The Theoretical Justification for the Design of a Communicative Course for Nurses: *Nurses on the Move*

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Chapter 1
Introduction

1. Context and rationale

The importance in the medical profession of effective communication between doctors, nurses, patients and other relevant parties is the main motivation for the development of the *Medics on the Move* (*MoM*) in Europe (Van de Poel & De Rycke, 2011). Van de Poel and De Rycke (201: 70,71) outline how mobility among medical professionals in Europe has been increasing and how this has led to the need for communication training. However, medical professionals rarely have the time to attend contact teaching to learn a new language, and thus an interactive online language learning tool was developed as part of a multinational interdisciplinary project (Van de Poel & De Rycke, 2011: 71,72). Medical professionals can thus access the language learning tool while "on the move" in their daily professional activities (Van de Poel & De Rycke, 2011: 72). The assumption underlying that course is that it is imperative to recognise the importance of communication training for medical practitioners who have to communicate effectively in their workplace, specifically when communication is complicated by taking place in an additional language. Without effective

communication in an additional language, doctor-patient relationships cannot be optimally developed and maintained. Against this background, the *Medics on the Move (MoM)* materials were developed to address the language and cultural challenges that medical practitioners encounter when using a second/foreign language in their workplace.

In 2012, the content of the *MoM* course was adapted for medical practitioners in South Africa, specifically to assist those medical students who study medicine in Cuba before completing their training in South Africa (Van de Poel, Fourie & Seberects, 2013). In addition, its online tool has also been extended, and now includes contact teaching sessions, to create a truly blended learning approach (Van de Poel *et al*., 2013). The *Nurses on the Move (NoM)* project derives from *MoM* Europe and South Africa, but will be aimed at the language and cultural communication needs of nurses specific to the South African context. Where *MoM* focussed on medical practitioners, the South African *NoM* project, which will be the focus of this study, targets nurses.

1.1. Nurse mobility

There is much migration of nurses across the globe, as will be discussed in this section, which potentially contributes to and may exacerbate communication problems. The controversy surrounding the "brain drain" from developing countries due to recruitment by developed countries, specifically in terms of nurses in the case of this thesis, is one aspect of the problems surrounding nurse mobility. A significant number of nurses from developing nations are recruited by countries such as the United States, Canada, Australia and the United Kingdom (Aiken, Buchan, Sochalski, Nichols, and Powell, 2004; Brush and Sochalski, 2007). Apart from the Philippines, which is a major source of migrant nurses, a large number of nurses are being sourced from Sub-Saharan Africa, and specifically South Africa (Kline, 2003; Aiken *et al*., 2004; Nullis-Kapp, 2005).

There are a number of push and pull factors that influence the migration of nurses (Kline 2003; Dovlo, 2007). One of the main reasons why nurses migrate is that developed nations such as the U.S. and Britain offer better working and living conditions (Larsen, Allan, Bryan, and Smith, 2005; Brush, 2008; Landau and Segatti, 2009) – a pull factor.

Such migration causes various problems for the source nations as well as for the migrant nurses themselves. Widespread migration of nurses from developing nations to first world countries has led to some imbalances in nurse to patient ratios in the source countries (Brush and Sochalski, 2007). Steps are being taken by international organisations such as the World Health Organisation (WHO), International Labour Organisation (ILO), International Council for Nurses (ICN), International Organisation for Migration (IOM) and the Organisation for Security and Cooperation in Europe (OSCE) to remedy or prevent further imbalances through various migration policies limiting the recruitment and migration of nurses (Brush and Sochalski, 2007; Brush, 2008). However, as Brush and Sochalski (2007) have pointed out, many such policies attend to the symptoms and not the source of the migration problem.

One problem migrant nurses face, particularly pertinent to this study, is that they often have trouble adapting to their new working environment, specifically in terms of language and culture. Brush (2008) points out that in the past nurses migrating from countries such as South Korea and India to work in the U.S. have expressed difficulty in adapting to the language as well as the culture of the workplace. Subsequent programmes to acculturate migrant nurses have been implemented to deal with such difficulties. Interestingly, Dovlo (2007) points out that the recruitment of nurses from Sub-Saharan African countries has been almost exclusively from Anglophone countries, probably due to the fact that nurses from such countries experience fewer problems adapting to the new language environments into which they have been recruited.

South African migrant nurses face similar problems in terms of communication. Apart from South Africans of various professions migrating from South Africa to other countries, migration also exists within the nation itself (Landou and Segatti, 2009). Considering the fact that South Africa has eleven official languages, we must note that such internal migration could present professionals with potential language and cultural obstacles in communicating with patients with whom they do not share a first language (L1). Despite its constitutional commitment to multilingualism, South Africa has all the characteristics of being a de facto Anglophone nation. South African nurses generally use English in their professional environments and may well have received their training either in English or, to a lesser extent, in Afrikaans. The fact is that a large number of them are likely to have English as an additional language.

In South Africa there is a specific type of migration unique to the health profession, where medical professionals such as doctors, nurses, physiotherapists and occupational therapists are required to work in public health care for a year or two after completion of their studies. According to subsection 2.1 of section 40(3) of the Nursing Act (2005) of South Africa, nurses must perform mandatory community service after graduation for a period of one year. The fact that South Africa has eleven official languages – each language belonging to a different cultural group – means that nurses have to contend with a working environment where they have to resort to communicating with their patients and medical personnel in what often becomes the default language – English. Language and intercultural communication could be a potential problem in this situation. In South Africa, therefore, neither the nurse nor the patient may communicate in their L1. The same might apply to nurse-nurse, nurse-doctor and nurse-(patient's) family interaction. In considering problems associated with nurse communication and possible solutions, we thus need to take into account that more often than not the nurses, patients, doctors and family will communicate in an additional language. Differences between L1 and English can potentially hamper communication and effective medical practice. Solutions to

assist nurses in effectively dealing with communicating in an additional language, as well as addressing intercultural communication, may have to be sought, taking these potential miscommunications into account.

1.2. Nurse communication

As will be explicated in Chapter 3, effective communication between nurses, other healthcare professionals, patients and their family is internationally upheld as essential in providing quality healthcare. The American Association of Colleges of Nursing (AACN) (2008) for example sets effective communication between healthcare professionals and patients as one of the standards in educating nurses in professional and effective nursing practice. Closer to home, the South African Nursing Act (1978) also points to effective communication as one of the keys to fulfilling the objectives in providing effective nurse care. Chapter 3 will examine, among other things, how communication could be key in achieving the objectives of treating others with respect, specifically in terms of language and culture, ensuring that interaction with patients is sympathetic and empathic, and doing so ethically. In order to design a language intervention that adheres to and promotes these standards, we first need to identify the potential pitfalls of communication in terms of being professional, ethical, sensitive, sympathetic and deferent in terms of language and culture.

Research has shown that effective communication is imperative to good nursing practice overall (McGilton, Irwin-Robinson, Boscart, and Spanjevic, 2006), and specifically in terms of nurse-patient interaction (Bowles, Mackintosh and Torn, 2001; Jones, 2003, 2007; Finke, Light and Kitko, 2008), nurse-doctor interaction (Manojlovich, 2005; Reader, Flin, Mearns and Cuthbertson, 2007), nurse-family members interaction (Larson and Tobin, 2000) and inter-professional communication (Leonard, Graham and Bonacum, 2004; Lingard, Espin, Rubin, Whyte and Colmenares, Baker, Doran, Grober, Orser, Bohnen and Reznick, 2005). In addition, Reader *et al*. (2007) point out that communication between nurses and other health care personnel can be life-saving. Researchers (Smith,

1983; Wilkinson, 1991; Bowles *et al*., 2001; Chant, Jenkinson, Randle and Russel, 2002; Jarrett and Payne, 1995, 2000) have long been concerned with the apparently inadequate communication skills of nurses in practice, as well as with communication training courses. This has included the difficulties of ethical communication (Fredriksson and Eriksson, 2003). Issues surrounding communication abilities have often been explored through means of conversation analysis (Jarrett and Payne, 2000; Jones, 2003, 2007). Others have explored how effective a variety of communicative language interventions have been, such as a solution focused brief therapy (SFBT) framework for a nurse communication short course (Bowles *et al*., 2001; McGilton, *et al*., 2006), a Patient-Centred Communication Intervention (PCCI) (McGilton, Sorin-Peters, Sidani, Rochon, Boscart and Fox, 2011), specifically a communication skills course for first year nursing students (Mullan and Kothe, 2010) and other communication courses for palliative care (Wilkinson, Roberts and Aldridge, 1998; Wilkinson, Salisbury, Bosanquet, Franks, Kite, Lorentzon, and Naysmith, 1999). Jones (2007) found that nursing education is often far-removed from the realities of their interaction with patients in the workplace. This investigation seeks to be informed by this research in order to identify interactions within the context of nurses' everyday work experience which could be addressed in a communicative language course.

2. Research problems and objectives

There seem to be at least two problematic factors surrounding nursing communicative ability in South Africa. The first problem is that nurses often have to communicate with other medical personnel and their patients in an additional language, as pointed out in section 1.1, language and intercultural communication could be a potential problem when nursing staff have to communicate in an additional language, which can in turn negatively impact on the extent to which they are able to perform their duties. The second problem, as

noted in the previous section, is that nursing education is often far-removed from the realities of their interaction with patients in the workplace.

This study firstly aims to gather data to design a syllabus for a *NoM* course that would assist nurses in acquiring the relevant communicative abilities that they need in practice in their workplace. Secondly, the communicative abilities to be discussed in the next chapter within specific nursing contexts will be addressed in terms of the problems resulting from communication in an additional language. The objective is to responsibly design (Weideman, 2006a) a syllabus for a language course that will address the interactive, communicative needs of nursing staff members. This research will overall aim to provide a theoretical rationale for the eventual course design.

3. Research design

In designing the *NoM* syllabus, a communicative approach to language teaching, often referred to merely as Communicative Language Teaching (CLT), will be followed as discussed in the next chapter. The syllabus will focus on the interactive, communicative abilities in various medical contexts that are central to effective everyday nursing practice. The syllabus will be designed in line with Bachman and Palmer's (1996:75) argument that "it is not useful to think in terms of 'skills', but to think in terms of specific activities or tasks in which language is used purposefully." The eventual course will thus be designed using a skills-neutral and task-based language teaching (TBLT) approach, both of which fall under the broader umbrella of CLT. Richards and Rodgers (2001: 174) describe some of TBLT's main features as

> 1) meaning is primary (language use rather than form), 2) there is some communication problem to solve, 3) the classroom tasks relate directly to real-world activities and 4) the assessment is done in terms of outcomes.

So, the critically important "activities and tasks in which language is used purposefully" by nurses in their profession will be selected through a needs analysis that will be reflected in the articulation of the syllabus.

The required communicative abilities for nurses in the workplace will be identified in terms of three broad categories: 1) Personal and Emotional Patient Care, 2) Diagnosis and Treatment, and 3) Organisational and Administrative Functions, although these categories may be revised as the research proceeds. The various deficiencies and problems that nurses have in demonstrating communicative abilities in these three categories will be identified and investigated to inform the content of the *NoM* syllabus. The process of their identification will focus on two main sources. Firstly, literature on nurse-nurse, nurse-doctor and nurse-patient interaction will be reviewed to identify the potentially most prominent and crucial interactions between these parties (Chapter 3). Secondly, a needs analysis, informed by the most crucial interactions identified in the literature, will be performed to select and refine the interactional contexts to be used in compiling an inventory of interactions for designing the *NoM* syllabus (Chapter 4). In this regard, permission and ethical clearance will be obtained from the relevant authorities and participants in the health sector to gather empirical data within the hospital setting. The University of the Free State's Department of Nursing and the Free State School of Nursing will be approached to request the involvement of final year student nurses in interviews. Nurses will be shadowed in their work environment and relevant conversations audio recorded. An ethnographic description will be provided for the empirical data gathered from the interviews and observations in hospitals to identify problematic aspects of interaction both in terms of communication and intercultural communication between participants. Written reports may be as critical to nurses' occupation as oral communication, and any inadequacy in this area of language usage may need to be addressed. Within the context of their workplace, nurses necessarily often perform oral interactions based on written information and vice versa. However, an analysis of written reports and documentation lies outside the scope of this study, but the activities to be suggested in the curriculum will approach each interactional scenario in context and will not necessarily differentiate between written and spoken activities.

Based on the ethnographic analysis, an inventory of items will be compiled to guide the design of a syllabus for *NoM* and ultimately to inform the design of the actual *NoM* course. Furthermore, interviews will also be performed with nursing staff in order to gather further data for selecting contextual interactions for the syllabus for *NoM* as well as problems associated with nursing communication which will inform the design of the *NoM* syllabus.

4. Value of the research

Following Weideman's (2007a: 30) concept of a 'responsible' approach to language testing and course design, the motivation for gathering data to inform the development of a *NoM* syllabus is to identify the lingual interactions that enable nurses to fulfil their duties and functions as professionals in whatever hospital or medical environment they may work in. As nurses, a large part of their job is to care (medically and emotionally) for others, and the *NoM* course is intended to enable nurses to do so more effectively through language. The purpose of designing a *NoM* syllabus derives from Weideman's (1999:45; cf 2006a) contention that,

> ... our designs are done because we demonstrate through them the love we have for others: it derives from the relation between the technical artefact that is our design and the ethical dimension of our life. In a country such as ours, satisfying the desperate language needs of both adults and children ... that will enable them to function in the economy and partake more fully of its fruits, stands out as possibly the biggest responsibility of applied linguists.

Thus, the syllabus which will inform the eventual design of *NoM* courses from basic to advanced level is intended to identify ways to improve nurses' communicative skills so that they can provide quality healthcare that is professional, ethical and potentially life-saving.

5. Overview

The chapters in this thesis will be organised as follows: Chapter 2 outlines the theoretical framework and research procedure that will be followed in this study; Chapter 3 consists of a review of the literature on nurse communication which

discusses the importance of communication in the practice of caring for patients as a defining feature of nursing practice, existing nursing communication training programmes and their shortcomings, and identifies the most common problems in nursing communication; Chapter 4 is a review of the international literature to identify the most common and crucial interaction scenarios in the categories of Personal and Emotional Patient Care, Diagnosis and Treatment, and Organisational and Administrative Function; Chapter 5 is a discussion of the observation data which allows the typology to be expanded and modified based on what is typical to nursing communication in the South African context; Chapter 6 is an analysis of the communicative functions common to and prominent in nursing communication in South Africa which a *NoM* course should be based on; Chapter 7 discusses the short-circuits and communication problems in nursing communication as identified from the observation data; Chapter 8 is a discussion of the data gathered during the interview phase of research which addresses issues raised during the analysis of the observation data; Chapter 9 is the theoretical justification of a *NoM* syllabus based on the needs analysis performed in this study; and Chapter 10 is the conclusion and recommendations for further research, as well as the assessment instruments.

The literature review, which follows in Chapter 2, explores various aspects of nurse communication. Nurse communication with patients, family members of patients, doctors, other nurses and various other medical personnel will be explored. The interaction between these parties will be categorised in order to structure the identification of the communicative functions that are crucial to good nursing practice, as well as the problems that have already been observed with regard to these functions. The communicative functions, as well as the way in which they may be embedded in interaction sequences and realised in different textual and grammatical forms, which are identified as potentially problematic in the literature, will then form the basis for the rest of the study.

Chapter 2
Elements of the design procedure

1. Introduction

The problems surrounding nurse communication that have been briefly outlined in Chapter 1, and that will receive more in-depth attention in Chapter 3, seem to be of consistent interest to researchers across the world. In order for these problems to be addressed meaningfully through a communicative language syllabus for nurses, as proposed in this study, adequate research needs to be done so as to inform the responsible design of such a course.

In order to justify the design of such a *Nurses on the Move* (*NoM*) syllabus, a few considerations will be examined in this chapter. I will firstly consider the theoretical framework for applied linguistic practice which will set out the design principles that inform and guide the design process. Secondly, we will consider the approach to language teaching within which the design principles are to be articulated. This will determine which type of research needs to be undertaken to provide us with the necessary data on which to base the design of

the syllabus. Lastly, the research procedure for gathering such data will be explained and described.

2. A theoretical framework for responsible design

The design of an applied linguistic artefact cannot occur in a vacuum; before any such instrument can be designed, a few things need to be considered. McDonough and Shaw (2012:4) posit that the 'common core' of selecting and/or designing language teaching consists broadly of two factors:

> firstly, on the various wide-ranging criteria on which decisions about language teaching programmes are based, and secondly, on the pedagogic principles according to which materials and methods are actually designed.

In other words, research firstly needs to be done about the context (learners and setting) of a proposed language course in order to determine the needs of learners given the context, and therefore the aims of the course (McDonough & Shaw, 2012:4,5). Secondly, a decision needs to be made about the pedagogic approach and method on which the design of the course will be based (McDonough & Shaw 2012:11).

Much of the context for the *NoM* syllabus has already been discussed in the previous chapter, but in order to determine the aims of the proposed syllabus we need to investigate also the purpose of designing linguistic artefacts in general. The design of language courses belongs squarely to the domain of applied linguistics, the field of study within which this research is located. Weideman (2014:1) defines applied linguistics as "a discipline of design: it solves language problems by suggesting a plan, or blueprint, to handle them". Weideman (2007a:29) argues that the design of linguistic artefacts, such as the *NoM* course to be proposed in this study, in essence needs to be done 'responsibly'. He bases his argument on "an ethics of responsibility" (Schuurman, 2005:42): "In general, a good starting point for an ethics of responsibility seems to be that the participants are aware of the positive tenor of their actions in or with technology and give account of the same to the public." In other words, the responsible

design of a linguistic artefact is intended to solve a language problem that leads to "reliev[ing] some of the suffering, pain, poverty and injustice in the world" (Weideman, 2007a:29). The very profession of nursing is intended to do just that: assist in the medical (and associated emotional and psychological) treatment of patients who are suffering from a given medical condition. The intended *NoM* course must be designed responsibly, as far as I am concerned, in order to aid nurses effectively in doing their jobs in alleviating the suffering and pain of patients. It would also potentially right certain injustices by enabling nurses to give better quality of care, a kind of support that the poor are often deprived of. Thus it is necessary to subscribe to a certain agenda for applied linguistics as put forward by Weideman (2007a). One aspect of this agenda, already referred to in the previous chapter, is that applied linguistics should (2007a:45)

> liberate language teachers and language professionals to works of care, service and mercy. This point on our agenda reminds us that our designs are done because we demonstrate through them the love we have for others: it derives from the relation between the technical artefact that is our design and the ethical dimension of our life. In a country such as ours, satisfying the desperate language needs of both adults and children to achieve a functional literacy that will enable them to function in the economy and partake more fully of its fruits, stands out as possibly the biggest responsibility of applied linguists.

Although this study is not concerned with literacy as much as functional communication of nurses, the point remains that the main motivation for the design of a language course for nurses is to empower them to alleviate the suffering of others more effectively. The aim of this study then is to design a solution, in the form of a proposed syllabus for a *NoM* communicative language course. This designed solution is aimed at the language problems associated with nurse communication in order to empower nurses to practice their profession of caring more effectively (emotionally and medically) for their patients.

Furthermore, in determining the pedagogical plan for achieving these aims in the form of the *NoM* syllabus, the perspectives of the field of applied linguistics need to be examined. Historically emphasis has been put on basing the design of

linguistic artefacts in the field of applied linguistics on scientific research, because of the modernist, progressivist view that scientific analysis would provide the ultimate answer or solution to any scientific problem (Weideman, 2015). Therefore, applied linguistics has often been viewed as providing definite solutions to language problems because it is presumed, in the modernist perspective, to be based on authoritative and extensive theoretical and scientific analysis (Weideman, 2015: 52). However, Weideman (2015: 47,48) argues that scientific analysis can be useful, but has its limits, because in applied linguistics we are dealing with individual teachers who employ certain knowledge, skills, experience and innovation and not with inanimate objects that are usually the subject of scientific analysis. Furthermore (Weideman, 2015: 48),

> [i]n the case of applied linguistics, it is especially important to distinguish between insights gained as a result of logical-analytical, theoretical linguistic analysis (which may or may not have implications for language teaching) and technical-analytical analysis that is specifically geared to analyze a given, concrete language problem with a view to gaining understanding of it and, ultimately, to propose and prepare mastery and control of it in a **technically designed** solution to the problem. (Emphasis in original)

The point is then that scientific analysis in applied linguistics is only useful when it is employed to inform the technical design of a language solution. In the subsequent development of the field, however, it was argued that scientific analysis is limited to offering descriptions of problems, which may or may not give us some understanding or insight into the language problem under investigation. However, such analysis cannot necessarily envisage useful solutions to the problem because the implementation of solutions often depends on the experience and innovation of language teachers (Weideman, 2015:54). It is the pedagogic nature of applied linguistic research that places limitations on the ability to do theoretical, scientific research in this field as a prescription for practice (Weideman, 2015: 67). In other words, scientific analysis or research can seek to provide some insight into a language learning problem, for example, but it cannot really fully determine the implementation of the pedagogic solution

to the problem; this requires the imagination and innovation of the designer and implementer of the instructional plan (Weideman, 2015: 67,68,80).

The postmodern era, on the other hand, has highlighted social and political accountability as central to the discipline of and research in applied linguistics (Weideman, 2007b; Weideman, 2015). The postmodern applied linguist is concerned particularly with the context within and purpose for which the applied linguistic artefact is implemented. However, both modernist and postmodernist perspectives have their respective limitations. The problem with these two conceptions is that

> Modernist or technicist conceptions open themselves up to critique by overemphasising the means, while postmodernist, politically sensitive notions, in their emphasis on accountability, focus perhaps too exclusively on the ends of the plans that are made. (Weideman, 2015: 76)

In applied linguistics, though, both the means and the ends in designing language teaching need to be adequately accounted for if one is to design an applied linguistic artefact responsibly. For example, audio-lingualism fell out of favour partly due to its rigid focus on systematically teaching language structure that derived from scientific means at the cost of being interesting and relevant. The postmodernist approach on the other hand gives prominence to the social and political ends while neglecting the scientific means available to design resources and materials to achieve those ends.

Before we discuss further the relationship between means and ends in applied linguistic designs, it is important to note first the commonality in modernist and postmodernist conceptions, that applied linguistics, "finds its characteristic feature in the moment of design" (Weideman, 2015: 75). Applied linguistics is then ultimately a discipline of design that has a defining technical nature (Weideman, 2015: 72). This means that the focus in applied linguistics is on the preparation phase of a technical design where the problem is adequately analysed or

> theoretical analysis comes to be used as a **means** in a technical procedure to reach specific objectives or **ends** (and so, in the foundational terminology

> adopted here, becomes bound or embedded into what is identified as technical problem and solution). (Weideman, 2015: 73,74; Emphasis in original)

Weideman (2006a:72) argues that a responsible design needs to be "informed by some kind of theoretical analysis or justification" but that the technical aspect of reality will always be the leading function of the design.

He puts forward a framework of design principles and conditions for applied linguistics to inform the responsible design of an applied linguistic artefact (Weideman, 2006a; 2006b; 2007a; 2007b; 2014). This framework proposes that the leading or qualifying function of an artefact such as a curriculum (or a course that derives from this) is to be found in the technical design of that artefact, while the founding function of the design is based on the theoretical or analytical mode (Weideman, 2007a:41). The qualifying and founding functions have a reciprocal relationship even though the leading technical design will always have precedence over the theoretical analysis since it is the qualifying function (Weideman, 2007a:41). However, this does not deny the necessity for the theoretical justification or rationale of the linguistic artefact deriving from the technical design (Weideman, 2007a:41), as is claimed by some postmodernist approaches to the field. Ultimately, the design principles deriving from the leading function guide the technical design of the applied linguistic artefact, which can and needs to be analysed or justified theoretically, since it is in the analytical or logical mode of experience that the design is founded.

The design principles being referred to emanate from the analogies or connections of the technical with each aspect of reality, or the idea that "each of the connections that the technical sphere has with other dimensions of our experience yields one or more design principle" (Weideman, 2007a:41). Each of these design principles consititutes a normative condition which should then guide the responsible design of a linguistic artefact. The connection between the technical mode of experience and the numerical, for instance, yields the principle of systematicity which requires that the design of a language course, as proposed here, should "systematically integrate multiple sets of evidence in

arguing for the validity of the ... course design" (Wiedeman, 2014:4). On the other hand, the technical also anticipates connections with other modes of experience such as the lingual and social, which in turn yield regulative ideas such as the *articulation* of the design (the lingual analogy) and its *implementation* in a specific social context, respectively. These regulative and constitutive concepts and ideas and the design conditions or principles they yield, to be discussed below in further detail in relation to this study, guide applied linguistics in responsibly designing linguistic artefacts that, since the technical also anticipates the ethical, eventually also express our love and care for others.

3. Conditions for design of *NoM*

The design principles that Weideman (2006a, 2006b, 2007a, 2014) proposes that derive from the connection between the technical mode of experience and every other mode of experience will be used to inform the design of the *NoM* course. They are discussed below as derived from Weideman (2014: 16). The guiding principles for the *NoM* course are:

- *Systematically integrate multiple sets of evidence in arguing for the validity of the course design.*

  This entails gathering sufficient and reliable data, using various data gathering methods (to be discussed in a later section in this chapter) to inform the content and structure of the *NoM* course, and coherently argue how these data should be utilized.
- *Specify clearly to the users of the design, and where possible to the public, the appropriately limited scope of the intervention, and exercise humility in doing so.*

  The *NoM* course is to be limited to the nursing profession. Although offering content-based instruction is often fraught with logistical difficulties (Weideman, 2014), it is still preferable to more generic language courses.

- *Ensure that the instructional opportunities envisaged are adequately consistent.*

  The question that needs to be answered here is whether the syllabus will be consistently focussed on its goal of developing nurse communication.

- *Ensure effective instruction by using defensibly adequate material or tasks/exercises.*

  Here we are primarily concerned with the validity of the course, and the way that the course material, in the form of tasks and exercises, makes learning possible (McDonough & Shaw, 2012).

- *Have an appropriately and adequately differentiated course.*

  This means that in suggesting learning opportunities and instruction, a larger rather than a smaller variety of task and exercise types must ideally be used. Learners are unique and have different learning styles. The greater the variety of task type, the more likely it is that learning will indeed happen.

- *Ensure the course is intuitively appealing and acceptable.*

  This requires that researchers design an imaginative and innovative syllabus, and one that has "face validity" for its end users.

- *Mount a theoretical defence of what is taught in the most current terms.*

  This will be the main concern of the present study – presenting the theoretical rationale for the development of a *NoM* course through adequate research.

The principles that follow are to be kept in mind during the course of this study. However, some are beyond the scope of the study as only the theoretical justification of the design of the *NoM* syllabus is of concern here. The principles below are thus considered during later phases of design and the implementation of the design:

- *Make sure that the course is intelligible and clear in all respects, in order to ensure its accessibility at a multiplicity of ability levels.*

- *Make not only the course, but information about it, accessible to as many as are affected by them.*

  All required information will be made available on the *NoM* website.
- *Present the course efficiently and make every effort to ensure that it will be useful.*
- *Mutually align the instruction with the test that will either follow or precede it, and both test and instruction as closely as possible with the learning.*
- *Be prepared to give account to the users as well as to the public of how the course will be used, or what the course is likely to accomplish.*
- *Value the integrity of the course; make no compromises of quality that will undermine its status as an instrument that is fair to everyone, and that has been designed with care and love.*
- *Spare no effort to make the course appropriately trustworthy and reputable.*

4. Approaches to language teaching

Although it is necessary to keep all these principles in mind, the focus of the study is the theoretical justification of the design of a *NoM* course. In order to develop this theoretical justification, the above design principles need to be realised through an appropriate approach to language teaching. The selected approach will enable the articulation of a *NoM* syllabus that would be effective in achieving the aims of a *NoM* course. It is also necessary to mention at this point that I subscribe to the distinction that Edward Anthony draws between method and approach (Richards & Rodgers, 1986: 15) and I am concerned primarily with selecting an approach to language teaching that suits the project at hand. In order to select an approach to language teaching that is appropriate to the aims of this study it is useful to consider two questions posed by the *Common European framework of reference for languages: Learning, teaching, assessment* (Council of Europe, 2001:xii):

- What will learners need to do with the language?
- What do they need to learn in order to be able to use the language to achieve those ends?

Broadly speaking, the aim of a *NoM* course would be to assist nurses in learning to use language in a manner that augments and enhances the care and treatment of patients. In order for them to do so, learning should focus on functional language use in scenarios true to their profession. It is thus necessary to select a language teaching method that would most effectively accomplish these aims.

There are various approaches to language teaching such as the traditional approaches – the grammar translation method (making use of translating), the direct method (avoiding translation and emphasising reading, writing and speaking), the audio-lingual method (based on behaviourist structuralism which puts all emphasis on language structure) – which were followed by the communicative approach to language teaching (Weideman, 2002). It is a version of the latter approach, communicative language teaching (CLT), which will be used to realise the syllabus for a *NoM* course.

The use of authentic texts (Cook, 1981) to teach language for the purpose of achieving authentic communication signalled the beginning of the CLT approach. Weideman (2002:28,29) points out that the use of authentic texts was a reaction to audio-lingualism which used decontextualised texts and language to teach language structure. CLT sought to contextualise language teaching by using authentic texts that would be relevant to learners' lives. This differed from earlier approaches to language teaching that also used authentic texts in a number of ways. In this case the emphasis was on deriving information from texts that could be used for a specific, real-life purpose (Weideman, 2002:30), like finding information for the purpose of actually travelling by bus on a schedule.

CLT has taken different directions over the years, but there is one technique related to its use that is characteristic of them all – the information gap technique

(Weideman, 2002: 31). This technique is intended to elicit authentic communication by providing participants with a potentially real-life situation where they need to seek information from each other in order to complete an activity (Weideman, 2002:31-33). There are numerous variations and examples of this technique, but it is central to all directions in CLT, and essentially the aim is to allow students to learn and practice authentic communication that is relevant to their lives and experience.

The mainstream, British branch of CLT further focused on how meaning is functionally communicated through numerous grammatical realisations (Weideman, 2002:34). Activities are thus designed to teach learners how to choose the appropriate functions, realisable in a variety of grammatical forms, in order to communicate the intended meaning given a specific situation and context. The process in CLT through which such information is sought and used often takes the form of role play between at least two individuals (Weideman, 2002:38). In role play, participants need to seek and exchange information, using various communicative functions and often using authentic texts, in order to complete an information gap activity (Weideman, 2002:38,40,41). Here the different characteristics of CLT are exemplified.

A third variant to CLT is the ‘P’ (for psychological) emphases, as opposed to the ‘L’ (for those with a linguistic emphasis) of mainstream CLT. It emphasises the psychological and emotional aspects of language learning and teaching environments (Weideman, 2002: 45,46). This direction of CLT recognises the individual nature and personality of learners and how the affective domain influences individual learning experiences (Weideman, 2002:46). It addresses the affective domain of learning by seeking to create a learning environment where the learner does not feel threatened or uncomfortable, thus optimising learning (Weideman, 2015:104). Various techniques and methods, which collectively fall under the Natural Approach, are used in this direction, such as play and drama techniques, discussion exercises, total physical response (TPR),

stories, rhymes, songs and chants (Weideman, 2002:46-60). These methods and techniques are intended to create a non-threatening, fun environment with an emotional climate conducive to optimal language learning.

5. Di Pietro's strategic interaction method

Di Pietro's work provides us with a final variant of CLT that combines the 'P' and 'L' emphases discussed above, and is called the strategic interaction method. This approach to language teaching will be the approach used in this study to design a *NoM* syllabus, because, as Weideman (2002:78) points out, it allows us to combine meaningfully the most important parts of both mainstream CLT and the 'P' approaches. It emphasises the need for learning to make strategic lingual choices in communicative interactions, thus attaining transactional competence. This entails purposely allowing short-circuits to occur in an information gap activity, for example, so that learners are required to (re-)negotiate meaning strategically in order to complete a successful communicative transaction (Weideman, 2002:76).

One aspect of the approach to language teaching that has changed over time, and that is characteristic of CLT (Weideman, 2002:40), is that we no longer differentiate between reading, writing, listening and speaking skills, but rather view them as integrated (Weideman, 2014). Bachman and Palmer (1996:75) argue "that it is not useful to think in terms of 'skills', but to think in terms of specific activities or tasks in which language is used purposefully." It is thus preferable, in this view, to approach language teaching functionally. Di Pietro (1975; 1978a) observes that language does not simply consist of a grammar that must be taught and learnt in order to be able to communicate. An approach to language teaching, "[should] not focus on the forms of grammar but rather on how the language can be manipulated to gain certain ends. In short, the approach would be strategic" (Di Pietro, 1975:464). The purpose of language is not simply to convey information, but rather it includes knowing how to use language in a given context to achieve a desired result and how to use language to express

individual personality as you play your role in a conversation (Di Pietro, 1976: 50) or in other forms of talk. As Weideman (2014:5) argues: “The functions of comparing and contrasting, classifying and inferring, or making claims and extrapolating, ..., are one (functional) way in which we have gone beyond viewing language as grammar” in academic discourse. In other words, there are a number of strategies an individual can employ in an interaction, depending on both the context and the individual’s personality. In addition, the individual will also have to learn to interpret the other party’s role and personality, given the context (Di Pietro, 1978a: 151).

Learning an additional language is in such a case not simply about gaining grammatical competence of a new language, but also learning to select the appropriate strategies in using language in various contexts (Di Pietro, 1976). Di Pietro states that ritualised speech acts such as salutations can be relatively easy to learn to use, while it is the non-ritualised speech acts that are often problematic for second language learners (1976: 51). In an earlier article, Di Petro (1976:3,4) elaborates on the different roles that individuals can play in talk but also points out that the role you play can be ambiguous for the other party and can often be misinterpreted. If the roles in an interaction are at times ambiguous for first language speakers, then it can be doubly confusing for second language learners to interpret such roles.

Di Pietro (1976) further looks at various second language textbooks, discussing how they more often than not focus on teaching correct grammar at the cost of offering exercises that are aligned with the real-life interactions that the learners will need to engage in. Although the learners will be able to offer a grammatically well-formed utterance, this utterance may be so out of context in the real world as to be entirely inappropriate. Providing instruction based on real world scenarios is one of the defining aspects of the CLT approach as pointed out above. In designing materials for second language teaching, Di Pietro suggests activities that will teach learners to interact appropriately in real-life

situations, taking on different and appropriate roles, and also being able to express their own personality in the process (Di Pietro, 1976: 53-57). For such activities "[t]here are no set answers... Their sole purpose in the language classroom is to motivate the students to speak as naturally as they would if they were really in such a situation" (Di Pietro, 1976: 57).

Roberts (1986:54) explains that transactional competence is derived from communicative competence. He explains the four sub-competencies of communicative competence for advanced language learners as set forth by Robert Di Pietro as firstly, formal competence, which basically has to do with being able to make well-structured, grammatically correct sentences as well as understanding some of the finer, idiomatic nuances of the language (Roberts, 1986: 56). Secondly, sociocultural competence is concerned with knowledge about the expected manner in which to use the learned language in everyday situations (Roberts, 1986: 57). Thirdly, psychological competence has to do with "the ability to project one's personality and the ability to use language to achieve personal goals". This has to do with what Roberts (1986: 57) calls "strategic competence". This entails an individual's ability to use the correct linguistic strategy to communicate the appropriate personae in a given situation in order to attain a desirable outcome for that individual (Roberts, 1986: 58). The final sub-competence, performing competence, deals with linguistic devices or strategies that allow individuals to initiate, maintain and close a dialogue appropriately. Furthermore, communicative competence involves the knowledge of how to play the correct role in a given situation and culture (Roberts, 1986: 65). A language course for nurses could productively include teaching strategic transactional competence in order to avoid or negotiate short-circuits in communication.

Roberts (1986) summarises a number of features of dialogue as identified by Di Pietro in order for us to understand how to use dialogue in teaching strategic transactional competence. Firstly, dialogue involves seeking, processing or

producing information that effectively results in an exchange of information. Secondly, the purpose of a dialogue is to obtain some result. Thirdly, the personality, background and experience of the individuals involved in the dialogue will influence the content and style of communication. Fourthly, dialogue requires the individual to verbalise thoughts in an acceptable manner. Fifthly, an exchange of information in dialogue requires a shared knowledge. Sixthly, dialogues are usually framed, which means that requested information is often delayed while other information is being communicated. Lastly, in dialogue, there are a number of options in how an individual can respond to the other person and strategies need to be employed in order to attain the desired outcome. Each of these aspects of dialogue could potentially explain how short-circuits in communication occur. Identifying short-circuits in communication will therefore be investigated in this study (Chapter 7).

Di Pietro (1976: 57-61) discusses various strategies and methods for employing role play in helping students acquire transactional competence in a second language in order to bridge short-circuits. He ultimately suggests that using role play in language teaching requires "a typology of interactional situations" as well as "a list of verbal strategies suitable for use in these situations" (Di Pietro, 1976: 61). The research undertaken in this thesis is aimed at investigating such interactional situations and the manner in which the parties involved use various strategies to get a desired outcome in these situations.

Similar to Di Pietro's view on language teaching and learning discussed above, in a seminal document for the adoption of early CLT, Wilkins (1976) criticises grammatical syllabuses as being synthetic and argues for the use of a notional syllabus. In contrast to a grammatical syllabus, which is aimed at progressively teaching grammatical competence, Wilkins (1976: 15, 16) discusses the value of a situational syllabus. Such a syllabus uses the everyday situations in which a learner will need to communicate to inform the design of the syllabus, which includes the grammatical forms used in various situations (Wilkins, 1976: 16,

17). However, he also views the situational approach to syllabus design as inadequate because there are any number of factors that may influence, and thus compromise our ability to predict the content of situational interactions (Wilkins, 1976: 17). He thus proposes a third type of syllabus, namely a notional syllabus, on the grounds that although form and content are useful in designing a syllabus, communicative competence should be the starting point (Wilkins, 1976: 18). This echoes to some extent Di Pietro's argument for strategic interaction based on communicative competence. This study will similarly use communicative competence as the foundation for the course and will seek to define the communicative functions as described by Wilkins (1976: 41-54) within a typology of situational interactions.

Di Pietro (1978b) raises another important point in his discussion of culture and ethnicity in bilingual education. His argument is that bilingual and bicultural teaching tends to neglect addressing ethnicity or take into account that the method or approach taken in teaching can impact, often negatively, on an individual's ethnicity (Di Pietro, 1978b). As he puts it (Di Pietro, 1978b: 515):

> A major portion of the answer to the question of why attention should be paid to ethnicity in a bilingual program lies in understanding that ethnicity conveys a sense of belonging to someone or to some group in a world of strangers. Without this psychological anchor, the many cognitive advantages gained through the use of a bilingual-bicultural curriculum may be eclipsed by a feeling of rootlessness in the affectual domain.

Within the context of nursing communication in South Africa, ethnicity and culture is a necessary aspect to take into account. When aiding nurses in communicating more effectively in English, for example, we would have to be sensitive to these cultural and ethnic roots that the learners derive from. This would include making learners attentive to cultural differences and perhaps teaching them to navigate these in the interest of effective communication. This would have to be done in a sensitive enough manner that individuals are able to maintain a rootedness in their ethnicity. Coetzee van-Rooy (2006) for example investigates whether or not the notion of integrativeness is untenable for second language learning. This approach to language teaching is based on the

assumption that the level of target language proficiency attained is dependent on the learner's motivation to be integrated into the target culture (Coetzee van-Rooy, 2006:438). Coetzee van-Rooy (2006) offers extensive theoretical and empirical evidence to the contrary. The notion of integrativeness is particularly problematic in the South African context because for one, English tends to function as a lingua franca in South Africa and for another, because the target language group is quite small and so contact with English first language speakers is limited (Coetzee van-Rooy, 2006:446). She also discusses her research finding that there is a positive correlation between second language learners' positive in-group identification and a high level of proficiency in the target language (Coetzee van-Rooy, 2006:446; cf. Coetzee van-Rooy, 2002). Thus, the approach to language teaching adopted for *NoM* needs to help learners retain their positive in-group identification as they learn the medical English skills required to communicate with others who also speak English as an additional language.

Using the strategic interaction approach, the *NoM* syllabus should essentially make use of authentic texts, information gap techniques and functionally defined interactions. These will be used in designing a syllabus that teaches transactional competence through the short-circuiting of communication that requires strategic interaction. The research undertaken in this study will then aim, in part at least, to define interactions functionally in context. This entails observing nurses interacting with patients, with other nurses and with doctors as they work, and identifying the most common and crucial types of interactions. The data will then be analysed to determine the functions of each of these types of interactions, as well as the potential short-circuits that may occur. This will form the basis for the design of the syllabus for the *NoM* course.

Weideman (2002:35,36) explains that it is essential to perform a needs analysis of the learners' communication needs which is used to design a syllabus that forms the basis for language courses. The following five aspects must be focused on in such a needs analysis (Weideman, 2002: 36):

(a) the different *situations* in which students may be required to use the target language;
(b) the various *topics* that are relevant in such situations;
(c) the different *media* (telephone, letter) and/or skills (listening, speaking, reading and writing) through which communication is made possible in the relevant situations;
(d) the possible language *functions* (for example for greeting, requesting, apologising, thanking, etc.) that have the greatest prominence in the situations identified under (a);
(e) the *grammatical forms* that are the possible realisations of such communicative functions in the different situations.

To these we should add the typology of interaction that Di Pietro (1976:61) refers to (cf. too Weideman, 1985). In order for the syllabus for a *NoM* course to be designed based on the CLT approach, a needs analysis first needs to be done on the above aspects. This needs analysis will aim to develop a typology of communicative situations and their content, as well as the communicative functions typical to these situations. In addition, the short-circuits that may occur in communication, and the factors that may problematise communicative interaction will also need to be identified. The process through which the needs analysis for the *NoM* course will be performed is discussed below.

6. Research Procedure

A needs analysis will be performed in this study in accordance with the requirements for responsible design (referred to in 3. Conditions for Design of *NoM,* above) and the six dimensions of a needs analysis in the CLT approach discussed in the previous section. This needs analysis will consist of both a search of the relevant literature (with the results reported in Chapter 3 and 4), as well as field work (results to be discussed in Chapter 5, 6, 7 and 8). The ethnographic-type field work for this research project includes interviews with nurses and doctors and shadowing of nurses with the focus on observing their communication in practice. Doing both observations of nurse interactions and interviews with nurses, and then contrasting the data with prominent findings of the literature review will enable triangulation.

6.1.Literature review

The literature review will consist of searching the international body of research for prominent themes in nurse communication research. This will give us an indication of the common types of problems associated with nurse communication and the interventions designed to address these problems (Chapter 3). In turn this will provide the basis for the field work to be done in this study. A review of the literature will also yield an inventory of the most common types of interactions researched (Chapter 4) that will be further investigated and expanded through the field work of the current study. The purpose is to develop a grounded typology of nurse interactions that will be used to inform the content of the syllabus.

6.2.Observations

The first phase of the field work will consist of shadowing nurses as they go about their duties. This will entail shadowing nurses and recording their communication in practice, including making audio recordings of nurse interactions and taking down field notes. The shadowing will take place at two hospitals in Bloemfontein – one private and one semi-private. Shadowing sessions will last between three and five hours, usually from the morning shift handover until around lunch time. Some sessions will be done in the afternoons between lunchtime and the evening shift handover. Depending on whether different types of data are collected during the morning and afternoon shifts, the number of shadowing sessions performed in the morning and afternoon will be adjusted. In order to optimise research data and results, a decision will need to be made about how many morning and afternoon sessions will be done. I will shadow nurses on different nursing levels, including auxiliary nurse, staff nurse, professional nurse and sister. This should allow for a wide variety of interactions as performed by nursing staff with different ranks.

I am primarily concerned with identifying different types of interactions based on the inventory from Chapter 4 and potentially modifying this inventory with reference to the data gathered during shadowing. Such a modified inventory will provide us with the typical communicative situations that nurses encounter within which communicative competence is required (Chapter 5). The content of these situations will then be analysed to determine the communicative functions of these interactions, which will form the basis of the *NoM* syllabus (Chapter 6).

I will also be searching for instances of miscommunication or communication problems and the possible causes for these problems, since the development of transactional competence depends in good part on the ability to handle short-circuited communication (Chapter 7). Further information about these instances of miscommunication or communication problems will be sought from nurses through individual interviews.

6.3.Interviews

Based on the data gathered in the literature review and shadowing phase, individual interviews will be performed with a sample of nurses from different nursing ranks to elicit further information on the types of interactions identified, as well as potential problems with nurse communication (see Chapter 8). The interviewees will consist of a combination of nurses who either have English as an additional language or who are English first language speakers. This should potentially allow us to gain insight into the complexities surrounding communication by nurses using English as an additional language. The sample of participating nurses will be recruited from the two hospitals where observations take place.

The interviews are to be performed at the two hospitals, as this is likely to be the most convenient for both participants. An appropriate venue for the interviews will be identified with the assistance of the matron[1] or operational unit manager of the ward. The interviews should take between ten and twenty minutes to complete and will be audio-recorded. Field notes taken during the interviews will also provide further data to refine and compare with the data derived from the shadowing process and literature review.

An information sheet regarding the interview will be provided for interviewees at the beginning of the interview while I also explains the purpose of the research and interview to the interviewee, upon which the interviewees will be required to sign an informed consent form. The interview questions will be semi-structured and based on the information on nurse communication gathered in the literature review and shadowing. The aim is to elicit from the interviewees their personal experiences with and perspectives on what types of interactions are crucial to perform their jobs and what problems they experience with communication.

7. Conclusion

This chapter has considered the procedures to be followed for a responsible design of syllabus for nurse communication. It has focussed on the approaches to such design, and the selection of design principles. In line with the latter, it has articulated a potentially productive way of approaching the instruction, a variant of CLT, known as the strategic interaction method, and it has been outlined how, in subsequent chapters, the needs analysis to identify critically important components of the communication will be undertaken. I turn, therefore, first to

[1] Depending on the hospital and type of ward, the senior nursing staff member in charge of the ward will be either the Matron or the Operational Unit Manager. In this study this staff member will just be referred to as the Matron.

the consideration in the next chapter of the issues and problems surrounding nurse communication and programmes to improve nurse communication as discussed in some earlier studies, before discussing the inventory of common and crucial nurse interactions as derived from the literature on nurse communication (Chapter 4).

Chapter 3
Caring, interaction and communication: Some earlier studies

1. Introduction

The first step in justifying the design of a *Nurses on the Move* (*NoM)* syllabus, and doing so responsibly, as outlined in the previous chapter, is to review existing literature in order to identify the issues prevalent in nursing communication research. This chapter firstly considers the research on why effective communication in the nursing profession is important, as also reflected in various official nursing practice policies. Secondly, we will examine a number of nursing communication education and training programmes, as well as critiquing the effectiveness of these by identifying some of their limitations and shortcomings. Finally, this chapter will aim to identify what are some of the main problems associated with nursing communication that would guide the design of a potential *NoM* course. Examining these issues is intended to provide direction for the approach taken during the field work phase of this research project which is to be used to justify and inform the design of a *NoM* course.

2. Caring in interaction

Caring seems to be one of the centrally defining features of nursing practice (Sargent, 2012). The over-arching theme in much of the literature on nursing practice and caring is that caring for a patient constitutes both physical and psychological or emotional care. Based on Dr. Jean Watson's theory of caring (2001), Vicki Lachman (2012:112) defines caring thus:

> Watson's caring model requires the nurse to look at the uniqueness of the individual and go to all extents possible to preserve the patient's dignity. The second element, the transpersonal caring relationship, describes the nurse's caring consciousness and moral commitment to make an intentional connection with the patient. The third element, caring occasion/caring moment, is the space and time where the patient and nurse come together in a manner for caring to occur.

Caring thus refers to the attitude that nurses have towards their patients which is expressed through their actions in relation to the patient and the manner in which they relate to the patients. Caring would thus seem to be manifest in terms of the patients' physical and psychological or emotional well-being. Central to expressing care through actions and relating are the communicative interactions among nurses as care-givers and those receiving care.

Since the early research of Menzies (1961) and Norton, McClaren and Exton-Smith (1962) into some problematic issues surrounding communication in nursing, many researchers (Anderson, Helms & Kelly, 2004; Shattell 2004; Roth, Stevens, Burgio & Burgio, 2002; McGilton, Irwin-Robinson, Boscart & Spanjevic, 2006; Boscart, 2009) have continued to point out the varied problems associated with communication in the process of caring for patients. Miscommunication may, for example, lead to serious adverse events (Leonard, Graham & Bonacum, 2004; Sutcliffe, Lewton & Rosenthal, 2004; Lingard, Epsin, Rubin, Whyte, Colmenares, Baker, Doran, Grober, Orser, Bohnen & Reznick, 2005; Manias, 2010) or may even be a matter of life or death (Kuehster & Hall, 2010). If nurses are to provide adequate care for their patients, they need

to avoid communication problems at all costs, especially those leading to adverse events.

It is thus not surprising that various policies reflect and acknowledge the need for effective communication. For one, the American Association of Colleges of Nursing (AACN) (2008) has set effective communication as one of the requirements of nursing practice and education. Closer to home, the regulations governing the programme objective of any curriculum for training nurses in South Africa are set out in terms of section 45(1) of the Nursing Act, 1978 (Act 50 of 1978). The regulations specifically relevant for this study, which stipulate the cultivation of an attitude of caring for patients, are as follows:

> (2) Such curriculum shall provide for personal and professional development of the student so that, on completion of the course of study, he (*sic!*)
>
> > (a) shows respect for the dignity and uniqueness of man (*sic!*) in his social-cultural and religious context and approaches and understands him as a psychological, physical and social being within this context;
> >
> > (c) is able to direct and control the interaction with health service consumers in such a way that sympathetic and empathic interaction takes place;
> >
> > (d) is able to maintain the ethical and moral codes of the profession and practise within the prescriptions of the relevant laws;

Central to demonstrating these requirements would be communicative ability. Such regulations call for research into aspects of nurse communication such as communicative abilities of nurses, principles of effective and professional communication and strategies for nurse communication. The effectiveness of numerous nurse communication education and training programmes to develop or improve nurse communication also then needs serious investigating and will be considered in a later section of this chapter.

In addition, the *Policy of Language Services* (National Department of Health, 2011) for South Africa seems to be aimed at addressing the issues mentioned above. Within the healthcare setting, the purpose of the policy is to:

(a) Increase access to care;
(b) Improve quality of care, health outcomes and health status;

(c) Increase patient safety; and
(d) Enhance or ensure appropriate resource utilization

In relation to the current study, these aims would relate to the manner in which nurses communicate with patients in offering quality healthcare both in terms of physical and emotional or psychological care. Also, in terms of the work environment, the purpose of the policy is also to:

(a) Enable[...] informed and participatory decision-making;
(b) Improve[...] working relations;

These aims would then relate to the manner in which personnel collaborate with other medical personnel and hospital staff members. These aims seem to be in alignment with the main debate in the current international literature on nurse communication to be surveyed below. The focus in these debates seems to be on the extent to which nurses exhibit task-orientated communication with little or no, or not enough, attention to empathic or interpersonal communication, as well as how communication affects the extent to which nurses are able to collaborate with other medical personnel.

3. Importance of communication in nursing practice

Examining the issues which nursing education programmes focus on, specifically in relation to communication, offers us some valuable insight into the importance of effective communication in nursing practice. Education in nurse communication seems to centre on improving nurses' ability to perform their jobs, to collaborate with other medical staff, to achieve job satisfaction and to offer sufficient patient-centred care. These are all factors which might imply the importance of communication in the nursing profession, besides the danger noted above that miscommunication poses to patients' health.

Both collaboration and patient-centred care are identified as part of the definition of competency by the Quality and Safety Education for Nurses (QSEN) project funded by the Robert Wood Johnson Foundation (RWJF) in the United States (Cronenwett, Sherwood, Barnsteiner, Disch, Johnson, Mitchell, Sullivan &

Warren, 2007). In the deliberation among nursing scholars and practitioners who participated in this study, the focus of the discussion is their observation that "as we engaged in conversations with faculty at multiple schools and meetings, the consistent plea was to "tell us how to teach" the KSAs [Knowledge, Skills, Attitudes] that are not embedded in current curricula" (Cronenwett *et al*., 2007: 2). This seems to indicate the recognition that knowledge, skills and attitudes with regards to offering patient-centred care need to be taught to practicing nurses in order for nurses to acquire the defined competencies.

The relationship between nurse communication and the ability to collaborate with other medical personnel and offer patient-centred care also seems to be a recurring theme in much of the research into nurse communication. Critical thinking and clinical judgement have similarly been identified as necessary skills for effective and professional nursing practice. Marshall, Jones and Snyder (2001:78) observe that after recognising "the key components of competence in nursing as critical thinking, interpersonal skills, and technical skills", one is justified in proceeding to design education programmes for nurses to develop their critical thinking, clinical judgement and communication skills. Although all three skills are necessary in good nursing practice, communication skills would be essential to nurses' ability to practice both critical thinking and clinical judgment. As Marshall *et al*. (2001: 79) note: "The perception of critical thinking abilities is associated with the ability of staff to externalize these skills via verbal and written communication and professional interventions." Communication might therefore be included in the category of interpersonal skills, but from our point of view it is noteworthy that critical thinking and technical skills will be expressed and communicated through language. This means that communication is key in all three. Only one step in the programme referred to here focused on communication, though. It required the participants to specify which information would be communicated to physicians and which information would be recorded on a chart, helping nurses to enhance collaboration between nurses and physicians (Marshall *et al*., 2001).

Cheeks and Dunn (2010) similarly argue that job satisfaction and patient care are strongly influenced by factors such as analytical thinking, conflict resolution and interpersonal communication skills, especially among members of a medical team. They designed and implemented a retreat programme for new nurses entering the workplace to improve such skills, and achieved positive results. Although communication was not the focus of this retreat programme as such, it is nevertheless central to addressing problems such as analytical thinking and conflict resolution, and how these subsequently affect job satisfaction.

Communication therefore remains a topical part of nursing education interventions. So, for example, McCaffrey, Hayes, Stuart, Cassel, Farrell, Miller-Reyes and Donaldson, (2011) have more recently also contended that collaboration between healthcare providers is necessary to offer quality healthcare for patients and that communication is key to such collaboration. They designed an educational programme to improve positive communication and collaboration between nurses and physicians. This included impressing on nurses and physicians the importance of collaboration and communication between medical staff in providing optimal care for the patients. The outcome of the study showed the programme indeed improved communication and collaboration among medical personnel and that this led to improved care of patients. Thus, communication influences collaboration, which in turn has a definite impact on the quality of patient care.

Job satisfaction for nurses, the other component referred to at the beginning of this section, seems to be influenced to some extent by interpersonal relationships with other staff (Miller, Joseph & Apker, 2000; Amos, Hu & Herrick, 2005). Apker, Propp, Zabava Ford and Hofmeister (2006) contend in this regard that good interpersonal communication between nurses and other staff members is crucial to professional nursing practice. Interpersonal skills and communication are inextricably linked and can have a negative or positive impact on job satisfaction (Amos *et al*. 2005). Amos *et al*. (2005) thus designed an intervention

for nurses that consisted of teambuilding activities that would, among other things, improve communication among nursing staff members of a surgical unit. The results of their study showed that the intervention was effective to some extent, as the staff felt that communication and interpersonal relationships had definitely improved between staff members, which in turn led to higher job satisfaction.

Importantly, research on nurses in ICU highlights the interpretive role that nurses play between physicians and the patients and their families. As Kirchhoff, Walker, Hutton, Spuhler, Cole and Clemmer (2002: 207) say:

> As mediators and interpreters of information, nurses need to develop skills in helping patients' family members understand what physicians are saying and the relevance of that information for a patient's prognosis and decisions about treatment.

This seems to be one of the key functions of nurse communication – to mediate and interpret information provided by the doctor or other specialised medical practitioners for patients and patients' families. Similarly, Barrere (2007:114) states that "communication is important when nurses inform, explain, and instruct patients on a range of health matters." Although further training may be necessary for nurses in specific medical contexts, this study is concerned primarily, however, with identifying communication that is general to nursing practice and not medical-field specific.

The research discussed above points to the impact that communication has on collaboration and interpersonal relationships between nurses and other medical staff. This in turn affects, firstly, nurses' job satisfaction. Secondly, it impacts on medical teams' ability to provide adequate and quality physical and psychological care for their patients. The nurses' role as mediator between patient and doctor or other healthcare professionals is a further determinant of the extent to which the patient receives quality healthcare. Communication thus impacts on many aspects of the healthcare system and how effectively it functions.

In South Africa, however, even if the critical thinking and clinical judgement skills of nurses and physicians are developed and improved, the problem still remains that critical information is often communicated between nurses and physicians in an additional language. Miscommunication or misunderstandings due to communication in an additional language thus remain a potential problem. This will then affect the extent to which nurses are able to collaborate with others successfully, offer effective physical and emotional care of patients, as well as experience job satisfaction. Throughout this study, the problem surrounding communication in an additional language progressively emerges as a central issue in nursing communication in South Africa. We will return to this in the last section of this chapter, and it will be of specific interest during the field research phase to be reported on in chapters 6, 7 and 8, as it is of pertinence to the design of a *NoM* course.

4. Nurse communication education or training

In light of the importance of communication in the nursing profession as identified above in the different educational and training programmes, we turn now to the shortcomings of such programmes. The numerous educational programmes which have been designed with the intention to improve or develop nurses' communication skills have been aimed at teaching skills and strategies required in specific medical fields. These include: nurse communication with elderly patients (Caris-Verhallen, De Gruitjer, Kerkstra & Bensing, 1999), communication at sexually transmitted disease clinics (Bull, Rietmeijer, Fortenberry, Stoner, Malotte, Vandevantar, Middlestadt & Hook, 1999), with cancer patients (Fallowfield & Jenkins, 1999; Kruijver, Kerkstra, Bensing & Van De Wiel, 2001; Walczak & Absolon, 2001; Langewitz, Heydrich, Nubling, Szirt, Weber & Grossman, 2010), neonatal mothers (Fenwick, Barclay & Schmied, 2001), psychiatric patients (Fredriksson & Lindstrom, 2002), child patients (Lambert, Glacken & McCarron, 2010), child patients' parents (Baggans, 2001), patients with dementia (Weitzel, Robinson, Mercer, Berry,

Barnes, Plunkett, Vollmer, Foster, Friedrick, Allen, Holmes & Kirkbride, 2011) and hearing impaired patients (Hines, 2000).

Others have focused on the communicative needs of patients who have specific communicative needs that result from treatment or their medical condition. Several researchers have also investigated communication with patients in Intensive Care Units (ICU) who may have limitations in the extent to which they can communicate (Alasad & Ahmad, 2005; Magnus & Turkington, 2006; Merilainen, Kyngas & Ala-Kokko, 2013) as well as those who are completely unable to communicate (Baker & Melby, 1996; Radtke, Tate & Happ, 2012). Others have investigated nurse communication with patients who have other communication impairments due to suffering a stroke (Gordon, Ellis-Hill & Ashburn, 2009) and patients with a developmental disability or with complex communication needs (CCN) (Hemsley, Sigafoos, Balandin, Forbes, Taylor, Green & Parmenter, 2001; Finke, Light & Kitko, 2008; Hemsley, Baladin & Worrall, 2011; McGilton *et al*., 2011).

Other research into difficulties in nurse communication shows that nurses may suffer from high levels of death anxiety when communicating with patients and their families about death (Deffner & Bell, 2005). However, communication education on how to communicate about death with patients and patients' families is one factor that can have a positive effect on nurses' comfort levels in communicating about death (Deffner & Bell, 2005). Similarly, ICU nurses may need extra support in learning how to communicate with the family members of patients (Medland & Ferrans, 1998; Bogoch, Sockalingam, Bollegala, Baker & Bhalerao, 2005), and more specifically family members of end-of-life patients (Larson & Tobin, 2000; Kirchhoff *et al*., 2002; Beckstrand & Kirchhoff, 2005; Downey, Engelberg, Shannon & Randall Curtis, 2006; Davidson, 2009).

Although medical field specific training may be necessary in contexts such as the ones listed above, it would certainly be reasonable also to offer similar, albeit more general, communication training to nurses who are not specialised. One of

the guiding principles for the responsible design of a *NoM* course, as discussed in the previous chapter, is that such a course is to "specify clearly and to the users of the design, and where possible to the public, the appropriately limited scope of the intervention, and exercise humility in doing so" (Weideman, 2014:16). A *NoM* course will therefore be designed specifically for the purpose of improving nurse communication skills, as opposed to a more generic communicative competence course. However, it will not be limited to communication within a specific medical field within nursing practice.

Now, regardless of whether training programmes focus on nurses in specific fields, many debate the effectiveness of such programmes overall. Some researchers (Razavi, Delvaux, Marchal, Durieux, Farvacques, Dubus & Hogenraad, 2002; Delvaux, Razavi, Marchal, Bredart, Farvacques & Slachmuylder, 2004) have reported definite measures of success of educational and training communication courses and programmes for nurses. On the other hand, Veronique Boscart (2009) argues, for example, that many such training programmes often have little or no lasting effect on nurse communication in clinical settings. Both Boscart (2009) and Bowles, Mackintosh and Torn (2001) attribute this to the lack of using theoretical frameworks as the basis for designing nurse communication interventions. Both then selected Solution-Focused Brief Therapy (SFBT) as the framework for designing communication training for nurses. Boscart (2009: 1824 f.) explains that "[t]he goal of this approach is to shift interaction from being negative and problem-oriented to being positive, collaborative and solution-focused." McGilton *et al*. (2006) also use an adaptation of SFBT to improve nurse-patient communication, and similarly claim that the strength of their study lies in the use of a solid theoretical framework. Bowles *et al*. (2001), Boscart (2009) and McGilton *et al*. (2006) all found that the nurses perceived their communication with patients and other medical staff to have been enhanced due to the communication intervention based on this theoretical framework. Interestingly and aligned with the observations that have been made in the study by McGilton *et al*. (2006), nurses

expressed the view that this improved communication also led to greater job satisfaction. This reiterates the point made in the previous chapter that in order for the design of a *NoM* course to be responsible, it must necessarily be based on a theoretical framework. This is why Weideman's (2014) principles of design were selected to guide the design process to be manifested in the use of Di Pietro's strategic interaction method (Weideman, 2002).

The use of Di Pietro's strategic interaction method to inform the design of tasks could also potentially enable a *NoM* course to avoid one of the main pitfalls of many nursing communication programmes. This problem is that many educational programmes offer principles, general guidelines or strategies for more effective communication, while few are clear about how such strategies or skills should be applied in specific communication scenarios. Apker *et al*. (2006; 181) emphasise the need to do research on actual discourse between nurses, other medical team members and patients, since "[s]uch in situ research would provide nurses with authentic examples of how to successfully communicate with others and overcome communication barriers." And indeed Apker *et al*. (2006) suggest offering nurses videoed scenarios of professional and effective communication as a means of teaching nurses communicative skills for their profession. Similarly, Carroll (2006) and Kuehster and Hall (2010) assert that allowing medical personnel to practice their communication skills in critical medical settings through simulations rather than classrooms provides a safe environment for nurses to practice communication and to learn from their mistakes. In fact, Kuehster and Hall (2010: 125) found "actually practising SBAR [Situation, Background, Assessment and Recommendation] during a simulated patient experience is exceedingly more effective than the standard didactic approach." Similarly, Brunero, Lamont and Coates (2010) found in their literature review of intervention programmes for teaching empathy that experiential learning through case-studies and role playing was key to the success of increasing empathy in nurses. Similarly, the printed, as well as online, resource materials that Van de Poel, Vanagt, Schrimpf and Gasiorek (2013:vii)

designed and which is "aimed at second language or language-discordant medical professionals", is "evidence-based" and offers communicative strategies within scenarios, such as a consultation with a patient, that they will actually encounter during the course of their work.

This is exactly what this thesis is aimed at – collecting data consisting of actual interactions between nurses, medical staff and patients to inform the design of a nurse communication course. Following the Communicative Language Teaching (CLT) approach as discussed in the previous chapter, a communicative language course for nurses would need to enable the development of communicative skills in context. The research undertaken in this study will investigate real instances of nursing communication in order to identify, on the one hand, the communicative functions prevalent in nursing communication and, on the other hand, where the short-circuits in communication occur. This will enable the designer of a *NoM* course to purposefully design tasks that will teach nurses to approach strategically the use of communicative functions to deal with short-circuits in communication, as opposed to general and vague guidelines.

So while educating nurses on the importance of effective communication, and teaching them principles, techniques and strategies for effective communication are necessary, nurse communication and training should ultimately include practising communication within typical and crucial nurse interactions. Indeed, Roberts (1986) explained the concept of Di Pietro's transactional competence in relation to second language learning and specifically how role-playing can be utilised as a pedagogical tool. Roberts (1986: 52) contends that transactional competence in an additional language is

> ...the ability to conduct *transactions* through the medium of the spoken language – that is, the ability to use spoken language as a tool in order to achieve personal goals whose realization depends upon interaction with and co-operation from other people.

Roberts (1986: 53) suggests that the basis for teaching transactional competence in an additional language should be dialogue, as a transaction will always occur

between two people. Importantly, it is only advanced language learners who should be concerned with transactional competence, as it requires the language learners to have acquired considerable phonological, lexical and grammatical knowledge of the target language (Roberts, 1986:52). The concept of transactional competence is thus relevant as a *NoM* course would be designed for learners who have a suitable knowledge of English but need further training in how to use various strategies to negotiate meaning in professional communication.

Instances of communicative interactions then need to be identified in order to serve as starting point for the design of a communicative course for nurses in South Africa which includes strategic transactional communication. Many of the courses and programmes discussed above include role-playing or simulated interactions as a means of practising new communication skills, but it is unclear whether these are always linked directly to nurses' actual daily interactions in practice. This study is aimed at investigating typical and crucial nursing interactions that will be used to design a syllabus not only based on the needs identified, but also justifiable with reference to an appropriate and acceptable theoretical framework for a communication course for nurses in the unique South African context of this investigation.

5. Problems surrounding nurse communication

There are numerous factors that can lead to ineffective communication between nurses, patients and physicians. Here I will discuss some factors that feature most prominently in the literature and which would need to be taken into consideration in designing a *NoM* course. The problems discussed below then provide a basis for the next phase of research. As will be reported on in chapters 5, 6, 7 and 8, nurses are to be observed in practice as well as interviewed with the purpose of investigating the extent to which these problems present themselves in the nursing profession in South Africa. Furthermore, additional

aspects of communication that prove to be problematic through the manifestation of short-circuits in communication will be identified.

5.1. Differential communication training

One major factor that causes miscommunication between nurses and physicians is that they are trained to communicate differently (Leonard *et al*., 2004). Nurses are told that they are not responsible for diagnostics and thus tend to provide physicians with very broad and narrative information on the patient in order for the physician to make a diagnosis, while physicians on the other hand are taught to get to the point quickly (Leonard *et al*., 2004). This may be a point of friction between nurses and physicians. The physicians and nurses tend to develop different medical cultures (Casanova, Day, Dorpat, Hendricks, Theis & Wiesman., 2007) which could be as a result of the different focus of their education. Similarly, Eggertson (2012) explains that often physicians have very little knowledge of the role and responsibilities of nurses, and vice versa, which could lead to unrealistic expectations and consequently frustration and conflict. Leonard *et al*. (2004) contend that the SBAR method can be taught to medical staff to overcome such communicative difficulties. They also argue that nurses need license to express to doctors that they are concerned about a patient and although they may not quite pinpoint what the problem is, that they need the doctor to come and attend to the patient right away.

5.2. Power relations

Another factor that complicates communication is power relations between nurses and physicians (Edmondson, 1999; Arford, 2005; Reader, Flin, Mearns, & Cuthbertson, 2007). Arford (2005) argues that often power relations are determined by the structure of the hospital and in order for nurses to obtain more autonomy in performing their job, this structure may need to be challenged and modified. At other times though, vertical violence occurs when a physician or other medical professional in a position of authority employs verbal aggression

(either real or perceived) towards a nurse in a lesser position of power, often in a life or death situation with a patient (Buback, 2004). In fact, a study by Rosenstein and O'Daniel (2008) found disruptive behaviour by physicians can lead to adverse events in patient treatment and even mortality. One suggestion that Leonard *et al*. (2004) make to facilitate communication within a hierarchy of medical staff is the adoption of critical clinical language derived from the CUS programme:

> CUS stands for "I'm concerned, I'm uncomfortable, this is unsafe, or I'm scared'', and is adopted within the culture as meaning: 'we have a serious problem, stop and listen to me'. This ability to get everyone to stop and listen is essential for safe care. Critical language creates a clearly agreed upon communication model, that helps avoid the natural tendency to speak indirectly and deferentially.

Reader *et al*. (2007) confirm this need for there to be openness in communication between staff members, as it has a direct impact on the occurrence of medical errors due to miscommunication.

5.3. Task oriented vs patient oriented communication

The concept of patient-centred communication was introduced by Balint (1955, 1956) and can be defined as

> ...communication that elicits and understands the patient's perspective and social context, reaches a shared understanding of the problem and its treatment, and involves patients in choices to the extent they desire. (Teal & Street, 2009: 1)

Because patient-centred care enables the patient to express needs and concerns and allows them to be part of the decision-making process, it helps patients and nurses to build trust. As a result, the patient is more likely to co-operate with the nurse in receiving treatment as well as medication adherence (Gilbert & Hayes, 2009; Hartley & Repede, 2011).

Although patient-centred care is considered fundamental to offering quality health-care (Sully & Dallas, 2005; Aled, 2007), many researchers have pointed out that nurse-patient communication is predominantly task-orientated, with little affective talk (McCabe, 2004; Shattel, 2004; Boscart, 2009; Chant,

Jenkinson, Randle & Russel, 2002; Roth *et al*., 2002; McGilton *et al*., 2006). Medical training, policies in hospitals and ward cultures often emphasise the acquisition and practice of technical and medical knowledge and skills at the cost of imagination and interpersonal skills (Chant *et al*., 2002; McCabe, 2004). Physical care of patients becomes the priority while affective communication and empathy are seen as a luxury or even as demonstrating laziness on the part of the nurse (Yam & Rossiter, 2000; Chant *et al*., 2002). A task-orientated communication style can also be a protection mechanism against the stress of emotional interaction with patients (Kruijver *et al*., 2001; McCabe, 2004).

It is important to remember, however, that nurse communication happens within a specific context and at times information transfer will trump interpersonal connection. The key to healthy interpersonal relationships and communications in the medical context may in fact lie in understanding the rules governing task-orientated and interpersonal communication. Being able to discern when to utilise which type of communication, and to which degree, depends very much on context. In the medical context, knowledge and information transfer may often be viewed as more important than interpersonal or empathic communication. In other words, conveying information accurately may take priority over cultural and emotional sensitivity. However, if cultural and emotional sensitivity in communication are observed and respected to an acceptable level (avoiding the superfluous), then perhaps the transfer of information may occur more effectively. The problem is how you define an "acceptable level of cultural and personal sensitivity" in communication. It may very well depend on the context, which might range from a routine check on the patient's condition to an emergency situation in the ICU.

Patient-centred care has been presented as being a necessary approach to offering quality care to patients. From as early as 1983, good communication has been presented, from a patient-centred care perspective, as necessary for nurses to fulfil key functions of their job, such as assessing the health needs of patients

(Aled, 2007). In a study by Pytel, Fielden, Meyer and Albert (2009) patients in an Emergency Department (ED) ranked nurses communicating key medical information about tests and treatment to patients as most important, followed closely by the need for nurses to show care in their communication. Both of these needs are centred on the patient's needs, that relate directly to their medical condition, which was primarily for adequate information to be communicated in a manner that the patients can understand in order to help allay their fears and concerns. Patient-centred communication thus does not necessarily mean offering comfort or the opportunity to speak about emotions, but is rather referring to a specific approach to dealing with tasks and transferring information. This is similar to what Skilbeck and Payne (2003) found in a literature review of studies dealing with patients receiving palliative care. Patients' need for emotional support often refers to providing the patient and patient's family with physical comfort and information about their condition and treatment, rather that inviting patients to express their feelings and emotions (Skilbeck & Payne, 2003). In the study by Pytel *et al*. (2009), nurses completed the same survey as the patients and their rankings differed somewhat, but nevertheless recognised the need for patient-centred communication. Whether or not nurses do in fact exhibit patient-centred communication is a different matter altogether. It is necessary to note that the Pytel *et al*. (2009) study was done in an ED setting, where the communication of specific information is often more important than the means of communicating that information. Despite this, the study showed that both patients and nurses expressed the need for patient-centred communication. Importantly, we may be able to generalise these results to other medical settings as well. The conclusion seems to be, however, that "patient-centred" care may productively be interpreted as care related to the treatment of a medical condition and communicated respectfully.

Indeed as with the findings of Beach, Price, Gary, Robinson, Gozu, Palacio, Smarth, Jenckes, Feuerstein, Bass, Powe and Cooper (2005), to be discussed later in this chapter, in cultural competence training, in part motivated by the

need to offer more patient-centred care, many such programmes did not lead to higher patient adherence to treatment. It would seem that the training impacted positively on the patient's satisfaction with the care they received, yet this does not translate into positive results in patient adherence to treatment. Thus, if patient-centred care is not understood and implemented correctly, it has the potential to be rendered counter-productive, as it may not lead to improved patient health outcomes.

Langewitz *et al*. (2010) therefore argue that patient-centred care should not mean that psychosocial communication should take place to the exclusion of medical care. The two should as far as possible rather occur concurrently. Nurses or physicians may need to communicate large amounts of information to the patient and the patient may have difficulty processing this information (Langewitz *et al*., 2010). The patient needs to be given the opportunity to respond to the information, whether it is in terms of the content or an emotional response to the information (Langewitz *et al*., 2010). As Langewitz *et al*. (2010: 2275) state:

> Communication in oncology might be viewed as a mixture of giving information and dealing with emotions. ... To achieve this, 'closing the loop' ... is required in order to adapt the information closely to the patient's needs.

The care thus centres on the treatment of a medical condition, and explains why it remains a treatment-centred rather than a patient-centred event. Barrerre's (2007) discourse analysis of nurse-patient interactions revealed that even when nurses exhibit caring and interpersonal communication with their patients, the nurses still maintain dominance in the interaction. This is not surprising, since the patients have placed themselves in the hands of medical professionals for the treatment of a specific condition. The professional expertise that nurses bring to bear on the treatment therefore explains their dominant, expert role. Where such communication goes wrong is where it denies patients the opportunity to elicit information that they need. Barrerre (2007: 121) therefore correctly suggests that nurse education needs to include training for nurses, for example, in

> using respectful forms of patient address, ascertaining patient choice, using greater sensitivity in maneuvering direction or topic of a discussion, and reacting more adeptly to patient conversational cues.

The conclusion is that such training is not foreign to, but a necessary component of the further professionalization of the nursing profession. And indeed a patient-oriented approach to teaching communication skills to language-discordant mobile medical professions has been utilised through materials designed by Van de Poel *et al*. (2013). Training in such communication techniques as mentioned by Barrerre and designed by Van de Poel *et al*. (2013) could facilitate more caring, empathic conversation, while nurses communicate necessary information to patients, creating a balance between task- or treatment-oriented and patient-centred communication.

Although nurses may lean towards emphasising medical or procedural over affective communication, the two seem to be interlinked and need to be balanced. Kruijver *et al.* (2001) argue that during the admission of oncology patients to hospital for treatment, both instrumental and affective communication need to occur congruently. While important administrative and medical information was communicated between the nurse and patient during the admission process, the nurses in the study often neglected affective communication (Kruijver *et al*., 2001). Affective communication refers to, among other things, eliciting the patient's concerns, and providing information to allay any fears or anxiety they may have (Kruijver, 2001). Such communication serves to build a trusting relationship between the nurse and patient which would facilitate more effective medical and administrative information exchange (Kruijver *et al*., 2001).

It would perhaps be useful, in addition, to use the term "treatment-centred" communication rather than "patient-centred" communication. The purpose of health care services is to deal with the health issues of patients while also viewing the patient as coming from a socio-cultural context. The purpose of communication should therefore be to deal with the treatment of the patient's

health issues and doing so in a manner that respects the patient as a holistic being with physical, psychological and social needs. In this survey of the literature, however, I shall retain the conventional categories of task- versus patient-oriented communication.

5.4. Ethnicity and culture

Patient-centred care can be undermined by miscommunication or misunderstandings due to cultural differences. Teal and Street (2009) point out that while patient-centred care is focused on offering each patient high quality medical care, cultural competence is aimed at offering quality medical care to all cultural and language groups (Teal & Street, 2009). Cultural competence would then impact on the quality of medical care offered to patients. It is no surprise that Ferguson and Candib's (2002) literature review reveals that differences in ethnicity, culture and language can have a negative impact on the doctor-patient relationship. When patients and medical professionals do not share a common language, and one or both parties have to communicate in a language socio-culturally far removed from their own, affective and/or semantic misunderstandings may occur (Robinson & Gilmartin, 2002). The emphasis on enhancing medical practitioners' cultural competence has therefore given rise to and been incorporated into numerous training programmes (Beach *et al*., 2005; Boutin-Foster, Foster & Konopasek, 2008). Van de Poel *et al*. (2013:5-8), for instance, consider the cultural component of interacting with patients as integral to providing mobile medical professionals with resources on communicative competence for their profession. Cultural competence training such as those mentioned above includes deepening medical practitioners understanding of cultural differences, challenging attitudes based on stereotypes or misconceptions about other cultures, and teaching communication strategies to improve intercultural communication (Beach *et al*., 2005; Van de Poel *et al*. 2013).

Beach *et al*. (2005) found that the vast majority of such programmes had a definite positive impact on the medical practitioners' cultural competence, which in turn lead to higher patient satisfaction. Interestingly though, there was little evidence to suggest that it led to improved adherence to treatment on the part of the patient (Beach *et al*., 2005). As already discussed elsewhere in this chapter, this last finding may be indicative of a potential pitfall of patient-centred care. Patient-centred communication may lead to higher patient satisfaction, but communication also needs to be treatment-centred to truly achieve its purpose of facilitating medical care.

In another literature review on intercultural communication between patients and physicians, Schouten and Meeuwesen (2006: 21) identify five factors that may lead to intercultural communication barriers. These factors are:

> (1) cultural differences in explanatory models of health and illness; (2) differences in cultural values; (3) cultural differences in patients' preferences for doctor–patient relationships; (4) racism/perceptual biases; (5) linguistic barriers.

These factors should to be taken into consideration when attempting to address barriers to intercultural communication between patients and medical practitioners. Furthermore, Schouten and Meeuwesen (2006) suggest that further research should be done to ascertain which aspects of physician-patient communication could be considered universal as opposed to being specific to a given culture. Determining the same for nurse communication would then be useful in order to overcome barriers in intercultural communication. As discussed elsewhere, interpersonal interaction between nurses and other medical staff as well as with patients can have a definite impact on the physical and psychological care given to patients. Thus, when communication is hampered by cultural factors, patient care may be negatively affected. Once manner in which the factors leading to intercultural miscommunication could be addressed is through strategic interactional competence training as discussed above in the section on the effectiveness of nurse communication education and training.

In South Africa, where the population is so culturally diverse, factors such as culture and ethnicity and the manner in which they relate to language and communication can potentially have a negative impact on the way that nurses interact with others and the way they thus practice their profession. In this study, the inventory of typical and crucial interactions between nurses and others that will be generated for the design of a syllabus for a communicative course for nurses in South Africa will of necessity include attention to intercultural communication. Including some cultural competence training in the various interactions in the design of the course could perhaps facilitate the development of communication specific to nursing practice and that transcends some of the hazards of intercultural communication. As Teal and Street (2009: 1) explain:

> A culturally competent physician has the capacity to recognize and reconcile socio-cultural differences between the physician and the patient in order to have a more patient-centered approach to care.

But cultural competence may not develop automatically. So in the interest of promoting patient-centred care, medical professionals may need to receive cultural competence training. Boutin-Foster *et al*. (2008) for instance introduce a conceptual framework for a professional culture of medicine within which to teach cultural competence. Boutin-Foster *et al*. (2008) found that students of medicine are often resistant to cultural competence training because it is viewed as a "soft science" and as having little relevance to their profession (Boutin-Foster *et al*., 2008). However, cultural competence could be incorporated into the concept of a professional culture of medicine, which "can be viewed as the language, thought processes, styles of communication, customs, and beliefs that often characterize the profession of medicine", and taught as integral to maintaining this culture (Boutin-Foster *et al*., 2008). When teaching what professionalism is in medical practice, attributes such as honesty and altruism are usually emphasised, but these concepts need to be translated into practical elements such as

> the white coat, a shared stylized dress code among physicians; doctor talk, a shared language or unique pattern of communication among physicians; and the physician explanatory model, a shared system of beliefs regarding health.

Such elements, especially the latter two, can then be used to teach cultural competence as a part of a professional medical culture of competence, which includes intercultural communication skills. A professional culture of nursing, which includes cultural competence, could be a useful framework for developing a communicative language course for nurses.

This would be in line with the legislation on nursing curriculum in South Africa quoted at the beginning of this chapter, which states that nursing services need to be professional and respect others in terms of the socio-cultural context they come from. These aims could be reached in part by developing a "shared language or unique pattern of communication" among nurses and other medical personnel which could potentially transcend some of the pitfalls of intercultural communication. This is in line with the recommendations by the *Common European framework of reference for languages: Learning, teaching, assessment* (Council of Europe, 2001) where sociocultural competence is presented as a key component of the competencies required in language learning. Similarly, teaching intercultural communication skills as an integral part of professional competence for nurses could be a step towards improved communication with patients and therefore an improvement in medical services offered. It might also be important for nurses to differentiate between the shared pattern of communication among medical staff, and the type of language to be used in communicating with patients. Developing a professional culture for nurses could improve collaboration with other medical professionals, but nurses need to then be aware that patients do not share that culture. In addition, the various linguistic and cultural communities that medical personnel belong to and that they bring to the medical team they work with should be viewed as a valuable resource to enhance the quality of service that the medical team can offer to patients (Van de Poel *et al*. 2013: 7,8).

Developing a professional culture of nursing which promotes effective intercultural communication should include some of the key elements proposed

by Teal and Street (2009) in their model for culturally competent communication (CCC). The CCC model integrates elements of cultural competence with communication skills: cultural specific non-verbal and verbal behaviour, recognition and exploration of potential cultural and communication differences, incorporation of acquired cultural knowledge into approaches to interaction, and using this knowledge to facilitate negotiation and collaboration in treatment (Teal & Street, 2009). Medical professionals will probably acquire knowledge about differences in culture and communication over time through experience, but it would be helpful to offer nurses some training on core cultural differences and how these relate to communication problems. Although it would be highly problematic to educate nurses on all the core cultural issues that might occur between themselves and individuals of all eleven official language groups in South Africa, some issues pertaining specifically to the care and treatment of patients may be highlighted to mitigate possible misunderstandings or miscommunication. This would include teaching nurses to be aware that others' behaviour and communication may differ from their own and that when they perceive differences, to be adaptable and accommodating. Thus, providing nurses with a basic knowledge of cultural differences that may exist within specific medical encounters, as well as communication strategies to circumnavigate potential misunderstandings associated with these differences, could allow nurses to adapt their approaches to interactions more readily. The danger that needs to be avoided here is reinforcing cultural stereotypes. Nevertheless, training similar to CCC training could lead to higher patient satisfaction and adherence to treatment.

Although investigating what the cultural differences are that lead to miscommunication or misunderstandings lies beyond the scope of this study, it will be useful to attempt to determine whether cultural differences do indeed lead to misunderstandings or miscommunication in the medical context. In this case, cultural competence training, specifically in relation to intercultural communication, could enable nurses to interact with other staff as well as their

patients in a manner that leads to higher job satisfaction for nurses and higher patient satisfaction with the physical and psychological care they receive. CCC training could productively be incorporated to some extent into a communicative language course for nurses in the future.

It is important, however, to note the shortcomings of cultural competence training, more specifically the shortcomings of merely teaching attitudes, knowledge and skills. Kumagai and Lypson (2009) argue that the point of cultural competence training is to achieve social justice, but much cultural competence training lacks a focus on the philosophical basis that underpins the concept of social justice that informs cultural competence (Kumagai & Lypson, 2009). Kumagai and Lypson (2009) contend that cultural competence training should emphasise the development of a critical consciousness as motivation for learning the attitudes, knowledge and skills that are necessary to exhibit such competence. Kumagai and Lypson (2009: 783) explain that critical consciousness

> ...involves a reflective awareness of the differences in power and privilege and the inequities that are embedded in social relationships – an act that Freire calls "reading the world" – and the fostering of a reorientation of perspective towards a commitment to social justice.

In order to develop in medical students this critical consciousness with its commitment to social justice, the University of Michigan Medical School has incorporated multicultural education into its curriculum (Kumagai & Lypson, 2009). This included small group discussion of case studies and stories about cultural differences and injustices in the medical context (Kumagai & Lypson, 2009). Engaged discussions on narratives of social injustice could lead to the development of critical consciousness, although Kumagai and Lypson (2009) acknowledge that this is very difficult to assess, as students can offer all the correct answers without internalising any of the learning. Nevertheless, they may have a point in arguing that the teaching of cultural competence in the form of attitudes, knowledge and skills as discussed should ideally be informed by a critical consciousness.

6. Conclusion

Clearly effective communication is essential to nurse job satisfaction, collaboration between nurses and other medical professionals, as well as patient satisfaction and adherence to treatment. However, there are barriers to such effective communication. The latter two problems nurses experience in communicating in their jobs are of especial concern in the research performed in this thesis. The design of a communicative language course essentially needs to take a treatment-centred approach while also taking into consideration culturally competent communication.

However, designing a communicative language course such as *NoM* needs to be based on evidence systematically gathered for this purpose. This chapter is the first step in that process and indicates that data need to be gathered during the following phases of the research. In order to design a *NoM* course that is specific to the nursing profession, without being specific to any one field of medicine, data need to be gathered about the typical and crucial communicative interactions that occur in nursing practice on a daily basis. We will firstly consider the specific types of nurse interactions that were identified in the literature in the following chapter. This inventory of communicative interactions will be expanded through observing and audio recording nurse communicative interaction in context (Chapter 5). This could allow the designer of a *NoM* course to training nurses to communicate in a treatment-centred manner while exhibiting cultural competence given real world scenarios as required by Di Pietro.

Chapter 4
Literature review: Typical nursing interactions

1. Introduction

In light of the importance of effective nurse communication with patients and medical personnel discussed in the previous chapter, as well as the barriers to effective communication, it is now necessary to consider the specific types of interactions that nurses engage in. Hence, a review of the international literature on nurse communication research was performed in order to determine which interactions are most critical to nursing practice and thus to patient safety and satisfaction. Based on the literature review to be discussed below, nurse interactions can broadly be divided into two categories, namely: Personal and Emotional Patient Care, and Diagnosis and Treatment. These categories will be discussed below in order to understand which interactions are central to the service that nurses provide and that nurses may find problematic. Identifying these crucial interactions and potential problems associated with them will form

the platform for the empirical research that will be performed in justifying the design of a theoretical rationale for a *NoM* course.

2. Literature review procedure

A review of the international corpora of literature was performed using CINAHL, MEDLINE, Health Source: Nursing/Academic Edition and Google Scholar. A combination of the following search terms was used: nurse, communication, interaction, conversation analysis and discourse analysis. The information provided in the abstracts of the journal articles were then used to identify articles that either investigated a specific type of nurse interaction or would be likely to refer to specific types of nurse interactions. Due to the plethora of research reports available on nurse communication and interactions, only articles between 2007 and 2013 were selected. A total of 62 articles were selected, but after a careful reading of the articles 44 were found to contain reference to specific nurse interactions. A search of the reference list in the articles resulted in the addition of another 13 relevant articles that were considered relevant even though the publications dates of some of these are older than those used in the original search.

3. Typical nurse interactions

Much research, as seen in the three tables below, has been done on certain types of nurse interactions that seem to be typical of nursing duties, for example shift handover and medication communication. However, it could be that these types of interactions are chosen as areas of research because such interactions are more easily observed than other interactions. The occurrence of other interactions, such as a personal conversation that takes place as the nurse readies a patient for lunch, may not be as easily predictable. In what follows, the various types of nurse interactions mentioned in the research on nurse communication have been categorised in order to bring to the fore the differences among them, and the various functions they fulfil in making responsible treatment possible. These

lists of typical nurse interactions will provide the basis for further investigation during the field work phase of this project.

The purpose is to develop a taxonomy of the most typical nurse interactions to use as a basis for a *NoM* course which addresses nurse communication in context as discussed in Chapter 2. This chapter thus forms the second step in gathering sufficient data to inform the content of a *NoM* course that is specific to nursing communication and that can be justified theoretically, as required by Weideman's (2014) framework for responsible design discussed in Chapter 2 (Section 3).

3.1. Personal and emotional patient care

Little research that pertains to the category of emotional, personal or empathic conversations is available. This could be because such conversations take place in the process of treatment or administration related discussions and cannot be separated from these contexts. One study, however, does refer to conversations which would constitute instances of "chit-chat" between nurses and patients (Chan, Jones, Fung & Chu Wu, 2011). Nurses explained that they often do not make time for such informal conversations because they serve no real purposes except to help make the experience of hospitalisation more individualised and humane (Chan *et al*., 2011). Thus, chatting to patients about non-medical matters may appear to bear no direct relation to their treatment, but it may address to some extent the personal and emotional needs of the patients which could affect their willingness to cooperate with and be receptive to treatment of their medical condition.

Time constraints are then offered as a reason why such informal conversations, or even more personal conversations with the patient, are not initiated very often (Pearcey, 2010; Chan *et al*., 2011). Thus, if a *NoM* course is to be developed, it is debatable whether an extensive section on personal and empathic interactions should be included. Considering the time pressures that nursing staff work

under, perhaps it would be more advisable to teach nurses to incorporate such talk into their routine communication regarding treatment and medication. The study by Chan *et al*. (2011:1173) indicates that when caring, empathic or even personal talk is integrated into interactions as part of routine medical tasks or procedures, the relationship that is built with the patient can actually save time in the long run, as it usually results in increased patient cooperation.

The interactions listed below can all serve to build the nurse-patient relationship that can make the medical care and treatment process easier and improve health outcomes. Sahlsten, Larsson, Sjostrom, Lindencrona and Plos (2007) for instance argue for using a therapeutic approach to communicating with patients. This approach would entail enabling patients to be partners in negotiating and deciding on the course of treatment. They argue for "participation as a partnership, but in a therapeutic, i.e. goal-oriented, supportive and healing relationship requiring intimacy and reciprocity" (Sahlsten *et al*., 2007). This would be what could be called a "treatment-centred approach" as opposed to a "patient-centred approach". A treatment-centred approach to communication would mean having treatment and medical care as the focus of communication, but utilising affective communication to reach these goals. In the table below these various types of affective communication identified in the literature have been listed.

Table 1. Personal and emotional interactions

Type of interaction	Source(s)	Participants
Personal/informal conversation during medical procedure, administration of medication or other routine duties (humour/teasing/greetings/ small talk/ asking about a patient's well being is often used here)	Barrere 2007; Chan *et al.*, 2011; Gordon, Ellis-Hill & Ashburn, 2009; Henderson, Van Eps, Pearson, James, Henderson & Osborne, 2007; James, Andershed, Gustavsson & Ternestetd, 2010; Cleary, Hunt, Horsfall &	Nurse-patient

	Deacon, 2012	
Breaking bad news (prognosis)	Pirie, 2012; Rosenzweig, 2012; Baer & Weinstein 2013	Nurse-patient
End-of-life interactions	Nyatanga, 2012; Aslakson, Wyskiel, Thornton, Copley, Shaffer, Zyra, Nelson & Pronovost, 2012; Zargham Boroujeni, 2008; Larson & Tobin, 2000; Gauthier, 2008; Bushinski & Cummings 2008;	Nurse-patient
Socialising	Kerr, 2002; Moore & Prentice, 2013	Nurse-nurse
During discharge, nurses may ask specifically about potential familial, financial or social problems that could lead to re-admittance	Chan *et al.*, 2011;	Nurse-patient

3.2. Diagnosis and treatment

The category of diagnosis and treatment contains an extensive list of interactions, as this forms the core of medical care. There is a range of interactions such as medication communication, ward rounds and shift handover that have also been investigated in many different settings, from paediatrics to oncology. The literature is not always explicit as to what these interactions may entail, perhaps because it may differ between wards and hospitals, or because it may contain information about any number of topics. The various components of these interactions thus need to be identified in order to understand what is common to all such communication, will be further investigated during the field research phase of this project, and is reported on in the following chapter.

In addition, an important part of the medical care that nurses perform is based on a range of documentation (James *et al.*, 2010), and examples of these should be examined in order to gain a deeper understanding of how the verbal interaction relates to the documentation. Although this is not the focus of this chapter, the

types of documentation that have nevertheless been identified in the literature in relation to verbal interactions include medication charts and observational charts (Liu, Manias & Gerdtz, 2012). Patient reports were also mentioned in conjunction with documents regarding test results and examinations (James *et al*., 2010). Although including an analysis of such documentation in relation to the verbal communication lies outside the scope of the current study, this should be investigated in future research. Below the types of interactions related to diagnosis and treatment have been listed.

Table 2. Diagnosis and treatment

Type of interaction	Source(s)	Participants
Pain assessment	Rischel, Larsen & Jackson, 2008	Nurse-patient-doctor
Discuss/Explain prognosis	Rosenzweig, 2012; Helft, Chamness & Uhrich, 2012; Gutierrez, 2012	Nurse-patient-patient's family-doctor
Preparation for surgery	James *et al*., 2010	Nurse-patient
Explaining diagnosis	Cleary *et al*., 2012	Nurse-patient-patient's family-doctor
Debriefing (sharing info and asking advice)	Cleary *et al*., 2012; Leonard *et al*., 2004	Nurse-nurse
Discussing end-of-life care	Nyatanga, 2012; Aslakson *et al*., 2012; Gauthier, 2008; Barton, Aldridge, Trimble & Vidovic, 2005; Curtis, Tzannes & Rudge, 2011; Gutierrez, 2012; Helft *et al*., 2012; Pirie, 2012; Rosenzweig, 2012; Bushinski & Cummings, 2007	Nurse-patient-doctor
Deciding on pain management strategy	Arber, 2007; Rischel *et al*., 2008	Nurse-doctor

Patient medication education	Barrerre, 2007; Manias, 2010; Ashbrook, Mourad & Sehgal, 2012; Bolster & Manias, 2010; Cleary *et al*., 2012; Flood, 2009; Hartley & Repede, 2011; Henderson *et al*., 2007; Catangui & Slark, 2012;	Nurse-patient-doctor
Perioperative briefings	Leonard *et al*., 2004; Lingard, Epsin, Rubin, Whyte, Colmenares, Baker, Doran, Grober, Orser, Bohnen & Reznick, 2005	Nurse-patient
Explaining medical procedure	Barrerre, 2007; Hemsley, Balandin & Worrall, 2012; Major & Holmes 2008	Nurse-patient
Logistical arrangements of medical procedures	Major & Holmes, 2008; Barrere, 2007	Nurse-patient-administrative staff
Nurses explaining a patients' condition/symptoms to physician telephonically and requesting orders or that physicians come to attend to patient immediately (SBAR)	Beckett & Kipnis, 2009; Leonard *et al*., 2004	Nurse-doctor
Deciding of treatment plan	Aslakson *et al*., 2012; Bae, Brewer & Kovner, 2012; Burns, 2011; Hartley & Repede, 2011; Pirie, 2012; Hobbs, 2009; Catangui & Slark, 2012	Nurse-doctor-patient
Deciding on prognosis	Aslakson *et al*., 2012; Catangui & Slark, 2012	Nurse-doctor
Making Diagnosis	Catangui & Slark, 2012; Hemsley, *et al.,* 2012; Chapman, 2009	Nurse-doctor

3.3. Duty-specific interactions

Above is a list of the more general nurse interactions that will occur in a variety of contexts, while below is a list of the specific interaction scenarios that are part of nursing duties and that may include different types of interactions, including some of those listed above. The administration side of the nursing profession involves, to a large extent, the recording of patients' symptoms, test results, medication and other treatment and condition related aspects. These interactions also largely involve the logistical arrangements of medical procedures and treatment, or of the administration of medication to patients. Between nurse and doctors, such interaction usually includes making the arrangements for the administration of tests and procedures. Such interactions cannot productively be removed from the medical category of interactions and are thus listed together with the medical interactions that they occur in, as can be seen in Table 3 below.

It is also necessary to note that even though the shift handover can be seen as a type of handoff interaction, the two have been listed as separate interactions. This is because the shift handover interaction should happen on every shift, while handoff may happen only occasionally and may in fact contain some differences in terms of content.

Table 3. Duty-specific interactions

Type of interaction	Source(s)	Participants
Medication education:		
Instructions for taking medication, patient concerns about medication, reasons for medication	Sibley, Latter, Richard, Lussier, Roberge, Skinner, Cradock & Zinken, 2011	Nurse-patient-doctor
Admission:		
Medical information (type of medication, reason for medication, dosage, etc.)	Duffy, Karasch & Du, 2010; Paans, Muller-Staub & Nieweg, 2013; Hobbs 2009	Nurse-patient

Emotional and psychological well being, treatment	Paans *et al*., 2013	
Ward layout and rules	Aled, 2007; Cleary *et al*., 2012; Paans *et al*., 2013	
Pain assessment	Aled, 2007; Jones, 2003; Faulkner, 1998; Latimer, 2000; Kruijver *et al*., 2006	
Shift handover:		
General	Cleary *et al*., 2012; Costedio, Powers & Stuart, 2013; Jukkala, James, Autrey, Azuero & Miltner, 2012; Arora, Johnson, Lovinger, Humphrey, & Meltzer., 2005; Petersen, Blackmer, McNeal & Hill, 2013	Nurse-nurse
Patient medication	Liu *et al*., 2012	
Patient's condition Code status	Kerr, 2002; Chapman, 2009; James *et al*., 2010	
Diagnosis	Chapman, 2009	
Procedures/Surgery to be performed	Kerr, 2002	
Fall risks	Chapman, 2009	
Shift handover (Admin):		
Test Schedule	Chapman, 2009; James *et al*., 2010;	Nurse-nurse-administrative staff
Ward rounds:		
General	Graci, 2013; Kilpatrick, 2013; Desai, Caldwell & Herring, 2011	Nurse-doctor – patient
Nurse rounds	Neils, 2010	Nurse-patient
Pain assessment	Barrerre, 2007; Burns, 2011; Catangui & Slark, 2012; Chapman, 2009	Nurse-patient-doctor
Assessment of condition	Chapman, 2009; Burns, 2011; Meade, Bursell & Kettelsen,	Nurse-patient-doctor

	2006; Catangui & Slark, 2012	
Making diagnosis	Catangui & Slark, 2012	Nurse-doctor
Deciding prognosis		
Deciding on treatment	Catangui & Slark, 2012; Weber, Stockli, Nubling & Langewitz, 2007; Bae *et al*., 2012	Nurse-doctor (-patient)
Deciding on medication	Burns, 2011	Nurse-doctor – patient
Medication education	Catangui & Slark, 2012; Graci, 2013	Nurse-patient
Explaining medical procedure	Graci, 2013	Nurse-patient
Explaining treatment		
Discuss discharge	Weber *et al*., 2007	Nurse-patient-doctor-administrative staff
Review test results	Chapman, 2009	Nurse-doctor-patient
Upcoming tests		Nurse-patient-doctor
Ward rounds (Admin):		
Arranging for treatment	Bae *et al*., 2012; Catangui & Slark, 2012	Nurse-patient-administrative staff
Arranging for tests	Chapman, 2009	Nurse-patient-administrative staff
Discussing discharge date	Chapman, 2009	Nurse-patient-administrative staff-doctor
Discharge:		
General	Hobbs 2009;	Nurse-patient
Medication education	Manias, 2010; Ashbrook *et al*., 2012; Bolster & Manias, 2010	
Discharge (Admin):		
Placement in home care or hospice	Chan *et al*., 2011; Ashbrook *et al*., 2012	Nurse-patient-doctor-administrative staff
Rehabilitation arrangements	Chan *et al*., 2011	Nurse-patient-administrative staff
Arrangements pertaining to medication	Manias, 2010; Ashbrook *et al*., 2012;	Nurse-patient

	Bolster and Manias, 2010	
Handoff/Transfer:		
General	Ardoin & Broussard, 2011; Calleja, Aitken & Cooke, 2011; Mayor, Bangerter & Aribot, 2012; Berkenstadt, Haviv, Tuval, Shemesh, Megrill, Perry, Rubin & Ziv, 2008; Leonard *et al*., 2004; James *et al*., 2010; Jukkala *et al*., 2012; Staggers & Blaz 2013	Nurse-nurse
Treatment	Cohen & Hilligoss, 2010	Nurse-nurse
Recent or anticipated changes	Mascioli, Laskowski-Jones, Urban & Moran, 2009	
Current condition		
Diagnostic tests performed		
Diet and nutritional support		
SBAR (or variation)	Cohen & Hilligoss, 2010; Mascioli *et al.,* 2009; Beckett & Kipnis, 2009	

4. Discussion

Importantly, the interactions listed in the two categories above, Personal and Emotional Care and Diagnosis and Treatment, are not exactly mutually exclusive. In reality the interactions in the two categories tend to occur in relation to one another. Although the first category deals with the emotional, psychological and social needs of the individuals, this does not mean that the interactions in the second category should not include sensitivity towards such needs, and perhaps even address such needs. In fact, as discussed in the previous chapter, the literature shows that all interactions in the Diagnosis and Treatment category should be patient-centred, or perhaps treatment centred, and this would mean integrating the affective and cognitive communication needs of the patient.

One type of interactions which may facilitate such treatment-centred communication is answering patients' questions and being sensitive to cues they may give. This type of interaction is not limited to any one of the types of

interactions from the two categories, because it may occur at any time and relate to any medical or personal matter. This may occur at any point during a nurse's duties but a nurse must always be willing and ready to respond to a patient's request for more information about their diagnosis, treatment, discharge date or an array of other matters. Offering treatment-centred care would mean responding positively to patients who request more information, usually in an attempt to alleviate anxiety. Barrere (2007) found that many nurses do not respond to patient cues for more information, because they either do not notice them, or ignore them. This potentially damages the nurse-patient relationship. Nurse communication education thus needs to train nurses to be sensitive to patient cues and to respond satisfactorily.

One limitation of the interactions listed is that often the participants normally involved in any given type of interaction will differ depending on individual hospital policy and practice. For instance, there are different types of rounds which include different participants. In most hospitals there seem to be rounds performed by an interdisciplinary medical team including nurses (Desai, Caldwell, & Herring, 2011; Burns, 2011; Catangui & Slark, 2012; Kilpatrick, 2013), but Graci (2013) and Neils (2010) argue for the benefits of hourly nursing rounds in addition to rounds by the interdisciplinary team. In other cases, patient participation in ward round discussions, that usually include only nurses and physicians, has been emphasised (Weber *et al*., 2007; Chapman, 2009). Similarly, with the shift handover, the information for nurses coming on duty can be communicated through audio recordings (Chapman, 2009), discussion in person (Kerr, 2002; Chapman, 2009; Tucker, Brandling & Fox, 2009), records and documentation (James *et al*., 2010; Petersen *et al*., 2013), or may even be communicated telephonically (Liu *et al*., 2012).When shift handover takes place in person it can also be located in various spaces, such as a staff room, the patient's bedside, the corridor, or a combination of these (Chapman, 2009; Liu *et al*, 2012; Costedio *et al*., 2013). Regardless of the policy and practice of the hospital, it is necessary to identify what would be considered the crucial content

that needs to be communicated during interactions that take place during ward rounds or shift hand-over.

5. Conclusion

Through the interactions listed above, we can gain some insight into variety of types of communication, purposes and roles that nurses have to fulfil in the course of doing their duty. The research all seems to point to the relative importance of a number of these interactions, as well as using a treatment-centred approach in these interactions. The question now stands whether the same emphasis would be placed on these interactions in South African hospitals. In the next phase of the research where the shadowing of nurses takes places and which will be reported on in Chapter 5, 6 and 7, the aims will then be to determine:

- Which of the interaction types listed in the inventory above also occur in the two hospitals where research will be performed?
- Are there any other common interactions that nurses participate in that have not been listed?

Once these issues have been addressed and a refined inventory has been developed (Chapter 5), the most common communicative functions found in these types of interactions will be discussed (Chapter 6). This is necessary if a *NoM* course is to be developed based on Di Pietro's strategic interaction method as proposed in Chapter 2, which is in line with Weideman's (2014) framework for responsible design that requires a language course to be based on adequate research to provide, among other things, the content and purpose, as well as a theoretical justification for the course. It is specifically in addressing this last requirement that the problems in nurse communicative interactions will be investigated based on the data gathered during shadowing. The observation phase of the research will thus be broadly aimed at investigating which types of interactions from the refined typology seem to be most problematic, and

identifying the most common types of, and reasons for, short-circuits in communication.

Based on the findings of the shadowing to be discussed in Chapter 5, 6 and 7, the interviews will then be constructed to elicit answers to any questions that remain unanswered, as well as new ones that may arise from the observations (Chapter 8). These questions need to be answered if a course is to be designed that will address the most important, and potentially problematic, aspects of nurse communication identified in the previous chapter, namely: collaboration between nurses and other medical personnel, treatment-centred communication and intercultural communication.

Chapter 5 Observations: A typology of communicative nursing interactions

1. Introduction

The inventory of communicative nurse interactions presented in Chapter 3, and the problems associated with these interactions as identified in the literature (Chapter 4), are now further investigated through the second phase of research. This second phase of research (see outline in Chapter 2, Section 6.2) consists of fieldwork, in the form of observations within two hospitals in Bloemfontein, South Africa. The aim is firstly to refine and broaden the original inventory of typical and crucial communicative nurse interactions to provide a basis for the content of a *Nurses on the Move* (*NoM*) syllabus. Secondly, communication problems or short-circuits in communication that are common to nurses in South Africa, in accordance with or in contrast to those identified in international research (Chapter 3), are to be identified in order to be addressed by a *NoM* syllabus.

The process and procedure followed in this phase of the research, as well as the modified inventory, is discussed below. This process involved, firstly and perhaps most importantly, a rigorous process for obtaining ethical clearance to do research in hospitals. An explanation of the method used to perform the observations, once ethical clearance had been granted, is also described below. This is followed by the modified inventory, a typology of nurse interactions, based on the data gathered during observations.

2. Ethics

The fieldwork for this thesis has been performed in hospitals, which can be high-risk medical environments, since they include participants who are mainly involved in either treating or caring for patients, or being treated and cared for as patients. It follows that the ethical dimension of the research therefore needs to receive adequate attention. The important ethical issues with this type of research are observing patients' right to privacy and confidentiality of their medical information, and ensuring that the research activities do not infringe on patients' rights to receive the medical care they are due by hindering nursing staff from doing their work. Both of these rights are stipulated in the South African National Patients' Rights Charter, which all medical professionals are required to adhere to in practice. The research activities should thus not infringe on these rights in any way.

In order to ensure that the research is ethically conducted, ethical clearance and permission to do the investigation under certain conditions need to be obtained from various parties. Firstly, a research protocol, outlining the purpose and procedure of the research, was submitted to the ethics committee of the Faculty of Health Sciences. This protocol specifically also explicated how the ethical issues affecting the research would be addressed. Only participants who voluntarily gave their informed consent would be included as participants in the investigation. This meant that all participants needed to understand the purpose of the research, as well as the requirements and conditions of their participation.

In the case that a participant perceived my presence to be invasive or intrusive or that the research was interfering with medical or hospital procedure, I could be asked to terminate observation of that interaction. The participants were also informed that their names would be kept confidential, and that the research would be reported on in a thesis and potentially in academic journals. After explaining the above, participants who were willing to participate signed an informed consent form (see Annexure 1).

In addition, the ethics committee has a number of requirements that need to be fulfilled pending its approval. Firstly, the hospitals in question need to grant permission for the research to be conducted. Thus, letters requesting permission to perform the research, together with the research protocol which describes how the research would be conducted ethically, were submitted to management of the two hospitals. Secondly, the protocol had to be submitted and approved by the Vice Rector: Academic and the Head of the School of Nursing at the University of the Free State, since nursing students from the university who were undergoing practical training at the hospitals could potentially be included in the research. Only after these parties gave their permission, and the ethics committee granted their approval, was the research able to begin.

During the course of the research, there was minimal refusal to participate, as most medical personnel expressed the view that they felt the research was necessary and important. However, one doctor raised concerns that her patient's rights to confidentiality would be violated. The patient in question had willingly consented to participation earlier in the shadowing session when the doctor had not been present. However, that particular shadowing session was terminated in order to respect the doctor's refusal to participate, as well as her concern for her patients. In another session a doctor in an Intensive Care Unit questioned whether all the necessary permission and ethical clearance had been obtained for the research. After it was explained that approval was granted at various levels, the doctor was satisfied.

The process of research itself also sometimes hindered my ability to obtain informed consent. As the nurses were shadowed, they would ask informed consent from other participants as we encounter them. In some cases the interaction occurs so quickly that the we would have to approach the person who interacted with the nurse and ask for their consent only after the interaction has already occurred. Other than these incidents, which can be expected of this type of research, no serious ethical issues were reported that I am aware of.

3. The research process

The observation process entailed shadowing various nursing staff members. In all, 14 shadowing sessions were performed, and included the following wards: Ear, Nose and Throat, Cardiothoracic, Gynaecology, Urology, Coronary Intensive Care Unit, Vascular Surgery, Geriatrics, Dermatology, Emergency, General Intensive Care Unit, General Medical ward, Oncology and Surgery.

A typical shadowing session began at the start of a shift where the previous shift hands over to the next shift. Information regarding each patient's condition, treatment or important incidents that occurred with the patients is communicated. This is followed by a ward meeting attended by staff (nursing staff and secretary) on duty for that shift. These meetings included scripture reading and singing of hymns followed by the communication of information from the hospital management about policies, procedures, incidents or any other necessary and relevant information. At this meeting I was introduced to the staff on duty and the purpose of the research explained. The staff members who were willing to participate were then asked to sign consent forms. There was only one instance where a staff member expressed unwillingness to participate. However, unknown to myself, the matron spoke to this nurse about her refusal to participate, after which she did consent to participate.

Nursing staff from all nursing ranks were shadowed, including those of staff nurse, auxiliary nurse, nurse, sister, and matron. Interactions between nurses

from these ranks and other nurses, patients and patients' family members, doctors, ward secretaries and porters were observed.

While accompanying a staff member as they perform activities and interactions with others within the categories above, field notes were taken about the type of interaction being performed, the basic content of the interaction, the function of the interaction, and any other note relevant particularly to miscommunication. In some instances the communicative interaction was audio recorded to provide examples of different types of interactions, its typical content and short-circuits in communication.

4. Limitations

Due to the nature of observations as a method for gathering data, the authenticity of the data will always be in question. My presence in itself could influence the way participants interact, thereby compromising the authenticity of the data. However, although most participants initially seemed somewhat uneasy with my presence, they would soon settle into the work. Interviews were thus performed to establish the validity of various aspects of the data. However, further research would still be required to confirm all aspects of the analysis of the data below.

5. The data

The original inventory reported on in the previous chapter (Chapter 4. Literature review: typical nurse interactions) was expanded through the observation process. The original inventory listed interactions within the categories of Personal and Emotional Patient Care, and Diagnosis and Treatment, and initially the intension was to shadow one nurse per shift and look for interactions from each of these categories. However, I discovered that this was not practically ideal for gathering the necessary data. Instead it was more useful to shadow a nurse as he/she performs activities within one of the following activity-specific categories of communicative interactions:

- **Shift handover**
- **Observations**
- **Doctor rounds**
- **Administering medication**
- **Admission**
- **Discharge**

This means that I would shadow a number of nursing staff during different parts of the shadowing session, depending on when and where certain types of communicative interactions would occur. Typically the day would start with the shift handover, followed by observations and doctors' rounds, after which medication would be administered. Activities performed that fall within these categories would often overlap. Thus, different nursing staff members were shadowed at different times in order to gather data for each category. For instance, I would at first accompany a specific sister and doctors on rounds. After rounds with the doctors, the sister proceeds to fill out paperwork based on the information communicated during rounds, while I move on to shadow a different sister who is handing out and administering medication to patients. In this way I made optimal use of opportunities to observe communicative interactions.

While the categories above refer specifically to activities that are performed on a daily basis in a specific order, there are other, more general, categories of interaction that emerged from the data gathered through observations. These interactions may occur at any point in time, as part of any of the above activity-specific categories, and seem to be just as important as the activity-based interactions. These are:

- **Pervasive**
- **Administration**
- **Treatment information**

- **Briefing**

These activity-based and multiple-category communicative interaction categories are presented in two sections below. Each category contains topics of discussion as derived from the type of activity taking place. The topics discussed in each category will vary as well as overlap in the different categories.

6. Activity-based communicative interaction categories

6.1. Shift handover

Here the nurses going off their shift communicate important information to the nursing staff coming onto the new shift. Although the participants almost exclusively consist of nursing staff, it is not unusual for the new staff to greet patients as they move around the ward. The content of the communicative interactions mainly consists of reporting on what has been done during the shift in terms of care and treatment and other relevant information, and what needs to be done or paid attention to during the new shift. Incidents that have bearing on the course of treatment are also reported so that the nursing staff on the new shift can adapt the care and treatment accordingly, or request that the doctor make the necessary changes. The typology below contains a list of the topics of the information that is communicated. However, the particular content depends firstly on the type of ward; for instance, the type of information communicated in a gynaecology ward is quite different to that of oncology. Secondly, the individual patients and their own, unique needs will also determine the specific information communicated.

Table 4. Shift handover

Shift handover
Treatment (Nurse-Nurse-Matron)
Type of treatment (medication, chemotherapy, physiotherapy, etc.)
Frequency and duration of treatment
Method of administering treatment

Patient reaction to treatment
Changes in treatment
Patient, nurse or doctor queries about treatment that need to be addressed
Catheter inserted, removed or problems with catheter
Medication (Nurse-Nurse-Matron): this is an integral part of treatment, but is so broad and diverse that it is being treated as a separate category.
Type of medication
Reason for medication (for example, the doctor prescribed it or the patient complained of pain)
Dosage
Time or frequency of administering medication
Patient's reaction to medication
Whether or not additional medication, beyond the prescribed medication, was administered due to patients' complaints of pain, nausea or other symptoms
Method in which medication was administered (orally, injection, drip, etc.)
Drips for administering medication: drips put up, taken off or changed
Ask the doctor about changes in prescriptions, or report patients' reaction to medication which would necessitate such changes
Specific concerns nurses have about patients that they would like the new shift to be aware of
New instructions that the doctor has given
Physical and emotional/psychological condition of patient (Nurse-Nurse-Matron)
Changes in condition: improvement, deterioration, complication
Condition stable
Whether or not patient has eaten that morning
Hygiene: whether or not patients have bathed or been bathed
Patients' general state of well-being
Whether or not patients' family/friends have been visiting or need to be contacted (where relevant)
How well or how much each patient slept (night and day)
Tests, procedures and operations (Nurse-Nurse-Matron)
Which have been performed on the relevant patients
Schedule for patients who have to go for a specific test, procedure or operation during the new shift
Patients on nil per mond (n/m: patients are not allowed to eat before certain test, procedures and operations)
Diagnosis (Nurse-Nurse-Matron)
Diagnoses that have been made during the shift
Diagnosis of new patients admitted during shift
Patients who still do not have a diagnosis (possibilities sometimes discussed here)
Senior nursing staff member may explain diagnosis to others
Wound condition and treatment (Nurse-Nurse-Matron)

Change in condition of wound: improvement, deterioration, complication
Time or frequency that wound has been cleaned or the dressing changed
Drainage: whether or not wound is being drained, problems with drainage such as a blocked tube, the amount of fluid drained
Pain level that a patient experiences due to the wound
Mobility (Nurse-Nurse-Matron)
Degree of mobility that the patient has
Particular problems with a patient's mobility that staff need to be aware of
Change in degree of mobility: improvement, deterioration, complication
Doctor's orders regarding a patient's mobility
Discharge (Nurse-Nurse-Matron)
Patients that have been discharged
Patients that will be discharged on new shift
Conditions under which patient may be discharged (for example, the pending outcome of tests)
Non-medical problems that prevent discharge
Admissions (Nurse-Nurse-Matron)
New patient admitted, re-admitted or transferred from another hospital
Reason for admission
Diagnosis
Mobility
Specific needs (for example, the patient wears a nappy)
Treatment (may include any information from the treatment category above)
Medication (may include any information from the medication category above)
Tests, procedures and operations the patient will undergo
Dietary requirements (Nurse-Nurse-Matron)
Diabetic patients
Specific dietary requirements (lactose or gluten intolerant)
Patient suffering from severe nausea who needs a special diet
Dietician will come to see a patient regarding specific dietary requirements
Patients who are n/m
Diabetic (Nurse-Nurse-Matron)
Changes in glucose levels
Query about whether or not a patient is diabetic (the new shift needs to keep testing the patient's glucose levels to determine if there is a problem)
Hypertension (Nurse-Nurse-Matron)
Staff need to be aware which patients suffer from hypertension
Vital signs (Nurse-Nurse-Matron)
Stability of or changes in the following:
Blood pressure
Respiration rate
Temperature
Saturation levels

Blood glucose levels
Patient complaints (Nurse-Nurse-Matron)
Nausea
Pain
Diarrhoea
Pervasive (See Table 10.)
Briefing (See Table 13.)

6.2. Observation

Nurses perform a variety of duties which are associated with checking on the condition of the patient and recording any changes. This includes several activities such as taking vital signs and measuring fluid intake and output. During this time, patients will often ask the nursing staff questions about their treatment, medication, when the doctor will come to see them again, which tests, procedure or operation they are scheduled for, or any number of aspects of their treatment and care. The nurses will then offer them this information where possible while also communicating to them, where relevant, changes in their condition. The communicative interaction thus occurs predominantly between nurses and patients. Occasionally the nurse performing observations may also interact with other nursing staff when information needs to be checked or reported, for instance.

Table 5. Observation

Observation
Information while doing observations (Nurse-Patient)
Purpose of activities and questions (measuring glucose, measuring blood pressure, etc.)
Tell patients what to expect (whether or not they will experience pain or discomfort)
Directing patients on how to work with the nurse (sitting up, rolling over, taking deep breaths, etc.)
Asking the patient for specific information
Instructing patient to increase or decrease fluid intake

Informing patients about what the measurements are and whether it is good or bad
Patient questions and complaints (Nurse-Patient)
Medication
Treatment
Discharge
Which tests, procedures and operations they are scheduled for and when
Results of tests
When doctor will come to see him/her
Feeding tube
Catheter
Nurses check patients' physical and psychological/emotional condition* (Nurse-Patient)
Nausea
Pain assessment
Wound
Bleeding
General well-being
General checking* (Nurse-Patient)
Whether patient has taken medication or needs specific medication
Whether patients have eaten that morning or need help eating
Hygiene: whether patients have bathed and if they need assistance
Whether patients have been informed about the tests, procedures or operations they will go for and if they know the reason for the test, procedure or operation (followed by treatment information – See Table 12.)
Pervasive (See Table 10.)
Treatment information (See Table 12.)
Briefing (See Table 13.)

* This category is not always a requirement of the observation process, but nurses often include it in their communication with the patient while performing the required observation activities.

6.3. Doctor rounds

Doctor rounds usually take place at specific times during the day and evening, and this is where the patients' condition is assessed and instructions for treatment and care are given. However, doctors will sometimes also perform unofficial rounds during the day to check in on their patients and issue the necessary changes in orders for treatment and care. During unofficial rounds the doctor and nursing staff will communicate about things such as the completion of instructions given during official rounds, patients' reaction to treatment or complaints that doctors need to be aware of as observed in the doctors' absence,

or suggestions that the nursing staff have about treatment based on patients' reactions to treatment, complaints or change in condition. Also, when necessary, the nurses will phone the doctor during the day when it is necessary to inform the doctor about patient complaints or changes in condition that the doctor needs to address.

Apart from the actual instructions that the doctor issues, rounds also include a form of briefing, where the nurse and doctor need to communicate specific information in order to keep each other up to date on the necessary aspects of the patients' condition and treatment to ensure the effective treatment of patients. This form of briefing differs from that in Table 13 discussed later in this chapter in section 7.4, where briefing occurs between nursing staff throughout the day. Depending on the hospital and ward procedure or protocol, at least one senior nursing staff member will accompany the doctor(s) on their rounds. Here the doctor will check on the patients' condition by gathering information from the patient and the nurse, as well as checking the patients' files, test results and various other documents where information about the patient's condition or treatment is recorded. Based on this information, the doctor will then give orders concerning, among other things, the patients' treatment, discharge, tests, procedures and operations. The communicative interaction during rounds thus mainly occurs between the nursing staff and doctor, although the patient is also included in discussions at times.

Table 6. Doctor rounds

Doctor Rounds
Doctor asks for information (Nurse-Matron-Doctor-Patient)
Patient hygiene
Patients' reaction to treatment
Test results
Assessment of patients' condition: improvement, deterioration, complications
Significant changes in vital signs
Pain assessment

Other doctor’s instructions and/or opinions
Diagnosis (Nurse-Matron-Doctor)
Patient’s diagnosis
Patient’s prognosis and end-of-life care (usually not in front of the patient)
Doctor’s suspicions about diagnosis pending confirmation based on test results
Doctor's instructions (Nurse-Matron-Doctor)
Various aspects of treatment
Medication: type, dosage, frequency and method of administering medication
Changes in treatment or medication based on information the nurse and/or patient provide
Changes in treatment or medication to be made based on pending test results
Mobility
Discharge date
Conditions under which patient can be discharged
Check-up date
Tests, procedures and operations to be scheduled
Dietician, physiotherapist, psychologist, counsellor or specialist to be asked to see patient
Wound care
Various aspects of dietary requirements
Insertion or removal of catheter
Insertion or removal of drainage pipe
End-of-life care (not in front of patient)
Update doctor on critical changes in condition or vital signs
Put patient in isolation
Transfer patient to different ward or hospital
Administration (Nurse-Matron-Doctor)
Patient documentation
Nurse offers information, asks questions and makes suggestions (Nurse-Matron-Doctor)
Patient complaints
Patient's psychological state
Patient condition: improvement, deterioration, complications
Patient's reaction to treatment
Prescription or orders regarding treatment
Clarify details of treatment
Suggests a form of treatment or tests
Pervasive (See Table 10.)

6.4. Administering medication

Medication is administered only by the sisters who are specifically qualified to do so. The sister will administer the medication patient by patient and will record the details of the medication administered to each patient in their individual files as the medication is administered. Keeping accurate and up-to-date records is crucial in ensuring patient safety, effective treatment and controlling the medication in the ward. During this process, the sisters often have the opportunity to provide patients with information regarding their treatment, to listen to their complaints and to answer their questions. It is important for the sisters to assess the patients' condition in order to ascertain whether or not to administer non-prescription medication such as mild pain and nausea medication. Even though these medications may be suggested by the doctor, patients may have different needs or reactions to medication that the nurses need to be aware of in order to administer the appropriate medication. Another particularly important category is information regarding treatment (see also Table 12 in section 7.3), specifically informing patients on how to take their medication correctly. As can be seen in the table below, nurses may need to interact with one another while administering medication, but interaction with patients is almost always present.

Table 7. Administering medication

Administering medication
Briefing (Nurse-Nurse)
Whether or not medication was administered at a given time
Informing other nurses about change in prescription
The method for administering certain prescriptions
Nurses asking each other for help:
To assist in administering medication through a drip or injection
To determine the correct dosage
To assist patient (cleaning patient, helping patient to the bathroom) while administering medication
Dosage of medication to be administered

Frequency of administering medication
Requesting a prescription from the doctor
Requesting a change or continuation of a prescription by the doctor
Treatment information (See Table 12.) (Nurse-Patient)
Type of medication being administered
Purpose of medication
Possible side-effects
Necessity of reporting side-effects so that these can be treated if necessary
Change in prescription
Completion of prescription
Discontinuation of prescription
Directing patients (Nurse-Patient)
Directing patients on moving into correct position for administration (sitting up, rolling over, raising arm, etc.)
Drinking enough fluids with oral medication
Reporting any side-effects
To finish eating before taking oral medication
Checking with patient (Nurse-Patient)
Whether patient is experiencing side-effects of medication that needs treatment
Whether patient is experiencing any other ailments that need treatment
Whether oral medication has been swallowed
Whether medication takes effect
Whether certain medication has been administered at a given time (ensuring dangerous over-medication does not occur)
General condition and well-being
Patient questions, requests and complaints (Nurse-Patient)
Complaints about side-effects of treatment
Complaints about other pain, nausea, constipation or diarrhoea
Requests for assistance (going to the bathroom, bathing, drinking water, phoning family, etc.)
Questions about purpose of aspects of treatment
Questions about various aspects of medication
Pervasive (See Table 10.)

6.5. Admission

Although various administrative activities are performed with regards to admission, which will necessarily include interaction between nurses, doctors and administrative staff, the majority of the interactions in this category pertain to the process of actually admitting the patient to the ward. The process of

admitting patients is based on a standardised form, which may differ somewhat from hospital to hospital, is used to elicit the necessary information from patients as can be seen in the categories in Table 8 below. The nursing staff member admitting the patient, often assisted by another nursing staff member, also needs to take each patient's vital signs and record these on the admission document. There is therefore communicative interaction between the nurse and patient, as well as between the nurses themselves. A certain degree of tact and sensitivity is necessary when asking questions that may be of an embarrassing nature. The type of information elicited is usually standard, as stated above, but under certain circumstances such as an emergency admission, more specific information may need to be elicited from the patient or a family member or friend accompanying the patient. In such a case, for instance, the doctor may also be present and may be giving orders concerning the care and treatment of the patient, some of which need to be carried out while the patient is being admitted. This is not a frequent occurrence, however, as patients in such a condition will be admitted through the emergency ward where they are first stabilised before being admitted to a ward. Such admissions will therefore not be reported on here.

Table 8. Admission

Admission
Administration (Nurse-Doctor-Administrative Staff)
Patient must be sent to correct unit to open a patient file before being admitted to the ward
Nurses, doctors and administration personnel check with each other whether admission schedule is correct
Nurses request all necessary documents from administration personnel
Briefing (Nurse-Nurse-Matron)
Nurses discuss new patient's condition
Taking vital signs (Nurse-Nurse-Patient)
Directing patients on how to cooperate with nurse taking vital signs (open mouth and put thermometer under the tongue to measure temperature)
Nurse asking other nurse to assist him/her by taking vital signs while he/she asks patient the admission questions and fills out the paperwork
Nurse communicating the vital signs measurements to the nurse filling out the

paperwork
Questions based on documents (Nurse-Patient)
Personal details
Initials and surname
Date of birth
Medication
Names of medication (prescription and non-prescription) patient uses at home
Use of sleeping tablets
Frequency
Dosage
Which medication the patient has taken that day
Allergies
Test, procedures and operations
Previous procedures or operations
Informing patient of tests, procedures or operations to be done while admitted
Dietary requirements
Diabetic
Allergies
Special needs (soft foods because patient does not have many teeth, formula for baby, etc.)
Assessment of condition
Problems with urination
Problems with bowel movements - diarrhoea or constipation
Nausea
Pain - locality and degree of pain
Sleeping problems
Hypertension
Any other health problems
*Socio-economic status**
Size of house patient lives in (number of rooms) and number of residents
Access to water and electricity
Reason for (re)admission
Treatment
Diagnosis
Pervasive (See Table 10.)
Ward layout and rules

*Not required by all hospitals.

6.6. Discharge

As with admission, when patients are discharged a certain procedure needs to be followed based on standardised forms. Specific information needs to be communicated to the patient to ensure that the patient continues to adhere to the treatment while at home, and communication thus occurs between nurse and patient. If the patient does not continue with the treatment at home, the treatment may not be completely successful, which in turn could lead to health complications and even re-admittance to hospital. Patients thus need to be informed about the details of their treatment to ensure adherence. In cases where the patient is a child or an elderly person, important information regarding treatment and care will be communicated to a family member responsible for the patient.

Table 9. Discharge

Discharge
Problems that could lead to re-admission (Nurse-Patient)
Social
Familial
Financial
Treatment (Nurse-Patient)
Treatment information (See Table 12.)
The importance of completing treatment
Hygiene
Medication still to be taken today after discharge
Administration (Nurse-Patient)
Check-up date
Doctor to see for check-up
Paperwork
Transport document
Discharge letter
Document with details for check-up
Pervasive (See Table 10.)

7. Multiple-category interactions

As stated above, the interactions in this section can be observed in any of the categories of activity-based interaction reported on above in the section 6. However, these interactions are general only in so far as they are common to all the above categories rather than being tied to a specific activity. They do seem to be just as imperative to the effective treatment and care of patients as the activity-based interactions. It needs to be said, though, that some of the categories below seem to be more prevalent in certain activities than others, with the exception of the first section (7.1). Also, the interactions in the sections below tend to follow the activities that give rise to the sections above rather than necessarily be part of those interactions. These general categories and their typologies are discussed below.

7.1. Pervasive

This category may consist of a wide variety of interactions that range from personal talk with the patient to dealing with patient complaints. The term assigned to the category is intended to indicate that the interactions it contains are diffused through most of the others, and that their ubiquity is such that they may occur anywhere. These interactions can take place in any of the activity-based interaction categories discussed above (section 7.1) and may occur between nursing staff, patients, doctors and other staff members. The most prevalent types of interaction are those within the category of Pervasive interaction (see Table 10 below) which includes personal talk, socialising and humour, which all occur frequently throughout each shift and across all the activity-based interactions. However, the prevalence of these types of interactions can be dependent on a wide variety of factors such as the mood of nurses, the time of day, the patient's personality, language and culture, as well as the atmosphere that the matron or operational unit manager creates. Interaction in the table below can occur between nurse and patient, nurse and nurse, as well as nurse and doctor. The importance of or need for these types of interactions,

specifically small talk, was of particular interest and was included in the questions asked during the interviews with the nurses, which will be discussed later in a later chapter (Chapter 8).

Table 10. Pervasive

Pervasive
General interaction (Nurse-Matron-Patient-Doctor-Administrative Staff-Family Members)
Small talk
Socialising
Greetings
Introductions
Taking leave
Humour (joking or teasing)
Patient concerns, complaints or questions (Nurse-Nurse-Matron-Patient)
Reassuring worried/anxious/frustrated patients
Pain or discomfort
Side effects of medication
Medication
Treatment
Other patients
Other nurses
Checking on patient (Nurse-Patient)
Pain or discomfort
Improvement or deterioration after procedure or operation
Psychological or emotional condition
Physical condition
Nurse as mediator (Nurse-Matron-Doctor-Patient-Family Members)
Between patient and doctor
Between patient and family members
Between doctors

7.2. Administration

These interactions relate to administrative activities such as organising various activities. For instance, a nurse will need to arrange for patients to move to a different room/ward, call a porter to take patients for procedures or tests, or telephone a patient to confirm that they will be admitted on a given date for a

procedure. These activities are necessary for the effective and timeous treatment and care of patients. Nurses will thus have interactions with one another, the doctors, administrative staff and porters.

Table 11. Administration

Administration
Medication (Nurse-Nurse-Matron-Administrative Staff)
Details of prescription
Ordering medication
Directions to bed, room or ward (Nurse-Porters-Visitors)
Porters fetching or returning patients
Patient visitors
Patient whereabouts (Nurse-Administrative Staff-Porters)
Patients leaving the ward for test, procedure, operation, to smoke, etc.
Ordering or handing out supplies (Nurse-Nurse-Administrative Staff)
Medication
Linen
Equipment
Logistical arrangements (Nurse-Nurse-Matron-Doctor-Administrative Staff)
Documentation
Means of moving patient (walking, in wheelchair, on bed)
Theatre schedule
Arranging with another department to perform test, procedure or operation
Arranging a porter to fetch and/or return patient from another ward or department (for treatment, administration, etc.)
Obtaining consent from patient for a test, procedure or operation
Arranging transport for a patient to be transferred to another hospital or taken home
Moving patients to different beds and/or rooms
Admission (documents, bed, linen, etc.)
Discharge (documents, transport, medication, etc.)
Arranging with another ward or hospital for patient to be transferred
Admission (Nurse-Nurse-Matron-Doctors-Administrative Staff)
Documentation
Room, bed and linen
Date scheduled for re-admission for test, procedure or operation
Identity bands for patients
Discharge (Nurse-Nurse-Matron-Doctor-Administrative Staff)
Documentation
Discharge date

Arranging transportation
Shift schedule (Nurse-Nurse-Matron-Administrative Staff)
Changes in schedule
Swopping shifts

7.3. Treatment information

This entails giving the patients the necessary information related to taking specific medication or undergoing a specific test, procedure or operation that the patient must be aware of and cooperate with to ensure the treatment works correctly. Much of this information will be communicated to the patient by the doctor or sometimes the matron or operational unit manager. However, if the patient is unsure about some aspect of the treatment, he/she will often ask a nurse to give them more information or clarify some aspect of the information for them. The information listed in Table 12 below can be included in any of the activity-based interactions discussed in section 6. However, the information in the table below is a standard part of activities such as doctor rounds (section 6.3), administering medication (section 6.4) and discharge (section 6.6), or as part of the process of obtaining informed consent from a patient for a test, procedure or operation.

Table 12. Treatment information

Treatment information
Dietary requirements (Nurse-Patient)
Patient's lack of appetite as side-effect of treatment or due to illness
Reason why a patient cannot eat certain foods
Reason for n/m
General treatment information (Nurse-Patient)
To get enough rest
Purpose of treatment
Reason for selecting that type of treatment
Treatment procedure
Duration and frequency of treatment
Tests, procedures and operations (Nurse-Patient)
Necessity of and reason for test, procedure or operation

Procedure for completing the test, procedure or operation
Medication (Nurse-Patient)
Type of medication
Purpose of medication
Possible side-effects
Necessity of reporting side-effects so that these can be treated if necessary
Method for taking medication (dosage, frequency, drinking enough water, etc.)
Safety (avoiding over-dosage, taking medication with meals, etc.)
Wounds (Nurse-Patient)
Reason for proper wound care
Correct method for cleaning, binding and protecting wound
Materials needed for wound care
Drip (Nurse-Patient)
Purpose of drip
Mobility
Safety (preventing blockages in the line or removing the needle accidently)
Mobility (Nurse-Patient)
Necessity of increased or decreased mobility
Reason for increasing or decreasing mobility
Catheter (Nurse-Patient)
Reason for inserting catheter
Mobility
Importance of keeping catheter bag at lower level than patient

7.4. Briefing

This was evident to varying degrees in different wards depending on the organisational structure and size of individual wards and hospitals, and occurs mainly between the nursing staff. Briefing between nurses and doctors usually occurs during official and unofficial doctor's rounds as reported above in section 6.3. Briefing can occur at any point during the shift and the nursing staff will inform other nursing staff members about a range of information with regards to patients that the other staff will need to know. This includes information such as a complaint the patient has and how the nurse has addressed it, or keeping other staff updated on the whereabouts of a patient who has left the ward for reasons as diverse as going for an operation or smoking in a designated area. Briefing is particularly common during shift handover (section 6.1), but will also occur

while, or after, performing the activities in the other categories (section 6.2 – 6.6). The nursing staff do not communicate information about everything they do or communicate with patients, but rather only such information as they deem necessary, particularly their concerns and problems with patients. The purpose of briefing is to share their concerns about patients with each other and to seek advice in dealing with patients. Thus, some information will primarily be shared with senior members of the nursing staff. On the other hand, nursing staff and auxiliary nurses are either still in training or do not have as extensive medical training as the nurses higher up in the hierarchy and will therefore ask the nurses and sisters many questions about treatment and care that they are unsure of.

Table 13. Briefing

Briefing
Treatment (Nurse-Nurse-Matron-Doctor)
Concerns about patient's symptoms
Medication (type, dosage, frequency of administering medication, method, etc.)
Patient medication on reaction to medication
Referring patient to another hospital for treatment
Correct way to administer medication
Whether to request that the doctor adjust treatment
A patient's pain levels
Effectiveness of the doctor's pain management strategy for a specific patient
Patient complaints, questions or concerns
Assisting one another with treatment
A patient's general physical condition
Doctor's instructions (See Table 6) (Nurse-Nurse-Matron-Doctor)
Tests, procedures and operations
Diagnosis
Treatment
Medication
Care of wounds
Mobility
Drip
Giving medical information to patient
Discharge
Contacting another doctor regarding treatment, a test, procedure, operation, or about a second opinion

Tests, procedures and operations (Nurse-Nurse-Matron-Doctor)
Whether they should suggest a test, procedure or operation to the doctor
Patient's condition when returning from a test, procedure or operation
Problems with gaining consent for a test, procedure or operation
Whether the patient was under local or general anaesthesia
A patient's unusual reaction to anaesthesia that other nurses should be aware of
Mobility after test, procedure or operation
Patient condition (Nurse-Nurse-Matron-Doctor)
No or little reaction to medication, and whether to increase dosage of medication
Patient's condition deteriorating
Patient's condition improving
Slow/quick recovery from disease or after procedure or operation
Unusual symptoms that do not fit with the diagnosis
Condition of wound (improvement or deterioration)
Patient behaviour and psychological problems (Nurse-Nurse-Matron-Doctor)
A patient who seems to be depressed
Whether to request that the family visit the patient (either because the patient is depressed or because the patient is terminally ill)
Effectiveness of depression medication
Patient's abnormal behaviour
A patient's stress causing spikes in vital signs readings
End of life care (Nurse-Nurse-Matron-Doctor)
"Tender Loving Care" (TLC)
Contacting the patient's family
Patient suffering from depression
Requesting that a counsellor or psychologist see patient
Medical information (Nurse-Nurse-Matron-Doctor)
Whether medical information was given to patient (before test, procedure, operation, discharge or when administering medication)
A patient's questions regarding medical information
Admission (Nurse-Nurse-Matron-Doctor)
When patient to be admitted will arrive
Which nurse will admit the patient
Bed and room that new patient will occupy
Discharge (Nurse-Nurse-Matron-Doctor)
When patient will be discharged
Worrying symptoms or condition of patient to be discharged
Removal of catheter or drip
Medication to be handed to patient at discharge
Which nurse will discharge a patient
Dietary requirements (Nurse-Nurse-Matron-Doctor)
The dietician's proposal regarding the dietary requirements of a patient with

specific health problems
Method to feed a patient with difficulty eating due to medical reasons
Patients who are n/m and from what time onwards
Administration (Nurse-Nurse-Matron-Doctor)
Accounting for supplies (medication, linen, documents, etc.)
Moving a patient to a different room or ward
Transferring a patient to another hospital
Completing documentation before a patient is discharged
Whereabouts of patients
Supplies (Nurse-Nurse-Matron-Doctor)
Where supplies are stored
Which medical supplies were given to a patient
Whether new supplies need to be ordered
Problems with shortage of some supplies

8. Conclusion

These categories of interactions, together with the activity-specific interactions listed earlier, allows for categorisation of the communicative interactions that appear to be both common and crucial to nursing practice as encountered during observations. Based on the interactions observation and the typology that derives from it, interviews were conducted, reported on in Chapter 8, with a number of nurses in order to determine the importance of or to identify the problems associated with these types of interactions.

The observation phase of the field work for this research project thus allowed for the initial inventory of communicative nurse interactions to be modified quite extensively. As seen in the various sections above, the data from the observations gave rise to a typology of communicative interactions for nurses which is rather more comprehensive than the two categories of Personal and Emotional Patient Care, and Diagnosis and Treatment initially identified in Chapter 4. This typology of interactions above lists the topics nurses discuss and deal with on a daily basis as part of their routine activities. A more detailed discussion of the communicative functions common to the various categories in

the typology follows in Chapter 6. Doing so is necessary in designing a *NoM* course that can facilitate the learning of strategic interaction.

Chapter 6 Observations: Communicative functions

1. Introduction

The typology of communicative nurse interactions as listed in the previous chapter (Chapter 5) provides us with a refined typology of communicative situations that nurses encounter on a daily basis during the various activities they engage with while performing their duties. This chapter will provide a more comprehensive discussion of the types of interactions, specifically focusing on their communicative functions, including the most common combinations in which the functions occur, which will provide the basis of the *Nurse on the Move* (*NoM*) syllabus. The analysis of the communicative functions will be based on the notion of speech acts and Wilkins's (1976) adaptation of that to identify categories of communicative functions that he proposes as necessary in designing a language course syllabus that focuses on developing communicative competence.

2. Speech act theory and communicative functions

Speech act theory proposes an explanation of the purpose that is fulfilled through the act of speaking. Searle (1976) proposes macro-classes of speech acts to classify the different ways in which illocutionary force works in speech (Cutting, 2008: 14,15):

- *Declarations:* "These are words and expressions that change the world by their very utterance, such as 'I bet', 'I declare', 'I resign'."
- *Representatives:* "These are acts in which the words state what the speaker believes to be the case, such as 'describing', 'claiming', 'hypothesising', 'insisting' and predicting'."
- *Commissives:* "This includes acts in which the words commit the speaker to future action, such as 'promising', 'offering', 'threatening', 'refusing', 'vowing' and 'volunteering'."
- *Directives:* "This category covers acts in which the words are aimed at making the hearer do something, such as 'commanding', 'requesting', 'inviting', 'forbidding', 'suggesting', etc."
- *Expressives:* "This last group includes acts in which the words state what the speaker feels, such as 'apologising', 'praising', 'congratulating', 'deploring' and 'regretting'."

Categorising actual speech into these categories can be problematic, however. As Searle pointed out, the first reason is that there are indirect speech acts (Cutting, 2008: 16,17). Often what we mean to say is implied rather than directly stated, where the underlying meaning differs from the apparent meaning of the actual words used, and at times the speech may even carry both direct and indirect meaning (Cutting, 2008: 17). In addition, an utterance can often also be classified into more than one of the macro-classes listed above (Cutting, 2008: 17). In other words, an utterance may be a direct expressive, while indirectly also being a commissive.

These difficulties make it necessary to consider Brown and Yule's (1983) distinction between the two main macro-functions of talk: transactional and interactional functions. Transactional functions are concerned primarily with the transfer or transmission of information (Cutting, 2008: 21). Interactional functions, on the other hand, are concerned with "expressing social relations and personal attitudes, showing solidarity, and maintaining social cohesion"

(Cutting, 2008: 21). This is an underlying problem in nurse communication, as discussed in Chapter 3 (5.3). Researchers advocate the use of patient oriented (interactional) communication as opposed to task oriented (transactional) communication (Teal & Street, 2009; Gilbert & Hayes, 2009; Hartley & Repede, 2011; Sully & Dallas, 2005; Aled, 2007). Patient centred communication tasks nurses with using the transactional function in communication to transmit information and obtain patient cooperation in treatment, while using the interactional function to achieve the former through interpersonal communication successfully. As proposed in Chapter 3, it would be useful to use the term "treatment-centred" communication to label the combination of the transactional and interactional functions that is necessary in order to achieve the successful treatment of the patient.

Another relevant aspect of speech act theory is the role of context. There are various social and cultural factors that will impact on the manner in which language is used, and which can lead to miscommunication (Cutting, 2008:111). These will be explored in the following chapter, which focuses on the short circuits in nurse communication.

In the following section we will analyse some of the functions of the speech recorded during the field work phase of this research project. Here we will analyse the actual communicative functions of the speech. This analysis will be based on the relevant categories of communicative functions as proposed by Wilkins (1976). Based on the results of the analysis of the functions present in nurses' communicative interactions, additional sub-categories are proposed. The modified framework of communicative functions then looks as follows:

- Information
    - Seeking information
    - Stating information or informing
    - Explaining
    - Describing
    - Reporting

    - Checking
- Agreement, disagreement and concession
- Suasion
    - Inducement: Suggesting, advising and recommending
        - Compulsion
        - Instructing
        - Directing
- Emotional relations
    - Greeting and introduction
    - Sympathy: Comfort and reassurance
    - Chatting and socialising
    - Humour

These categories are similar to Searle's macro-classes. However, each of these categories can be further divided into sub-categories which allow for an even more detailed breakdown of the functions of communication than Searle's macro-classes. Wilkins's (1976) categories of functions lend themselves to the purposes of this study more appropriately than any other categorisation and will be used to analyse examples of nurse interactions.

The functional communication categories which seem to feature most prominently in nursing communication are *Argument, Suasion, Personal Emotions* and *Emotional Relations.* The first two categories are primarily transactional. The relevant sub-categories under *Argument* consist of Information being Asserted, Sought and Denied, as well as Agreement, Disagreement and Concession. Under *Suasion*, the sub-categories of Inducement, Compulsion, Prediction and Tolerance will be discussed. On the other hand, the two interactional categories to be discussed are *Personal Emotions*, both Positive and Negative, and *Emotional Relations*, which consists, amongst others, of Greetings, Sympathy and Gratitude.

Analysing speech based on these categories is problematised by overlapping of the functions of speech within any length of interaction. One section of speech can often contain multiple functions, as Cutting (2008:20) points out. As Wilkins (1976: 49) also noted earlier:

> It is not to be assumed that each category of function listed here is automatically realized as a single sentence. It may be a longer stretch of language and this in turn makes it possible for one function to be contained within another.

This overlapping of functions can form patterns of typical combinations of functions that are potentially distinctive to the context of nursing communication. In the analysis below, only the functions which feature most prominently in nurse communication will therefore be discussed, as opposed to all the functions, while the most common combinations of functions, particularly interactional and transactional combinations, will also be discussed.

3. Transactional communicative functions of nurse interactions

3.1. Information

The primary function of communicative interactions in this category is to provide or offer information, to seek information by asking questions, and to check information. This occurs across all of the activity-based interaction categories presented in the typology in the previous chapter, specifically as part of shift handover, doctor rounds, administering medication, admission and discharge. The purpose of asserting and seeking information is primarily related to ensuring effective treatment, either by allowing informed decision-making or obtaining cooperation or compliance. The specific communicative functions in this category are discussed below.

3.1.1. Seeking information

Seeking information is an important part of decision making in the medical profession. For instance, communication while administering medication is focused in part on seeking information to guide decisions made about

medication and treatment. In the example below, the nurse is seeking information about whether the patient is experiencing pain in order to determine whether or not to administer additional pain medication:

(1a) N: Alright, is there not pain there?
P: [Shakes head]

Based on the patient's answer, the nurse will then not administer the additional pain medication in this instance. The nurse's utterance thus functions to seek information, while the patient's non-verbal response provides the required information.

In the second instance, the nurse is seeking information about the patient's wound to determine whether the dressing has come loose:

(2) N: Ok, that plaster there [indicates area on body], it is still there, nê?
P: [Nods]

The patient provides the information required, but nurses may in such a case also check the dressing themselves to determine the condition of the dressing and the wound, because the patient is not necessarily able to attest to its condition.

There are two differences between the two examples above and the one below. Firstly, above the responses are sometimes non-verbal and come in the form of nodding or shaking the head. In the example below, however, the patient gives verbal responses. Secondly, in the above instances, information is sought in order to inform the nurses' immediate decisions, while in the following example the information obtained is to inform future actions regarding the patient's care:

(3) N1: Het meneer enige allergie waarvan meneer weet?
(Do you have any allergies that you are aware of, sir?)
P: Hmm nee
(Hmm no)
N1: Is meneer 'n diabetiese patient?
(Are you a diabetic patient, sir?)
P: 'n Wat?
(A what?)
N1: Diabetic
(Diabetic?)

P: Nee
(No)

The interaction above takes the form of a question and response pattern where the nurse seeks information from the patient by asking questions based on the admissions document, and the patient provides verbal answers. The information that the patient provides is recorded on the admission sheet. The information recorded on this sheet guides the care and treatment of the patient for the duration of his/her stay in hospital. If the specified information is recorded as standard procedure during admissions, it may save time later on.

The purpose of and context within which the information is sought is thus important. In all three examples information is sought to guide decisions about the care of the patient, but the context varies. In the first two instances, the information is sought while the nurse is administering medication and an immediate decision and course of action are required at this point in time. With the last example, information is being sought as part of the admission process which will direct treatment and care during of the patient's stay in hospital. Thus, when a nurse is administering medication, she/he need not again seek information about whether the patient is allergic to any medication, because the information is already recorded in the patient's file.

3.1.2. Stating information or informing

In many instances, as in the three examples above, two of which exhibit non-verbal responses, as well as the following example, sharing of information is preceded by the seeking of information. The response to the question will determine what type of information is shared:

(4) N: Alright, what did doctor say today, are you going home today?
P: [Inaudible]
N: Oh, he didn't come yet. Alright, we'll just phone him and find out where he is.

Firstly the nurse seeks information, which the patient provides. Based on the patient's response, which is inaudible on the recording but could be inferred

from the nurse's response, the nurse informs the patient what will happen since the doctor has not yet been to see the patient that morning. Here, a decision needs to be made about the date of discharge, and therefore she will contact the doctor to find out when he will be in to evaluate the patient's condition and decide on a discharge date. These first two functions often occur in combination, because information is sought in question format and an answer is provided, which in itself can function as stating information. Based on the response, further information is shared.

In other instances, the purpose of informing is to provide the patient with the information they need. In the following example, the nurse asks the patient whether the doctor has been in to have a look at her wound. The nurse then asks to look at the wound as well:

(5) N: Ok, ek is baie nuuskierig, ek wil sien hoe lyk hy. Laat ek sien waarmee ons nou hier te doene het. [Positions patient so that she can look at the wound] [...] Daar's hy. [Pause while nurse inspects wound] Ok, hy't so paar plekkies oopgetrek, nê. Nee wat, ons gaan hom gou-gou op-'fix', hoor? Ons gaan hom gou gou op-'fix'. [...]
(Ok, I am very curious, I want to see how it looks. Let me see what we are dealing with here. [Positions patient so that she can look at the wound] [...] There we go. [Pause while nurse inspects wound] Ok, it has opened up in a few places. We will fix it up quickly, ok? We will fix it up quickly. [...])

Thus, following her inspection of the wound, she informs the patient about the condition of the wound, stating that the wound has opened up in places, but that it is not a major problem. Keeping the patient thus informed will potentially put the patient's mind at ease.

3.1.3. Reporting

While stating information usually occurs in response to information being sought or to inform a party of something, reporting occurs when doctors and nurses provide one another with information about an event or occurrence, often without it being sought. This communicative function will be called reporting here. Reporting also differs from the function of informing in that informing is

usually associated with or anticipated future events, while reporting pertains to past events. Reporting also usually occurs when one party feels the other needs to know specific information about an event or incident that occurred which will influence decisions made about the patient's care and treatment. When a nurse, for instance, informs a doctor of specific information relating to the patient without it being requested, it usually functions to report an incident or change in condition. For instance, in the example below the nurse informs the doctor about the patient's condition upon his request for information, but then proceeds to report further information that he has not specifically asked for, but is relevant:

(6) D: [Addressing N] When did the bleeding start?
N: She's been bleeding since the, uh, ------ and catheter were removed but it wasn't that bad//
D: //Ok
N: //We kept on checking. And so far she didn't pass urine yet, but now she told me she's started to see clots. [...]

Here the nurse reports the patient's condition to the doctor which could potentially influence his decision making about how to further treat the wound or the problem with her inability to urinate. Depending on the exact circumstances surrounding the course of treatment decided on by the doctor and the patient's reactions to treatment, the information offered could also perhaps be an explanation from the nurse's side about why certain actions by the nurses were, or were not, taken. On the other hand it could be that she is reporting information which confirms that the doctor is taking the correct action, or perhaps it could be a subtle way for the nurse to express her disagreement with the doctor's course of action. The reasons for reporting this information can thus vary.

Sometimes the patient will be the one to report something to the nurse or doctor in order to express a concern they have:

(7a) P: [...] ek het nou nog nie vandag medisyne gekry nie..., ek moet mos vandag nog medisyne kry, van—vandag se medisyne.
([...] I haven't yet been given my medication today..., I am supposed to still get medication today, to-today's medication.)

Here the patient reports to the nurse that her medication has not yet been administered, which signals her concern that the nurse responsible for administration of medication has missed her. In response to this report, the nurse checks the patient's medication chart as well as with the nurse administering medication.

3.1.4. Explaining

In many instances it is not enough only to provide others with information, regardless of whether it functions to inform or report. Often it is necessary to explain the details and implications of that information to them. While informing or stating information is about letting a party know about the future occurrence of an event, such as that a procedure will be performed for example, explaining is about providing the details about the when, how, why or other relevant information surrounding the event or occurrence.

Staying with example 5 above, the nurse continues the interaction with the patient by explaining some of the problems and solutions associated with her particular condition (being diabetic) in relation to caring for her wound:

(8a) N: [...] Oraait, want ek's seker daar's, uh, sister ------[2] het al reeds die, die Stoma sister, hy's nou die expert wat wonde aanbetref, dat hulle vir ons kom raad gee vir presies die regte ding wat ons op daai wond moet sit, jy weet
(Ok, because I'm sure there's, uh, sister ------ has already called the, the Stoma sister, he's the expert concerning wounds, that they come to give us advice on what exactly is the right thing to put on that wound, you know)
[...]
N: Ja, kyk ons moet hom mos bietjie van binne af ook help, ons kan hom nie aan die buitekant pamperlang nie, ons moet maar binnekant ook bietjie, antibiotika gaan dit net help om vinniger gesond word
(Yes, look we have to help it from the inside as well, we can't just pamper it from the outside, we have to also from the inside, antibiotics will just help it to heal faster)

[2] Names of people, places and specialised medical devices, procedures or operations have been removed to protect patient anonymity and privacy.

P: O, want sy sê dis maar deel van die suiker wat dit doen//
(Oh, because she says it's part of what the sugar does)
N: Diabetes doen dit
(Diabetes does this)
P: Want hierdie kant is baie mooi
(Because this side looks very good)
N: Ja, ja
(Yes, yes)
P: Dis nou net hierdie kant//
(Now it's just this side)//
N: Dis ongelukig nou maar een ding van as mens suikersiekte het, mens se wonde word swaar gesond, maar hulle word gesond. Ons sal hom wen, hoor? Jy moet net nie moed verloor nie.
(That's unfortunately one thing about when you have diabetes, your wounds have difficulty healing, but they do heal. We will beat it, ok? You mustn't become discouraged)

The sister thus explains to the patient that the Stoma sister will advise them on how to best treat the wound, also explaining what a Stoma sister is. Following the patient's further expression of concern, the sister explains that they need to treat the wound both from the inside and outside. She also confirms for the patient that diabetes does complicate the healing process, but informs her that they can and will treat it.

In the next instance, the nurse provides the patient with medical education, which is extremely important. She explains what type of medication she is administering:

(9a) N: Ok, dis die spuitjie wat die bloed moet dun hou, nê? Omdat jy nog nie so mooi rond loop nie nê? Oraait? Ek gaan vir hom stadig spuit sodat hy nie vir jou seer maak nie, nê.
(Ok, this is the injection that must keep the blood thin, ok? Because you are not walking around so much yet? Ok? I am going to inject it slowly so that it does not hurt you, ok.)

Similarly, in the next example, the nurse not only informs the patient that a catheter has been inserted, but also briefly explains why:

(10) N1: [...] That's it, you've got your catheter in again, so the urine will come out through the catheter. [...]

Given the context within which this interaction occurred, it would be clear to the patient that the catheter was necessary as she was not mobile enough after the

operation to use the bathroom herself. The nurse thus explains that the catheter is there to take care of that problem for her. Two turns later, the nurse further states:

(11) N1: [...] [Looks at catheter bag] You see the bladder was already quite full, that probably why it was also uncomfortable.
P: [Inaudible]
N: You see, usually it's still swollen after the operation and then it blocks... then the urine cannot come out.

Here the nurse provides the patient with further clarifying information about her condition, explaining why she has been experiencing some discomfort besides the pain of the wound. The patient's response is inaudible so it is unclear whether she merely expresses that she understands or asks another question, but the nurse then explains why the patient is unable to urinate after the operation and by implication why a catheter is necessary. In this way, without the patient necessarily having to ask specific questions, the nurse provides the patient with the relevant information to put the patient's mind at ease about her condition.

3.1.5. Describing

Describing may also be necessary when simply informing, reporting or explaining is not enough. It provides the patient with even more detailed information specifically necessary to obtain a patient's cooperation. For example, a patient may be informed that upon discharge they must continue to take their antibiotics twice a day while pain medication can be taken every four hours. If the patient has difficulty remembering the names of the medication and therefore is unable to recognise the difference between the two types of medication, which both come in pill form, the nurse may resort to describing the colour of the respective pills to help the patient differentiate between the two. As will also be seen in this example, as well as the two below, in nursing communication participants often have to rely on their ability to explain their sensory perception to provide information. This communicative function thus differs from informing or explaining, but rather functions to describe.

For example, while administering medication, a nurse may not only inform the patient that medication will be administered and explain what it is for, but also describe to the patient what he/she can expect:

(9b) N: Is jy gereed vir hom? Huh? Hy brand mos so bietjietjies, maar nie te erg nie, nê?
(Are you ready for it? Huh? Remember, it burns a little bit, but not too much, hey?)
P: [Nods] [Inaudible]
N: Ok [Injects P]

Following is a longer sequence of interactions, where the nurse is seeking information about the patient's wound to ascertain the condition of the wound and whether further steps need to be taken to treat it. The patient thus attempts to describe the discomfort she faces from the wound while the nurse provides prompts to help the patient express herself:

(12) M: Hoe voel dit, is daai wond seer?
(How does it feel, does that wound hurt?)
P: Nee, weet jy, hy't plekkies wat hy...
(No, you know, there are places that it...)
N: Wat hy gevoelig is?
(That it's sensitive?)
P: Ja
(Yes)
N: Gewoonlik is hulle nie rerig seer nie.
(Usually they don't really hurt much)
P: Nee, nee, weet jy soos ek se, as ek moet ... dan pyn hy...
(No, no, you know, like I said, if I have to... then it hurts...)
N: Is dit?
(Is that so?)
P: Ja, dit voel partykeer asof dit bietjie brand...
(Yes, sometimes it feels as if it burns a little bit...)
N: Mmm?
P: ...en dan, bietjie jeukerig
(...and then, a bit itchy)
N: ...bietjie jeukerig is. Ok. [...]
(...a bit itchy. Ok. [...])

Based on the patient's description of the type of pain she experiences with the wound the nurse does not seem too concerned that it is a problem, and in the last turn the nurse provides the patient with information about what the next step will be in treating the wound. In the above example, some of the nurse's utterances

are examples of the function of checking, which will be discussed below (section 3.1.6).

3.1.6. Checking

Checking is prominent in nursing communication and is particularly frequent in the category of nurse briefing (see Chapter 5, Table 13). However, it was also observed in varying degrees across all of the other categories in the typology of nurse communication. Checking occurs when information has been communicated, for example, and a nurse, doctor or patient requests clarification or confirmation of some part. In the first instance below, the nurse firstly seeks information about whether or not the patient is experiencing pain, and then further checks it to confirm that she heard the right answer:

(1b) N: Alright, is there not pain there?
P: [Shakes head]
N: Ok, nothing?
P: [Nods]

The purpose of checking here is to ensure that the nurse has understood the patient correctly and will therefore make a decision based on correct information.

Another example where checking functions to seek confirmation is:

(13) N1: Um, is this the ------ that you wanted to use?//
D: //Yes, that's the one. And will you just get me ---- and jelly
N1: Is, uh, K-Y jelly alright?
D: Yes, that's fine

In this example, the nurse checks in order to confirm with the doctor that she has prepared the correct plug and an acceptable type of lubricant for the procedure. In many cases adequate prior checking can eliminate problems and wasting time later in finding the correct devices and lubricant in the middle of the procedure.

In example 9a from section 3.1.4 above, where the nurse describes to the patient what he/she can expect when the medication is administered through injection, the first half of the utterance by the nurse also checks whether the patient is

ready for her to administer medication. This is necessary because, as the nurse then explains, she can expect a burning sensation:

(9b) N: Is jy gereed vir hom? Huh? Hy brand mos so bietjietjies, maar nie te erg nie, nê?
(Are you ready for it? Huh? Remember, it burns a little bit, but not too much, hey?)
P: [Nods] [Inaudible]
N: Ok [Injects P]

The patient nods assent but her spoken response is inaudible, and it is unclear whether the patient is agreeing that she is ready or that she knows that the injection will burn, or both. However, the nurse acknowledges the patient's response and proceeds to inject the patient, so perhaps we can assume that she understood the patient's response to be that she understood that she is aware that the injection will cause a burning sensation and is therefore ready to be injected. In this case, the nurse combines checking whether the patient is ready for medication to be administered with an explanation of what the patient can be expected to ensure that the patient is prepared for the treatment to be administered.

The nurse also responds to the patient's concern in Example 7a above by doing some checking:

(7b) P: [...] ek het nou nog nie vandag medisyne gekry nie..., ek moet mos vandag nog
medisyne kry, van—vandag se medisyne.
([...] I haven't yet been given my medication today..., I am supposed to still get medication today, to-today's medication.)
N: Het hulle nie gegee nie?
(Did they not give it?)
P: Nee.
(No.)
N: [Nurse checks charts] Nee wat, daar is niks vir vandag opgeskryf nie. Kyk, mevrou vra mos soos jy pyn het
(No, nothing is written down for today. Look, you ask for it when you experience pain)
P: Nee, ek moet, uh, um, 'n gereelde... 'n gereelde botteltjie...
(No, I must get a, uh, um, regular... a regular bottle of...
N: [Nurse checks charts again] Laat ek net by hulle hoor.
([Nurse checks charts again] Let me just check with them.)

The nurse thus firstly checks the charts where the administration of medication must be meticulously recorded. When the patient is, however, adamant that she is supposed to receive medication, contrary to the information on the charts, the nurse decides to be on the safe side by checking with the nurse administering medication. There are thus again a number of communicative functions occurring in this sequence of utterances. The patient reports that she has not received medication yet, the nurse then checks to ensure she understands the patient correctly. She then checks the medication chart in the patient's file and informs and explains to the patient that she is not on any chronic medication and only receives pain medication as required. When the patient insists that she does receive daily medication but is unable to describe what it is, the nurse decides to check with another nurse and informs the patient that she will do so.

Here is another good example where nurses check with one another about administering medication:

(14) N1: Moet ons maar 'n --------- op haar sit?
(Should we put up a --------- for her?)
N2: Hmm, sit maar.
(Hmm, put it up.)
N3: By bed 11? Ek het al.
(At bed 11? I already have.)
N1: Oh, jy't klaar?
(Oh, you already have?)
N3: Klaar.
(Already have.)

One nurse checks with the sister in charge whether she should proceed with a specific type of treatment for a patient. Another sister also present at the time checks which patient they are talking about and then informs her that she has already performed the specified treatment. The first nurse then checks to make sure that she has understood correctly that the sister has already performed the treatment, and the sister provides confirmation. Such checking can also be important in eliminating the incorrect administration of medication and can also prevent nurses from wasting time.

3.2. Agreement, disagreement and concession

These three sub-categories are being discussed together, as actual communicative interactions will often consist of a combination of these three rather than in isolation. In this first example, two nurses are discussing a patient's puzzling condition and speculating about a possible diagnosis. Although not a serious disagreement, they do disagree to some degree on what could be the cause of the patient's pain:

(15) N1: Ek wonder wat wys haar X-strale?
(I wonder what the X-rays show?)
N2: Het hulle buik X-strale ook gedoen?
(Did they take abdominal X-rays as well?)
N1: Mmm. Ek wonder of sy nie maar êrens infeksie het nie...
(Mmm. I wonder if she doesn't have infection somewhere..)
N2: Ja, heel moontlik
(Yes, quite possibly)
N1: ------- of 'n ding, maar dan ------- gaan nie vir jou borskaspyn gee nie//
(------- or something, but then ------- doesn't give you chest pain//)
N2: //Mmm, ja//
(//Mmm, yes//)
N1: //hy gee lae rugpyn en hier by die boude
(//it causes pain in your lower back and here by the buttocks)

Above the nurses discuss the different options that could explain the patient's condition. As they are not responsible for making a diagnosis, it is not a serious discussion, but rather speculation based on their past experience. The second nurse agrees with the first nurse that the pain could be caused by an infection. Then the first nurse suggests another condition that could lead to the patient's symptoms, but ends up disagreeing with her own diagnosis, and the second nurse agrees with her final conclusion.

In the following example, the nurses and doctor are also discussing a patient's condition that the doctor is having trouble diagnosing. At first glance the communication functions to inform one another of their concerns about a patient's condition, but one can also find examples of agreeing and disagreeing:

(16) D: Sy begin te stress, dan raak haar lippe so blou, en dan sit sy daar, en dan is

haar stats --
(She begins to stress, then her lips turn blue, an then she sits there, and then her stats are --)

N1: Nou dink jy dis rerig n kardiologie probleem?
(So do you really think it's a cardiology problem?)

D: Wel, ek dink die panic attacks trigger dit
(Well, I think the panic attacks trigger it)

N1: Ja
(Yes)

D: Maar van panic raak jy nie sommer... jy clutch nie uit van dit nie
(But panic doesn't cause you to just... you don't just clutch out because of it)

N1: Mmm

N2: En haar haar pols is sommer [Inaudible]
(And then her pulse is [Inaudible])

D: Dis nie asof sy vinnig asemhaal wanneer dit gebeur nie, sy sit daar met hierdie blou lippe
(It's not as if she breathes quickly when it happens, she just sits there with these blue lips)

N2: Hmm

N1: Jinne, dis 'n snaakse besigheid
(Man, this is a funny business)

N2: Hmm... en dan sweet haar handpalms en dan...
(Hmm... and then the palms of her hands sweat and then...)

N1: Mmm, sy was yskoud en papnat gewees toe ek haar gister kry
(Mmm, she was ice cold and drenched with sweat when I found her yesterday)

N2: En sy sê, sy sê nou vir ons as sy haar maar kom kry dan lê sy op die vloer dan weet sy nie hoe sy daar gekom het nie
(And she says, she tells us now that when she comes to again, then she's lying on the floor and she doesn't know how she got there)

Here the nurses agree with the doctor on the patient's strange symptoms, and even provide examples from their own experience and interaction with the patient that corroborate the doctor's opinion. The function of agreeing with the doctor and supporting her claims is not necessarily aimed at making a diagnosis, but simply to agree with the doctor and support her claim that this is a strange case and it is not simply a cardiology problem. That may be precisely why the first nurse asks her whether she thinks it is simply a cardiology problem, because the nurse does not agree with this idea. When the doctor then states that she thinks it is more complicated, the nurses agree and provide supporting evidence to demonstrate further that they agree with her.

3.3. Suasion

3.3.1. Inducement: Suggesting, advising and recommending

Here the purpose is to attempt to influence the behaviour or decision of another party. The three main functions in this category are giving or asking for suggestions, advice or recommendations. These three functions are so closely related that we will consider them as falling under the same heading. The first example below consists of a sister informing the doctor about a patient who claims she is diabetic and follows a particular diet as a result, but they are unsure how to treat her because no medication has been prescribed for her. Rather than directly asking the doctor for instructions (to be discussed in section 3.2.2 below) she asks for his advice and makes a suggestion:

(17a) N: Sy het nie medikasie nie, maar sy eet nou so, sy eet 'n 'diet', dis haar woorde. So ek weet nie moet ons ons vreeslik daaraan steur nie//
(She doesn't have medication, but she eats, she eats a diet, those are her words. So I don't know if we should worry about it too much...//)
D: //Nee, nee//
(//No, no//)
N: //...moet ons maar so twee of drie keer haar suiker toets//
(//...should we perhaps test her sugar two or three times//)

In this scenario, the sister was an experienced senior nursing staff member while the doctor was an intern in his first year of practicing medicine. The nurse, however, does not undermine his authority by informing him of what they should do in this situation, but rather informs him of the problem first, and then asks for his advice on whether they should bother much with the patient's claim about being diabetic. When the doctor, who is filling out paperwork at this point, simply responds by agreeing with her not to worry too much about it, she follows up with a suggestion. In this way, advising and suggesting function very similarly.

Suggestions and advice are frequently discussed during briefings between nurses. Such briefings are not official, but rather occur ad hoc during the course of performing their duties. Often nurses will discuss suggestions with one

another regarding the care and treatment of patients, which may lead to making a suggestion to the doctor later. In the case below, the nurses are discussing a suggestion they would like to make to the doctor:

(18) N2: Ek wou hom nog gevra het of ons 'n ------ in kamer een[3] kan in sit en --- kan afhaal, want sy kan nou nie rondloop nie
(I still wanted to ask him if we can put a ------ in room one and take the ----- off, because now she can't walk around)
N1: O ja
(Oh yes)
N2: Maar nou ja
(But in any case)
N1: Maar hoekom kan sy nie maar bietjie rond loop nie?
(But why can't she walk around a bit?)
N2: Dan kan ons dit vanaand weer opsit as sy slaap
(Then we can put it up again tonight when she sleeps)
N1: Mmm
N2: Ek dink so
(I think so)
N1: Anders moet jy maar weer vir huisdokter bel, of dan ons moet maar wag tot hy kom, om vir haar 'n drip op te sit
(Otherwise you should phone the house doctor, or then we have to wait until he comes, to put up a drip for her)

The second nurse informs the other nurse about a suggestion she wanted to make to the doctor, and they proceed to discuss the merits of this suggestion. The first nurse then advises her either to phone the doctor or to wait until he does rounds in the evening. The functions of advising and suggesting again overlap here, together with the function of agreeing as discussed in the section above, in the sense that one nurse is advising the other on how to follow through with a suggestion.

Advising also features specifically in the communicative category of medical education. As part of giving medical education, usually while administering medication, the nurses will advise patients to inform them if they experience any pain or side-effects:

[3] Patients are often referred to by room and/or bed number rather than by name.

(19) N: Is the pain very bad?
P: [Inaudible]
N: Ok. Otherwise if the pain is very bad you must say.

In the example above, the nurse does ask the patient if she is experiencing any pain, but advises her to inform them if she does have pain later on so that they can administer pain medication. It is important for patients to know that they have the right to do this, because some patients may be afraid to ask for pain medication and so endure the pain until someone later asks them if they have pain, which may only be a few hours later when routine medication is being administered again.

It could be argued that this type of advising is in fact an instruction (to be discussed below in section 3.3.2.1). However, it will be included here as an example of advising because the patient is not under compulsion to perform a specific action or act of communication. The conditional "if...then" sentence construction that is implied in the nurse's last utterance indicates that the action should, but does not have to, be performed under certain conditions. The nurse thus gives her the right to perform an act of communication with them under a specified condition, but the patient is under no obligation to do so if she so chooses, however unlikely.

3.3.2. Compulsion

Due to the power structures and hierarchy within which nurses work, as well as the nature of their work where successful treatment is often dependent on patient compliance and cooperation, this is an expected part of communication. This category of functions can be viewed as a stronger form of suasion than inducement. Compelling someone to perform an action quite often occurs in conjunction with the functions of informing, explaining or describing. Quite frequently, these functions do not function merely to transfer information, but actually to persuade an individual to comply with an instruction or direction.

3.3.2.1. Instructing

The communicative function of instructing is prevalent across communication in hospitals, and can occur during any number of the communicative categories from the previous chapter. It is ubiquitous in doctor rounds where the doctor gives the nurses instructions on each patient's care and treatment, but can also occur in a number of other scenarios.

During rounds with doctors, nurses have to pay particular attention to the instructions that doctors give regarding the care and treatment of their patients. In the example below, the instructions are preceded by the explanatory information about the steps being followed to diagnose the patient:

(20) D: I spoke to him yesterday as well, he first wants to make sure there wasn't any tablets that was [inaudible], so we really only putting the ointment, but I'll talk to Prof today and hear doesn't the patch test means anything and I'll talk to him tomorrow and hear, but for today lig maar die been so op, hou hom rustig, ok? *(lift the leg and keep him quiet, ok?)*

Thus the doctor informs the nurses that they are still performing tests to determine the diagnosis and that she is in contact with the specialist who could provide a definitive answer. She then instructs the nurse to keep the leg elevated and limit his mobility.

In the following example 17a continued from section 3.3.1 above, the doctor seems to follow the nurse's advice in giving instructions regarding the patient:

(17b) N: Sy het nie medikasie nie, maar sy eet nou so, sy eet 'n 'diet', dis haar woorde. So ek weet nie moet ons ons vreeslik daaraan steur nie//
(She doesn't have medication, but she eats, she eats a diet, those are her words. So I don't know if we should worry about it too much...//)
D: //Nee, nee//
(//No, no//)
N: //...moet ons maar so twee of drie keer haar suiker toets//
(//...should we perhaps test her sugar two or three times//)
D: //ek dink ons kan soos twee keer haar suiker toets en as dit normaal is dan los ons dit. Want baie van hulle kom dan sê hulle hulle is allergies vir een of ander... //

(//I think we can test her sugar about twice and if it's normal then we leave it. Because many of them come saying they are allergic to some or the other...//)

N: //En dan bestaan dit ook nie, Mmm.
(And then it also doesn't exist, Mmm.)

This is a good example of how the functions of explaining, agreeing, disagreeing, advising and instructing occur together in an interaction. The nurse firstly explains the problem to the doctor and then seems to suggest testing the patient's sugar, as she may not agree with his statement that it is not worth worrying about. In this way, the nurse seems to lead the doctor to give the instruction to test the patient's blood sugar a few times before making a decision.

Another frequent occurrence is instructions that nurses give to patients. This is most prominent during observations and the administration of medication. For example:

(21) N: Mmm, sê vir my, dan moet jy bietjie stap, en dan moet jy bietjie gaan kuier vir die mense hier in die saal nê, by jou bure bietjie kuier.
(Mmm, tell me, then you must walk around a bit, and then you must go and visit the other people here in the ward, hey, visit your neighbours a bit.)
P: Mmm...
N: Oraait, dan gaan jy elke dag bietjie beter en bietjie beter word
(Alright, then you are going to get a bit better and a bit better every day)
N: Sê vir my, drink jy baie water? Huh?
(Tell me, do you drink lots of water? Huh?)
P: [Nods]
N: Belowe? [P nods] Hmm? Baie watertjies drink, my skat, ons wil nie weer daai drip terug sit nie, hoor? Oraait.
(Promise? [P nods] Hmm? Drink lots of water, my dear, we don't want to put up that drip again, ok? Alright.)

The nurse thus instructs the patient firstly to mobilise and then explains that this will help with the healing process. She secondly seeks information about whether the patient drinks enough water and then instructs her to make sure she consumes enough liquids, explaining that if she does not do so, they may have to put up another drip. The nurse does not only instruct, but to some degree provides reasons for her instructions, which may motivate the patients to comply.

In many instances senior sisters will also give instructions to junior nursing staff members. For example, in the first instance below, two senior sisters are discussing a patient, which leads one of them to give an instruction to an auxiliary nurse:

(22) N1: Weet jy, en die ander ding is die kateter is uit en sy't nog nie urine passeer nie, as
jy nou 'n ----- in kry dan gaan sy dit nie kan doen nie.
(You know, the other thing is is that the catheter is out and she hasn't passed urine yet, if she gets a ----- put in then she won't be able to do it.)
N2: [Turning to N3] -----, ag prepare a tray for putting back catheter for ouma in bed eleven please, sommer number fourteen. Doctor is, uh, gonna put the plug back and she's not going to be able to pass urine.

As can be seen, one sister notes to another that the patient will be unable to pass urine once the doctor has performed the procedure on the patient and thus a catheter will need to be inserted first. It seems the doctor has not given instructions in this regard, but it seems that it is standard procedure to insert a catheter in such cases and thus the nurse gives the auxiliary nurse nearby the instruction to make preparations for inserting a catheter. It is also necessary to note that the sister gives specific instructions regarding which patient it is for and what type of catheter is needed. Such specifications serve to eliminate unnecessary subsequent checking.

3.3.2.2. Directing

In order to gain a patient's compliance and cooperation during care and treatment, as well as minimise discomfort and pain, it is necessary for the patient to know what is expected of him/her. For this reason, the nurses provide patients with directions on how to comply and cooperate. The function of directions could be seen as a type of instruction that deals particularly with a patient's movements and is usually accompanied by a non-verbal response, as the patient performs the physical movement in response to the direction given. For example,

(23) N: [...] Do you want to lift the buttocks so we can put on the clean plastic sheet for you, or rather just...?
N2: [Translates for P]

N2: Ok, one, two, three [lifts up patient to remove and replace sheets]
P: [Inaudible]
N: Yes, you can lay back. How is that feeling? A bit more comfortable? [...]

The nurse first seeks information about whether the patient wants them to replace the plastic sheet on her bed. Then when they lift her to replace it, she counts to three so that the patient knows exactly when to move as directed. She also directs the patient to lie back when they are done. In the end she again checks how the patient is feeling overall and whether she is comfortable. Thus, seeking information, directing and checking function in combination.

Here is another example of where directing occurs in combination with other communication functions:

(24) N1: Um, because you need some antibiotics, it doesn't look very promising. Just do a fist.

The nurse firstly informs the patient that they need to put up a drip to administer antibiotics. She then directs her to make a fist in order for her to find a vein for the drip's needle.

As can be seen from all these examples in this section, and as will be discussed in section 4 below, communicative functions rarely, if ever, are used in isolation. They are almost always used in combinations with other functions. Nevertheless, the functions that feature most prominently can be identified.

4. Interactional communicative functions of nurse interactions

4.1. Emotional relations

The communicative functions in this section are an extension of the original categories proposed by Wilkins (1976). Introductions have been added to Greetings, as they often occur together, and in the category of Sympathy, the specific functions pertinent to this study are Comfort and Reassurance. Meanwhile a new category of Chatting and Socialising has also been added.

4.1.1. Greetings and introductions

This category consists of interactions which serve as greetings, both formal and informal. This first one occurs when the nurse sees the patient for the first time that morning, while administering medication:

(25) N: Hoe gaan dit vanmôre jong?
(How are things going this morning, dear?)

The greeting is not lengthy in this case and is immediately followed by the nurse seeking information. The greeting is kept brief perhaps because the patient has been in the ward for some time and is well acquainted with the nurse. Thus the nurse does not need to introduce herself to the patient. If it were a newly admitted patient, however, the greeting might be accompanied by an introduction. Many nurses do not necessarily introduce themselves to new patients but simply get down to business after a greeting. This may be because they are acting in their professional capacity and may feel that their uniform and name tag adequately identify them to the patients. It may also be a matter of preference or time constraints.

Below is an example of a more formal greeting, specifically over the telephone, where the other participant may, for example, be a family member of a patient, a doctor or a nurse from a different ward. In this case then, the nurse offers a greeting together with an introduction:

(26) N: Morning, -------- ICU, --------- speaking, how may I help you?

The nurse thus firstly offers a greeting, followed by identifying the ward the person has reached, as well as the person who is speaking. This is not necessarily required protocol, but most nursing staff members do seem to practice it. How greetings and introductions differ across cultures may prove to be problematic in intercultural communication, which will be investigated further in chapter 8.

4.1.2. Sympathy: Comfort and reassurance

As will be seen in the examples below, in many instances of communicative interaction, the communicative function may appear to be informing or explaining at first glance, but upon consideration, it could be argued that informing or explaining actually functions to provide comfort or reassurance. This seems to warrant the current category where informing or explaining occurs not merely because it is the patient's right to know about their treatment, but actually functions to provide comfort and reassurance. What is significant in the examples in this section is that it seems informing and explaining are coupled with endearing terms used to refer to the patient, apologies for pain or discomfort, and expressions of encouragement.

In the first two examples, the nurse is trying to offer the patient some comfort during a particularly uncomfortable and potentially painful procedure:

(27) N1: Sorry, my deary. Hold steady, I know it's uncomfortable.
[...]
N1: Sorry my dear... It's in, it's in, it's all over, ok, sorry.

Here the nurse is acknowledging the patient's discomfort during the procedure and apologising for it as a means of expressing her sympathy for the patient. The function of directing her to stay still is also present as she asks her to remain still despite the pain. She also provides the patient with information about the end of the procedure so that the patient is aware that the discomfort is now at an end. In this way, the function of providing patients with information can actually take on the function of providing comfort.

The next example, from example 8a in section 3.1.4 above, illustrates the nurse explaining medical information to the patient, again functioning to reassure the patient about her condition:

(8b) N: Dis ongelukig nou maar een ding van as mens suiker siekte het, mens se wonde word swaar gesond, maar hulle word gesond. Ons sal hom wen, hoor? Jy moet net nie moed verloor nie//

(That's unfortunately one thing about when you have diabetes, your wounds have difficulty healing, but they do heal. We will beat it, ok? You mustn't become discouraged)

The nurse then assures the patient that they will be able to treat the wound successfully and tells her not to become discouraged. The main function is thus to provide the patient with reassurance.

4.1.3. Chatting and socialising

The frequency with which functions such as chatting and socialising occurs between nursing staff, doctors and patients depends on various factors. Generally it seems to be determined by the amount of time that nurses have during the course of their duties to stop and talk to others on matters not directly related to treatment or care. This will often accompany transactional communication but remain brief, depending on the amount of time nurses have. For example, a nurse who is preparing to leave at the end of her shift informs one of the patients who is quite attached to her that she is off for the following two days:

(28) N: Dit moet nou lekker goed gaan nê//
(It must go well, ok//)
P: //O
N: Ek gaan nou een uur huis toe
(I'm going home now at one o'clock)
P: O, gaan jy huis toe?
(Oh, you're going home?)
N: Dan's ek af vir twee dae
(Then I'm off for two days)
P: O, dis oraait
(Oh, that's alright)
N: Dan sien jy my eers weer Donderdag en Vrydag
(Then you'll only see me again on Thursday and Friday)
P: Nou jy bietjie gaan rus
(Now you going to rest a bit)
N: Mmm, so moenie vir ---- soek nie, hoor
(Mmm, so don't look for ----, ok)
P: [Laughter; comment to another nurse in the room] sien hoe word sy al kwaad, sy noem my mos ----
([Laughter; comment to another nurse in the room] see how angry she gets already, she just calls me ----)
N: Ek se mos sommer ----
(I just say ----)

In this instance, the patient is quite elderly and seems to have grown rather attached to this specific nurse. The nurse thus chats to her about her time off, but reassures her that she will be back later in the week. The nurse then conversationally comments to another nurse in the ward how the patient refers to her by her nickname, rather than by her title as is usually the case.

When interactional communicative functions overlap with transactional, as is seen below, the interactional will still take precedence, however. In the instance below, a nurse and patient chat while she is cleaning and dressing his wound. They are talking about the town the patient comes from, how he ended up in this hospital, and how this may have caused additional stress which caused problems with his heart. The nurse interrupts their conversation to give instructions and directions, though:

(29) N: Ok. So maybe it was, um, uh, stressful... that you were supposed to... that is why
P: Ja, maybe that is why.
N: Let's hope then you'll be fine
N: Don't bend it Ntate, just keep it straight, straight. Is it straight? [Checks the leg] Ok. I'm now going to...[Inaudible]. Actually I don't know Brits, but I can know the name.

As can be seen, she picks up their conversation again and they proceed to converse about various topics while she deals with the wound. Here, chatting may not merely be to get to know the patient but it may also function to provide a distraction. The nurse may actually be asking the patient various questions about his life to try to keep his mind off the pain or discomfort he may experience while she is dealing with his wound. Chatting and socialising between nursing staff and other staff thus function to build relationships between parties, which may lead to increased cooperation.

4.1.4. Humour

Humour appears to be quite a general feature of nursing communication. Although many may consider humour trivial or an insignificant function in

nursing communication, research points to the contrary; for example, research has indicated that humour has a social function (Coser, 1959; Emerson, 1973; Yoels & Clair, 1995), and that it helps medical personnel to cope with stress (Smith & Kleinman, 1989; Rosenberg, 1991). In their study on the use of humour in palliative care, Dean and Gregory (2005: 292) specifically found that

> Both clients and team members used humor to build relationships, contend with circumstances, and express sensibilities ... Combined with caring and sensitivity, humor is a powerful therapeutic asset in hospice/palliative care. It must neither be taken for granted nor considered trivial.

The point is thus that humour can be used for a variety of purposes that ultimately benefit the patient. In their research on the physiological benefits of exercise, Wilkins and Eisenbraun (2009) identify three explanations for the function of humour: "dealing with misfortune, making sense of rule violations, and bonding with others". In the nursing profession, humour thus appears to be an important tool in caring for and treating patients and seems to function specifically to offer relief in a stressful situation and to build relationships between patients and staff.

The first example here occurs during the admission of a patient:

(30) N1: So meneer eet normale kos?
(So you eat normal food, sir?)
P: Ja, normale kos. Dit moet net nie oud wees nie, dan gee ek dit terug vir jou.
(Yes, normal food. It must just not be old, otherwise I'll give it back to you)

The patient is joking with the nurses, perhaps to make light of a rather serious process, thus alleviating some of the accompanying stress.

In the next example, a nurse enters the patient's room to see how the procedure went. She refers to the deterioration of the patient's condition in a jocular fashion, not out of disregard for the patient, but perhaps to indicate to the patient that the problem is not overly serious and therefore something that can be made light of. She quickly follows this up with reassurance that they are addressing the problem and that they should see improvement soon.

(31) N3:[Addressing P] My dear, what's going on? We moving backwards now?

[Laughter] No, we going to fix it, tomorrow morning everything is going to be..., well again, alright?

Other personal comments also often occur in conjunction with humour:

(32) P: [Inaudible] glad you here
N3: Oh! Are you glad to see me?//
P: Mmm...
N3: Ja, then you feel safe, nê? I'm better than the doctor, nê? [Laughter]

Here the nurse checks in on the patient after a procedure. The patient's comment is an indication of the relationship that exists between the nurse and patient. The nurse also jokes that the patient is glad to see her because she does not hurt the patient the way the doctor does. This serves to lighten the mood after a rather invasive and uncomfortable procedure.

5. Common combinations of functions in interaction sequences

Now that the most common communicative functions in nursing communication as a whole have been identified and discussed, it is also necessary to indicate which of these are most common to the various categories from the typology in chapter 5, as well as the most common combinations in which they occur in interaction sequences. In the table below, the types of interactions in which the various communicative functions occur most frequently have been listed. This could provide the basis for structuring the content of a *NoM* syllabus, as communicative functions could be taught constructively in relation to the content where it may be most relevant.

Table 14. Functions common to interaction types

Communicative function	Interaction Type
Seeking information	All
Stating information/Informing	All
Reporting	Shift handover, Doctor rounds, Administration, Briefing
Explaining	All
Describing	Observation, Administering medication, Discharge, Treatment information
Checking	All

Agreement, disagreement and concession	Shift handover, Doctor rounds, Administration, Briefing
Suggesting, advising and recommending	Shift handover, Briefing, Doctor rounds
Instructing	Observations, Doctor rounds, Administering medication, Discharge, Treatment information
Directing	Observation, Doctor rounds, Administering medication, Administration
Greetings and introductions	Shift handover, Observations, Doctor rounds, Admission
Sympathy: Comfort and reassurance	Observations, Doctor rounds, Administering medication
Chatting and socialising	All
Humour	All

Furthermore, the design of a *NoM* syllabus should also be based on the how these functions most commonly occur in interaction sequences. For example, the most common combination of functions overall seems to be the question and response pattern:

(a) Seeking information
+
Stating information/Informing
} (1), (2), (3), (4), (5)

Combination (a) then forms the basis for many other combinations. Often a question and response sequence will include or be followed by a number of the other communicative functions:

(b) Combination (a)
+

Reporting	(6)
Explaining	(9a),
Describing	(9b), (12)
Checking	(9b), (13), (15)
Agreement, disagreement and concession	(16), (17)
Suggesting	(19), (20)
Instructing	(22)
Directing	(24)

As can be seen from the examples above, stating information or informing is also commonly paired with functions such as explaining. Such combinations

seem to be one of the most prevalent, even when not preceded by the seeking of information:

(c) Stating information/Informing + Explaining	(8), (9a), (10), (11)

Checking also features prominently in combination with just about every other function:

(d) Checking +	
Combination (a)	(1b)
Stating information/Informing	(4)
Reporting	(7a), (7b)
Explaining	(8), (9b)
Describing	(12), (9b)
Instructing	(13), (21)
Chatting and socialising	(28), (29)
Humour	(30), (31), (32)

Finally, the interactional functions are prevalent across all the transactional functions and the frequency and degree to which the interactional ones feature in combination with the transactional may vary. For example, the question and answer sequence is also a common pattern with the interactional functions, although the pattern does not function mainly to seek information. See examples (26) and (27), which are questions that function not primarily to seek information, but rather as a greeting. Besides the question and response pattern, a number of communicative interactions would appear to be transactional at first glance, but can be said to have a primary interactional function. Similarly, in examples (5) and (8), the nurses are explaining information to the patient, but the purpose is to reassure the patient. Also, in example (27), the nurse is comforting the patient, while also giving directions. In addition, humour is frequently included with any of the other functions, such as in example (30) where the nurse's question is followed by a humorous response.

Although the use of the interactional is so widespread, the focus of a *NoM* syllabus would be on teaching mainly the transactional, with the exception perhaps of the functions of greeting and introducing. A *NoM* course should, however, encourage and emphasise the use of the interactional in conjunction with the transactional. However, using the interactional functions may prove to be problematic when it comes to the cultural conventions that guide the appropriate use of the interactional. Teaching nurses about how the acceptable and appropriate use of interactional functions within various contexts where individuals from different cultures are involved would be an aspect of communication that needs to be addressed in a *NoM* course. The various problems that a *NoM* course would need to address in this regard will be further investigated in the following chapter.

6. Conclusion

Nursing communicative interactions can be based on a wide range of topics, as seen in the typology in the previous chapter. However, regardless of the topic of the communicative interaction, nursing communication exhibits a broad range of interactional and transactional functions. Given the typicality of the functions in the typological categories, and the commonality of these functions in combination with one another in interaction sequences, a *NoM* course could be designed to teach the communicative functions embedded in relevant content. These functions and their sequences could be used to teach advanced communicative competence, using Di Pietro's strategic interaction method, because these are the communicative functions that nurses will need to utilise in the communicative interactions in which they participate on a daily basis as part of their routine duties as nurses.

Also, both the interactional and transactional functions are important in nursing communication. This is due to the nature of the nursing profession, where the nurses' responsibility is to treat and care for the patient not only physically but also to some extent emotionally and psychologically. However, often the

transactional will take precedence over the interactional, as it pertains directly to treating the patient. The conditions according to which these functions are used, particularly the interactional functions, are often determined by factors such as culture, gender and power, which may lead to misunderstandings and miscommunication (see section 5, Chapter 3) and should receive attention in further research. In the following chapter the problems or short-circuits that arise in nursing communication, which a responsibly designed *NoM* course may need to address, will be discussed.

Chapter 7
Observations: Problems and short-circuits in communication

1. Introduction

In this chapter the problematic areas of communication and short-circuits identified during the observation phase of the research are categorised and discussed. These are problems and short-circuits which may indicate a definite need for a *Nurses on the Move* (*NoM)* course. The communication problems identified below occurred for a variety of reasons, and are mainly related to difficulties presented by patients' limited knowledge of medical terminology, especially in an additional language, patients' medical condition, proficiency in the various first and additional languages that participants use, as well as cultural norms in communication.

The examples of the problems areas and short-circuits in communication derived from the data audio recorded during field research in the hospitals are fairly limited. It is likely that a much wider range of short-circuits are extant in nurse communication in South African hospitals. However, the ones that were present

during observations will be discussed below. These types of problems and short-circuits form the basis for the questions asked during the interview phase of the research, which are aimed at providing more insight into the types of communication problems nurses experience, whether they experience other problems not identified here, and the manner in which they may attempt to negotiate these problems.

2. Problems in nursing communication

2.1. Offering treatment information

It is very important for the nursing sister to communicate treatment information to patients so that they know what the medication or treatment they are undergoing is for, how to respond correctly and what side-effects could be expected, thus using the communicative functions of informing, explaining and describing. This is especially true during the administration of medication (see Table 7 in Chapter 5) or when patients are being prepared for a procedure, test or operation. Where communicating while administering medication lacks these functions, the patients may become confused or bewildered, probably because they do not know what is going on, and some patients may not be assertive enough to ask the relevant questions.

There are a number of factors associated with limited treatment information being offered to patients. One factor is that when a patient receives treatment or medication continuously, it would be redundant to communicate the information every time that they administer medication. However, assumptions about whether patients are informed should be avoided and nurses need to check whether patients are informed about all the details of their treatment and medication. For instance, in the example below the nurse assures the patient that

they will be able to treat the wound successfully, but the patient remains unsure, which prompts the nurse to explain exactly how they will treat it:

(1) N: [...] Oraait, want ek's seker daar's, uh, sister ------[4] het al reeds die, die Stoma
sister, hy's nou die expert wat wonde aanbetref, dat hulle vir ons kom raad gee vir presies die regte ding wat ons op daai wond moet sit, jy weet
(Ok, because I'm sure there's, uh, sister ------ has already called the, the Stoma sister, he's the expert concerning wounds, that they come to give us advice on what exactly is the right thing to put on that wound, you know)
[...]
P: [Inaudible]
N: Ja, kyk ons moet hom mos bietjie van binne af ook help, ons kan hom nie aan die buitekant pamperlang nie, ons moet maar binnekant ook bietjie, antibiotika gaan dit net help om vinniger gesond word
(Yes, look we have to help it from the inside as well, we can't just pamper it from the outside, we have to also from the inside, antibiotics will just help it to heal faster)
P: O, want sy sê dis maar deel van die suiker wat dit doen//
(Oh, because she says it's part of what the sugar does)
N: Diabetes doen dit
(Diabetes does this)
P: Want hierdie kant is baie mooi
(Because this side look very good)
N: Ja, ja
(Yes, yes)
P: Dis nou net hierdie kant//
(Now it's just this side)//
N: Dis ongelukig nou maar een ding van as mens suikersiekte het, mens se wonde word swaar gesond, maar hulle word gesond. Ons sal hom wen, hoor? Jy moet net nie moed verloor nie.
(That's unfortunately one thing about when you have diabetes, your wounds have difficulty healing, but they do heal. We will beat it, ok? You mustn't become discouraged)

Above the patient makes some hesitant statements about the wound they are treating based on what other nurses have told her. This prompts the nurse to provide her with additional information to clarify how it will be treated and to reassure the patient that the treatment should be successful.

[4] Names of people, places and specialised medical devices, procedures or operations have been removed to protect patient anonymity and privacy.

In another case, a patient related her experience of being prepared for an emergency procedure. She related how the nurses were providing very little communicative interaction to offer her the essential information about the procedure. She had to ask one of the nurses specifically what they were preparing her for. While preparing her they were understandably task-oriented in the little communicative interaction they had with her and were mainly giving her instructions on how to work with them in completing the necessary preparations. The patient later observed that the fact that she was going for emergency surgery alone was traumatic, while the impersonal and almost harsh manner in which the some nurses where treating her during the preparations aggravated the situation for her. As a result her reaction was to be resistant in working with them to complete the preparations. She did recognise that it was right at the end of their shift with the new staff already arriving, and she could understand that they may have been very tired at this point. She also later spoke to one of the nurses who then informed her that they assumed that the doctor, who had been in to see her minutes before they started their preparation, had informed her that she will be going for surgery, as this is usually the doctor's responsibility. In this case, the communication between the nurses and doctor may have been somewhat lacking due to the urgency of the situation. However, nurses may still require some training in how to be adequately polite or caring particularly under difficult or stressful conditions.

In other cases when medication is administered, nurses may also speak to the patients in a manner that borders on being rude when a patient asks for medication. In the case of at least one nurse observed, the nurse's tone of voice and body language indicated to the patient that it is not his or her responsibility to ensure that the responsible nurse administers this medication. While in some cases this could be due to the nurse being in a bad mood or is very tired towards the end of a 12 hour shift, in other cases this is because the patient is notoriously difficult and demanding. For example,

(2) N1: Sister, --------- sê sy't nie pille gekry nie
(Sister, --------- says she hasn't received her pills yet)
N2: Wie's --------?
(Who's --------)
N1: Wat in kamer, uh, drie, bed twee gele het
(Who was in room, uh, three, bed two)
N2: Uh, kamer drie, bed twee... sy wat mos so gesê het
(Uh, room three, bed two... she who said)
N1: Nou sy weet mos jy gaat mos nog so [indicates direction in which nurse is moving to administer medication from room to room] ons sou mos gewees het by six bed four
(Now she knows you are still going like that [indicates direction in which nurse is moving to administer medication from room to room] we would already have been to six bed four)
N2: Ek gaan nie weer by kamer drie nie
(I'm not going to room three again)
N1: Ja...
(Yes)
N2: Kamer drie, wie's by kamer drie?
(Room three, who's in room three?)
N1: Sy is nou daar
(She is there now)
N2: Sy is daar?//
(She is there?//)
N1: Ja
(Yes)
N2: Ok, ek sal kamer twee gee, dan kom ek...//
(Ok, I will give to room two, then I'll come...//)
N1: Na haar toe?
(To her?)
N2: Ja
(Yes)

In the above example, the first nurse tells the second that one of the patients claims not to have received her medication yet. Although it may not be completely clear from the transcriptions, the second nurse's tone of voice seems to indicate that she thinks the patient is being a nuisance for implying that she is not doing her job because she has already been to the patient's room and would therefore have administered her medication. In this scenario, it turns out that a few of the patients had been moved to different rooms while she was administering medication and this is why the patient had not received her medication. Right after this interaction, although not audio recorded, the second nurse commented in passing to another nurse that this particular patient, who is

quite elderly, is very difficult. As a result of her apparent frustration with the patient, she may be disinclined to react favourably to the patient's complaint that her medication has not yet been administered.

Informing a patient about treatment or medication and offering the associated details are essential and the consequences of not doing so can be dangerous to the patient and staff. A communicative training course for nurses would need to address this issue. However, nurses cannot necessarily be expected or trained to always be in a good mood or not to allow their personal experience (positive or negative) with a patient to cloud their judgement when they are working 12 hour shifts and they have to face the many strains and challenges of their profession. Nevertheless, the type of training proposed in the form of the *NoM* course should reinforce the importance of offering the necessary treatment information and to place a patient's treatment above their personal feelings. Although it is debatable whether it can be realistically expected of nurses to do so, the need for it should nevertheless be emphasised.

2.2. Complex communication needs

Nurses in wards who specifically care for and treat patients whose ability to communicate verbally is limited by their medical condition may need specific communication training. The problems surrounding the complex communication needs (CCN) of patients and the augmentative and alternate communication (AAC) tools that nurses can use to deal with these needs have been widely investigated and consistently indicate the need to offer nurses preservice or inservice training in AAC tools (Hemsley, Sigafoos, Balandin, Forbes, Taylor, Green & Parmenter, 2001; Finke, Light & Kitko, 2008; Hemsley, Baladin & Worrall, 2011; McGilton, Sorin-Peters, Sidani, Rochon, Boscart & Fox 2011). It comes as no surprise then that this type of short-circuit was also evident during the observation phase of the research. In the Ear, Nose and Throat (ENT) and ICU wards, for instance, nurses could benefit vastly from being taught some AAC tools and skills for interacting lingually with patients who have CCN due

to their condition or treatment. Such training may be offered by some hospitals, but general training for such skills and strategies may be useful for all nurses. This is because, on the one hand, nurses may be required to work in wards, such as ENT and ICU wards, in which the majority of their patients have specific CCN due to their medical condition. On the other hand, nurses working in other types of wards may on occasion also encounter patients with CCN which are unrelated to the medical condition they are admitted for, for example having a deaf patient admitted to a dermatology ward for a skin condition.

In the ENT ward where observations took place specifically, one nurse being shadowed made some comments about how they have to teach patients how to talk when the patients lose their ability to speak, either permanently or temporarily, due to disease or treatment. Although there should be a speech therapist to assist patients in learning to speak or communicate sufficiently in such cases, in the interim the nurses still need to be able to communicate with the patient to ensure effective treatment and care. For example, ENT nurses face challenges when communicating with patients whose hearing is impaired:

N: So the ENT nurse must learn to speak clearly to the patient, so these who are hearing... having hearing problems, and then listen properly to the ones of the nose and these ones of the 'trachies' [tracheotomy].

The nurse explains that ENT nurses have specific difficulties not only in speaking to patients with hearing impairment, but also ones who have speech impediments. The same nurse later adds:

N: The throat, all of it is removed, that operation is called laryngectomy but we don't have a patient now, laryngectomy. That one I think they are the hard ones to understand what they say, I think they are the most difficult ones, because they say their speech are coming from their abdomen, so they call it abdominal speech, more especially they speak like "ugh egh guch" [mimics sounds these patients make when trying to speak], just like that, so you must try to listen what is he saying, because sometimes they also become frustrated when they can realise that you can't hear, so at least if you see that you can't hear you just call a second person, maybe she will hear better than you. But there is no specific training.

As she indicates, patients who have had a laryngectomy (usually due to cancer) use 'diaphragmatic' communication which is very difficult to understand. The more experienced nurses may have developed some skills to decipher what the patients are trying to communicate or have developed other strategies, such as asking a second person to try to hear what the patient is trying to communicate. However, ENT nurses do not receive specific communication training, which could curb the level of frustration that often accompanies nurses and patients' attempts to communicate, and assist nurses in caring and treating patients.

Similarly, in one ICU ward, the sister commented that they received no training on how to communicate with their patients when they are unable to communicate verbally. The most common means of communication with a patient unable to communicate verbally is to have the patient write. However, when patients have been inactive for an extended period of time, usually due to being in a comatose state, and they suffer from extensive muscle atrophy, they lose the ability to write. In these cases, the sisters have learned through combined experience to use various methods such as gestures, reading lips or asking an extensive range of close-ended questions that the patients can reply to by nodding, shaking their heads or blinking their eyes. Teaching nurses some skills for communicating with these patients, providing them with AAC tools and empowering the patients by helping them to communicate, could make the nurses' and patients' lives easier, and probably enable nurses to offer more treatment-centred care.

Interestingly, in the cardiothoracic unit in one hospital, some guidelines were posted on the notice board on how to communicate with patients who have some difficulty with communication, but these were absent in the ENT and ICU wards. These guidelines included the following: repeating/rephrasing; allowing time for the patient to answer; using key words (write them down for the patient); using gestures; verifying that the patient understands; giving the patient choices in answers; keeping speech short and simple; using pen and paper;

semantic cueing (i.e. give sample meanings of the word); using closed rather than open-ended questions; and phonemic cueing. If it is not standard practice in all hospitals to have such guidelines available to nursing staff, perhaps this could be introduced. For instance, a flow chart such as the one in Annexure 2 could provide the nurse with a more comprehensive approach to dealing with communication problems. The design of a *NoM* course, which would need to include a section on CCN, could draw on the existing literature and training material referred to above to provide nurses with a useful range of AAC tools and skills.

2.3. Communication in an additional language

Medical terminology and vocabulary related to illness, condition or treatment are not always familiar to patients. Nursing staff members cannot assume that patients will understand medical terminology, unless they know the patient has knowledge of or experience with the tests, procedures, operation or treatment that is being referred to. This can be complicated even further when additional languages are being used to communicate.

For instance, a nurse was observed asking a patient whether she has been for X-rays and an EKG the previous day. The patient was unwilling for the interaction to be audio recorded although she consented to allowing me to be present during the interaction. The following description is based on the field notes taken while observing the nurse's interaction with the patient. Initially the patient seemed hesitant in offering a definite answer to the nurse's question about the tests performed on her the previous day. The patient seemed to be attempting to save face rather than appear ignorant and replied with a tentative 'yes' that she had been for the tests. The nurse seemed to recognise the patient's uncertainty and when she asked the patient for confirmation that she had gone for both the X-ray and EKG, the patient seemed unsure and again hesitated in responding. The nurse then attempted to clarify by prompting her to indicate firstly whether she had been for an X-ray. The patient then replied in the affirmative with a definite

'yes'. However, when the nurse asked about the EKG, she was unsure, stating that she went for another test but did not know what it is called. The nurse then explained and described to the patient how an EKG is performed, referring to the 'stickers' they place on your body and attach to a machine that measures problems in with your heart. As the nurse was describing the procedure, the patient was nodding in what seemed like recognition of the steps the nurse described, and the patient gave a definite answer that they had performed the EKG.

In such cases, the nurse will need to discern that the patient is not merely confused, perhaps due to his/her condition, but is unsure of how to respond because he/she does not necessarily understand the question. As we have observed before, nurses' ability to notice and recognise a patient's hesitancy or uncertainty is important in order to elicit the correct information from patients and to prevent a short-circuit in the transfer and understanding of such information. The communicative function of checking is essential in this regard; if nurses notice a patient seems uncertain or confused, they should state that they can see that the patient seems unsure, and ask what they need clarification on. Failing to do so may result in the nurse recording incorrect information on the observation charts, which may be to the patient's and nursing staff's detriment. It may lead to unnecessary confusion later when it is reported on one document that the patient has not been for a test while another document states that the patient claims otherwise. It could also potentially lead to sending a patient for the same test twice, or even accidental over-medication, or any number of unnecessary complications or interferences with treatment. This is also why cross-checking the relevant documents in the patient's file where available, or checking with the patients themselves or with another staff member, is important.

There were a number of instances of short-circuits in communication that seem to occur because of the nurse's use of terminology that the patient does not

understand, similar to the description above. In the example below, a nurse is explaining medical information to a patient, and even though the nurse checks whether the patient understands, the patient may be too embarrassed to indicate that they do not understand. Patients may try to save face by affirming that they have understood the nurse, even if they do not:

(3a) N1: Ok. Otherwise if the pain is very bad you must say. [Pause while washing hands]
The bleeding should be much better now after this plug is in, but still if it recurs again then just call us. And there's a little, uh, rope hanging out here, so you mustn't pull on it, then it will come out
P: [Inaudible]
N1: No, you shouldn't pull it. That's it, you've got your catheter in again, so the urine is going to come out through the catheter. Do you want to lift the buttocks so we can put on the clean plastic sheet for you, or rather just...//
P: [Pause]
N2: [Translates for patient in Sotho] //Re batla ho tlosa ena enang le mali mama, re kenye e skono neh//
(We want to remove the one with the blood on and replace it with a clean one)
N2: [Pause] Ok, one, two, three [lifts up patient to remove and replace sheets]
P: [Inaudible]
N1: Yes, you can lay back. How is that feeling? A bit more comfortable? [Looks at catheter bag] You see the bladder was already quite full, that probably why it was also uncomfortable
P: [Inaudible]
N1: You see, usually it's still swollen after the operation and then it blocks... then the urine cannot come out
P: This is there for now?
N1: For the night it stays in, at least until tomorrow hey, so you don't have to bother to get up.
N2: Akere o robetse o no sa kgone ho tswa mama?
(Because last night you slept without being able to urinate, mama?)
P: Eya, ke hona kere nako e khutswanyane fela ke bone o sole mongata. So ke re ekaba ke hona o tlang.
(Ok, this is why I'm saying, I see it fills up quickly. So I'm thinking it's only coming out now.)
N2: Ha re kenya ka tube ele, automatically eya bladdereng, it drains the bladder
(When we put in that tube, it automatically connects with the bladder, it drains the bladder)
P: Eya ohoo
(Oh ok)

The first nurse is explaining to the patient that the doctor has inserted a plug to stop the bleeding, and that she should not pull on the string used to remove the

plug. Although the patient's response is inaudible, it seems that she is checking whether she understood this instruction correctly as the nurse reaffirms that she should not pull on the string. However, when she asks the patient whether they should replace the plastic sheet, a second nurse has to translate the questions for the patient. When the first nurse then further explains to the patient that she was unable to urinate because the operation caused swelling, but that the catheter will now take care of it, it is unclear whether the patient understands her explanation and the nurse does not check whether the patient understands. However, the second nurse seems to recognise the patient's uncertainty and so switches to Sotho in order to clarify to the patient what the catheter is for.

Sometimes a breakdown in communication can also occur when the patient or nurse knows medical terminology in their first language, but not in the additional language they are using to communicate with others who they do not share a common first language with:

(4) N: Enige vorige operasies?
(Any previous operations?)
P: Long time ago, here [indicates area on abdomen] breuk operasie
(hernia operation)
N: What?
P: What do they call it in Afrikaans? Die breuk operasie [raises his voice and tries to speak more clearly]. The... this...//
(The hernia operation)
N: //Mmm... //
P: //The... dit kom altyd so by die manne
(men always get it)
N: [Laughter] Ok

The patient does not have the medical vocabulary in English, an additional language, which would enable him to answer the nurse's question. They have to resort to indicating physically what type of operation it was that he had. His gesture that is intended to indicate a cut in the abdomen is what gives the nurse a clue about the type of operation it is. However, the nurse does not give an indication or check whether she has understood him and it is unclear whether she has correctly recorded on the admission document that he has undergone a

hernia operation. It remains unclear then whether or not this short-circuit has been successfully negotiated.

Below, the nurse also has to adjust her vocabulary to ensure that the patient understands her question:

(5) N: Uitskeiding? [Pause] Sukkel nie om te pie-pie nie?
(Excretions? [Pause] Do you struggle to wee-wee?)
P: Nee
(No)
N: Ope-lyf?
(Bowel movement?)
P: Ja
(Yes)

As part of the admissions process, the nurse asks the patient about his excretions. During the pause the patient had a confused look on his face, which seems to be the reason why the nurse asked the question more explicitly.

Similarly, during observations, nurses sometimes also need to adapt their vocabulary to ensure that the patient understands their questions:

(6) N: Sê vir my, die maag, kom daar by die maag ietsie uit? [Pause] Maak hy die wind?
(Tell me, the stomach, is anything coming out? [Pause] Is it making wind?)
P: Die wind, ja...
(The wind, yes...)

Here the nurse is also asking the patient about her bowel movement, but is looking for specific information pertaining to her individual case. Initially the patient does not respond to the nurse's question, but after she asks a more specific question, the patient responds affirmatively. However, it could be questioned whether this is not also related to the patient's level of language proficiency in Afrikaans, which is not her first language.

Many of the nursing staff members seem to have a basic proficiency in English, which in most cases was an additional language, but may have difficulty with communication that requires the nurse to communicate in finer detail or to be very polite or euphemistic. Dissonance between the speakers' first and additional

language proficiency can lead to communication problems. For example, one nurse commented that she has difficulty directing the patient to change his position on the bed while she changes the bedding, because she does not know all the correct adverbs in directing the patient's movements. If this is the case, then the converse could also be true where nurses do know the correct adverbs while the patient does not. When the patient has very limited vocabulary in English, the language in which nursing staff or doctors are communicating with the patient because they do not have another language in common, the nursing staff and doctors have to adopt a colloquial vocabulary in order to elicit or supply the necessary information. Such colloquial language may vary widely, depending on, amongst other things, the patient's first language.

Also, language proficiency may prove to be a problem for nursing staff when recording information on documents. In most hospitals, and in all state-funded hospitals, information is recorded in English. Several nurses commented that they find it difficult to express themselves correctly and accurately in English when completing documentation; they worry about whether other nurses will understand correctly the information they record. A communicative language course may need to include some attention to how to record such information succinctly but comprehensively by teaching the necessary vocabulary, for example. The potential problems associated with differences in language proficiency are addressed specifically during the interview phase of the research, which is reported on in the following chapter.

In the above examples, communication is also complicated by the nurses' attempt to be polite. During observations, nurses often use euphemisms to explain invasive or potentially embarrassing procedures, conditions or treatments to patients. Due to patients' and nurses' limited proficiency in the additional language that one or both of them are communicating in, the euphemisms used may have the unanticipated result of confusing the patient instead of putting the patient at ease. The result is that the nurse may have to

resort to using more explicit, and potentially offensive or even vulgar, terminology to ensure that the patient understands. In some cases this leads to embarrassment for both the patient and nurse.

For instance, I observed a nurse trying to be polite while explaining to the patient that she is scheduled for a colonoscopy. Again, I was not permitted to audio record the interaction. They were communicating in English, which is an additional language for both the nurse and the patient. The nurse used figurative language to explain this rather invasive procedure and the patient had some difficulty understanding the nurse. She used wording such as "putting the camera up your behind" to see if there were any problems in the digestive track. This seems to confuse the patient, who has to ask the nurse to clarify. The nurse is compelled to use ever more literal wording to explain to the patient what the procedure entails, stating that "they will put the camera up your 'poephol'". The nurse and patient both looked rather embarrassed but it did clarify the matter for the patient. Nurses may often have to resort to using such rather crude and vulgar terminology in order to ensure that the patient is clearly informed about procedures.

Also, telephone etiquette specifically may vary depending on the culture of the participants. A number of telephone conversations were observed where nurses will engage in extensive greeting procedure before engaging with the business at hand. At other times the barest of greetings would suffice. Introducing a standardised greeting, such as identifying yourself, the hospital/ward they are phoning from and the patient or matter that they are phoning about before expressing their reason for phoning, as standard practice in hospitals when phoning a doctor or a different ward, department or hospital may be useful. The Situation, Background, Assessment and Recommendation (SBAR) method in communication between healthcare personnel is specifically designed to ensure effective patient care and thus to maximise the safety of patients. This method is widely accepted and taught in the medical field as a valuable communication

tool to improve patient care (Institute for Healthcare Improvement [IHI], 2014; World Health Organisation [WHO], 2014; Casey & Wallis, 2011; Barsteiner, 2011). SBAR is generally incorporated into the nursing curriculum, but nursing personnel may need to be reminded to use this tool or hospitals may need to ensure that it is implemented as standard procedure.

In one particular ward, a nurse who is a second language speaker of Afrikaans in an Intensive Care Unit (ICU) had to conduct a number of telephone conversations with family members of patients who want updates on the patient's condition. The nurse had to give the patient a number of messages from the family member. Cellular phones are not permitted in ICU wards due to the sensitivity of the type of machinery used in the ward. The nurses thus often have to facilitate communication between patients and their family members who are not able to see the patient. The nurse in question seemed to have a reasonable language proficiency in Afrikaans, though it is an additional language for him, but nevertheless used all the correct terms to be polite during the conversation:

(7) N: Morning, -------- ICU, -------- speaking, how may I help you?
N: Ja, ons het 'n meneer ----------, waarmee kan ek help?
(Yes, we have a mister ----------, how can I help you?)
N: Nee, nee hy is bietjie ver van die foon af en ons gebruik nie die selfone in ICU nie
(No, no he is a bit far from the phone and we don't use cell phones in the ICU)
[...]

Even though Afrikaans is an additional language for the nurse, he seems to respond politely to the person on the telephone. Following the initial greeting, the nurse provides the person with the requested information and decides to make an exception and allow the patient to put on his cell phone so that she can also speak to him personally. While the family member is put on hold, the nurse approaches the patient:

(8) N: Meneer ----------?
(Mister ----------?)
P: Ja

(Yes)
N: Jou ma het gebel//
(Your mother called//)
P: //Hmm
N: Hy wil net weet hoe gaan dit met jou. Ek het vir hom gese die doctor het gese, ons gaan hanteer met medikasie, gaan saal toe. Waar's u se selfoon?
(He just wants to know how you are doing. I told him what the doctor said, we are going to treat with medication, going to the ward. Where is your cellphone?)
[...]
N: Ek gaan, sal vir haar sê sy moet vir jou bel by die selfoon
(I will tell her that she must call you on your cellphone)
[Returns to telephone to speak to patient's family member]

Interestingly, he uses appropriate terms of respect. He addresses the patient formally as 'meneer' (sir), as well as using 'u', which is the formal Afrikaans term for 'you'. However, he uses the incorrect gender for the personal pronoun, referring to the female family member as 'hy' (he) and 'hom' (him). This does not appear to deter the communication, however.

After switching the patient's phone on, he again speaks to the family member on the phone:

(9) N: Hello tannie?
N: Uh, ek het die selfoon aansit nê, dan jy, jy sal hom bel by sy selfoon
(Uh, I have put his cellphone on, so you can call him on his cellphone)
N: Mmm. Ja, is net die bonus vir jou [laughter]
(Mmm. Yes, it is a bonus just for you [laughter])
N: Ok dan
(Ok then)
N: Nee dis reg. So j… ja, is nou die selfoon is aan, jy kan hom bel
(No, that's good. So y...yes, the cellphone is on now, you can call him
N: My naam is -----
(My name is -----)
N: Mmm
N: Ok ma
N: Dankie, bye
(Thank you, bye)

What is interesting to note here, is the change from using the formal terms of address to more informal forms such as 'tannie'. Although still denoting respect for an elder, the use of 'tannie' is much less formal than 'mevrou', which he uses earlier in the interaction. The humour that forms part of the conversation seems

to indicate further the development of the positive relationship between the family member and nurse. This is even more evident when the nurse addresses the family member as 'ma' at the end of their telephone conversation. In Sotho, which is the nurse's first language, 'ma' is both a term of endearment and respect used for an older woman. So it is interesting to note the development of the nurse's use of terms of respect in addressing patients and their family members. He starts off in a professional manner addressing them formally, but as they build a relationship through their interaction, he starts to address them more personally.

Similarly, in the example below, the nurse is chatting to the patient while she is cleaning his wound. Again, they seem to build a rapport as they tell each other about their lives, which is also a strategy to keep the patient distracted from the pain (see section 4.1.3 Chatting and socialising, Chapter 6). The nurse here also uses a term of respect to address the patient:

(10) N: Ok. So maybe it was, um, uh, stressful... that you were supposed to... that is why
P: Ja, maybe that is why.
N: Let's hope then you'll be fine
N: Don't bend it Ntate, just keep it straight, straight. Is it straight? [Checks the leg] Ok. I'm now going to...[Inaudible]. Actually I don't know Brits, but I can know the name.

The nurse addresses the patient as 'Ntate', which is a Sotho term of respect for addressing an older man, but it does not denote the same formality as 'sir'. Although there are no short-circuits in the above two examples, it could potentially lead to a problem in communication if a patient is offended by a term of address they do not recognise. This could also occur with other expressions such as the one in the next example:

(11) N: ... and don't forget your pills, ok? You must take it daily. The medication [inaudible] you must take it daily. And go to a GP or is it a clinic every month nê? So that they can check. [Inaudible] immediately just rush, run to the doctor. [Pause] How many children do you have?
P: Three boys
N: Hao hle. Ok. [...]

The nurse uses “hao hle” in this context to express the sentiment that she thinks it is lovely that he has three sons, and would be equivalent to some extent to saying “Wow, that’s nice”. Whether or not the patient understands her response is unclear as he does not respond.

The terminology and etiquette required to exhibit respect and politeness when engaging with patients and other staff will vary across cultures and languages. Nurses’ knowledge of or even sensitivity to these issues may depend on their exposure to other cultures and languages. Politeness in other languages may be something that nurses would need to be sensitised to in a *NoM* course to help ensure that they build and maintain good, professional relationships with others in the context of their work.

Another aspect of communicating in an additional language that seems to lead to short-circuits in communication is accent. In the example below, a short-circuit in communication occurs when the patient has difficulty understanding the nurse’s pronunciation while being admitted to the ward:

(12) N1: Is meneer 'n diabeties patient?
(Are you a diabetic patient, sir?)
P: 'n Wat?
(A what?)
N1: Diabetic
P: Nee
(No)

The communication here takes place in Afrikaans, which is the patient’s first language and an additional language for the nurse. As can be seen, the patient has to check what the nurse is asking because he did not understand the nurse’s pronunciation of ‘diabeties’. She resorts to using the English term to clarify the question for him. Nurses will often try to communicate with patients in the patient’s first language, and although this may show consideration on the part of the nursing staff, it may in fact lead to miscommunication.

In another instance, the short-circuit occurs when a nurse is chatting to the patient while cleaning his wound (see section 4.1.3 Chatting and Socialising, Chapter 6):

(13) P: It's bushveld , it's...
N: Ok, next to Bushbuckridge?
P: No, Bushbuckridge is in Gauteng, to the north
N: [Laughter] Oh! I know the places, the names, but I have never been there.

The nurse misunderstands the patient's reference to the type of climate and vegetation in the area he is from. She checks whether he is referring to a place by the name of Bushbuckridge, which is a town with a name that has some similarity with the term 'bushveld'. It seems that she has misunderstood him. There are at least two possible reasons for this short circuit. The first reason may be that the nurse has difficulty understanding the patient's pronunciation. Here they are communicating in English, which is an additional language for both of them, and they do not share a common first language. The other reason could be that the nurse is unfamiliar with the term 'bushveld', which is an originally Afrikaans term, and thus checks whether he is referring to the town of Bushbuckridge, which would be closest association she is able to make to what he is saying.

In example 13, the consequences of the short-circuit are not very serious, but the same cannot be said for example 12. If the patient had answered incorrectly because he did not understand the question, or if he had simply answered at random to save face, it may have led to serious consequences for his health. The patient's strategy to indicate on his body where the operation was in example 4 above and perhaps describing what the problem had been seems to be what led to the information gap being bridged successfully. Such strategies should be included in a *NoM* course to enable nurses to communicate more effectively with others when they have to communicate in an additional language, and when there is a problem in understanding terminology or accent. The flowchart suggested at the end of section 2.2 could perhaps be used, and adapted if

necessary, to provide nurses with practical suggestions on how to navigate communication problems associated by communicating in additional languages as discussed above.

2.4. Nurses as interpreters

One of the (unofficial) features of the nursing staff members' work is to act as mediator mainly between patients and doctors, and to a lesser extent also between patients and other nursing staff. This means they often take on the role of translator or interpreter, as in example 3 above, to facilitate communication between patients and doctors or other nurses. Their role as mediator between the doctor and patient may come into play when the doctor communicates treatment information to the patient who does not really understand this information, owing to a language barrier. As pointed out above (section 2.3), when the doctor and patient both have to communicate in an additional language, and where one or both parties have limited proficiency in the language being used to communicate, the nurse often has to step in and act as 'interpreter' between the two parties. So although both parties communicate in English, for example, the nurse will, on the one hand, simplify the information that the doctor offers for the patient in terms that the patient can understand, while on the other hand she may also provide the patient's information, questions and complaints to the doctor in medical terms. Again, the patient may be too intimidated or embarrassed to show their ignorance and may indicate that they understand what the doctor communicates. The nurse may need to check with the patient whether or not he/she really did understand, and offer any explanations in terms that the patient can understand.

The above form of interpreting is more indirect because the communication occurs in English, while the nursing staff also have to take on the literal role of interpreter at other times. This occurs when the patient and doctor do not share a common additional language in which to communicate, or when one or both have such a low level of proficiency in the additional language as to cause a

complete breakdown in communication. I observed a number of instances where the doctor would explain treatment or administrative information to the nurse in English and the nurse would then explain this information to the patient in Sotho. Whether or not the translation for the patient was accurate and comprehensive is questionable, however. For example:

(3b) N1: How is that feeling, is it more comfortable?
P: Yes
N1: You see the bladder was already quite full so that's also why it was uncomfortable//
P: //Yes, maybe I was trying to pee, because it wasn't coming out, I have to go to the toilet but nothing comes out
N1: You see, usually it's still swollen//
P: //Ok//
N1: //because of the operation and then it blocks, it's kind of blocking, then the urine cannot come out
P: This is there for now?
N1: For the night it stays in, at least until tomorrow hey, so you don't have to bother to get up.
N2: Akere o robetse o no sa kgone ho tswa mama?
(Because last night you slept without being able to urinate, mama?)
P: Eya, ke hona kere nako e khutswanyane fela ke bone o sole mongata. So ke re ekaba ke hona o tlang.
(Ok, this is why I'm saying, I see it fills up quickly. So I'm thinking it's only coming out now.)
N2: Ha re kenya ka tube ele, automatically eya bladdereng, it drains the bladder
(When we put in that tube, it automatically connects with the bladder, it drains the bladder)
P: Eya ohoo
(Oh ok)

In this example, also discussed in example 3a in section 2.3 above, the first nurse does explain to the patient about not needing to urinate because a catheter has been inserted. The second nurse switches to Sotho, which is a first language for both the patient and second nurse, and checks whether the patient has urinated yet after the removal of the catheter, and, based on her response, the nurse explains the situation with the catheter to the patient. The patient appears willing to express her concerns in more detail in Sotho and the nurse is able to reassure her.

In the following example, the nurse is doing rounds with the doctor, who gives her instructions:

(15) D: Ok, put her in the four female bedroom, she doesn't needs to be in isolation... sy
bietjie die ander ouma gaan company hou. Anything else on her sister?
(She can keep the other granny company)
N: No...
D: Thank you, then that's all
N: Ok. Re tloo isa ka mane hee neh, le ha ese hona jwale
(We are going to move you to another room, even if it is not now)
P: Ka siteng ele? [Points to room they are moving her to]
(On that side?)
N: Eya
(Yes)
P: Ka rumung enang le batho, re nne re kgasellese
(The room with other patients, so we I can chat)
N: [Laughter] [Addresses doctor] She says she would like to be with other people//
D: Ja [smiles], dis lekker. Daar's nog 'n ander oumatjie daar, dan kan hulle bietjie gesels. Dis mooi.
(Yes, that's nice. There's another granny there, then they can chat a bit. That's nice.)
N: Mmm

The nurse informs the patient in Sotho about the doctor's instruction to move her to a room with other patients. The nurse then also translates back into English that the patient is very pleased about this. In this case it is not necessary for the nurse to translate all the information for the patient or doctor, but is simply informing the patient and doctor respectively of the information that is necessary.

On one occasion observed, some of the nursing staff were having a discussion about which staff member would try to get consent from a patient for a test, which would include explaining the reason and procedure for the test. The patient spoke one of the eleven official South African languages that are not common to the Free State and which none of them were fluent in. The nurse who was most fluent in this language explained that she objected to trying to gain consent from the patient because she does not have the needed vocabulary in the language in question to explain the relevant information adequately. One also

has to question whether the medical terminology even exists in this language. It is likely that the nurse would have to use colloquial vocabulary to explain the information and perhaps this is where she lacks confidence in her ability to communicate the information accurately. This meant that a member of staff who does speak this language fluently would have to be found from elsewhere in the hospital, or they would have to wait for a family member to translate for the patient. The nurse's resistance to obtaining consent from the patient may also be further complicated by the fact that the nurse would have to offer AIDS counselling to the patient, which is a very sensitive topic for many patients. So the combination of a sensitive topic with a limited medical vocabulary in the language in question could lead to postponing the test and potential treatment until an interpreter who can also offer or help to interpret AIDS counselling can be found.

In another case, one nurse expressed her desire to learn Afrikaans in order to be able to communicate with her patients, some of whom refuse to speak anything else. This nurse moved to the Free State from another province in South Africa where Afrikaans is not prevalent. She works in ICU and as she cannot choose her patients, it does happen on occasion that she is assigned to patients with whom she then has difficulty communicating. She similarly expressed her concerns about the language used to communicate during emergencies in an ICU ward. She explained that when there is an emergency and multiple members of staff have to work together, members will often tend to slip, under stress, into their first language. Thus only some nursing staff will understand what is being said. Consequently, precious time is then wasted until the information is repeated in a language that they all understand.

Usually a nurse or staff member can be found in the hospital to act as interpreter, but there are exceptions. For example, while accompanying a nurse who was administering medication to patients, I observed an incident with a patient who spoke a language unknown to any of the members of staff in the ward, and in the

hospital, as far as the nurse was aware. There was no verbal interaction with the patient because of the above-mentioned language barrier. Initially the nurse simply offered the pills and a glass of water to the patient, but the patient shook her head and refused to take the pills. The nurse then crushed the medication into powder, mixed it with water and she then tried to use a syringe without a needle to administer the mediation to the patient orally. Using gestures she tried to indicate to the patient that she should drink the medication in the syringe. Although the patient was observed pursing her lips to prevent the nurse from administering the medication, the nurse succeeded in injecting the medication into the patient's mouth. The patient, however, promptly spat it out. Short of finding other means of forcing the patient to drink the medication, there is nothing more that the nurse can do, and the nurse recorded the incident accordingly on the medication administration document.

Whether the patient refused to take the medication because she did not know what it was, what it was for, out of stubbornness, because it tastes bad, or for some other reason, is unclear. According to the nurse, the patient had been admitted a few days before and the nurses commented that apparently the patient was from somewhere in the Kalahari and she did not know how or why the patient had been sent to Bloemfontein for treatment. A family member who could translate would only visit the patient on occasion. This made treatment highly problematic, as communication between the patient and nurses and doctors throughout the day is severely limited. In such instances, an interpreter from outside the hospital may need to be engaged, although this may not always be an option, especially in the public healthcare system.

In all the above examples, the need for and method of translation is problematic. While most South Africans tend to be at least bilingual, proficiency in additional languages, and specifically knowledge of medical terminology in those languages, may be limited. This problem could be solved by having trained interpreters available in hospitals. However, there are at least two factors that

render this proposition an unlikely solution. The first is practicality and feasibility. It is questionable whether the costs involved in training and employing a sufficient number of interpreters in hospitals would outweigh the need for it. In both of the hospitals where this research was performed, a number of nurses mentioned the perennial problem of nursing staff shortages due to lack of funds. If this is the case, then it seems unlikely that the hospitals could afford to employ additional staff for the sole purpose of acting as interpreters. In addition, even if interpreters could be employed, it may not be a viable solution on a practical level because at any given time the interpreter may be needed in multiple wards at the same time. Much time would be wasted in waiting for the interpreter and in critical cases this would simply not be an option. Therefore, employing additional staff for the sole purpose of acting as interpreters does not seem practicable.

The second reason why this might not be the ideal solution has to do with whether or not it is really problematic to have a nurse act as interpreter between a doctor and patient. Firstly, the information to be interpreted should be familiar to the nurse. Secondly, although they may not know the necessary medical vocabulary in an additional language, possibly because such vocabulary does not exist in that language, as nurses they should be able to explain the information in terms that the parties involved will understand. Nurses may invariably be expected to practice their profession in more than one language, which means that it may not be such a far reach for them to act as interpreters, provided they have an adequate level of language proficiency.

An alternative, and perhaps more feasible solution to the need to have interpreters in hospitals, would be to give nurses interpreter training. Nursing remains their profession, but giving them interpreter training may just make them that much more effective as nurses. During interpreter training, nurses will then also be instructed with regard to the required and appropriate vocabulary in the additional language(s) they can interpret in. Nurses' opinions and views on

this problem will be further investigated during the interview phase of this project which will be discussed in the following chapter.

3. Conclusion

The above problems are related both to the context of the medical profession and the various languages used to communicate in South Africa. It seems to point to the need for communication training to address these problems. If a *NoM* course is to be designed it would have to be based on the problems identified and how to negotiate meaning strategically in order to deal with the short-circuits, such as those identified above. It seems that many of the short-circuits that occur can be avoided if nurses employ more explicit checking techniques. The design of a *NoM* course would need to put some emphasis on using the function of checking to negotiate short-circuits in communication.

Based on both the communicative functions identified in Chapter 6 and the problems in communication related to the short-circuits in communicative interactions discussed in this chapter, a number of questions have arisen which are further investigated through the interviews in the next phase of the research. These questions, which are reported on in the next chapter, are related to:

- The importance of "small talk" with patients
- How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is
- Whether they encounter communication difficulties that occur due to cultural differences
- Whether they experience difficulties in communicating in additional languages

Chapter 8
Interviews

1. Introduction

In this chapter, the process and results of the interview phase of the research are discussed. These interviews were conducted based on the data gathered during observations performed in the two hospitals in Bloemfontein. As discussed in the previous three chapters, a typology was generated from the data and speficies the common nurse communicative interactions in relation to the duties performed by nurses (see chapter 5), and

the communicative functions common to nursing overall and to the categories in the typology in specific (see chapter 6). In addition, the problems and short-circuits that seem to occur in nurse communicative interactions with doctors, other nurses, patients, and other relevant parties (chapter 7) were identified. The latter especially seem to suggest the need for assisting the nurses in negotiating the various problems that they may face on a regular basis in communicating with the various parties in a medical facility. These problems are further investigated and given sharper relief through the interviews reported on in this

chapter. Below the research procedure as well as an analysis of the coded data is discussed with the intention of further delineating the communication problems that would indicate the need for a *Nurses on the Move* (*NoM)* course.

2. The research procedure

The interviews with 14 members of nursing staff were performed to gather further clarifying information on the data collected during the observation phase of the research. Permission to interview the nursing staff was obtained from the matron or operational unit manager of each ward, and with their assistance nursing staff were recruited for participation in the interviews. Individual interviews were performed with nurses from different ranks, specifically those of staff nurse, auxiliary nurse, nurse, sister and matron. The rank of the nursing staff member was not of particular relevance to the data obtained, because all members of nursing staff would presumably encounter similar problems in interacting lingually with doctors, patients and other nurses. This was confirmed during the process of coding and analysing data, where the responses by the participants from different ranks did not vary significantly.

Open-ended questions were asked (see Conclusion of previous chapter) regarding the problems and short-circuits in communication discussed in the previous chapter. The purpose is to elicit more information on the types of problems associated with communication and how these are addressed by nursing staff. The purpose of the research conducted by means of the interviews was explained to each participant and informed consent for participation was obtained before the interview commenced. Consent was also specifically obtained for the interview to be audio recorded. In the private hospital, however, none of the nurses felt comfortable being audio recorded, so the data was collected by means of field notes. The interviews took place in the wards where the respective nurses work, making use of the staff tearoom or an empty hospital room. Each interview lasted between 10 and 20 minutes. The data from the audio recordings and field notes were transcribed and coded according to

themes. The themes that were identified were related to each of the individual questions. Patterns of themes were identified in terms of whether the participants found specific aspects or types of communication problematic or important, the reasons why this would be so, and how they usually seek to address the problems specifically.

3. Limitations

There are a number of limitations to this part of the study. Firstly, due to the nature of the research, participants may not be willing to answer completely truthfully. Despite the fact that participants were assured of anonymity and confidentiality, they may not have been willing to discuss more sensitive issues that could get them into trouble with their superiors. Some participants seemed to try to avoid issues such as power relations, racism and sexism. This may in part be due to the fact that some of these issues are consistently in the spotlight in South Africa and they may have been tired of re-hashing topics that some may be over-sensitive towards, which could lead to unnecessarily severe repercussions for the staff as individuals and the hospital as a whole. Although the interview questions were not geared towards eliciting information in these topics specifically, the last two questions (see next section) could have led participants to make comments on, for instance, problems with racism in intercultural communication. These are, however, issues outside the scope of a *NoM* course, but the question does remain whether participants did offer their full opinion on the questions asked.

Secondly, the results may not be generalisible to other medical centres in South Africa. Doing research at multiple medical centres across the country would lie beyond the practical scope of the study. On the one hand, because the typology of common and crucial nurse interactions is closely linked to hospital procedure, which is largely standard across the country, it is likely that the typology will vary little at other medical centres. On the other hand, while some communication problems may be consistent in most medical centres in South

Africa, other factors that problematise communication may vary across regions and hospitals, especially in a highly multilingual context such as the South African workplace. Future research would be necessary to determine whether the same results might be obtained elsewhere.

4. Analysis

I sought to gather more information from nurses about their experience and perceptions regarding different aspects of nurse communication that were derived from the data yielded by the observations. Although ten questions were asked during the interviews, only the four below will be discussed here, as the responses to these questions pertained most directly to the research undertaken in this thesis. Open-ended questions were asked about aspects of nurse communication which emerged from the data gathered during observations as very important and potentially problematic to nurse communication. These aspects are:

- The importance of "small talk" with patients
- How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is
- Whether there are communication problems that occur due to cultural differences
- Whether they experience difficulties in communicating in additional languages

As already mentioned above, the data from the transcriptions of the audio recordings and field notes were coded according to themes. The purpose was firstly to confirm whether the communication problems identified (see chapter 7) were experienced as problematic by the nursing staff. Secondly, I sought to elicit what the nurses believe these problems could be attributed to, as well as the techniques or strategies they usually employ to address these problems. An analysis of the nurses' responses follows below.

4.1. Interpersonal communication

The nurses interviewed consistently expressed their belief that spending some time ‘chatting’ to their patients is very important. Interpersonal communication in the form of small talk is deemed very important for a number of reasons. Naturally there are also a number of factors that prevent nurses from engaging with their patients in small talk.

4.1.1. Importance of interpersonal communication

Firstly, eight out of the fourteen nurses interviewed stated that small talk is important because it is very often a means of discovering details about the patient’s physical and psychological condition that you would not otherwise be aware of. For example:

(1) N8: ...jy kan uitvind miskien het hy nooit genoem dat hy miskien allergies is vir 'n ding, of hy’t miskien, is hy soos in... eet hy nie, hou hy nie van iets nie, dan kom jy nie agter nie of so. *(...you can find out that maybe he never mentioned that he is allergic or something, he is like... he doesn’t eat, doesn’t like something, then you don’t realise or something.)*

(2) N6: ...ek dink dis baie belangrik, ek’t al baie agter gekom dis hoe jy soos, hoe jy goed optel wat hulle dalk nie raakgesien het vantevore nie. Byvoorbeeld een keer 'n drip wat infiltreer het wat die pasiënt nooit gedink het om vir iemand te sê nie, en 'n bandjie aan gehad het, en so verloor die pasiënt amper die hand. Ek dink dit is maar belangrik om elke keer alles te vat en te doen en maar bietjie te hoor hoe dit gaan. *(...I think it’s important, I have often seen that that is how you find out like, how you pick things up that you may not have noticed before. For example, once a drip infiltrated and the patient didn’t think to tell anyone, and he was still wearing the band, and thus the patient almost lost the hand. I think it is important to take and do and hear how things are going every time.)*

So small talk is an opportunity for patients to volunteer important medical information, which they may not realise is relevant, but that may impact on their treatment. The communicative function of Chatting and Socialising (see section 4.1.3, Chapter 6) thus becomes an important source of information pertaining to treatment, confirming the occurrence of the overlapping of transactional and interactional communication. During small talk, the nurses will not be seeking

information in relation to treatment, but if patients do offer or report such information, the nurses may use functions such as seeking additional information or checking to ensure that they gather all the necessary information. Although the documentation used during admissions is comprehensive, it is possible that nurses may miss something or that the patient does not offer relevant information because it does not occur to them. It is through small talk that the nurses occasionally seem to discover this important information missed during admission:

(3) N3: It is important because sometimes, uh, you obtain the uh, previous history, you see, because sometimes when they doing admissions, if it the ward is too busy, they don't have enough time to chat with patient about their previous operation, the cause of that illnesses, you see, so the main time I was busy inserting the drip, then we'll get chance to communicate, restfully with the patient, you see.

(4) N4: Ek dink dis van die belangrikste wat daar is, want kyk dis waarvoor ons hier is. Want ek meen, op daai manier kom jy op goed af, want as jy 'n pasiënt opneem fisies met 'n papier, dan se hulle nie vir jou als nie, dis wanneer jy daar gaan sit en begin soos 'n vriendin met hulle gesels, dan kom hulle met inligting na vore wat nogal saakmaak, uh, wat hulle behandeling, hulle... veral hulle psigiese behoeftes. *(I think it's one of the most important that there is, because look that's what we are here for. Because, I mean, in that way you come across things, because if you admit the patient physically with a paper, then they don't tell you everything, then they come up with information that actually matters, uh, in terms of their treatment, their... especially their psychological needs.)*

So small talk with patients can lead to the discovery of information which can have a direct impact on how effectively you can treat the patient. This may also indicate that in designing a *NoM* syllabus based on, among others, the communicative scenario of Admissions (see section 6.5, Chapter 5), the function of checking needs attention when the nurses seek information.

Secondly, nine of the nurses also noted that small talk is important in terms of the patient's psychological care, as also seen in the last example above. As discussed in Chapter 3, treating patients should not be limited to their physical needs, but should also extend to their emotional and psychosocial needs (Sargent, 2012; Langewitz, Heydrich, Nubling, Szirt, Weber & Grossman, 2010;

Barrere, 2007). When nurses offer patients the opportunity to talk about themselves, the patients tend to express their concerns or questions, or share information that that they did not feel comfortable sharing with any of the other nurses or the doctor who may employ a more task-oriented approach to communication.

(5) N1: Definitief, dis baie belangrik om met jou pasiënte te praat, dis al... jy vind somtyds goete uit oor hulle wat hulle nie gesê het voor die tyd nie, of hulle wil nie dit vir iemand anders sê nie, maar as jy met hulle gaan sit en jy gesels met hulle dan vinde jy goete uit oor hulle. *(Definitely, it's very important to talk to your patients, it's the only... you somtimes find things out about them that they didn't previously tell you, or they do not want to tell anyone else, but if you sit with them and talk to them, then you find out things about them.)*

So it seems that by taking the time to converse with a patient about non-medical matters, information may emerge that could indicate a need for emotional or psychological care that could have an indirect relationship on their treatment:

(6) N3: Vir my is dit belangrik want ek wil weet wat met my pasiëntjies aangaan, en baie keer uit die gesprekke kom jy maar agter, jy weet, iets by die huis is ook nie reg, dat mens daar kan probeer om jy weet dit te help, of 'n maatskaplike werkster of iets te kry om te help. Nee, vir my is dit belangrik, en dan kan jy sommer sien in watter gemoedstoestand die pasiënt ook is. *(It is important for me because I want to know what is going on with my patients, and many times from the conversations you learn, you know, something at home is also not right, that you can try, you know, to help, or get a social worker or someone to help. No, for me it is important, and then you can also see what mood the patient is in.)*

(7) N7: Ek sou sê dis baie belangrik omdat jy baie goed daar teëkom, miskien die pasiënt se familie makeer iets, daar's siekte of daar's dood, of hy's bekommerd oor sy mense want miskien hy's die enigste broodwinner en hy lê in die hospitaal, en daar's miskien nie kos nie. Sulke goed kom partykeer uit, dat jy miskien kan gesels daaroor. Dan voel hy ook beter baie keer. *(I would say that it is very important because you come across things, maybe there is a problem in the patient's family, there is disease or death, or he's worried about his people because maybe he's the only breadwinner and he's lying in hospital, and maybe there's no food. Such things sometimes comes out, that he can talk about it. Then many times he also feels better.)*

(8) N4: Talking to them just to get to know them, just to make them feel at home, you know just to make them that is..., you know usually when they are here 'mos' they are miss home, so at least when you talk to them they feel at home, so ja.

A patient's anxiety, stress and fears can have an indirect effect on the patient's condition and response to treatment. The risk of these factors affecting the patient's progress can be decreased just by being able to share these with someone, and doing so also makes them feel more safe and secure. In this way, small talk functions as chatting and socialising on one level, while also functioning as comfort and reassurance on another level in the same manner seen in section 4.1 in Chapter 6.

In addition, the interviews showed that it is often helpful to gain insight into your patient's psychological well-being, because it allows you to understand a patient's abnormal or difficult behaviour that would otherwise be frustrating or irritating. Gaining such insight, for example that the patient has just been through the trauma of losing a loved one to death or going through a divorce, leads to the patient being difficult to care for and treat:

(9) N2: Jy gaan kry verskriklike moeilike pasiënte waarvoor jy vies word, en as jy bietjie met hulle gaan gesels dan's dit oor hierdie trauma wat hulle die laaste ses maande, die een is dood, daai een is dood, en die een is geskei en so en so, en dis hoekom sy moeilik is. *(You are going to get extremely difficult patients who you get angry with, and you talk to them a bit then it's about this trauma from the last six months, this one passed away, that one passed away, and this one is divorced and so on, and that's why she is difficult.)*

Knowing this information allows the nurses to have more understanding for their patients and to do their job more effectively.

It is no surprise that when some of the respondents were asked whether the interpersonal communication with their patients leads to patient cooperation, they all replied affirmatively. Through interpersonal communication the nurses are able to win their patient's trust:

(10) N5: ...to them it helps, since they are here, some of them those patients they are not from Bloemfontein, some of them they are here for a long time and nobody's visiting, so it's our duty to keep them company, it's our duty to keep them to feel safe, ja, I think... if it's an elderly patient I treat them like my grandparents, if it's more like my mother, I'll treat that patient like my mother, if she's my age group I'll treat them like my

> sisters, and then we get along with them, you don't have stress with patients.

It stands to reason that when nurses show an interest in the patient beyond their basic care and treatment, the kind of communicative interaction they engage in functions to provide comfort and reassurance, and the patients are made to feel cared for and safe. This builds trust between nurse and patient. The patients are then more willing to cooperate with the nursing staff on the various aspects of their treatment because, as one nurse said, "...they believe in you", which confirms the argument made in Chapter 6 (section 4.1.3) about the link that exists between building trust through interactional communication and increased cooperation from the patient. Therefore, in order for a *NoM* syllabus to facilitate the learning of treatment-centred communication as argued in Chapter 3 (section 5.3), it is firstly crucial to include a provision for the communicative scenario of Small Talk (see section 7.1 Pervasive, Chapter 5). Secondly, it should allow for use of the functions of chatting and socialising in combination, when appropriate, with the underlying function of comfort and reassuring. Thirdly, nurses should also be alerted to the fact that when the patients use this type of scenario to share medical information, they will use the functions of checking in order to verify new information.

4.1.2. Factors that impede interpersonal communication

However, there are at least two main reasons why small talk may be limited. The first reason is time constraints. At times the ward can be very busy and there is no time to stop and chat to a patient. One nurse specifically commented that they have so much paperwork to do that it really steals from time spent with the patients:

(11) N2: ...maar daai tyd is maar 'n bietjie min, daai tyd is maar bietjie min, ja... So, ja, as mens dit kon gedoen het sou dit ideal gewees het. Party keer kry mens dit reg, die saal is nie altyd so chaoties besig nie, maar ander kere dan kom en gaan hulle en dan weet jy niks van hulle af nie. *(...but that time is limited, that time is very limited, yes... So yes, if one could do it it would be ideal. Sometimes you can do it, the ward is not always so chaotic, but*

other times then the patients come and go and then you still know nothing about them.)

(12) N4: Maybe when the ward is busy and you are having admissions, operations, then you don't get a chance to sit with the patient one on one and talk.

(13) N6: Maar dan is daar ook tye wat jy maar moet vinnig werk, ..., want partykeer is daar nou, moet jy nou eerder jou werk klaar doen as wat jy geselsies aanknoop, so ja. *(But then there are also times when you have to work quickly, ..., because sometimes there is now, you rather have to finish your work than chat, so yes.)*

(14) N8: ...op die oomblik sou ek sê dis omdat ons is so besig die afgelope tyd, jy weet, jy wil eintlik al die werk moet, jy wil hê al die werk moet klaar is as jy van diens af gaan, um, jy kry nie daai geselsies nie. As jy met die pasiënt werk, dis al wanneer jy geselsie kan aanknoop. *(...at the moment I would say it is because the last while, you know, you actually want all the work, you want all the work to be finished when you go off duty, um, you don't have those talks. When you work with the patient, that's the only time you can chat.)*

As the last nurse notes, sometimes the only time they really have to make small talk with patients is as they are doing their duties, while others also expressed their desire to have more time actually to sit down and converse with their patients. Although time constraints seem to be an innate feature in nursing practice, some strategies could be suggested in the *NoM* course to ensure that nurses are able to optimise their time by incorporating small talk, with its combination of communicative functions, into the activity-based categories of interaction in the typology.

Secondly, the language barrier also impedes interpersonal communication. When a nurse and patient do not share a common language in which they are both adequately proficient, the degree to which small talk occurs may be severely limited.

(15) N3: ...ag, ek dink dit is partymal die taalprobleem, jy weet nou met Afrikaans, Engels, Sotho, Tswana en so aan, kan ek my indink dis nogal 'n probleem, want dit is vir my ook party keer 'n probleem as die pasiënt net swart tale magtig is om met hulle te kommunikeer. *(...uh, I think it is sometimes the language problem, you know with Afrikaans, English, Sotho, Tswana and so on, I can imagine it's quite a problem, because it is*

sometimes also a problem for me to communicate with a patient if the patient only speaks a black language.)

(16) N9: I think, uh is yes, some of the patient is easier because of language, you see, the others you struggling because of the language, you want to express yourself, but you don't know how, you see.

It is intended that a *NoM* course would improve the functional communicative proficiency of nurse communication in English, but teaching additional languages is beyond the scope of such a course. However, the problems surrounding the language barrier as presented in this thesis indicate that healthcare authorities should consider these as detrimental to healthcare and try to address them as far as possible.

Essentially it seems that interpersonal communication between nurses and patients is crucial. Not only does it allow nurses to gather information about patients' physical and emotional/psychological well-being, which influences effective treatment, but it also enables nurses to offer holistic care and comfort that elicits patient cooperation, that in turn facilitates more effective treatment. However, a *NoM* course should address the problems and the use of the necessary combination of functions within this important communicative scenario.

4.2. Acting as interpreter

As pointed out in the previous chapter (see section 2.4), nurses acting as interpreters need not be considered a negative thing. In order to determine their perception of nurses acting as interpreters, they were asked about how often they either act as or need an interpreter, and whether they experience this as problematic. The discussion of their answers below points to a number of aspects that are relevant to designing the content of a *NoM* course.

4.2.1. Frequency of interpretation

The extent to which nurses are required to act as interpreters differs mainly based on the languages that the various nursing staff members in a ward are able

to speak, and there are various scenarios in which nurses either act as interpreters or require interpreters. Nurses and doctors who speak only English and/or Afrikaans often need another nurse to translate for them into Sotho or one of the other African languages when a patient does not speak English or Afrikaans. The nurses who do speak Sotho, usually as their first language, said that quite often they have to interpret for doctors and other nurses who do not speak Sotho, although it depends on how many nursing staff members and doctors in the ward do not speak Sotho themselves:

(17) N9: Oh almost every day, really, every day. Even after the rounds. You see this morning I was having patient who must go to gynae, uh, ward, so I contact doctor and ask about, uh, the translation, I mean the transfer. So it was already cancelled due to lack of bed, so I have to go to the patient and inform her, she can't understand doctor, you see.

(18) N5: Most of the time we do. Because sometimes it's just me and the sisters who are speaking Afrikaans. So definitely they [the patients] don't understand Afrikaans, patients who are coming from Lesotho most of them they are so into that [Sotho], they can't speak Afrikaans or English, only Sotho, so we must translate.

This means that nurses who do not speak Sotho often have to find a staff member who does to translate for them. For instance, when asked how often they need to find someone to interpret for a patient, one nurse commented:

(19) N1: Ja, maar dit hang af van ons se pasiënte en hoeveel ons het op daai stadium. Baie van die Vrystaat pasiënte is nogal goed Afrikaans, al die kulture, al die rasse, is goed Afrikaans, maar dan kry jy nou pasiënte uit 'n heel ander provinsie, of 'n heel ander streek, wat glad nie Afrikaans of Engels kan praat nie, dan moet jy maar 'n tolk inkry. Maar dit is nogal nie so gereeld, um, baie wat dit gebeur hier by ons nie, nee. [...] Hier is gewoonlik iemand wat sal Sotho kan praat... *(Yes, but it depends on our patients and how many we have at that stage. Many of the Free State patients are proficient in Afrikaans, all the cultures, all the races, are proficient in Afrikaans, but then you have a patient from a completely different province, or a completely different region, who cannot speak Afrikaans or English at all, then you have to find a translator. But that doesn't happen so often, um, that doesn't happen so often here with us, no. [...] There is usually someone here who will be able to speak Sotho.)*

So in her experience, most patients share a common language, Afrikaans, with the staff, and they do not require interpreters, while those who do not are

generally from this region and therefore speak Sotho, which a large proportion of nurses are able to speak. So finding another nurse to interpret for you is only a problem when there are patients from regions who do not share a common language with any of the staff. For example,

(20) N1: .., maar dit is nou net... as daar, as die pasiënt hier uit... die Kalahari uit, en hulle kan net "qie en qa". Sjoe, en dan moet ons maar net gebaretaal gebruik [laughter]. So ja nee. *(..., but that is only... if there, if there are patients here out of... the Kalahari, and they can only "qie en qua". Wow, and then we must use sign language [laughter]. So yes.)*

(21) N5: Because we once had one patient from Mozambique, so was Shangaan and nobody could understand that language [except this nurse].

Apart from patients who speak only foreign or uncommon languages, many of the nurses also noted that they quite often have to act as interpreter to foreign doctors who speak English only:

(22) N6: ...byvoorbeeld die Kubaanse dokters en die dokters van bo in Afrika, hulle kan baie keer net Engels praat, so ek moes al baie keer vir hulle in Afrikaans translate. Um, en dit gebeur ook baie dat ek 'n verpleegster of iemand roep om gou vir my in Sotho te kom translate of vir die dokter te kom translate. *(...for example the Cuban doctors and the doctors from up in Africa, many times they can speak English only, so I have often had to translate for them into Afrikaans. Um, and it also often happens that I have to call a nurse quickly to come and translate into Sotho, or to translate for the doctor.)*

(23) N8: Ja, ja, meeste van die tyd [find a nurse to interpret in Sotho]. Op die oomblik het ons mos 'n Ghana dokter, so nou kry ons ook die kans om Afrikaans te translate. *(Yes, yes, most of the time [find a nurse to interpret in Sotho]. At the moment we have a Ghana doctor, so now we also get a chance to translate into Afrikaans.)*

So there is generally a nursing staff member in the ward, or sometimes another ward, who can act as interpreter between nurses, patients and doctors. It becomes a problem only when the patient is from a different region or country where they speak a language that none of the staff speaks.

4.2.2. Communication strategies when no interpreter is available

However, when patients are admitted with whom no member of staff is able to communicate, the nurses have limited strategies in attempting to communicate with their patients. Out of desperation they will occasionally ask a cleaner or messenger in the hospital to try to interpret basic things for them. It seems the nurses often have to rely on them to assist them in such cases:

(24) N2: En soos ek sê, partykeer dan gaan 'n pasiënt hier in en hier uit... en dan moet jy nou 'n skoonmaker loop en skree en roep, "kom help my net hoor wat is fout met die pasiënt, kom laat jy kom verduidelik ek wil hê sy moet so en so maak..." *(And like I say, sometimes then a patient comes in and goes out... and then you have to go and shout and call a cleaner, "come help me just to hear what is wrong with the patient, come and explain that I want her to do this or do that...")*

(25) N3: //En baie keer dan kom die vrouens wat skoonmaak of die bodes, dan kom hulle en sê dat die pasiënt sê sy't 'n probleem met die pensioen gaan haal of... jy weet, dan weet 'n mens of die pasiënt vreeslik na mense, dan soek jy die nommer op en dan bel ons en dan laat ons die pasiënt kantoor toe kom sy met haar mense praat en so. So hulle help ons ook baie keer om problem op te spoor, maar jy kan nie regtig hulle vir mediese goed vra nie. *(//And many time then the women who clean or the messengers come, then they tell us that the patient says she has a problem with collecting the pension or... you know, then you know if the patient misses people, then you look up the number and then you call and then you allow the patient to come to the office to talk to her people and so on. So many times they also help us to discover a problem, but you cannot really ask them for medical things.)*

Although the cleaners and messengers are able to assist the nursing staff in communicating general information, it is questionable whether they should be used to interpret complex medical information. It would seem that ideally those acting as interpreters should be medical practitioners themselves to ensure effective translation. Even then, interpretation by a nurse can still be fraught with difficulties when the nurse herself does not understand the information to be translated. This does not appear to concern most of the nurses, though, and is not necessarily a problem, as one stated:

(26) N5: No, normally I'll ask the doctor what's that? Then the doctor will explain it to me until I understand it, then I can translate it to the patient.

It seems then that many of the nurses of a lower rank, such as the student nurses and auxiliary nurses, have a limited medical knowledge, and even they will need an explanation from a nurse of a higher rank or a doctor before they can translate the information for the patient. The communicative functions of seeking information (section 3.1.1, Chapter 6), explaining (sections 3.1.4, Chapter 6) and checking (section 3.1.6, Chapter 6) are of the utmost importance here. The nurses will first have to seek an explanation and check the information until they are confident that they understand what they need to translate, while the nurse who does the explaining will need to do so effectively, which also includes checking on his/her part.

4.2.3. Problems with nurses acting as translators

Even when a nurse who is able to interpret can be found, this poses its own problems. One complaint amongst the nurses interviewed is that it is sometimes very time-consuming and disruptive to their work:

(27) N9: ...it takes longer, and sometimes you are busy writing a report or giving medication, so you see, it takes sometimes thirty to forty-five minutes sometimes. And the patient is going to ask you the questions. It takes time, really, especially when the ward is busy, but if it's quiet like now, you don't mind.

(28) N2: ...en dan moet jy nou 'n skoonmaker loop en skree en roep, "kom help my net hoor wat is fout met die pasiënt, kom laat jy kom verduidelik ek wil he sy moet so en so maak, en..." dit is verskriklik tydrowend. En frustrerend. [...] En baie keer dan't ons byvoorbeeld 'n eerstejaar student wat die taal kan praat, maar sy's so oningelig want sy's nog heeltemal, sy... jy moet vir haar so stap vir stap verduidelik dat sy dit vir die pasiënt kan oordra, dan vat dit op die ou eind van die dag 'n half-uur. *(And like I say, sometimes then a patient comes in and goes out... and then you have to go and shout and call a cleaner, "come help me to just hear what is wrong with the patient, come and explain that I want her to do this or do that..." it is very time consuming. And frustrating. [...] And many times, for example, then we have a first year student who can speak the language, but she is so uninformed because she is still completely, she... you have to explain to her step by step so that she can carry it over to the patient, at the end of the day it takes a half-hour.)*

This second nurse's comment about how they have to take time to explain the information to the person interpreting raises the question about how accurate the interpretation is. This confirms yet again the importance of the communicative functions of explaining and checking.

When an interpreter, even in the form of a cleaner or messenger, cannot be found, the nursing staff resort to other means of trying to communicate. One way is to use gestures or a form of sign language, which seemed to be the general strategy to try to communicate with these patients:

(29) N7: Dis moeilik, ja. Ons het 'n pasiënt nou die dag, en ons moes maar met gebaretaal kommunikeer en op so manier kon ons dan.., jy weet, hy konnie Afrikaans verstaan nie, Engels of Sotho, niks nie, so hy kon darem verstaan wat ons wil hê hy moet doen met gebaretaal. *(It's difficult, yes. We had a patient the other day, and we had to communicate using sign language and in such a way we could then..., you know, he couldn't understand English or Sotho, nothing at all, so he could at least understand what we wanted him to do using sign language.)*

Alternatively, the staff try to find a family member or friend of the patient to translate for them:

(30) N6: Um, nou die dag het ons 'n pasiënt gehad wat Zimbabwean is, dis absolute chaos om dan iemand te kry om dit te praat, so ja. ...gelukig het die een verpleegster is soos amper elke taal magtig in Suid Afrika, so sy kan nou nie Shona praat nie, maar sy kon toe darem 'n taal wat hulle altwee verstaan toe min of meer die ding kry. Maar verder het die dokter gese ons moet maar kyk vir 'n translator, maar eintlik moet mense kyk in hulle community, want daai vrou is obviously nie alleen hier nie, so iemand moet haar verstaan en mens moet nou maar net vir haar beduie dat daai iemand moet saamkom as dit nou ingewikkelde goed is soos toestemming en sulke goed dat mens dit vir hom kan verduidelik en hy kan translate. *(Um, the other day we had a patient who is Zimbabwean, it's absolutely chaos to try to find someone to speak it, so yes. ...luckily one of the nurses is fluent in almost every South African language, so although she couldn't speak Shona, she could at least speak a language that they both understand so more or less follow. But other than that the doctor said to find a translator, but actually you should look within their community, because that woman is obviously not here on her own, so someone must understand her and you just have to indicate to her that someone must come with her when it comes to complicated things like permission and such things, so that you can explain to him and that he can translate it.)*

Again, this is not an ideal situation because the person interpreting does not necessarily have the medical knowledge required to interpret accurately.

The communicative functions of explaining and checking again feature prominently as means of ensuring effective translation, regardless of who the person performing the translation is. Also, the problems nurses face when no translator is available are similar to those faced by nurses who have patients with Complex Communication Needs (CCM) (see section 2.2, Chapter 7). As suggested in Chapter 7, the *NoM* course should perhaps include a section on practical strategies for basic communication with a patient when no translator is available (see flowchart in Annexure 2).

4.2.4. Accuracy and effectiveness of interpretation

However, being able to communicate complex medical ideas accurately through an interpreter need not be considered a problem. One of the nurses, who often has to translate for patients into Sotho, was specifically whether she thinks they are accurately able to interpret all the complex medical information and the medical terminology, which presumably have no equivalents in Sotho. The nurses simply replied:

(31) N4: No, just to make them understand, like in simple Sotho.

(32) N9: Ja, explain in a different way.

(33) N6: Ja, wel ek dink so, veral bedoel, baie rural Afrikaanse mense, soos byvoorbeeld nou die kleurling outjies (people of mixed race), of party van die ouens wat Sotho verstaan, hulle gaan nie noodwendig weet wat jou niere is of dis nou, dan gaan jy nou mooi vir hulle verduidelik die niere dit het eintlik te doen met die piepie wat jy het, maar jy gaan nie woorde soos urine gebruik nie, so dit wat nou daar gebeur, dis nou hoër op onsteking, die kidney in die niere, en dan gaan jy nou so vir hulle verduidelik dat dit ja, simplify dit maar so bietjie, want ek bedoel ek's seker dis wat die, ek bedoel ek is nou nie Sotho magtig nie, maar ek's seker dis wat die verpleegsters dan nou maar, of dit sou die ideaal wees, dat hulle dit so verduidelik, want dit help ook nie jy't die terme nie en die pasiënt gaan dit in elk geval nie verstaan nie. *(Yes, well I think so, especially I mean, many rural Afrikaans people, like for example the 'coloured' people (people of mixed race), or some of the guys who understand Sotho, they won't necessarily know what your kidneys are, then you are going to explain to*

them that the kidneys actually have something to do with the urine that you have, but you are not going to use words such as urine, so what is happening there now, that is infection higher up, in the kidneys, and then you will explain it for them in that way, simplify it a bit, because I mean, I'm sure that's what the nurses do, or it would be ideal, that they explain it in that way, because it doesn't help you have the terms and the patient can't understand it in any case.)

This does seem to make sense if you consider the fact that patients who come from a rural area and are only semi-literate, as the nurse above explains, do not understand most medical terminology. Doctors and nurses will generally have to simplify the information for them and explain (sections 3.1.4, Chapter 6) or describe (section 3.1.5, Chapter 6) it in lay terms so that the patient is able to understand. Thus, as long as the nurse who is interpreting understands the information correctly, he/she will be able to translate it not only into a different language, but at the same time is likely to also 'translate' the information into simpler terms that the patient can readily grasp. In this sense nurses will act as figurative interpreters who have to explain medical information or terminology to the patient that the patient does not understand, while in other cases, the nurse may have to interpret literally what the doctor said (see also example 15, section 2.4, in Chapter 7).

As already argued in the previous chapter, it would seem that ultimately it is still ideal to use nurses as interpreters, partly because they are already functioning in this capacity, and partly because there do not seem to be too many feasible alternatives. Regardless of who does the interpreting, this is a service that is necessary in hospitals, as can be seen from the discussion above. Additionally, as the nurse below notes, if communication is to be effective, it should ideally be in the patient's first language:

(34) N7: Ek dink soos ons wat nou nie 'n derde taal kan praat nie, is dit belangrik dat 'n pasiënt wel moet weet wat met hom aangaan, watter procedure jy gaan doen op hom, hy moet eintlik verstaan in sy eie taal in, uh, dit vergemaklik hom ook en stel hom gerus, as hy dit in sy eie taal verstaan. *(I think that those of us who cannot speak a third language, it is important for a patient to know what is happening to him, which procedure you are going to perform on him, he must actually understand it*

> *in his own language, uh, it also puts him at ease, if he understands it in his own language.)*

Thus in many cases translation into the first language of the patient may not be considered necessary or essential, but it definitely seems to be beneficial and useful in increasing how effective treatment is on a physical, emotional and psychological level. This relates back to the previous section on small talk. Patients need to be treated holistically, and the relationship and trust that develops between nurse and patient through interpersonal communication enables the nursing staff to treat and care for the patient not only physically, but also psychologically and emotionally. So even if the patient is not able to have that interpersonal communication with all of the nursing staff and doctors, if there is at least one nurse in the ward who they are able to communicate with, it is likely to decrease their stress and anxiety.

Hospitals should thus be advised to utilise their staff to the maximum in terms of their language abilities. Hospitals should try to ensure that as far as possible they have a wide range of nursing staff in every ward who in combination speak as many of South Africa's eleven official languages as possible. Also, nurses and patients would benefit greatly from receiving interpretation training and being taught strategies to try to communicate with patients when there is no one available or able to translate. Although a *NoM* course is not intended to focus on training nurses in translation, at the very least it should include how certain communicative functions, as discussed above, can be used when translating.

4.3. Language barrier

As a result of the eleven official languages that are spoken in South Africa, the combination of languages spoken in the hospital setting by each nurse, patient, doctor or by other participants will vary. In addition to the problems pointed out above in relation to the need for translation, as well as the issues discussed in section 2.3 in the previous chapter, communication in an additional language

poses a number of other problems which may need to be addressed through a *NoM* course.

4.3.1. Details get lost

One of the problems with communicating in an additional language, which relates to the discussion above on translation, is that finer detail may be lost. For example, one informant states that when no one is available to translate and the nurse is able to communicate with the patient to some extent in an additional language, this does not mean that the information communicated is in any way complete or comprehensive,

> (35) N2: Um, as 'n pasiënt, kom ons sê maar, kom ons sê sy't koors, of kom ons sê sy't keelseer, dis 'n tertiere hospitaal, hier is nie hoesstroop, hier's nie keelseer pilletjies nie. Nou wat maak jy met 'n pasiënt wat hier lê wat vir jou sê sy's verkouerig of haar keel is seer? Nou't van die ou sisters vir ons geleer, jy maak 'n Panado stropie in warm water aan, dit help vir keelseer. En nou't jy 'n kommunikasiegaping, jy weet nie wat 'n, met ander woorde, daai klein goedjies wat ons sou gedoen het vir die pasiënt as ons haar verstaan het, dan um, gebeur dit nie. *(Um, if a patient, let's say, let's say she has fever, or let's say she has a sore throat, this is a tertiary hospital, we don't have any cough syrup. So what do you do with a patient who lies here and tells you she has a bit of a cold and her throat is sore? Now, some of the old sisters taught us to mix a Panado syrup in warm water, and that helps for a sore throat. And now you have a communication gap, you don't know what, in other words, these little things we would have done for the patient if we had understood her, then um, it doesn't happen.)*

The nurse explains that even though they will be treating and caring for the patients based on the main medical problem that the patient is admitted for, minor ailments or side effects may also occur during their stay in the hospital. It is these minor problems that the nurses are often unable to address due to communication gaps that occur as a result of a language barrier. Although the patients' main medical issues will be dealt with by the time the patient is discharged, the treatment and care of a patient may have been more effective if the details could also have been addressed. This problem reiterates the importance of learning specific communicative functions (Chapter 6) in an additional language, given any of the typical communicative scenarios that

nurses encounter on a daily basis (Chapter 5). Specifically, a necessary component in the *NoM* course would be facilitating the learning of a means of eliciting such details in an additional langauge within a variety of communicative scenarios through the function of seeking information (section 3.1.1, Chapter 6) in combination with describing, as well as detailed checking (section 3.1.6, Chapter 6).

4.3.2. Accent and pronunciation

Another problem that occurs, also mentioned in Chapter 7 (section 2.3), is that misunderstandings occur due to the accent in which additional languages are spoken. For example:

(36) N7: Jy kon hom [doctor from Ghana] partykeer nie verstaan nie, sy Engels nie. Maar nou begin hy biejtie duideliker raak, jy weet, hoe langer hy hier is, maar dis ook nogal 'n probleem, om nie iemand rerig te kan verstaan nie, en ons verstaan hom nie rerig nie, maar ek dink dit het nou, hoe langer hy hier is, hoe beter raak dit. Hulle praat mos, hulle Engels is mos verskriklik moeilik. *(Yes, you could sometimes not understand him [doctor from Ghana], not understand his English. But now he is starting to become clearer, the longer he is here, but it's also quite a problem, not to be able really to understand someone, and we don't really understand him, but I think it has now, the longer he is here, the better it is getting. They speak, you know, their English is very difficult.)*

This seems to apply specifically to medical personnel from different regions or other countries, where their first language may cause them to have an unusual accent. Thus, even when communication occurs in a common additional language, the accent may lead to difficulty understanding one another. It does seem, however, that nurses become accustomed to the accent and that the accent may soften over time, leading to improved communication. To assist nurses in avoiding confusion due to accent or pronunciation, appropriate means of checking (section 3.1.6, Chapter 6) should be encouraged.

4.3.3. Writing in an additional language

When asked about their opinion on whether communication in an additional language poses problems for them, a number of nurses commented that they

sometimes feel unable to express themselves accurately and correctly in an additional language:

(37) N2: ...jy moet onthou, jy druk jouself beter uit in jou moedertaal. *(...you must remember, you express yourself better in your mother tongue.)*

Many of the nurses stated that this is a problem for them specifically when they need to complete documentation and reports in an additional language. At both hospitals where the interviews were conducted, hospital staff are required to complete all documents and report in English, which seems to be an additional language for a large number of the staff. The nurses' problem with writing in English as an additional language seemed to centre on a feeling of being unable to express important information accurately and correctly in English:

(38) N2: En natuurlik jy weet mens spel nie so goed in 'n anders taal soos jy in jou eie taal spel nie, en dan beteken 'n ding heel waarskynlik iets anders, en jy weet dit nie en jy gaan maar net aan. Ja, dis, dis, dit maak 'n mens dat jy twee keer dink voordat jy skryf, en dit vat tyd, waar 'n ding baie makliker kom as mens in jou eie taal skrywe. Ag weet jy baie goed, en dis die volgende ding, dit maak dat jy hierdie rympies skryf, nie regtig wat in jou kop is wat jy wou gesê het nie, maar omdat dit makliker is, omdat dit vinniger is, jy weet klaar hoe spel jy daai ding, want jy weet klaar want jy skryf dit honderd keer op 'n dag, skryf jy hom maar net weer. Met ander woorde, om in detail te se wat jy wou se van daai pasiënt gaan nie gebeur nie, want daar kan te veel taalfoute, spelfoute goed inkom, so jy los dit liewer. So ja, maar weereens hoe gaan mens dit oplos? Dit is nie haalbaar nie, en jy kan nou soveel Engelse opleiding kry as wat jy wil, ons het almal Engels op skool gehad as tweede taal of derde taal, maar dis nie so goed soos jou moedertaal nie. *(And of course you know you don't spell so well in another language as you do in your own language, and then in all probability something means something quite different, and you don't realise it and you just carry on. Yes, it's, it's, it causes you to think two before you write, and that takes time, where something would be much easier to write in your own language. Um you know many things, and that's the next thing, it causes you to write down these rhymes, not really what is in your head as what you wanted to say, but because it is easier, because it is quicker, you already know how to spell that thing, because you already know because you write it down a hundred times a day, so you just write it down again. In other words, to say in detail what you wanted to say about that patient is not going to happen, because there may be too many language errors, so you rather leave it. So yes, but once again, how can we solve it? It is not doable, you can get as much English training as you like, we all had English at school as second or third language, but it's not as good as you mother tongue.)*

The nurse here explains extensively how unsure she is of her ability to use the correct spelling, vocabulary and general expressions when completing reports in English. She seems to be quite concerned about possible misunderstandings that may occur due to her inability to express the correct information accurately and the impact this may have on the patient's treatment. Not only can this lead to serious adverse events for the patient, but the same nurse also pointed out how this puts the nursing staff at risk in terms of legal implications:

(39) N2: Ag, weet jy, ja, die taal ding is maar 'n probleem, en die ding is natuurlik ek dink dis baie gevaarlik vir ons, want ek skryf in 'n taal wat weereens nie my moedertaal is nie. Dis swart op wit bewyse, dit is legal goed, dit kan hof toe gaan, dit wat ek daar geskryf het is nie noodwending hoe ek dit wou uitgedruk het nie, en dit is gevaarlik, dit kan vir mens in groot probleme veroorsaak. *(Oh, you know, yes, the language thing is a problem, and the thing is, of course, I think it is very dangerous for us, because I write in a language that is once again not my mother tongue. It's black on white evidence, it is legal stuff, it can go to court, that which I wrote down there is not necessarily how I wanted to express it, and it is dangerous, it can cause big problems for you.)*

The nurses seemed to be at a loss as to how this problem could be solved. This nurse indicates that she uses certain typical expressions and stock phrases when she writes reports for lack of a wide range of vocabulary. Even though she also indicates that she does not feel that training in English will help, she seems to be speaking from the context of taking English as an additional language at school. This indicates the need for specifically offering nursing staff support in writing reports, with such instructions, perhaps including the extension of nurses' knowledge of vocabulary and collocations that will enable them to express medical information more accurately. Although outside the scope of the current study, the design of a *NoM* course, perhaps at a subsequent stage, should also investigate the problems related to report writing and how to address these.

4.3.4. Professionalism, compromise, collaboration and checking

Naturally one would prefer to communicate in your first language, in which you are most comfortable. The fact remains, though, that nurses in South Africa are

bound to have different first languages and therefore need to find a common additional language in which communication can take place. As seen in the hospitals where research was conducted, English seems to be the language of choice in which hospital staff communicate. However, many nurses indicate that Afrikaans seems to be more widely spoken than English in this region, and that it tends to be the language that nurses resort to in order to communicate with those who speak different first languages. This poses a problem for nurses from different regions who do not speak Afrikaans, but they also seem to offer solutions as to how they practically navigate these problems.

(40) N4: I don't know with the rest of the staff, but with me if I don't understand I ask, because with most of them they speak Afrikaans, then I'll say, "please say it in English". Me and Afrikaans, I can understand here and there, but you know 'mos' that side (Mpumalanga – the region she is from) there is no Afrikaans.

(41) N9: Because if I don't understand, I ask, but it happens rarely, very rarely. But me, I ask.

The first nurse is from a region of South Africa where Afrikaans is less widely spoken, so they tend to learn English at school as an additional language instead of Afrikaans. Working in a hospital in an area where Afrikaans seems to be the language that staff predominantly resort to in order to communicate with each other and their patients is problematic for her. However, they both clearly indicate that if the nurses speak in Afrikaans they simply ask them to repeat or explain it in English. The same also seems to apply to nurses who have Afrikaans as a first language and who do not speak Sotho as an additional language:

(42) N2: En baie keer as jou, as jou, sê nou maar jou Sothosprekende dokters by die Sotho-pasiënte kom, dan verduidelik hulle die hele storie van als deur en jy weet nie wat hulle praat nie. En dan sê hy byvoorbeeld vir die pasiënt, sister gaan so en so maak, maar jy hoor dit nie. En hy sê dit ook nie vir jou in jou taal sodat jy kan verstaan nie, dan verwag die pasiënt van jou goed, en jy weet nie want jy't dit nie gehoor nie. *(And many times if your, if your, let's just say your Sotho-speaking doctors are with the Sotho patients, then they explain the whole story about everything and you don't know what they are saying. And then for example, he tells the patient, sister is going to do this and this, but you don't hear it. And he also*

doesn't tell you in your own language so that you can understand, then the patient expects these things of you and you aren't even aware of it because you didn't hear it.)

In such cases, the communicative functions of seeking information (section 3.1.1, Chapter 6) and checking (section 3.1.6, Chapter 6) once again seem to play a central role in ensuring effective communication. When doing rounds with doctors, nurses need to make sure that the doctors repeat information for them in a language they understand, so that instructions for patient treatment can be carried out. As the nurse in the previous example states, you simply need to ask the doctor or nurses, depending on the scenario, to repeat or perhaps even explain (section 3.1.4, Chapter 6) the information for you.

The need for collaboration between nursing staff and doctors thus becomes evident, as also seen in a number of other comments by nurses. As already discussed in Chapter 3, communication is one of the keys to good collaboration between medical staff (Marshall, Jones & Snyder, 2001), and collaboration is necessary both in terms of patient care (McCaffrey, Hayes, Stuart, Cassel, Farrell, Miller-Reyes & Donaldson, 2011) and job satisfaction (Cheeks & Dunn, 2010). Although the nurses did not directly address these issues, they did point out that professionalism and collaboration is important:

(43) N2: Maar nou, aan die ander kant, dis professionele mense, as hy [die dokter] iets vir my se wat ek nie, wat ek nou wanverstaan, dan sê ek nou, "nee, wag 'n bietjie dokter, kom ons praat net bietjie weer, dit wat jy vir my gesê het is..., wat ek verstaan het is nou nie lekker nie." So ons is nie bang om met die dokters te query nie. Ons is nie bang om vir hulle te sê "nee, ek verstaan nie wat jy vir my 'gesêt' het nie", en ja, so, maar, ek't al baie agtergekom dit kom baie, ja kyk, ons het ook mos nou maar, elke taal het mos maar sy idiome, en sy sêgoed, wat die ander nie verstaan nie, en jy vang jouself dat jy sulke goed sê, en dan kan jy sien op daai een se gesig, maar hy't nou nie 'n clue waarvan jy praat nie. En, maar, en hulle doen ook dieselfde, maar dan verwag hulle jy moet eintlik nou geweet het wat hulle probeer sê het. Maar soos ek jou sê, verhouding tussen die sisters en die dokters is baie gelyk. Ek sal reguit vir hom sê, "hoor hier, ek het regtig nou nie 'n idee vaarvan jy praat nie, of ek kan nie lees wat jy skryf nie, of ek verstaan nie wat jy hier wil hê nie, um, kom ons doen dit oor en begin van voor af". Maar ek, ja, taal veroorsaak verwarring. *(But then, on the other hand, it's professional people, if he [the doctor] tells me something that I don't, that I now misunderstand, then I say, "no, wait a minute doctor,*

> *let's just talk again, what you told me is..., I have now not understood completely." So we are not afraid to query the doctor. We are not afraid to tell them, "no, I don't understand what you told me", and yes, so, but I've often noticed that it often comes with, yes look, we also have, every language has its idiomatic expressions, and its expressions, that the others do not understand, and you catch yourself saying things, and then at that moment you can see on that person's face that they don't have a clue what you are talking about. And, but, and they also do the same, but then they expect you actually to understand what they were trying to say. But like I say, relationship between the nurses and doctors is very equal. I will tell him directly, "listen, I really have no idea what you are now talking about, or I can't read what you write, or I don't understand what you want here, um, let's do it over again and do it from the start again." But me, yes, language causes confusion.)*

This nurse touches on the very important point of power relations between nursing staff and doctors. In Chapter 3 it was also explained that when negative power relations exist between nursing staff and doctors, and this affects communication between them, it can lead to lack of collaboration (Edmondson, 1999; Arford, 2005; Reader, Flin, Mearns, & Cuthbertson, 2007). Now this nurse is a senior nursing staff member who has extensive nursing experience, and this may be why she feels confident in her own abilities as nurse as well as in relating to the doctors. She seems and claims to be comfortable enough to check or ask the doctor for clarification when she feels she has misunderstood information or instructions communicated to her. This may also be influenced by the doctors' attitude and level of experience. Whether the same is true in all wards and hospitals, however, is debatable. Regardless, nurses need to be encouraged to ask for clarification and check information when they feel uncertain about whether they have understood information, specifically in the communicative scenario of Doctor Rounds (section 6.3, Chapter 5), which is another aspect that needs to be taken into account when designing a *NoM* course.

Also, if nursing staff and other medical staff are to collaborate optimally, there should be a fair amount of compromise and flexibility in communication. The two comments below strongly express the sentiment that medical staff should all be willing to compromise their preference for speaking in their first language in order to ensure that communication, and therefore treatment, occurs effectively:

(44) N5: With me in Free State, they are still more to Afrikaans, because there are those who can tell you "I'm speaking Afrikaans". If you speak Afrikaans, I'm speaking Shangaan, it means it's a disaster 'mos'; we won't understand each other. So the best way is to speak English. But for the patient it's fine, if the patient can't speak English we must, it's our duty to make them understand what's happening around the ward. But then I wish everybody, the doctors, the nurses, everybody can speak in English.

In this comment it would appear that the nurse is referring to the fact that occasionally nurses will insist on communicating in their first language, even if it is to the detriment of effective communication and, as a result, treatment. This nurse's first language is Shangaan, which is rarely, if ever, spoken in this region. She also speaks Zulu, Xhosa, Sotho and English, but not Afrikaans. She thus realises that if she is going to be able to practice her profession she will need to engage with her colleagues in a language they all understand. In this case that means communicating in English, as this nurse cannot speak Afrikaans, which the other nurses from this region would probably be more comfortable with. On the one hand, their preference for speaking Afrikaans does not seem unusual in light of the discussion above; people would generally prefer to communicate in their first language, or perhaps an additional language that they have a high level of proficiency in, because they feel more confident that communication in this language will be accurate and effective. On the other hand, nurses will need to engage with others, who do not speak their first language, in an additional language if any communication is to take place at all. Importantly, another nurse states that

(45) N5: ...we are not here for the doctors or our colleagues, we are here for the patients, so if you know all these languages it helps, because at the end of the day we don't struggle with patients. You can communicate with any patient.

Therefore, nursing staff need to be professional and collaborative. This means being considerate of their colleagues' language abilities, showing them respect in the first place, and thus being willing to compromise on the language of communication in order to ensure that communication occurs as effectively and efficiently as possible. In the end, this comment indicates that the nurses need to

prioritise the patients' safety, care and treatment above their own preferences, which means being willing to compromise on language of communication. The nurse states that, for the same reasons, this also means that nursing staff need to attempt to use the patients' language of preference as far as possible. Similarly, one of the nurses commented on her frustration with pressure from hospital management to communicate only in English, presumably to deal with problems of miscommunication due to additional languages:

(46) N2: Maar ek weet nie hoe..., of mens dit kan..., dis 'n onoorkombare probleem dink ek. En almal gaan net... so veel as wat hulle die Engels nou promoveer, uh, die mense... hulle kan nie almal Engels praat nie, dit is nou maar net so. *(But I don't know how..., if one can..., I think it's an insurmountable problem. And everyone will just... as much as they promote English, uh, the people... they cannot all speak English, that is just the way it is.)*

The nurse states that many of their patients do not speak English, so promoting English as the language of communication, a policy that the hospital management was implementing at that stage, would actually be to the detriment of the patients. During observations, a number of nurses expressed their belief that this new policy had as much to do with politics as it does with the intention to eliminate miscommunication due to the different languages spoken in hospitals. Regardless of the motives, the design of such policies, just as with any other applied linguistic artefact, need to be founded on extensive research to provide a sufficient rationale for their design. Whether this policy was designed on such research is unclear, but based on the problems with communication in additional languages identified in this study, such a policy would be inadvisable, at least as far as communication with patients is concerned.

In addition, as also mentioned elsewhere in this chapter, hospitals should try to recruit nurses who speak as wide a range of languages as possible. More than one nurse expressed their desire to learn different languages to enable them to communicate better with their patients in treating and caring for them:

(47) N3: Nee, ek kan nogal dink dat as mens 'n swart taal sou kan aanleer, sal dit jou baie help. Want op skool het ek Sotho gehad in die jaar toet, en dit was vir my vreeslik lekker, en ek het vreeslik goed gedoen, en ek het een jaar dit gehad en toe skaf hulle dit af... en ek vind dit nogal jammer. Dit kan die kommunikasie soveel vergemaklik, as ons dit kon aan gehad het ons hele skool loopbaan, en nou ook. Want dit is nogal 'n probleem, jy weet, dis frustrerend, en jy's bang die pasiënt doen die verkeerde ding, want jy kan nie altyd vir hulle dit goed oordra nie. *(No, I can imagine that if you could just learn a black language, it would help a lot. Because at school I had Sotho in the year zero, and it was great for me, and I did really well, and I had it for one year and then they took it away... I think it is a pity. It can make communication so much easier, if we could have had it our whole school career, and now too. Because it is quite a problem, you know, it's frustrating, and you're afraid the patients do the wrong thing, because you cannot always communicate it to them well.)*

However, even if additional languages were taught more widely, the question of proficiency remains a problem in this professional milieu. Even if nurses have a relatively high level of proficiency, this is not to say that they are able to use that language effectively in the context of their profession. Although a *NoM* course would not specifically be aimed at influencing or changing nurses' attitudes towards or opinions of other language that they may need to communicate in, the hope is that by enhancing nurses' strategic transactional competence in additional languages, they would be more open towards and comfortable in using these languages to communicate.

4.4. Miscommunication due to cultural differences

When asked about whether cultural differences in communication exist or present problems, most of the nurses seemed either to be reluctant to answer this, or simply denied that there are any problems. This could be attributed to two factors: firstly, it could be that the question was unclear, and the nurses thus were unsure of how to respond; secondly, due to the socio-political context of South Africa, this question could have been viewed as an allusion to the very sensitive topic of racism, which they would prefer to avoid. However, a number of comments made by the nurses in relation to other questions did provide some insight into the difficulties in communication that may be associated with

intercultural communication. The main problem here seems to be norms and rituals in communication that vary across languages and cultures.

4.4.1. Idiomatic expressions

Firstly, a comment by one of the nurses above (section 4.3.4 Professionalism, compromise, collaboration and checking) refers to the use of idiomatic expressions that vary based on culture:

(48) N2: Maar, ek't al baie agtergekom dit kom baie, ja kyk, ons het ook mos nou maar, elke taal het mos maar sy idiome, en sy sêgoed, wat die ander nie verstaan nie, en jy vang jouself dat jy sulke goed sê, en dan kan jy sien op daai een se gesig, maar hy't nou nie 'n clue waarvan jy praat nie. En, maar, en hulle doen ook dieselfde, maar dan verwag hulle jy moet eintlik nou geweet het wat hulle probeer sê het. *(But I've often noticed that it often comes with, yes look, we also have, every language has its idiomatic expressions, and its expressions, that the others do not understand, and you catch yourself saying things, and then at that moment you can see on that person's face that they don't have a clue what you are talking about. And, but, and they also do the same, but then they expect you actually to understand what they were trying to say.)*

Thus, when one nurse translates such an expression into another language, the other participant(s) in communication may need background knowledge of the expression in that culture to understand its meaning. As this nurse indicates, expecting others from different cultures to understand idioms from your culture may cause confusion. Although this may not necessary lead to communication gaps that result in serious adverse events for the patients, it could potentially influence collaboration between nurses or have a negative impact on interpersonal communication between nurses and patients. More research should be done on the idiomatic expressions and other culturally bound sayings or figures of speech that could eventually be included in a *NoM* course to aid nurses' understanding of intercultural language use.

4.4.2. Humour

One nurse also commented (not audio recorded) on how humour can be misunderstood based on culture. This nurse stated that one purpose of humour is

as a means of releasing tension or stress in the ward, and was consistently observed in nursing communicative interactions (see section 7.1, Chapter 5). However, this can be misunderstood by staff from a different culture, and she then has to 'back-pedal' (her term) to appease those who were offended. Thus, it may not always be apparent when one has offended a staff member from a different culture, either through misunderstood idiomatic expressions, humour, or greetings, but in order to optimise collaboration, it seems necessary for staff to be sensitive to unintended offense and to address it quickly to defuse the situation.

4.4.3. Greetings

Miscommunication in relation to cultural differences similarly extends to greetings. When asked about whether she experiences communication problems in general in terms of the language barrier between nurses and patients, one nurse specifically commented:

(49) N6: Ja nee, definitief, maar ek dink dis maar altyd, dis soos daai wat altyd maar soos met party kulture ook saam gaan, is maar, dit is maar net die mooi manier om altyd te vra hallo en hoe gaan dit, so ek dink dis maar iets wat ons ook van die kultuur kan vat. So ek het nou maar, ek vra altyd hallo en hoe gaan dit, jy weet, en dan gaan ons nou maar aan van daar af. So jy kan maar net elke keer vra al, en soos in die Sotho kultuur kan jy dit half 'n general greeting ook maak, so net vir almal hallo se, dan voel almal daar's goeie maniere gehandhaaf, dis maar net vinnig. *(Yes, definitely, but I think it is always, it's like that which always goes with some culture, it's just, it's just good manners always to say hallo and how are you, so I think it's something we can also take from their culture. So I have now, I now always say hallo and how are you, you know, and then we go from there. So you can just ask every time, and like in Sotho culture you also make it like a general greeting, so just say hallo to everyone, then everyone feels good manners have been maintained, it's just quicker.)*

Here the nurse expresses how she tries to communicate with her patients in a manner that is expected in their culture, even if the communication is in English or Afrikaans. She specifically refers to the use of extensive greetings in Sotho culture which is expected as good manners. Once she became aware that extensive greetings were expected in the Sotho culture, which includes all

present, she started to do so when entering a room with more than one patient, even when she only needs to speak to one patient. By showing respect for the patients' culture in this way, it is likely that the patients will reciprocate the respect and be more willing to cooperate with her.

The same is also true for communicative interactions between nursing staff and other medical personnel. For example, another nurse made a similar comment about greetings with doctors of a different culture, specifically when communicating over the telephone:

(50) N6: ...as ek nou net byvoorbeeld dink die groet ding, het ek vir 'n lang tyd byvoorbeeld deur die telefoon te antwoord dan is jy nou soos haastig en jy kan nie verstaan hoe iemand net nie tot die punt kom nie, hoekom moet hulle nou sê hallo en hoe gaan dit, en dan sê jy nou goed dankie en met jou en okay kan ons nou tot die punt kom. Maar deesdae is dit net soos selfs mense van my eie kultuur of taal, omdat ek in a swart omgewing werk het ek nou maar net aangeleer om altyd te sê, "Hallo, hoe gaan dit? Um, hierdie is die, dis wat dit is, dis hoekom ek bel". So dis maar net 'n standard vorm, en dit hou almal tevrede as jy vra hallo en hoe gaan dit, het ek nou al agtergekom. *(...if I now just think of, for example, greetings, for a long time I, for instance, when I answer the telephone then you are in a hurry and you can't understand that someone doesn't just come to the point, why do they first have to say hallo and how are you, and then you say well thank you and with you and okay can we now get to the point. But these days it is just like even with people from my own culture or language, because I work in a black environment I have now learnt to always say, "Hallo, how are you? Um, here is this, this is what it is, this is why I'm calling". So it's just a standard form, and it keeps everyone happy if you say hallo and ask how are you, I have come to realise.)*

The nurse was thus initially frustrated by the use of extensive greetings when on the telephone with a doctor from the Sotho culture, because she is calling him with urgent information about the patient and to ask for instructions for treatment. She experienced the extensive greetings as a waste of precious (treatment) time, but she says that because the other medical personnel are mostly from Sotho and other similar cultural backgrounds, she has had to adapt to their manner of greetings, and now even uses it with people from her own culture. It again points to the fact that nursing staff need to learn to be sensitive to forms of communication that vary based on culture, and learn to compromise

to some extent in order to show others respect and thus to enhance collaboration. The communicative scenario of greetings (section 7.1, Chapter 5) should then also form a crucial part of addressing intercultural communication in a *NoM* course.

4.4.4. Showing respect

The converse may also be true, however. If nurses are not aware of cultural norms and expectations, they may unintentionally offend patients, which will limit the degree to which patients are willing to cooperate or engage with the nurse in interpersonal communication. For example:

(51) N5: ...if it's an patient, I treat them like my grandparents, if it's more like my mother, I'll treat that patient like my mother, if she's my age group I'll treat them like my sisters...

This nurse, who is from a Sotho background, explains that she treats her patients as required by her culture. While her Sotho patients may respond very well to her, it does raise the question, however, about whether patients from other cultures would also respond favourably to being treated in this way. It is unclear from the interviews how this way of treating her patients practically translates into her conduct and speech, but perhaps in some cultures being treated in this manner could be unwelcome, as she may be regarded as being too familiar with her patients or even unprofessional, though her intentions obviously are to talk to patients with an appropriate measure of respect.

In fact, during observations, one nurse consistently made use of terms such as "my skat", "my liefie" and "my darling", particularly in communicative interactions with elderly patients. This can be viewed as an example of over-accommodation in speech accommodation theory which is characterised by the use of diminutives of patient names and terms of endearment such as the ones used by this patient, which many elderly patients experience as condescending and patronising (Brown and Draper, 2003: 16, 18). However, the research into speech accommodation theory in relation to the elderly was conducted almost

exclusively in the context of western culture. Whether being spoken to in this manner will also be offensive in other culture, such as the Sotho culture in the case of this study, is unknown. Also, whether the nurse who made the comment above makes use of negative over-accommodation in speech in addressing her patients in the manner that she describes is not known, but it does seem possible that it could potentially have a negative impact on communication with patients from a different culture. This relates back to the question raised about the use of terms of respect in different cultures discussed in the previous chapter (section 2.3 Communication in an additional language). The use of terms of respect in different languages and cultures is an aspect that would need to be addressed by a *NoM* course to ensure cultural sensitivity leading to a cooperative relationship among the nursing staff, as well as between nurses and patients.

4.4.5. Male/female interaction

Finally, appropriate interaction between men and women is also influenced by culture. Although audio record the comment was not permitted, one nurse stated that she has had instances where a husband answers all the questions for his wife during admission. It would seem that in their culture, the man is considered the head of the household to the extent that he speaks for his wife in public and, in this case, in the hospital. The nurse then expressed her concern that the husband may not be aware of all the details pertaining to his wife's medical information that they need during admission. This could potentially adversely affect treatment, because the husband could not provide all the relevant information. This does not occur regularly, however, but nursing staff would nevertheless need some guidance on how to deal with such situations. This may fall somewhat beyond the scope of a *NoM* course, and the hospital may need to decide on how to deal with such occurrences in a culturally sensitive manner, especially in terms of the medical risks it poses for the patient, as well as the legal risks for the hospital.

5. Future research

The research discussed in this thesis is intended to provide a theoretical justification for the design of a *NoM* course, which will specifically addressed in the next chapter. However, as noted in this chapter and elsewhere in the study, future research should be undertaken to confirm and revise, if necessary, the proposed content and structure of a *NoM* course based on the current project. Also, the problem of writing reports and completing documentation in an additional language needs to be attended to through further research in order for this aspect of nursing communication to be incorporated into its design. The data discussed in this chapter, in relation to the typology (Chapter 5), communicative functions (Chapter 6) and communication problems (Chapter 7) that appear to be common to nursing communicative interactions, raise a number of issues that should be addressed through future research:

- Male/female power relations and interactions based on culture
- Cultural or idiomatic expressions and figures of speech
- Writing reports in an additional language
- Accuracy of translations

6. Conclusion

The data derived from the interviews shed some light on important aspects that need to be addressed in a *NoM* syllabus. It confirms a number of arguments made throughout this study. Firstly, it confirms the need to include small talk as an integral part of the activity-based communicative interactions (section 6, Chapter 5) by using the interactional communicative functions (section 4, Chapter 6). It also re-emphasises the necessity of focusing on the transactional communicative functions of checking, explaining and seeking information across all the categories of communicative interactions listed in the typology. A *NoM* course would also need to take into account the manner in which the

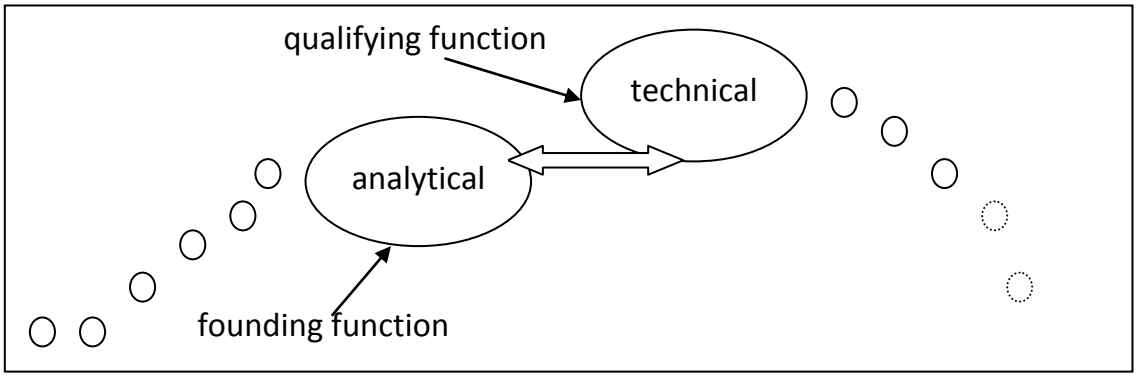
interactional functions often overlap with the transactional, and for nursing staff not only to make allowance for this, but also to use this to their advantage to enhance the care and treatment they offer patients (Chapter 6). Secondly, it confirms the problems associated with nursing staff acting as interpreters. However, the data also seem to indicate that with the necessary assistance and training, using nurses as interpreters would be a valuable resource to the medical profession, as argued in Chapter 7 (section 2.4). Thirdly, it ultimately confirms the need for communicative training for nursing staff who speak English as an additional language, because of the various problems associated with the language barrier and intercultural communication (section 2.3, Chapter 7). This would include creating awareness about aspects of intercultural communication which could create friction among the staff, as well as with patients. Based on the results of the interviews, as discussed in this chapter, and the observation phase of the research from the previous three chapters, the following chapter will argue the rationale for and theoretical justification of a *NoM* syllabus.

Chapter 9
The justification of a syllabus for nursing communication

1. Introduction

The purpose of this thesis is to offer a justification for the design of a *NoM* course in terms of current theory in language teaching. A language course is a prime applied linguistic artefact, and displays the two terminal functions that both guide the design (the technical modality) and provide a rational basis for that instructional plan in its analytical founding function (Weideman, 2015). This can be represented diagrammatically:

Figure 1. Terminal functions of applied linguistic designs



Without that theoretical justification, the design of the course does not qualify as an applied linguistic artefact, but merely as a plan for language teaching. As Weideman (2011) points out, language courses have both normative (or conditioning) formats for their designs, and factual or end-user formats. Below is a representation from Weideman (2011: 15) which indicates the conditioning and corresponding end-user formats of applied linguistic artefacts:

Table 15. Levels of applied linguistic artefacts

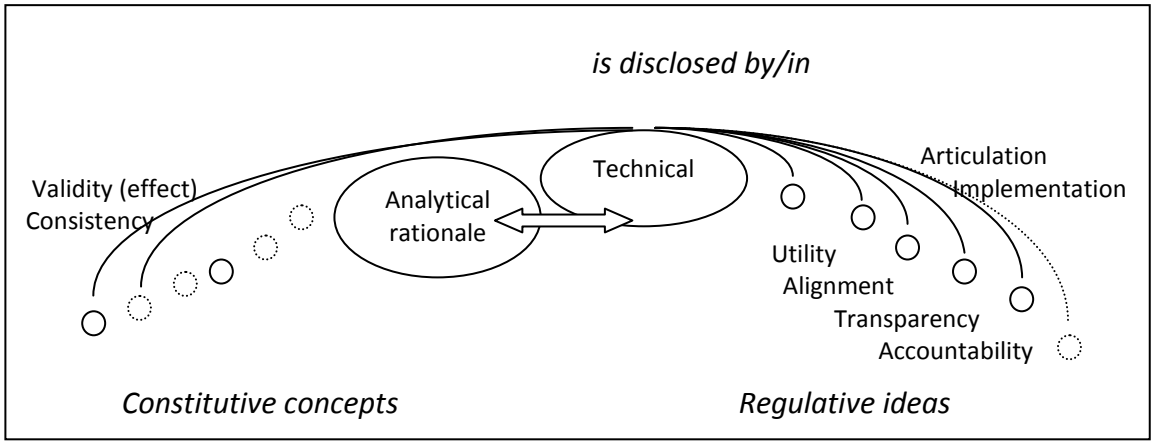
Prior, conditioning artefact	End-user format of design
language curriculum/syllabus	language course
construct and test specifications	language test
language policy	language management plan

A syllabus belongs to the normative dimension of the design, while a language course is evidence of the concrete shape that the design takes when it is prepared for implementation. A syllabus belongs to the normative or conditioning side of a course design because it contains the specifications for the instruction. A syllabus is in that respect a typical technical artefact, since it is the first of at least two preparatory stages before the design may be implemented. The leading technical function is evident in the preparatory nature of the design: in order to make a plan for the intervention envisaged (the language course), a mediating preparatory phase is introduced.

This study is concerned with providing the prior curriculum, or syllabus, that will give rise to the end-user format of the actual *NoM* course. A crucial element of the preparatory phase is its theoretical grounding. The preparatory phase is therefore characterised, as is the case with all technical designs, by a detour into theory and analysis: such analysis not only grounds the design in theory, but also strives to provide corrections and modifications to the design.

Such a theoretical grounding, however, though important as the founding aspect of the plan, is not the only basis for the justification of the design. This is because the leading technical function connects not only with the analytical aspect of reality, but contains echoes of all the other dimensions. These analogical connections among the technical and other aspects of reality yield technical concepts and ideas. From these, in turn, emanate technical principles for the design of language courses and other applied linguistic artefacts. These analogical connections and their associated technical principles can be presented diagrammatically as follows (Weideman, 2006a: 82):

Figure 2. The leading technical function of an applied linguistic design and its analogical connections yielding technical concepts and ideas



This chapter will therefore first deal with the theoretical justification of the syllabus being proposed, by relating its articulation to current theory, before justifying the syllabus in terms of other analogical concepts. The *NoM* syllabus will be theoretically justified below mainly in terms of the sociolinguistic idea of communicative competence, especially as this has been taken up in Communicative Language Teaching (CLT). The eventual *NoM* course will thus be aimed at helping nurses acquire communicative competence by teaching communicative functions within contextualised content relevant to nursing practice, and in alignment with the principles of CLT. In order to reach this goal, the design will utilise a variant within CLT, Di Pietro's strategic interaction method (Weideman, 2002:72,73).

2. The language of caring

Central to the idea of a differentiated communicative competence is the notion of material lingual spheres. This idea (Weideman, 2009: Chapter 4) provides for distinguishing between various kinds of language that are different not only in terms of content (hence the term 'material' lingual sphere), but also as regards their typical qualifying function (Patterson & Weideman, 2013). Thus, the language of a business transaction, being qualified by the economic modality of experience, will be typically and materially different from the aesthetically qualified language of literature, or the confessionally stamped language of worship, or the typically social nature of banter and conversation.

For an idea of what makes nurse communication unique, one has to refer, therefore, not only to its difference in content to other material lingual spheres, but also to that dimension of reality which specifically stamps and typifies it. The typical nature of nurse communication, as identified in Chapter 3, is related to the purposeful caring that nurses engage in with their patients. They communicate with those in their care through a type of discourse, therefore, that is stamped by the love, care and concern that we originally encounter in the ethical dimension of life. To define the ability of nurses to communicate with their patients as part of their overall (though differentiated) communicative competence, one therefore needs to acknowledge its ethical typification.

As discussed in Chapter 3 (section 2), caring can be defined as the attitude that nurses have towards their patients where they are oriented towards preserving the patient's dignity and humanity (Lachman, 2012:112). This attitude of caring is then expressed through their actions and the manner in which they relate to their patients (Lachman, 2012:112). Caring is exhibited through the manner in which the nurse relates to the patient as a unique person with personal experiences. The moment at which caring occurs is not necessarily when the nurse asks the patient how he/she is doing, or only when the nurse reassures the patient or allays their fears. It is more generally exhibited at the moment, for

example, when the nurse realises that the patient is experiencing extreme discomfort after a procedure and the nurse goes out of his/her way to obtain and administer pain medication in order to alleviate the patient's suffering. In short, a caring approach is pervasive and uniquely characteristic of nursing actions.

If we view caring as an attitude towards their patients, the question arises: Can we teach nurses to have a caring attitude and approach? How does one teach nursing staff to approach the work they perform within their profession with the motive of demonstrating care and compassion for their patients? Although it would not be impossible to find a means of eliciting compassion for others or to influence the way nursing staff view their patients, this lies outside the scope of what a *NoM* course is to be designed for. A *NoM* course has limitations of scope, in that it would be aimed at developing communication, yet it cannot ignore the typical ethical stamp of nursing in general. One would hope that those engaged in this profession would exercise care and compassion because they are motivated by a desire to express their concern for others, and it would be through their studies and practical experience that they acquire the knowledge and skills to express the attitude of caring.

A *NoM* course should, however, be designed to add to the knowledge and skills that nursing professionals acquire, and to enhance their ability to utilise these. By designing a communicative language course which facilitates the learning of functional communication, we are providing nursing professionals with the instructional basis from which to develop and express the knowledge, skills and attitudes they gain through their studies. The goal is that, as a result of the development of these acquired skills and knowledge, nurses will be able to express more fully and demonstrate care, both physically and psychologically, for their patients.

As many of the observations and analyses of lingual interactions in previous chapters have shown, care can in fact be severely hindered by or facilitated through communication. A *NoM* course should be aimed at enabling nursing

staff to care (physically and psychologically) for their patients specifically in terms of how care is manifest through communication. This aim is what prompts the research undertaken in this study to be based on an ethics of responsibility (Schuurman, 2005). The starting point of this study, as discussed in Chapter 2, is that the design of any linguistic artefact should be done responsibly and that the design process should therefore meet certain requirements. The research presented in this study is thus aimed at providing first a theoretical rationale for the design of a *NoM* course, and second to show how such a course may be further justified with reference to other and further principles of responsible design (Weideman, 2014:16). The condition of providing a theoretical justification for the course in terms of current theory is the design principle that this research is then primarily concerned with. The theoretical approach to language teaching which this study is based on is the communicative approach, also referred to as Communicative Language Teaching (CLT). This approach, as outlined in Chapter 2, focuses on teaching communicative competence and is supported by a number of seminal works which focus not on so much what language is, but rather on what we do with language (Searle, 1969; Wilkins 1976; Hymes, 1971; Di Pietro, 1974, 1976, 1978a, 1978b). Below we will therefore consider various competencies and aspects of the CLT approach which guides the design of the *NoM* syllabus.

3. Competencies in CLT

The pedagogical approach in CLT is aimed at providing instruction that enables the development of certain competencies. Various frameworks have been offered to define the competencies that a design based on CLT needs to adhere to (Canale & Swain, 1980; Bachman & Palmer, 1996; Celce-Murcia, Dorneyi & Thurrell, 1995). More recently, Littlewood (2004, 2014) has also proposed a conceptual framework called Communication-Oriented Language Teaching. For the purpose of this study, however, we will use the framework of competencies used in the CLT approach, as suggested by Celce-Murcia *et al.* (1995). Four of

the competencies from their research, which is a reworked version of both Canale and Swain and Bachman and Palmer's models, will be used in the design of the *NoM* course. These four competencies are functional competence accompanied by linguistic, sociocultural and strategic competence. As already discussed in Chapter 2, this syllabus is to be a functional syllabus. However, functional communication occurs within sociocultural boundaries, has various linguistic realisations and the functions have to be used strategically. Thus, although functional communication is to be the focus of this syllabus, the design will incorporate the linguistic, sociocultural and strategic competencies that accompany functional competence.

Sociocultural competence varies between cultures and languages. South African nurses will deal with patients from various cultural backgrounds but will often need to communicate in an additional language (often both their own and the patient's additional language). It is questionable whether sociocultural competence should be limited to that of the language being taught, in this case English. If the purpose of the communicative interaction is to reassure the patient, it might be advisable for the interactional functions to be aligned with or at least to recognise the sociocultural competence of the patient's first language and associated culture.

For example, let us take a nurse and patient with different linguistic and cultural backgrounds – Afrikaans and Sesotho respectively – and who communicate in English, as it is the only language they have in common. When trying to be polite when greeting the patient, would it be appropriate for the nurse to adhere to the sociocultural norms of communication in English? It is likely that the patient will be unaware of these norms and may potentially be confused or even offended. It would be more advisable for nurses to defer to the patient's linguistic and cultural background when selecting politeness strategies for interactional functions such as greetings. Although the *NoM* course is to be designed in English initially and later 'translated' into the other South African

languages, it would perhaps be useful to provide nurses with a sociocultural guide for the different language groups in South Africa. Such a guide would enable nurses to engage with their patient more effectively, on an interactional level at least, by using appropriate sociocultural norms regardless of the language they use to communicate with the patient.

Strategic competence will be approached somewhat differently to that laid out by Celce-Murcia *et al.* (1995). It is proposed that in this case Di Pietro's notion of short-circuits in communication should be used to teach strategic interaction. This means designing learning activities that intentionally create a short-circuit in communication, upon which learners are required to negotiate meaning in order to overcome the short-circuit.

There are a number of characteristic features of CLT, to be discussed below, which are reflected in these competencies and which guided the research in this project in providing a theoretical justification for the design of the *NoM* course.

4. *NoM* content: Typology, functions and problems

CLT has various characteristics which are associated with its different directions or interpretations. The CLT approach is in part characterised by the use of authentic texts (Cook 1981; Widdowson 1978). This means that the language learning tasks must have some form of authenticity in terms of the real-life use of the target language (Weideman, 2003: 30, 31). It has been argued that language learning should be based on "a sample from the real-life, highly contextualised language that is the target of the solution" (Weideman, 2015), or what Bachman and Palmer (1996) refer to as "target language use" (TLU). In order to design a language course such as *NoM*, research is required and was undertaken to determine what constitutes authentic target language for the nursing context.

Weideman (2015) also points out, with reference to Bachman and Palmer (1996), that one cannot meaningfully teach differentiated 'skills' such as

reading, writing, speaking and listening because in real life these are so integrated. They cannot be taught separately, as this would decontextualise the learning, which would contradict the argument above for the content to be appropriate and relevant to the target use of the language. A *NoM* syllabus should thus take a communicative approach which features a combination of these 'skills' as they would occur in the real-life scenarios used to inform the content of the course as discussed above. Thus, the idea is to teach learners strategic communicative competence which transcends specific 'skills', by teaching functional communication which could increase their confidence and fluency in the target language within the specified context of their profession.

This study therefore consisted of a needs analysis to determine what content and communicative functions would be authentic to nursing practice. An analysis of the data gathered through the needs analysis on nurse communicative interactions in situ firstly led to the development of a typology of nurse communication (Chapter 5), a list of the most common and crucial communicative functions (Chapter 6) and the problems and short-circuits in communication that a *NoM* course should attempt to address (Chapter 7). The data gathered and analysed in the needs analysis means that the design of the *NoM* course should be able to meet the requirement of appropriateness in design, and as a result, increase the validity of the course (to be discussed later in this chapter).

Firstly, the typology developed from the data gathered in the needs analysis provides the designer with a range of communication scenarios that relate directly to the communication involved in the work nurses do in real life. So the content of the syllabus, as based on the typology, has been identified in such a way that it is adequately aligned with the target language of nurses in the workplace. This typology of nurse communicative interactions prevalent in a number of the nursing staff's daily duties was based on empirical evidence gathered by observing nursing staff in their daily duties (Chapter 5). The

evidence is divided into activity specific and more pervasive categories of interaction.

It is important to note that the typology mainly provides topics around which learning activities can and should be designed to ensure that the syllabus is relevant to what nurses actually do. However, once activities are designed around these topics, it is important that they undergo a quality assurance process with qualified nurses, to ensure that the content is accurate and indeed relevant to their work in real life. This process should be conducted in consultation with a range of nursing staff during the later stage of the design process to ensure that the tasks designed are true to their profession.

Not only should the content, however, be aligned with nurse communicative interactions in real life, but also the communicative functions displayed within the content. Nunan (1991:281) asks the relevant question: "What is it that learners potentially or actually need to do with the target language?" In order to answer this question, an analysis of the data generated through the observations and recordings of nurse communication while they are performing their job has enabled the identification of the most common and most important communicative functions in nursing communicative interactions (Chapter 6). The design of the syllabus should ultimately be aimed at teaching these functions within the content systematized in the typology.

With reference to the argument above that caring can optimally be expressed and demonstrated through communication, it is necessary to emphasise that caring is expressed through both transactional and interactional communicative functions (Chapter 6). The overlap of these functions was evident in the discussion on communicative functions (section 4.1.3, Chapter 6) and confirmed through the interviews (section 4.1.1, Chapter 8). Caring for patients is not confined to interactional communicative functions such as offering comfort or reassurance. It also becomes manifest when, for example, the nurse provides a patient with an explanation of the procedure the patient will undergo, in order to allay the

patient's fears. The transactional communicative functions of explaining, describing and checking, in order to achieve this purpose, thus demonstrate the underlying function of providing comfort and reassurance. The interactional functions of comfort and reassurance thus, more often than not, seem to be disguised as a transactional function. It could even be argued that the amount of caring that is explicitly expressed through the interactional functions is quite limited. This is not to say that functions such as greetings, introductions and small talk do not demonstrate care. However, caring seems to be exhibited just as strongly, if not more so, through the deliberate and concerted use of transactional functions to ensure that patients are more than adequately being treated both physically and psychologically. As discussed in Chapter 7, the interactional functions are a key to enabling nurses to perform their jobs more effectively, because they lead to both the discovery of information pertinent to the patient's treatment and to the development of a relationship of trust between nurse and patient, increasing patient cooperation and reducing patient anxiety. It is therefore important that the learning activities facilitate the learning of both transactional and interactional functions, as well as appropriate combinations of these.

Also pointed out in Chapter 7 is that the appropriate use of the interactional functions can differ across cultures, and a *NoM* course would need to take these differences into account. The initial *NoM* course proposed here is concerned only with teaching these communicative functions in South African English and its associated culture. Subsequent versions of the course in the other official languages of South Africa should be adjusted accordingly to teach the sociocultural competence relevant to the language in question and its associated culture.

However, due to the complexity of the South African nursing context, nursing staff, other medical staff and patients will often communicate in an additional language, while having different first languages. When this occurs, the

communication is complicated potentially by the discordant use of sociocultural competence by the participants in communication. For example, a nurse with Afrikaans as a first language may communicate in English with a patient who has Sesotho as a first language. English is thus an additional language for both of them. The question then arises, should the sociocultural competence be aligned with what is the norm for English? Or do the participants align the sociocultural component of their communication with their own first language, even when they are communicating in a different language? Based on the interviews with nurses (Chapter 8), it would seem that nursing staff tend to use the sociocultural norms in communication of the patient's first language, regardless of the language in which the actual communication occurs. On the other hand, when nursing staff communicate with one another and other medical staff like doctors, they appear to feel that they should try to defer to the sociocultural norms of the other participant's first language to show respect for their colleagues. However, this is not always practical in high-risk and time-sensitive situations. In such cases many of the social and cultural niceties should rather be dispensed of – and in fact are – in favour of speedy communication. That being said, it would be very useful for the *NoM* course to include a sociocultural guide for the various language and cultural groups in South Africa, that nurses can utilise regardless of the actual language communicated in.

Finally, apart from providing for teaching the most common functions and their combinations, the syllabus should also focus on teaching functional communicative strategies that address short-circuits and problems in communication. The use of the information-gap technique, another characteristic feature of CLT, is ideal for teaching strategic communicative competence. An information-gap exercise can in fact be seen as implicitly containing a short-circuit in communication that the learners need to overcome. For example:

> Learners are put into pairs and assigned the roles of nurse and a family member of a patient. The nurse is given a map of a ward with the room and bed numbers indicated, as well as the bed which is relevant to the exercise highlighted. The family member must ask the nurse for directions to the patient in the ward that

> they want to see. The nurse has to give the family member directions to the patient's room based on his/her map (which the other participant is not allowed to see). After the nurse gives the directions, he/she gives the family member a second map, without the bed and room numbers, and the family member must then attempt to locate the patient's room on the map based on the directions.

Depending on the complexity of the map and the learners' language ability, short-circuits are likely to occur. The learners could misunderstand or be prompted to misunderstand the directions and have difficulty locating the right bed, or the patient could have been moved to a different room which the nurse would need to check, apologise for the misunderstanding and give new directions.

In addition, there are numerous problems in the realm of nurse communication as identified by this study (Chapter 7). However, some of these fall outside the scope of the syllabus proposed. Problems such as Complex Communication Needs and translations may require specialised training. As pointed out in Chapter 7, one barrier to communication is participants' attitude and mood. Although this is interesting as far as theoretical analysis is concerned, this cannot be related to a general pedagogical solution within the limits of a communicative language syllabus.

The *NoM* syllabus should, however, deal with such short-circuits and communication problems that can be adequately addressed through teaching functional communication. So apart from just teaching the actual functions within specific contexts as discussed above, it is crucial that such a syllabus also specifically address how to use these, given specified problematic situations. This lies at the heart of transactional competence and the strategic interaction method – the ability to employ communicative strategies to negotiate and surmount short-circuits. This necessitates the inclusion of learning units focusing on the following:

- Simplifying complex medical terminology

- Incorporating interactional functions into the transactional, especially in the context of a high-stress/emergency situation.
- Checking whether you or the other participant has correctly understood the information communicated. This is important across the board and should be taught in combination with every other communicative function.
- Creating awareness of appropriate terminology for politeness in different cultures when combining interactional and transactional functions.
- Checking, or asking for clarification, when someone uses a term or phrase from another language that you do not understand.

The above are focused on the use of specific functions and should be taught in the context of various scenarios, as these short-circuits or misunderstandings can happen in a range of contexts that nurses face in their profession.

Ultimately, the data from the needs analysis allow for the design of a *NoM* course that is based on the CLT approach. The typology provides us with a database of typical communicative interactions on which learning activities can be based and that are authentic and relevant to nursing practice. In addition, these learning activities should also be aimed at teaching a (combination of) communicative function(s) and how to use them strategically to negotiate short-circuits and communication problems as determined by the analysis of the data.

5. Structure of the syllabus

The designer of a *NoM* course would thus be able to structure a syllabus in a number of ways in facilitating the learning of communicative functions based on real life nursing scenarios. The structure of the course will depend on factors such as the required or desired length of the course, proficiency level, and feasibility and practicality of the design. Nonetheless, the typology provides a designer with a vast array of potential materials for designing learning activities based on real life scenarios that nurses will most likely face in the day-to-day

activities of their profession. The designer could potentially organise the learning activities based on a number of structures. For example, the designers may decide to design the course based primarily on the participants in communication. In this case the three main categories which could be used are

1. **Nurse-Nurse** - *e.g. shift-handover (reporting)*
2. **Nurse-Patient** - *e.g. administering medication (explaining, instructing)*
3. **Nurse-Doctor** - *e.g. doctor rounds (informing, recommending)*

Another possible means of structuring the syllabus would be based on the communicative functions as discussed in Chapter 6. In such a case, the two main categories would be interactional and transactional communicative interactions (Chapter 6). The outline for such a means of structuring the course could look something like this:

1. **Interactional**
    a. **Greetings and introductions** *(during admission or shift handover)*
    b. **Offering comfort or reassurance** *(when the patient receives a serious diagnosis)*
    c. **Socialising and humour** (with your patient and with other staff)

2. **Transactional**
    a. **Seeking information** *(during admission and while administering medication)*
    b. **Informing** *(another nurse that the doctor has given new instructions regarding the patient's treatment)*
    c. **Explaining** *(to the patient what the medication is for and what the possible side effects are)*
    d. **Describing** *(the type of pain the patient may experience)*
    e. **Reporting** *(to the new staff coming on duty that the patient had a negative reaction to a certain medication)*
    f. **Checking** *(whether you have understood the doctor's orders correctly)*
    g. **Instructing** *(the patient not to move the injured leg for a specific period of time)*
    h. **Directing** *(the patient on how to move their arm while drawing blood during observations)*

As can be seen above, the learning activities for each of the functions should be couched in the real-life scenarios from the typology.

The final possible structure, which may perhaps be the most logical and appealing for nursing staff, is to base the organisation of learning on the various nursing activities. The learning activities could be based on various activities that nursing staff perform in on a daily basis, in relation to the communicative functions prominent in each category:

1. **Shift-handover (N-N-M)**
    a. **Treatment performed (Activities completed during the shift)**
        i. *– Informing*
    b. **Medication administered (Type, dosage frequency)**
        i. *– Informing*
    c. **Tests, procedure, operation during new shift**
        i. *– Informing, Instructing*
    d. **Diagnosis of new patients**
        i. *– Informing*
    e. **Wound condition and treatment**
        i. *– Informing, Instructing*
    f. **Doctor instructions for mobility (increase, decrease)**
        i. *– Informing, Instructing*
    g. **Date for discharge**
        i. *– Informing, Instructing*
    h. **Dietary requirements (diabetic, nil/mond)**
        i. *– Informing, Instructing*
    i. **Patient complaints and treatment administered (nausea, pain)**
        i. *– Informing*
    j. **Nurse handing over asking other staff to monitor specific patient that they are worried about**
        i. *– Instructing, Advising*

2. **Observations (N-P)**
    a. **Greeting patient**
        i. *Greeting*
    b. **Tell patient about purpose of activities**
        i. *Informing*
    c. **Tell patient what to expect during observations (pain, discomfort)**
        i. *Informing*
    d. **Directions for cooperation with nursing activities**
        i. *Directing*
    e. **Asking whether the patient has eaten or has difficulty eating**
        i. *Seeking information*
    f. **Asking whether the patient needs assistance with bathing**
        i. *Seeking information*
    g. **Asking whether they have been informed about test, procedures, operations they are to undergo**

   i. *Seeking information, Informing*

h. Giving patient instructions based on observations (increase fluid intake, increase mobility)

   i. *Instructing*

i. Patient questions and complaints

   i. *Informing, Explaining*

j. Reassuring/offering comfort to distraught patient

   i. *Reassurance, Comfort*

3. Doctor rounds (N-D)

a. Doctor asks for information which the nurse provides

   i. *Informing (in response to questions)*

- Test results
- Changes in condition
- Patient reaction to treatment
- Other doctor's recommendations/instructions

b. Nurse checking doctor instructions

   i. *Checking*

- Medication to be administered (type, dosage, frequency)
- Change in mobility
- Discharge and check-up date
- Test, procedure, operation to be scheduled

c. Nurse makes suggestions for treatment

   i. *Suggestion, Recommendation*

d. Nurse informs doctor of patient complaints that need attention

   i. *Informing, Requesting, Recommending*

4. Administering medication (N-P)

a. Greeting patient

   i. *Greeting*

b. Offering treatment information

- Purpose of medication
  - *Informing, Explaining*
- Possible side-effects
  - *Explaining, Describing*
- Reporting side-effects
  - *Informing, Instructing*

c. Checking with patient

   i. *Seeking information*

- Whether patient has experienced side-effects
- Whether medication appears to be effective
- Whether patient has other ailments (side-effects) that require additional medication

d. Giving patient directions for cooperation while administering medication

   i. *Directions*

e. **Giving patient instructions for taking medication (only after eating, drinking enough water)**
    i. *Instructions, Explaining*
f. **Dealing with patient complaints or questions**
    i. *Explaining, Reassuring*

5. Admission (N-P)

a. **Greeting patient**
    i. *Greeting*
b. **Introducing yourself**
    i. *Introduction*
c. **Directions for cooperation while taking vital signs**
    i. *Directions*
d. **Asking admission questions**
    i. *Seeking information*
        - Personal information
        - Medication
        - Previous procedures or operations
        - Dietary requirements (diabetes, allergies)
e. **Assessment of conditions**
    i. *Seeking information*
        - Difficulty urinating or with bowel movements
        - Difficulty sleeping
        - Nausea or pain

6. Discharge (N-P)

a. **Giving treatment information**
    i. *Informing, Instructing*
        - Medication to be taken at home
        - Hygiene
        - Wound care
b. **Administrative information**
    i. *Informing, Instructing*
        - Check-up date
        - Doctor to see for check-up
        - Discharge paperwork
c. **Asking if there are any problems that could lead to re-admission**
    i. *Seeking information*
        - Social
        - Familial
        - Financial
d. **Saying goodbye to patient**
    i. *Leave-taking*

This is just an outline of the structure that the course can take. At least one learning activity should be designed for each of the six categories of communicative scenarios and their accompanying communicative function(s). Depending on the limitations for the implementation of the course, the number of scenarios and activities in each category can be adjusted as circumstances dictate. However, at least one activity for each of the most important functions should be retained when cutting scenarios. This is important if the course is to exhibit adequate differentiation, to be further discussed below, and therefore for the designed course to be characterised as conforming to design principles.

It is necessary to note that the rank of the nurse will, however, determine the extent to which they engage in these activities. For example, a course designed for auxiliary nurses will probably consist primarily of categories 1, 2, 5, and 6 because usually only the higher-ranking nurses accompany the doctor on their rounds and are licensed to administer medication. On the other hand, if the course is aimed at these higher-ranking nurses, the category of observations may be omitted. It is important to note that the interactions included in the Pervasive categories still remain relevant and should be included in whichever activities are chosen to inform the content of such a course. Structuring the syllabus based on the activities they perform will allow nurses to participate in learning activities that pertain to the treatment-related activities they perform as nurses. Thus the focus remains on facilitating the learning of communicative functions within the content of each category.

However, as was noted in Chapter 6, the functions tend to occur in combination in the real life scenarios observed and recorded. Thus, a *NoM* syllabus should ideally be aimed at teaching these functions in combination with others. Depending on the level of proficiency that the course is aimed at, the functions could first be taught in simplified form, and then be paired systematically with other functions as they are bound to occur in real life. The appropriate pairing of

interactional and transactional functions becomes important here, as pointed out above.

The strategies for closing the short-circuit will also depend on the role players. The strategies that learners select may vary depending on whether they are addressing the patient, a doctor or another nursing staff member. The design of the learning activities needs to take this into account and needs to be aimed at raising awareness about appropriate strategies in relation to the role players that communication occurs with; for example:

> Learners are divided into groups of three – patient, N1, N2. N1 is given an information card regarding a complex procedure that the patient must undergo. N1 must inform N2 about the procedure and instruct him/her to inform the patient. N2 must be ready to provide simplifications of complex medical information/terminology. The patient, who is to act uneducated and uninformed, must ask for clarification and check aspects of the explanation that N2 does not adequately explain or describe. Learners should then discuss strategies for providing simplifications for patients.

It is important to note that regardless of the organisational structure that the syllabus takes, the point is always to teach communicative functions in relation to real life scenarios. However the designer chooses to organise and structure the learning units, the focus remains on teaching transactional competence by strategically employing communicative functions to negotiate potential and real short-circuits. This means that learning activities would need to present learners with a potential short-circuit which requires them to select and use appropriately a (combination of) communicative function(s) to complete the activity successfully. The research conducted in this study provides the designers with the most pertinent types of communicative interactions (the typology in Chapter 5) as well as which combinations of functions are most relevant to each of these categories (section 5, Chapter 6).

6. Conditions for design

The guiding principles for course design (Weideman, 2014:16) were presented in Chapter 2. Although this study is primarily concerned with the condition of

providing a theoretical justification for the design of the course, the other principles of design which constitute the remaining requirements for the design should also be considered.

Firstly, performing a needs analysis to inform the content and structure of the syllabus seeks to ensure that the course adheres to the principle of systematicity in design, as well as to the requirements of appropriateness and relevance, referred to above, to which I shall return again below. This condition for design requires that a design should "systematically integrate multiple sets of evidence in arguing for the validity of the course design". The needs analysis provides the evidence, which was *systematically* gathered using different methods, on which the content can be based. This evidence is expressed in the typology, the list of communicative functions and the problems with nursing communication which will inform the design of the syllabus. The manner in which these aspects can be addressed systematically can be seen above in the proposed possible structures of the *NoM* course.

In order for the activities to be consistent and valid, the *scope* of the course needs to be well defined. As already outlined in Chapter 1 and 2, this course is to be designed specifically for nursing staff to improve their communicative competence within the setting of nursing practice. This means that it is limited to communication that occurs between specific role players within the hospital/clinic setting. These role-players include, among others, nursing staff, patients, doctors, administrative staff, and family members or friends of patients. For the purposes of this course, which needs to be designed within certain practical limitations, it will have to be designed specifically to aid interaction between the following role players: nursing staff, doctors and patients.

Basing the design of the syllabus on this data allows us to argue for the *validity* of the course, another condition for responsible design. Firstly, the envisioned course will seek to be relevant and appropriate to nursing practice by making use of learning activities that are true to real-life nursing communicative scenarios

and their accompanying communicative functions. The learning activities then need to provide a platform for the development of communicative competence, as outlined above in accordance with the CLT approach, in order to be valid. Whether they are in fact valid will eventually be confirmed through actual teaching and feedback, but provided that the syllabus is based on a sound theoretical framework and the content is informed by systematic research, the activities should have a high level of validity. That is, it should do what it sets out to do – help nurses develop and improve their communicative competence in the context of their work, as outlined in this chapter.

The validity of the learning activities will, however, also be dependent on whether they are *consistently* designed with this aim in mind. Each learning activity needs to be consistently designed in line with the purpose of the syllabus. In other words, only activities that are relevant to the nursing context as outlined in the typology and that teach a communicative function are appropriate to the course. Any activities that do not meet these requirements are not consistent with the purpose and therefore invalid. Such activities should then be excluded from the course. The proposed CLT framework for the course should also help to ensure consistency. Although it can be argued that the reliability and validity of the course should potentially be high because of the research presented in this study, this can only be confirmed once the design has been implemented and tested.

In addition, the limited scope allows for adequate *differentiation* within the syllabus. That is to say that each activity needs not only to be consistent in pursuing the purpose of the syllabus, but also need to address consistently the individual aspects of the communicative needs of those involved. The activities designed thus need to not only align with actual nursing activities, but they also need to facilitate the learning of the individual communicative functions (and their appropriate combinations) with various role players as defined in the scope. The activities thus need to be organised in a manner that ensures that the

learning occurs systematically (again meeting the requirement for systematicity) from simpler to more complex aspects of competence. The design needs to ensure that the learning takes place systematically in order to achieve its goal of teaching communicative competence and therefore having validity. Systematically differentiated learning activities should enhance the validity and reliability of the syllabus as a whole. In the structure for the course proposed in the previous section, it is evident how the activities are differentiated in terms of systematically addressing the various communicative functions in relation to the relevant role-players.

The design of the syllabus should furthermore be intuitively *appealing* and acceptable. In other words, the design of the learning activities should be creative and imaginative for the purpose of engaging learners in the learning process. It can be argued that the use of the information-gap technique, which requires learners to think critically and come up with solutions to communicative problems, should assist substantially in engaging learners. Also, basing the activities on content and communicative needs that are relevant to their work should motivate learners to engage. The learners should be able to identify how these activities are useful in helping them to improve their communicative ability and to perform their work more effectively. Another way of engaging learners is by using gamification, which can be defined as "the use of game design elements in non-game contexts" (Deterding, Khaled, Nacke & Dixon, 2011a, 2011b) and can be applied to both online and offline educational settings (Muntean, 2011). Gamification can be used to make learning 'fun', without compromising the usefulness of activities, in order to make the course more appealing.

The research performed in this study provides us with sufficient data to design a syllabus. This syllabus is the *articulation* of the blueprint for the course that is eventually to be designed. The specifications for the syllabus are to be found in the typology of nursing communicative scenarios, the communicative functions

within the typology, and the short-circuits and communicative problems that need to be addressed.

The needs analysis helps us to meet the conditions for *appropriateness*. The data gathered and analysed through the needs analysis provide us with appropriate and relevant content. This meets the social condition of design which yields the design requirements that the course should be relevant and appropriate to those who will actually use it. The scope discussed above defines who the end users are, as well as the context within and for which learning will take place. If the activities designed are then based on the data gathered and articulated in the needs analysis, the course should be appropriate for reaching its objectives and (theoretically at least) do what it sets out to do, which is to make possible the development of communicative competence within the context of nursing communication.

The *NoM* course must also be accomplished in terms of the financial and other resources and time available to offer it. For example, nursing staff already working may have less time to attend a course than students. They would therefore be likely to find an online version of the course more useable. Also, the hospital management might object to paying for such a course while experiencing a potential shortage of staff, as is often the case. So when the course is implemented, it must be *economical* both in terms of time and money for the participants. Feasibility of design is not a requirement that is easy to satisfy, and trade-offs are always likely.

The principle of *alignment* should also be considered in the design. The instruction of the activities should be in line with the purpose of the course if the course is to be valid. The activities designed, and the manner in which they are presented in class, should then align with the course's purpose. In designing the activities, you must also anticipate how you will test the ability that they aim to develop. The activities and the teaching thereof should therefore be aligned with

the testing, and vice versa, and both of these should contribute to the learning, and how communicative competence may be developed.

The next condition is that of transparency. Firstly, this study in itself provides a description or explanation for what nurses need to be able to do and how we may aim to help them by means of the *NoM* course. This information should also be provided to learners by whatever means available. For instance, this information should be available on the *NoM* and associated websites. Learners should thus have ready access to all the relevant information on the course and the designers should in this way be *accountable* to both users and to the public for their design.

The condition of *fairness* is a further requirement of the course. This means that the activities should in no way discriminate against learners on the basis of gender, race, sexual orientation, culture, or any other factor. Although it is impossible to take into account every single factor that could possibly create a bias against a learner, measures should be taken to ensure, as far as possible, that such biases do not exist, and remedy them if they are discovered.

The final requirement is that the course should be *trustworthy*. This will only really be achieved once the course has been implemented and evaluated. However, the first step towards ensuring the trustworthiness of the *NoM* course has already been taken by performing the research that underlies the course in order to meet all of the above conditions of responsible course design.

7. Conclusion

The purpose of this study has been to provide a theoretical defence of the design of a *NoM* course. Based on the discussion above, one may claim that the design of the proposed *NoM* course is grounded in the theoretical framework of the CLT approach and its characteristic features. The needs analysis performed has generated sufficient data to inform the design of the necessary content and the manner in which it could be structured in order to reach the aims of the course.

This means that the proposed design strives to adhere to the requirements for the theoretical justification of an applied linguistic artefact (Weideman, 2007a). The proposed design can also be justified in terms of the appropriateness and relevance of the content to the envisioned end-users of the course defined in the scope. The manner in which this content is to be systematically organised and presented means that the course should meet the requirement of adequate differentiation, as well as potentially offering a high level of validity. Whether the course does in fact measure up to the various requirements or conditions for design will only be fully assessed after the implementation of the design. However, this study provides a first rationale for its initial design.

There are, however, a number of limitations to this study. As discussed elsewhere in this study (see also section 2.3, Chapter 7 and section 4.3.3 and 5, Chapter 8), in order to design a comprehensive language course that addresses all aspects of communication between nursing staff and others, an analysis of documentation used by nurses is required in order to develop nursing staff's ability to write in an additional language. Also, this study was limited to two hospitals in the Bloemfontein, South Africa. Research in other medical centres in other cities in South Africa or even other countries could offer us with further insight into the findings in this study, or even contradict the conclusions drawn here. This would, of course, impact on the design of the course.

Based on the requirements for design set out in this chapter, the next stage of design can commence. This will entail designing a range of actual learning activities and tasks that are adequately differentiated and that consistently and systematically seek to achieve the aim of improving nursing staff's communicative ability. One of the limitations of this theoretical justification for the design of an eventual course for nursing communication is that it has dealt only with its justification as regards language content and pedagogy. A further justification that will be needed once the course is implemented, is to check whether its activities are structured so as to facilitate language learning and

development (Lightbown, Spada, Ranta & Rand, 2006). While this was not always the case, communicative activities in the classroom are now eminently justifiable in terms of what we know about developing language in instructional settings. Nonetheless, upon implementation, this needs to be checked for effectiveness in this particular case.

Thus, the extent to which the course is valid – achieving its aims – can best be measured once the course has been piloted on a group of nursing staff. A process for determining the validity of individual tasks and learning activities, as well as the course as a whole, will need to be undertaken. This would include a pre- and post-course test for learners to investigate the extent to which the communicative competence of nursing staff who have taken the course has improved. Focus groups of learners can also be used to determine how useful and relevant the types of learning activities used in the course are. Revision of and corrections to the course can then be made based on the feedback from the tests and the focus groups. This process of piloting and revision is necessary to ensure quality control. Therefore, some further research is required before the *NoM* course can be implemented in South Africa, although the theoretical justification and the conditions for the design set out in this study provide us with a basis from which subsequent phases of design can proceed.

Chapter 10
Conclusion

1. The importance of and problems in nursing communication

There can be no doubt that communicative ability could be considered a requisite for nurses to be able to care (physically and psychologically) for their patients. As discussed in Chapter 3, caring is central to nursing practice, and communication enables nursing staff to offer care for patients. Caring, as defined in Lachman (2012), occurs on both a psychosocial and physical level. The international literature repeatedly points out that nurses need to use patient-oriented communication as opposed to purely task-oriented communication in order to address not only patients' physical needs, but also to cater for their psychological and emotional needs which have an impact on their treatment (Chapter 3). The literature reviewed in Chapter 3 points out that communication can be used to build interpersonal relationships between nurse and patient that lead to trust and cooperation with the aim of ensuring effective treatment. The current research project (Chapter 8) has confirmed that nurses deemed it important to use communication to build this trust and subsequently a cooperative relationship with patients, and that such a relationship can have a

definite impact on helping (or hindering) nurses to treat and care for patients. The term treatment-oriented communication was proposed in Chapter 3 as an alternative to task- or patient-oriented communication, because it implies that the focus of communication be on achieving the aim of effective care and treatment both on a physical and psychological level. Thus, even when a given communicative interaction between a nurse and patient constitutes "small talk", the purpose is still building a relationship that aids the treatment process.

In addition, communication also affects the extent to which nursing staff are able to collaborate effectively with other medical personnel, impacting on their own job satisfaction (Chapter 8). The criterion of offering quality (physical and psychological) care has also been articulated in various international and South African standards for healthcare, as pointed out in Chapter 3, and communication is an integral part of providing care in alignment with these standards.

In the South African healthcare setting, achieving these standards is complicated by the use of multiple additional languages by participants in their communicative interactions. The purpose of the envisaged *NoM* course is to improve nursing staff's communicative competence in additional languages. This study therefore aims to provide a theoretical justification for a course that would assist nurses in acquiring the communication competence that enables them to meet these standards. A lack of such a justification seems to be one of the factors that limits the extent to which existing training courses and programs achieve the desired outcomes on nursing communicative ability (Chapter 3). The hope is that as a result of the justification offered here we can avoid designing a course, albeit with good intentions, that, among other things, lacks validity because there is a lack of adequate research to support its design.

2. *NoM*: A design solution

Following Weideman's (2011) framework for the principles of design for a linguistic artefact, I have characterised the possible *NoM* syllabus is a technical artefact that provides us with the conditions or requirements for the design to be expressed in the end-user format, that is, the eventual *NoM* course that is prepared for implementation. This means that on the one hand we need to provide a justification in terms of the most current language teaching theory, which reflects the connection between the leading technical function of the design and the analytical dimension of reality. On the other hand, we also need to justify the design based on the analogical connections between the technical dimension and all the other dimensions of reality. In order to provide the first justification, Communicative Language Teaching (CLT) has been selected as the most appropriate method of language teaching for a *NoM* course. CLT centres on teaching communicative competence using authentic texts and the information gap technique, among other things, which led to the needs analysis performed in this study. Through the needs analysis the typical nursing communicative scenarios and the communicative functions common to these have been identified to inform the design of the content and structure of the *NoM* course based on the CLT approach.

Chapter 9 then also outlines the other guiding principles for the design of the course which emanate from the analogical connections between the technical and every other dimension of reality, except for the analytical, which has already been mentioned above. These include such conditions for design as systematicity, validity, consistency, usefulness and relevance, economy, transparency and so forth. The design of the tasks, activities and assessment which the course will comprise of should all be guided by the principles set out in the justification in this chapter. Using scenarios and communicative functions that are based on real-life nursing practice should also increase the validity, relevance and appropriateness of the course for nursing staff, which are all

pitfalls of many nurse communication training programs identified in Chapter 1 (section 1.2) and Chapter 3 (section 4).

In performing the research that underpins the design proposed in this study, it is necessary to investigate the problems that inhibit communication in the nursing profession. One of these problems of particular concern in this study is that communication is complicated by the fact that South Africa has eleven official languages. Also, language use in nursing communication is further complicated by the migration of nurses to other parts of South Africa, because different South African languages tend to be dominant in various regions of the country. Thus the L1 and additional languages in which migrating nurses are proficient or semi-proficient may vary from the languages predominantly used in the area they migrate to. This means that participants in communicative interactions in the healthcare setting often have to use an additional language to communicate with others and that either or both participants are not sufficiently proficient in the language of communication. *NoM* seeks to enable nurses to improve their communicative competence in their additional languages in order to do their jobs better, given this complex context. Based on the CLT approach, communicative scenarios and communicative functions specific to nursing communicative interactions, as identified through the needs analysis performed in this study, can be used to design a *NoM* course that is aimed at improving the communicative competence of nursing staff. The aim is that by improving nurses' communicative competence, the quality of (physical and psychological) care will also improve.

The needs analysis was performed in two hospitals in Bloemfontein after a thorough process of obtaining ethical clearance from all relevant parties, as reported in Chapter 5. An analysis of the data generated informs various aspects of the design of a *NoM* course. The observations of nursing staff on duty and interviews with nursing staff allowed for the development a typology of typical and crucial nursing communicative interactions (Chapter 5). This typology

significantly expanded on the initial inventory based on the review of the literature in Chapter 4. The scenarios in the modified typology were based on the activities that nurses performed rather than the broader categories initially used – Personal and Emotional Patient Care, and Diagnosis and Treatment. The typology serves as an extensive database which divides the typical nursing communicative scenarios into categories based on routine nursing activities and the accompanying categories of communication that can occur during any of the specified nursing activities. This typology enables us to design a *NoM* course that is based on real-life scenarios, which should make it useful to actual nursing practice, as opposed to a more generic course. Designers can thus select relevant scenarios and organise them in the course in a manner that is meaningful, useful and best serves the purposes of the course, which meets a number of Weideman's (2011) requirements for design discussed above.

The data were also analysed in order to identify the most common and important communicative functions typical to nursing communicative interactions (Chapter 6). Designers of the *NoM* course can thus focus on what nursing staff actually need to be able to do with language given the typical scenarios of interaction in the typology. Furthermore, the combination of interactional and transactional communicative functions is quite prevalent throughout nursing interactions (section 4, Chapter 6). In addition, during the interviews, the participants repeatedly expressed their belief that it is very important to engage in various forms of "small talk" (interactional functions) with their patients when possible, because it not only leads to the development of a trusting and cooperative relationship with the patient, but it also often leads to the discovery of information about the patient that is pertinent to their treatment (Chapter 8). Even "small talk" is in this context specifically stamped by the ethical function that guides not only nursing care and treatment in general, but also communication. Thus the design of a *NoM* course should take into account that it is important to combine interactional (section 7.1, Chapter 5) and transactional (every other category in Chapter 5) communicative functions in the appropriate

context. This allows nursing staff to achieve the aim mentioned above of ensuring that communication is treatment-centred as opposed to using either patient-centred or task-oriented communication.

Possibly one of the most important communicative functions identified in this study is checking (section 3.1.6, Chapter 6). Because so many important decisions are made and instructions given on a daily basis that could have a very serious impact on patients' physical (and psychological) well-being, checking becomes crucial. When a nurse is asked for information, given an instruction, or in any other relevant scenario, it would be useful to practice checking as a standard part of these scenarios to ensure that miscommunication or a short-circuit does not occur. Based on the findings in this study, checking is thus one of the most important communicative functions to be included in a *NoM* course and should be taught in combination with every other communicative function.

The data from the observations were also analysed for the short-circuits and problems in communication that a *NoM* course would need to address. These communication problems mainly centred on the complications associated with communication in an additional language, which confirms one of the two problems with nursing communication identified in Chapter 1 and Chapter 3 (section 5.4). Although there are other problems associated with nursing communication, as identified in Chapter 3, the focus here is mainly the issue of communication in an additional language. Given the South African context, a *NoM* course would need to assist nursing staff in improving their communicative competence in additional languages. This would include focusing on the importance of understanding differences in intercultural communication so that the communication problems typically associated with communication in additional languages can be circumvented.

One way to address communication in additional languages is providing the learners with the necessary vocabulary for nursing staff to explain medical terminology in simplified terms. Except for the fact that most patients will not

possess an extensive knowledge of medical terminology, in South Africa nurses will often have to engage with patients in an additional language, or even with illiterate patients, which requires nurses to be able to explain complex concepts or procedures in simplified terms in an additional language. During the interviews nurses expressed their concern at being able to express themselves correctly and accurately in an additional language when completing documentation or reports. Once adequate analysis of nursing documentation and reports has been performed, a *NoM* course should also include the vocabulary necessary to perform these written tasks.

3. Limitations and future research

There are limitations to the research performed in this study which point to future projects that can be undertaken to supplement and refine the proposed *NoM* course. The main limitation is that the scope of this project, in combination with the practicalities of doing research, necessarily limits the focus of the study.

Firstly, the literature review was conducted between 2013 and 2014. New research may have been conducted and published since then that sheds new light on issues raised in this thesis or even contradict certain points made. Remaining aware of the most current research in nursing communication to identify either new problems or solutions to these will aid designers in keeping the design relevant.

Secondly, as pointed out in Chapter 5, my presence during the observation phase of the research could potentially compromise the authenticity of the data. Similarly, fear of repercussions for answers and opinions provided during the interviews, despite assurance of anonymity and confidentiality, may have led the participants to provide the answers that they think are expected as opposed to their honest opinions. Although every precaution was taken to minimise the tainting of the data, this effect cannot wholly be eliminated due to the nature of fieldwork. However, due to the extensive confirmation of the results, where the

same communicative scenarios and functions, and the problems with nursing communication, were evident repeatedly given the same contexts, it is suggested that my presence did not influence the authenticity of the results to the extent that the results in this study can be invalidated. The level of congruence of the results in fact suggests the opposite.

Thirdly, the fieldwork was performed only in Bloemfontein, South Africa, so the results are not necessarily generalisable to the whole of South Africa, or even the whole of Bloemfontein. Further research in other parts of the country should be conducted to confirm the typicality of the nursing communicative scenarios and communicative functions identified. Further research should also be performed to investigate the prevalence, extent and characteristics of problems associated with communicating in additional languages in the South African nursing profession.

Research should also be done to investigate the impact of power relations on communication. The interviews seemed to point to the fact that nursing staff generally have a good relationship with one another and with the doctors, which means that they are comfortable enough to acknowledge that they do not understand what the other party is saying and to request clarification, or even to make suggestions to the doctors. This may not be true for all hospitals or wards in a hospital. More research is required to determine the extent to which power relations may inhibit communication so that strategies can be included in the course to enable nursing staff to deal sufficiently with such problems in communicative scenarios.

Another important potentially problematic aspect of nursing communication in the South African healthcare setting is that nursing staff are frequently required to act as interpreters (Chapter 8). Research should be conducted to determine the accuracy of such interpretation so that a solution to the problem of interpretation can be designed. This falls outside the current scope what a *NoM* course is to be designed for. However, with sufficient research to underpin it, a guide with

strategies for interpreting could be included in a *NoM* course, or *NoM* could potentially even be extended to include interpreter training. Regardless of whether this is included in *NoM* or not, interpreter training is an aspect of nursing communication that definitely seems to need attention, as it is so prevalent in nursing communication in South Africa.

Also, sufficient research into the differences in intercultural communication in all eleven official languages is required. The issue of differences in intercultural communication was evident in the data from both the observations (section 2.3, Chapter 7) and the interviews (section 4.4, Chapter 8), but more research is required to delineate these particular differences. Ideally *NoM* should be expanded into all eleven official South African languages, although it remains to be seen whether this can be achieved, or is financially and logistically possible. Regardless, a component on intercultural communication for all eleven official languages and their associated cultures should be included in the *NoM* course. This should include ensuring that nursing staff know the appropriate terms of respect for addressing others in terms of age and gender, for example. The issue of appropriate male/female interaction for different cultures can prove to be a particularly sensitive issue and it will be useful for nursing staff to have strategies for navigating those problems that this potentially creates.

Finally, an analysis of nursing reports and documentation is required, as these are an integral part of communicative interactions in nursing practice. Many nurses expressed their concerns and fears about completing these in an additional language that they feel they are not adequately proficient in (section 4.3, Chapter 8). They expressed their doubts about the accuracy and preciseness of the information recorded on these, and their fears for the consequences, should their doubts be validated. Providing nurses with training on how to complete documentation and reports in an additional language, usually English, can increase their confidence in their own ability and that of other nursing staff to record written information correctly. This could not only reduce some of the

stress that nursing staff are already faced with daily as a part of their jobs, but also minimise the chances of misunderstandings that could potentially lead to adverse events in patient treatment.

4. The purpose of responsible design

This study provides a preliminary theoretical justification for the design of a *NoM* course by articulating the principles that both ground the design in theory and guide it, based on technical principles, by setting out the specifications for instruction. The aim is to provide a basis from which a *NoM* course can be designed to ameliorate some of the difficulty surrounding communication in additional languages within the nursing profession, as is common in South Africa. The goal is that as a result of improved communicative competence of those involved in the nursing profession, the physical and psychological care of patients in the South African healthcare system will be improved. As pointed out in Chapter 1 (section 4) with reference to Weideman (1999:45; cf. 2006), as applied linguists we are compelled by the ethical dimension of our life to express our love and care for others through the deliberate and careful consideration and research we apply to our designs. The intention is that the consequent responsibly designed artefact, such as the *NoM* course envisioned in this study, will essentially contribute towards firstly alleviating some of the (physical and psychological) suffering of patients, which is one of the core principles of nursing practice. Secondly, the aim is to thus empower both nursing staff and others they communicate with as part of their profession "to function in the economy and partake more fully of its fruits" (Weideman, 1999:45; cf. 2006).

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Abstract

This study provides a theoretical justification for the design of a communicative course for nursing staff – *Nurses on the Move* (*NoM*) – in the South African context. Communication is deemed a key in achieving effective, safe nursing practice. One of the main problems associated with nursing communication in South Africa relates to the fact that South Africa has eleven official languages. Nursing staff are thus often required to communicate with other healthcare professionals, patients and the family and friends of patients in an additional language. As a result, miscommunications can occur, which could lead to serious adverse events.

An intervention to address this problem in the form of an applied linguistic design, such as a *NoM* syllabus, displays two terminal functions – the technical modality, which guides the design, and the analytical function, which provides the rational basis for the design (Weideman, 2006a). A detour into theory and analysis is thus required in order to provide a theoretical justification for the technical design. Based on this justification, the design of the syllabus can proceed, which will ultimately prescribe what the course should consist of, including its assessment.

This study thus consisted of a needs analysis to inform the design of a *NoM* course that could help to address the communication problems in the nursing profession. The approach to language teaching selected for this design is Communicative Language Teaching (CLT), which requires that, among other things, authentic texts and functional communication be used in the design of the syllabus for the course. The needs analysis, therefore, consisted of a review of the international literature to develop a typology of nursing communicative interactions, as well as to identify nursing communication problems. After a rigorous ethical clearance process, the literature review was followed by observations of nursing staff and the various individuals they interact with during their work, which included audio recording interactions and making field

notes. This enabled us to extend and refine the initial typology. The data were also analysed for the most common communicative functions, and their common combinations, given the typology. In addition, the problems and short-circuits in communication are also identified and interviews conducted to further clarify issues raised in the data from the observations. Based on these analyses we outlined what the content and structure of the envisioned *NoM* course should comprise.

Furthermore, the principles for design that derive from the analogical connections between the technical and all the other dimensions of reality were also discussed to specify the requirements for the design of a *NoM* course (Weideman, 2006a). The data generated and analysed in this study allows us also to justify, or in certain cases to anticipate the justification of, the proposed syllabus in terms of the following requirements: systematicity, scope, validity, consistency, differentiation, appealing, articulation, appropriateness, economy, alignment, accountability, fairness and trustworthiness. As a result, the subsequent phases of design can commence, in which the syllabus is articulated into a complete course and its assessment. Ultimately the aim is to alleviate some of the pain and suffering of South Africans by helping nurses to improve their communicative competence, and thus enabling them to practice their profession more effectively.

Abstrak

Hierdie studie bied 'n teoretiese regverdiging vir die ontwerp van 'n kommunikatiewe kursus vir verpleegpersoneel – *Nurses on the Move* (*NoM*) – in die Suid-Afrikaanse konteks. Kommunikasie word as belangrik in die bereiking van doeltreffende, veilige verpleegpraktyk geag. Een van die hoofprobleme wat met verpleegkommunikasie in Suid-Afrika verband hou, is die feit dat Suid-Afrika elf amptelike tale het. Daar word dikwels van verpleegpersoneel verwag om met ander professionele gesondheidsorgpersoneel, pasiënte en die familie en vriende van pasiënte in 'n addisionele taal te kommunikeer. As gevolg hiervan kan misverstande voorkom, wat ernstige gevolge vir ʾn pasiënt kan inhou.

'n Intervensie om hierdie probleem te adresseer – in die vorm van n toegepaste linguistiese ontwerp, soos 'n *NoM* leerplan – moet twee hooffunksies vertoon, naamlik die tegniese modaliteit wat die ontwerp lei en die analitiese funksie wat die rasionele basis vir die ontwerp vorm (Weideman, 2006a). 'n Fokus op teorie en analise is dus nodig om 'n teoretiese regverdiging vir die tegniese ontwerp te voorsien. Die ontwerp van die leerplan kan op grond van hierdie regverdiging geskied, wat uiteindelik sal voorskryf waaruit die kursus moet bestaan, insluitend die assessering.

Hierdie studie bestaan dus uit 'n behoefte-ontleding wat die ontwerp van 'n *NoM*-kursus wat kommunikasieprobleme in die verpleegberoep kan help oplos. Die gekose benadering tot taalonderrig vir hierdie ontwerp is *Communicative Language Teaching* (*CLT*), wat vereis dat, onder andere, outentieke tekste en funksionele kommunikasie in die ontwerp van die leerplan vir die kursus gebruik moet word. Die behoefte-ontleding bestaan daarom uit 'n oorsig van internasionale literatuur wat gedoen is met die oogmerk om 'n tipologie vir kommunikatiewe interaksies in verpleging te ontwikkel, asook om verpleging kommunikasieprobleme te identifiseer. Ná 'n streng etiese klaringsproses, is die literatuuroorsig opgevolg deur die waarneming van verpleegpersoneel en die verskillende individue met wie hulle interaksie tydens die uitvoering van hulle

pligte gehad het. Die waarnemingsproses het aan die hand van klankopnames en die maak van navorsingsnotas geskied. Op grond van die data wat hierdeur gegenereer is, het ons die aanvanklike tipologie uitgebrei en verfyn. Die data is ook ontleed vir die mees algemene kommunikatiewe funksies, en hulle algemene kombinasies, gegewe die tipologie. Daarbenewens is die probleme en "kortsluitings" in kommunikasie ook ondersoek en onderhoude is gevoer met verpleegpersoneel om die kwessies verder te ondersoek gebaseer op die data van die waarnemings. Gebaseer op hierdie ontledings is die inhoud en struktuur van die beoogde *NoM* uiteengesit.

Verder is die beginsels vir die ontwerp wat voorkom uit die analogiese verbindings tussen die tegniese en al die ander dimensies van die werklikheid, ook bespreek om die vereistes vir die ontwerp van 'n *NoM* kursus te spesifiseer (Weideman, 2006a). Die data wat gegenereer en ontleed is in hierdie studie stel ons in staat om ook dan die voorgestelde leerplan te regverdig, of in sekere gevalle die regverdiging te antisipeer, in terme van die volgende vereistes: sistematiek omvang, geldigheid, konsekwentheid, differensiasie, estetika, artikulasie, toepaslikheid, ekonomie, belyning, aanspreeklikheid, billikheid en betroubaarheid. Gevolglik kan die daaropvolgende fases van ontwerp begin waar die leerplan verwoord word in 'n volledige kursus en die assessering daarvoor. Die uiteindelike doel is om die pyn en lyding van Suid-Afrikaners te help verlig en verpleegpersoneel in staat te stel om hulle kommunikatiewe bevoegdheid te verbeter sodat hulle hulle beroep meer effektief kan beoefen.

ANNEXURE

ANNEXURE 1. CONSENT FORMS

The theoretical justification for a communicative course for nurses: Nurses on the move.

You have been informed about the study by …….
.
You may contact Marilize Pretorius at pretoriusm4@ufs.ac.za any time if you have questions about the research.

You may contact the Secretariat of the Ethics Committee of the Faculty of Health Sciences, UFS at telephone number (051) 4052812 if you have questions about your rights as a research subject.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to terminate participation.

The research study, including the above information, has been verbally described to me. I ..... understand what my involvement in the study means. I understand that my participation in this research is voluntary, that I will not be remunerated for my participation and that I will not be penalized or lose benefits if I refuse to participate or decide to terminate participation. I understand that the interview will last between 20 and 30 minutes. I also understand that my name will be kept confidential at all times and that the findings of this research will be reported on in a Master's dissertation and subsequently published in academic journals. I understand that I may terminate the interview if I feel that the researcher's presence is intrusive, that there is the potential for breach of confidentiality or that it is interfering with medical or hospital procedure. I also give my permission that this interview be recorded by the researcher.

_____	_____
Signature of Participant	Date
_____	_____
Signature of Witness *(Where applicable)*	Date
_____	_____
Signature of Translator *(Where applicable)*	Date

The theoretical justification for a communicative course for nurses: Nurses on the move.

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Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to terminate participation.

The research study, including the above information, has been verbally described to me. I ..... understand what my involvement in the study means. I understand that my participation in this research is voluntary, that I will not be remunerated for my participation and that I will not be penalized or lose benefits if I refuse to participate or decide to terminate participation. I understand that my participation will only include the time that I spend interacting with the nurse. I also understand that my name will be kept confidential at all times and that the findings of this research will be reported on in a Master's dissertation and subsequently published in academic journals. I understand that I may terminate any shadowing session if I feel that the researcher's presence is intrusive, that there is the potential for breach of confidentiality or that it is interfering with medical or hospital procedure. I voluntarily agree to participate in the following way:

Researcher only observes my interaction with the nurse	
My interaction with the nurse is audio recorded but the researcher is not present	
Researcher both observes and audio records my interaction with the nurse	

_____ _____
Signature of Participant Date

_____ _____
Signature of Witness Date
(Where applicable)

_____ _____
Signature of Translator Date
(Where applicable)

The theoretical justification for a communicative course for nurses: Nurses on the move.

You have been informed about the study by …….

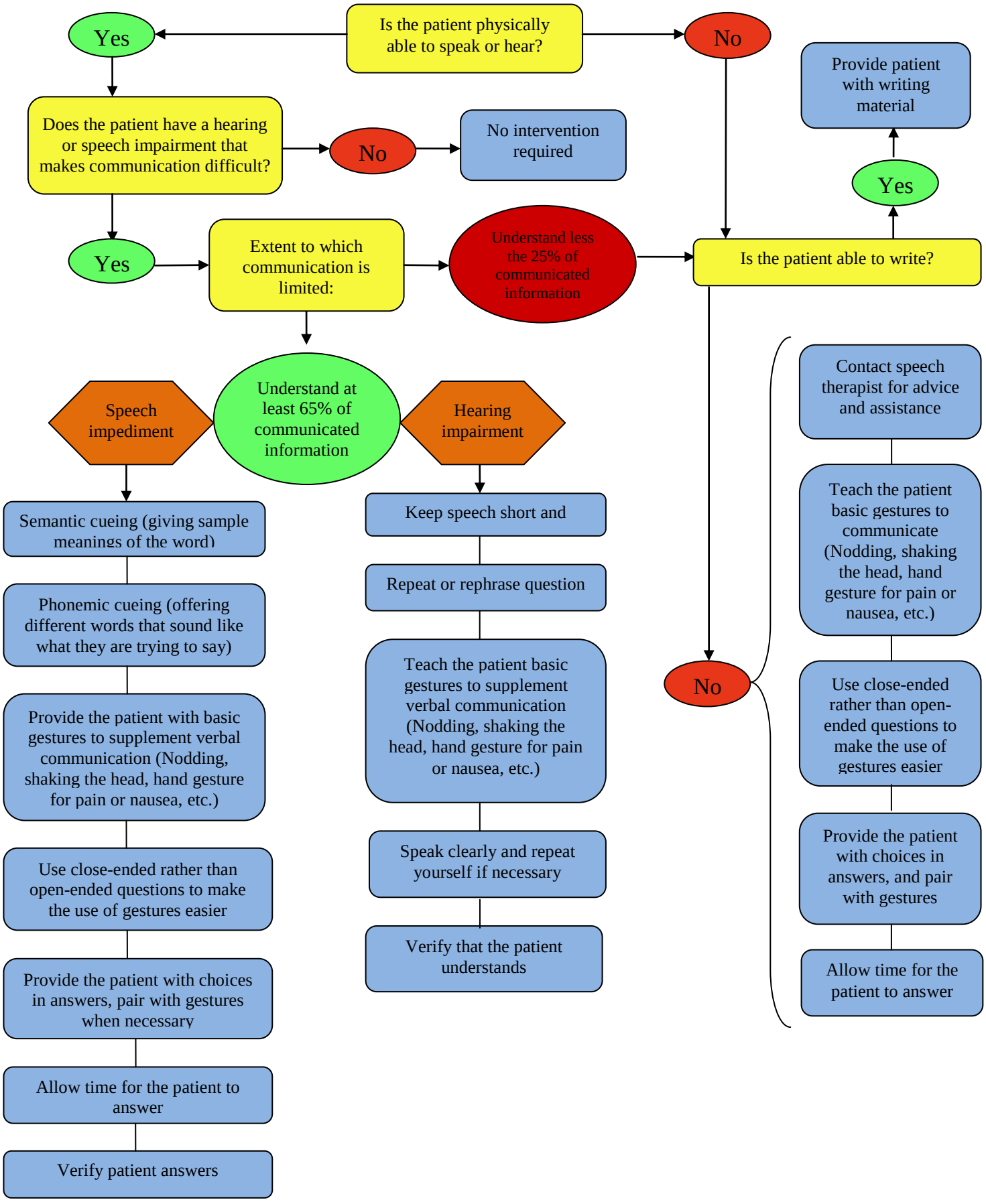
You may contact Marilize Pretorius at pretoriusm4@ufs.ac.za any time if you have questions about the research.

You may contact the Secretariat of the Ethics Committee of the Faculty of Health Sciences, UFS at telephone number (051) 4052812 if you have questions about your rights as a research subject.

The research study, including the above information, has been verbally described to me. I ..... understand what my involvement in the study means. I understand that my participation in this research is voluntary, that I will not be remunerated for my participation and that I will not be penalized or lose benefits if I refuse to participate or decide to terminate participation. I understand that I will be shadowed for one shift for a period of between 3-5 hours and that this will include the time it takes for informed consent to be obtained from the other participants. I also understand that my name will be kept confidential at all times and that the findings of this research will be reported on in a Master's dissertation and subsequently published in academic journals. I understand that I may terminate any shadowing session if I feel that the researcher's presence is intrusive, that there is the potential for breach of confidentiality or that the shadowing is interfering with medical or hospital procedure. I also give my permission that all my interactions be observed and audio recorded by the researcher, granted there is informed consent by the other parties involved.

_____	_____
Signature of Participant	Date
_____	_____
Signature of Witness *(Where applicable)*	Date
_____	_____
Signature of Translator *(Where applicable)*	Date

ANNEXURE 2. COMMUNICATION FLOWCHART



ANNEXURE 3. TRANSCRIPTIONS – OBSERVATIONS

Administering medication

Talking while administering medication
(Chapter 6, Section 3.1.3 and 3.1.6; Chapter 7, Section 2.1)

N: Wat sê doctor hulle?
P: huh?
N: Wanneer gaan mevrou huis toe?
P: Nee, ek weet nie, ek het nou nog nie vandag medisyne gekry nie..., ek moet mos vandag nog medisyne kry, van—vandag se medisyne.
([...] I haven't yet been given my medication today..., I am supposed to still get medication today, to-today's medication.)
N: Het hulle nie gegee nie?
(Did they not give it?)
P: Nee.
(No.)
N: [Nurse checks charts] Nee wat, daar is niks vir vandag op geskryf nie. Kyk, mevrou vra mos soos jy pyn het
(No, nothing is written down for today. Look, you ask for it when you experience pain)
P: Nee, ek moet, uh, um, n gereelde... 'n gereelde botteltjie...
(No, I must get a, uh, um, regular... a regular bottle of...
N: [Nurse checks charts again] Laat ek net by hulle hoor.
([Nurse checks charts again] Let me just check with them.)
P: ...gereeld 'n hele paar pilletjies, niks van pyn nie//
N: Laat ek net by die meisitjie hoor wat pille uitdeel
[Nurse moves to hallway where she speaks to another nurse]
N1: Sister, --------- sê sy't nie pille gekry nie
(Sister, --------- says she hasn't received her pills yet)
N2: Wie's --------?
(Who's --------)
N1: Wat in kamer, uh, drie, bed twee gele het
(Who was in room, uh, three, bed two)
N2: Uh, kamer drie, bed twee... sy wat mos so gesê het
(Uh, room three, bed two... she who said)
N1: Nou sy weet mos jy gaat mos nog so [indicates direction in which nurse is moving to administer medication from room to room] ons sou mos gewees het by six bed four
(Now she knows you are still going like that [indicates direction in which nurse is moving to administer medication from room to room] we would already have been to six bed four)
N2: Ek gaan nie weer by kamer drie nie
(I'm not going to room three again)
N1: Ja...
(Yes)
N2: Kamer drie, wie's by kamer drie?
(Room three, who's in room three?)

N1: Sy is nou daar
(She is there now)
N2: Sy is daar?//
(She is there?//)
N1: Ja
(Yes)
N2: Ok, ek sal kamer twee gee, dan kom ek...//
(Ok, I will give to room two, then I'll come...//)
N1: Na haar toe?
(To her?)
N2: Ja
(Yes)

The nurse is reassuring the patient while giving an injection
(Chapter 6, Section 3.1.4, 3.1.5 and 3.1.6)

N: Ok, dis die spuitjie wat die bloed moet dun hou, nê? Omdat jy nog nie so mooi rond loop nie nê? Oraait? Ek gaan vir hom stadig spuit sodat hy nie vir jou seer maak nie, nê.
(Ok, this is the injection that must keep the blood thin, ok? Because you are not walking around so much yet? Ok? I am going to inject it slowly so that it does hurt you, ok.)
N: Is jy gereed vir hom? Huh? Hy brand mos so bietjietjies, maar nie te erg nie, nê?
(Are you ready for it? Huh? Remember, it burns a little bit, but not too much, hey?)
P: [Nods] [Inaudible]
N: Ok [Injects P]

The nurses are talking to a patient transferred from another hospital while they are putting up in a new intravenous drip
(Chapter 6, Section 3.3.2.2)

N1: Um, because you need some antibiotics, it doesn't look very promising. Just do a fist
N2: [Addressing N1] Ja, she had drips last week when she was here... before last week
N1: Mmm. Make a fist//
P: //I was in hospital for many... I just get drips
N1: Is it?
N2: After you've been discharged from here?//
N1: //Make a fist, make a fist for me//
P: //Mmm. I was admitted on Tuesday
N2: Oh, shame. [Pause] this thing...
N1: [Addressing N2] Ja, jy moet nou net nie water op sit nie, want dan kan [Inaudible]//
(Yes, you must just not put water on it, because then [Inaudible])
N2: //Did you have in this hand as well?
P: Ja, in this, this hand they were trying to find it [Inaudible]//

N1: //Mmm, but they were not successful. You see why I'm saying, I'm not even gonna try
P: Mmm//
N1: Let the doctor come and try
P: Alright sister
N1: Alright [Laughter]

The doctor is inserting a vaginal tampon to stop the bleeding after the patient's operation
(Chapter 6, Section 3.1.3 and 4.1.2)

N: [Addressing P] Sorry my deary. Hold steady, I know it's uncomfortable.
D: [Addressing N] When did the bleeding start?
N: She's been bleeding since the, uh, ------ and catheter were removed but it wasn't that bad// we kept on checking
D: //Ok
N: And so far she didn't pass urine yet but now she told me she's started to see clots. [Pause] Is that enough? Do you need...
D: Ja, it should be enough
N: [Addressing the P] Sorry my dear... It's in, it's in, it's all over, ok, sorry. [Pause] Ok, Doctor, I will clean up, it's fine. [Pause while he she starts to clean up] And for the other new patient, you will write up the orders for pain medication, or should I call the house doctor?
D: Eh, yes, I wrote pain medication
N: Oh, you did, ok
D: Ja
N: It's not necessary for blood tests and thing?
D: I did do the bloods
N: Oh ja, sorry
D: And the -----
N: And she can eat and drink and everything?
D: Eh, ja. That's why I'm gonna phone doctor ----- now//
N: Who is he?
D: He's the other consultant who works with doctor -----//
N: Oh, oh yes
D: ...to see if, eh, if should keep an MPO and if there's a need to do a laroscopy
N: Oh, ok. Thanks doctor
D: Sure

Admission

Two nurses working together to admit a patient. N1 is asking questions the relevant questions and completing the documentation while the other is taking the patient's vital signs
(Chapter 6, Section 3.1.1 and 4.1.4; Chapter 7, Section 2.3)

P: Ja, laat ons gaan
N1: Meneer, ons wag nog vir die porter, so ek sal net vir meneer//
P: //Jy wag vir die wat?
N1: For the porter
P: Oh. And this one wants to take my blood pressure? [Gestures to indicate N2]
N1,2: Yes
P: You must watch out, I'm a blood donor hey
N2: I was actually going to explain//
P: //Watch out, I'm a blood donor//
N2: //But you already know it
[Laughter]
P: Ja, I know that, and I know the injections
N2: Ok
P: Hy's nie so seer soos die rug
N2: Ok//
N1: //So they won't rob because you know them, nê?
P: Mmm. Ek dink ek sal maar klap
N1: They won't escape [Laughter]
P: Mmm, ek sal maat net klap [Laughter]
N1: Please sir, please sir, I'm allowing you, I'm allowing you. They must do things by the book [Laughter]
N1: Mr. Botha, kan ek vir meneer se pille asseblief sien?
P: Die wat?
N1: Die pille wat meneer by die huis drink
P: [Starts looking for medication in suitcase]
N1: Het meneer al vandag dit gedrink?
P: Die wat?
N1: Die pille, het meneer vandag die pille gedrink?
P: O jus, jy vra my nou n mooilike ding nou hierso. Nou waar het ek die pille gesit. Ok, begin maar net, ek sal later vir jou die pille gee. [Continues to rummage in suitcase] It's somewhere around here in the case.
N1: Gebruik meneer enige slaap pille?
P: Slaap pille? Mmm
N1: Die naam van die pille, weet meneer?
P: Dis alles hierso, ek sal nou vir jou sê [still looking for his pills]
N1: Ok, alright
N1: Het meneer enige allergie waarvan meneer weet?
(Do you have any allergies that you are aware of, sir?)
P: Hmm nee
(Hmm no)
N1: Is meneer 'n diabetiese patient?
(Are you a diabetic patient, sir?)

P: 'n Wat?
(A what?)
N1: Diabetic
(Diabetic?)
P: Nee
(No)
N1: So meneer eet normale kos?
(So you eat normal food, sir?)
P: Ja, normale kos. Dit moet net nie oud wees nie, dan gee ek dit terug vir jou.
(Yes, normal food. It must just not be old, otherwise I'll give it back to you)
P: Nou waar is die zip nou hierso?
N2: Let me help you, I can see that you are not fine
P: No, I am not fine at all, but ja
N2: Mmm, you are starting to panic now
P: No, I am not starting to panic [hands pills to N1], ek het dit by die doctor gekry, pyn pille, nê
N1: Ok [Takes pills, writes down information on form]
N2: [To N1] Can I take the respiration in the meantime? Do you want to do the temperature?
N2: [To P] Please open up your mouth, and put it under the tongue
[...]
N1: Gaan meneer goed by die toilet elke dag?
P: Ja
N1: So daar's geen probleme nie?
P: Nee wat
N1: Is meneer 'n suiker lyer? Of eet meneer enige iets?
P: Eke et enige iets [Pause] behalwe die vroumense//
//[Laughter]//
N1: //Dit eet ek nie. Ek los dit vir die duiwel
[Laughter]
P: Ek maak net 'n grap, hoor?
N1: [Laughter] Ja, meneer
[...]
N: Enige vorige operasies?
(Any previous operations?)
P: Long time ago, here [indicates area on abdomen] breuk operasie
(hernia operation)
N: What?
P: What do they call it in Afrikaans? Die breuk operasie [raises his voice and tries to speak more clearly]. The... this...//
(The hernia operation)
N: //Mmm... //
P: //The... dit kom altyd so by die manne
(men always get it)
N: [Laughter] Ok

Nurse is asking admission questions and needs to rephrase to make it clear for the patient
(Chapter 7, Section 2.3)

N: Uitskeiding? [Pause] Sukkel nie om te pie-pie nie?
(Excretions? [Pause] Do you struggle to wee-wee?)
P: Nee
(No)
N: Ope-lyf?
(Bowel movement?)
P: Ja
(Yes)

Briefing

Doctor and nurse discussing patient's condition
(Chapter 6, Section 2.3)

N1: Waarvan praat julle nou?
N2: Dit het nou weer gebeur toe doctor by haar is
D: Sy begin te stress, dan raak haar lippe so blou, en dan sit sy daar, en dan is haar stats--
(She begins to stress, then her lips turn blue, an then she sits there, and then her stats are --)
N1: Nou dink jy dis rerig 'n kardiologie probleem?
(So do you really think it's a cardiology problem?)
D: Wel, ek dink die panic attacks trigger dit
(Well, I think the panic attacks trigger it)
N1: Ja
(Yes)
D: Maar van panic raak jy nie sommer... jy clutch nie uit van dit nie
(But panic doesn't cause you to just... you don't just clutch out because of it)
N1: Mmm
N2: En haar haar pols is sommer [Inaudible]
(And then her pulse is [Inaudible])
D: Dis nie asof sy vinnig asemhaal wanneer dit gebeur nie, sy sit daar met hierdie blou lippe
(It's not as if she breathes quickly when it happens, she just sits there with these blue lips)
N2: Hmm
N1: Jinne, dis 'n snaakse besigheid
(Man, this is a funny business)
N2: Hmm... en dan sweet haar handpalms en dan...
(Hmm... and then the palms of her hands sweat and then...)
N1: Mmm, sy was yskoud en papnat gewees toe ek haar gister kry
(Mmm, she was ice cold and drenched with sweat when I found her yesterday)
N2: En sy sê, sy sê nou vir ons as sy haar maar kom kry dan lê sy op die vloer dan weet sy nie hoe sy daar gekom nie
(And she says, she tells us now that when she comes to again, then she's lying on the floor and she doesn't know how she got there)
N1: Maar ek vra nou vir hulle, ek sê het julle nou nooit daaraan gedink om maar doctor toe te gaan nie,
N2: Hmm
N1: Nee sy't maar gedink dis van die hitte
N2/D: Laughter
N1: Mens pass mos so uit van hitte. So nee hoor.

Nurses discussing patient's condition and treatment
(Chapter 6, Section 3.3.1)

N1: Want as dit nou erg bloei moet hulle haar teater toe vat
N2: Nou hoekom haal hulle dan uit? Hoekom los hulle nie maar tot môre toe nie?

N1: Tot môre ja
N2: Ek wou hom nog gevra het of ons 'n ------ in kamer een[5] kan in sit en --- kan afhaal, want sy kan nou nie rondloop nie
(I still wanted to ask him if we can put a ------ in room one and take the ----- off, because now she can't walk around)
N1: Oh ja
(Oh yes)
N2: Maar nou ja
(But in any case)
N1: Maar hoekom kan sy nie maar bietjie rond loop nie?
(But why can't she walk around a bit?)
N2: Dan kan ons dit vanaand weer opsit as sy slaap
(Then we can put it up again tonight when she sleeps)
N1: Mmm
N2: Ek dink so
(I think so)
N1: Anders moet jy maar weer vir huisdokter bel, of dan ons moet maar wag tot hy kom, om vir haar 'n drip op te sit
(Otherwise you should phone the house doctor, or then we have to wait until he comes, to put up a drip for her)
N2: Hoekom?
N1: Want sy's dan dokter ------- se pasiënt
N2: Maar dis dan eers om trent 10uur vanaand
N1: Nee, hy verwag as sy nou weer aktief bloei, soos wat sy nou begin is, toe daai ding uit is
N2: Ek hoop dit gaan help
N1: Mmm

Nurses checking with one another
(Chapter 6, Section 3.1.6)
N1: Moet ons maar 'n --------- op haar sit?
(Should we put up a --------- for her?)
N2: Hmm, sit maar.
(Hmm, put it up.)
N3: By bed 11? Ek het al.
(At bed 11? I already have.)
N1: Oh, jy't klaar?
(Oh, you already have?)
N3: Klaar.
(Already have.)

[5]Patients are often referred to by room and/or bed number rather than by name.

Nurses discussing patient's medication

N1: Sister, ek het vir haar ------ gegee, en hierso gegee [Shows N2 document]
N2: Ek is by kamer 10, -------, ek sien sy's 'n diabeet//
N1: //Mmm?//
N2: Maar daar is niks...
N1: Haar goed is nie opgeskryf nie, en die probleem is sy weet nie hoeveel ------- drink sy nie. Sy weet sy drink twee, uh, gram -------, uh, dink so iets het sy gesê, maar sy weet glad nie, sy sê sy drink twee -------, maar jy kry mos die 30 en die 80 milligram//
N2: //Mmm//
N1: //maar sy kannie vir my sê wat dit is nie//
N2: //Ja
N1: Maar sy gaan mos nou in elk geval mos nou huis toe
N2: Mmm. Ek het vir haar nou nou ----- set pilletjie gegee vir die pyn
N1: So hulle moet in elk geval net opskryf dat ons dit kan afmerk, want ek het dit gisteraand gegee, en ------- het dit vanmôre ook gegee.

Briefing with D about P who claims she is diabetic
(Chapter 6, Section 3.3.1 and 3.3.2.1)

N: Sy het nie medikasie nie, maar sy eet nou so, sy eet 'n 'diet', dis haatr woorde. So ek weet nie moet ons ons vreeslik daaraan steur nie//
D: //Nee, nee//
N: // moet ons maar so twee of drie keer haar suiker toets//
D: //ek dink ons kan soos twee keer haar suiker toets en as dit normaal is dan los ons dit. Want baie van hulle kom dan sê hulle hulle is allergies vir een of ander... //
N: //En dan bestaan dit ook nie, Mmm.
N: [Pause while N and D do paperwork] Ons het die bloede en alles getrek.
D: So alles is gedoen? Het sy 'n lêr?
N: Ja, hierso is hy [Hands D the file]. [Pause; refers to other P] Ek weet nou nie as sy nou met so gejuig kom met 'n ambulaans van ------ af kom, of ------ dalk nodig is nie.
D: Het sy sepsis, of wond sepsis, of wat?
N: Nee, sy't 'n pyn op haar regter borskas onder hierdie, aan die kant blykbaar, en aanvanklik het hulle gesê akutte buik-pyn, maar dit het sy glad nie, toe is dit nou 'n pyn regs op die borskas. Nou ja, toe het ons haar vir ekstrale vir die buik en vir die borskas gestuur
D: Ek sien 'query' op appendisitis
N: Is dit wat hy geskryf het?
D: "Query appendisitis, query intra-abdominale trauma"//
N: Ek het hom gevra wat is haar diagnose, toe sê hy hy weet nie [Laughter]
D: [Laughter] Oh, is dit?
N: Ai, ons vat dit wyd nê? [Laughter]
D: Ja [Laughter]

Doctor and nurses discuss patient
(Chapter 6, Section 3.3.2.1)

N1: [Adressing N 2] Weet jy, en die ander ding is die kateter is uit en sy't nog nie urine passeer nie, as sy nou 'n ------- in kry dan gaan sy dit nie kan doen nie *(You know, the other thing is is that the catheter is out and she hasn't passed urine yet, if she gets a ----- put in then she won't be able to do it.)*

N2: [Turning to N3] ------, ag prepare a tray for putting back catheter for ouma in bed eleven please, sommer number fourteen. Doctor is, uh, gonna put the plug back and she's not going to be able to pass urine

D comes to insert ------- referred to in previous scene and notes to N3 that P has catheter in, N1 hears D and comments
(Chapter 6, Section 3.1.6)

N1: Ja, she should have the catheter in again because she won't be able to urinate
D: Ja Sister
N1: Um, is this the ------ that you wanted to use//
D: //Yes, that's the one. And will you just get me ---- and jelly
N1: Is, uh, K-Y jelly alright?
D: Yes, that's fine

Nurses discussing supplies and patient

N1: Ek't vier 'gibsons' gekry
N2: Ah, wonderlik
N1: Lyk my dis al vooraad by hulle
N2: Dis wonderlik. Ek dink ----- het nou die dag so gesê, maar ek't nou weer vergeet.
N1: So dis genoeg vir tot môre oggend
N2: Totdat ons [inaudible]
N1: Ja. Hier is... sy gaan meskien teater toe
N2: Mmm. Ek kan nou nie onthou of die dokter so gesê het nie [inaudible]
N1: [Inaudible] Dis dalk seker net 'n aartjie, veral as hulle die ------ uittrek, dis net 'n aartjie partykeer wat seer kry.

N1 phones a patient's family to ask them to visit because the patient is deteriorating rapidly and is showing signs of depression

N2: Ag dame, dis Sister ---------- by -------, ek wil tog net 'n pasiënt se familie skakel asseblief [Pause] ek gaan met mevrou ----- praat, [gives telephone number], baie dankie. [Addresses N1 while on hold] dis 'n ou vriendelike stemmetjie die, dis een wat ek nie ken nie
N1: Maybe they [Inaudible]
N2: Mmm, the switchboard. Nou gaan sy seker vir jou sê sy't nie geld nie, om die kinders to bring nie [referring to family member she is phoning].
N3: Sister, het Sister klaar ----- gemaak vir kamer 6? Klaar gemaak?
N2: Mmm, vat gou asseblief vir my net 'n droeë nighty by kamer 1, sy sit uit in die stoel, maar sy's pap-nat van die sweet en die rokkie is nat.
N3: Wie?
N2: By kamer 1

N2, a sotho-speaking nurse, has phoned the family member of the depressed patient and is reporting back to N1

N1: Wat sê sy?//
(What does she say?)
N2: //Sy sal 25 kom//
(She'll come on the 25th)
N1: 25, but it's so far still, it's now only the 17th. Why can't she come earlier?
N2: Hmm... earlier, like on Monday?
N1: Mmm, ja what does she say, how's the children?
N2: She says they alright, but when they phone her she's only talking about the small one, so she wanted to bring her on the 25//
N1: //Is it//
N2: She was planning to bring the child on the 25
N1: Mmm
N2: So but then, if its eh, eh, hospital transport she can bring both of them
N1: Mmm. Is it two, two children?
N2: Mmm
N1: Because will she be able, should be able to use the hospital transport
N2: Mmm
N1: So unless if we can phone her and ask if she can, can she make it on Monday
N2: Mmm, I hear you said you were going to phone her back//
N1: //Mmm//
N2: //for what?
N1: No, I just wanted to confirm if everything is sorted
N2: 'Cause she is 'mos' not working, she can come 'mos' anytime, why postpone it to 25, it's môre than a week, from now
N1: I can call the sister and ask if can she make it on Monday
N2: Let's phone 'maar' tomorrow again. Just put the number on the brown file, it's not hers, is it now who's she? Is she the sister...?
N1: She said it's her aunty
N2: Is, is she the aunt?
N1: Mmm

Previous discussion continues later

N1: This aunt says, when she phones home, she only wants to speak and speak about the small one. It seems like she doesn't care for the older one. Maybe it's a different daddy.
N2: Mmm
N1: [Pause] Is this the aunt the same one who was here last week?
N2: HmmMmm [shakes head] that one who was here last week is the aunt's child
N1: Because that one was too young to be the aunt, the one that was here
N2: No, that aunt says she did send a child last week
N1: But why didn't she come with the children at that time?
N2: She came to the clinic
N1: Oh, ok, herself?
N2: The --------- clinic. She walks//
N1: //Oh ja, I remember she walks funny, nê?

N2: Ja, she said she was having pain, that's why she came... because they are worried, we are keeping her here for two months
N1: [Laughter] Oh no, the first month she was at -------- (different hospital)
N2: Yes [Pause], they keeping her here for two months, and she doesn't want to keep [Inaudible]
N1: So it seems like we are keeping her for no reason at all
N2: Yes
N1: [Laughter]

Nurse and doctor are discussing a particular case
(Chapter 6, Section 3.2)
N1: Ek wonder wat wys haar X-strale?
(I wonder what the X-rays show?)
N2: Het hulle buik X-strale ook gedoen?
(Did they take abdominal X-rays as well?)
N1: Mmm. Ek wonder of sy nie maar êrens infeksie het nie...
(Mmm. I wonder if she doesn't have infection somewhere..)
N2: Ja, heel moontlik
(Yes, quite possibly)
N1: ------- of 'n ding, maar dan ------- gaan nie vir jou borskas pyn gee nie//
(------- or something, but then ------- doesn't give you chest pain//)
N2: //Mmm, ja//
(//Mmm, yes//)
N1: //hy gee laer rug pyn en hier by die boude
(//it causes pain in your lower back and here by the buttocks)

Chatting

Nurse comes to say goodbye to the patient at the end of her shift
(Chapter 6, Section 4.1.3)

N: Dit moet nou lekker goed gaan nê//
(It must go well, ok//)
P: //Oh
N: Ek gaan nou een uur huis toe
(I'm going home now at one o'clock)
P: Oh, gaan jy huis toe?
(Oh, you're going home?)
N: Dan's ek af vir twee dae
(Then I'm off for two days)
P: Oh, dis oraait
(Oh, that's alright)
N: Dan sien jy my eers weer Donderdag en Vrydag
(Then you'll only see me again on Thursday and Friday)
P: Nou jy bietjie gaan rus
(Now you going to rest a bit)
N: Mmm, so moenie vir ---- soek nie, hoor
(Mmm, so don't look for ----, ok)
P: [Laughter; comment to another nurse in the room] sien hoe word sy al kwaad, synoem my mos ----
([Laughter; comment to another nurse in the room] see how angry she gets already, she just calls me ----)
N: Ek sê mos sommer ----
(I just say ----)
P: [Pause] Ek wonder waar is sy nou met my pille
N: Sy gaan dit seker nou, ek het haar mos gesê//
P: Nee, maar...//
N: Nee sy kom. Kyk mevrou het mos by kamer drie gelê, bed twee, toe skyf ons jou by bed ses nou
P: Ja, maar sy't netnou daar gestaan en nou's sy glad nie...
N: ...te vinde nie
P: Toe ek nou na jou roep, toe, toe't sy pad gegee, kyk net...
N: Moet ek kyk waar's sy?
P: ...maak net oop daar. Toe ek vir jou roep toe loop sy
N: Ek sal nou kyk, moeder
P: Laat ek net my pille kry

The nurse is chatting to the patient while she is cleaning his wound
(Chapter 6, Section 4.1.3; Chapter 7, Section 2.3)

N: I'm going to work in this area, just move like this [places legs into position]
P: Then I came to Bloem[fontein]//
N: There comes a problem [Laughter]
P: He's, he's an agent [Inaudible]

N: Ok. So maybe it was, um, uh, stressful... that you were supposed to... that is why
P: Ja, maybe that is why.
N: Let's hope then you'll be fine
N: Don't bend it Ntate, just keep it straight, straight. Is it straight? [checks the leg] Ok. I'm now going to...[Inaudible]. Actually I don't know Brits, but I can know the name.
P: Mmm. It's next to...
N: It's next to [Inaudible]
P: Hmm?
N: [Lance?]
N: Oh Brits! In, in Morutsi!//
P: //Brits is, is...//
N: Ok, ja. Hmm. Next to Brits.
P: Ja
N: But it's far
P: Ja, it's far.
N: It's far, outside of Pretoria
P: Ja
N: Far from Mpumalanga?
P: Ja, it's...not too far, but ja...
N: Mmm, Mmm
[Pause while nurse works]
P: It's bushveldt , it's...
N: Ok, next to Bushbuckridge?
P: No, Bushbuckridge is in Gauteng, to the north
N: [Laughter] Oh! I know the places, the names, but I have never been there.
P: Mmm
N: But when you say Brits, ok, 'cause I know that one. When I'm staying in Vanderbijl, I was seven years old, I went with the other girl from Levubu that side. [Pause] I was starting at Tech
P: Mmm?
N: Hmm.
P: Where did you grow up?
N: I grow up in the eastern Free State//
P: //Mmm//
N: Ficksburg, cherry world//
P: Ficksburg, Mmm, ok
N: Do you know it?
P: Ja
N: Mmm
[Pause while nurse works]
N: My father worked a lot at the...
N: Sorry for the pain, sorry
P: That's alright
N: So meaning they are going to discuss whether they are going to do the bypass, the doctor?
P: Ja. They think bypass.
N: Mmm. [Pause] So wena, you are not sure?

P: Ja, I don't know
N: Ok. Ja, that is why they said they send you to the ward, so that you can think
P: Ja [Inaudible]
N: We had a patient yesterday, that side [referring to the other side of the ward] So it is not an easy decision.
P: Ja, this will be my second
N: Oh, this is supposed, is gonna be the second?
P: Ja
N: Ok. The first one was in?
P: Two years ago
N: Hao hle, did you take your medication with?
P: Yes, yes
N: Really? You on ----------?
P: Ja. [Inaudible]
N: Mmm. But at least here you have experience. I thought it would be your first time. [Pause] And you must take care of yourself. You are still smoking?
P: Ja, a little bit.
N: MmmMmm. But at least you are at home
P: Ja
N: So you must try to... have enough time to rest, exercise...
P: HmmMmm
N: ... and don't forget your pills, ok? You must take it daily. The medication [inaudible] you must take it daily. And go to a GP or is it a clinic every month nê? So that they can check. [Inaudible] immediately just rush, run to the [Inaudible].
[Pause while nurse works]
N: How many children do you have?
P: Three boys
N: Hao hle. Ok. [Pause] I'm now going to [Inaudible]. I'm done
P: Ok
N: I'm done killing you
[Laugther]
P: Jis
N: So everything is still fine. Matrone? [Calls the Matron]
M: [Enters curtained area] Ek het gehoor, everything is still fine.
(Yes, I hear everything is still fine)
[Inaudible]
M: Draai mooi toe
(Close the wound properly)
N: Askies Ntate
(I'm sorry sir)
P: Oh, moet jy nou eers weer 'n pleister weer opsit//
(Oh, you must first put a bandage on again)
M: //Ja, ons moet 'n pleister opsit, dan moet jy weer die been reguit hou, nê?
(Yes, we must put a bandage on, then you must keep the leg straight, ok?)
P: Ja
M: Jy moet hom nie buig nie, dan buig jy hom, dan gaan daai aartjie weer oop, dan bloei jy weer van voor af

(You must not bend it, if you bend it the vein will open up again, then it will start bleeding all over again)

P: Mmm

M: En ons wil mos nie dit hê nie
(And we don't want that)

P: Mmm

M: Ok

P: Nee, dis reg
(Ok, that's fine)

M: Daar's hy
(There we go)

N: I'm going to press it, more harder. Help us nê?

P: Hmm?

N: When you are in the ward, help us, keep this leg straight.

P: Ja

Observations

The nurse asks the patient questions during observations
(Chapter 6, Section 3.1.1, 3.1.2 and 3.1.6)

N: Did you sleep well, my dear?
P: Yes
N: How are you feeling?
P: Fine [Inaudible]
N: Is it? Is it handible? [Gestures to wound]
P: Hmm [Nods]
N: Are you walking around?
P: Hmm [Nods]
N: Ok, that plaster there [indicates area on body], it is still there, nê?
P: Nods
N: Alright, is there not pain there?
P: [Shakes head]
N: Ok, nothing? Alright, what did doctor say today, are you going home today?
P: Inaudible
N: Oh, he didn't come yet. Alright, we'll just phone him and find out where he is.

The nurse asks the patient questions during observation
(Chapter 6, Section 3.3.2.1)

N: Sê vir my, die maag, kom daar by die maag ietsie uit? [Pause] Maak hy die wind?
(Tell me, the stomach, is anything coming out? [Pause] Is it making wind?)
P: Die wind, ja...
(The wind, yes...)
N: Mmm, sê vir my, dan moet jy bietjie stap, en dan moet jy bietjie gaan kuier vir die mense hier in die saal nê, by jou bure bietjie kuier
P: Mmm...
N: Oraait, dan gaan jy elke dag bietjie beter en bietjie beter word
N: Sê vir my, drink jy baie water? Huh?
P: [Nods]
N: Belowe? [P nods] Hmm? Baie watertjies drink, my skat, ons wil nie weer daai drip terug sit nie, hoor? Oraait.

The nurse asks questions during observation
(Chapter 6, Section 3.1.2, 3.1.4, 3.1.5, 4.1.1 and 4.1.2, and Chapter 7, Section 2.1)

N: Hoe gaan dit vanmôre jong?
(How are things going this morning, dear?)

[Inaudible]

N: Het doctor oop gemaak daai wond?

P: Ja, hy het hom oop gemaak
N: Is dit, ek wou nou gesien het. Is hy nog steeds oop, of weer toe gemaak
P: Nee, nog niks nie

N: Laat ek gou gou net bietjie sien, ek het hom nou nog nie gesien nie. [Moves to close the door] Net die deur so bietjie toe maak, nee, [P moves from chair to bed] sit net daar waar jy is ek wil net//
P: Nee jy sal nie so sien nie
N: Sal ek hom nie so sien nie?
P: Nee
N: Ok, ek is baie nuuskierig, ek wil sien hoe lyk hy. Laat ek sien waarmee ons nou hier te doene het. [Positions patient so that she can look at the wound] Laat ons net gou die boude so bietjie toe maak, hoor. Daarsy. [pause while nurse inspects wound] Ok, hy't so paar plekkies oopgetrek, nê. Nee wat, ons gaan hom gou gou op-'fix', hoor, ons gaan hom gou gou op-'fix'. Ek wonder, wat se sister het saam met dokter hulle gekom vanmôre, toe hulle kom kyk het?
(Ok, I am very curious, I want to see how it looks. Let me see what we are working with here. [Positions patient so that she can look at the wound] [...] There we go. [Pause while nurse inspects wound] Ok, it has opened up in a few places. We will fix it up quickly, ok? We will fix it up quickly. [...])
P: [Inaudible]
N: Dink dit was seker sister ------, daai lang sister, met die donker hare?
P: Mmm, sy was saam gewees
N: Was sy saam gewees
P: Nee, sy was//
M: Hoe voel dit, is daai wond seer?
(How does it feel, does the wound hurt?)
P: Nee, weet jy, hy't plekkies wat hy...
(No, you know, there are places that it...)
N: Wat hy gevoelig is?
(That it's sensitive?)
P: Ja
Yes)
N: Gewoonlik is hulle nie rerig seer nie.
(Usually they don't really hurt much)
P: Nee, nee, weet jy soos ek sê, as ek moet ... dan pyn hy...
(No, no, you know, like I said, if I have to... then it hurts...)
N: Is dit?
(Is that so?)
P: Ja, dit voel partykeer asof dit bietjie brand...
(Yes, sometimes it feels as if it burns a little bit...)
N: Mmm?
P: ...en dan, bietjie jeukerig
(...and then, a bit itchy)
N: ...bietjie jukkerig is, ok. Oraait, want ek's seker daar's, uh, sister ------ het al reeds die, die stoma sister, hy's nou die expert wat wonde aanbetref, dat hulle vir ons kom raad gee vir presies die regte ding wat ons op daai wond moet sit, jy weet
...a bit itchy. Ok, because I'm sure there's, uh, sister ------ has already called the, the Stoma sister, he's the expert concerning wounds, that they come to give us advice on what exactly is the right thing to put on that wound, you know)
P: Nou daar waar hy oop getrek het?

N: Nee, ons moet hom nou maar, hy moet nou so van onder af gesond word. Hulle sal nou vir ons die regte ding gee wat ons daarop moet sit//
P: //Mmm//
N: //en vir ons sê wat wil hulle hê moet hulle doen, want hulle is mos nou die spesialiste op die wonde
P: Is dit?
N: Dan, uh, dan doen ons dit nou maar net soos hulle sê elke dag, en dan moet ons nou kyk of hy verbeter elke dag.
P: Maar hy is...[Inaudible]
N: Ja nee wat! Hy sal definitief, ons sal hom wen, nee, ons sal hom wen
P: [Inaudible]
N: Ek't so gehoor, ja, ek't so gehoor
P: [Inaudible]
N: Ja, kyk ons moet hom mos bietjie van binne af ook help, ons kan hom nie net aan die buitekant pamperlang nie, ons moet maar binnekant ook bietjie antibiotika gaan dit net help om vinniger gesond word
(Yes, look we have to help it from the inside as well, we can't just pamper it from the outside, we have to also from the inside, antibiotics will just help it to heal faster)
P: Oh, want sy sê dis maar deel van die suiker wat dit doen//
(Oh, because she says it's part of what the sugar does)
N: Diabetes doen dit
(Diabetes does this)
P: Want hierdie kant is baie mooi
(Because this side look very good)
N: Ja, ja
(Yes, yes)
P: Dis nou net hierdie kant//
(Now it's just this side)//
N: Dis ongelukig nou maar een ding van as mens suikersiekte het, mens se wonde word swaar gesond, maar hulle word gesond. Ons sal hom wen, hoor? Jy moet net nie moed verloor nie.
(That's unfortunately one thing about when you have diabetes, your wounds have difficulty healing, but they do heal. We will beat it, ok? You mustn't become discouraged)
P: //Nee, nee//
N: //Ok? [Laughter] Oraait? Ok.
P: Dankie, hoor

Rounds with nurse and doctor

Nurse with doctor doing rounds
(Chapter 7, Section 2.4)

D: It still looks rosy, just continue with the ----
N: Ok
D: Ok, put her in the four female bedroom, she doesn't needs to be in isolation..., sy bietjie die ander ouma gaan company hou. Anything else on her sister?
N: *(She can keep the other granny company)*
N: No...
D: Thank you, then that's all
N: Ok. Re tloo isa ka mane hee neh, le ha ese hona jwale
(We are going to move you to another room, even if it is not now)
P: Ka siteng ele? [Points to room they are moving her to]
(On that side?)
N: Eya
(Yes)
P: Ka rumung enang le batho, re nne re kgasellese
(The room with other patients, so we I can chat)
N: [Laughter] [Addresses doctor] She says she would like to be with other people//
D: Ja [smiles], dis lekker. Daar's nog 'n ander oumatjie daar, dan kan hulle bietjie gesels. Dis mooi.
(Yes, that's nice. There's another granny there, then they can chat a bit. That's nice.)
N: Mmm

After explaining to the patient that they are waiting for the biopsy results before they can make any further decisions about treatment, the doctor addresses the nurse (Chapter 6, Section 3.3.2.1):

D: I spoke to him yesterday as well, he first wants to make sure there wasn't any tablets that was [inaudible] so we really only putting the ointment, but i'll talk to Prof today and hear doesn't the patch testing that means anything and i'll talk to him tomorrow and hear, but for today lig maar die been so op, hou hom rustig, ok?
(Lift the leg and keep him quiet, ok?)

D checking charts while with patient, turns to nurse

N: They did not send the results, let's just check [inaudible]
D: But it needs a UV as well, did they take the blood?
N: I'm sure they did, 'cause they can't take the..., and then I'll just ask the sister.
D: Ok, you must check for me, I'll just draw and take it and send it to her
N: The blood, it went to the lab
D: The blood was sent...?
N: There was blood
D: Who took it?
N: Um [laughter]
D: Well it wasn't me [laughter]

N: I think maybe it was the intern or something. But then, I'm sure the//
D: Ja, 'cause the lab...//
N: The lab would have called to ask if there wasn't, would they just test the urine and just...?
D: They just say specimen insufficient

Telephone conversation

Telephone conversation between nurse and a patient's family member
(Chapter 6, Section 4.1.1 and Chapter 7, Section 2.3)

N: Morning, ------- ICU, ------- speaking, how may I help you?
Ja, ons het 'n meneer van der Merwe, waarmee kan ek help?
(Yes, we have a mister ----------, how can I help you?)
Nee, nee hy is bietjie ver van die foon af en ons gebruik nie die selfone in ICU nie
(No, no he is a bit far from the phone and we don't use cell phones in the ICU)
Nee.
Hmmm?
Askies?
Susan?
Die suster?
Nee, sy is af vandag, hmmm.
Hmhmm?
Net 'n oomblik, laat ek net seker maak wat het ons op die kaart gesit, net 'n oomblikkie (Nurse checks with another nurse in the ward about what D said about moving patient into a general ward, the other nurse confirms that the patient will be moved to a general ward)
Ah, Mr van der Merwe hy gaan by saal 3A
Ja, so hulle gaan die (toestand) hanteer met medikasie, hulle gaan nie opereer nie
Mmmm [confirmation]
Nee, hy's nog hier by ons, meskien later hy sal saal toe gaan.
Hy is ver van die telefoon en hy's gekoppel aan die masjien.
Met wie praat ek nou? [laughing]
By saal 3A, by saal 3A is dit bietjie makliker, hy sal die selfoon gebruik, miskien jy kan hom bel daar as hy het [trails off]
Mmmm
[laughing]
Mmmm
Ah, so na 12uur se kant.
Nee, nee, hy sal net mobiliseer daar bo by die saal, hy sal miskien môre by die huis wees.
Ok, met wie praat ek nou?
Ok, ek sal hom sê.
Hmmm?
Ok, net n ooblikkie, laat ek net n plan maak.
Ok [laughter]
(Puts phone on hold and goes to P)

N: Meneer -------?
(Mister ----------?)

P: Ja
(Yes)

N: Jou ma het gebel
(Your mother called)

P: Hmm
N: Hy wil net weet hoe gaan dit met jou, ek het vir hom gesê die doctor het gesê ons gaan hanteer met medikasie, gaan saal toe. Waar's u se selfoon?
(He just wants to know how you are doing. I told him what the doctor said, we are going to treat with medication, going to the ward. Where is your cellphone?)
P: Man, my selfoon is êrens in daai tas, daai groen tas.
N: Want ek wil laat jy sit die selfoon aan, want sy's *so* bekommerd
P: Hmm
N: Sy will saam met jou praat. Waar is die tas?
P: [Inaudible] die groen een
N: [nurse finding suitcase] Die groen, laat ek net gou kyk.
P: [nurse looking for cellphone in suitcase] in so sak, jy moet maar kyk
N: Watter kant? [Pause] Dan, maak hom aan, sy, hy sal vir jou bel hoor, want sy wil graag vir jou praat [nurse hands cellphone to patient] sit vir my aan nê.
P: Ok
N: [Inaudible – putting the suitcase away again] ek gaan, sal vir haar sê sy moet vir jou bel by die selfoon
(I will tell her that she must call you on your cellphone)
[returns to telephone to speak to patient's family member again]
N: Hello tannie?
Uh, ek het die selfoon aansit ne, dan jy jy jy sal hom bel by sy selfoon.
(Uh, I have put his cellphone on, so you can call him on his cellphone)
Mmm. Ja, is net die bonus vir jou [laughter]
(Mmm. Yes, it is a bonus just for you [laughter])
Ok dan.
(Ok then)
Nee dis reg, so j… ja, is nou die selfoon is aan, jy kan hom bel.
(No, that's good. So y...yes, the cellphone is on now, you can call him
My naam is -------.
(My name is -------.)
Mmmm.
Okay ma, dankie, bye.

Treatment information

The doctor has inserted a device to prevent the patient from bleeding further, after he leaves, the nurses finish up
(Chapter 6, Section 3.1.4, 3.3.1, 3.3.2.1 and 4.1.4; Chapter 7, Section 2.3, 2.4)

N1: Is the pain very bad?
P: [Inaudible]
N1: Ok. Otherwise if the pain is very bad you must say. [Pause while washing hands] The bleeding should be much better now after this plug is in, but still if it recurs again then just call us. And there's a little, uh, rope hanging out here, so you mustn't pull on it, then it will come out
P: [Inaudible]
N1: No, you shouldn't pull it. That's it, you've got your catheter in again, so the urine will come out through the catheter. Do you want to lift the buttocks so we can put on the clean plastic sheet for you, or rather just...
N2: [Translates for patient in Sotho] //Re batla ho tlosa ena enang le mali mama, re kenye e skono neh//
(We want to remove the one with the blood on and replace it with a clean one)
N2: Ok, one, two, three [lifts up patient to remove and replace sheets]
P: [Inaudible]
N1: Yes, you can lay back. How is that feeling? A bit more comfortable? [Looks at catheter bag] You see the bladder was already quite full, that probably why it was also uncomfortable
P: [Inaudible]
N1: You see, usually it's still swollen after the operation and then it blocks... then the urine cannot come out
P: [Inaudible]
N1: For the night it stays, at least until tomorrow hey, so you don't have to bother to get up.
N2: Akere o robetse o no sa kgone ho tswa mama?
(Because last night you slept without being able to urinate, mama?)
P: Eya, ke hona kere nako e khutswanyane fela ke bone o sole mongata. So ke re ekaba ke hona o tlang.
(Ok, this is why I'm saying, I see it fills up quickly. So I'm thinking it's only coming out now.)
N2: Ha re kenya ka tube ele, automatically eya bladdereng, it drains the bladder
(When we put in that tube, it automatically connects with the bladder, it drains the bladder)
P: Eya ohoo
N3: [Enters P's room, addressing N2] Het julle hom, um, toe in gekry? En toe is die blaas baie vol?
(Did they manage to, um, get it in? And so, was the bladder very full?
N2: Ja, daai wat in die sak is, seker so 500ml//
(Yes, that which in the catheter bad, about 500ml)
N3: [Addressing P] My dear, what's going on? We moving backwards now? [laughter] No, we going to fix it, tomorrow morning everything is going to be..., well again, alright?
P: [Inaudible] glad you here

N3: Oh! Are you glad to see me?//
P: Mmm...
N3: Ja, then you feel safe, nê? I'm better than the doctor, nê? [Laughter]

Nurse Comments

Nurse in ENT ward making comments to the researcher
(Chapter 7, Section 2.2)

N: So the ENT nurse must learn to speak clearly to the patient, so these who are hearing... having hearing problems, and then listen properly to the ones of the nose and these ones of the 'trachies' [tracheotomy].

N: The throat, all of it is removed, that operation is called laryngectomy but we don't have a patient now, laryngectomy. That one I think they are the hard ones to understand what they say, I think they are the most difficult ones, because they say their speech are coming from their abdomen, so they call it abdominal speech, more especially they speak like "ugh egh guch" [mimics sounds these patients make when trying to speak], just like that, so you must try to listen what is he saying, because sometimes they also become frustrated when they can realise that you can't hear, so at least if you see that you can't hear you just call a second person, maybe she will hear better than you. But there is no specific training.

ANNEXURE 4. TRANSCRIPTIONS – INTERVIEWS

Interview 1

- **The importance of "small talk" with patients**

I: Sister, hoe belangrik dink jy is dit om met jou pasiënte te gesels sommer terwyl jy n drup op sit, of medisyne uit deel?

N: Definitief, dis baie belangrik om met jou pasiënte te praat, dis al... jy vind somtyds goete uit oor hulle wat hulle nie gesê het voor die tyd nie, of hulle wil nie dit vir iemand anders sê nie, maar as jy met hulle gaan sit en jy gesels met hulle an vinde jy goete uit oor hulle, en jy... vind uit hoe voel hulle op daai stadium, nie almal... anders as sê jy "nee, eks orraait", en as jy daar in gaan dan bars daai persoon uit in trane, net omdat jy gevrad het, "Is jy orraait", of jy gaan sit langens die bed, en jy vra, "mevrou, is daar iets wat ek vir jou kan doen?" of "hoe voel jy op hierdie stadium?", of jy gee vir hulle inligting dan's hulle soos in, "Sjoe sister, ek het..., ek voel heelwat beter omdat jy vir my meer verduidelik het". So dit is baie, baie belangrik om te gesels met die pasiënte.

I: Want ek sien nou, jy weet as dit nou, die verskil tussen die oggend en die middag, dan sien ek daai geselsies raak al hoe minder, ek weet nie of dit nou maar is of julle moeg raak hier teen die einde van die dag nie...

N: Ek dink die pasiënte raak ook slaperig in die middae, dan is hulle nou die oggend, die middag ete is verby, al die toetse is verby, en hulle is op hulle bedens en hulle rus meer, so ek dink jy gee daai middag tydjie ook vir hulle om te rus, verstaan jy? Die oggende is maar die gesels periode wat alma look gesels.

I: Nee, ek het soo gesien.

- **Their opinion on an area of communicaiton that is problematic**

I: In oor die algemeen, waar sou jy sê is een ding wat jy voel dalk... veroorsaak miskommunikasie tussen dokters en verpleegsters, of verpleegsters en pasiënte, en so aan?

N: Ek dink, uh, dokters wat net in kom, hulle sê nie "sister, maar ek gaan nou 'n rondte doen" en jy's meskien besig met iets, en woeps is hulle uit by die deur, en dan kom... dan's daar... verstaan jy? Dan's daar nie daai ge-kommunikeer met hom om te sê "sister ek wil dit gedoen hê met daat pasiënt, of ek wil hê die pasiënt moet vir dit en dit en dit gaan nie", so... Maar rerig ons moet sê ons het nogal goeie kommunikasie met ons. Ons het even as jy êrens iets moet onthou meskien op die bord langs die pasiënt se naam skrywe ok dit en dit en dit moet gedoen word by hulle.

- **How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is**

I: En nou dat jy dit sê, voel jy partykeer dat die dokter gee nie al die inligting nie, en dan moet jy na die tyd weer terug gaan en weer mooi gaan verduidelik presies//

N: //Definitief, veral met die tale ook, want dan praat die doctor Afrikaans, of hy praat Engels, maar dan verstaan die persoon nie, maar sy gaan nie sê, "maar doctor ek verstaan nie mooi nie", en as julle uit is en jy gaan net weer terug, dan sê, "Sister, maar nou wat het doctor bedoel met dit en dit" en dan moet jy nou weer terug gaan en verduidelik aan die pasiënt, so ja.

- **Whether they experience difficulties in communicating in additional languages**

I: Ek wil graag terug kom na wat jy nou-nou gesê het van die tale; hoe gereeld dink jy moet jy half 'translate' vir die pasiënt dit wat die doctor gesê het? Jy weet, in ander tale. Ek weet nou nie hoeveel tale praat jy self nie?

N: Mmm. Twee, Engels en Afrikaans.

I: Ja, en hoe baie moet jy half daai vertaal werk doen?

N: Ja, maar dit hang af van ons se pasiënte en hoeveel ons het op daai stadium. Baie van die Vrystaat pasiënte is nogal goed Afrikaans, al die kulture, al die rasse, is goed Afrikaans, maar dan kry jy nou pasiënte uit 'n heel ander provinsie, of 'n heel ander streek, wat glad nie Afrikaans of Engels kan praat nie, dan moet jy maar 'n tolk in kry. Maar dit is nogal nie so gereeld, um, baie wat dit gebeur hier by ons nie, nee.

I: En reel die hospitaal dan vir julle 'n tolk, of hoe maak julle?

N: Ons reel maar sommer self...

I: Is dit? So sommer tussen mekaar?

N: Ja, ons is baie gemeng. Hier is gewoonlik iemand wat sal Sotho kan praat, of..., maar dit is nou net... as daar, as die pasiënt hier uit... die Kalahari uit, en hulle kan net "qie en qa", sjoe en dan moet ons maar met gebaretaal gebruik [laughter]. So ja nee.

I: En wat doen julle dan, by voorbeel, julle kry nie 'n tolk nie? So jy sê julle gebruik maar gebare taal, en wat anders doen julle maar om met die pasiënt te probeer kommunikeer?

N: Somtyds dan moet jy maar neer skryf ook, om te... om iets te sê... ja. Ek dink ons het al 'n pasiënt gehad, maar daar was iemand, maar dan moet jy iemand in kry om met daai pasiënt te kommunikeer.

- **Whether they encounter communication difficulties that occur due to cultural differences**

I: En dan gepraat van kulture, dink jy party keer die kultuur verskille tussen dokters en verpleegsters en die pasiënte, is daar party keer mis-kommunikasie as gevolg van dit?

N: Ek dink nie die kulture nie, maar die tale wel. Die kultuur, ons het nie rerig te doene met die kultuur self nie, maar die die taal self ja. Maar onse dokters is ook van so aard, as julle weet um, ok die pasiënt verstaan... hulle staar jou net so aan, hulle sê nie nee of ja nie, dan weet, okay nee dis tyd vir my 'n tolk in te bring.

Interview 2

- **The importance of "small talk" with patients**

I: Hoe belangrik is dit vir jou om sommer net te 'chat' of geselsies te maak, of sommer net uit te vra oor die patiente se algemene "well-being"?

N: Ek dink dis van die belangrikste wat daar is, want kyk dis waarvoor ons hier is. Want ek meen, op daai menier kom jy op goed af, want as jy 'n pasiënt op neem fisies met 'n papier, dan sê hulle nie vir jou als nie, dis wanneer jy daar gaan sit en begin soos 'n vriendin met hulle gesels, dan kom hulle met inligting na vore wat nogal saak maak, uh, wat hulle behandeling, hulle... veral hulle psigiese behoeftes. Jy gaan kry verskriklike moeilike pasiënte waarvoor jy vies word, en as jy bietjie met hulle gaan gesels dan's dit oor hierdie trauma wat hulle die laaste ses maande, die een is dood, daai een is dood, en die een is geskei en so en so, en dis hoekom sy moeilik is. Dis nie 'n ander rede nie, so, maar daai tyd is maar 'n bietjie min, daai tyd is maar bietjie min, ja... So, ja, as mens dit kon gedoen het sou dit ideal gewees het. Party keer kry mens dit reg, die saal is nie altyd so chaoties besig nie, maar ander keure dan kom en gaan hulle en dan weet jy niks van hulle af nie.

I: Ja, want ek't gesien as mens dit doen so sommer terwyl mens 'n drip op sit of iets//

N: Ja, die ouer mense het verskriklik behoefte daaraan. Dis amper asof die hospitaal nou 'n uitlaat klep is vir hulle. En hulle kan vir jou die geskiedenis gaan haal agter die berge, maar, en dan raak jy geirriteerd want jy't so baie goed wat jy moet doen en jy kan nie ongeskik wees nie want jy, dit is 'n moeilike situasie. En baie keer is hulle alleen, hulle kom uit oue-tehuise en goed uit, en daar's niemand wat luister nie, en hulle, en hulle het hierdie ding oor 'n sister, 'n sister is 'n wonderlike ding wat op 'n troon sit en as die sister so gesê het dan is dit so, en dan as hierdie sister net so bietjie luister ook nou nog dan is dit nou wonderlik ja.

- **How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is**

I: Hoe voel jy daaroor dat verpleegsters moet tolk of vertaal vir die dokter of vir mekaar of so? Want dis nou maklik in Engels of Afrikaans, want jy ken die terminologie en so aan, maar as jy nou na die ander tale toe gaan, dink jy daai inligting word wel reg vertaal?

N: Dit sal ideal wees as dit so kan wees, maar um, dit sal nooit gebeur nie, want daar is nie staff nie, daar is nie geld om niemand te betaal nie, en die hele 'rig-merole' het ons nou vir baie lank hier, dit sou ideaal gewees het, um, want ja, die goed word, want weet jy wat, dis baie moeilik as jy kyk na jou urologie deal van ginekologie, daar's 'n verskil tussen 'n pasiënt wat urine lek as sy hoes, as sy gaap, as sy net loop, as sy sit, staan, daar's verskillende, dit beteken die blaas is hier gesak, dit beteken die pypie is hier te nou, so jy moet daai inligitng so korrek hê, um, kan jy knyp tot by die toilet, of loop dit uit voor jy by die toilet kom, um, voel jy jou blaas word vol, of is hy ewe skielik vol en dan moet jy hardloop, dis die goed is so naby aan mekaar, maar as jy nie presies daai ding het nie, dan weet jy nie wat gaan doen jy op hierdie pasiënt nie, gaan jy die blaas lig, gaan jy die blaas net bietjie dilateer, die blaas pypie, of wat gaan jy maak, so as dit iemand met mediese kennis kon

gewees het wat die vertaal werk doen dan sal dit absoluut ideaal gewees het, absoluut ideaal.

- **Whether they encounter communication difficulties that occur due to cultural differences**

I: En dan die taal en kultuur verskille, meer oor die algemeen, jy weet, ek praat nou meer in terme van, um, jy weet, al praat jy en die dokter met mekaar in Engels, maar jy's meskien Afrikaans eerste taal, en hy's meskien sê nou maar Sotho eerste taal, dink jy daai tipe goeters kan tog miskommunikasie veroorsaak... of dalk net belemmer?

N: Ja, jy moet onthou, jy druk jouself beter uit in jou moedertaal, en um, ja dit doen. Maar nou, aan die ander kant, dis professionele mense as hy iets vir my sê wat ek nie, wat ek nou wan-verstaan, dan sê ek nou, "nee, wag n bietjie dokter, kom ons praat net bietjie weer, dit wat jy vir my gesê het is..., wat ek verstaan het is nou nie lekker nie," so ons is nie bang om met die dokters te query nie, ons is nie bang om vir hulle te sê "nee, ek verstaan nie wat jy vir my 'gesêt' het nie, en ja, so, maar, ek't al baie agter gekom dit kom baie, ja kyk, ons het ook mos nou maar, elke taal het mos maar sy idiome, en sy sê goed, wat die ander nie verstaan nie, en jy vang jouself dat jy sulke goed sê, en dan kan jy sien op daai een sê gesig, maar hy't nou nie 'n clue waarvan jy praat nie. En, maar, en hulle doen ook dieselfde, maar dan verwag hulle jy moet eintlik nou geweet het wat hulle probeer sê het. Maar soos ek jou sê, verhouding tussen die sisters en die dokters is baie gelyk, ek sal reguit vir hom sê, "hoor hier, ek het regtig nou nie 'n idée vaarvan jy praat nie, of ek kan nie lees wat jy skryf nie, of ek verstaan nie wat jy hier wil hê nie, um, kom ons doen dit oor en begin van voor af, maar ek, ja, taal veroorsaak verwarring.

I: En ek dink dis belangrik wat jy nou sê, want dit hang seker ook maar af van waar jy op die range lê, en ek wonder die wat onder op die ranglys is, of hulle party keer nie bang is, soos jy sê, om vir die dokter te vra...?

N: Ja, want weet jy wat nou baie gebeur is, hier's van die sisters wat hier werk 20 en 30 jaar, en die dokters wat inkom, hulle sirkuleer mos nou, so hulle's jonk en hulle weet ook, kyk kom ons vat 'n voorbeeld, 'n pasiënt gaan vir 'n abdominal hestorektemie, hulle moet 'n enima kry, en hulle moet antibiotika kry die aand voor hulle teater toe gaan, sy moet geskeur word, sy moet dit en dit en dit, daai dokter weet dit nie, nou kom hy in die teater, nou's dit nie gedoen nie want dis nie voor geskryf nie, dan is die professor op sy kom en dis 'n helse drama, maar die sisters wat jare hier werk sê, "hoor hier dokter, die pasiënt moet dit en dit en dit kry", "oh baie dankie sister", skryf hy neer, nou dan kom jou wond sisters in, hulle weet dit ook nie, hulle moet ook nog eers..., en elke procedure, want elke ding het verskillende voorbereiding, en verskillende benadering oor hoe dit gehanteer moet word, en jy weet, dis simple om te baklei oor 'n pergasie, noem dit nou maar so, vir 'n pasiënt, gee dit man, wat maak dit saak, dit maak saak vir die pasiënt, want hier's twee toilette in die saal, hier's sestien beddends, as vier pasiënt op hierdie verskriklik pergasie sit, is die toilette permanent toe, hulle, moenie, jy, dis, dit verontrief die pasiënt, so dis waar ons nou kom en sê "jinne dokter, maar gewoonlik vir so procedure gee ons dit nie, is dit regtig nodig?" ons sal nie sê ons gaan dit nie gee nie, ons sal eerder sê is dit regtig nodig, um, want onthou ek moet nogsteeds sy

bevele kry, maar jy guide hulle maar so bietjie. Dan sal jy nou byvoorbeeld kom met 'n jong sister wat rondte gedoen het, sy kom terug in die kantoor, um, dan sal jy vir haar vra ons gaan seker nou daai drip en daai kateter af haal? "nee, dokter het niks gesê nie", ek sê "maar jy moet hom mos sê dit moet afkom man", as jy hom nie sê nie hulle weet nie, jy weet, so, maar dan, ag jy word dan mos groot en hulle leer mos maar op daai menier.

- **Whether they experience difficulties in communicating in additional languages**

I: En dan, die verskillende tale. Dink jy dit beinvloed, of kan dalk mis-kommunikasie veroorsaak? As dit nou jy, en die pasiënt, en die dokter almal verkillende tale praat?

N: Erg, baie, baie erg. Dit lei tot ongelooflike verwarring, en dis baie sleg, baie keer gaan jy by voorbeeld 'n naweek deur wat jy en jou verpleegster nie jou pasiënt sê taal kan praat nie. Jy weet nie rerig hoe dit met haar gaan nie, jy weet nie wat sy vir jou bedeie nie, jy weet nie, sy gaat hier uit en jy het net gedoen wat jy dink sy nodig het. En baie keer as jou, as jou, sê nou maar jou Sotho sprekende dokters by die Sotho pasiënte kom dan verduidelik hulle die hele storie van als deur en jy weet nie wat hulle praat nie, en dan sy hy by voorbeeld vir die pasiënt sister gaan so en so maak, maar jy hoor dit nie, en hy sê dit ook nie vir jou in jou taal sodat jy kan verstaan nie, dan verwag die pasiënt van jou goed en jy weet nie want jy't dit nie gehoor nie. En so is dit nou maar vir al die tale, dit gaan nie net oor die swart tale en Afrikaans of Engels nie, want baie van die oumatjies wat van die platteland en veral uit Lesotho uit, praat 'n verskriklike moeilike Sotho, nou ons Sotho mense baie keer kan hulle nie eers verstaan nie, dis baie, baie, baie sleg. En soos ek sê, party keer dan gaan 'n pasiënt hier in en hier uit van haar... en dan moet jy nou 'n skoonmaker loop en skree en roep, "kom help my net hoor wat is fout met die pasiënt, kom laat jy kom verduidelik ek wil hê sy moet so en so maak, en..." dit is verskriklik tyd-rowend. En frustreerend.

I: Ja, ek is seker. En dit het dan seker ook 'n impak op hou jy die pasiënt kan behandel?

N: Ja, natuurlik, natuurlik. Want jy weet, um, baie van die behandeling wat die, wat ons vir die pasiënt gee, kom nie noodwending van die dokters af nie, dis rade wat ons oor die jare geleer het wat werk. Um, as 'n pasiënt, kom ons sê maar, kom ons sê sy't koors, of kom ons sê sy't keel seer, dis 'n tertiere hospitaal, hier is nie hoes stroop, hier's nie keelseer pilletjies nie, nou wat maak jy met 'n pasiënt, wat hier lê wat vir jou sê sy's verkouerig of haar keel is seer? Nou't van die ou sisters vir ons geleer, jy maak 'n panado stropie in warm water aan, dit help vir keel seer. En nou't jy 'n kommunikasie gaping, jy weet nie wat 'n, met ander woorde, daai klein goedjies wat ons sou gedoen het vir die pasiënt as ons haar verstaan het, dan um, gebeur dit nie.

I: So julle het nie offisiele tolk dienste of so nie?

N: //Niks. Die eerste een, ons gil maar hier in die gang af, en hoor of iemand kan, kan iemand die taal verstaan [laughter]. En wat baie sleg is is as 'n pasiënt baie siek is, nou wil ons vir haar met spoed verduidelik dat ons dit en dit en dit gaan doen, nou's hier niemand wat dit vir haar kan verduidelik nie. En baie keer dan't ons by

voorbeeld n eerste jaar student wat die taal kan praat, maar sy's so oningelig want sy's nog heeltemal, sy..., jy moet vir haar so stap vir stap verduidelik dat sy dit vir die pasiënt kan oordra, dan vat dit op die ou eind van die dag 'n half-uur. Maar ek weet nie hoe..., of mens dit kan.., dis 'n onoorkombare probleem dink ek. En almal gaan net... so veel as wat hulle die Engels nou promoveer, uh, die mense... hulle kan nie almal Engels praat nie, dit is nou maar net so.

I: En die ander ding is, dis baie gespesialiseerde kommunikasie en terminology wat julle gebruik, en dan wonder ek, as jy sê nou maar in Sotho vir iemand moet verduidelik, het jy noodwendig die "medical vocabulary" om dit vir daai persoon te verduidelik?

N: Dis die ding, ek dink daar bly baie goed agterwee en wat baie sleg... ag aan die een kant is dit vir ons seker goed, maar sleg vir die pasiënte veral jou ouer mense, hulle aanvaar so alles wat mens vir hulle sê en met hulle doen, hulle glo jou, hulle vertrou jou, dit wat jy doen is reg, daai pilletjie wat ek haar laat sluk, sy sluk hom maar want ek het so gesê, en as die dokter vir haar gaan maak dan's dit reg, dan's dit fine, dit maak nie saak nie. Hulle het amper hierdie... maar dis fine, verstaan jy, en dis eintlik sad, want eintlik moet jy... hulle moet weet, moet verstaan.

- **General**

I: Anything else about communication that you want to say?

N: Ag, weet jy, ja, die taal ding is maar 'n probleem, en die ding is natuurlik ek dink dis baie gevaarlik vir ons, want ek skryf in a taal wat ek weereens nie my moedertaal is nie, dis swart op wit bewyse, dit is legal goed, dit kan hof toe gaan, dit wat ek daar geskryf het is nie noodwending hoe ek dit wou uitgedruk het nie, en dit is gevaarlik, dit kan vir mens in groot probleme veroorsaak. En natuurlik jy weet mens spel nie so goed in 'n anders taal soos jy in jou eie taal spel nie, en dan beteken 'n ding heel waarskynlik iets anders, en jy weet dit nie en jy gaan maar net aan, ja, dis, dis, dit maak 'n mens dat jy twee keer dink voordat jy skryf, en dit vat tyd, waar 'n ding baie makliker kom as mens in jou eie taal skrywe. Ag weet jy baie goed, en dis die volgende ding, dit maak dat jy hierdie rympies skryf, nie regtig wat in jou kop is wat jy wou gesê het nie, maar omdat dit makliker is, omdat dit vinniger is, jy weet klaar hoe spel jy daai ding, want jy weet klaar want jy skryf dit honderd keer op 'n dag, skryf jy hom maar net weer, met ander woorde om in detail te sê wat jy wou sê van daai pasiënt gaan nie gebeur nie, want daar kan te veel taal foute, spel foute goed inkom, so jy los dit liewer, so ja, maar weereens hoe gaan mens dit oplos? Dit is nie haalbaar nie, en jy kan nou soveel engelse opleiding kry as wat jy wil, ons het almal Engels op skool gehad as tweede taal of derde taal, maar dis nie so goed soos jou moedertaal nie. Nogals interessant, daar by Pretoria is 'n Zuid Afrikaanse Hospitaal, is sy naam, ek weet nou want 'n familie lid van my moes daar iets gedoen geword het, en blykbaar vandat jy by die deur instap tot jy by die agterdeur uitstap is alles net Afrikaans, nou dink ek by myself, wow, wat 'n verligting kan dit wees om nie te gaan staan en dink wat ek nou eers moet skryf nie, jy doen net en jy praat net en jy skryf net, dit is, jy dink nie daaroor nie, dit moet eintlik heerlik wees, maar nou ja, dit gaan nie so maklik gebeur nie.

Interview 3

- **The importance of "small talk" with patients**

I: Hoe belangrik is dit dat mens bietjie daai persoonlike geselsies en sommer net vra hoe gaan dit met die pasiënt, hoe belangrik is dit vir julle?

N: Vir my is dit belangrik want ek wil weet wat met my pasiëntjies aangaan, en baie keer uit die gesprekke kom jy maar agter jy weet, iets by die huis is ook nie reg, dat mens daar kan probeer om jy weet dit te help, of 'n maatskaplike werkster of iets te kry om te help. Nee, vir my is dit belangrik, en dan kan jy sommer sien in watter gemoeds toestand die pasiënt ook is.

I: En beinvloed dit hoe hulle saam werk met die behandeling?

N: Ja, dit doen.

I: Sister het nou baie ondervinding al, met al die verpleegsters en sisters waarmee julle saam werk, wat veroorsaak, wat speel 'n rol daarin dat verpleegsters dalk nie altyd daai tipe kommunikasie kan hê nie?

N: Ag, ek dink dit is partymal die taal probleem, jy weet nou met Afrikaans, Engels, Sotho, Tswana en so aan, kan ek my indink dis nogal 'n probleem want dit is vir my ook party keer 'n probleem as die pasiënt net swart tale magtig is om met hulle te kommunikeer, ag en hulle het meskien nog nie die um, die volwassenheid amper om jy weet nou met die pasiënt, dit kom, mens kan dit sien in die tweede, derde jaar, dan is dit al vir my makliker en dis meer spontaan, hulle is vir my nog bietjie terug-houdend omdat hulle nog onervare is en so met die kommunikasie.

I: En sou sister se tyd speel 'n rol daarin? Jy weet, julle het dalk nie altyd tyd daarvoor nie.

N: Dit kan ook 'n rol wees ja, jy weet as 'n saal baie vinnig, uh, besig is en dit gaan 'n biejtie dol, dan het jy nie altyd tyd om vir die pasiënt alles mooi te verduidelik nie.

- **How they communicate with patients when the patient is unable to communicate verbally due to medical reasons, or when the patient speaks a language that none of the staff can speak and no interpreter is available**

I: Gepraat nou van die verskillende tale, wat maak jy nou as jy 'n pasiënt het wat nie enige van die tale wat julle hier kan praat nie? Wat doen julle met sulke pasiënte, hoe kommunikeer julle met hulle?

N: Ja, mens probeer maar met gebaretaal ook maar reg kom, ja want dit is nogal moeilik. Vroeer het ons mos heelwat Sjinese en Taiwanese gehad, toe ek nou 'n Kraam afdeling gewerk het, en toe't ons nou heelwat papier gehad met sinnetjies op van het jy pyn, of kom jy reg met die borsvoed, of die tipe van dinge, en dit het ons ook nogal gehelp. Maar goed, ons het nou nie meer eintlik sulke pasiënte nie, dis nou meer maar die swart tale wat maar vir ons so bietjie van 'n probleem gee.

- **How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is**

I: En as julle dan moet vertaal byvoorbeeld, as 'n dokter vir die pasiënt nou iets verduidelik het hoe gereeld voel jy dat jy moet terug gaan en mooi gaan verduidelik, um, en as jy weet jy sal dit nie in daai taal kan verduidelik nie, dan kry julle seker maar iemand anders wat die taal kan praat, of hoe maak julle?

N: Ons, kyk gewoonlik is hier darem is swart verpleegster, indien nou nie, sou mens nou maar die volgende dag as daar nou wel een aan diens is nou maar weer vir haar vra om te tolk, of ons kry anders maak enitjie uit die kliniek uit want dis wat infertiliteits kliniek ook baie doen, hulle leen gou 'n verpleegster by ons om vir hulle te tolk, want hulle is nou net twee blanke sisters daar.

- **General**

I: En dan oor die algemeen, wat sou sister sê is een van die groot dinge wat sister voel veroorsaak kommunikasie, or verwarring in terme van kommunikasie? Of dit nou met sister se pasiënt of die dokters, of wat ookal?

N: Dis maar dat die kommunikasie is nie die... jy weet, daar is nie goeie kommunikasie nie, so 'n ding is nie oorgedra byvoorbeeld vandag na nag staff, of van die oggend na die middag skof, en dan word dit nie uitgevoer nie, en dan's ons later in die moeilikheid daaroor. Dit kan partykeer net 'n klein dingetjie wees, die pasiënt moet op tee, toast en jelly bly en nou't iemand vir haar normale kos gegee, nou kom die dokter daarop af, dan is hulle vies, jy weet, dit is maar as daar nie kommunikasie is. Of selfs met die pasiënt ook, as jy nie vir die paisent sê jy moet dit drink of dit is daarvoor nie, dan sê jy "ag wat, waarvoor moet ek dit drink", en dan is dit nie gegee nie, en dan is dit op die ou einde 'n hele ketting reaksie, dan kan die toets nie gedoen word nie want die medikasie is nie gedrink, mens kan maklik in die moeilikheid kom van klein kommunikasie gapings.

I: Goed, ek wou met net hoor wat sê julle oor hierdie dinge, julle het mos maar baie ondervinding oor die jare.

N: Nee, ek kan nogal dink dat as mens 'n swart taal sou kan aanleer, sal dit jou baie help, want op skool het ek Sotho gehad in die jaar toet, en dit was vir my vreeslik lekker, en ek het vreeslik goed gedoen, en ek het een jaar dit gehad en toe skaf hulle dit af, en snaaks geneog met my kinders ook in die hoerskole, een jaar in graad 8 het hulle Sotho gedoen en dit was lekker en hulle het maklik dit aangeleer, goed gedoen in die toetse en dan stop hulle dit en ek vind dit nogal jammer, dit kan die kommunikasie soveel vergemaklik, as ons dit kon aan gehad het ons hele skool loopbaan, en nou ook. Want dit is nogal 'n probleem, jy weet, dis frustreerend, en jy's bang die pasiënt doen die verkeerde ding, want jy kan nie altyd vir hulle dit goed oordra nie.

I: En daar is seker nie altyd iemand wat vir hulle kan verduidelik of vertaal nie...

N: Ja, en ons mag eintlik nie die bodes en die skoon makers gebruik nie, want hulle het nie die medies agtergrond nie...

I: En hoeveel van daai mediese terminologie het mens rerig in ander tale?//

N: //En baie keer dan kom die vrouens wat skoon maak of die bodes, dan kom hulle en sê dat die pasiënt sê sy't n probleem met die pensioen gaan haal of... jy weet, dan weet 'n mens of die pasiënt vreeslik na mense, dan soek jy die nommer op en dan bel ons en dan laat ons die pasiënt kantoor toe kom sy met haar mense praat en so. So hulle help ons ook baie keer om problem op te spoor, maar jy kan nie regtig hulle vir mediese goed vra nie.

Interview 4

- **The importance of "small talk" with patients**

I: So sister, tell me, the first thing I want to know is how important is it for you, or do you think it is to chat with your patients?

N: Talking to them just to get to know them, just to make them feel at home, you know just to make them that is..., you know usually when they are here 'mos' they are miss home, so at least when you talk to them they feel at home, so ja.

I: And what do you think sometimes keeps you from doing that?

N: Maybe when the ward is busy and you are having admissions, operations, then you don't get a chance to sit with the patient one on one and talk.

- **Whether they have to act as interpreter and what problems are associated with this**

I: When it comes to translation, how often do you have to translate for patient for instance what the doctor is saying or one of the other nurses is saying

N: A lot

I: And what languages do you have to translate into usually?

N: In Sotho, sometimes Tswana

I: You speak Tswana?

N: Yes

I: So you speak 3, 4 languages?

N: Yes, it's Tswana, Sotho, English, Afrikaans

I: Ok, and is it easy or difficult to translate? Or what do you think is maybe a problem for you when you have to translate?

N: Hmm, there's not a problem

I: Ok, and do you have medical terminology, for instance in Sotho? How do you, have you come up with other ways to explain things?//

N: //No, just to make them understand, like in simple Sotho.

I: Ok, and then, let's say you have patient that doesn't speak Sotho or Tswana or any language that any of you know, what do you do with those patients then?

N: [Inaudible] the patients, like if you don't speak the language that you speak then we usually speak English, so ja, I haven't experienced that.

I: Patients that you can't communicate with at all?

N: Mmm

I: Ok. And like even with other nurses or doctors, like when you speak and you have different mother tongues or you have different cultural backgrounds, do you think that can influence communication or maybe sometimes cause misunderstandings, you mean one thing and they understand it's another thing.

N: Yes, 'cause if you say something like lightly, and then they think it will be something harsh, its harsh or something.

I: Ok, so miscommunication, or not really miscommunication, it's more//

N: Ja, not understanding cultures and stuff

- **General:**

I: And then what do you think maybe can cause miscommunication between you and the doctor, you and the nurse, you and the patient? What do you think is a major thing that can cause miscommunication?

N: Like if you don't understand, then maybe you act like you understand. Ja, that one I think it can cause communication. I think it's only that.

I: So you have to ask, and then sometimes they are intimidating?

N: Ja

I: So that's all you want to say about communication. Is there anything else you want to say about communication?

N: Nothing

Interview 5

- **The importance of "small talk" with patients**

I: The first thing I want to know is, how often or how important is it to you to just chat with your patients a little it here and there, sort of just talk to them a little bit about everyday things?

N: How often do we talk to them?

I: Mmm

N: I love talking to the patients, I spend most of the time with them, if the ward is not busy we go to their rooms.

I: And why do you think it's important, what do you get out of it, what does it do?

N: To me, I get nothing, but to them it helps, since they are here, some of them those patients they are not from Bloemfontein, some of them they are here for a long time and nobody's visiting. So it's our duty to keep them company, it's our duty to keep them to feel safe, ja, I think... But with me I love talking, I'm so outspoken, so with everyone besides the patients, I love to talk in a way, ja, under general circumstances. So with patients, we bond with them, that's why most on them even when they leave the hospital, we keep contact.

I: And it's interesting what you say about your personality. Do you think for other nurses it's more difficult, because it's not their personality to talk all the time?

N: Ja, with others, that's why the last time the others ask me, why do you it looks like you know all the patients and you are so close with them? I prefer to spend time with the patients because with them we can talk, we can discuss, when they left the hospital everything we discussed is over, but if I discuss it with my colleagues, at the end of the day it might come back and haunt me. So with the patients it's safer for me, if it's an elderly patient I treat them like my grandparents, if it's more like my mother, I'll treat that patient like my mother, if she's my age group I'll treat them like my sisters, and then we get along with them, you don't have stress with patients.

I: And do you think that if you have that kind of relationship with your patients, does it help for instance when you have to for instance give them an injection, when you have to do something that they might feel scared of?

N: Mmm, they feel safe. They believe in you.

- **How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is**

I: And then, how often do you have to translate, which languages do you speak?

N: My home language?

I: Ja, and you speak English obviously, and what else do you speak?

N: I speak Shangaan

I: And what else?

N: I can speak Shangaan, I can speak Zulu, Xhosa, I can speak Sotho

I: Ok, so you can speak a little bit of everything. And how often do you have to translate for patients for instance if they don't understand what the doctor or nurse is saying?

N: Most of the time we do. Because sometimes its just me and the sisters who are speaking Afrikaans so definitely they don't understand Afrikaans, patients who are coming from Lesotho most of them they are so into that, they can't speak Afrikaans or English, only Sotho, so we must translate.

I: And do you think its effective? Because that's the other thing I want to ask you, because I mean obviously you received your training in English, so how do you then take all that medical information and translate it into Sotho?

N: No, normally I'll ask the D what's that? Then the D will explain it to me until I understand it, then I can translate it to the patient. Because we once had one patient from Mozambique, so was Shangaan and nobody could understand that language.

I: And then what did you do? How did you communicate?

N: No, I can speak Shangaan, so I can communicate with her

I: Have you had patients who no one can speak their language at all?

N: No

I: Ok//

N: Because most of them its Afrikaans, Sotho, most of the patients

- **Whether they experience difficulties in communicating in additional languages**

I: And then how do you think the different home languages, having different home languages, does that ever affect or cause misunderstandings between you and the nurses, or you and the doctors or whatever?

N: I think it helps, because we are not here for the doctors or our colleagues, we are here for the patients, so if you know all these languages it helps, because at the end of the day we don't struggle with patients. You can communicate with any patient.

I: And do you think there are times when the doctor will speak to you and that you maybe don't quite understand them, is there any miscommunication like that or not really?

N: I don't know with the rest of the staff, but with me if I don't understand I ask, because with most of them they speak Afrikaans, then I'll say, "please say it in English". Me and Afrikaans, I can understand there and there but you know mos that side (Mpumalanga) there is no Afrikaans.

- **General**

I: So in general, what do you think in general might be things that cause miscommunication? Because I mean miscommunication happens anywhere and everywhere, so specifically as a nurse, what do you think is maybe one or two things that really cause miscommunication in your profession?

N: With me in Free State, they are still more to Afrikaans, because there are those who can tell you I'm speaking Afrikaans. If you speak Afrikaans, I'm speaking Shangaan it means its a disaster mos, we won't understand each other. So the best way is to speak English. But for the patient it's fine, if the patient can't speak English we must it's our duty to make them understand what's happening around the ward, but then I wish everybody, the doctors the nurses everybody can speak in English.

I: And anything else that you think maybe causes miscommunication?

N: Hmm it's only that, Gynae ward is nice. We get along.

Interview 6

- **The importance of "small talk" with patients**

I: Goed, sister, laat ek gou bietjie by jou hoor – my eerste vraag is as jy nou moet sê op 'n skaal van een tot tien, hoe belangrik is dit om sommer net geselsies aan te knoop met mense, sê nou maar terwyl jy 'n drip op sit of medikasie uit gee, sommer net vinning so bietjie te gesels met die patiente?

N: Um, 9, ek dink dis baie belangrik, ekt al baie agter kom dis hoe jy soos, hoe jy goed optel wat hulle dalk nie raak gesien het van te vore nie. Byvoorbeeld een keer 'n drip wat infiltreer het wat die pasiënt nooit gedink het om vir iemand te sê nie, en 'n bandjie aan gehad het en so verloor die pasiënt amper die hand. Ek dink dit is maar belangrik om elke keer alles te vat en te doen en maar bietjie te hoor hoe dit gaan. Maar dan is daar ook tye wat jy maar moet vinnig werk, so dis hoekom ek maar daai een minus, want partykeer is daar nou, moet jy nou eerder jou werk klaar doen as wat jy geselsies aanknoop, so ja.

I: En dit sou dan nou my tweede vraag wees, wat verhinder julle om dit te doen? Dink jy dit kan 'n persoonlikheids ding ook wees? Vir party sisters is dit net makliker voor?

N: Ja nee, definitief, maar ek dink dis maar altyd, dis soos daai wat altyd maar soos met party culture ook saam gaan, is maar, dit is maar net die mooi manier om altyd te vra hallo en hoe gaan dit, so ek dink dis maar iets wat ons ook van die kultuur kan vat, so ek het nou maar, ek vra altyd hallo en hoe gaan dit, jy weet, en dan gaan ons nou maar aan van daar af. So jy kan maar net elke keer vra al, en soos in die Sotho kultuur kan jy dit half n general greeting ook maak, so net vir almal hallo sê, dan voel almal daars goeie manier gehandhaaf, dis maar net vinnig.

- **How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is**

I: In terme van die verskillende tale, mens praat nou Engels en Afrikaans en Sotho en watookal anders nou nodig is in die sale, ek neem aan jys nou Engels en Afrikaans magtig, het dit al gebeur dat jy bevoorbeeld moet translate vir 'n dokter? Sê nou maar die dokter kan net Engels praat, en jy moet vir die pasiënt verduidelik in Afrikaans? Gebeur sulke goed gereeld?

N: Ja, veral byvoorbeeld die Kubaanse dokters en die dokters van bo in Afrika, hulle kan baie keer net Engels praat, so ek moes al baie keer vir hulle in Afrikaans translate. Um en dit gebeur ook baie dat ek n verpleegster of iemand roep om gou vir my in Sotho te kom translate of vir die dokter te kom translate. Um nou die dag het ons 'n pasiënt gehad wat Zimbabwean is, dis absolute chaos om dan iemand te kry om dit te praat, so ja.

I: En dan wat maak julle met so pasiënt as julle, niemand daardie taal kan praat nie?

N: Um die dokter het by voorbeeld, gelukig het die een verpleegster is soos amper elke taal magtig in Suid Afrika, so sy kan nou nie Shona praat nie, maar sy kon toe darem 'n taal wat hulle altwee verstaan toe min of meer die ding kry. Maar verder het die dokter gesê ons moet maar kyk vir 'n translater, maar eintlik moet mense kyk in hulle community, want daai vrou is obviously nie alleen hier nie, so iemand moet haar verstaan en mens moet nou maar net vir haar beduie dat daai iemand moet saam kom as dit nou ingewikkelde goed is soos toestemming en sulke goed dat mens dit vir hom kan verduidelik en hy kan translate.

- **Whether they encounter communication difficulties that occur due to cultural differences**

I: In terme van taal verskil en kultuur verskil, dink jy dit versoorsaak party keer miskommunikasie of verwarring, al is dit net 'n snaaks incident, dit hoef nie noodwendig 'n negetiewe ding te wees nie, maar//

N: Nee, ek dink definitief taal en kultuur, as ek nou net be voorbeeld dink die groet ding, het ek vir 'n lang tyd by voorbeeld deur die telefoon te antwoord dan is jy nou soos haastig en jy kan nie verstaan hoe iemand net tot die punt kom nie, hoekom moet hulle nou sê hallo en hoe gaan dit, en dan sê jy nou goed dankie en met jou en ok kan ons nou tot die punt kom. Maar deesdae is dit net soos self mense van my eie kultuur of taal, omdat ek in a swart omgewing werk het ek nou maar net aangeleer om altyd te sê hallo hoe gaan dit um hierdie is die, dis wat dit is, dis hoekom ek bel, so dis maar net 'n standaard vorm, en dit hou almal tevrede as jy vra hallo en hoe gaan dit, het ek nou al agter gekom.

- **Whether they experience difficulties in communicating in additional languages**

I: En, jyt in Afrikaans geswot nê?

N: Ja

I: So dan help dit, want jy ken seker die terminologie in Engels, jy leer dit seker maar aan... anders om, jyt dit seker geleer in Afrikaans, en jy leer dit aan dan seker in Engels seker maar oor tyd.

N: Wel eintlik, ek moet sê ons teorie, handboeke en goed in Engels is so um die terminologie is meestal in Engels en dan, wat ook sleg is is baie keer in wetenskaplike Engels, so by voorbeel soos teroeid vandag kon ek nie op die word kom om vir iemand te verduidelik ek praat van my skuld klier nie, toe weet hulle waarvan ek praat, so um, dis moeilik, maar jy leer dit in Engels basis, en dan's dit nou maar basies jou voer taal Afrikaans, as jy lus het om dit te vertaal. Maar die swottery self is Engelse handboeke.

I: Want met dit, ek weet nie of daai terminologie beskikbaar is in Sotho nie, en ek weet nie, hoe vertaal jy dan in 'n ander taal in, of verduidelik jy nou maar seker in detail vir die pasiënt...

N: Ja, wel ek dink so, veral bedoel, baie rural Afrikaanse mense, soos by voorbeeld nou die kleurling oukies, of party van die ouens wat Sotho verstaan, hulle gaan nie noodwendig weet wat jou niere is of dis nou, dan gaan jy nou mooi vir hulle verduidelik die niere dit het eintlik te doen met die piepie wat jy het maar jy gaan nie woorde soos urine gebruik nie, so dit wat nou daar gebeur, dis nou hoer op onsteking, die kidney in die niere, en dan gaan jy nou so vir hulle verduidelik dat dit ja, simplify dit maar so bietjie, want ek bedoel eks seker dis wat die, ek bedoel ek is nou nie Sotho magtig nie, maar eks seker dis wat die verpleegsters dan nou maar, of dit sou die ideaal wees, dat hulle dit so verduidelik, want dit help ook nie jy't die terme nie en die pasiënt gaan dit in elk geval nie verstaan nie.

- **General**

I: En as jy moet sê oor die algemeen wat dink jy is een van die groot faktore wat miskommunikasie veroorsaak tussen of jou as verpleegster of sister, en ander verpleegsters en die dokters of met die pasiënte of watookal?

N: Daar's klomp goed, um, daars rerig klomp goed, partykeer is dit net rerig general manier, of ways of approach, of selfs ek het hierdie wonderlike verpleegster gehad wat by voorbeeld dadelik as jy vir haar sê om iets te doen dan sê sy eks nou by sister ek maak net gou hierdie klaar. Maar net soos die manier wat sy dit sê, nie soos ek doen nou eers dit of watookal nie, so dit is baie keer in 'n manier van net soos 'n way of oordrag, dis rerig cool, want, um, by voorbeeld niemand het met haar probleme ooit gehad nie, want sy het hard gewerk en haar goed gedoen maar syt jou ook nie laat voel jy vra nou vir haar iets ekstra of watookal nie, sys nou daar sys net gou eers besig met hierdie, wat nogal cool is. En um, verder is dit partykeer maar net 'n manier van praat of 'n manier van goed doen, hoe jy partykeer maar net elke keer vir iemand moet dankie sê, ja, ek weet nie, dis maar verskillende goedjies, ja.

Interview 7

- **The importance of "small talk" with patients**

I: Ok sister, op 'n skaal van een tot tien, hoe belangrik is dit vir jou om biekie met jou pasiënte te gesels, terwyl jy nou sê nou maar observasie doen, of medikasie gee of watookal?

N: Tien. Ek sou sê dis baie belangrik omdat jy baie goed daar tee kom, meskien die pasiënt se familie mekeer iets, daar's siekte of daar's dood, of hys bekommerd oor sy mense wat meskien hy's die enigste broodwinner en hy lê in die hospitaal, en daar's meskien nie kos nie, sulke goed kom partykeer uit, dat jy meskien kan gesels daaroor. Dan voel hy ook beter baie keer.

I: Dan, um, wat sou jy sê is redes hoekom daai gesels nie altyd gebeur nie, wat verhinder julle?

N: Partykeer is dit besig ook, jy weet, partykeer is daar pasiënt wat nie rerig, is nie praterige pasiënte nie. Jy kan tog op hulle gesigte sien daar is tog wel 'n probleem, iets wat hom pla jy weet. Partykeer dan as dit nou rustiger is, dank kan jy nou meer bietjie aandag skenk en net 'n rukkie bestee daarso, of 'n pasiënt knoop 'n gesels aan en dan is dit daar waar die probleem eintlik uit kom, as jy bietjie vertoef daarso, het ek uit gevind.

- **How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is**

I: Dan wil ek net vir jou vra, in terme van tale, jy weet, ons praat nou Engels, en Afrikaans, en Sotho, en en en, as julle sê nou maar moet vertaal vir 'n pasiënt in Sotho, um, dink jy dis baie effektief, dink//

N: //Mmm dis beter. Ek dink soos ons wat nou nie 'n derde taal kan praat nie, is dit belangrik dat 'n pasiënt wel moet weet wat met hom aangaan, watter procedure jy gaan doen op hom, hy moet eintlik verstaan in sy eie taal in, uh, dit vergemaklik hom ook en stel hom gerus, as hy dit in sy eie taal verstaan.

I: Ja, en dis goed jy sê dit nou, want my volgende vraag, ek sal nou weer terug kom na die tale toe, maar hoe belangrik, of is daar spesifieke tye wat jy vir die pasiënt sal verduidelik soos wat die medikasie doen, of dis die procedure?

N: Dis maar as jy iets gaan doen met die pasiënt, gaan jy meskien hom vertel wat jy gaan doen.

I: En wat doen jy byvoorbeeld as julle 'n pasiënt kry wat van 'n area of kom en glad nie enige een van julle tale verstaan nie, wat doen julle dan?

N: Dis moeilik ja, ons het 'n pasiënt nou die dag, en ons moes maar met gebare taal kommunikeer en op so manier kon ons dan.., jy weet, hy konnie Afrikaans verstaan

nie, Engels of Sotho, niks nie, so hy kon daarem verstaan wat ons wil hê hy moet doen met gebaretaal.

I: En het julle vertalers wat kan in kom om sulke pasiënte te help, want...

N: Ja, soos Sjinese is baie keer mense wat sjinees praat, dan kom, op die bord het ons ook daar..., of het ons nog daai uh, mense kom tolk.

I: Ok. En dan om terug te kom na die tale toe, want al is jy, praat jy en sê nou maar die dokter met mekaar, en hy's sê nou maar Sotho agtergrond en jys dalk Afrikaans agtergrond, kan daai tipe goeters partykeer biekie verwarring bring en miskommunikasie dalk?

N: Ja..., meskien, ons het dokter wat van..., van waaraf kom hy matron? Ghana? (addresses matron who is working nearby)

M: Van Ghana ja.

N: Maar ek dink hy't nou begin beter word? Jy kon hom partykeer nie verstaan nie, sy Engels nie, maar nou begin hy biejtie duideliker raak, jy weet, hoe langer hy hier is, maar dis ook nogal 'n probleem, om nie iemand rerig te kan verstaan nie, en ons verstaan hom nie rerig nie, maar ek dink dit het nou, hoe langer hy hier is, hoe beter raak dit. Hulle praat mos, hulle Engels is mos verskriklik moeilik.

Interview 8

- **The importance of "small talk" with patients**

I: Op 'n skaal van een tot tien, hoe belangrik is dit bietjie geselsies aan te knoop met jou pasiënte, om sommer net hier en daar, sommer terwyl jy die drip op sit, te gesels?

N: Baie belangrik, op die manier sien jy, of jy hoor iets wat die pasiënt nooit gesê het nie meskien, of uh, hoe sal ek dit nou sê, ek kan vir jou..., as jy gesels kan ek maklik vir jou, dan kommunikeer hy ook maklik vir jou, dan kan hy maklik vir jou opsom wat gaan in sy eie gedagtes aan.

I: En hoe beinvloed dit hoe mens hulle kan behandel, in terme van die medikasie en sulke goeters?

N: //Ja, medikasie en so..., jy kan uitvind meskien het hy nooit genoem dat hy meskien allergies is vir 'n ding, of hy't meskien, is hy soos in... eet hy nie, hou hy nie van iets nie, dan kom jy nie agter nie of so.

I: En wat sou jy sê is redes hoekom julle nie altyd kans kry as verpleegster, nou nie net jy nie, maar al die verpleegsters nie, hoekom kry julle nie altyd kans, of wat sou jy sê weerhou jou om daai tipe goeters te kan gesels?

N: Hoekom kan ons dit nie gereeld doen nie?

I: Ja

N: Op die oomblik sou ek sê dis omdat ons is so besig die afgelope tyd, jy weet, jy wil eintlik al die werk moet, jy wil hê al die werk moet klaar is as jy van diens af gaan, um, jy kry nie daai geselsies nie, as jy met die pasiënt werk, dis al wanneer jy geselsie kan aanknoop.

- **How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is**

I: Jy weet, ons werk nou met allerhande verskillende tale, soos ons maar in Suid Afrika het, so as jy, ek weet nou nie wat praat jy? Engels? Afrikaans?

N: Engels, Afrikaans, hoor hier tussen in, meskien verstaan ek een word uit die sin uit en maak maar afleidings wat gevaarlik kan wees, maar, ons verstaan op 'n manier mekaar, bedye.

I: Ja, want ek will nou vra wat maak julle met die pasiënt wat glad nie verstaan nie?

N: Bedye maar, jy sal maar 'n aksie uit oefen as jy wil sê sputum, so jy oefen maar 'n aksie uit, of jy wys iets, ja.

I: En sê nou maar, sal julle ander sisters hê wat kom translate, jy weet, sal sy kom tolk?

N: Ja, ja, meeste van die tyd. Op die oomblik het ons mos 'n Ghana dokter, so nou kry ons ook die kans om Afrikaans te translate.

I: En dink jy dis effektief om so te translate?

N: Ja, ek dink dis 'n beter manier, want op hoe manier anderste?

I: Ja, want as julle sê nou maar 'n profesionele tolk moet in kry, dit moet seker iemand wees met 'n mediese agtergrond?

N: Ja, dit is die ding ja.

- **Whether they encounter communication difficulties that occur due to cultural differences**

I: Um, net meer oor die algemeen, as julle nou tussen die kulture moet kommunikeer, jy kommunikeer dalk met die dokter in Engels, maar sy kultuur is so veel anders, dat jy sê dalk 'n ding so en hy verstaan hom dalk anders, sien julle van dit, of is dit nie rerig 'n probleem nie?

N: Meskien, nie die dokters nie, meskien van die pasiënt jy weet, soos ons sal nou sê "dis warm" nê, dan kom iemand met sy kultuur met 'n kombers in, jy weet, so dis sy kultuur, hy voel hy moet 'n kombers om hom hê, al sweet hy.

I: En dink jy dit kan miskommunikasie, of verwarring veroorsaak, as hulle nou verskillende taal en kulture het?

N: Ja, ek dink dis veral tussen ouer mense, verstaan jy? Dis so, ouer mense is so outyds, jonger mense is meer...

- **Whether they have to explain information to patients at times that the doctor has already communicated, but that the patient did not completely understand**

I: Sien jy dit partykeer dat die dokter verduidelik vir die pasiënt iets, en die pasiënt ja, ja, ja, maar die pasiënt het niks verstaan nie?

N: Ja, baie, maar dis hoekom hulle deesdae maak doodseker, daar's twee witnesses twee teken, so jy wat teken is net so skuldig as daai pasiënt, jy verstaan, jy moet seker maak.

I: Ja, en jy moet dalk maar terug gaan na die tyd en weer gaan verduidelik?

N: Ja, meeste van die tyd vat die dokters nou maar Sotho sprekend saam, of as die pasiënt nou regtig nie, sal hulle baie moeite doen. Xhosa is ook moeilik, Vrystaat is

mos meer Sotho, so hulle sal iemand in die hande kry, van die personeel kan hier en daar verduidelik en dan verstaan meeste van hulle.

- **General**

I: Enige iets anders wat jy voel kan miskommunikasie veroorsaak, of nou tussen jou en ander sisters, met die pasiënte of dokters? Dink jy daar's ander goed wat dalk ook miskommunikasie veroorsaak wat jy al gesien het?

N: Ja, ek sal sê meeste van die tyd is dit uh, 'n pasiënt sê, meskien die dag, partykeer is dit pasiënte wat konflik ook bring, want hy sê die nag mense maak so en as jy aan diens kom dan sê hy die dag mense maak so, so hy dra 'n storie van die een groep nie die ander groep, so, maar meeste van die tyd verstaan ons mekaar.

I: En jy weet die dag, of die nag staff sal nie sulke goed aan vang nie//

N: //Ja, ons het 'n goeie verstandhouding, ja.

I: En dis seker dan belangrik om by hulle te gaan check, en te sê die pasiënt sê dit//

N: //So pas op, kyk maar net, maak seker, dis al. As die pasiënt sê julle't nie sy wond gedoen nie, so is julle skuldig of onskuldig? (Laughter)

Interview 9

- **The importance of "small talk" with patients**

I: Sister, first of all, on a scale of one to ten, if you say ten is very important, one is not important at all, on a scale of one to ten, how important is it to just talk to your patients a little bit, so while you are putting up a drip or something, or just, you know, having a little bit of a chat with them, how important is that?

N: It is important because sometimes, uh, you obtain the uh, previous history, you see, because sometimes when they doing admissions, if it the ward is too busy, they don't have enough time to chat with patient about their previous operation, the cause of that illnesses, you see, so the main time I was busy inserting the drip, then we'll get chance to communicate, restfully with the patient, you see.

I: And how often do you try and do that, all the time? Do you think there's sometimes times when you can or can't//

N: //Ja, sometimes you can't, if you are busy you don't have that chance really, but if it's like now, neh, the ward is little bit quiet, then you'll have time to communicate and chat with the patient, but if we are busy we don't have time really, because you are in a hurry, you want to finish everything.

I: And do you think personality, do you think for some nurses it comes easier, because we have different personalities, some of us like to talk to other people, some of us//

N: I think, uh is yes, some of the patient is easier because of language, you see, the others you struggling because of the language, you want to express yourself, but you don't know how, you see.

- **How often they have to act as interpreter between patients, nurses, doctors or other staff members, and their perception of how effective this is**

I: And on that point, how often do you have to translate, for instance if the doctor can only speak Afrikaans, and you have to speak... I don't know what other languages you speak?

N: Sotho yes

I: Ok Sotho. How often do you have to translate for doctors or so on.

N: Oh almost everyday, really, everyday. Even after the rounds. You see this morning I was having patient who must go to gynae, uh, ward, so I contact doctor and ask about, uh, the translation, I mean the transfer, so it was already cancelled due to lack of bed, so I have to go to the patient and inform her, she can't understand doctor, you see.

I: And I don't know if you sometimes struggle, I'm assuming you did your training in English?

N: Yes

I: Ok, and do you sometimes struggle with not having all the medical terms in Sotho, or is that not really a problem?

N: No, if I don't understand, I ask the doctor.

I: So do you have those medical terms in Sotho? Or do you having try and explain it in a different way?

N: In a different way, mmm.

I: And do you think this is effective? Do you think it would be better if you had a professional translator here, or do you think it's better for the nurses to just translate?

N: No, I think it would be better if we got a professional translator, really. I think so.

I: Do you think it also keeps it out of your work if you have to translate the whole time?

N: They take time, really, mmm, and a lot of time.

I: And I'm sure it takes longer//

N: //it takes longer, and sometimes you are busy writing a report or giving medication, so you see, it takes sometimes thirty to forty-five minutes sometimes. And the patient is going to ask you the questions. It takes times really, especially when the ward is busy, but if it's quiet like now, you don't mind.

- **Whether they encounter communication difficulties that occur due to cultural differences**

I: Now coming back to the languages and translating, um, because we've spoken about the languages now, do you think sometimes with doctor even there's miscommunication because of language differences or not really?

N: uh, towards the doctor? If I'm not there?

I: Well, no, you and the doctor, if the doctor is telling you you must do this and this and this, is there sometimes even miscommunication between nurses and doctors because of the language?

N: Ah no, I didn't have a problem. That's fine. Towards my side, I don't know about the other people. Because if I don't understand, I ask, but it happens rarely, very rarely. But me I ask. [Irrelevant] And the other thing I experience, most of our

people, some of them, they don't understand Afrikaans clearly, fortunately neh, I understand both of them, Afrikaans and English, you see, so they struggle a little bit.

- **General**

I: And then in general, what do you think is one thing that can cause miscommunication? Either between you and other nurses, or between you and the patient, what do you think is the main thing that you think causes miscommunication?

N: Uh, miscommunication of the conflict?

I: Uh, or any type of communication, where you don't understand what they are saying or they don't understand what you are saying, or you think you understand they meant something else?

N: I think a problem is our personality differs, so that is why we fight a lot, we differ, really. Maybe I'm like this, I expect you to be like me, and I expect you to do the work the way I work, you see, which is wrong. You have to accept each other, the way we are, and then we have to respect each other even the culture also.

I: And do you ever have funny things that happen because of different cultures, that you misunderstand each other?

N: Yes [laughter] sometimes the language, neh, the first time I came here, they say, doctor during the rounds, he say, "just give, uh, TLC". I go to the sister, I ask "what is TLC? Is the blood?" Oh they laugh [laughter] they laugh a lot. So I didn't understand what they mean, yes.