviors embedded in the nurse practitioner-patient encounter was supported.

Limitations for this study were cited by the authors as small sample size, and lack of outcome data on patient satisfaction. From the reader's perspective, additional information on the demographics of the study participants and how data analysis was accomplished would have been valuable.

Taylor, Pickens and Geden (1989) studied interactional styles of nurse practitioners and physicians in their attempts to control patient decision making. The ethical concepts of paternalism, maternalism, and shared decision making, operationalized as command, consequence and concordance, respectively, provided the conceptual framework for this quantitative study. Taylor et al defined paternalism as attempts to influence in which the provider made a decision for the patient. Maternalism was defined as attempts to influence by stating consequences rather than offer alternatives. Earlier studies cited by the authors supported paternalism as the expected mode of interaction for male physicians. It was expected that nurse practitioners (predominantly female) would be more maternalistic in their interactions. A sample of 85 physicians and 42 nurse practitioners in solo and joint practice participated.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Provider-patient interactions, videotaped as part of a larger study were transcribed and analyzed for attempts to influence the patient's decision making. Speech acts were used to classify 906 "attempts to influence" as: command statements, consequence statements, or shared decision making statements. Attempts to influence was defined as a process of interpersonal communication wherein cognition, attitudes, and behavior were targets for change in the direction of the provider's goals.

The results of this study were mixed, in that physicians and nurse practitioners were nearly equal in their use of both command statements and concordance statements. Nurse practitioners, however used more consequence statements than physicians. The low amount of concordance statements for nurse practitioners, in light of gender related literature which asserts women's language is more egalitarian, was surprising. The authors suggested that the finding indicated that perhaps justice and care issues are not exclusively related to gender. It was also noted that nurse practitioners and physicians in joint practice may be more similar in their approach to influencing patients, which raises questions about socialization for nurse practitioners working in a medical model of practice. This study provided insight on linguistic expressions used by nurse practitioners to control decision making by patients. While the findings appear to conflict with the prevailing literature on women's language which is characterized as more egalitarian, mutual,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and supportive, we note that the cummulative studies on women's discourse has not addressed nurse practitioners. Therefore, the need for further research, using naturalistic inquiry, to discover what it is that characterizes the interactions between nurse practitioners and patients is suppported by this study.

Forrest (1983) reported her work in developing an analysis system to provide for coding verbal behaviors in nurse-patient interactions that were thought to be facilitating or blocking to patients self disclosure. A list of behaviors perceived to be either facilitating or blocking were identified from a review of the literature. These behaviors were operationalized and examples were provided for each behavior. The list consisted of 18 behaviors, nine facilitating and nine blocking which were judged to be adequate by a panel of scholars. The system was tested, using a sample of 31 post RN students taking a communications course. A nurse-patient dyad was videotaped during a 30 minute interaction in which the nurse attempted to use therapeutic communication techniques to assist the patient do some self-exploration and problem solving. Trained coders were used to view the videotapes and code the instances of facilitating and blocking language. The study findings indicated that for this special sample of post-RN students, 80% used facilitating rather than blocking language. It was suggested that these results were significantly better than similar studies by Beanlands & McKay (1981) or Clark (1981)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

because the nurses were enrolled in a communication class at the time of the study. Closed questioning was the most common blocking behavior. The study provided evidence of continued interest in language research in nursing. There are a number of limitations related to the outcome of the study however, including a skewed sample and an untested analysis system. It would have been interesting to see what categories would have evolved from using a grounded theory or ethnographic approach to data collection and analysis.

Kliewer's study (1986) focused on language in nurse-patient interactions and addressed the communicative dimensions of effective nursing practice. This was a qualitative study of "expert" hospital nurses at work in their "natural" environment. Assumptions leading this inquiry were that communication is therapeutic, involves information exchange and requires competence (knowing and know how) to be used effectively by nurses. Kliewer proposed that competence in communication is linked to notions of effectiveness in nursing action. Competent communicative behaviors, identified in the practice of expert nurses, can be used to improve communication skills of student and novice nurses, thereby improving patient care.

The research methodology was a qualitative case study using a typological analysis approach. Data were gathered using participant observation and intensive and informal interviews of the subjects. Ten nurses were chosen to be in the study, based on selection by their supervisors as being

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

expert or effective nurses. The subjects were observed for a minimum of 15 hours over a two week period, during which time they were also interviewed. Data were analyzed and coded using a perceptual or theoretical framework that developed categories and relationships which typified the research setting.

The study yielded three functional areas of language use in nurse interactions. The first is regulative talk related to controlling and ordering behavior, either controlling others or being controlled. The second is informative talk that conveys knowledge or information; either giving or seeking. The third is interpersonal talk that creates and alters relationships, performs greeting or thanking rituals, gives support, or is nonsupportive. Further data analysis evolved a taxonomy of communicative strategies used by effective nurses. Kliewer reported 65 different communication strategies used by expert nurses. Of these, 12 were used for information functions, 25 were used for regulative functions, and 28 were used for interpersonal functions. Nurses used 18 ways to express control with six variations on giving an order. Most orders were indirect. Contrary to findings by Taylor, Pickens, & Geddens (1989) on nurse practitioners, imperative command orders were almost never used by these expert hospital staff nurses. Finally, four hypotheses were formulated from the data analysis:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

1) communication as practiced by nurses refers to information management rather than therapeutic intervention;

2) communicative situations in nursing can be categorized as three functions involving five categories of interactants;

3) nurses have developed a wide range of communicative strategies to accomplish their goals;

4) effective nurses systematically vary their patterns of communication to fit their goal for the interaction and the status of the interactants.

Kliewer's study was well developed and logically posited. The methodology section holds considerable interest for future research using qualitative approaches. The patterns of communication strategies identified in hospital nurses who were judged to be experts can provide a perceptual frame for future studies in other areas of nursing.

These studies approached nurse-patient encounters from the perspective of interpersonal communications. Problem areas addressed were therapeutic versus nontherapeutic communication skills, aspects of competence, compliance, attempts to influence, and patterns of language strategies used in face to face encounters with patients.

Summary

The theoretical and empirical literature reviewed here has explored the interpersonal and linguistic dimensions of interactions between nurses and patients. The theoretical

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

literature demonstrated some movement away from nurses use of instrumental language strategies for controlling encounters with patients. However, the few empirical studies available on nurse-patient encounters, demonstrated that nurses in fact continue to use a variety of language strategies in order to achieve their own goals in encounters with patients. Furthermore, in the only study of nurse practitioner-patient interactions, the predominantly female nurse practitioners used language in much the same way as their predominantly male physician counterparts. While the finding appears in conflict with some of the prevailing feminist literature in which female discourse is described as typically nurturant, egalitarian, or over polite, more research is needed on female nurse practitioner-patient dyads before drawing any conclusions.

The next section focuses on exemplar studies from sociology which explored physician-patient interactions and which have implication for research on encounters between nurse practitioners and patients.

## Language and Power: Micro-sociological Processes in Medicine

Roger Shuy (1983), reported on the analysis of 100 audiotaped medical interviews, in which he identified barriers to effective exchange of information between doctors and patients. The study participants were described as primarily male physicians, and working class female patients being seen in outpatient clinics of a large university medical center. The first and most obvious barrier

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

identified was the use of medical language or jargon, noted earlier in this paper. Use of jargon has significant implications for control of the doctor-patient exchange. According to the investigator, analysis of audiotaped interviews, demonstrated that the doctors had a clear expectation that the patient would adjust to or acquire the needed medical jargon to negotiate survival in the medical system.

One other barrier found in medical interviews was discourse structure. Shuy identified structures at work in conversations which are often taken for granted, but are necessary for effective exchange. For example, patterns of discourse involve marking sequences, which provide predictable and structured ways to start, maintain, and close conversations. Similarly, there are predictable and structured ways to provide cohesion in conversations such as reference to past, present, and future time. Finally, there are topics which are the focal points of conversations and are identified by subject matter, prosodic differences (intonation, pauses, rate of speech) and internal cohesion. Topic questions focus on such things as who introduces the topic, who switches it to another topic, how topics are maintained and how interruptions take place. Taken together, structures of discourse may be analyzed to reveal patterns of power and control not normally noticed.

Shuy concluded that the analysis of physician-patient encounters in his study demonstrated that physicians clearly

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

controlled the medical interview by topic initiation, maintenance, and switching. Other strategies employed by doctors were interrupting patients, and ignoring requests for clarification or additional information. The threat to the validity of the health history, given decreased opportunity for patient input is significant. A potential decrease in patient satisfaction and adherence to the treatment regimen was also demonstrated in the analysis. Once again, this study illuminates a continuing and ubiquitous thread of paternalism in encounters between health care providers and patients.

A strength of the study lies in the description of discourse structures central to language research and the identification of forms of power and control in doctor-patient interactions. The doctors appeared to use a position centered interactional style to control the encounter. The contextual issues, demographics related to subjects, and specific methods of analyzing the data were not reported. The implications for nursing parallel those of medicine, since nurse practitioners, in particular, hold similar positions of control in relation to the patient.

Treichler, Frankel, Kramarae, Zoppi and Beckman (1984) reported on a similar study which attempted to identify the dimensions of power in doctor-patient interactions through analysis of videotaped encounters in an outpatient setting. The study was conducted as part of a larger medical center research project where medical interviews were routinely

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

videotaped. The analysis was multi-dimensional, in that the videotaped interaction was compared to the written transcript of the medical record to look for evidence of concurrence or divergence. Exit interviews with the patients were used to confirm areas of agreement or divergence derived from the data by the researchers.

The findings indicated that frequently, the focus of concern varied significantly between doctors and patients. Important areas of concern for the patient were often not documented or addressed by the doctor. This finding supports the notion that mutual and divergent goals are brought to provider-patient interactions, and underscores the need for negotiation and mutual goal setting by participants (Kasch, 1986; Kasch, et al,1987). Analysis of verbal encounters identified episodic use of dismissive and demeaning language which tended to bring premature closure to topic discussion. One can speculate that language acts of this sort may also have prevented topics of concern to the patient to emerge in the interaction. Overall, the authors suggested that there were both structural and analytical evidence that language use and interviewing style hindered a full expression of patient concerns. Language is a powerful tool used by doctors to control medical encounters. The evidence provided by this research adds to the existing body of knowledge about language and power in professional-client interactions, with applications for nursing research and practice.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Fisher (1979), West (1984), and Richards (1988) studied doctor-patient interactions in outpatient settings involved in medical education. Although the goals and participants of their research varied, the focus was on the doctor-patient relationship. All of the researchers used ethnographic methodology including participant observation, and participant interviews. Data were recorded using audiotapes, when permitted, and field notes that were transcribed for on going recursive analysis.

Fisher (1979) explored how treatment decisions were negotiated in doctor-patient interactions within the context of private and public oncology clinics. She found differences in how patients in these two settings were guided into treatment decisions through strategic use of language. Fisher's sociolinguistic analysis of doctor-patient discourse suggested that power resided in the asymmetry of their relationship. Information exchange was central to the interaction. Doctors had information about cancer and treatment options which patients needed to make decisions. Patients had social and demographic information about their lives that doctors needed. The medical interview was organized around achieving this information exchange. However, doctors clearly controlled topic initiation and topic subject, as well as who spoke and when. Furthermore information could be presented in ways that functioned to persuade the patient to choose a treatment option that the doctor felt was best, irrespective of the medical facts in

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the case. Fisher concluded that women with abnormal papsmears seen in community clinics were more likely to receive nonconservative treatment (hysterectomies) than women with the same diagnosis seen in private clinics. These findings suggested that given equal physical findings, treatment decisions were based on cultural, social class and economic factors and negotiated through the strategic use of information control.

West (1984) analyzed data collected in a family practice setting. The encounters analyzed were described as typical doctor visits, therefore they varied in duration of visit and purpose of visit. West was interested in the structure of doctor-patient discourse as described by Shuy (1983). As in the previous studies, the medical interview provided the arena for analysis of the linguistic exchange between doctors and patients. West identified all the instances of interruption in the transcribed exchanges and compared the initiation of interruptive acts by dyadic encounter. Male doctors interrupted communicative exchanges twice as much as patients. White male patients were interrupted far less than white females and minorities of either gender. When female doctors' interruptions were analyzed, the findings were exactly reversed. Female doctors interrupted patients half as often as male doctors Near symmetry was noted when analyzing female doctor and female patient interactions.

West concluded that these data demonstrated clear violations of patient's rights to speak, and that these

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

rights appeared to be violated both systematically and disproportionately. Further more, it appeared that male doctors used interruptions as devices for exercising control in their interactions with patients, particularly female patients. Female doctors in this sample appeared to be more egalitarian in their encounters with patients of either gender, demonstrating a positive kind of power associated with womens voices. Positive expressions of power invite mutual sharing, turn taking, and opportunities to introduce topics. West's paper provides direction for further investigation of language as a means to control or dominate others, or as a means to empower and enable others in healthcare settings.

The interactional aspects of Richard's study (1988) parallel those of Fisher (1979). Richards analyzed doctor-patient encounters in outpatient surgical clinics, again with private and public care aspects and within the same university based medical system. Richards found recurring evidence of linguistic control in the exchanges between doctors (and doctors in training) and patients. Analysis of observational and interview data, identified the social and organizational factors which determine how student doctors learn to use language to manage the patient encounters. The author suggested that the hierarchical nature of medical education contributed to differences noted in language strategies used by attending doctors, resident doctors and student doctors. The contextual overlay of private clinic

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

versus public clinic was another dimension which influenced the kinds of language strategies used to further the medical objectives in the interaction. It is interesting to note that in the nearly ten years that separate Fisher's and Richard's study there has been little apparent change in physician interactional and language behaviors that so clearly impact patient care.

A final study by Alexandra Todd (1989) was directed toward observed communication between male gynecologists and their patients. Todd used ethnographic, participant observation methods including audiotaping of interactions and interviews, to gather data over a two year period. Similar to findings by West (1984) and Richards (1988), the relationship between physicians and patients was repeatedly truncated by the dynamics of the prevailing medical model. That model encourages physicians to focus on the immediacy of the medical problem, that is, "the body, its control, and its treatment" (Todd, 1989, p. 121). Examples were given of women patients attempting to give social and biographical data to their doctors, which was either ignored or misunderstood. Women patients tended to view their biological concerns as a part of their whole life experience, a connection which was frequently missed by the physicians in Todd's study.

Todd also identified disturbing differences in physician-patient interactions based on race and class. Two relevant trends emerged from her observations. "The darker a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

woman's skin and/or the lower her place on the economic scale, the poorer the care and efforts at explanation she received" (Todd, 1989, p. 77). The second trend was that all women were treated similarly, along a continuum, in regard to society's prevailing "definitions and attitudes about women, their bodies and reproduction".

Todd's inquiry provided grounding for the focus and methodolgy of future research. She gave explicit descriptions of the settings used, methods for gaining entry, demographic profiles of participants in the study, as well as consideration of approaches for data analysis. Her attention to issues of race, and class, beyond the issue of gender make an important, and troubling contribution to our growing knowledge on interactions between doctors and female patients.

Taken as a whole, these studies from the sociology of medicine literature provided support and direction for undertaking a study of language characteristic of nurse practitioner encounters with patients. Nurse practitioners are faced with many of the same treatment decisions, and contextual factors in patient encounters as physicians. The socialization process to the role of nurse practitioner varies on a continuum from a strong nursing model to a strong medical model of practice. Nurse practitioners have, from time to time, been accused of a "mini-doctor" syndrome. It has been suggested that nurse practitioners have forgotten their roots. There is a nagging concern that nurse

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

practitioners may loose their tradition of caring and intersubjectivity as their professional status increases. There is also concern that nurse practitioners will be seduced by either the medical model or the business model (or both) in structuring practice and ultimately interactions with patients.

Descriptions of language behaviors from the few studies reviewed here, suggests that nurses (student nurses, expert staff nurses, nurse practitioners) engage in a variety of language behaviors in interactions with patients. Qualitative approaches to discover and describe the linguistic dimensions that characterize those interactions will add to the body of knowledge about this clinical speciality, interaction between women, and perhaps nursing in general. We need to understand the particulars of power embedded in language, which is often taken for granted. Bolinger (1980), in a discussion of the dangers of unrecognized bias in language, asserted "Language is a loaded weapon!" The metaphor should not be lost on those who practice the caring and healing arts.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# CHAPTER 3

## RESEARCH METHODOLOGY AND METHOD

The purpose of this chapter is to lay out the methodology that guided the research design, describe the methods employed for data collection, and elaborate on the research process from inception to completion. Harding (1987) has suggested a precise distinction between the terms research methodology and research methods. Research methodology refers to philosophical and theoretical considerations about how one conducts research and how theories are applied. For example, sexist or elitist research topics, biased research designs which exclude women and minorities, and exploitative relationships between researcher and subjugated/subjectified participants are concerns that frame feminist methodology (Jayaratne & Stewart,1991). Research method refers to particular procedures used in the course of the research. For example, guided interviews, participant observation, and descriptive field notes are procedures typically associated with qualitative research method.

### Methodology

The philosophical perspectives/methodology which guide the research project derive in part from those offered by feminist scholars (Fonow & Cook, 1991; Harding, 1987; Lather,



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

1991; Street, 1992). Those perspectives include a concern to locate my self in the research. That is, to identify my self as a white middle class woman, university educated nurse practitioner, and aspiring academic, with all of the associated privileges and influence. In addition my view of the world is more typically informed by those philosophies and goals that are often associated with liberal feminism rather than a radical or Marxist agenda. Never-the-less, I feel compelled to expose and make explicit discursive practices of female nurse practitioners, including evidence of power or domination of female patients. I wish to raise awareness of the impact of particular discursive practices on patient outcomes and satisfaction, as well as to bring about change, that is to initiate "transformation" of those practices (Street, 1992, p. 11). In this respect I am beginning to appreciate and incorporate the goals of critical ethnography that go beyond describing what is, to ask what could be (Thomas, 1993). I honor the necessity of creating a collaborative relationship with the participants, eliciting their perspectives about data analysis, and finally, I hope to avoid the very practices I seek to uncover in the process of conducting my research, which includes a priori recognition of the power embedded in the researcher role.

Research Method

Given the methodology outlined above, ethnography was the research method chosen to explore and describe dimensions of language that characterized nurse practitioner talk with

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

patients. It should be noted that ethnography, as a qualitative research method, has come under critical appraisal by postmodern feminist scholars concerned with "the way ethnography has functioned in the construction of the authority of social science discourse" (Clough, 1992, p. xi). Like any other research method, it can be (and has been) used to advance and reproduce partriarchal perspectives. Bell Hooks (1990, p. 127) critiques traditional ethnography as perpetuating the notion of "the white male as writer/authority" while consigning people of color, particularly women, to the margins. However, I suggest that ethnography can be useful for the exploration of topics of concern to women. It is the motives and world views of the researchers that determine how the method is employed (Harding, 1987).

As a type of qualitative research, ethnography involves a variety of techniques or approaches to data generation. These approaches include, but are not limited to, participant observation, unstructured interviews, review of appropriate records, including demographic data, and the analysis of interactions (Fetterman, 1989). The purpose is to capture what people say and do as they interact within the context of their social world.

Ethnographic methods involve describing the interactants in the social situation, what they are doing, and saying, and the physical setting in which the interaction occurs (Lutz, 1981). Ethnographic research begins by asking questions

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

which come from the social scene, collecting ethnographic data, making an ethnographic record, analyzing the data, and discovering more questions which will continue to guide data collection (Spradley, 1980). The recurrent process allows the researcher to assess her or his understanding of the phenomena under study and to make adjustments in the focus of inquiry on the basis of that emerging understanding (Goetz, & LeCompte, 1984 p.69).

Germain (1986 ) stated that ethnographic methods were useful for revealing, as well as exploring prevailing nursing practice. Furthermore, ethnography has been the primary mode of inquiry directed toward explaining the patterns and functions of spoken language in relation to social life (Bauman & Sherzer, 1974; Fisher, 1978; Gumperz & Hymes, 1964; Hymes, 1962; Todd, 1989). In order to reveal the dimensions of nurse practitioner talk with patients, these interactions must be studied in the setting and at times which provide the usual contexts for the participant's activities, since human behavior (including language) is uniquely bound to the context in which it occurs (Omery, 1989).

According to Fetterman (1989) ethnography that provides a concentrated view of a small social unit or an identifiable activity within the social unit can be referred to as micro or topic focused ethnography. Given the focus of my research, narrowly directed toward the language of face-to-face encounters between nurse practitioners and patients within the context of routine office visits, micro-

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ethnography appeared to be ideally suited to the scope and purpose of the endeavor (Lutz, 1981; Spradley, 1980).

The choice of research method was thus based on the belief that ethnography provided the best means for gathering rich data "in situ" (Kleiwer, 1986, p. 16). According to Taylor and Bogdan (1984), participant observation involves the researcher in the social setting, interacting with participants in order to systematically gather data. Through the role of observer as participant, I was able to observe the real life situations as they evolved during routine office visits. Since I was introduced as a nurse practitioner as well as researcher in the setting, I occasionally became an active participant when clinical practice questions were directed to me by the participants, typically the nurse practitioner. Patient questions were rarely directed to me but when they were I acknowledged them and usually redirected them back to the attending nurse practitioner. Although this did not occur frequently, it is an example of the potential influence of a third party involved in an otherwise dyadic relationship.

Immersion in the setting provided the opportunity to observe, listen to, and audio tape the talk between the nurse practitioners and patients within the confines of the examining room. In addition, informal and unstructured interviews with nurse practitioners provided data on their awareness of their linguistic repertoires and how those repertoires were used in encounters with patients. I was

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

also able to talk privately and informally with patients about their perceptions of the encounters when the NP was out of the examining room. Taken together, the data derived from observations and "guided conversations" (Lofland & Lofland, 1984, p. 12) provided an encompassing view of the social situation and the linguistic dimensions that characterized those encounters.

Ethical Considerations and Protection of Human Participants

All aspects of this study were conducted under the guidelines established by the Committee on the Protection of Human Subjects at the University of San Diego, and affiliating agencies. Informed and voluntary participation, protection of privacy rights, and potential risks related to participation, were addressed initially with the agencies where data was collected, and then individually with participants.

Assurance of anonymity is a standard in social research and includes "the promise that real names of persons, and places will not be used in the research report and/or that pseudonyms will be substituted"(Lofland and Lofland, 1984, p. 29). To insure privacy for the participants in this study, all data sources were coded so that no names or identifying description remained in the data. For example, all observation sites were labeled numerically beginning with "Observation Site 1", and all study participants were coded with pseudonyms selected at random. Only the researcher had access to the list of participants and the corresponding

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

codes, and all records related to participating agencies and individuals were kept in a locked office file to assure confidentiality.

An information letter provided all participants with details about the study, how data were to be collected, (including the use of audio tapes), transcribed and stored. Participants were assured that any future publications resulting from the study would report data in a way that ensured confidentiality and protected the privacy of all participants. All audio tapes are to be destroyed at the conclusion of the research study.

A small degree of risk existed in this study since the investigator was an observer in an otherwise typically dyadic encounter. It was also anticipated that the issue of audio taping the encounters could possibly create some stress in the participants, particularly the patients. Assurances were given that tape recordings would serve as an adjunct to the construction of field notes and would be destroyed on completion of the study. Participants were also assured that if there was any evidence of discomfort with either the presence of the investigator and/or the tape recording during the office visit, tape recording would stop and the investigator would leave the examination or consultation room. Furthermore, all patient participants were assured that a decision to decline participation at any time would not compromise their relationship with the nurse practitioner or the health care facility.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

All concerns related to the data collection methods were dealt with early in the discussions about participation in the study. No problems regarding any of the above concerns were brought to my attention during actual data collection. Several nurse practitioners declined to participate after considering the project. Reasons given for not participating were lack of time, job stresses, being new to the setting, and feeling uncomfortable with the audio tapping.

The Setting

Nurse practitioner-patient encounters were observed in the natural setting of routine office visits in both public and private health care facilities. The facilities were located in both urban and suburban settings of several metropolitan areas in southern California. The clinics and offices offered a variety of ambulatory health services to women and families and employed significant numbers of female nurse practitioners. These sites typically provided services to patients from a range of racial, socio-economic, and cultural backgrounds. As anticipated, the philosophy of health care, the reimbursement models (fee for service versus free, or sliding fee scale), environmental factors including ambiance, and patient demographics varied across the sites. No effort was made to control for homogeneity of the settings, since it was anticipated that contextual diversity would serve to enrich the data and reveal important links to the language behaviors observed.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Entree to the Setting and Access to Participants

Once approval for the study was obtained from the University of San Diego's Committee on the Protection of Human Subjects, formal requests for entree were made through the administrative offices, human subjects committees, nursing research councils, medical directors and office managers appropriate to the various potential observation sites selected for data collection. In the case of the public settings, another formal human subjects review was required by the governing agency, in addition to approval by individual medical directors, or office managers in the system. This process took several months to be completed given the diverse backgrounds and interests of those in the gate keeping positions. For example, although the study was classified as an expedited research project (having minimal risk to participants) by both the University of San Diego and a major medical center review process, individual clinic managers and medical/nursing directors within the medical center system had opportunity to review the project in relation to their own particular setting. Entree to the private settings was less problematic and was facilitated by previous personal and professional contacts with the nurse practitioners and physicians. These private practice settings based access for research purposes on pre-existing approval of the university's research review committee, and the assumed integrity of the investigator. Given the small number of practitioners involved, review of the researchers

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

credentials and research project usually took less than a week to accomplish.

After entree to the settings was gained, nurse practitioners were actively recruited for participation. Taylor and Bogdan (1984) advised the field researcher to choose settings which offered minimal roadblocks to access, and facilitated the establishment of rapport with informants, as well as have sufficient situations which yield appropriate data for the study.

Initially participants for this study were accessed through nurse practitioner colleagues who worked and taught in public and private settings. In addition, I attended local and regional professional networking groups to discuss my research proposal and asked for participation. There was generally good support for the project. Nurse practitioners who could not participate, did not hesitate to suggest names of other NPs for me to contact.

All potential nurse practitioner participants were given a letter introducing the study purpose, overview of methodology and my personal background data, including my evolving interest in the topic (see Appendix A). Those practitioners who agreed to participate were given consent forms to review and sign (see Appendix B).

Separate information and consent documents were provided for the patient participants (Appendix C) at the time of the office visit. Questions about the study were encouraged from

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

all participants in order to increase the probability of informed consent.

Davis (1986) advised researchers to give attention to all of the relationships and contacts made for purposes of entree and access into the setting, in addition to those which further the research and insure continuing access to places, persons, and documents. As a nurse practitioner with 20 years of experience, I had general "insider" information on the dynamics of nurse practitioner practice and settings. I was, never-the-less, an outsider to these particular office settings and the existing cultures. It was important therefore, to project a positive, non evaluative, non intrusive persona throughout the research process. It was not only my intent to maintain the goodwill of the agencies and the participants for the course of the present research, as suggested by Davis (1986), but also for any projects that I may attempt in the future. It is my assumption that this was accomplished.

The Sample

According to Lincoln & Guba (1985) all sampling is done with some purpose in mind. Naturalistic sampling differs from random or representative sampling in several important ways. The first is that its purpose is to maximize information rather than yield generalizations. A second difference is that there are no a priori specifications as to sample size. In naturalistic inquiry the sample size is determined by reaching informational redundancy (Lincoln &

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Guba, 1985, p. 202), rather than achieving a pre-determined statistical confidence level. Given the exploratory, naturalistic approach of this study, the sample size was not determined a priori. However, it was estimated that at least 10 nurse practitioners would be followed for data collection, yielding a minimum of 30 encounters with patients for observation and audio taping. I wanted to observe each nurse practitioner at least three times to increase the likelihood of capturing her usual language behaviors. A total of nine nurse practitioners actually participated in the study. All but one was observed for three discrete encounters with patients. One nurse practitioner was only observed for two encounters because of scheduling problems.

Only women were selected as participants, given the goals of the study focusing on the language of female practitioners interacting with female patients during routine office visits. Patient participants were selected from the nurse practitioner's regular appointment schedule, based on the criteria that they were females, 18 years of age or older, and able to speak and understand English. In addition, no distinction was made as to whether the patient was a new or a continuing patient of the agency or the participating nurse practitioner. It was anticipated that only women who were unaccompanied by children in the examining room would be selected as patient participants for the study, in order to avoid distractions. This restriction was actually set aside and was not problematic for the visit

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

or data collection. Children accompanying mom in the examining room, and the distractions that they may or may not present, is a reality that nurse practitioners and women patients contend with routinely.

Data Collection

Multiple data sources were used over the course of the study. Lofland and Lofland (1984) suggested that in the tradition of naturalistic inquiry, the words and actions of the people being interviewed or observed are the prime sources of data. Participant observation provides for observation of spatial, social and temporal dimensions of the research setting (Schatzman, & Strauss, 1973). On a typical observation day, I would accompany the nurse practitioner into the exam room where I was usually introduced as both the researcher and a nurse practitioner. As an observer I took a position in the examining room where I was able to record the actual language used in the visit between the nurse practitioner and the patient, as well as observe the contextual components of the encounter. According to Spradley's general guidelines (1980), data collection is a process that proceeds using broad descriptive observations, focused observations and finally selective observations. Unstructured and informal conversations with selected nurse practitioners and patients were undertaken to ask questions about what was going on in the encounters, clarify observations, and check on themes and patterns that emerged from the recursive aspects of data collection and analysis.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

These interviews were deferred until after the data gathering process had been established to allow for some initial questions to develop from the field notes and transcripts. In order to provide for privacy and allow time for thoughtful reflection on the questions asked by the researcher, participating nurse practitioners were asked about the availability of suitable interviewing time and space. While structured considerations for interviewing participants was outlined in the research proposal, in fact, most of the interviews occurred spontaneously, typically in the privacy of practitioner's office, or the examining room during my visits for continuing data collection. Several interviews were conducted by telephone, and on another occasion two nurse practitioners were interviewed over dinner. Although interview data from the patient participants was planned to be obtained through follow up appointments, these arrangements proved impractical due to the transient character of many of the patients in the study, as well as scheduling conflicts. After several failed appointments, I decided to use informal conversations with patients as time allowed during the regular office visit. This approach basically precluded returning to the patient to ask questions and raise issues on data specifically derived from their personal encounter with the nurse practitioner. As a result the desired intent to involve all participants in the recurrent process of data analysis was weakened. However, as the data collection and analysis progressed, and patterns and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

categories were developed, I was able to recognize instances of a category or pattern more easily within the context of the evolving office visit. In that way I was able to ask patients about issues pertinent to their own encounter, as well as have them reflect on issues identified from earlier field data.

Care was taken to use recognized interviewing strategies such as active listening, feed back, clarifying and nonverbal cues to encourage open dialogue with the participants. Appendix D provides examples of questions that initially guided the interviews with participants. The demographic data appears in Appendix E.

Data Recording

The data were recorded as field notes using a format developed by Schatzman and Strauss (1973). These authors stressed the importance of carefully preparing the field notes so that data are accessible and understandable over a relatively long period of time. The participant observer was advised to record sufficient detail about the context in order to recreate the scene, including the thoughts and feelings which resulted (Schatzman & Strauss, 1973).

Using the analogy of a constant companion, the authors stated that a good set of field notes would provide data that are both factual and reliable. The field researcher was also advised to record both fleeting and developed interpretations and thoughts about the situation, and give a contextualized account of the operational decisions that were made.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Organization of the collected data was facilitated by arranging it according to three types of notes (Schatzman & Strauss, 1973). The first was the observational note (ON), comprised of statements about the observed situation which are derived mainly from listening and watching. As much as possible, these notes are to be free of interpretation and reliably constituted. "An ON is the Who, What, When, Where, and How of human activity"(Schatzman & Strauss, 1973, p. 100). They may contain direct, exact word quotes, or paraphrases of conversations. Examples of these observational notes recorded during my study included descriptions of the various settings, what they looked like, how they were staffed, how busy they appeared to be, as well as what went on in the exam room, what the nurse practitioner did or did not do, including the nuances of nonverbal cues used during the encounters. The verbatim transcripts of the audio taped conversation between the nurse practitioner and the patient were a special instance of the observational note, providing a rich source of data for this study.

Theoretical notes (TN) record the researchers attempts to derive meaning from the observational notes. This type of note records the interpretations, conjectures, and linkages that result from reflection on the events or situations experienced in the field.

The methodological note (MN) records instructions, reminders, and critiques about the field work in progress and the researcher's methods. This type of note reflects on the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

operational side of the research process. It records what is planned, what is in progress and what is completed, as well as what worked and what did not in gathering and managing data.

Personal notes (PN) may also be useful to the field researcher. Personal notes reflect personal, internal observations, biases, frustrations and flashes of insight about the research in relation to the setting, participants, or the process. These notes provide the internal contextual background to the data gathering process. Throughout data collection, the personal notes, although often scribbled as an after thought reflected some of the frustration and subsequent insight regarding data collection, particularly the patient interview data. These notations led to several methodological decisions, including the decision not to exclude women participants who brought their children with them into the examining room.

All field notes were made outside of the examining or consultation rooms. Usually I was able to find some space in the office setting to retreat to for note writing, reviewing audio tapes, and general reflection. In most instances the nurse practitioner participant allowed me to use her private office for this purpose. In those settings where the nurse practitioner had her office combined with an examining room, I was able to find a corner in the hallway or waiting room to record brief field notes.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Standard formatting of field note transcripts, including the verbatim transcripts, was followed which included date, time, location, an observation site code and a participant pseudonym. A wide right margin was provided for coding and writing, theoretical, methodological and personal notes.

With the consent of the participants, interview data were also recorded by audio tape and transcribed verbatim. The addition of observational notes made during the interview about nonverbal cues given by the participants along with any other contextual factors fleshed out this data. The transcripts of interview data followed the same format as the observational data, to allow room for coding and notations. I made the decision to personally transcribe all of the audio tapes. While this was a time intensive undertaking, it allowed me to become immersed in the data and to capture such nuances as voice inflection and intensity. Listening to the audio tapes also helped me recall some of the contextual details of the encounter as well.

Spradley's (1980) notion of recording ethnographic data with attention to language principles was incorporated into data recording since it seemed so appropriate to the study. The idea refers to recording and highlighting the kind of language used in the interactions in the field notes, including verbatim transcripts as a record of what is said. This particular principle is frequently violated in the absence of audio taping, by condensing or summarizing conversations there by loosing some important cultural

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

information, such as the use of medical or technical jargon in the health care setting. Another principle which applies to enriching the descriptive nature of the ethnographic record is referred to as the concrete principle. According to Spradley (1980), concrete description is expanded not condensed.

Verbatim transcription of the audio taped talk of nurse practitioner-patient encounters assured attention to the identification of the kinds of language used, as well as the verbatim recording of that language. However, I had some trouble consistently attending to expanding the descriptions in the written observation notes, because of my insider status. In particular, I struggled with a tendency to condense descriptions of what occurred in the examining room because it was so familiar and seemed routine.

Data Analysis

Ethnographic analysis is "iterative, building on many ideas throughout the study" (Fetterman, 1989, p. 88). The final stage of analysis that occurs after all data has been collected, is a time for organizing those insights and ideas which emerged during the data collection process (Lofland & Lofland, 1984).

According to Goetz and LeCompte (1984, p.171), "the task of analysis used by the ethnographer is one of comparing, contrasting, aggregating and ordering the observed phenomena". General questions are asked of the data including which things are like each other, which things go

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

together and which do not. By comparing similar groups, basic properties of the categories and patterns are identified. Through this sorting process, commonly referred to as open coding (Strauss & Corbin, 1990), a taxonomy of conceptual categories is eventually established which seem to make sense to the ethnographer. It is important to note that this is an interpretive process that is informed by the ethnographer's background knowledge and beliefs about situation under observation, as well as what the participants have to say about the situation. For example, the conceptual category that I labeled "supporting" was derived from reflection on a cluster of language behaviors that in my view affirmed the patient, or attempted to create an environment that put the patient at ease. However, before the category was established, participants were asked for their interpretation of the data.

In an ethnography, the key to analysis is thinking about the observed behaviors, including the sociolinguistic dimensions, and then looking for patterns in those behaviors as they occur throughout the study (Fetterman, 1989; Spradely, 1980). When new patterns or categories stop appearing in the data the categories are usually considered saturated. In reality other factors also influence decisions about ending data collection, including time, money, and researcher fatigue (Fetterman, 1989).

Data collection and analysis ran concurrently throughout my study. Analysis began with the transcription of the audio

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

taped encounters and observational notes, using the format discussed in the section on data recording. A line by line reading of the transcripts followed in an attempt to label or code things, events, and behaviors that would eventually become categorized as the linguistic patterns characteristic of nurse practitioner-patient encounters. Coded items were placed on index cards identified by observation site, nurse practitioner and patient encounter. A tedious sifting, sorting and categorizing process followed with some codes eventually emerging as major patterns. Other codes were collapsed or reformed to become related subcategories or components, a process referred to as axial coding by Strauss & Corbin, (1990). Given the focus on language, as more and more audio tapes were transcribed I was able to begin comparing the linguistic dimensions common to nurse practitioners within a specific observation site, as well as between observation sites. I also was able to begin the integration of some contextual data from the observation notes, to make some inferences (Agar,1986) about contextual issues such as environmental circumstances peculiar to each setting that might be affecting the encounters.

Patterns that were identified early in data collection and analysis, related to how the office visit was managed linguistically. For example, nurse practitioners seemed to routinely engage in some initial polite conversation that included greetings, and introductions, followed by brief social talk that transitioned to the reason for the visit.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Once the nurse practitioner and the patient began to talk about the reason for the visit, the nurse practitioner asked most of the questions while the patient provided most of the answers. Another pattern that became apparent early in the analysis of the verbatim transcriptions was the inclusion of medical/nursing jargon in the nurse practitioner's talk with patients.

Once all of the transcripts had been read and coding was complete the transcripts were read once again to locate examples of the coded items (events, behaviors, verbatim excerpts), which were then added to the appropriate index cards. Eventually, the index card system proved to be unmanageable, so all of the data were transferred to a personal computer to simplify access, handling and storage. A list was developed for each of the major patterns, related subcategories, and examples of coded items taken from the transcripts, according to observation site and nurse practitioner. This data became a valuable resource for on going analysis and eventual report writing.

Trustworthiness and Qualitative Methods.

According to Polit and Hungler (1987) the central question underlying research validity and reliability (trustworthiness) is: "Do the data collected by the researcher reflect the truth" (p. 331). Although the purpose of establishing trustworthiness is the same in both qualitative and quantitative research, the methods used to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

achieve a satisfactory level of confidence in the data are in fact different (Sandelowski, 1986).

Lincoln and Guba (1985, p.295) described four criteria appropriate to establishing trustworthiness in qualitative methods. The first criteria is truth value which demonstrates that the inquiry is carried out in a manner that enhances the probability of the findings being viewed as credible by other investigators; the study participants themselves acknowledge the truth of the findings; the investigator's biases and assumptions are stated, and set aside to allow the participants' experiences to be fully expressed (Lincoln & Guba, 1985). Several ways of assuring that this criteria is met were suggested. One is to provide sufficient information about the study, including descriptions of settings, participants, data gathering, and analysis, to allow the reader to evaluate the methodology. Another is to assure that data reflect the explicit experiences of the participants and not the implicit assumptions of the researcher. Approaches used for this study included an attempt to identify preconceived notions (assumptions) about the topic, in advance, to locate myself in the study, as well as verifying the results of data analysis with the participants. For example, coded items related to the phases of the office visit were evaluated by selected nurse practitioners for their perceptions as to how well the codes and patterns represented their own practice.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The second criteria is transferability, which is the extent to which the findings of a qualitative inquiry can be transferred or applied to other contexts or subjects. This criteria is often cited as a weakness of qualitative methods. The extent to which findings may be transferable depends on the richness of the data provided by the investigator (Marshall & Rossman, 1989). According to Lincoln & Guba (1985), it is the task of qualitative researchers to provide a sufficient data base to enable those who would use the research to make judgments about transferability. This criteria was addressed by providing in depth, descriptions of all aspects of the research process, from entree to analysis. Consistency or dependability is the third criteria for establishing trustworthiness. Lincoln and Guba (1985) suggested the use of an inquiry auditor to evaluate the acceptability of the inquiry process and verify the dependability of the inquiry. The inquiry auditor also attests that the interpretations and recommendations are consistent with and can be supported by the data. Marshall and Rossman (1989) similarly suggest the use of a research partner who plays 'devils advocate' and critically appraises the researcher's analyses. This criteria was addressed by having a doctorally prepared qualitative researcher review the transcripts, codes and evolving patterns to assure that interpretations, conjectures and linkages were consistent with the data provided by the participants. Participants were interviewed formally and informally about the patterns

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and inferences for validation of the findings as well, which also strengthened the criteria.

The fourth criteria is confirmability which reflects the degree to which the findings represent truth, as experienced by the participants, and remain relatively free of investigator bias. In theory the investigator approaches the data relatively free of bias. In truth the imposition of ones biases on the data is practically unavoidable. I approached the data recognizing my assumptions and concerns about power in nurse practitioner-patient relationships. My interpretations of the data were then shared with participants for confirmation, negation, or negotiation of meaning.

Sandelowski (1986) suggested that confirmability is accomplished when truth value, consistency and transferability are established. Methods for addressing these criteria have been discussed already. In addition, triangulation is another method which addresses this question. The use of multiple methods to generate data sources, such as the verbatim transcripts of nurse practitioners talking with patients, observational notes which captured the context of the encounter, and interviews with participants about emerging linguistic patterns, (such as the use of professional jargon) provided a basis for convergence on the actual lived experiences of the participants in the study.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Overall, the strategies establishing the trustworthiness of this study follow those suggested by Sandelowski (1986, p.35):

1. Checking for the representativeness of data
2. Triangulating across data sources and data collection procedures
3. Checking that descriptions, explanations, or theories about data contain the typical and atypical elements of data
4 Obtaining validation from the subjects themselves

The methods used for this research were qualitative in nature and were intended for the discovery and generation of descriptions which characterized the language behaviors used by nurse practitioners in patient encounters.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# CHAPTER 4

## LANGUAGE AS PROCESS

The intent of this chapter is the presentation and discussion of findings derived from field data which revealed a recurring language pattern or process that moved the encounters between nurse practitioners and patients along in a nearly linear fashion from beginning to end. While the focus is primarily on the nurse practitioner, the participation of the patient in the evolution of the linguistic process, will also be addressed.

The word process may be a noun or a verb depending on the context in which it is used. As a noun it refers to a series of steps, actions or operations used to bring about a desired end. As a verb it means to move along in or as if in a procession. Interestingly, both meanings have application to the discussion of what goes on linguistically when nurse practitioners and patients talk during routine office visits. After multiple readings of the data derived from the various observation sites, it was clear that there was a pattern to the encounters that could be characterized as a process. That is, it comprised a series of steps or actions that were used to help accomplish the work of the office visit. Five action oriented steps were identified which I have labeled as follows:



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Openings

Transitions to business

The business at hand

Transitions to closure

Closures.

The identification of the various components of this process evolved, with minor variations, throughout data collection and analysis. Each of the action steps were derived from the language of the encounter, that is, the audio taped talk between nurse practitioners and patients. However, there were also some non-verbal behaviors or actions which accompanied the verbally derived components and served to augment their delineation. Description and discussion of these non-verbal behaviors has been integrated, where appropriate, into the discussion of the various components of the encounters.

The five action steps of the process will be discussed in the following sections. Excerpts from formal and informal interviews with nurse practitioners and patients, as well as from the verbatim transcripts of the office visit are used throughout this chapter to help illustrate and explain the findings.

## Openings

A specific opening step was identified in each of the twenty seven nurse practitioner (NP), patient (Pt) encounters. Openings may be further characterized as the set of language behaviors which: 1) alerted the patient to the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

arrival of the nurse practitioner, 2) greeted or welcomed the patient to the setting, and/or 3) introduced the interactants in the encounter to one another. Each of these opening sub-components will be presented and discussed along with examples from the transcripts.

Language behaviors which alerted the patient to the entrance of the nurse practitioner were typically used when the patient was already in the examination room, usually assigned there by an assistant and possibly in the process of undressing. It was most common for the nurse practitioner to approach the room, knock on the door once or twice, then open the door and enter the room. Some of the practitioners called out a verbal greeting simultaneous with walking into the room, "Hi there Mrs. Clark, how are you?" The nurse practitioners rarely waited for permission to enter the exam room after knocking on the door. More precisely, the knocking appeared to serve as a warning, a "ready or not here I come" or "better cover up I'm coming in." Interviews with nurse practitioners about this particular opening behavior revealed an acknowledgment of concern for privacy, courtesy and respect for the patient. Although the practice of knocking was not used consistently with every encounter, NPs reported that they specifically knocked if the patient would be disrobing as in preparation for a pelvic examination. Several NPs stated that if they felt rushed by a busy schedule, they did not take time to knock on the door before walking in. From an interview with NP Alice: "It's a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

courtesy thing, you know? If they're not ready they can always say 'just a minute' or 'I'm not quite ready' to let me know to wait up. I've never really thought about it beyond that." An NP who will be called Betty suggested it was a way of sharing ownership of the encounter with the patient. "It's the patient's turf, as long as they occupy the room, I think it demonstrates my respect for them as a person." Connie, another NP, reported she routinely used that approach even if the exam room door was open or she was about to see a hospitalized patient sequestered behind a closed fabric drape. "I usually just say ' knock, knock' just to let them know I'm there. I think it's a matter of respecting their privacy." Yet another NP, Phyllis, stated she used the knock on the door out of respect for her patients because she had experienced being "walked in on" by physicians on a few occasions. "I know how that made me feel, panty hose down around my knees, my bare bottom hanging out. It's not that they haven't seen it all before, I don't know, it's just kind of embarrassing. It made me feel vulnerable. I don't want to do the same thing to the patients I work with so I let them know I'm there before just walking in."

The following probe was used in informal interviews to get at patient responses to door knocking: "I've noticed that the NPs in this clinic tend to knock on the door of the exam room before walking in. What do you think about that?" Amy, a middle age woman, reported with a smile "I really appreciate the advanced warning. It gives me time to pull my

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

gown together." A young women who will be called Bonnie felt that it was a show of respect for her by stating "I just wish that they would all do it." Finally, a patient who will be called Colleen, stated "It's nice, really, it gives me the chance to sing out if I'm not ready, you know, 'hold on a second', or something like that."

A connection can be made to work by John Fiske (1992, p. 160) in his discussion of "place" versus "space". The term place is defined as the ordered structures of those who hold power to control and organize them. The clinic or office examination room is ultimately a place under the control of the nurse practitioner. Space is referred to as "practiced place", in which people, in this case patients, create their own place while temporarily using resources owned by others. It is clear that there is consensus between these nurse practitioners and the patients they serve about the value of the knock on the exam room door as a signal to the patient that the privacy of their created place is about to be breached.

The greeting is the second component of the Openings segment. In most social situations in Western culture the greeting is an accepted custom which serves as a welcome or gesture of friendly respect between interactants. The greeting is typically verbal in nature but often includes the nonverbal acts of hand shaking, smiling and hand waving. In the context of the office visit, the responsibility for initiating the greeting is assumed by the health care

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

provider. There was evidence of some form of greeting in all of the transcripts and in all cases the greeting was initiated by the nurse practitioner. In most instances the greeting was augmented by a smile and the extension of the NP's hand to shake hands with the patient. In all of the observed encounters, the patient acknowledged the practitioner with a verbal response and returned the handshake when it was offered. In two encounters, it was the patient who initiated the handshake and it was returned by the nurse practitioner. The verbal exchange of greeting and response demonstrates the reciprocal nature of this part of the opening ritual. These brief excerpts taken from the transcripts are examples of the greeting process between nurse practitioners and patients.

NP 1 Hi, Gloria, how are you doing?

Pt 1 Oh, pretty good actually, how about you?

NP 2 Hi, is it Elenore?

Pt 2 No, it's Ellena, but you can call me Lena.

In the next two examples the nurse practitioners combined the alerting knock on the door with the greeting and an abbreviated introduction.

NP 1 (knocks on door and questions) Hello?

Pt 1 Hello

NP 1 (opens door and walks in) Hi, Connie, I'm Connie also, how are you today?(NP and Pt.shake hands).

Pt 1 Fine.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

NP 2 (knocks on door, opens and enters room) Hello, is this Edna?

Pt 2 Unhuh

NP 2 Hi, how are you?

Pt 2 Fine

NP 2 Good, my name is Alice, I'm the nurse practitioner here and I'll be seeing you for your appointment.

In some situations the greeting takes place out side of the exam room. In settings where the NP is expected to call her scheduled patients to the exam room and set up for exams without the help of an assistant, the greeting and often the introductions take place in the waiting room or in the hallway as they walk to the exam room. The following excerpt is an example of that situation:

NP (walks down the hall to the waiting room) Hello, Lydia Marshall?

Pt Hi (gets up from chair, smiles and walks with NP to exam room.)

NP Just take a seat there by the window. Lydia, my name is Ellen, (they shake hands) I'm a nurse practitioner and I'll be doing your exam today.

The last component of the opening segment is introductions. The introduction may be best described as that part of the opening where the interactants are identified by name and presented to one another. In all of the observed encounters, where introductions occurred, the NP

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

took responsibility for making them, including the introduction of the nurse observer. As demonstrated in the last example, introductions may occur as an integral part of the greeting exchange. They may also occur as a separate component, or may be overlooked entirely. The following excerpt includes all components of the opening phase, alerting, greeting and introduction.

> NP (knocks once on exam room door opens and walks in) Hello, Margaret?
>
> Pt Unhuh, hello.
>
> NP Have you been waiting a long time here?
>
> Pt Awhile, not too long.
>
> NP Okay, good, I'm sorry for the delay, uh your chart was sitting on my office chair, not in the door rack so I wasn't aware that you were waiting. I apologize for keeping you waiting. My name is Betty Packard, I'm a nurse practitioner (she reached out and shook the Pt's hand). It's nice to meet you.

In this next excerpt, the NP gives a brief greeting along with a formal introduction of her self and the researcher.

> NP Hi Mrs. Richardson, I don't know if I've seen you before. My name is Dottie Cook, one of the nurse practitioners, and this is Merrily Allen the nurse practitioner who is observing today.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

There were only three encounters where the transcript did not reveal an introduction component in the opening phase of the office visit. In one of the encounters, the nurse practitioner was already known to the patient, and the introduction of the nurse observer was in fact, overlooked. In the other two encounters alerting and greeting actions were noted, and the nurse observer was introduced but the nurse practitioner simply forgot to introduce herself. The following is one instance of an opening with a partial introductory component.

NP (raps twice on exam room door, opens and enters) Hi how are you?

Pt.Oh pretty good.

NP Colleen, I'd like to introduce the nurse that's doing the observing this morning, Merrily Allen.

Pt.(smiles and reaches out to shake hands with the observer) Good to meet you. She's gonna have to be on her toes today. (We all laugh).

NP So Colleen, what brings you in today?

In this exchange, the patient took the initiative after the introduction by responding verbally and shaking hands with the nurse observer. The patient also added some small talk by referring to the nurse practitioner in a joking way. The nurse practitioner acknowledged the joke by joining in the laughter but moved the discussion immediately to the business at hand.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

In summary, the opening component of the nurse practitioner encounter with patients may be characterized as a set of verbal and nonverbal acts that served to alert, greet and identify the interactants. When used, the alerting knock on the exam room door always occurred before greetings or introductions. Greetings and introductions however were used in a variety of ways, sometimes as distinct actions, sometimes linked together in the same sentence, and on occasion the introduction was omitted altogether.

Taken as a whole, the opening of the office visit is a mini social event that occurs within the confines of the nurse practitioner's exam room. A "place" which temporarily becomes the patient's personal "space" or "practiced place" (Fisk, 1992, p. 160). It is a reproduction in the office setting of what current social custom dictates as the minimum in polite society. That is, you say hello, how are you, you smile and shake hands. This greeting ritual is a ubiquitous part of our social milieu. Perhaps by adhering to this custom the nurse practitioner attempts to bridge the gap between being a stranger, and giver of intimate care to the patient. It is the incorporation of a familiar ritual in an unfamiliar setting which may set the patient's mind at ease, and engender a sense of security.

## Transitions

The ninth edition of Webster's New collegiate Dictionary (1983) defines a transition as an instance or process of changing from one form or subject to another. Transitions,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

within the context of the nurse practitioner-patient encounter, were accomplished linguistically and served the purpose of moving the interaction on to the next step, and perhaps signaled to the patient that it was time to move on. Transitions occurred between openings and the business at hand, and near the end of the business segment, prior to closure, the final step in the encounter. Not all of the transcripts revealed verbal transitions to the business of the visit, however all of the transcripts which included formal closures also included at least some brief transition statement. Transitions were occasionally accompanied by some type of nonverbal action which further substantiated that things were "moving right along". Each of these instances of transition which served to move or process the interactants in the encounter on to the next phase of the visit will be discussed.

Transitions to the business at hand were typically a brief instance of social interaction unrelated to the reason for the office visit. Like openings, the transition to business could be seen as another attempt to introduce some normalcy to the emerging relationship. The "chit chat", as one NP referred to it, "acts like an ice-breaker of sorts before getting into the nitty gritty of the history and examination." However it is sometimes this very "chit chat" that is omitted or significantly cut short by the NP when she feels pressured by an over loaded patient schedule. The following excerpt from an interview with Ellen Mark a nurse

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

practitioner in a community clinic setting illustrates this finding.

> NR So you don't feel pressured by the front office staff to hurry your appointments?
>
> NP Well, (laughing) I didn't say that exactly. What I said is I try to give each patient a fair shake. Of course I may cut the chit chat a bit, not engage in any just personal talk.

The following excerpts demonstrate the varying styles of transition talk by nurse practitioners. Nurse practitioners 1 and 2 demonstrate a slightly more relaxed personal style, taking several minutes for opening and transition talk.

> NP 1 I understand that you got a little lost trying to find the office.
>
> . Pt 1 unhuh, I went over to the old building.
>
> NP 1 On fourth avenue? We sent out announcements but if you're like me, you don't pay much attention until it's needed.
>
> Pt 1(laughs, nods head in agreement)
>
> NP 1 (looks around room) Well, it looks like some one ran off with my stool, I'll just go across the hall and borrow one, be right back.

The nurse practitioner returned with a rolling stool, she sat down and opened the patient record.

> NP 1 Well, this is your annual exam, so lets review your record to see what's needed today.
>
> NP 2 So, you're changing health plans huh?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pt 2 unhuh

NP 2 Where have you been going?

Pt 2 To my family doctor most recently. Before that I'd go into the ER. where I worked.

NP 2 Where were you working?

Pt 2 Up in the valley, with all that blowing dust.

NP 2 So you're in school now, where are you going to school?

Pt 2 State, I'm majoring in history.

NP 2 Well that should be nice there.

The nurse practitioner dropped her gaze from the patient to the patient record which she opened and asked:

Okay now, just how bad is this asthma?

As noted in both excerpts the act of opening the patient record or focusing attention on it may be an unconscious behavior that further signals that the transition from social talk, to the business at hand has occurred.

The next two excerpts are examples of brief versions of transition talk.

NP 1 How have you been this past year? Any problems or changes in your health?

Pt 1 No, I'm feeling great, actually.

NP 1 Good! Lets look over your history then.

NP 2 Well, Jane have you been at the university long?

Pt 2 Oh this is my second year in grad school.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

NP 2 All right, that's great! Okay, uh well what seems to be bothering you today?

In both of these examples the transition took less than ten seconds of time and involved only one question and answer exchange between the nurse practitioner and the patient. In summary, it appears that the transition to the business at hand, whether extended or brief, is marked by a social interaction which focuses on the personal side and perhaps affirms the patient as an individual who the nurse practitioner really cares about. It is a brief instance of what Fosbinder (1990, p. 95), described as "getting to know you" in her examination of interactions between nurses and hospitalized patients.

The language behaviors which comprise openings and transitions, taken as a whole, rapidly moves the patient from the realm of "stranger in a strange land" to an acknowledged individual; greeted, introduced and whisked on to social intimacy with the nurse practitioner. One could argue that the process was perhaps superficial, if not at times perfunctory especially if the nurse practitioner was feeling pressured by time constraints. However, the brief social exchange between the N. P. and the patient can be said to prepare both patient and the practitioner for the instant intimacy that characterizes the next step of the encounter; the business at hand which includes the revelation of often sensitive and personal issues and the invasive laying on of hands.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Transitions to closure may be characterized as those verbal and nonverbal acts which served notice to the patient that the office visit was coming to an end. The transition to closure talk identified in the transcripts was typically brief, usually not more than a few sentences. The content of transition talk was usually related to the patients understanding of treatment regimens, arrangements for follow up appointments, instructions, and any remaining questions or concern. Once all instructions were given, appointments or referrals arranged for, and questions and concerns were addressed, the encounter was brought to closure. Nonverbal cues which accompanied closing transition talk included glancing at the clock or watch, closing the patient record, standing up if the NP had been seated, and edging toward the door. One NP told me that she usually arranged to step out of the room while the patient dressed and would return with instructions, samples, or what ever was needed. That was how she signaled to the patient that closure was at hand. The following excerpts from the transcripts and field notes provide examples of transition to closure behavior.

> NP 1 I'm going to ask Dr. Keith to see you just to check the thyroid. Just to be sure, you can make an appointment with her for next week. Go ahead and get dressed, I'll get you some decongestants and you come out when you're ready." (NP walked out of the room)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

NP 2 All right, your lungs are clear, hearts fine, no tachycardia, like I said, your doctor has done a good job of managing your asthma. (NP closed the patient record) Anything else?

Pt Not that I can think of.

The nurse practitioner walked to the exam room door in preparation for closure.

NP 3 Okay then, I'm just about finished here, you'll have to keep this clean and dry until tomorrow, then take off the band aid. Okay?

At this point the NP removed her gloves, washed her hands, picked up the patient record and said:

> If you don't have any other questions or concerns, that'll just about do it.

The nurse practitioners in excerpts two and three made it clear by verbal and nonverbal behaviors that they were finished with the business at hand and were preparing to bring the encounter to an end. On all occasions when the patient asked another question, the nurse practitioner acknowledged the patient, and attempted to address the concern through information giving, or clarification. If the patient was raising a new, and as yet undisclosed health concern, the NP acknowledged the concern but usually advised another appointment unless it seemed to be an emergency.

In summary, transition language, plays an important part in the management of the office visit by alerting and preparing the interactants for what is coming next in the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

encounter. The first kind of transition language, transitions to the business at hand, prepares the patient for an interlude of instant intimacy. The second kind, transitions to closure, signals the last opportunity to ask a question or express a concern, a final opportunity to be heard. Although patient concerns were always acknowledged and addressed in some part, it was also very apparent that the nurse practitioners used the transitions to manage and control the pace and direction of the office visit. Using both verbal and non-verbal cues the nurse practitioner signaled that she was moving the encounter on to a new phase or direction. I found the instances of the NP opening and closing the patient record at each of the related junctures a striking visual image of the transition process within the context of the patient encounter.

## The Business at Hand

The business at hand may be thought of as the "real work" of the encounter. It is during this step that the reason for the office visit is presented and discussed, diagnoses and treatment decisions are made and therapies are initiated, reviewed or revised. This is the real work that patients anticipate when they come to see the provider.

Drawing from 20 years of experience as a nurse practitioner, I see this phase of the visit as a complex process, with both recursive and sequential activities being shared by both the nurse practitioner and the patient. The recursive activities are related to asking questions and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

giving replies, the work of information exchange. Much of this work begins when the patient reveals the reason for the office visit. The nurse practitioner then initiates a series of questions aimed at gathering historical and current information about the patient's concerns. The patient replies to the direct questions and sometimes volunteers additional information that further explains her concerns or situation. Sometimes the volunteered information is tangential to the reason for the visit and sometimes it may be related to another, as yet undisclosed concern. The patient also asks questions during this step of the encounter.

The exchange of information, which is usually focused on one topic at a time, continues until the nurse practitioner determines that the information gathered is sufficient to move the work on to the next activity which typically involves the physical examination of the patient. During the physical examination phase, the NP continues the questioning, often reviewing data gathered earlier for patient confirmation or clarification, then pursuing branching questions as she gathers more physical data from the patient.

Field data demonstrated that the nurse practitioners in the study managed the "business at hand" phase of their office visits in a manner consistent with my experience. For the most part, the nurse practitioners asked questions and the patients provided answers, particularly during the more ritualized history taking component. Frequently, the nurse

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

practitioners prefaced their history taking with a statement similar to one used by NP Gayle:

> Okay then, I'll have some pretty routine questions to ask you, to start your health history. Let me quickly review the information you have already given me here on the history form, then we can fill in the gaps.

During the physical examination, patients typically asked more questions and nurse practitioners responded with more information and teaching. Some nurse practitioners also engaged in social talk, as they progressed through the physical examination portion of the visit. This was not uncommon during pelvic exams, for example. As one nurse practitioner stated: "During the pelvic is when I generally take the time to just chat, it helps the patient to relax a bit I think." The following excerpts reveal the sociolinguistic dimensions of these activities, including the recursive nature of information exchange throughout the business at hand.

Excerpt 1: The NP was involved in the physical examination of a patient with multiple concerns.

NP Lets take them one at a time. So tell me about your stomach problem.

Pt Oh, it's only been this last week or so. I feel like I've got too much acid in my stomach.

NP Okay.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pt My intestines or something, they were kinda acting up last night, uh at first in the evening, started maybe last week, I feel some times I get too hungry.

NP Is the pain above or below the belly button?

Pt Above, what normally happens when I get hungry, it happened a couple of times last week and uh, I took a couple of antacids, it helped a little.

NP If you eat does the pain go away?

Pt Sometimes if, I can catch it early enough. If not then I have to eat something and lay down and after awhile it goes away.

NP unhuh

Pt It kinda feels like, just last week, I felt I could feel something here (points to sternal area).

NP Like heartburn?

Pt Yah, then it moved down you know? And last night my intestines felt all bubbly, you know?

NP Does this hurt in this area? (touches lower abdomen)

Pt No.

NP Hmmm, how about here? (moves to sternal area).

During the exchange of information, the question and answer segments involved fairly lengthy responses by the patient, as the nurse practitioner attempted to clarify the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

nature of the stomach problem in relation to physical findings.

Excerpt 2: The nurse practitioner was gathering general women's health history information prior to doing a pelvic exam.

NP Lets just review for me your history. How many pregnancies?

Pt One!

NP And how many children?

Pt Well actually two pregnancies and one child.

NP and what happened to the other pregnancy?

Pt I, uh, canceled it.

NP Terminated it?

Pt Yes.

NP And uh any vaginal or urinary symptoms today?

Pt No, uh, discharge? uh, yes.

NP What kind of discharge?

Pt Just mucous like, clear.

NP Usual?

Pt Yah.

NP Sexually active?

Pt Husband.

NP Type of contraceptive?

Pt Diaphragm.

NP Any discomfort with sex? Any problems?

Pt No.

NP Okay, periods still regular?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pt Very!

The nurse practitioner asked brief questions and the patient responded with equally terse replies. The nurse practitioner's approach could be described as scanning or routinized as she rapidly proceeded through a set of routine history questions. This scanning technique was observed in four encounters, involving two different NPs. In all cases, there was an identified time constraint on the visit due to scheduling issues or the number of presenting concerns revealed by the patient.

Excerpt 3: The nurse practitioner was examining a young woman who was concerned about hair growing on her breasts.

NP All right now lets take a look. Is this what you're concerned about? These hairs around the nipple area?

Pt Yah, and those bumps there, they really look bad.

NP Well I can see a few hairs, but to be honest it's not particularly unusual for women to have a few like this around the areola. That's the term for this darker colored area around the nipple.

Pt But what about the bumps?

The nurse practitioner turned on a goose neck lamp and carefully examined the woman's breasts.

NP You know, uh what I think is that the skin is very sensitive right here, and the tweezing has

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

in fact irritated it. But the good news is that I don't see any evidence of infection, like you'd have with ingrown hairs. Okay?

Pt Will they go away?

NP Yes I think they will. My recommendation is to stop the tweezing immediately, that's the most likely source of irritation. You could try some warm wet packs to the nipple area three to four times a day for a few days and my hunch is that you'll start to see dramatic improvement.

Pt You think so?

NP Yes I do. I'll tell you what, you try this for two weeks then come back and see me. Now if anything comes up in the mean time be sure to call. Okay?

With the exception of the nurse practitioners question: "is this what you're concerned about?", the patient asked all of the questions, while the nurse practitioner provided answers in the form of information and recommendations during the physical examination component of the business at hand.

In summary, the business at hand phase of the office visit involved a complex and recursive interactive process between the nurse practitioners and the patients. Initial information was gathered, reviewed, analyzed, and clarified as needed. Physical data were also obtained when appropriate to the visit, and more information was exchanged between the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

practitioner and the patient as decisions were made about diagnoses and recommended interventions.

Patients were noted to have frequent opportunities to ask questions and introduce new topics for discussion throughout the office visit, with most patient questions coming during the actual physical examination portion of the business at hand. However, it was apparent that the nurse practitioners exerted some control over the visits by pacing the rate of information exchange as demonstrated by the scanning technique used when they faced time constraints. Additionally, by dominating the questions asked early on in the encounter, the nurse practitioner could also potentially determine the kind of information that was obtained from the patient, and potentially influence the overall direction for the visit.

## Closure

Closure is the last step in the office visit and in most cases it is fairly brief, taking less than a minute to transpire. In all observed encounters closure was initiated by the nurse practitioner and was usually preceded by the transition step that alerted the patient to the end of the visit. The NP's closure language usually included some solicitous remarks such as "I hope this helps", or "take care now" or a brief affirming comment such as "it was good visiting with you." NP's also made references to treatment instruction or some future visit, such as "so I'll see you next week", or a more general, "Okay, see you again."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The patients participated in closure by acknowledging the NP's instruction about therapies, appointments, or referrals, and by giving a socially appropriate response to closing remarks by the nurse practitioner. The following excerpts illustrate closing activities by nurse practitioners and patients in this study.

The nurse practitioner had just given the patient an alternative medication prescription for post surgical pain.

NP I hope this helps, I'm sure it will.(NP walks out into hall with the patient) Take care now.

Pt Thank-you.

In the next example, the nurse practitioner had stepped out of the exam room to obtain some sample medication, in transition to closure. She gave instructions on medication use, then closure followed with this exchange:

NP All right any questions? No?

Pt uh, nothing, no.

NP Take care then and come back if you don't begin feeling better in a few days.

Pt Thanks, I will.

Affirming language is illustrated in the following example where the NP has spent longer than she anticipated addressing multiple and somewhat divergent concerns. After treating some warts, and giving instructions on post treatment care, the encounter closed with the following exchange:

NP Okay, I'll see you in about two to three weeks.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pt OK, and I'll work on the massage, body and mind connection in the meantime to see if that helps

NP Give it a go, bye, bye.

In summary, closures are typically brief sociolinguistic acts that are initiated by the practitioner. Closures include reminders about prior instructions, future visits, and solicitous and affirming remarks, by the nurse practitioner and are intended to end the encounter. Patients usually take a passive role by responding to the nurse practitioner in socially acceptable ways such as thanking, acknowledging "okay" or saying good bye. I did not observe any instance of a patient interjecting further thoughts or concerns about the visit once the nurse practitioner initiated closure. This suggests that patients invest nurse practitioners with power and authority similar to physicians.

## Summary

Taken as a whole, the language patterns or process derived from the field data has some similarity to that described by Kasch, Kasch and Lisnek (1987). For example, these authors suggested that the nurse-client encounter involved five phases which were termed establishing an interpersonal bond, information exchange, collaboration, action, and termination. The establishment of the interpersonal bond is singularly relational according to Kasch et al.(1987) and has importance through out the nurse-client encounter. It is the beginning of the relationship in which the nurse attempts to set a tone of friendly interest

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

in and concern for the client. Similarly the opening phase identified in my research suggests the intent of the nurse practitioner to initiate the encounter with the patient by reproducing at least the illusion of an emerging social relationship through traditional greetings, introductions, and social small talk.

The second phase identified by Kasch et al.(1987), eliciting information corresponds to the business at hand phase. A significant portion of the work in this phase involves eliciting information from the patient related to the purpose of the office visit. Nurse practitioners used language strategically to facilitate history taking and the physical assessment portion of the encounter in much the same way Kasch et al. refer to interaction management strategies to maintain control over the flow and direction of nurse-client discourse.

While Kasch et al. saw collaboration and strategic action as separate phases, collaborative decision making and action directed toward meeting patient treatment and outcome goals was subsumed as part of the business at hand. The final phase which Kasch et al. refer to as termination, is similar to my discussion of transitions to closure and closure. The key to this phase of the encounter is that it is the last opportunity for the practitioner to reinforce patient teaching, and motivate the patient to adhere to treatment decisions whether or not they were arrived at in a collaborative manner. Furthermore it signals the last

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

opportunity for the patient to ask questions or voice concerns (at least for this visit). Similarly, Kasch et al.(1987, p. 250) suggest that one of the "primary goals at this stage is retaining referent power, the motivating power resulting when the client perceives the nurse as likable, benevolent, admirable, and accepting and a valuable source of social support". Kasch et al. did not consider transitions per se in their discussion of nurse-client encounters, where as I found the transition phases to be integral to the progress of the encounter.

Theoretical suggestions by Kasch and Knutson (1985) that nurse communication with patients is goal directed and follows implicit interpersonal rules also appears to be supported. That is, the language of the interaction accomplishes specific purposes and goals, similar to Habermas's (1981/87) discussion of strategic communicative acts being oriented toward success. In addition patients and nurse practitioners respond to a social norm that reflects the understanding each have regarding the power differential inherent in their respective roles and positions, giving control over the visit to the health care provider.

In the context of the office visit, an over riding goal is to move the encounter through a series of steps which culminate in a plan to address the concerns which brought the patient to see the nurse practitioner. Although the patient role was not entirely passive, (patients frequently initiated new topics for discussion and asked questions of the nurse

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

practitioner) it seems clear that the nurse practitioner controlled the pace and direction of the encounter by taking the initiative for opening the visit, transitioning to the business at hand and finally moving to closure. The nurse practitioners clearly dominated the encounters and were in a position to exert considerable influence over patients regarding treatment decisions and outcome goals. There is marked similarity between these observations and some made by Roger Shuy (1983) in his analysis of 100 audio taped medical interviews. Shuy suggested that physician control was identified in physician-patient encounters through linguistic components, such as ways to start, maintain and close conversations, as well as deciding which topics had relevance for the patient's visit.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# CHAPTER 5

## PATTERNS OF LANGUAGE THAT CHARACTERIZE NURSE PRACTITIONER TALK WITH PATIENTS.

> The patient feels what a convenience it would be if there were any single person to whom he could speak simply and openly.
>
> Notes on Nursing
> Florence Nightingale, 1859 p. 55

Chapter five presents striking linguistic patterns that characterized the talk of the nurse practitioners in the study, as they interacted with patients during routine office visits. Support for the development of the language patterns and the relevant discussion that follows, flows from the field data and the theoretical and empirical literature review.

A line by line examination of the verbatim transcripts taken from the nurse practitioner encounters with patients, initially revealed nine language patterns that were common to most of the nurse practitioners across all of the observation sites. Through continuing analysis of the field data, the nine original patterns were eventually collapsed to yield four major language patterns. Each pattern was further defined by a cluster of related subcategories that can be described as characteristic of the nurse practitioner talk with patients in this study. The major patterns are as



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

follows: Supporting, informing, controlling, and professional jargon. The patterns and their related components will be discussed, and illustrated by excerpts from the verbatim transcripts of office visits, and formal and informal interviews with the participants in the study.

Supporting

Supporting is an action word that is defined as the act of holding up or maintaining in position; to keep from failing during stress; to substantiate; or to aid (Webster's Ninth New Collegiate Dictionary, 1983). These variations on the meaning of the word supporting seemed particularly appropriate to the consideration of the linguistic behaviors that characterized nurse practitioner's talk with patients in this study. The nurse practitioners consistently used language that suggested encouragement, acknowledgment, concern, as well as interest in the patient as a person. Empirical and theoretical support for the idea of supporting linguistic or communicative action comes from the work of Kasch and Knutson (1985), and Kliewer (1986).

Kasch and Knutson (1985) discussed communicative action used by nurses in interactions with patients that comforted, maintained and developed relationships and enhanced self esteem. Pauline Kliewer (1986) analyzed field data from observations of expert nurses talking with patients. The taxonomy of communicative strategies developed from her study included the category Supportive Strategies, which was further defined as "talk that

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

builds and sustains relationships." (Kliewer, 1986, p.56).

Sociolinguistic behaviors or actions identified as contributing to nurse practitioner talk that was supportive of patients were as follows: affirming/acknowledging, expressions of concern, and socializing. Each of these language behaviors will be presented and discussed in relation to the major pattern of supporting language in nurse practitioner talk with patients.

Affirming/acknowledging

To affirm means to validate, confirm or uphold as being true, while acknowledging refers to the act of recognizing, understanding, or responding to claims about some thing or situation (Webster's Ninth New Collegiate Dictionary, 1983). For the purposes of this study, affirming linguistic action was viewed as value positive, while acknowledging linguistic action was viewed as either value positive or value neutral. In some instances the same word or phrase was categorized as both an acknowledgment and an affirmation. The differentiation between affirming and acknowledging behavior was found within the context of the interaction and in the tone of voice used by the nurse practitioner. For example, in the following scenario, the nurse practitioner was listening to the patient disclose details of a recent illness. The patient paused for a brief moment, as though hesitant to continue. The nurse practitioner said "all

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

right" softly and with a slightly rising tonal inflection to signal acknowledgment of the patient's disclosure, and to invite her to continue talking. In another situation the same nurse practitioner responded to a patient who had just revealed she had not smoked a cigarette since the last annual anti-smoking campaign with "All right!" Stated briskly, with emphasis and a big smile, the nurse practitioner signaled approval and support for the patient's achievement.

All of the nurse practitioners in this study used affirming and acknowledging language at some point in their encounters with patients. Kliewer, (1986) suggested that acknowledging and affirming actions included encouraging, praising, expressing concern, and laughter as examples of language strategies that expert nurses use to support patients. Spitzberg and Cupach (1984) also identified talk that validates the personhood of patients as central to developing and maintaining positive relationships between primary care nurses and patients.

As in Kliewer's study, the nurse practitioners in this study used affirming language to positively validate patient's ideas, and decision making, as well as to confirm patient responses to treatment plans. Affirming linguistic behaviors included phrases such as "That's very good news!", "Ooh wonderful!", "Well good, that should be fun.", and single words such as "Great!", or "All right!", both stated with emphasis and smiles.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Acknowledging language was used by the NPs to convey recognition or understanding of information disclosed by the patient. Acknowledgment of patient responses took several forms including brief linguistic utterances such as, "I see", "Okay", "All right", and "You have?", and para-linguistic utterances such as "unhuh", "hmmm" or "oh". The para-linguistic "oh" was used as an utterance of recognition, and/or understanding, as well as an utterance to lead the patient into further disclosure.

The findings are reflective of women's talk identified in feminist and social science literature. For example, Treichler and Kramarae (1983) reported that women are more likely to elaborate and build on utterances of others, and use more verbal and vocal fillers such as "right", "okay", or "um hum" to keep the conversation flowing and to signal acknowledgment and encouragement to their conversation partners. Dubois and Crouch (1975) discussed the use of interpersonal strategies which allow speakers to address multiple and perhaps divergent/conflicting goals in conversations with others. These strategies allow for the recognition of others' perspectives on a topic while maintaining the right to express ones own position. It suggests a more collaborative interaction where in nurses can use skilled communication strategies to pursue their own goals while simultaneously inviting and encouraging patients to express their own (Kasch et al. 1987). The use of para-

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

linguist utterances or vocal fillers along with kinesic gestures (head nodding, hand movements) are strategies which can convey recognition of and interest in the patients perspective without necessarily conveying agreement with that perspective. The nurse practitioners in this study frequently augmented their linguistic and para-linguistic behaviors by maintaining eye contact with the patient and nodding their head to signify recognition or understanding of what the patient was speaking about.

For example, Dottie Cook a nurse practitioner in one of the public clinics, used positive affirmations and expressions of acknowledgment and concern throughout all of the observed office visits. Dottie also used nonverbal displays of acknowledgment such as maintaining eye contact, smiling, and head nodding to emphasize agreement or understanding. The following scenario with excerpts from the transcript illustrates affirming/acknowledging linguistic behaviors.

The patient, Mrs. Bell had returned to the health center for follow up on a problem with anemia. Although Mrs. Bell was a frequent patient of the center this was Dottie's first encounter with her.

NP (smiling) Mrs. Bell, this is a follow up appointment is that correct?

Pt Yes, yes that's correct.

NP (Dottie looked quickly through the patient record, then looked up and smiled at Mrs. Bell)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Okay! Looking at your record here, uh so!
You're in good shape! You're hematacrit has
gone way up so you're doing real well!

Pt Good, huh?

NP (nodding her head)So that's good news!

Later in the visit Dottie and Mrs. Bell discussed dietary considerations to maintain iron intake since Mrs. Bell was an ova-lacto vegetarian.

NP Are you a vegetarian by choice or religion?

Pt Oh, we just want to eat better.

NP Well I don't remember where I, uh read this but
the people with the best cardiovascular health
are vegetarians and Boston marathon runners.

The nurse practitioner used affirming language in discussing the patient's positive response to therapy for anemia. Later the NP affirmed the patient's dietary choice to be a vegetarian by relating to an article on the positive effect of vegetarian dietary practices on cardiovascular health.

In another encounter, a young woman was transferring her care to the center. The discussion moved to current work and school activities.

NP Where do you go to school?

Pt Right now I'm at community college finishing up
some prep courses but I think I'll transfer to
State to major in anthropology.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

NP Well that should be nice there. So, you're majoring in anthropology?

Pt Yup, I opted out of a career. Now I just want to do something for me.

NP Well good! That should be fun!

Later in the visit ,the patient talked about her health history related to an asthma condition. She disclosed previous treatment regimens and current management of the asthma by her family doctor and her general response to that intervention.

Pt So it's definitely been better, oh once in awhile I get bronchitis and have some sputum, but for the most part I'm much more in control now.

NP (acknowledging patient's statement) unhuh.

Pt Oh and another thing is that I've had to use an antibiotic, lets see it starts with a C.

NP Cipro?

Pt No, uh C.(looks at bottle just taken from her purse) ah, C-Chlor, yah, that's it.

NP Oh, yah, (laughing) I couldn't even think of it, okay.

Pt And before that they even had me on prednisone. I'm glad to be done with that!

NP Well, good. You seem to be doing well here then?

Pt Oh yah, pretty much.

NP Umhmm

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pt Well for awhile I was pretty shaky from the medicine, but that was temporary, so uh, that's really it.

NP Okay, that's it?

Pt Yah, well I was tired a lot then.

NP Well, uh asthma can wear you out!

The nurse practitioner reviewed some women's health questions then asked about asthma medication refills.

Pt I'm actually all right, I just got them refilled.

NP Oh, okay.

Pt See, I knew I needed a provider for my health insurance plan, so I came here to get acquainted.

NP Oh, yah all right!(Dottie smiled and nodded her head in agreement).

Pt I'll come back though, because I know I need to be followed.

NP You're so sophisticated about your health care I think you can monitor your response to the meds and continue to wean your self off the asthmacort.

Pt Yah, I guess so, like I said I cut my self back.

Throughout this interaction, Dottie, the nurse practitioner, used a combination of acknowledging and affirming language as she talked with the patient. Dottie was encouraging about the patient's decision to return to school, she praised the patient for her knowledge about her asthma medicines and acknowledged how tiring asthma can be. Dottie used both linguistic and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

para-linguistic utterances such as oh, alright, unhuh, to encourage the patient to continue disclosure about her health status, and non-verbal cues such as smiles and head nods to add emphasis.

Expressions of Concern

The nurse practitioners used expressions of concern under three circumstances. The first was in response to patient disclosures about health problems or personal situations. The second circumstance was informing patients about therapeutic interventions and follow up care, and the third was in response to an identified over sight or mistake.

Expressions of concern by the nurse practitioner served to underscore her interest in the patient's health, reinforce the importance of recommendations or instructions given to the patient, and reconcile gaps or mistakes in the provision of health services to the patient. Although there were not significant numbers of expressions of concern identified in the field data, their importance as a strategy for supporting the nurse-patient relationship can be found within the context of each situation. For example, Irene was a nurse practitioner who worked in a busy specialty clinic, seeing patients before and after surgical procedures. One of her follow up patients had problems with pain control and had returned to the out-patient clinic for

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

some help. During the visit the NP and patient talked about the problem.

NP Uh, how often are you taking it? (the pain medication).

Pt Just like you said, every 12 hours, don't miss any, and that's just what I been doing. Really!

NP Okay, um, where is the pain? In your neck or farther down the spine?

Pt It's just here (points to cervical spine) where it's always been.

The nurse practitioner examined the patient while eliciting more information about the problem.

NP Well, Clare, I can get you some stronger pain medication but I'm concerned about the fact that you're still having a problem with pain. I'd like to have the doctor see you okay? Just to check you out a bit, We'll get you taken care of, don't worry.

The nurse practitioner then arranged a follow up appointment with the doctor and ordered a different pain prescription then returned to the exam room, giving the patient final instructions and exchanging goodbyes.

NP:(walking out with patient)I hope this helps, I'm sure it will.

The nurse practitioner emphasized her interest in and support for the patient through her stated concern for

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the unresolved problem with neck pain and hopeful expectation that the new medication would help.

In another scenario, Gayle the nurse practitioner was discussing menstrual cycle irregularities with a young woman who came to the health center for a pap smear and refill of her birth control pill prescription.

NP Any thing unusual about your period?

Pt My periods are very irregular, extremely irregular.

NP Because of the mini-pill?

Pt I don't think it's the pill. I think it's my weight, I do a ton of running.

NP Yah?

Pt And it all fluctuates with my body weight, my weight doesn't change all that much, it may fluctuate as little as three pounds but if I'm doing a lot of miles I just tend not to get periods.

NP Okay.

Pt And like right now, I started one today, and I kinda never know when it's going to happen, and it's not heavy when it happens.

NP Are you having this out of cycle? While you're on the pill? That's what I'm concerned about, I mean is this the time you should be having withdrawal bleeding on this pill?

Pt Uh, no.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

NP It's not?

Pt No, and it never has been and I've always, uh someone always said to me don't worry about it.

The discussion continued about high mileage running, body fat and endogenous estrogen as it related to menstrual cycle regularity. Then the nurse practitioner came back to her original concern. It was the timing of the bleeding in relation to the pill taking that was significant.

NP But it worries me that you're having out of cycle bleeding when you do bleed.

Gayle then recommended that the patient keep a log of her periods since she had not paid any attention to when they occurred.

NP Okay, and lets not worry if its real consistent on week three say, but if it's jumping all over the place, uh then I'm really worried that it's not being real efficient for you, then maybe it's not being effective, not as effective as you want it to be."

Pt Umm, I see.

The nurse practitioner used the phrases "That's what I'm concerned about", "but it worries me " and "then I'm really worried" as a strategy to impress the patient with the significance of irregular menstrual periods, which the NP referred to as out of cycle bleeding. The patient has been told in the past that it's not a problem to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

worry about because she is a runner and has low body fat.

Gayle the NP, was concerned because the irregular menstrual bleeding could cast doubt on the efficiency and effectiveness of the mini-pill as a contraceptive. The patient responded to the potential ineffectiveness of the mini-pill with a thoughtful "Umm, I see". She then agreed to keep a log and return in three months for follow up evaluation. The nurse practitioner did not use command statements or warnings to convince the patient about the significance of the problem, rather she expressed her concerns about irregular periods as an indicator of inefficient and ineffective birth control.

Finally, in the following interaction, Ellen (NP) saw a woman for a re-check on an atypical pap smear. When Ellen asked the patient if she had any other questions or concerns, the patient hesitated momentarily and then asked if she could also have a breast exam.

Pt I uh, Dr. Davidson at the medical center, he checked me, he said I was okay, this was two years ago and I'm still skeptical. I mean I read more things daily, breast cancer is up 27 percent and I'm so lumpy, and every time they try to take a mammogram, the breasts are so dense they can't see any. So I have two lumps and I can't even tell the difference.

NP Well it certainly is reasonable, if you still have this lumpy bumpy stuff, to send you back to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the breast clinic and I would do that because I think it's important for them to do the follow up.

The patient continued to explain that she had returned to the breast clinic for follow up but was told by one of the consulting physicians "a group of us doctors think you're really nuts to be back here, it's only fibrocystic."

Pt I said I don't care, I'm really not comfortable with this. A gal right at my school had one a year ago and now a year later she's diagnosed with breast cancer. You didn't find anything a year before. I said I'm, I'm paranoid, I'm scared to death.

Ellen asked some further questions and completed the breast examination.

NP My feeling is that they are fibrocystic, and that would be my sense, especially with your pattern of dietary changes affecting it and menstrual cycle changing it, uh but still it's a good idea to have them checked, okay?

Pt Okay.

NP I'll call down there and make the arrangements. And those doctors should be able to reassure you. You have a right to feel comfortable with what they come up with. But you can always call me if you're having any concerns. I don't want you wondering like last time.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The patient was "scared to death" about the lumps in her breasts and was not comfortable with the reports she had received from the breast specialists. Her confidence in the breast clinic was eroded even further when one of the physicians implied that he and the other doctors thought she was "nuts" for returning for a recheck, after all the breasts were only fibrocystic. Ellen's demonstration of concern for the patient was reinforced by her willingness to intercede in her behalf and declaration of availability and support. "You can always call me I don't want you wondering like last time."

Attempts to reconcile gaps or mistakes in the delivery of care to patients took the form of apologies. An apology is defined as an expression of concern or regret for an offense or oversight (Webster's Ninth New Collegiate Dictionary, 1983). Apologies may arise from self awareness of a mistake, or from having the mistake pointed out by some one else. As a general rule, for an apology to be considered genuine, the one who apologizes must truly feel regret for the action which gave offense and communicate a desire for reconciliation. The major goal of a genuine apology then is to restore and or support relationships.

There were only three observed instances of nurse practitioners apologizing to patients noted in the transcripts. However the small number does not diminish

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the over all importance of apologizing in the nurse-patient relationship. The following excerpts demonstrate the circumstances and nature of apologies as expressions of concern for patients in this study.

In this first scenario, Connie, the nurse practitioner was interviewing a middle aged female patient she had not met before about her reason for the office visit. The patient replied that she was there to have a scheduled three month follow up on an abnormal pap smear, but as long as she was there she also wanted to have a test for cholesterol. The nurse practitioner acknowledged her request with "sure, okay, lets see" as she reviewed the patient's health record. After asking a few questions to clarify information related to the pap smear, the nurse practitioner moved the discussion to the issue of cholesterol testing.

NP (looking once again at the patient's record)Yes, there shouldn't be, uh, yah there it is (pause) you were 314 last year, that's rather high, are you fasting this morning?

Pt Yah, I did.

NP You haven't?

Pt (interrupting the NP) I didn't eat this morning.

NP Good, yes what we'll do is uh, I'll do the pap smear, and uh, then do a lipid panel too, so, uh, that will give us a good picture of your

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

cholesterol, triglycerides, your HDL and LDL.

Pt What's all that?

NP Oh, I'm sorry, I just carry on here, uh that stands for high density and low density lipids or fats, uh they're the so called good and bad cholesterols? I'll give you a hand out to read that explains all about it, including some thing about the triglycerides, and some life style changes that help bring it down, okay? Uh, basically you want the highs to be high and the lows to be low, and in some folks the low density fat is too high and that's the thing you want to work on.

The nurse practitioner went on to explain about some other community based resources for the patient to access for more dietary information. Then, having completed the health history, she started to prepare the patient for the actual examination.

NP Alright, I'll just get you set up for the pap smear, and since it's just a repeat, I won't do a whole pelvic exam today.

Pt What's your name?

NP Connie. Ohh, didn't I introduce my self when I came in?

Pt (shakes her head no)

NP I <u>am</u> sorry, I don't know what to say, that's certainly not very nice of me.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pt That's okay.

The nurse practitioner gave apologies in response to two separate triggers from the patient. The first time it was in response to the use of medical/nursing terminology (jargon) which the patient did not understand and asked for clarification "what's all that"? The second time it was in response to the patient's request for an introduction, "what's your name?" In each situation the patient did not appear particularly upset by the oversights on the part of the nurse practitioner, rather she wanted clarification of terminology and an introduction. The nurse practitioner seemed genuine in her attempt to reconcile her oversights with the patient based on congruence of facial expressions and tone of voice in expressing regret to the patient.

In the second scenario Betty, another NP working in the same private practice setting as Connie, found she was suddenly behind schedule due to an over sight by one of the office assistants. It was customary for the nurse practitioners to look for charts placed in the door rack as a cue that their next patient had arrived and was ready to be seen. Seeing no charts "up", Betty thought she had a few extra minutes to talk with the nurse researcher about the clinic setting, the organization of work loads and patient care practices. Betty then returned to her office to discover that a patient record had been placed on her chair rather than in the rack on

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the door of the exam room where the patient was waiting to be seen.

NP (Knocks on exam room door, then walks in and asks) Hello Margaret?

Pt Unhuh, hello.

NP Have you been waiting a long time here?

Pt Awhile, not too long.

NP Okay, good, I'm sorry for the delay, your chart was sitting on my office chair, not in the door rack so I wasn't aware you were waiting. I apologize!

When asked about giving apologies to patients, nurse practitioners indicated that they felt it was important for patient self esteem, and the nurse-patient relationship that nurses be willing to acknowledge when an error or oversight has occurred. For example, Connie stated "When I tell a patient I'm sorry, I admit to them and me that I'm human the same as they are. I think it helps equalize our positions, and hopefully makes the patient feel like they're not just a number in the system." Betty was conscious of the need to maintain patient good will in the private setting and suggested that it was also good public relations. "If I'm running behind schedule, I make a point of letting the patient who has been waiting for me know why, and that I'm sorry for any inconvenience. It's really a matter of common courtesy as well as PR."

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Socializing

Kliewer (1986) identified socializing talk as that which highlights the nurse's interest in personal activities of the patient. Fosbinder (1990) identified personal sharing as a technique used by the nurses in her study to decrease patient anxiety about the illness, and to build rapport. Nurses interviewed by Fosbinder indicated that they shared selectively from their personal lives as ways to equalize the nurse-patient relationship, help the patient relax, and possibly deal more effectively with their problems. Social talk therefore was not focused on the hospitalization per se but rather reflected the nurse's interest in the patient as a whole person within the context of family and community

Although socializing talk was a common component of nurse-patient interaction in the hospital setting (Kliewer, 1986; Fosbinder 1990), only three of the nine practitioners consistently engaged in social talk with patients in my study. The amount of socializing varied according to contextual circumstances, particularly the amount of time the nurse practitioner had available for the office visit. If the nurse practitioner was strapped for time, the only socializing that occurred was integrated into the opening ritual, typically appended to the greeting or as a transition to the purpose of the visit as discussed in chapter four. The following

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

excerpt illustrates an abbreviated form of socializing talk between a nurse practitioner and patient.

NP: Hi, Mrs. Pringle. Haven't seen you for some time, how's the family?

Pt Oh, you know how it is, don't come unless I've got a problem. Everyone's doing okay. Can't complain as they say. How about you?

NP Fine, fine, a little too busy with work and school things some days though. So, how are you?

The nurse practitioner combined her greeting of the patient with a brief and perhaps cursory inquiry about the status of the family. The patient responded with a brief social inquiry of her own. The nurse practitioner gave a cursory "fine, fine" then engaged in a brief instance of personal sharing about her busy schedule.

Other examples of socializing occurred during the hands on part of examination, often involving more extensive social conversation about family, vacation plans, and personal health experiences. One nurse practitioner revealed that she used social talk to help the patient relax during uncomfortable procedures such as pelvic exams but emphasized that she was very attuned to her office schedule and would not compromise it by engaging in extended social conversation.

In the following example, Helen, the nurse practitioner was preparing the patient for a pelvic

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

examination. After assisting her into position she engaged the patient in conversation about summer activities.

NP What are you doing this summer?

Pt Well it's summer vacation for me since I'm a teacher. We all went back east to a conference, my husband is an administrator here.

NP Oh, he is?

Pt Yah, and so we went for a university administrators meeting, they meet every two years at a different university, two years ago it was here.

NP Really, I didn't know that.

Pt Yah, I'll tell you, Harvard was interesting but I'd rather send a child here anytime, especially the housing for students, my God what they put them in are like stalls.

NP That's surprising considering the cost of what people pay to go there.

Pt And, they have to live on campus, for the first year or two, it's really pathetic.

NP So what else did you do?

Pt Uh, after we got back we had two weeks up in Tahoe, that was really nice.

NP (finishing up exam) Well that sounds great! Okay, let me help you sit up here.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

In an encounter with another patient, Helen was again involved in a pelvic examination. The patient had revealed she was leaving for a Hawaiian vacation where she intended to do some scuba diving.

NP Where is it you're going in Hawaii?

Pt Kuai

NP Oh, that's my favorite place.

Pt Yah that's why I wanted to be certified to dive, my family are all divers.

NP It sounds like you're going to have a great time.

Pt Yah if I can get this ear problem cleared up.

Both NP and Pt. laugh because they had discussed the ear problem at length earlier in the office visit.

NP I've always thought that was something I'd like to do but the cost of lessons and equipment has always put me off.

Pt Well the place I went to wasn't that expensive, you know? It was okay too, I liked the concentrated classes, I think I learned more that way.

NP Oh that makes sense, what was the name of the place?

The patient went on to give the nurse practitioner information about the classes and encouraged her to try scuba diving lessons.

Pt You should really try it!

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

NP (smiles) I guess I'll have to.

Occasionally as part of socializing talk the nurse practitioners included references to personal experiences or situations that were similar to those disclosed by the patient.

NP How old is your baby now?

Pt She's seven months old and really getting to that busy stage.

NP Oh how I remember those days! Mine are all grown now but I still remember how exhausted I was when they were that age.

In the following excerpt the patient had disclosed that she was having problems with morning joint stiffness and pain.

NP Did the doctor prescribe anything for the pain?

Pt Yes, but it took five weeks to kick in.

NP Family history of arthritis?

Pt My father, uh osteoarthritis.

NP Well if we live long enough we'll all get some tweaks and twinges. I myself, I uh had some joint pain that'd been bothering me so I finally went in and they told me it's a little osteoarthritis.(shaking her head and smiling) Isn't life grand?

Pt (laughing) My elderly aunt told me getting old is the pits!

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Research on women's talk suggested that women focused on the establishment of interpersonal bonds through linguistic means, including the use of self disclosure (Pearson, 1985; Treichler & Kramarae, 1983). Although socializing talk was not a dominant component of supportive language used by the nurse practitioners in my study, those nurse practitioners who engaged in social talk did so consistently and included personal sharing or self disclosure as a means to build rapport with their patients.

In summary, female nurse practitioners demonstrated supporting language action by instances of affirming and acknowledging patient choices, expressions of concern for patient situations, apologizing for perceived oversights or shortfalls in the delivery of care, and engaging the patient in social talk that included the nurse practitioner sharing personal interests and disclosing personal experiences with the patient. These findings corroborate previous research on women's language which suggested that women tend to share experiences, relate similarities in personal situations, listen in supportive ways, and offer reassurance when talking with others (Kasch, Kasch, & Lisnek, 1987; Pearson, 1985; Throne, Kramarae, & Henley, 1983 ). "It may be that nurses are 'feeling' specialists who are skilled in using communication to deal with the uncertainty and anxiety

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

that often accompanies diagnosis and treatment" (Kasch et al., 1987 p. 249).

Informing

Information exchange was the language pattern most frequently identified in the verbatim transcripts of nurse practitioner talk with patients. Every transcript revealed numerous instances of informing language action on the part of the nurse practitioner.

Kasch et al. (1987) identified providing information to the patient as the nurses primary interactional objective. Kliewer's 1986 study of hospital nurses identified information exchange as the most important and prevalent communication function since it was the basis for making nursing decisions. Furthermore, the nurses in Kliewer's study perceived the information they held "to be their major source of power and status" (Kliewer, 1986, p.79). Fosbinder (1990) identified informing activities as occurring "almost continuously in the nurse-patient interaction" (p.73) and included activities such as answering patient questions and giving information about all aspects of patient care as examples of informing from her study of hospital nurses.

The nurse practitioner's primary purpose for eliciting information from the patient was to obtain necessary data about life style and general health practices, past and current health problems, and responses to past or current therapeutic regimens. The

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

main purpose for giving information to patients was to increase patient knowledge about their personal health or illness situation, give specific recommendations and/or instructions about therapeutic regimens, and eventually to influence patient decision making to effect a positive health outcome. Nurse practitioners gave information to patients in one of two instances, in direct response to requests for information, or voluntarily as result of the nurse practitioners perception of the patient's need for information. The following excerpts from the transcripts exemplify informing language activities observed during the course of data collection.

NP (Informing patient about new terminology for pap smear reports)"Your last pap smear was benign, that's a new designation for paps. We are moving away from using the class I or class II. It's part of an effort to standardize the terms so there'll be less confusion about pap reports from one lab to another.

NP (In response to patient request for information about mammograms) Well usually it's recommended to have your first one about age 35, unless you find something on the breast exam that's suspicious, you know, like a cyst or lump."

NP (While doing a breast exam on a young woman) Areola, that's the term for this darker colored area around the nipple.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

NP (While doing a pap smear) Condoms have a fairly high contraceptive rate but there is a small margin of error. You may want to combine condoms with another method like gel or foam.

Informing activities appeared to be a natural and spontaneous component of the nurse practitioners' repertoire. Although information giving was interspersed through out the office visits, more indepth informing seemed to occur at the end of the visits in the form of specific recommendations, and instructions. It was common for the nurse practitioner to review the major concerns identified during the visit, and then focus informing activities on those areas that she perceived to be most important. However, patients were also actively encouraged to ask more questions, and comment on recommendations and therapeutic regimens. Nearly every observed visit concluded with the nurse practitioners asking the patient if there were any other questions or concerns that needed to be addressed. In the following excerpt, the nurse practitioner was summing up her concerns about the patient's vegetarian diet in relation to a problem with anemia.

NP Now you're vegetarians and so you probably have a better handle of vegetarian diets than I have but uh what do you do for iron?

Pt (chuckles) Well I'm very picky.

NP (smiling at the patient) Oh you are are you.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Pt I uh, I like to eat cheese.

NP Unhuh, but there's not much iron in cheese.

Pt Right, umm.

NP (continues) We've always said eat green leafy vegetables, but uh, as you probably know they, umm, there's some kind of interaction with calcium, uh especially with spinach, which was one vegetable we pushed years ago?

Pt Umhmm.

NP And uh, dried fruit sometimes has iron in. . .

Pt (interrupting) yah, I like raisins.

NP Do you? And I think apricots are high too.

The nurse practitioner continued, telling the patient that she was not as current on vegetarian dietary information as she would like to be.

NP Uh, do you read a book or have something that guides you in meal planning?

Pt No.

NP No? uh okay you just don't eat meat?

Pt Right.

NP But you do eat dairy products?

Pt (shakes head yes) Umhmm.

NP Okay, well that's good, but I think we'd better get some consultation with a dietitian on what to do about your iron intake on a vegetarian diet okay?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The patient agreed to the diet consult, then the NP proceeded to summarize her concerns with the following closing comments.

NP Okay, well uh you're hematocrit is fine now, it's up and it's fine, but uh, just keep an eye on it, it may go down again since you're not getting a lot of iron in your diet right now.

Pt Okay.

NP So, uh anything else going on, or questions that we didn't get to?

Pt No, (smiling) I guess we covered it.

The nurse practitioner engaged in information gathering to assess the patient's ability to maintain adequate iron intake on a vegetarian diet. Although the NP readily admitted that she was not as knowledgeable as she should be, she gave the patient some general information on how to increase dietary iron while maintaining a vegetarian routine. However the NP suggested dietary consultation to increase their mutual understanding of vegetarian diet practices and decrease the likelihood of the patient becoming anemic once more because of inadequate iron intake. Throughout the informing activity, the nurse practitioner maintained eye contact with the patient, acknowledged the patient's personal choices, and used humor and self disclosure, (about her lack of knowledge about vegetarian diets) to create a supportive and collaborative atmosphere. These

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

communicative strategies tended to diffuse the power differential between the nurse practitioner and the patient. As a result the patient was able to accept the nurse practitioners suggestions for increasing the iron content in her vegetarian diet, and a consultation with a dietitian.

Nurse practitioners interviewed about informing activities agreed with the literature that identified information exchange as central to accomplishing the goals of the nurse-patient encounter (Kasch & Lisneck, 1984; Kliewer, 1986). However they also suggested that informing activities were not universally appreciated or accepted by all of the patients in their respective practices. For example Suzanne, a nurse practitioner in a rural setting, explained that many of the patients' in her practice had limited knowledge about general health matters and did not seem interested in her efforts to explain about therapeutic regimens or to be involved in decision making about their health care. NP Suzanne made the following comment.

> I feel like it's important for me to take the time to talk about what's going on and why I'm suggesting a particular approach, but frequently what I have to say just falls on deaf ears. I mean, they just look at me as though I'm wasting their time, don't bother them with the details, just give'm a prescription and get on with it. But on the other

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

hand, I do have some who seem to appreciate my efforts, so that's what keeps me going.

Dottie, explained that no matter how appropriate or correct your health teaching or information may be, one thing you have to be prepared for is that the patients may not agree with you or be able to accept what you are sharing with them at the time. Dottie gave examples of patients refusing pap smears, and prostate exams as part of their routine health screening appointments.

> What can you do? You're not going to bar the door and not let them leave are you? You've just got to give them enough information about the situation, and give it to them in a way they can understand, and hope that they'll eventually make the right decision for themselves.

In the following excerpt the NP was examining a patient who had reported cold symptoms that were getting worse rather than better.

NP Let me start with looking at your ears first. (NP examines both ears) Well your TMs look a little retracted and pink. I'm going to blow some air onto the drum to see if it moves appropriately so you'll feel some pressure now, okay? (NP used the bulb attachment on the otoscope) Okay they seem to move all right.

Pt What does that mean anyway?

NP Oh, uh, if the TMs, the ear drums, if they

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

don't move it could mean that your Eustachian tubes could be blocked by a little swelling in your throat. It could lead to an infection, it's not common in adults but it could happen.

Pt Oh.

The nurse practitioner went on to examine the patient's nose and throat.

NP (NP smiling at patient) Okay now I want to take a peak in your nose, so I want you to hold your breath a bit so you wont steam up the lens. Okay?

Pt Unhuh.

NP Well you certainly do have a lot of swelling and discharge. It looks like an infection all right. How long have you had this green discharge? Is this recent?

Pt Oh, uh I'd say since yesterday. It was clear before but I noticed it changed yesterday."

NP Okay, well that could signal a sinus infection and if the drainage runs down the back of your throat it could be contributing to the soreness you're experiencing.

During the examination the nurse practitioner elicited information from the patient to further assess the meaning of the physical findings. The patient responded to direct questioning with information, but also asked for information in return. "What does that

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

mean anyway?" The nurse practitioner went on to explain what she was doing and the significance of the physical findings in relation to the patient's symptoms. We also see examples of medical jargon in this brief exchange such as "TM's", as an abbreviation for tympanic membrane and the anatomical term, Eustachian tubes. The significance of jargon and other examples of professional parlance will be discussed at length later in this chapter as one of the major patterns of linguistic behavior that characterized nurse practitioner talk.

## Controlling

To control implies the exercise of position or authority to regulate or manage the behavior of others; to be in charge (Webster's Ninth New Collegiate Dictionary, 1983). Outside of physical manifestations, control or power is typically exercised linguistically (Kramarae, et al. 1984)

Defined as language designed to regulate behavior, Kliewer (1986), identified controlling or regulating language as one of the major categories of communicative patterns in her study of hospital nurses. Nurses were observed issuing commands, warnings, advice and suggestions in 165 of 216 interactions.

All of the nurse practitioners who participated in my study were observed using some form of linguistic control in their encounters with patients. The components of controlling language identified in the transcripts were

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

categorized as advising, requesting, commanding, and warning. Each of these components will be discussed and illustrated with excerpts from the field data

Advising

Giving advice to patients is a common and accepted activity for nurse practitioners to engage in during the course of an office visit. Assuming that the advice given was appropriate for the patient's situation, and met community standards for care, advice giving would be viewed as a good and helpful activity. As a component of controlling language, it is the most subtle since it is often cast in the guise of suggestion. Advising may also have the least potential to sway patient decision making, since there is an inherent implication that advice can be ignored, even if it was requested. Never the less, the underlying intent of advising is to eventually impact patient behavior. This is accomplished in part by the status imputed to the nurse practitioner as holder of specialized knowledge that is subsumed by the notion of expert power. The following examples of advising are taken from the transcripts.

Gayle the NP discussed the efficacy of birth control methods with a young woman

NP Well you may want to consider using condoms with a spermacide. Neither approach alone is actually fool proof you know, but combined you get good protection.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Later in the visit Gayle suggested a class on birth control.

NP Oh, one more thing, we have a program, a class really, for people considering birth control methods which'll give you a lot of information.

Betty (NP), discussed elevated cholesterol levels with a patient.

NP Okay, it looks like your cholesterol has gone up again this year. This is a trend you'll want to reverse.

Dottie (NP) gave advice on the continued use of a steroid anti-asthma drug in response to the patient's question about its safety.

NP: "Yah, well we used to worry about that, but we just had a speaker out here a couple of weeks ago to talk about this very issue and it appears that Asthmacort is the drug of choice now. So uh, we can watch you. I wouldn't want to make a change until you're used to the climate and change here."

Although subtle in form, the intended outcome of advice giving was to influence the patient to make a personal health care choice that was congruent with the nurse practitioners opinion, albiet informed by community standards for practice. For example, Gayle (NP) believed that condoms were not totally reliable as a birth control method. Even though Gayle's concern was expressed in the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

form of a suggestion (you may want to consider), her intent was to influence the patient to add a spermacidal gel or foam to increase protection against pregnancy. Advising to seek congruence with ones beliefs or values (it is not good to have an unintended pregnancy) versus advising based on standards of care (condoms with spermacidal gel increase contraception) may reveal a subtle form of power over the patient.

Requesting

Although framed as a question, linguistically requests were often statements of intent by the nurse practitioners, signaling to the patient that their cooperation or compliance was expected. For example:

"Let me listen to your chest," "Can I get you to open your mouth a little wider?" "How about slipping your feet into the stirrups here."

There is never any real doubt in the nurse practitioners mind that the request will be refused. In many cases the stethoscope was already out and poised for placement on the patient's chest, the tongue blade was in position applying pressure to the lower jaw, or the nurse practitioner was placing the patient's feet into stirrups. The nurse practitioners were in fact making a command wrapped in the guise of a simple request. When Dottie (NP) said to her patient:

> "I'd like to look at your ears now, can you tip your head just a bit?"

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

She actually intended:

"I am <u>going</u> to examine your ears now, tip your head just a bit."

Similar to the intention order identified by Kliewer (1986), this component of controlling language states "this is what I am about to do and I am expecting cooperation." The linguistic power embedded in this kind of requesting is not as subtle as that noted in advising.

<u>Commanding</u>

Command statements, designed to regulate patient behavior, were used by all of the nurse practitioners in this study. In terms of force, commands are stronger than advising or requesting language, and reflect the distribution of power between the nurse practitioner and the patient. When nurse practitioners used command language the intention was to convey importance for and/or the intention to carry out some activity in relation to the situation under discussion. Commands were typically issued in relation to treatment regimens, health maintenance, and health promoting activities where the nurse practitioner anticipated some resistance by the patient. The following are examples of commands issued by nurse practitioners in routine office visit talk.

Florence (NP) to a patient who had just been told she needed to have an echocardiogram because of a newly identified heart murmur

NP I don't want you to get all shook up about

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

this, we're going to go ahead and do it.

The patient's only response was a somewhat hesitant "Oh, okay."

Helen (NP) to a patient having menstrual regularity problems related to hormone replacement therapy.

NP Now I don't want to increase either of those hormones yet unless I have to. I would rather switch you to another type, so that's what I will be doing.

Ellen (NP) gave instructions to a patient about to have a sore throat examined.

NP I am going to use a tongue blade here, I'll try not to gag you.

Pt I really don't like this.

NP Just relax your tongue so I can get a good look. I know this is no fun.

Although Ellen acknowledged that she knew "this is no fun" she commanded the patient to "Just relax your tongue.", leaving no room for negotiation.

Warnings

Like commands, warnings were used to emphasize the importance of the situation under discussion but also implied undesirable consequences if the patient ignored the instructions. Warnings therefore were an escalation of the command statement in a effort to control patient behavior. Only three instances of warnings were noted in the verbatim transcripts of nurse practitioner talk.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Helen (NP) had been discussing sinus problems with a patient who was insistent on going scuba diving.

NP Well, you'll have to use your own judgment then. It'll just make it worse and you'll have even more troubles. Okay?

In a visit with another patient undergoing treatment for plantar warts.

NP You'll have to come back fairly often for treatment otherwise these things tend to take awhile to go away. They can be resistant to treatment, so I want you back here every two weeks for a couple of months.

Irene (NP) gave instructions to a patient about a new pain medication that was being ordered because her previous one was not helping.

NP Okay I want you to pick up the prescription before going home so when the doctor calls you can tell him if the new medicine is working.

Although not a dire consequence, the warning implies that the patient will some how inconvenience the doctor more than herself if she fails to pick up her prescription.

The patient responded with: "umhmm, okay."

NP Okay! I want you to take this <u>just</u> like it's ordered.

The message here is "listen up!" Failing to take it "just like it's ordered" will lead to more problems.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The exercise of control or being in charge is not inherently a bad thing. For example, the patients in Fosbinder's study (1990) viewed the nurse who was "in charge" as being confident and knowing what she or he was doing. The patient's perception that the nurse was "in charge" was comforting, and increased the patient's trust in the nurse. However, linguistic behaviors such as interruptions, commands, and warnings, which sometimes accompany notions of "being in charge" do little to enhance any sense of mutual participation or collaboration in the nurse-patient interaction. While not specifically noted in my study, controlling language may also impede accurate data collection by intimidating the patient and cutting off information exchange.

Although controlling language behaviors may be well intended, they are not necessarily in the patient's best interest, and imply the use of control (being in charge) that can compromise health care outcomes. Treichler, et al., 1984; West, 1984). For example Shuy (1983) demonstrated that resident physicians who used controlling language during history taking often aborted patients attempts to give further information about past or current health problems. The physicians therefore made intervention decisions based on incomplete or inaccurate information with implied threats to health outcomes for the patients. DiNicola and Dimatteo (1983) reported that physicians who used collaborative

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

interpersonal styles that reflected respect for patients' decision making rather than authoritarian interpersonal styles encountered less resistance to treatment plans. Furthermore, Treichler et al.(1984) reported a significant divergence between physicians perceptions of presenting problems and those of the patients they were seeing. This divergence was caused in part by the physicians' controlling behaviors which included interrupting the patient and selecting which topics to pursue during history taking. The implication for health care outcomes relates to patient dissatisfaction with and resistance to treatment plans that do not appear to address their health concerns.

As suggested in the review of literature, controlling linguistic behaviors have long been identified as a dominant pattern in interactions between professionals such as doctors and lawyers and their patients/clients (Parson, 1951; Fisher & Todd, 1983; Stoeckle, 1987). Society has ascribed authority to professional practitioners based on advanced education, and specialized knowledge in the form of technical skills and information. The result has been that significant disparity often exists between the professional and the patient/client in terms of social standing, and power to control or influence decision making (Freidson,1970; Freund, 1982).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Nurses, have also been identified as professional practitioners with potential for power over those seeking care (Kliewer, 1986; Taylor et al. 1989). The nurse practitioners in my study demonstrated controlling language behaviors consistent with the regulative communicative strategies identified by Kliewer (1986), Kasch and Knutson (1985), and Taylor et al. (1989). In doing so they added to the data linking language and power. Although the female nurse practitioners did use para-linguistic utterances and kinesic gesturing consistent with women's discourse, more consideration must be given to the notion of increased intersubjectivity and mutuality in talk between women, particularly professional women and their clients/patients. Perhaps, as suggested by Edmunds (1984), nurse practitioners need to consider whether they conform to interactional styles commonly associated with medical behaviors (professional dominance) because those are the behaviors that are valued and rewarded in their work setting. Nurse practitioners who value language strategies oriented to building consensus and empowering patients to be active participants in their own health care decisions may face serious conflict with models of practice where other values are dominant.

## Professional Jargon

Professional jargon is defined as specialized and often hybridized language or vocabulary used by people in

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the same work or profession. To the lay person it may seem incomprehensible, however to those on the inside, jargon serves as a linguistic short cut, as well as a mark of insider status. Shuy (1986) identified medical jargon as a barrier to physician-patient interactions. Henry and Leclaire (1987) suggested jargon was similarly problematic in talk between nurses and patients. All of the nurse practitioners in this study, but one, used medical/nursing jargon or medical terminology in their talk with patients. On several occasions patients spoke up and asked for clarification from the nurse practitioners. When asked, the nurse practitioners readily explained the terminology they had used, and in several cases included an apology to the patient. But, more typically, the professional jargon was used by nurse practitioners without explanation, and perhaps, unrecognized as such since it was a natural part of their working vocabulary.

Because health teaching and informing activities often requires the use of some technical terminology, the terms, acronyms, or other abbreviations identified in the transcripts were designated as jargon only if they were used with out an accompanying explanation. When asked about the use of jargon, nurse practitioners agreed that it was a problem, but they tried to avoid using it as much as possible. There was considerable surprise and chagrin for some of the practitioners therefore, when

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

they learned just how pervasive jargon use was, as demonstrated in the transcripts of their own office visits. For example, Alice, a nurse practitioner with many years of practice experience expressed embarrassment because she often chided her physician co-worker about his use of what she called "medicaleze." "I'll really have to clean up my act now. I wonder if it's catching."

Dottie, the only NP to have no evidence of jargon use in the transcripts of her office visits, suggested that jargon is learned in the hospital setting. "I never did hang around hospitals that much. I went into community health before becoming a nurse practitioner so I just didn't pick it up. It's those hospital people that use all the latest technical jargon. I really think it's learned behavior."

The following excerpts illustrate the variety of professional jargon used by the nurse practitioners during routine office visits.

Alice (NP) was asking her patient about past medical problems. When the patient revealed that she had a hysterectomy 15 years earlier Alice asked "Was it an abdominal hyst?" The patient replied "a what?" Alice then clarified by saying "an abdominal hysterectomy, through the abdomen?"

Connie (NP) discussed cold symptoms with a patient.

> "There are literally hundreds of adenoviruses that can give a kind of general malaise like you

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

described."

Later in the same conversation:

"Okay, umm we can get a CBC and Sed Rate too. Okay?" The patient responded with an "Uh okay." When asked later if she had any questions about the lab work that had been ordered, the patient smiled and said she "guessed it was blood tests to tell how sick she was. But just what's a 'general malay' any way?"

Ellen (NP) examined a patient complaining of ear pain and a sore throat.

NP Your TMs look a little retracted.

Pt What does that mean?

NP Oh umm, if the TMs, the ear drums don't move, it means your Eustachian tubes could be blocked.

When asked "What does that mean?" Ellen went on to define "TMs" as the ear drums but then used more medical jargon as she explained the significance of immobile ear drums in relation to blocked "Eustachian tubes." Later Ellen moved on to examine the patient's throat, describing the appearance as follows:

NP Your throat is definitely red and you have patches of hypertrophic tissue which confirms my suspicion.

Although Ellen had difficulty avoiding the use of jargon in this particular visit, no jargon was identified in any of her other transcripts.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Occasionally the use of jargon produced some contradictory responses from the patient.

NP Have you noticed any extra hair growth anywhere else? Uh like facial hair or hair along your umbilical line?

The young woman patient shook her head no, then pointed with her finger to the umbilical area and said:

"no just here around my belly button."

Florence (NP) was explaining a special procedure called an Echocardiogram to patient who was feeling anxious because she had just learned she had a heart murmur.

NP We've talked to Dr. Shot about this and we're going to go ahead and get what's called an Echocardiogram. It's not uh, no needles or anything, all it is uhm, is some uh jelly and a diaphragm, an uh, an external device to look at the valves that way.

The patient responded with a pensive "oh, okay." The nurse practitioner continued to explain about the ramifications of the heart murmur and mitral valve prolapse.

NP It's a good idea to document it, and then you'll know for sure whether it's important to take prophylactic antibiotics when you have procedures like dental procedures and things. Okay?"

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The patient once again responded "oh okay", but it was impossible to know what she may have been thinking, given her anxiety level. There was already some doubt about her ability to fully comprehend what was being said given terms such as "jelly" and "diaphragm". After all, in another orientation they could apply to a method of birth control. However, the NP's choice of terminology "prophylactic antibiotic" (referring to an antibiotic drug taken to prevent the onset of infection) without any further explanation possibly increased the patient's anxiety and confusion even more.

The field data clearly demonstrated that the nurse practitioners in my study were inclined to use medical/nursing jargon in their talk with patients. Furthermore, jargon was confusing to the patients as evidenced by the questions they asked, and their requests for clarification. One patient, who didn't understand the term "general malaise" used by the nurse practitioner, expressed some embarrassment later on in discussion with the nurse researcher when she asked for clarification.

Shuy (1983) suggested that the choice of medical jargon was intended to demonstrate the superior knowledge, and special insider status of those who used it. Henry and LeClair (1987) described the use of jargon in hospital settings as a way of identifying with the various professional groups, however noted that its use

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

was potentially detrimental to effective communication across all hospital staff. In a similar fashion medical/nursing jargon is problematic in nurse practitioner talk with patients. It seems clear that the jargon used by nurse practitioners in this study was in fact problematic for patients. It interfered with their understanding of physical findings and possibly unnecessarily contributed to anxiety about their health status.

For the most part, professional jargon went unrecognized by the practitioners unless it's use was called to their attention by the patient. An indication of just how subtle and embedded jargon use is in our professional practice was reinforced by the fact that I initially over looked a number of its uses although I was actively attempting to identify it. As a nurse practitioner I was enculturated. It took the careful reading of the auditor to remind me that what I recognized implicitly was foreign to most patients.

Although the use of jargon may not have been intended to obscure meaning or mystify the health assessment process, that was certainly an outcome. One can only imagine what the patient was thinking about the implications of "general malaise" until she finally called up the courage to ask.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

## Summary

The language patterns which seemed to characterize the talk of nurse practitioners during routine office visits with female patients were those that supported, informed, controlled, and some times, in the case of professional jargon, confused the patient. Language behaviors that were considered supporting were those that helped to build and sustain a relationship of caring and respect between the nurse practitioner and the patient.

Informing activities were a major part of all nurse practitioner-patient encounters. Nurse practitioners engaged in a variety of informing activities both voluntarily in response to perceived needs of the patient, and/or in direct response to patient requests for information. Controlling language behaviors were also noted as a significant pattern of nurse practitioner talk, and included advising, requesting and commanding activities as strategies to influence patient decisions and actions. Warnings however were used infrequently by the nurse practitioners in this study to control or influence patient behavior.

Finally, professional jargon was identified as a pervasive, powerful and yet largely unrecognized linguistic behavior that nurse practitioners incorporated into their talk with patients throughout this study. There was also evidence that the use of professional

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

jargon contributed to patient confusion and perhaps anxiety about various aspects of their health care.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# CHAPTER 6

## A QUESTION OF POWER

> We know that discourse has the power
> to arrest the flight of an arrow in a recess
> of time, in the space proper to it.
> Language to Infinity
> Michel Foucault, 1977, p. 53

Michel Foucault (1983) wrote that the critical question about power was not how does it manifest itself, but rather by what means is it exercised? For Foucault the answer was that power is a matter of relationships between individuals or groups. When we consider power "we suppose that certain persons exercise power over others. The term 'power' designates relationships between partners . . . an ensemble of actions which induce others and follow from one another" (Foucault, 1983, p. 217). Foucault extended the theme of power relationships in suggesting a link to discursive practices (symbolic systems) that produce and circulate meaning.

Habermas (1981/87) also linked power and discourse in his theoretical discussion about communicative action in which he elaborated on language strategies oriented toward success. The aim of such strategies was to gain an advantage (have power) over another in order to bring about certain intended outcomes. The implication is to get what one wants. Conversely, non-strategic communicative action is oriented



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

toward understanding, and entails the development of mutual goals and collaborative interventions. Therefore non-strategic discourse is more consistent with interactional and interpersonal skills considered characteristic of women's speech and perhaps integral to nursing practice.

As stated in the Chapter 1 the purpose of this research was to provide a contextual account of the discursive practices of female nurse practitioners during routine office visits with female patients. I hoped to discover that the something special referred to by Sullivan (1982, p. 8) was language behaviors that empower and affirm patients rather than control them. My concern was the issue of power in relationships between female nurse practitioners and female patients, and the potential for that power to be embedded in the very language that was intended to be helping. That is, assisting patients to identify and resolve health problems.

The idea of power as relationship, and communication as strategic action converged for me in the analysis of the data produced over the course of this research project. As evidenced by the discussions in chapters four and five, nurse practitioners exhibited power in relationships with patients, and that power was embedded in their language behaviors. While the exercise of power may be balanced in some respect by instances of caring, supportive and affirming language behaviors, its presence is never-the-less troubling, as well as instructive.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The nurse practitioner's strategic use of language determined the sequence and pace of the encounter with the patient. For example, transitions were identified in nurse practitioners language as brief instances of socializing talk that eased the conversation and activities of the visit from one phase to the next. Language behavior that moved the encounter from openings to the hands on business of the visit, or alerted the patient that closure was about to occur are examples of transitional talk. If nurse practitioners felt pressed for time they either cut short or eliminated transitions thereby exercising considerable control over the pace of the visit. Another linguistic practice that controlled the pace, as well as direction of the encounter was the use of a scanning style of terse, rapidly posed questions during history taking. While not commonly used, this style of questioning was a clear signal to the patient that the nurse practitioner was in a hurry. Similarly, when a nurse practitioner closes the patient chart, stands up and begins to edge toward the door, the message is "I'm finished here." It makes little difference that she may ask "Do you have any other concerns?" It takes a bold patient to bring up a new problem at this point. Power is exercised in decisions to bring closure to the visit which may not be in the patient's best interest. The issue here is that under such circumstances patients may be reluctant to elaborate on topics or raise new ones for fear of inconveniencing the nurse practitioner. The implications for health outcomes are

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

related to treatment or intervention decisions being made without complete information, and/or that the identification of a significant health problem may be missed. This concern is supported by Molde & Baker's (1985) findings that suggested that patients often come to the office visit with hidden agendas. Furthermore the patient often will not readily disclose those agendas unless they feel invited.

Language also sets the interactional ambiance for the encounter as well. A cordial welcome and introduction and some social talk interspersed throughout the office visit for example, tends to convey acknowledgment, respect and affirmation of personhood for the patient. I saw the use of the alerting knock on the exam room door as a potential demonstration of respect for the patient's privacy, while conferring temporary ownership of the space (Fisk, 1992) to the patient. Conversely I saw the exercise of power when nurse practitioners walked in on the patient without knocking, or used the knock perfunctorily, such as when not actually waiting for a response before entering the room. This action clearly illustrates the power of the concept "place" described by Fisk (1992), resident with the nurse practitioner and, interestingly, is out of sync with other attempts to create the illusion of a mini social encounter.

All of the nurse practitioners in this study used some form of controlling language during their encounters with patients. The most explicit were outright commands or warnings, while giving advice and making requests were more

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

subtle linguistic practices which revealed the exercise of power in relation to the patient. The key here is the notion of expert power associated with health care professionals.

Although there is continuing movement toward greater consumer knowledge and participation in health care decisions, patients continue to defer to the presumed knowledge and authority of the professional practitioner. The nurse practitioners acknowledged their use of control in patient encounters and usually pointed to their professional responsibility to inform and guide the patient to make the best possible decisions. The nurse practitioners assumed that they were in the best position to judge the direction and outcome of treatment decisions, therefore some exercise of power was justified. The perspectives of these nurse practitioners are consistent with those discussed by Taylor et al. (1989) related to paternalistic behaviors used by both nurse practitioners and physicians in gaining patient adherence to treatment regimens. While nurse practitioners acknowledged and used consensus gaining strategies in interactions with patients, they did not hesitate to resort to commands and warnings to achieve their intended outcomes. Clearly a tension exists between paternalism in health care delivery, however well intended, and collaboration that elevates the patient to a partner in decisions about their health. Similar to Habermas's (1981/1987) strategic communicative action, discursive practices were oriented

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

toward successfully convincing the patients to follow the practitioners advice.

Finally I want to address the use of professional jargon as an exercise of power. All of the nurse practitioners in my study, save one, used medical/nursing jargon in one or more observed encounters with patients. Most reported that they were not aware of just how much jargon they used and several expressed dismay when they saw the evidence in the form of written transcripts. Jargon was dismissed by one nurse practitioner as simply a short cut to use when talking with other health professionals. It could be said that jargon in many respects was unrecognized by those who used it. One of the nurse practitioners was clearly aware of the jargon her physician associate used but had not recognized it in her own speech. Perhaps we may even say that its use by many of the nurse practitioners in this study was not explicitly intended. However the fact remains that professional jargon was problematic for patients. They recognized the terms as foreign and confusing. Some were almost embarrassed because they didn't know what the nurse practitioner was talking about. Shuy (1983) reported that there was an implicit assumption by the physicians in his study that patients would understand medical terminology. Such assumptions can lead to dangerous outcomes, and dismissing jargon as a short cut between professionals is an indication of its power over both patients and practitioners.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The effects of the exercise of power revealed in this study are potentially cumulative. For example, I can envision a scenario wherein diagnostic decisions are made without all of the information available because time is short, and the nurse practitioner is in a hurry to move on to closure. In addition, the patient is reluctant at this point to bring up new concerns or elaborate on old ones for fear of delaying the practitioner. The nurse practitioner issues commands and even warnings to encourage or coerce the patient to cooperate with decisions for treatment that may be inappropriate, or perhaps culturally unacceptable. Finally the instructions to the patient are couched in so much medical/nursing jargon that the ability of the patient to comprehend and follow through is left in doubt.

This scenario is purely fictitious. However in reality, the unrecognized use of professional jargon and deviation from basic interactional practices such as active listening, definition of common goals and building consensus (in this case for treatment decisions based on a full disclosure of appropriate heath/illness data) may converge to produce actual untoward health outcomes for patients. The potential for the exercise of power through language remains troubling and should not be underestimated in nurse practitioner practice.

## Contexts of Power

A discussion of the exercise of power identified in the verbatim transcripts would not be complete without

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

acknowledging some of the contextual aspects of the encounters between nurse practitioners and patients. As noted in Chapter Three, the data were collected in six different clinical sites in urban, and suburban to rural locations. The practice sites differed considerably in the socio-economic status of the general population they served. For example clinical site four was a public clinic in an upper middle class neighborhood adjacent to a large university, while clinical site two was a public clinic in a low to lower middle class neighborhood. The patients served by clinical site one, in the lower income neighborhood, were more likely to have their care covered by medical coupons, where as the patients served by clinical site four were more likely to have their care covered by private insurance.

The patient participants in the study were predominantly Caucasian females. Only seven of the 26 patients were from ethnic minority groups. Of those patients three were seen at clinical site two, one was seen at clinical site 6, and three were seen at clinical site one, a private practice setting that served a generally middle class population.

Regardless of the apparent diversity in the locations and populations served by the various practice sites, all of the facilities appeared equally well equipped. With the exception of one site that was undergoing some renovation, all had clean, comfortably furnished waiting areas with ample general reading and patient education materials. The examining rooms were likewise clean, with new or newer

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

furnishings and equipment. All of the sites had basic laboratory and x-ray services available, and adequate ancillary staff to support the nurse practitioners. In addition, the support staff, from receptionists to nursing assistants, appeared friendly and respectful of the patients they served.

Each of the participating nurse practitioners were provided with their own personal offices, typically furnished with desk, bookcases, file cabinets and a phone. In one setting the NP's office also served as her examining room, and in another the personal offices for both nurse practitioners and physicians were located in another building on the medical center campus. For the most part the nurse practitioners were not involved in scheduling patient appointments. A receptionist typically made appointments for the patient based on nurse practitioner availability, and expertise. The amount of time allocated per appointment was usually derived from perceptions about past experience with presenting problems, concerns for increasing productivity, as well as the not so infrequent need to "work someone in". A typical office visit was allotted 15 to 20 minutes. The "work ins" and "no shows" provided frequent alterations for the daily schedules.

While acknowledging that the overall number of interactions observed for this study was relatively small, and that the number of interactions involving minority and/or low income patients was even smaller, the nurse practitioners

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

in this study appeared to use language in powerful ways irrespective of the socio-economic status, or ethnicity of the patients. In other words, across clinical practice sites the nurse practitioners engaged in powerful language strategies to achieve therapeutic outcomes for (if not with) patients. That is, language strategies oriented toward success. Given the feminist perspective that women are more likely to engage in collaborative, mutually empowering language strategies oriented toward consensus rather than success, the question must be raised about other factors that may be bearing on the issue of power in the observed interactions.

One striking commonalty across the clinical sites in this study was the organizational structure and care delivery model. Without exception, the participating nurse practitioners worked in a traditional hierarchical organization, headed by a physician. In the public clinics the physicians usually held the title of Medical Director. In the private settings the physician was the employer. In all cases care was delivered in the illness focused medical model. Furthermore in nearly every setting there was an emerging expectation for increased productivity from the staff. That is, the number of billable activities performed by the nurse practitioners and physicians were expected to increase in order to offset reduced or capped reimbursements, and the costs of providing uncompensated care. These were

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the issues most frequently identified as barriers to a more holistic approach to patient care.

All of the nurse practitioners who participated in this study engaged in some health teaching and health promoting activities, and demonstrated concern and support for the patients they served. Never-the-less, power was evidenced in the speech acts of the nurse practitioners during encounters with patients. It may be that the current health care environment and resulting workplace pressures put the NPs in a double bind. In other words, the power evidenced in the encounters with patients may be explained in part by the tension between the practice values held by the nurse practitioners and the practice values and expectations of the organizations that employ them.

Organizational arguments, couched in the all too familiar clichés, "increase productivity", "do more with less", "work smarter not harder" seem very compelling in today's economic climate. Nurse practitioners must remain cautious however, of those contextual aspects of their practices that reward the uncritical exercise of power over patients in the name of efficiency.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# CHAPTER 7

# REFLECTIONS AND SUMMATION

## Limitations

There are a number of limitations to this study. I have selected several of the most obvious to address in this section. The first limitation was the small number of practitioners who agreed to participate in the study. More time in the field would probably have facilitated the enrollment of more participants, however I did not have the luxury of extended field work. As a result of the small sample size it would be unwise to attempt to generalize findings about power and language to all nurse practitioners. In addition, all of the participants were self selected, that is to say they volunteered to participate and therefore it is impossible to determine if motivation for participation somehow affected the data collected.

Several nurse practitioners declined to participate because of lack of time and reported stresses in their work setting. They may have provided additional insight about the effects of stress on nurse practitioner language patterns. Although there was considerable diversity in the clinical sites where nurse practitioners worked, such as university medical center versus private community practice, the



Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

settings were not representative of all possible work settings. Clearly there could be some differences in language practices based on factors associated with geographical location as well. All of the data collection sites were located in urban/suburban west coast areas.

The affect of the researcher, present in the examining room, observing interactions and recording the language of the encounters may also have had an impact on the data collected. Although I observed a minimum of three encounters with each nurse practitioner in an attempt to acclimate her to my presence, it is not possible to know what differences a fourth or fifth encounter may have revealed. Likewise it not possible to know what language behaviors would have been exhibited in my absence.

Another limitation to the study was the inability to do follow up interviews of the patient participants as proposed in the methods section. The patients were more mobile and transient than I had anticipated, making follow through on interview arrangements very difficult. In retrospect, some external motivating factor such as a free lunch or money may have resolved this limitation.

Another issue which I had not considered in the design of the study and which I have become more aware of in discussions with colleagues about the research findings is the issue of gender role orientation. Mills (1992) discussed language competence in relation to speech characteristics identified as either masculine or feminine. Further

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

consideration of these factors in relation to gender role orientation may have shed some understanding on the language practices of female professionals in relation to female patients. For example, were controlling speech acts the result of professional socialization in a male dominated medical model or was it the result of a masculine gender role orientation? Given all of these identified limitations, I never-the-less feel the process had value and has added to the knowledge on discursive practices of female nurse practitioners in relation to female patients.

## Summary Considerations and Self Reflection

Early in my doctoral studies, I experienced the force of language, particularly the erudite language of academe, and the idea of language as an exercise of power struck me as an incredibly obvious yet often unrecognized abstraction. I had not read the pragmatic philosophers yet, nor knew about Bourdieu's notions of language as symbolic violence. The discovery of a decade of scholarly work focused on the connection between language and power lay in the future. Never-the-less, the impact of that early experience served to crystallize years of intuited knowledge about language and the role it plays in personal and professional relationships. The experience of language and power along with the crystallization process motivated the present research.

The question most frequently asked of me after "When will you be finished?" has been "Would you do a qualitative study again knowing what you know now about the process?"

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The answer is yes, but I would do it differently. This has been a lonely process. One needs a companion researcher or two with whom to share all of the joys, frustrations, insights and conjectures. The analysis of data requires another perspective to provide balance. I had a tendency to get bogged down, and to anguish over the evolving codes. On the other hand it was important not to rush to closure on a category which was often tempting.

In writing this ethnographic report, I was forced to make choices about what data would be illuminated and brought to the foreground for exploration and what would be set aside for consideration at some later date. The research method generated innumerable bits of data that seemed overwhelming at the beginning of the study. What were the important ones? Was I making the right connections? There seemed to be so many possibilities.

Strauss and Corbin (1990) discussed the idea of developing a story line as part of the analysis and writing process. In reality I developed two story lines that eventually converged on the question of power in the language practices of nurse practitioners. In the first story I affirmed the exercise of power by nurse practitioners in the identification of a linguistic process that organized and paced the sequential flow of the encounters. In the second story line language patterns were identified that clearly illuminated caring and concern for the patient that included many instances of reciprocity, self disclosure and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

affirmation. However, the troubling issue of professional dominance was also identified in the overt attempts to influence and control patient decisions. In addition, numerous instances of medical/nursing jargon, were noted to be confusing to patients and frequently transparent to the nurse practitioners.

Finally, in addressing the question of power versus empowerment in the practice of these nurse practitioners, I came to the conclusion that both claims hold, however the evidence on power was most striking. It is clear that nurse practitioners enjoy many of the same privileges physicians do in relationships with patients (the notion of referent power). Authority is ascribed to nurse practitioners in that they have specialized health/illness knowledge and many have prescribing privileges, a symbol of power shared only with physicians and dentists. When any group of professionals has discretionary power to give or withhold prescription drugs, or has the legal authority to confer diagnostic labels of health or sickness, there is a potential for abuse. That is, there is potential for the use of excessive influence by the professional in relation to the client/patient based on the assumption (by both parties) that the professional obviously knows best. Uncritical acceptance of this kind of power or authority can be very problematic in any arena, but most particularly in health care. Therefore, nurse practitioners who routinely engage in linguistic behaviors that control their office visits to meet their own needs or those of the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

organization without questioning outcomes for the patient; uncritically use professional jargon without considering the effect on the patient; or deny the patient the right to private space (the examining room) in which to disrobe for a physical examination are indeed exercising power over the patient. Such activities can not possibly be mistaken for empowerment.

The notion of research that transforms practice, as opposed to merely describing it (Street, 1992) is both new and intriguing to me. If I have any aspirations for my work it is that it may in fact change the way many nurse practitioners engage patients during routine office visits. Here I make an assumption about the generalizability of the power embedded in linguistic practices of nurse practitioners which I disclaimed in the limitations section. However this assumption derives in part because the research process raised my awareness of the language I used in my own practice. I began to see my own language behaviors reproduced/mirrored many times over by the participants in the study. I suspect that there may be exceptional nurse practitioners out in the larger world of practice. Like Dottie in my study they never use jargon, they are consistently collaborative and affirming, and controlling linguistic behaviors are not characteristic of their practice. Unfortunately I suspect that there are many more nurse practitioners, like most in my study who do exercise power over patients in ways that remain unrecognized by them.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

These are the nurse practitioners I hope will read this work and begin a reflective process which leads to change. Cameron (1985) tells us that we can change our language practices. We need not be satisfied with the status quo.

Implications for practice, education and research

These observations and the insights derived from data analysis has forced me to change my personal practice enormously. For example, I knock on the exam room door and wait until I hear an acknowledgment before walking into the room. I consciously remain seated in the exam room until I am satisfied that the patient's questions have been addressed. I am trying to listen critically to my own talk with the patient to discover the stubborn remnants of professional jargon. If I can attempt changes such as these then my practicing colleagues can as well, particularly if they are made aware of the power embedded in their own talk with patients.

There is some evidence that medical schools are beginning to teach student physicians about the benefits of interpersonal communication skills. However, according to Richards (1988) there is still minimal evidence that those skills are being role modeled by the attending and chief resident physicians. Eventually the interpersonal skills learned in medical school fall by the way to be replaced by those linguistic practices the young physicians see used by the older more experienced physicians. They thereby reproduce the same controlling behaviors over and over again

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

with each new generation of physicians. The lesson for educators of nurse practitioners seems clear. Teaching the content is not sufficient. Educators must be role models as well. In addition, preceptors should be chosen carefully to reflect those traits consistent with collaborative language practices. Students will emulate those language behaviors they see used by experienced nurse practitioners in every day practice.

Finally, some implications for future research on nurse practitioner's language behaviors in relation to power. An initial question relates to replicating the study with a larger sample of participants and in different geographic regions to see if the same process and language patterns would emerge. Such an effort would certainly increase the potential for generalizing the findings. More importantly I would recommend further research on this topic be designed to more fully reflect aspects of critical ethnography in the style of Annette Street's (1992) work on nursing practice.

"A critical ethnography develops from a commitment to an emancipatory critical social science designed to empower the research participants and engage in a process of collectively developed emancipatory theory building" (Street, 1992, p.123). That is, to openly advocate for and with the research participants to effect change through the identification of key issues that impact their "rational pursuit of justice in nursing" (Street, 1992, p.125). In terms of my study, a greater emphasis would have been placed

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

on gaining the collaborative involvement of patient participants with the nurse practitioners to engage in critical reflection of those linguistic practices that impact health care outcomes.

Future consideration of language behaviors of new practitioners would also be enlightening. Study participants were limited to those with a minimum of one year of experience. The years of experience for the sample ranged from one year to 20 years with an average of 11 years experience. We have no baseline data on new practitioners as they graduate from school. A longitudinal study might reveal changes in language behaviors over time and provide insight for continuing education directed toward communicative action and interpersonal skill.

As noted earlier, the issue of gender role orientation as opposed to gender also may be an important issue to address in the language practices of female nurse practitioners. Further reflection on these dimensions may be fruitful in future research considerations. In addition, the inclusion of male nurse practitioners in future studies also may prove instructive.

In conclusion, this inquiry has contributed to nursing practice, and the education of nurse practitioners as well as providing direction for future research. The nine nurse practitioners and twenty six patients who participated in this study have helped bring attention to issues of power embedded in the everyday language of routine office visits.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The nurse practitioners' decisions to risk having their talk recorded and analyzed is a credit to their professionalism and dedication to the improvement of nursing practice, education and research.

A considerable portion of this report has been focused on relations of power and strategic language behaviors that some times silences and confuses patients rather than invites collaboration and informs. However, we must not over look the many instances of caring, teaching, supporting and affirming behaviors that were also identified as characteristic of the nurse practitioner participants in this study.

What has been illuminated is a tension between language behaviors that are affirming, such as apologizing to the patient, and those that reflect the exercise of power. It may be that it is the nexus between these dichotomous linguistic practices that provide insight into that something special referred to by Sullivan (1982) as characterizing nurse practitioners. Furthermore the social context in which power is exercised must not be overlooked, nor under estimated. It is my hope that this work will foreground and transform the way language is perceived and used in the every day practice of all nurses regardless of setting or scope of practice.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

REFERENCE LIST

Agar, M. H. (1986). Speaking of ethnography. Beverly Hills: Sage Publications.

Aries, E. (1976). Interaction patterns and themes of male-female, female, and mixed groups. Small Group Behavior. 7 (1) 7-18.

Austin, J. (1962). How to do things with words. Cambridge, Mass.: Harvard University Press.

Austin, J (1970). Performative Utterances. In J. Urmson & G. Warnock,(Eds.), Philosophical Papers. Oxford: Oxford University Press.

Bauman, R. & Sherzer, T. (1974). Explorations in the ethnography of speaking. Cambridge: Cambridge University Press.

Beanlands, H., & McKay, R. (1981). Nurse do you hear me? The Canadian Nurse, 77 (7), 41-43.

Benner, P. E. (1983). Uncovering the knowledge embedded in clinical practice. Image: The Journal of Nursing Scholarship, 15 (2), 36-41.

Bolinger, D. (1980). Language: The loaded weapon. New York: Longman.

Bourdieu, P. (1977). The economics of linguistic exchanges. (R. Nice, Trans.) Social Science Information, 16 (6), 645-668.

Brykcznski, K. (1989). An interpretive study describing the clinical judgement of nurse practitioners. Scholarly

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Inquiry for Nursing Practice: An International Journal, 3 (2),75-104.

Cameron, D. (1985). Feminism and linguistics theory. New York: St. Martins Press.

Carnap, R. (1937). Logical Syntax of Language. London: Kegan Paul

Cartwright, A. (1964). Human relations in hospital care. London: Routledge and Kegan Paul.

Chomsky, N. (1975). Reflections on language. New York: Parthenon Press.

Clark, J. (1983). Nurse-patient communication: An analysis of conversations from the surgical wards. In J. Wilson-Barnett (Ed.). Nursing research: Ten studies in patient care (pp. 25-56). New York: John Wiley.

Clegg, S. (1989). Frameworks of power Newbury Park: Sage Publications.

Clough, P. (1992). The end(s) of ethnography: From realism to social criticism. Newbury Park: Sage Publications

Cornforth, M. (1965). An open philosophy, an open society. London: Lawrence & Wishart.

Davis, M. (1986). Observation in natural settings. In C. Chenitz & J. Swanson (Eds.) From practice to grounded theory. Menlo Park, Ca: Addison-Wesley.

Dubois,B. & Crouch, I. (1976). The sociology of languages of American women. San Antonio Texas: Trinity University.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Edmunds, M. (1984). Do nurse practitioners still practice nursing? Nurse Practitioner: The American Journal of Primary Care. 9, (3) 39-42.

Fetterman, D. (1989).Ethnography step by step. London: Sage Publications.

Fisher, S. (1979) The Negotiation of treatment decisions in doctor/ patient communication and their impact on the identity of women. (Doctoral dissertation, University of California, San Diego).

Fisher, S. (1983). Doctor talk/patient talk: How treatment decisions are negotiated in doctor-patient communication. In S. Fisher & A. D. Todd (Eds.), The social organization of doctor-patient communication (pp. 135-159). Wash. D.C: Center for Applied Linguistics.

Fisher, S. (1986). In the patient's best interest. New Brunswick New Jersey: Rutgers University Press.

Fisher, S. & Todd, A. (1983) The social organization of doctor-patient communication. Wash. D.C.: Center for Applied Linguistics.

Fisk, J. (1992). Cultural studies and the culture of everyday life. In L.Grossberg, C, Nelson & P. Treichler (Eds.), Cultural Studies. (pp.159-172) New York:Cornell University Press.

Fonow, M. & Cook, J. (1991). Beyond methodology: Feminist scholarship as lived experience. Bloomington: Indiana University Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Forrest, D. (1983). Analysis of nurse's verbal communication with patients. Nursing Papers, 3, 48-56.

Fosbinder, D. (1990). Nursing care through the eyes of the patient. (Doctoral Dissertation, University of San Diego).

Foucault, M. (1972). The archaeology of knowledge and the discourse on language. ( A. M. Smith Trans.). New York: Pantheon.

Foucault, M. (1977) Language to infinity. In D. Bouchard (Ed.), Language, counter-memory, practice. Ithaca New York: Cornell University Press.

Foucault, M. (1983) Afterword: The subject of power. In H. Dreyfus, & P.Rabinow (Eds.), Michel Foucault: Beyond stucturalism and hermeneutics. 2nd edition. (pp. 208-226). Chicago: University of Chicago Press.

Fox-Genovese, E. (1991). Feminism without illusions. Chapel Hill: University of North Carolina Press.

Freund, P. (1982). The civilized body: Social domination, control and health. Philadelphia: Temple University Press.

Freidson, E. (1970). Professional dominance. New York: Atherton

Gadamer, H. G. (1985). Truth and method. New York: Seabury Press.

Germain, C. (1986). Ethnography: The method. In P. Munhall & C. Oiler (Eds.), Nursing Research: A qualitative perspective (pp. 148-162). Norwalk, Conn.: Appleton-Century-Crofts.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Goetz, J., & LeCompte, M. (1984). Ethnography and qualitative design in educational research. New York: Academic Press.

Goodwin, M. (1980). Directive response speech sequences in girls and boys task activities. In S. McConnell-Ginet, R. Borker, & N. Farmer (Eds.) Women and language in literature and society (pp. 157-173). New York: Praeger

Gorman, M. (1958). The educational implications of the theory of general semantics. Lincoln: University of Nebraska Press

Gortner, S. (1984). Knowledge in a practice discipline: Philosophy and pragmatics. In C Williams (Ed.), Nursing research and policy formation: the case for prospective payment (pp.5-16). Kansas City: American Academy of Nursing.

Gumperz, J. (1981). Conversational inference and classroom learning. In J. Green & C. Wallat (Eds.). Ethnography and language in educationalsettings. Norwood, N. J. : Ablex.

Gumperz, J. & Hymes, D. (1986) Directions in sociolinguistics: The ethnography of communication. New York: Holt, Reinhart & Winston.

Habermas, J. (1979). Communication and the evolution of society. (T. McCarthy, Trans. ). Boston: Beacon Press

Habermas, J. (1987). The theory of communicative action. (Vol 2)(T. McCarthy, Trans.). Boston: Beacon Press. (original work published 1981)

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Harding, S. (1987). Feminism and methodology. Bloomington: Indiana University Press.

Hays, J. (1966). Analysis of nurse-patient commumications. Nursing Outlook, 9, 32-35.

Hellinger, M. (1980). Effective social change through group action. In C.Kramarae, M. Schulz, & W. O'Barr (Eds.). Language and power. Beverly Hills: Sage

Henry, B., & LeClair, H. (1987). Language, leadership and power. Journal of Nursing Administration. 17, (1) 19-25.

hooks, b. (1990). Yearning: Race, gender, and cultural politics. Boston: South End Press.

Jayaratne, T. E. & Stewart, A. (1991). Quantitative and qualitative methods in the social sciences: Current feminist issues and practical strategies. In M.Fonow & J. Cook, (Eds.). Beyond methodology. (pp. 85-106). Indianapolis: University of Indiana Press.

Kasch, C. (1986). Toward a theory of nursing action: Skills and competency in nurse-patient interaction. Nursing Research. 35, (4) 226-230.

Kasch, C., & Dine, J. (1988). Person-centered communication and social perspective taking. Western Journal of Nursing Research. 10, (3), 317-326.

Kasch, C., Kasch, J., & Lisnek, P. (1987). Women's talk and nurse-client encounters: Developing criteria for assessing interpersonal skill. Scholarly Inquiry for Nursing Practice. 3, 241-255.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Kasch, C, & Knutson, K. (1985). Patient compliance and interpersonal style: Implications for practice and research. The Nurse Practitioner: The American Journal of Primary Care. 10, 52-64.

Kasch, C., & Lisnek, P. (1984). The role of strategic communication in nursing theory and research. Advances in Nursing Science. 6, (2) 71-88.

King, I. M. (1971). Toward a theory for nursing: General concepts of human behavior. New York: John Wiley & Sons.

King, I. M. (1981). A theory for nursing: Systems, concepts, process. New York: John Wiley & Sons.

Kliewer, P. (1986). Communicative dimensions of effective nursing practice. (Doctoral dissertation, University of Washington 1986).

Kramarae, C., Schutz, M., & O'Barr, W. (1984). Language and Power. Beverly Hills: Sage Publications.

Lather, P. (1991) Getting smart: Feminist research and pedagogy with/in the postmodern. New York: Routledge.

Lincoln, Y. & Guba, E. (1985). Naturalistic Inquiry. Beverly Hills: Sage.

Lofland, J. (1971). Analysing social settings: a guide to qualitative research. California: Wadsworth Publishing.

Lofland, J., & Lofland, L. (1984). Analyzing social settings. Belmont, Ca.: Wadsworth Publishing Co.

Lukes, S. (1986). Power. Oxford U.K.: Basil Blackwell.

Lutz, F (1981). Ethnography: The holistic approach to understanding schooling In J. Green & C. Wallat (Eds.),

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Ethnography and language in educational settings (pp.551-63).Norwood, New Jersey: Ablex Publishers.

Marshall, C. & Rossman, G. (1989). Designing qualitative research. London: Sage.

Martinich, A. P. (1985). The philosoph of language. Oxford: Oxford University Press.

Mathews, B. (1962). Measurement of psychological aspects of the nurse-patient relationship. Nursing Research. 11, 154-162.

McCarthy, T. (1979). The critical theory of Jurgen Habermas. Boston: The MIT Press.

Mills, S. (1992). Discourse competence: On how to theorize strong women speakers. Hypatia. 1 (2) 4-17.

Molde, S., & Baker, D. (1985). Explaining primary care visits. Image: The Journal of Nursing Scholarship. 27, (3), 72-76.

Molde, S., & Diers, D.(1985). Nurse practitioner research: selected literature review and research agenda. Nursing Research. 34,(6), 362-367.

Omery, A. (1988). Ethnography. In B. Sarter (Ed.). Paths to knowledge: Innovative research methods for nursing. (pp 17-32). New York: NLN

Orlando, I. (1961). The dynamic nurse-patient relationship: Function, process, and principles. New York: G.P. Putnam's Sons.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Palmer, R.E. (1989). Hermeneutics: Interpretation theory in Schleiermacher, Dilthey, Heidegger and Gadamer. Evanston Ill.: Northwood Press.

Pearson, J. (1985). Gender and communication. Dubuque, Iowa: Wm. C. Brown Co.

Peplau, H. (1952). Interpersonal relations in nursing. New York: G. P. Putnam.

Peplau H. (1992) Interpersonal relations: A theoretical framework for application to nursing practice. Nursing Science Quarterly 5, (1) 13-18.

Peirce, C. S. (1934). Collected papers. Cambridge Mass: Harvard University Press

Pluckhan, M. (1978). Human communication: The matrix of nursing. New York: McGraw Hill.

Polit, D., & Hungler, B. (1987). Nursing research: Principles and methods. (3rd ed.). Philadelphia: Lippincott.

Prescott, P. & Driscoll, L. (1979). Nurse practitioner effectiveness. A review of physician-nurse comparisons studies. Evaluation and the health professions, 2 (4), 387-418.

Ramazanoglu, C.(1989). Feminism and the contradictions of opression. London: Routledge.

Ramsay, J., McKenzie, J., & Fish, D.(1982). Physicians and nurse practitioners: Do they provide equivalent health care? American Journal of Public Health. 72, 55-57.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Richards, M. (1988). Doctor-patient interaction in the teaching hospital. (Doctoral dissertation, University of California, San Diego).

Sandelowski, M. (1986). Rigor in qualitative research. Advances in Nursing Science. 8, (3), 27-37.

Saussure, F. de (1974). Course in general linguistics London: Routlege

Schatzman, L., & Strauss, A. (1973). Field research. Englewood Cliffs, New Jersey: Prentice-Hall.

Scheffler, I. (1974). Conditions of knowledge. Chicago: Scott Forsman

Searle, J. (1968). Austin on locutionary and illocutionary acts. Philosophical review. 1, 405-424.

Searl, J. (1985). What is a speech act? In A. P. Martinich (Ed.), The philosophy of language (pp. 125-135). Oxford: Oxford University Press.

Shulz, M. (1975) The semantic derogation of women. In B. Thorne & N. Henley (Eds.), Language and sex: Difference and dominance (pp. 176-89). Rowley Mass.:Newbury House.

Shuy, R. (1983). Three types of interference to effective exchange of information in themedical interview. In S. Fisher, & A. D. Todd (Eds.), The social organization of doctor-patient communication. (pp.189-201). Washington D.C.: Center for Applied Linguistics.

Silverman, H. J. (1991). Gadamer and hermeneutics. London: Routledge

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Souza, F. de (1984). The rationality of emotion. Cambridge Mass.: MIT Press

Spelman, E. (1988) Inessential woman: Problems of exclusion in feminist thought. Boston: Beacon Press.

Spender, D. (1980). Man made language. London: Routledge & Kegan Paul.

Spitzberg, B., & Cupach, W. (1984). Interperson comunication competence. Beverly Hills: Sage Publications.

Spradley, J. R. (1980). Participant Observation. New York: Holt, Rheinhart and Winston.

Sullivan, J. (1982). Research on nurse practitioners: Process behind the outcome? American Journal of Public Health. 72, 8-9.

Sullivan, J., & Armignacco, F. (1979). Effectiveness of comprehensive health program for the well elderly. Nursing Research. 28, 70-75.

Stoeckle, J. (1987). Encounters between patients and doctors. Cambridge, Mass: The MIT Press.

Strauss, A. & Corbin, J. (1990). Basics of qualitative research. Newbury Park: Sage Publications.

Street, A. (1992). Inside nursing: A critical ethnography of clinical nursing practice. New York: SUNY Press.

Tarsky, A. (1985), The semantic conception of truth and the foundations of semantics. In A.P. Martinich (Ed.), The Philosophy of Language. (pp.48-71). Oxford: Oxford University Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Taylor, S. & Bogdan, R. (1984). Introduction to qualitative research methods.New York: John Wiley & Sons.

Taylor, S., Pickens, J., & Geden, E.(1989). Interactional styles of nurse practitioners and physicians regarding patient decision making. Nursing Research. 38, (1), 50-55.

Thompson, J. (1984). Studies in the Theory of Ideology Los Angeles: Univ. of California Press.

Thompson, J. (1987). Language and ideology: A framework for analysis.Sociology Review, 35, (3), 516-536.

Thorne, B., Kramarae, C., & Henley N. (1986). Language, gender and society. Rowley, Mass: Newbury House.

Todd, A. D. (1989). Intimate adversaries:Cultural conflict between doctors and and women patients. Wash. D. C.: The Center for Applied Linguistics.

Thomas, J. (1993). Doing critical ethnography. Newbury Park: Sage Publications.

Tong, R. (1989). Feminist thought. San Francisco: Westview Press.

Travelbee, J. (1971). Interpersonal aspects of nursing. Philadelphia: F. A. Davis

Treichler, P., Frankel, R., Kramarae, C., Zoppi, K., & Beckman, H. (1984). Power relationships in medical encounters. In C. Kramarae, M. Shutz, & W. O'Barr (Eds.), Language and power . (pp. 62-88). Beverly Hills: Sage

Watkins, L., & Wagner, E. (1982). Nurse practitioner and physician adherence to standing orders: Criteria for

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

consultation or referral. American Journal of Public Health, 72, 55-57.

Weedon, C. (1987). Feminist practice and poststructuralist theory. London: Basil Blackwell.

West, C. (1984). Routine complicatons: Troubles with talk between doctors and patients. Bloomington: Indiana University Press.

Wilson, H. (1977). Limiting intrusion: Social control of outsiders in a healing community. Nursing Research, 26, (2), 103-111.

Wittgenstein, L. (1968) Philosophical Investigations. London: Blackwell, 3rd ed.

Wrong, D.H. (1980). Power: Its forms, bases, and uses. New York: Harper and Row.

Yoos, L. (1984). Compliance: Philosophical and ethical complications. The Nurse Practioner: American Journal of Primary Care, 6, (4), 27-34.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# APPENDIX A

## INFORMATION LETTER TO NURSE PRACTITIONERS

October 1, 1990

Dear Colleague,

My name is Merrily Allen. I am a nurse practitioner with 18 years of practice experience in family, community, and occupational health. I am currently working full time as a nurse practitioner in an employee health setting.and completing work towards a doctoral degree in nursing at the University of San Diego.

From the beginning of my graduate work in nursing I have had an interest in how language appears to control important aspects of social relationships. As a nurse I have observed and experienced the powerful and diverse affects of language used by healthcare workers. While a significant body of literature exists on language and doctor-patient relationships, the number of studies on nurse-patient interactions is much smaller. Unfortunately very little is known about language behaviors which characterizes interactions between nurse practitioners and their patients This area of research is nearly nonexistent. What we do know however, is that nurse practitioners generally have a good record of patient satisfaction, treatment adherence and outcomes. Its been suggested that nurse practitioners have "something special" in their encounters with patients. That something special may be the way they talk with patients

As part of my doctoral education I am doing a study to identify and describe aspects of nurse practitioner-patient talk.as it occurs in the natural setting of routine office visits. I am particularly interested in talk between female nurse practitioners and female patients. I hope that I can interest you in participating in this research.

The research process will involve observing and listening to you as you talk with patients during routine office visits. If permission is granted by both nurse and patient participants, the interaction will be audiotaped.to facilitate data gathering and recording. I may wish to interview you about the observed interactions with patients on one or more occasions.through out the research period. All interviews would be arranged for in advance, at a time and place convenient for you.and would last about one hour. All information gathered during audiotaping and interviews will be kept strictly confidential. Your participation is voluntary and there is no obligation to continue with the research should you change your mind.at any time. There is no payment for participation.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

If you are willing to participate, please carefully read and sign the attached consent form. I will call you to discuss your participation and answer any questions you may have.

I am excited to begin this research in anticipation of learning more about the importance of language and its power in our encounters with patients. I thank you for your time and consideration of this project and look forward to working with you.

Sincerely,

Merrily J. Allen, RN, MN,CFNP
8880 Villa La Jolla Drive
La Jolla, Ca. 92037
(619) 587-2733
(619) 541-4620

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# APPENDIX B

## CONSENT TO ACT AS A RESEARCH PARTICIPANT

Merrily J. Allen RN, FNP is conducting a study to identify and describe the language which characterizes nurse practitioner- patient encounters during routine office visits. This study is being conducted as part of her doctoral dissertation project. I have been asked to participate because I am a nurse practitioner who routinely sees female patients in this health care setting.

If I agree to participate in this study the following will happen:

1. The nurse researcher will observe visits with female patients.
2. The encounter will be audio taped to insure an accurate account of the visit.
3. I may request that the observation or audio taping stop at any time I feel uncomfortable or feel my patient is uncomfortable with the process.
4. I may be asked to be interviewed about the encounter at a later date. The interview time and place will be arranged at my convenience and will not last longer than one hour.

No added risks or discomforts are anticipated as a result of my participation in this study other than the possibility of the mild discomfort of having the nurse researcher present during my visit with the patient. While information from this study will be useful in the future for nurse practitioners and patients, I will receive no direct benefit or compensation.

I have read the information letter and have had my questions answered. If I have other questions or research related problems, I may reach Ms. Allen at (619) 587-2733.
Participation in research is entirely voluntary. I may refuse to participate or withdraw from the study at any time without jeopardy to my self or my patients.

Research records will be kept confidential to the extent provided by law.
I have received a copy of this consent document to keep and a copy of "The Experimental Subject's Bill of Rights."

I agree to participate.

Participant______________________________ Date______________
Witnesss ______________________________ Date______________
Researcher______________________________ Date______________

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

PATIENT INFORMATION AND INFORMED CONSENT

Dear Patient,

My name is Merrily Allen, I am interested in ways to improve patient care and nurse practitioner education Your Nurse Practitioner is participating in a research study which will help me learn more about what it is that nurse practitioners do to help their patients. In order to conduct this research, it is important for me to observe and record nurse practitioners talking to patients during routine office visits. I am particularly interested in talk between female nurse practitioners and their female patients. I hope that I can interest you in participating in this research project today.

The research involves my being in the examining room during your visit with the nurse practitioner. I will be listening to the nurse as she and you talk about your visit. If permission is granted the visit will be audiotaped so that what is said will be recorded accurately. I may wish to talk to you later about your visit with the nurse practitioner on one or more occasions. If you agree to talk with me it will be arranged at a time and place convenient for you and would not take more than one hour.

Confidentiality will be strictly observed. All materials resulting from your visit today and any following interviews will be coded so that no personal identifying information will remain. Only myself as the researcher will have access to the code, and all transcripts and recordings will be kept in a locked office file. All tapes will be destroyed after the study is complete. If any part of the transcribed material is used in publications in professional journals, all personal identifying information will be changed in order to assure anonymity.

There is minimal risk involved in this study. It is understood that participation in this study is voluntary and that neither refusal to participate nor withdrawal from the study will have any consequences for participants. If at any time during your visit you feel uncomfortable, and wish to withdraw, all recording will stop and the researcher will leave the room. The benefit of this study will be to improve patient care and nursing education and practice. No compensation is provided for participation.

If you are willing to participate please read the following consent section and sign your name. Your agreement will be witnessed and a copy of this consent will be kept in your health record. and will be available to you on request. Please feel free to ask any questions regarding the study now or at any time in the future My name, address and phone number will be given to you Thank you for considerating to participate in this project.

AUTHORIZATION AND CONSENT

I voluntarily agree to participate in this research study. I further acknowledge my full understanding of all conditions, risks, and benefits involved.

Participant______________________________ Date_____________

Witness ______________________________Date_____________

Reseacher______________________________ Date_____________

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# APPENDIX D

## DEMOGRAPHIC PROFILE

Nurse Practitioners

Nurse Practitioners ranged in age from 30 to 52 years. All were caucasian females. Income was in the 41,000 to 51,000 or greater range with a median of 48,000 annual salary.

Level of nursing education: Five of the nine nurse practitioners had a minimum of a masters degree in nursing, while two had bachelor degrees in nursing, and two had diploma education. The four BSN or diploma educated nurses obtained their nurse practitioner preparation in certificate programs in university settings or through employer training.

Patient Participants.

Patient participants ranged in age from 18 to 81 years. All were female. Nineteen of the patients were caucasian, two were black, three were Pacific Islanders, and one was Asian American, and one was Mexican American. Although exact income data was not obtained from the participants, economic status ranged from those eligible for Medicare or medicaid, to working professional women

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# APPENDIX E

## POTENTIAL INTERVIEW PROBES

Nurse Practitioner

1.What approaches do you use in patient interviews to get the information you need?

2. Tell me how you think that language encourages or discourages patient disclosure? How about patient understanding and acceptance of treatment plans?

3.Tell me about any particular strategies you use with your patients when they do not appear to accept the treatment plan or life style changes indicated by their diagnosis.

4.Does your communication with the patient change when you are pressed for time? If yes, How?

5. How would you describe your communication with (name of patient)?. Did you listen actively? What things if any, were distracting?

6. These are examples of language structures noted in transcripts of your visit with(patient name). They may be interpreted as (ie. supporting, controlling or power). What were you feeling here?

Patient

1.Patients some times have trouble understanding what the nurse practitioner is telling them. If this has happened to you how did it make you feel?

2. Do you feel you are listened to in talks with the nurse practitioner?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

3.In your last visit with (nurse practitioner name) did you have an opportunity to have all of your questions answered?

4.How would you describe the nurse practitioners verbal communication?

(ie. used plain English, little or no jargon, gave information, told you what you had to do, should do, could do, shared information, etc.).

5 These are examples of talk between you and the nurse practitioner during your visit. Can you tell me what was happening here? There are aspects of the talk that could be interpreted as demonstrations of (ie. support, control, power). What were you feeling here?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

# APPENDIX F

## EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

The faculty and staff of the University of California, San Diego wish you to know:

Any person who is requested to consent to participate as a subject in a research study involving a medical experiment, or who is requested to consent on behalf of another, has the right to:

1. Be informed of the nature and purpose of the experiment.
2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be used.
3. Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.
4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.
5. Be given a disclosure of any appropriate alternative procedures, drugs, or devices that might be advantageous to the subject, and their relative risks and benefits.
6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.
7. Be given an opportunity to ask any questions concerning the experiment or the procedures involved.
8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time, and the subject may discontinue participation in the medical experiment without prejudice.
9. Be given a copy of a signed and dated written consent form when one is required.
10. Be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.

If you have questions regarding a research study, the researcher or his/her assistant will be glad to answer them. You may seek information from the Human Subjects Committee - established for the protection of volunteers in research projects - by calling (619) 534-4520 from 8 am to 5 pm, Monday through Friday, or by writing to the above address.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.