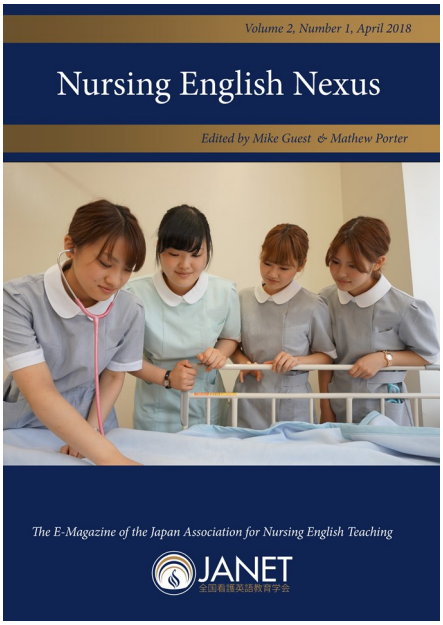

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Authentic Nursing English Spoken Discourse and Its Representation in Textbooks

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In 2010 and 2011 the author and a colleague conducted fieldwork aimed at uncovering the types of workplace speech events that nurses most frequently participated in, as well as how these discourses were typically managed. One major finding (Guest & Nambu, 2011a and 2011b) was that the speech events that constituted the majority of actual spoken nursing discourses observed were rarely or only marginally addressed in commercial textbooks. Moreover, where they were addressed, they often failed to conform to the standards and norms of nursing English discourse management that had been noted in the field work. In 2017, as a follow-up to this earlier research, the author analyzed six nursing English textbooks that had been published within the interim period (2009-2017) in order to compare their presentation of nursing speech events and the management thereof with those noted in the previous study. The author found that recent textbooks were addressing nursing spoken discourse in a much more comprehensive and accurate manner than previous materials had. As a result of this, it is argued that nursing English teachers should become more aware of the roles and functions of these discursive features when choosing textbooks or making their own nursing English classroom materials.

Keywords: *nursing discourse, ESP textbooks, materials development, discourse analysis*

In 2010, the present author and a colleague conducted a series of interviews with nursing professionals in Japan, the U.S., Singapore, The Philippines, and Malaysia aimed at discovering what types of spoken discourses were typically carried out in the nursing workplace. This was combined with field reports analyzing these interactions in terms of participants, speech events, and discourse management.

The observation of discourse management entailed a focus upon external factors such as power relations, politeness strategies, symmetry, and turn-taking. Internal factors observed included the use of informal discourse markers, ellipsis, strategic competencies such as repair, and illocutionary acts.

Among the salient findings uncovered in the earlier research (Guest & Nambu, 20010a, 2011b) was that approximately 90% of all nursing discourse observed in all locales was conducted nurse-to-nurse or nurse-to-allied health professional (AHPs - including doctors, technicians, caretakers, case workers etc.), with under 10% being conducted nurse-to-patient. Prominent among nurse-nurse (as well as AHP) interactions were the speech events of 1) Handover (also known as handoff or pass-off) — the nurse-to-nurse briefing performed when turning over patient monitoring at the end/ beginning of a shift, 2) Roll call – the debriefing sessions held at beginning of a dayshift, generally led by a senior member in which daily priorities, including updates and concerns, were conveyed to the departmental nursing team, and 3) Preceptor-Preceptee training sessions, in

which a junior or trainee is examined either formally or informally by a senior member as a part of the instructional process (Guest & Nambu, 2011a). Authentic samples of these speech events are included in the appendix.

In terms of discourse management, it was noted that spoken interactions were rarely symmetrical. Power differentials were particularly marked in events such as roll call. Adjacency pairs initiated by the preceptor were a standard feature of training sessions. Both handover and roll call employed ellipsis, indirect speech, abbreviated forms, and repair/confirmation strategies (Guest & Nambu, 2011b). Even nurse-patient and nurse-patient family were rarely symmetrical, with most such interactions initiated by the nurse, whose turns were more elaborate and extended when compared the patients' often brief or truncated responses. Authentic samples of these forms also appear in the appendix.

In the same study, the current author further compared these findings to the manner in which spoken nursing discourse was portrayed in a number of Nursing English textbooks. These covered both international and local (Japan-based) publications, keeping in mind that target audiences will differ according to the intended readership. We found that the major speech events were rarely addressed in any of the texts, particularly as model dialogues. Instead the emphasis was placed almost exclusively upon nurse-patient encounters, which constituted almost 90% of the speech model texts, a near 180-degree departure from what our field research had indicated. Moreover, these nurse-patient interactions were portrayed as highly symmetrical in terms of power and turn-taking, utilized fully-formed syntactical structures, and never required the speakers to utilize strategic competence such as clarifying, confirming, or repairing discourse breakdown — all in contrast to our findings. As a result, we called for greater attention to be paid to both nurse-nurse interactions and the development of more realistic interactive speech models in teaching materials.

The Follow-Up Analysis of Nursing English Textbooks — Methods and Materials

In 2017, the author performed a similar analysis of six current Nursing English textbooks. Two were newer, updated versions of the same publications analyzed in the previous investigation. Added to that were four new publications. Three of the 6 total publications were offerings from major international publishers, while three were from smaller, local publishers. Two of these locally published textbooks were aimed solely at Japanese nursing students. I did not name the textbooks analyzed in the previous study in order to avoid drawing negative or positive attention to the authors/publishers or their commercial interests and I will maintain the same principle while reporting the follow-up data. It should be noted that not all of the textbooks analyzed were explicitly written 'for nurses' but that some

were expanded to cover healthcare workers or caregivers more generally.

For the follow-up analysis, I noted only those texts that modeled spoken discourse or those that were directly connected to speech tasks. From these texts, I initially calculated the number of speech models according to both participants and speech events. I then further analyzed model speech texts to determine if any, and to what degree, the features of nursing speech discourse management described earlier had been incorporated into the textbooks. These results were then compared to the results obtained seven years previously. Where publishers offered differing proficiency levels of textbooks, it was the lowest level that was analyzed.

It is important to distinguish texts that are presented primarily for modeling purposes from those which are tied to tasks in which learners are required to answer comprehension questions or asked to provide a socio-cognitive analysis of a text (e.g., '*Why do you think Ms. Brown refused the drink? Do you agree with her decision? What would you say in this case?*'). In my analysis, discourse management emphasis was applied to the former type but not to the latter.

Results

The most salient result of the recent analysis was the increase in the variety of participants in the spoken texts. Nurse-patient (or 'client') interactions accounted for just over half of the model texts. This was particularly pronounced in the international publishers' offerings, where up to 75% of the speech texts involved nurses speaking with allied health professionals, clinicians, or other working staff.

One reason that the international textbooks would emphasize this more diverse participant orientation is because their target audience consists of not only nursing students learning English as a foreign language but also due to the very great possibility that their students/ learners will be aiming to research or practice in English-speaking locales (such as Cambodian or Indonesian nurses seeking employment in Singapore or Hong Kong). This would require using English as a working language. Workplace English proficiency may also be desired in order for non-native English-speaking nurses to gain positions at prestigious international hospitals in their own countries.

However, even the locally-produced textbooks displayed a greater awareness of the variety of participants within the nursing workplace than previously published versions had. One Japan-published textbook contained a welcome section on interactions with foreign students, researchers and clinicians, as opposed to the solely Japanese nurse-foreign patient interactions that had dominated the discourse in earlier textbooks.

The textbooks from major international publishers also contained significant sections on handover and informational

briefing interactions that mirrored roll call -- these events covering a larger percentage of the total text than they did in previous versions of the book. Likewise, the Japan-produced books now contained small sections related to handover, albeit focusing more on reading, writing and discussion skills related to this event rather than creating practice or study models of the speech event itself. Nonetheless, this represents an improvement in terms of workplace scope over the textbooks analyzed in the previous study.

Preceptor-preceptee interactions were also more notable in the follow-up analysis. Dialogues involving supervisors and nurses or nurses and nurses' aides that focused upon instructional content or similar training scenarios appeared in four of the textbooks, including all of the international publications.

In terms of displaying authentic or realistic examples of spoken discourse management, two of the international publishers' textbooks claimed to base their models on authentic language. This was most evident in the accurate application of turn-taking and symmetry; power differentials in the participants were rendered such that those giving orders or providing advice or information took longer turns than their counterparts.

Strategic competence, particularly in terms of checking and confirming functions, was also more visible in all the textbooks analyzed. However, breakdowns, misunderstandings, and subsequent repair, whether initiated by the speaker or the interlocutor, were still not in evidence in any of the textbooks.

While the use of medical shorthand terms was well distributed throughout the speech models in 4 of the 6 textbooks, the use of situational ellipsis, which was very widespread in our earlier field research, was largely limited to informational responses; the models were not otherwise indicative of the type of truncated speech patterns that typically marks real-time interactions between in-service professionals, which often involves the use of indirect speech and illocutions. It might be argued, though, that these forms are dependant upon the immediate environment of the interactants and therefore do not readily lend themselves to models for use in textbooks, where the immediate surrounding context is not shared by the reader/ student.

One feature of spoken discourse that was notable in some of the local textbooks was extemporaneous speech, perhaps better described as extended social chat, between nurses and patients/clients – often operating symmetrically in both directions. However, these types of interactions were exceedingly rare in our field research. These constructions were particularly in evidence when the textbooks writers were attempting to illuminate certain sociolinguistic features of speech, such as politeness, distance, and backchanneling.

Discussion

The increasing awareness of the variety of nursing English discourse events, the diversity of participants, and modes of discourse management manifested in these more recent publications was a welcome sign that materials writers are becoming increasingly aware of applying specialized discourse analysis to teaching materials. This will benefit nurses who plan to work in internationalized environments such as those who plan to train or practice abroad or work at large, international hospitals in Japan, as well as those who may work in medical tourism.

One critique of this extended focus might be that Japanese nursing students or trainees would only use English in interactions with patients, whereas they would use their native language for work-related functions. This is true, but one must also be cognizant of the increasing number of non-Japanese caretakers and other healthcare workers, as well as trainees and researchers from abroad, in Japan, in which case English might well serve as a lingua franca. Certainly, Japanese trainee nurses or students who hope to train or practice elsewhere, even on a temporary basis, would be better served by this more wide-reaching approach.

The positive impact, however, is not limited to the development of more authentic or wide-ranging English speech skills. An increased awareness of the various workplace roles and functions that a nurse may encounter in any language or culture can have a positive washback effect onto the trainee or student nurse's first language and culture, helping novice nurses to strengthen cognitive awareness, both social and medical, in relation to their current or future workplaces.

Therefore, this expanded approach to nursing discourse also provides benefits for those majority of Japanese nursing students who will not train or practice abroad, nor work in fully internationalized workplaces, in that their cognition as nurses become engaged in a more holistic manner. I would argue that this focus holds greater long-term value than what I call the 'retrieval' notion of pedagogy — in which language forms are taught with the hope that particular terms or set phrases learned as a student might be retrieved and appropriately deployed by Japanese nurses based on the small chance of them encountering non-Japanese speaking patients at some indeterminate point in the future.

One suggestion that can be made based upon this analysis is that model texts would do well to provide examples of misunderstandings and breakdowns, with models as to how repair might be achieved. The world of spoken discourse is rarely as perfect as the textbook models indicate and the strategic competence required to manage such discourse is a skill worthy of address.

Finally, one must remain cognizant of the fact that applying discourse authenticity should not be an end in itself and does not automatically validate language teaching materials. 'Authentic' language is not necessarily more suitable

language for teaching purposes, particularly within EFL environments. Language models informed by authentic data, and thereafter judiciously applied to classroom materials, however, have certain obvious benefits. Not only do they prepare the learner more adequately for actual in-service encounters but they also allow learners to internalize the ebb and flow of interactive discourse in a way that more stilted, artificial models cannot.

Conclusions

Our earlier research on the nature of English nursing spoken discourse seems to have been validated by the growing number of informed materials makers and textbook writers who are incorporating a wider variety of participants, a greater number of workplace speech events, and a deeper understanding of specialist discourse management into their textbooks. Nursing English teachers should take these factors into consideration when making materials or when choosing a textbook for their learners, as the productive value of English for Specific Purposes (ESP) research is most readily manifested when findings can be realized in more pedagogically sound materials.

Although I would not claim that our small-scale previous research is in any way directly responsible for the present shift towards a more nuanced presentation of nursing spoken discourse in textbooks, it is evident that there is a conscious movement towards understanding the management of specialized discourses in a manner that can aid in developing more accurate and suitable teaching materials. The true beneficiaries will be, of course, the students themselves.

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Appendix

1. **Authentic Roll Call sample text**
   (senior nurse to junior nurses – Philippines. Note that the numbers are written as originally stated and refer to beds. X and Y refer to medical terms/variables):

SN: Ok, *7- maintain x, avoid y, x removed, decrease y. 8,9- on liquid diet, start IVM, 9 discharge expected PM. 10- x expected tomorrow, y to start 4 pm, CBC 12, x positive. 11- ongoing IV, (no.) minimum, ultrasound scheduled (time). 12- painkiller to follow X at same rate, Y 1 liter at 54cc per hour, may go ahead with contemplative surgery, loss of blood, limited fluids at (no.) per day. Post-partum (?), now prescribing y.*

JN: *Prescribed y?*

SN: *Y. 12 is the issue. Suggest panadol.*

JN*: Then we can give panadol? What if there is a reaction to the panadol?*

SN: *Then you cannot initiate X and you inform the doctor. So, unless there's anything else, that's all.*

2. **Authentic handover sample text (nurse-nurse, Singapore):**

A: *So, still radiating, now extending to lower leg. Hypertensive meds. Y stable. PTOP (?) was just now so just document it. And x was restarted again.*

B: *So, so far no z. She already knows, yeah?*

A: *No, the x is still there. So today's review is x, tomorrow blood, and they'll do the x-ray. So far blister still isn't broken.*

B: *So, now how long? Is the family asking?*

A: *They are agreeable to y, so I noted it and will confirm with Dr. Z. Suggestion was y. Refer the patient to cognitive assessment. Initial level was (number). Follow-up. Trace blood CS and echo. Update after repeat echo.*

B: *So, this is a case of y.*

3. **Samples of repair by confirmation/ clarification as noted in the author's original field research:**

N1: We're now prescribing X.
N2: You prescribed X?

N1: The initial assessment was (inaudible)
N2: Initial assessment was…?

N1: Discharge is expected tomorrow.
N2: Tomorrow?

Preceptor: So what is the priority?
Preceptee: We must remove it. But (pause) what if response is minimum?
Preceptor: Minimal response?

4. **Common self-initiated repair signals:**

Well, …

You know,…

It's like..,

What I mean is…

5. **Common checking/confirming signals and strategies**

We can bring the drip, yeah?

Only for tomorrow, right?

I'm not sure I understand.

Did you mean..?

Just to clarify….

So, it's like… right?

So, my understanding is that…,

Is it OK if…

Only for tomorrow, yeah?

Hypertension has been noted, right?

Any questions?

Anything else?

6. Authentic samples of ellipsis

(Did you) make rounds already?

(Have) You finished the dressing?

(Do) You want the new one?

(I) Don't have it with me. (I) Need twenty.

(There is) No need for x.

(It's the) Same diagnosis.

(There is) Nobody there I know.

7. Samples of turn taking (indicating power relations)

a. The use of negative questions as a face-saving strategy:

"Wouldn't it be in the patient's best interest if…?"

b. Preceptor-Preceptee adjacency pairs

Preceptor- *What are some of the related factors?*

Preceptee- *Heredity. Gender…*

Preceptor- *What are the manifestations?*

Preceptee- *Difficulty in breathing.*

Preceptor- *What else aside from that? What other risks?*

c. Trainer-Trainee (open-ended forms)

So then, this is a case of…?

And so what you will do next is…?

d. Trainer-trainee session/Roll call closing signals

So, that's it.

That's all.