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Creating history: documents and patient participation in nurse-patient interviews

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Abstract Strongly worded directives regarding the need for increased patient participation during nursing interaction with patients have recently appeared in a range of 'best-practice' documents. This paper focuses on one area of nurse-patient communication, the hospital admission interview, which has been put forward as an ideal arena for increased patient participation. It uses data from a total of 27 admission interviews, extensive periods of participant observation and analysis of nursing records to examine how hospital admission interviews are performed by nurses and patients. Analysis shows that topics discussed during admission closely follow the layout of the admission document which nurses complete during the interview. Whilst it is tempting to describe the admission document as a 'super technological power' in influencing the interaction and restricting patient participation, this analysis attempts a more rounded reading of the data. Findings demonstrate that, whilst opportunities for patient participation were rare, admission interviews are complex interactional episodes that often belie simplistic or prescriptive guidance regarding interaction between nurses and patients. In particular, issue is taken with the lack of contextual and conceptual clarity with which best-practice guidelines are written.

Keywords: nurse-patient interaction, acute hospital care, technology, conversation analysis

Introduction

Over 13 million patients were admitted to hospital for in-patient care within the National Health Service (NHS) in England and Wales during 2006-07 (HES 2007) and each patient had their care needs assessed by a registered nurse (RN) or student nurse. These 'nursing admission assessments' therefore form a significant part of nurses' routine daily work pattern in hospitals. Nursing assessments usually take place at the patient's bedside forming one part of a hectic admission process which sees patients also undergo a medical assessment and various interventions such as blood pressure measuring, height and weight recording and blood taking.

In this paper I explore the work of nurses when initially assessing the health and social care needs of adults undergoing admission into hospital. The simultaneity of the patient's entry into hospital with the need for nurses to gather assessment information regarding the individual, has led to the synonymous use of multiple terms to describe these activities. During this study, for example, nurses stated that they were 'admitting a patient', 'assessing a patient', 'taking the history', 'interviewing a patient' – with each term relating to the same activity.

Nursing literature is unequivocal regarding the significance of the admission process for the nurse-patient relationship being forwarded as *the* important area of nursing work to be performed when a patient enters hospital (Latimer 2000). Furthermore, the assessment interview has long been identified by nurses as an opportunity to encourage patients to participate in their care (Crawford and Brown 2004, King 1971). For example, Sully and Dallas (2005: 74) refer to the admission interaction as a phase of nursing work which offers opportunities 'to develop a partnership' with patients (2005: 74). Similarly, Tutton's (2005) interview study reported that nurses viewed history taking as fundamental 'to the process of participation' (2005: 149) creating an opportunity 'for knowing what was important to them' (2005: 148).

The above descriptions of the admission interview are typical of those found in the nursing literature which largely focuses on verbal communication during the admission interaction. However, nursing in general, and the admission process in particular, sees nurses routinely writing in and reading a variety of patient records and other kinds of documents. Systematic reviews of nurses' record keeping and recording systems (Currell and Urquhart 2004, Moloney and Maggs 1999) report there to be a lack of credible research which examines the interactional practices of nurses and patients when records are being consulted or filled. Similarly, Heath *et al.* (2003) and Timmermans and Berg (2003) draw attention to the disregard in sociological research for the ways in which people, in ordinary, everyday circumstances, use tools and technologies, objects and artefacts, to accomplish social action and interaction.

Recently, authors such as Ventres *et al.* (2006), Kaner *et al.* (2007) and McGrath *et al.* (2007) have explored the effects of medical records on the interaction of physicians and patients. However, few studies examine the use of seemingly mundane technologies such as paper-based or electronic patient records (EPR) and their detailed effects on healthcare talk and interaction. In addition, studies rarely attempt the fine-grained analysis of talk in non-primary care contexts or contexts involving nurses.

Study aims

The data presented here provide a rare glimpse into the interactions of nurses and patients during episodes of acute hospital care. The aim of this paper is to explore nurses' use of mundane technology (paper-based nursing record) during the admission process of patients into hospital and whether the use of such technology affects the extent of patient participation during the admission process. What emerges from the analysis is a better understanding of the interactive and interdependent relationship within nursing assessment interviews between the spoken words of nurses, the written word of the assessment document and the spoken words of the patients' contributions. The analysis will subsequently inform a discussion regarding nursing practice during admission interviews, as well as contribute to the debate regarding record keeping at a time of great change where hospital records, such as those used during the admission process, are soon to be completed in electronic format.

Background - patient participation

The image of the consumer stands at the heart of attempts by policy makers to reform health systems to meet the demands of a 'modern' world in which citizens are assumed to have greater involvement and confidence in challenging clinician authority (Newman and

Vidler 2006). In the UK and beyond, such a conception has been a central feature of the increasing value placed on patient participation (and patient involvement and partnership) at all levels of healthcare delivery. For example, patient participation has been prioritised in a plethora of supra-national (WHO 2005), national (NHS Executive 1996) and sub-national (Welsh Assembly Government 2003) government policy documents.

Professional bodies and regulators of nursing practice in the UK have also identified patient participation and involvement as central to good nursing practice. For example, Royal College of Nursing (2003: 3) identifies a 'commitment to partnership' with patients as one of its six defining characteristics of nursing. The Nursing and Midwifery Code of Professional Conduct (NMC 2008: 2) recommends that nurses should uphold 'people's rights to be fully involved in decisions about their care'. However, despite the many writers and policy documents advocating patient participation within the context of nursing care, there is little consensus about what participation means.

Fieldwork for my study was undertaken at hospitals using Dougherty and Lister's (2004: 36) manual of clinical nursing procedures as a 'best-practice' guide. The manual offers guidelines on various aspects of nursing practice including 'communication and assessment'. For example, the assessment interview 'should progress logically, ensuring meaning for the participants' whilst also providing nurses with an opportunity to 'gain an understanding of the patient's priorities for care' (2004: 30). Overall, the procedure manual characterises the initial interview as an interaction which enables the gathering of patient information whilst also facilitating the establishment of a therapeutic nurse-patient relationship. Whilst patient participation during initial assessment is not explicitly mentioned, the manual does state that effective assessment 'should be a process in which the patient ideally plays an active role' (2004: 25).

The procedure manual therefore avoids presenting guidelines to nurses about participation during patients' admission (or any other phase of care). In so doing, the manual reflects a wider trend in nursing literature and policy documents which encourages patient involvement during the admission phase but avoids offering specific guidance. The lack of specific guidelines is probably indicative of the potentially complex nature of participation and care giving in practice settings. For example, hospital wards, such as those recruited into this study, admit adult patients suffering from a wide variety and severity of illness which result in varying opportunities for patient participation. Such potential complexity would quickly make redundant specific guidelines for use on acute medical wards, for example.

What remain, therefore, are literature and policy documents that exhort nurses to involve patients. Sahlsten *et al.*'s (2008: 9) in depth analysis of the patient participation literature describes the defining attributes of patient participation as including interaction where 'The nurse displays genuine interest and empathy' and 'where the patient volunteers information without being asked, or is invited to do so by means of open questions'. Sahlsten and colleagues' defining attributes neatly capture how nursing literature has traditionally portrayed patient participation as being dependent on a command of relevant communication skills (interest and empathy, the use of open questions, etc.). As such, they provide a useful conceptual 'baseline' for further exploration in this study.

Peräkylä and Vehviläinen (2003) have called on conversation analysts to explore the relationship between professional-client interaction and organised knowledge (referred to as 'stocks of interactional knowledge' or SIKs) that are found in textbooks and policy documents. In particular, they propose that conversation analysis (CA) findings can provide a more detailed picture of practice than that described in SIKs. In doing so, CA can add a new dimension to the understanding of practices described within abstract or

general documents. The intention in this paper therefore is to create a dialogue between nursing SIKs which describe patient participation and the actual practices of nurses, in the hope of adding a new dimension to the understanding of practices described by an SIK.

Methods

Sample and recruitment

This study focused on three acute hospital sites in the UK with data being collected from five hospital wards in total (two medical wards and one ward from general surgery, neurology, cardiology). All patients recruited were classified as 'unscheduled admissions', having been admitted to the wards via a referral that day from a primary care practitioner or the accident and emergency unit. The initial admission interviews were carried out by registered nurses within two hours of the patient arriving on the ward. It is inevitable that nurses also assessed patients during subsequent interactions but the study's attention was maintained purely on the initial admission interview which, as discussed earlier, has been presented in the literature as a prominent and important event within which information is gathered and rapport with the patient established.

The method used is conversation analysis (CA) as applied to the study of institutional interaction (see Drew and Heritage 1992). Twenty-seven admission interviews were observed, audio-taped (621 minutes of talk) and transcribed, whilst 25 nursing documents produced as a result of these interviews were photocopied and analysed; no nurse or patient was recorded/observed more than once. There were no explicit inclusion/exclusion criteria adopted for recruitment to this study, and a purposive sampling approach was undertaken, with the researcher choosing cases that illustrated the process under scrutiny (Silverman 2005). Relevant ethical approval for the study was granted and data anonymised before publication.

Prior to audio recording a total of 45 admission interviews were observed during 175 hours of participant observation on the wards. The need for a period of field-work became clear during preliminary visits to clinical areas. Particularly apparent during these visits was the complexity of activities undertaken during the assessment interview and the range of distributed activities which feature, sometimes only momentarily, in the accomplishment of the work in question. Therefore, various forms of data were collected using 'field methods' (ten Have 2004: 127). Observations, note taking, documents which were perused and copied, all helped to sketch the overall features of the setting, while the audio recordings were collected to identify the spoken strategies used to actually 'do' the assessment interview.

Notes were taken during the admission process (*e.g.* 'nurse writing in notes', 'patient points to left side of head') and a summary report of each admission was written up immediately at its completion. The report was a particularly useful record of the interaction between nurse and patient, allowing more detail to be added to the notes taken during the admission and leading to a fuller consideration of nurses' and patients' conduct.

My observations built upon previous studies that had utilised observational data to understand doctor-patient work in primary care settings (Heath 1986, Ruusuvuori 2001). These studies reveal how participants co-ordinate tasks with the actions of others, how they monitor each other's conduct and its relevance, and how attending to the medical record shapes and constrains interpersonal communication. During the course of this study it became apparent that nurse-patient interaction was similarly influenced on occasion through nurses attending to or reading the admission record during the admission

interview. In particular, the close working of nurses with the assessment document, appears at times, to limit the patient's voice and restrict opportunities for patient participation.

Analysis

Analysis involved repeatedly listening to the tapes and reading through the transcriptions, based on Jefferson's (1984) orthography, which were produced as soon as possible following recording. The analysis of talk was augmented by the field-data detailed above. For example, photocopies of the nursing notes gave an insight into what nurses wrote during the admission. Timing the admission interview with a digital stopwatch enabled handwritten fieldnotes regarding gestures, laughter or nurses reading the notes to be co-ordinated with the transcripts at a later stage. For example, a fieldnote entry such as 'NW 3.12' was subsequently translated into 'nurse writing in the notes at 3 minutes and 12 seconds' of the admission interview. The overview of the admission, which I wrote at its completion, also enabled me to access useful supplementary information during analysis. Such additional data proved invaluable in the absence of video-recording, the use of which proved impractical for a variety of reasons associated with the acute-care nature of the settings.

Topical organisation of talk: One feature of the admission interaction was the extent to which the topics discussed during admission followed the sequence of topics as they appeared on the admission document being completed by the nurse at the time of the interview.

Extract 1: SB1 – 3 minutes into assessment of surgical patient admitted for 'observation re. abdominal pain/distension'

25	n	any problems with your bowe[ls or w]aterworks
26	p	[no-no]
27		(6.0) ((nurse writing in notes))
28	n	and you manage to wash and dress yourself
29	p	yeh yeh
30		(8.0) ((nurse writing in notes, patient looking through window))
31	n	and you're walking about ok [you] don't get short of breath [walki]ng
32	p	[yeh] [no-no]
33	n	walking around or anything
34		(7.0) ((nurse writing in notes))
35	n	sleeping what you're like with your =
36	p	= well you know it's off and on you know not good not bad ((short
38		laugh)) you know we both sleep for about three to four hours and then
39		we're awake you know so:::
40		(4.0) ((nurse writing in notes '*sleeps 3-4 hours'*))
41	n	(do you do anything?) with religion or anything
42	p	uh:: > > no < <

When reading Extract 1 with Figure 1 (below), we can see how the nurse asks the patient questions concerning bowels/waterworks and hygiene 'and you manage to wash and dress yourself' (line 28 relating to 'Personal cleansing and dressing' on the document) before moving on to the unconnected topics 'and you're walking about ok' (line 31 – 'Mobilising' on the document), sleeping (line 35) and religion (line 41).

As was noticeable across the dataset, the nurse's action of reading and writing in the admission document (Extract 1 lines 27, 30, 34, 40) seemed to influence topic-ordering

Topic sequence during assessment.	**Layout of the assessment form.**		
The sequence of topic areas discussed - numbers correspond to boxes that are filled in on the form (right).	**Roper's model of nursing** *For assessment of patient on admission*		
1 Language spoken	**Maintaining safe environment**	**Communicating**	**Breathing**
2 Any problems with diet?	***Not discussed***	***1***	***5***
2 Drinking fluids well?			
2 Weight loss?	**Eating & drinking**	**Eliminating**	**Personal cleansing and dressing**
3 Any problems with bowels or waterworks?	***2***	***3***	***4***
4 Manage to wash and dress yourself			
5 Walking about ok, no short of breath walking?	**Controlling body temperature**	**Mobilising**	**Working and playing**
7 What are you like sleeping?	***Not discussed but 'no problems' entered***	***5***	***9***
8 Do you do anything with religion?			
9 Any hobbies?	**Expressing sexuality**	**Sleeping**	**Dying**
10 You've come in with abdominal pain?	***Not discussed***	***7***	***8***
11 Do you smoke at all?			
11 Alcohol?	**Pain**	**Health promotion**	**Named nurse**
'There we are' – interview completed.	***10***	***11***	*Not discussed*

Figure 1 *Sequence of nurse-patient talk (SB1) compared to layout of the admission document*

during the assessment interview. However, this is not to suggest that the document 'controlled' the interaction, as Figure 1 also shows that the nurse chooses to skip certain topics (*e.g.* 'controlling body temperature' is not discussed before 'mobilising') and covers some topics out of the order presented on the assessment form. It is therefore worth noting that the choice of how to specifically question patients regarding these topics is at the discretion of individual nurses. The assessment form merely reminds the nurse of the details that might be noted during admission and lists them in a prefixed order, but does not dictate the practical shape the gathering of the patient information might take. Indeed, the topic headings merely mapped out the topic areas for discussion as nurses rarely followed the exact order of the topics as written on the assessment sheet.

Concerns have previously been noted about how nurses' and physicians' use of paper or computerised templates tends to 'crowd out' the patient's voice (Berg and Bowker 1997, Harris *et al.* 1998, Rhodes *et al.* 2006). These concerns have led to guidelines recommending that nurses should not follow assessment frameworks too rigidly as they may prevent nurses from critically thinking about the significance and type of information they are gathering from patients (Dougherty and Lister 2008). It is evident from the data presented in this section that, on the whole, topic selection during the admission interview is guided by the admission framework, rather than being rigidly followed by nurses. However, in the next section data are explored which suggest that nurses, on occasion, follow the admission framework more rigidly. It will be shown that a more rigid adherence to the admission template has implications both for the type of information that is gathered from patients and for the patient's voice within the interaction.

Delaying patient descriptions of their illness history to fit with corresponding areas of the nursing record: The previous section discusses how the assessment document functions as an informal prompt sheet for the topics to be covered during the patient's admission and that the

patients' 'activities of daily living' were assessed as a series of single, unconnected topic areas (bowels, hygiene, walking). However, patients rarely experience symptoms of illnesses or problems with daily living activities as single events or as clearly defined topic areas. Regardless of this, nurses repeatedly directed the interaction according to the particular area of the paperwork (and the one topic) that was being completed at that time. The focus on one topic at a time was problematic for patients as seen in the following extract, where a nurse is admitting a patient onto the neurology ward for investigations into recurring headaches.

Extract 2: Mb2 – Delayed discussion of headaches, 11 minutes into the admission.

176 n YOU DO a lot round the house then to help is it-
177 p well (.) mu::muck in- with the daughters come in=
178 n =do they oh ok
179 p wu since April I can't (.) bloody do much cos I (.)=
180 n =alrigh
181 p because these headaches come straight away-
182 n …°*right*…
183 (0.8)
184 n what type of accommodation do you live in↑
185 p we've gorra council house

2 minutes later, following discussion/recording of patient's occupational status (retired) and confirmation of his General Practitioner's details.

208 n right (.) reason for admission
209 (1.6)
210 p hu:headac[hes]
211 n [hu] (.) headaches right how long have you been having these
212 headaches
213 p uhm since last April

In Extract 2, the nurse whilst completing the 'Social factors' part of the form asks the patient a question regarding his house cleaning arrangements. In the course of answering, the patient discusses needing assistance with the house work ('I can't bloody do much' – line 179) in relation to his reasons for being admitted ('these headaches' – line 181). Therefore, the patient clearly introduces 'headaches' at this point as a relevant consideration which limits his ability to 'do much'. However, in this case it paves the way for a further question on 'social factors' concerning 'accommodation'. Previous CA studies reveal that acknowledgement tokens, such as the nurse's 'right' (line 182) and subsequent pause (line 183) are 'closure implicative' (Jefferson 1972: 317) and pave the way for the introduction of another topic. In this case, however, a topic is re-introduced, namely the discussion of 'social factors' such as 'accommodation' (line 184).

The subject of headaches, however, is re-introduced later in the admission as the nurse asks 'reason for admission' (line 208 – corresponding to the box 'Reason for admission/referral'). Interestingly, the question is met with a considerable silence (1.6 seconds) suggesting that the patient experiences some difficulty with the preceding talk (Pomerantz 1984). Furthermore, fieldnotes written immediately afterwards noted how 'exasperated' the patient appeared during this stage of the admission.

One possible reason for the difficulty is that the patient had already clarified that 'headaches' were a major concern and constituted the reason for admission. The pause may

also display the patient's expectation that the nurse takes into account what had been said beforehand, an expectation related to the notion of 'recipient design'. Boyd and Heritage (2006) note that the principle of recipient design is critical to the achievement of rapport in healthcare interaction, as questioning patients in a way that is orientated to their responses to previous questions 'will generally tend to be heard as sensitive, concerned, and caring' (2006: 164).

Extract 3 demonstrates a similar occurrence, featuring a different interview and nurse on the neurology ward, where a patient is being admitted for 'investigations into ?prolapse disc'.

Extract 3: VG432 – 9 minutes into admission – delayed discussion of sleep

211	n	are you able to sleep with the pain
212	p	oh:: I'm no good sleeping like (.) I'm up at 3
213	n	have you been taking tablets to help with the sleep
214	p	the GP wouldn't give me sleeping tablets and when I go to bed =
215	n	= right you've come in for tests into pain in your back
216		(9.0) ((nurse writing in notes))
217	n	right have you had any falls at all

6 minutes later following discussion of mobility, hygiene, diet and elimination

499	n	how are you with sleeping
500		(2.0)
501	p	I::: uh I'll go to sleep (.) wake up (.) for a bit like =
502	n	=mmhuh↑

Whilst discussing 'reason for admission' (back pain) the nurse asks the patient 'are you able to sleep with the pain' (line 211). The patient proceeds to explain that sleeping is difficult (line 212), adding that the GP refused to prescribe sleeping tablets (line 214). However, the discussion of sleep/bed time is terminated by the nurse stating the reason for admission (line 215) and withdrawing eye contact via the act of writing 'admitted for investigation re. back pain' in the notes. Six minutes later the nurse re-introduces the topic of sleep (line 499), resulting in a delay component of two seconds before the patient hesitantly begins to answer.

Patients therefore display difficulties when previously disclosed information is revisited during the assessment interview. As they never see a copy of the assessment form, patients have no way of knowing that earlier discussion of 'headaches' or 'sleep' are re-introduced by nurses in an attempt to co-ordinate talk with the sequence of topics appearing on the paperwork. Fieldnotes suggest that this feature of the assessment interview proved irritating to the patients, and it may well be that patients expect nurses to be sensitive to earlier answers. Interestingly, critics of standardised research interviews have similarly found that a lack of recipient design during interviews produces awkward interactions (Maynard and Schaeffer 2006, Woofitt and Widdicombe 2006).

The influence of reading and writing in the notes on patient interaction: As already noted, the assessment was frequently punctuated by nurses writing in the patient's admission documents. For example, Extract 4 (below) sees the nurse and patient discussing the patient's previous medical history before the nurse's gaze moves towards the notes placed on the table in front of her where she writes in the 'previous admissions' box 'Hysterectomy 24 years ago'.

Extract 4: VR206 – 4 minutes in, patient admitted to medical ward for shortness of breath

51	p	I had a hysterectomy
52	n	when was that
53	p	hu::: twenny four years ago now twenny five
54	n	°oh alright° ok
55	n	(10) ((writing in notes))
56	n	any other medical problems
57	p	uhm (.) yeh my ( ) (on-going?) problems (swelling?)
58	n	your ankles still swell do they
59	p	yeh and my blood pressure is quite high my blood pressure
60	n	(4.0) ((writing in notes))

Following the 10 seconds it takes for the nurse to write in the notes (line 55), supplementary questions on the related theme of 'other medical problems' are introduced, followed by the patient's answers which are immediately written in the notes. Although none of the nurses explained to patients that periods of interaction would sometimes be followed by periods of writing, the patients' conduct was sensitive to nurses' interactions with the notes as they rarely interrupted or questioned nurses whilst they wrote. Therefore, nurses' re-direction of gaze (away from the patient) when writing in the notes had significant consequences for the production of patient talk. However, rather than assuming that the use of nursing notes remain stable throughout interactions, Heath and Hindmarsh (2002: 118) recommend that the use of objects such as nursing records be examined to understand how they 'come to gain their particular significance at specific moments within courses of action'. With this in mind, the following extracts demonstrate specific moments where the nursing records achieve particular significance during the admission interview.

Extract 5: TDJ034 – opening turns of admission to medical ward, the patient being interviewed by the nurse following assessment by the doctor.

1	p	what's this for now↑
2	n	we're just going to admit you
3		((nurse shuffles the forms and bangs them on the desk))
4		(1.5) ((nurse reading the notes))
5	p	[you shouldn't have to]
6	n	[you remem-member]=
7	n	mmh
8	p	=shouldnt have to readmit me ther-the Dr came to clerk me this morning
9	n	°ahh°
10		(10) ((nurse reading through notes and organising the paper work))
11	n	°right° (.) can I have your telephone number
12	p	zero two three

The patient mistakenly reports there to be no need for the nurse to repeat the admission process as she has already been admitted by the ward doctor (see line 8). Whilst joint medical-nursing admissions do occur in some hospitals, it was not the case here. The nurse's hushed utterance (ahh – line 9) is followed by his engagement with the notes in such a way that is influential within the interaction. For example, the patient's behaviour is sensitive to the re-direction of the nurse's gaze (line 10) as no further discussion of the need

to 'readmit' occurs whilst the notes are consulted. The silence which accompanies the nurse's reading is only broken when the nurse asks for the patient's telephone number' (line 11), an utterance that simultaneously starts the disputed admission interview and silences the patient's queries about the need for 're-admission'. Overlooking the opportunity to explain the separate nursing and medical admission processes, the nurse then proceeds with a full assessment of the patient from this point onwards.

Extract 6 also demonstrates how reading the notes alters the course of the interaction, this time when a patient attempts a discussion of his cancer and treatment options.

Extract 6: DWA95 – 6 minutes into admission to a surgical ward for ongoing cancer treatment

47	n	did he get you to sign a consent form
48	p	no =
49	n	= sorry about that
50	p	not yet (.) so I think this is uh::m (.)°I can't° this is ( ) cancer in
51		the uh colon I had removed a tumour [remo]ved
52	n	[mhuh]
53	p	about uh > > twelve months ago < < by Mr Y and he's passed me on now
54		to Mr X so I don't know whether its all related with the cancer in the uhm (.)
55		oesopha::g
56	n	oesophagus
57	p	oesophagus yeh (.) so they're trying to burn it away now
58	n	righty ho
59		(10) ((nurse reading/looking at notes))
→ 60	p	I don't know whether I've got much to worry about at my age (laughs
61		a bit) I think they're anxious for me to get a telegram from the Queen
62		((patient laughs for 1.2 seconds))
64		((nurse laughs for 1.5 seconds)
65		(4.0) ((nurse looking at notes))
66	n	so you've had a right hemicolectomy in the past didn you
67	p	yes

Towards the end of an explanation of recent hospital treatment which begins on line 53, the patient appears to 'probe' for more information towards the end of this turn, stating 'I don't know whether it's all related with the cancer…' (lines 54-55). The nurse does not 'hear' this as a probe, for example by responding to or exploring the patient's concerns; instead, she helps with the pronouncement of terminology (line 56). The patient continues describing his treatment 'they're trying to burn it away now' (line 57) followed by the nurse's response 'righty ho' (line 58), an idiom associated with attempts to close interaction (Beach and Dixson 2001), and disengagement of eye contact to read the notes (2001: 59).

A deviation from the norm, however, occurs, as the patient breaks the silence accompanying the nurse's reading by repeating an earlier theme of uncertainty, stating 'I don't know if I've got much to worry about at my age' (line 60). The patient continues by speculating that his imminent treatment is motivated by others': ('they') wish him to 'get a telegram from the Queen'. Both laugh at this point, with the nurse's laugh marginally outlasting the patient's before trailing off into another four seconds of silence as the nurse

reads the notes. This short period of reading leads to the re-starting of the interview with an unrelated point 'so you've had a right hemicolectomy….' (line 65). The word 'so' can be heard as a direct effect of the nurse reading the notes, and has the immediate effect of orientating the interaction to what was just read (Beach and Dixson 2001) in contrast to what was just discussed and laughed about (cancer and prognosis). Further talk about cancer treatment and prognosis remained unvoiced during the remainder of the interview.

Extract 6 sees the patient offer an account of his previous hospital experience which is unrelated to a question. Such 'off-topic' departures can be used by patients to accomplish a range of ancillary tasks, for example they can be used to introduce features of the patient's life-world which are matters of significance or preoccupation. Heritage and Stivers (1999) propose that departures exist in defiance of the restrictive agenda of physicians' questioning, providing insights into what was 'on the patient's mind' (1999: 165). The off-topic departure in Extract 6 can be heard in the same way, with the talk, temporarily at least, being focused on the patient's own preoccupations and topics rather than the nurse's.

Patient-initiated departures have the potential to offer nurses different interactional possibilities where patients lead the discussion. Yet what is emerging is that the initial assessment constitutes an environment in which patient-led talk is most often curtailed. As a result, what was 'on the patient's mind' is not responded to during the admission, which according to nursing literature and policy at least, appears to be the ideal forum for such discussion. One possible reason for this could be related to a question of relevance. Off-topic expansions neither respond to a prior question nor offer clarification of an earlier response. As the nurses' actions suggest, they therefore have little relevance to the form-filling task at hand.

Documentation reduces patient participation: In this section I compare the entries written into the nursing record with the 'raw material' (Hak 1992: 145) of the actual spoken interaction used to produce the record. In particular, the comparison will show how patients' utterances are transformed into a written 'nursing history'. Guidelines produced by the UK nursing regulatory body specify that the nursing record should demonstrate a full account of the patient's assessment in addition to being factual, accurate and 'recorded in terms that the patient/client can understand' (Nursing and Midwifery Council 2007: 2).

With this in mind, Extract 7 provides a typical stretch of interaction where the nurse and patient are discussing the topic of sleep.

Extract 7: EGH 239 – 14 minutes into admission to a cardiology ward for investigations into chest pain

247	n:	How-how long do you sleep (.) for ↑
248		(3.2)
249	p:	°Uh:: I wake quite early uhm:: °
250	n:	How many hours do you sleep at night?
251	p:	Well I try and get 8 hours but its not- its not always 11 o'clock umh
252		(0.6)
253	n:	Broken sleep is it↑
254	p:	I sleep til seven probably yeh yeh
255		(0.5)
256	n:	How many hours a night rough::ly↑
257	p:	(0.5) Say seven um I think
258		(7.8) ((n writes in notes))
259	n:	Righty ho (.) so you're a retired gentleman

Of interest here is that the above interaction about the patient's sleep is written onto the assessment sheet by the nurse as 'Sleeps 7hrs a night'. Looking at the transcript and listening to the tape, it is clear that the written version of the patient's sleep (entered into the 'Sleeping' section of the form) does not capture the nuance of the verbal description of the patient's sleep pattern. The transcript shows a series of qualifiers ('probably' line 254, 'I think' line 257) which together with the pauses between questions (lines 248, 252) and equivocation (line 249) suggest that the patient may regard the nurse's questions as problematic. Indeed the patient appears to reject the original premise of the question (How long....) by attempting an answer that initially avoids any quantification of the length of sleep.

However, the question of how long the patient sleeps is repeated a further two times (lines 250 and 256). Each repeat of the question follows a response by the patient which draws upon personal experience to describe a night's sleep (lines 249 and 251), answers which are declined until a more objective quantification of time is produced (7 hours line 257). What becomes apparent is that the repeating of the question is due to the nurse pursuing a category of answer (number of hours) which is different from the category of answer (quality of sleep pattern) actually given by the patient. The initial question regarding how duration of sleep is repeated until this category of answer is provided.

A review of the 'Sleeping' section of the assessment documents collected during this study showed that all documents contained a quantification of sleep rather than a description of sleep pattern. However, it is important to note that the discussion of quantity rather than the quality of patients' sleep in Extract 7 is not 'caused' by the assessment tool; it is instead the result of the way nurses choose to implement the record at this particular time. Whilst other nursing records specifically determine the type of content allowable (certain sections of a fluid chart can only be filled using metric numerical data *e.g.* 20mls), the assessment sheet only pre-structures broad topic areas rather than the exact type of information to be collected. In this way the assessment sheet can be seen as a mediating rather than a determining presence during the interaction.

As already touched upon, the information about 'sleeping' that is finally recorded in the patient's notes is not a direct reflection of the patient's utterance but the outcome of the nurse's interpretation of the nature of a permissible response and her pursuit of such a response. While the statement 'sleeps 7 hours a night' may be technically correct the patient's actual experience, which he tried to volunteer, was lost. A comparable restriction of patient histories is noted in Berg's (1996) study of doctor-patient consultation. Berg noted that writing down one line summaries of complex medical and social issues produced a particular rendering of patients' histories that appeared more manageable on paper than when communicated verbally by the patient.

Discussion

Assessing the impact of paper-based technology on nurse-patient interaction is timely, as the UK health service moves towards the use of EPRs. Policy makers have favourably contrasted EPRs to current paper-based records which they describe as antiquated, inefficient and a threat to patient safety (WAG 2003). However, nurses have consistently adopted a negative stance towards EPR, with a particularly enduring concern being that electronic systems restrict the patient's voice and individuality (Darbyshire 2004, Kirshbaum 2004, Lee 2006, Rhodes *et al.* 2006, Rodrigues 2001). For example, Rhodes *et al.* (2006: 374) state that moves towards the use of computerised templates in nursing 'risk emphasising diagnostics over therapeutics and diminish the patient to a minor supporting

role'. Somewhat ironically, therefore, this study shows that nursing practice using 'old' paper-based technology limits patient participation and the patient's voice in similar ways to those attributed to 'new' electronic technologies.

Therefore, an alternative consideration of the use of technology in nursing and in other areas of healthcare practice is required, one which follows on from Timmermans and Berg's (2003) plea neither to over- nor under-estimate the role of technology in healthcare and which focuses not only on templates (computerised or paper), but on the practitioners who use them. Ventres *et al.* (2006) provide a fine example of one such study that considers the practitioner more fully than most. Their recent ethnographic findings discuss how 'physician style' was a major determinant of how EPR technology was used in encounters with patients. For example, those doctors with an 'interpersonal style' were led more by patient narratives than those with an 'informationally focused' style who positioned themselves at the computer monitor and asked computer-guided questions.

Borrowing Ventres' terminology, the nurses in this study utilised an 'information focused' style of interaction asking 'template-guided' questions. It is impossible in this study to categorically state why the nurses utilised a 'template-guided' style of interaction with patients which appears at odds with best-practice guidelines for the assessment. In these busy and time-scarce clinical environments nurses' use of the admission template certainly aided in managing the recurring task of taking a patient's history.

An easy answer would be to cite the admission document template itself, a position that would reverse the historical tendency that sees nurses view such technologies as neutral objects which have little tangible effect on actual care-giving (Barnard 2002). For example, one could point to the way in which the interaction follows the overall shape of the template, and the way in which detailed answers given by patients were sometimes reduced to a few words and figures that fitted into, for example, the 'Sleeping' box. In other words, one could claim the document controlled the interaction. Yet, at other times nurses could be seen to skip or change the sequence of topics appearing on the document (as shown in Figure 1) and the template makes no practical recommendations about how nurses should interact with patients during its completion. Overall, the admission document could not function without the nurses working with it, the implication of which is that no one element is in control, nurses, patients or the assessment template.

Viewing the assessment documents as only one of many factors that influence interaction between nurses and patients is an alternative to the somewhat naive notion that technologies such as paper documents act with 'super technological powers' to control the actions of all others (Timmermans and Berg 2003: 100). Yet, such technological determinism is still evident in literatures and policy documents concerning management and information technologies. For example, the case for introduction of the Electronic Patient Record in Wales is partially made by policy makers who describe how 'antiquated paper-based systems' frustrate 'effective record keeping and potentially threaten the quality of care and patient safety' (Welsh Assembly Government 2003: 59). Explanations rarely consider exactly how the use of paper-based systems (could) exert these effects.

What the data do show is that the initial assessment interview, which has been forwarded as an important area of nurse-patient interaction within which patients are supposed to be active participants, sees patients largely take the role of passive responders. There is, however, little consensus about what patient participation is (Collins *et al.* 2007); at the same time there is mounting evidence that whilst some patients expect greater involvement during healthcare, others want little (Barratt 2005).

The kinds of guidance that nurses are given regarding communication with patients during initial admission interviews and how to provide opportunities for their participation

should therefore be more informed by a better understanding of the interactional dynamics of, and the contextual influences on, nurse-patient encounters. For example, evidence suggests that many health professionals lack the requisite skills and that the contexts of care delivery (including socio-economic influences and work pressures) bring their own constraints (Collins *et al.* 2007), all of which are important factors which textbooks and policy documents do not currently address. Therefore, in any nurse-patient encounter, the particular constraints that govern how patients are involved and the extent of their influence on interaction are likely to shift from one moment to the next. Making this point clear in 'best-practice' guidelines would better highlight the potential for patient participation regardless of the presence of electronic or paper-based templates, the constraints of time, and so on.

Conclusion

Most hospital nurses in the UK still operate with paper rather than electronic technology, thus the data provide a timely insight into current nursing practices. The imminent introduction of EPRs into hospitals provides a challenge to all health professionals, and nurses have raised concerns regarding the introduction of EPRs on the grounds that electronic records will 'crowd out' the patient's agenda, resulting in the 'de-individualisation of care' (Lee 2005: 345). However, on the evidence of this study, nurses' decisions to shape the assessment interview around the structure and layout of the assessment document serve to suppress the expression of patient concerns whilst minimising patient participation.

Berg and Bowker's (1997) work on medical interaction suggested over a decade ago that instead of focusing on either the tool or the work practice it is their interrelation that is central. The analysis here similarly suggests that other factors need further consideration rather than merely focusing on the technology which accompanies the interaction. Nurses' use of paper-based or electronic records needs to be seen by nurse managers, researchers and policy makers as a social action embedded within a larger system of activity. This socio-technical view of nursing work, therefore, undermines the previously rationalist, technology-centred writing so pervasive within the nursing literature. A more balanced approach towards technology and its effects on nursing work suggests further research is needed into how nurses learn to use and then apply their understanding of paper-based (and electronic) technology to their daily practice. Such work would provide an invaluable adjunct to the current plethora of studies which focus on nurses' attitudes and perceptions regarding the introduction of specific information management technology.

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References

Barnard, A. (2002) Philosophy of technology and nursing, *Nursing Philosophy*, 3, 1, 15–26.

Barratt, J. (2005) A case study of styles of patient self-presentation in the nurse practitioner primary health care consultation, *Primary Health Care Research and Development*, 6, 327–38.

Beach, W. and Dixson, C. (2001) Revealing moments: formulating understandings of adverse experiences in a health appraisal interview, *Social Science and Medicine*, 52, 25–44.

Berg, M. (1996) Practices of reading and writing: the constitutive role of the patient record in medical work, *Sociology of Health and Illness*, 18, 4, 499–524.

Berg, M. and Bowker, G. (1997) The multiple bodies of the medical record: toward a sociology of an artifact, *Sociology Quarterly*, 38, 511–35.

Boyd, E. and Heritage, J. (2006) Taking the history: questioning during comprehensive history-taking. in Heritage, J. and Maynard, D. (eds) *Communication in Medical Care. Studies in interactional Sociolinguistics 20*. Cambridge: Cambridge University Press.

Collins, S., Britten, N., Thompson, A. and Ruusuvuori, J. (eds) (2007) *Patient Participation in Healthcare Consultations*. Buckingham: Open University Press.

Crawford, P. and Brown, B. (2004) Communication. In Mallick, M, Hall, C. and Howard, D. (eds) *Nursing Knowledge and Practice Foundations for Decision Making*. 2nd Edition. London: Balliere Tindall.

Currell, R. and Urquhart, M. (2004) *Nursing Record Systems: Effects on Nursing Practice and Health Care Outcomes*. The Cochrane Library. Issue 4.

Darbyshire, P. (2004) 'Rage against the machine?': Nurses' and midwives' experiences of using computerized patient information systems for clinical information, *Journal of Clinical Nursing*, 13, 1, 17–25.

Dougherty, L. and Lister, S. (2004) *The Royal Marsden Manual of Clinical Nursing Procedures*. Oxford: Blackwell Science.

Dougherty, L. and Lister, S. (2008) *The Royal Marsden Manual of Clinical Nursing Procedures. Student Edition* Oxford: Blackwell Science.

Drew, P. and Heritage, J. (eds) (1992) *Talk at Work. Interaction in Institutional Settings*. Cambridge: Cambridge University Press.

Hak, T. (1992) Psychiatric records as transformation of other texts. In Watson, G. and Seiler, R. (eds) *Text in Context. Contributions in Ethnomethodology*.Newbury Park: Sage.

Harris, R., Wilson-Barnett, J., Griffiths, P. and Evans, A. (1998) Patient assessment: validation of a nuring instrument, *International Journal of Nursing Studies*, 35, 303–13.

ten Have, P. (2004) *Understanding Qualitative Research and Ethnomethodology*. London: Sage.

Heath, C. (1986) *Body Movement and Speech in Medical Interaction*. Cambridge: Cambridge University Press.

Heath, C. and Hindmarsh, J. (2002) Analyzing interaction: video, ethnography and situated conduct. In May, Y. (ed.) *Qualitative Research in Action*. London: Sage.

Heath, C., Luff, P. and Sanchez Svenson, M. (2003) Technology and medical practice, *Sociology of Health and Illness*, 25, 3, 75–96.

Heritage, J. and Stivers, T. (1999) Online commentary in acute medical visits: a method of shaping patient expectations, *Social Science and Medicine*, 49, 1501–17.

HES (2007) Headline Figures 2006-07. Accessed 18th July 2008 from http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=193.

Jefferson, G. (1972) Side sequences. In Sudnow, D.N. (ed.) *Studies in Social Interaction*. New York, NY: Free Press.

Jefferson, G. (1984) On the organization of laughter in talk about troubles. in Atkinson, J. M. and Heritage, J. (eds) *Studies in Conversation Analysis*. Cambridge: Cambridge University Press.

Kaner, E., Heaven, B., Rapley, T., *et al*. (2007) Medical technology and communication: a video based process study of the use of decision aids in primary care consultations, *BMC Medical Informatics and Decision Making*, 7, 2, 1–11.

King, I. (1971) *Toward a Theory of Nursing: General Concepts of Human Behaviour*. New York: Wiley.

Kirshbaum, M. (2004) Are we ready for the electronic patient record? Attitude and perceptions from staff from two NHS trust hospitals, *Health Informatics Journal*, 10, 4, 265–276.

Latimer, J. (2000) *The Conduct of Care*. Oxford: Blackwell Science.

Lee, T. (2005) Nurses' concerns about using information systems: analysis of comments on a computerized nursing care plan system in Taiwan, *Journal of Clinical Nursing*, 14, 344–53.

Lee, T. (2006) Nurses' perceptions of their documentation experiences in a computerized nursing care planning system, *Journal of Clinical Nursing*, 15, 11, 1376–82.

Lipsky, M. (1980) *Street-level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage Foundation.

Maynard, D. and Schaeffer, N.C. (2006) Standardisation-in-interaction. The survey interview. In Drew, P., Raymond, G. and Weinberg, D. (eds) *Talk and Interaction in Social Research Methods*. London: Sage.

McGrath, J., Arar, N. and Pugh, J. (2007) The influence of electronic medical record usage on non verbal communication in the medical interview, *Health Informatics Journal*, 1, 32, 115–18.

Moloney, R. and Maggs, C. (1999) A systematic review of the relationships between written manual nursing care planning, record keeping and patient outcomes, *Journal of Advanced Nursing*, 30, 51–7.

Newman, J. and Vidler, E. (2006) Discriminating customers, responsible patients, empowered users: consumerism and the modernisation of health care, *Journal of Social Policy*, 35, 2, 193–209.

NHS Executive (1996) *Patient Partnership: Building a Collaborative Strategy*. Leeds: NHS Executive.

Nursing and Midwifery Council (2007) Record Keeping. Accessed 21/04/09 from http://www.nmc-uk.org/aDisplayDocument.aspx?documentID=4008.

Nursing and Midwifery Council (2008) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC.

Peräkylä, A. and Vehviläinen, S. (2003) Conversational analysis and the professional stocks of interactional knowledge, *Discourse and Society*, 14, 6, 727–50.

Pomerantz, A. (1984). Agreeing and disagreeing with assessments: some features of preferred/dispreferred turn shapes. in Atkinson, J.M. and Heritage, J. (eds), *Structures of Social Action*. Cambridge: Cambridge University Press.

Rhodes, P., Langdon, M., Rowley, E., *et al*. (2006) What does the use of a computerised checklist mean for patient-centred care? The example of a routine diabetes review, *Qualitative Health Research*, 16, 353–78.

Rodrigues, J. (2001) The complexity of developing a nursing information system: a Brazilian experience, *Computers in Nursing*, 19, 98–104.

Royal College of Nursing (2003) *Defining Nursing*. London: Royal College of Nursing.

Ruusuvuori, J. (2001) Looking means listening: coordinating displays of engagement in doctor-patient interaction, *Social Science and Medicine*, 52, 1093–198.

Sahlsten, M., Larsson, I., Sjöström, B. and Kaety, P. (2008) An analysis of the concept of patient participation, *Nursing Forum*, 43, 1, 2–11.

Silverman, D. (2005) *Doing Qualitative Research. A Practical Handbook*. 2nd Edition. London: Sage.

Sully, P. and Dallas, J. (2005) *Essential Communication Skills for Nursing*. Edinburgh: Elsevier Mosby.

Timmermans, S. and Berg, M. (2003) The practice of medical technology. *Sociology of Health and Illness*, 25, 3, 97–114.

Tutton, E. (2005) Patient participation on a ward for frail older people, *Journal of Advanced Nursing*, 50, 2, 143–52.

Ventres, W., Kooienga, S., Vuckovic, N., *et al*. (2006) Physicians, patients and the electronic health record: an ethnographic analysis, *Annals of Family Medicine*, 4, 2, 124–31.

Welsh Assembly Government (2003) *Putting Patient and Public Involvement into Practice*. Signposts 2. London: OPM.

WHO (2005) *Health promotion in Hospitals: Evidence and quality management*. Copenhagen: World Health Organisation.

Woofitt, R. and Widdicombe, S. (2006) Interaction in interviews. In Drew, P., Raymond, G. and Weinberg, D. (eds) *Talk and Interaction in Social Research Methods*. London: Sage.