

Reported Speech in Conversational Storytelling During Nursing Shift Handover Meetings

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Shift handovers in nursing units involve formal transmission of information and informal conversation about non-routine events. Informal conversation often involves telling stories. Direct reported speech (DRS) was studied in handover storytelling in two nursing care units. The study goal is to contribute to a better understanding of conversation in handover and use of DRS in storytelling in institutional contexts. Content analysis revealed that the most frequent sources quoted were oneself and patients, followed by physicians and colleagues. Further, DRS utterances are preceded by reports of situations, actions, and other reported speech, often constituting the climax of a story. Conversation analysis revealed how DRS participates in multimodal reenactments, complaints about patients, and justifying deviations from medical protocols. Results inform understanding of the uses of DRS in institutional storytelling, show how they index relevant membership categories and related knowledge and expectations, and serve as resources for making sense of non-routine events.

High-reliability organizations like hospitals maintain task continuity around the clock (Roberts & Bea, 2001; Weick & Roberts, 1993). Thus, work is often organized in shifts. Shift changes occur several times per day and are punctuated

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by *shift handover meetings* (hereafter, *handovers*) during which relevant task information is transferred from an outgoing shift to an incoming one. In nursing care units, handovers serve to transfer relevant patient information. Handovers are complex events (Grosjean, 2004): They are formal communicative routines conducted according to specific roles while also allowing informal conversations. Informal conversation during handover serves to make sense of ambiguous, non-routine events, thereby helping nurses construct and update a shared understanding of the current state of the care unit. However, little is known about how informal conversation facilitates the emergence of shared understanding. Much information transferred during handovers is in narrative form (e.g., stories about noteworthy incidents, circumstances justifying a medical order, or conflicts with patients). Stories are vivid, collectively elaborated, grounded in experience, and constitute important means of creating shared understanding in professional groups (Orr, 1996). Thus, they may be a means by which nurses create shared understanding. Despite the theoretical and practical importance of understanding stories in handover conversations, there has been little research on this topic.

Here we study the interactional functioning of *reported speech* (RS) in handover storytelling. RS is using “talk to report talk” (Clift & Holt, 2007, p. 1). RS can be direct or indirect. In direct reported speech (DRS), or quotation, one purports to use the exact words of a speaker. In indirect reported speech (IRS), one adapts the speaker’s words to the current circumstances (Clift & Holt, 2007). DRS and IRS are very different linguistic acts: In DRS, speakers *depict* a selected aspect of the speech they are citing, whereas in IRS, they *describe* it (Clark & Gerrig, 1990). Depiction makes DRS a potent narrative device. As such, RS is ubiquitous in storytelling.

We present results of both quantitative content analysis and qualitative conversation analysis. Content analysis reveals the various sources quoted in DRS (patients, colleagues, doctors, and oneself), as well as how DRS utterances are embedded in stories. Conversation analysis of selected excerpts shows how DRS is used as a resource for flagging non-routine events that happened during patient care and for constructing accountability of the nurses’ professional conduct. Taken together, results suggest that DRS constitutes an important tool in the ongoing social construction of shared culture in care units through storytelling. We now review research on discourse in handover and RS before presenting our study.

DISCOURSE PROCESSES IN NURSING HANDOVER MEETINGS

Nursing handover is a communicative routine that takes many forms. For example, it may involve all shift members or only pairs of nurses responsible for

particular patients; it may take place at the bedside or in an office; it may be fully interactive, fully written, or even tape-recorded (Kerr, 2002). In many settings, however, it is an organized dialogue (Coulmas, 1981) between representatives of the outgoing and incoming shift. Topics are typically organized according to the sequence of patients in the unit. Obviously, outgoing members have more information to contribute initially and, thus, talk more (however, incoming members may participate by asking questions or introducing information from earlier meetings; Bangerter, 2002). There are also implicit rules governing rights to the floor, with high-status personnel talking more (Grosjean, 2004; Grosjean & Lacoste, 1999).

Within this routine, however, Grosjean (2004) documented the emergence of *polylogues* (spontaneous multi-participant talk). In such situations, extant rights to the floor (the participation framework; Goffman, 1981) are temporarily suspended, allowing all participants to potentially contribute. For example, in a pediatric unit, she found that discussing the juvenile patients often led beyond strictly medical topics (e.g., emotional issues or gossip). In such moments, nurses and auxiliaries can talk on an equal footing in a storytelling mode, rather than a clinical reporting mode. Data on storytelling during handover is sparse. However, Grosjean and Lacoste (1999) noted a large variety of story forms during handover, including minimal narratives; concrete, emotional stories; argumentative accounts; talk about dysfunctional aspects of the workplace; or “war stories” about trials that were overcome. They also noted that these stories may serve different collective purposes in different care units.

Handover meetings are, thus, routinized dialogues with periodically emerging informal conversations that feature stories. Because informal conversations are more time-consuming and less task-focused in a narrow sense, commentators have questioned the utility of handover, arguing that the content transmitted often is poor or duplicates written records (Sexton et al., 2004). There have been influential initiatives to standardize oral communication in shift handover (e.g., focus charting—a technique for structuring information content; Lampe, 1985). However, health care delivery systems must ensure patient safety. It is here that informal conversation may have important functions in handover meetings beyond transmission of relevant patient information in a narrow sense. First, the information sharing, serendipitous cross-checking, and updating of task-related common ground that is a natural byproduct of informal conversation (Clark, 1996) can enhance a system’s resilience against errors and incidents (Patterson, Woods, Cook, & Render, 2007). Moreover, informal conversations in work settings may also have social functions (i.e., social support of individual members or collective legitimation of nursing acts by colleagues; Grosjean & Lacoste, 1999). Finally, although it is less efficient than formal routinized transmission, informal conversation may be more accurate to convey information in non-routine situations, as suggested by data from air-traffic control dialogues

(Morrow, Rodvold, & Lee, 1994). The storytelling activities recurrent in informal conversations may constitute important ways of accomplishing sharing of experience and collective learning in professional communities (Middleton, 1997; Orr, 1996). However, little is known about how stories are actually accomplished in handovers. RS is instrumental in this accomplishment.

RS IN CONVERSATIONAL STORYTELLING

The study of RS has a long tradition in pragmatics and philosophy of language (e.g., Bakhtin, 1981; Clift & Holt, 2007). Contemporary work on DRS, especially in conversation analysis, focuses notably on what it accomplishes in interaction, its design features, recipient participation, and the related phenomenon of reported thought.

What DRS Accomplishes

In an influential article, Clark and Gerrig (1990) argued that DRS selectively depicts a particular aspect of an action for an addressee. Thus, it is an effective way of telling stories by presenting evidence for claims speakers are making about what others have said (Holt, 1996). It allows recipients direct access to the quoted utterance and the circumstances of its production, enabling them to experience those circumstances for themselves. Ironically, despite its ostensibly accurate nature, DRS often depicts reprehensible comments embedded in complaints about the persons quoted (Holt, 2000). For example, speakers can exaggerate prosody or accent to convey a negative evaluation of the reported utterance (Buttny, 1997). More generally, DRS enlivens complaint stories, especially as part of climaxes (Drew, 1998; Holt, 2000). Also, experiments show that when instructed to entertain, narrators use more DRS than when instructed to be accurate (Wade & Clark, 1993).

Design Features

Quotations can be verbal (e.g., DRS) or physical acts (e.g., miming Roger Federer serving an ace). They are semiotically different from other types of language use in that they depict, or mimic, rather than describe, the event they refer to. Thus, DRS exhibits particular design features (Holt, 1996) like (a) shift of personal, spatial, and temporal deixis toward the site of the reported talk; (b) prosodic marking; and (c) enquoting devices like *she said* or *like* (Fox Tree & Tomlinson, 2008; Jones & Schieffelin, 2009).

As a selective depiction of another's action, DRS is embedded in narrative. This creates a *binding* problem (Levinson, 2006) for participants who

have to parse the often fast-paced switches between those narrative components grounded in the immediate context and those grounded in the context being recounted. To solve this problem, they may use cues like deixis or the enquoting devices mentioned earlier to identify the onset of DRS (Sidnell, 2006). Several techniques are also used to mark its offset, including “unquote” devices (Bolden, 2004) or speaker gaze (Goodwin, 1984). Talk, gesture, and gaze are coordinated in reenactments of events, thereby helping participants parse depictions and descriptions. For example, Sidnell quoted one case where a speaker mimics honking a horn with a gesture while producing a vocal imitation of sound. During the reenactment, he averted his gaze from the other participants and returned it only afterwards.

Recipient Participation

DRS is associated with increased recipient participation. The fact that speakers often refrain from commenting on their own DRS (Holt, 2000) often elicits spontaneous assessments from recipients. Thus, recipients often are the first to offer independent evaluative comments on DRS. This subsequently allows speakers to collaborate with the listener’s response; or, they may be explicitly enlisted by speakers: Returning gaze to recipients at the end of a reenactment may solicit reactions from them (Sidnell, 2006; see also Bavelas, Coates, & Johnson, 2002). Also, other individuals who have experienced the narrated events can participate in the retelling by projecting concurrent actions that anticipate an imminent narrative element (e.g., anticipatory laughter; Goodwin, 2007).

Reported Thought

A phenomenon related to DRS is reported thought: quoting a thought of the speaker’s during a narrated event, as in “I thought oh hang on I have to learn a little more about cars” (Barnes & Moss, 2007, p. 134). The design features of reported thought are similar to RS. Often-used enquoting devices include “I thought,” “I was thinking” (Barnes & Moss, 2007), or “At first I thought” (Jefferson, 2004b). Sometimes, it is not explicit whether a quote was actually said during the interaction or whether it remained a “silent” thought, as when speakers use “I was like” (Haakana, 2007). Reported thought, like RS, is used in complaint stories as an evaluation device to express “silent criticisms” (Haakana, 2007, p. 167) of someone’s attitude or behavior. Moreover, reported thought in institutional interactions constitute a device for conveying “how it appeared to me then” (Barnes & Moss, 2007, p. 127), as well as for constructing an account of one’s behavior as rationally motivated according to shared norms.

OUR STUDY

Our goal is to contribute to a better understanding of (a) discourse processes in handover situations and (b) DRS use in institutional contexts. More generally, in pursuing the question of what DRS accomplishes, we seek to understand how storytelling contributes to creating and updating collective mind among unit members. This is an important function in work groups. In a classic ethnography of service work, Orr (1996) documented the “war stories” photocopy repair technicians tell each other about the machines they fix. These stories are routines for updating their collective state of knowledge, but also for sharing insights about newsworthy aspects of copier repair:

Much of technicians’ talk about machines really involves keeping track of each other’s movements and collecting the latest news about what is happening to their flock [i.e., the machines], and as such it is necessary business. This is not, however, the most interesting part of talking about machines for the technicians. What really holds their interest is a situation they do not understand. (p. 95)

Talk excerpted by Orr (1996) features DRS, leading us to surmise that DRS may play an important role in stories about both routine and extraordinary circumstances of the technicians’ work. Although the work of service technicians and nurses is very different in some respects, they both feature technically complex tasks and recurrent social interactions. As described earlier, prior work (Grosjean & Lacoste, 1999) has documented a rich variety of forms and functions in nurses’ storytelling, but without examining in detail how these stories are accomplished. In this study, we therefore examine DRS in storytelling in handovers of two nursing care units in French-speaking Switzerland.

Research Questions

Our first research question is, simply, “Who is quoted?” Hospital work involves many complex social interactions grounded in an intrinsic situational uncertainty (Iedema, 2007; Middleton, 1997). For nurses, typical interaction partners include colleagues, physicians, patients, and their families. Nurses’ choices as to whom they cite using DRS in handover stories may reveal important aspects of their everyday social interactions, as well as how social relationships in the hospital are constructed.

Our second research question is, “How is DRS positioned within a story?” We explore this question both quantitatively and qualitatively. The quantitative analysis seeks to determine typical patterns of narrative elements that precede DRS. The qualitative analysis draws out, in detail, how the positioning of DRS contributes to the dramatization of the story. This combination of quantitative and qualitative approaches speaks to the ongoing research on (a) the sequential

organization of DRS (Holt, 1996, 2000), (b) the demarcation of DRS from other narrative elements (Sidnell, 2006), (c) its multimodality, and (d) the role of recipients in the co-construction of narrative discourse.

Our third research question is, “What does DRS accomplish for participants?” Here we explore the types of interactional work that gets done by the use of DRS. Research on DRS has documented its recurrent role in complaint stories and amusing anecdotes (Holt, 1996, 2000). Complaints (e.g., about patients) may also emerge as a recurrent feature of DRS narratives in handover settings. In an institutional context, however, complaint stories may reveal nurses’ notions of what constitutes deviant conduct. That DRS and reported thought plays a role in constructing claims to epistemic access and authority (Sidnell, 2006) and in constructing rational accountability (Barnes & Moss, 2007) may also be particularly important in institutional settings like handover, where justification of professional acts to colleagues is an important activity (Grosjean & Lacoste, 1999).

We brought complementary methods of content analysis and conversation analysis to bear on our research questions. First, we identified all DRS utterances in the transcripts. We then coded the source (i.e., the type of person quoted) of each utterance, as well as its context (i.e., the content of the preceding utterances). This data addresses the first and second research questions: Who is quoted, and how is DRS positioned within a narrative. In a second step, we re-transcribed in more detail selected sequences of DRS from the corpus and subjected them to qualitative microanalysis, using the methods of conversation analysis. This data reveals the sequential organization of DRS, as well as what it accomplishes for participants (our third research question).

Care Units

The units, a surgery and a rehabilitation unit, differed regarding their institutional context, the tools mediating communication, and care provided (acute and non-acute). The surgery unit was part of a small hospital. Its mission covered orthopedic, vascular, visceral, and ophthalmic surgery. Verbal communication during handover was supported by handwritten notes and patient files. Handovers took place four times per day. The cardiovascular rehabilitation unit was part of a large clinic. Its mission covered thoracic surgery and general and cardiovascular rehabilitation. Verbal communication during handover was supported by patient-related information entered into a laptop at the patient bedside. Handovers also took place four times per day.

Participants

There were, on average, 5.7 persons present per handover in the surgery unit and 2.9 in the rehabilitation unit. Observers conducted exploratory interviews prior

to data collection and secured trust from staff by observing some handovers without filming.

Data Collection and Transcription

In each unit, three of the four handovers per day were videotaped during five consecutive days (30 handovers in total) and subsequently transcribed. The surgery corpus contained 59,225 words and the rehabilitation corpus 28,865. Names of patients, caregivers, physicians, and hospitals were anonymized in the transcriptions. In the surgery unit, we were contractually obliged to destroy recordings after initial transcription. The video recordings of handovers in the cardiovascular rehabilitation unit could be kept longer for more detailed transcription. Hence, selected transcriptions of this material were transcribed following the Jefferson system (Jefferson, 2004b; also see the Appendix). Prosody was intuitively noted (i.e., through listening) and, where necessary, checked against a prosodic representation generated through Praat (Boersma & Weenink, 2007). In the excerpts we analyze, the original French dialogue is displayed along with an English translation on the line below.

CONTENT ANALYSIS OF SOURCE AND CONTEXT OF DRS UTTERANCES

First, we coded the sources quoted by means of DRS. This is interesting because, as a device for presenting evidence augmenting vividness in storytelling, DRS may reveal what kind of authoritative claims are relevant in nurses' stories. Second, we coded the content of the three utterances immediately preceding each DRS utterance. This allowed us to shed light on how DRS is embedded in stories by analyzing what kind of utterances constitute the pre-context of a DRS utterance.

Coding

We first searched for all occurrences of DRS in the transcriptions, according to design features described by Holt (1996) and discussed earlier. Reported thoughts (Barnes & Moss, 2007; Haakana, 2007) were also included as DRS.

Initial qualitative analyses indicated that DRS was used differently depending on who was quoted. Therefore, we coded for the type of person quoted (the *source*): *self* ("I said oh it's alright it looks like it's improving"), *patients* ("She said give me a Temesta because I can't sleep"), *physicians* ("He said no it's okay he didn't bleed much let's check that tomorrow morning"), *colleagues*

(“She said wait I need to get your pulse”), and *other persons* (“and his wife oh but if we look at how you do it”). We double-coded 23% of the data for interrater agreement, which was high (Cohen’s $\kappa = .86$). We operationalized the *context* of a DRS utterance as the three utterances immediately preceding it. We coded each context utterance for content, according to the following categories (inductively derived from inspection of the data): *situation/medical order*, *actions*, *RS*, and *other*. An example of this coding is provided in Excerpt 1:

Excerpt 1

- 1 PAM et: et alors euh: (.) euh:: (..) elle est un peu eum:
and and then she is a bit
- 2 y a (quand même) Ivan qui est passé après qui a été la voir,
Ivan came around after he came to see her
- 3 (.)et pis qui a rediscuté de son traitement,
and talked about her treatment again
- 4 et pis elle elle me disait que:: ouais (.) ça la perturbe=
and she she told me that yeah it disturbs her
- 5 =un peu c’te changement de: de spray, euh:
a bit this change of spray
- 6 par rapport au au (Perubar).
in relation to the (Perubar)
- 7 elle a dit **je sais pas si je vais le garder**,
she said I don’t know if I will keep it
- 8 **ou si je vais pas reprendre les autres**, euh
or if I won’t start the others again
- 9 on sent qu’elle est assez:: (.) assez récalcitrante au changement.
you can feel that she is quite resistant to change

This excerpt illustrates how a nurse is narrating a patient’s dissatisfaction with a recent change of medication. Consider one of the target DRS utterances (line 7): “She said I don’t know if I will keep it” (the source is coded as the patient). The three immediately preceding utterances are “and she she told me that yeah it disturbs her a bit this change of spray in relation to the (Perubar)” (content coded as *RS*), “and talked about her treatment again” (content coded as *action*), and “Ivan came around after he came to see her” (content coded as *action*). We computed interrater agreement for coding content of contextual utterances on 20% of the data. It was high (Cohen’s $\kappa = .80$).

Results and Discussion

Number and length of quotations. There were 123 occurrences of DRS in the surgery unit corpus and 61 in the cardiovascular rehabilitation unit corpus.

We computed the ratio of the number of words devoted to DRS in each session to the total words used in the session. The two units do not significantly differ on this ratio: $F(1, 28) = 0.622, ns$.

Quoted sources and unit types. The units differed according to the distribution of sources quoted: $\chi^2(4, N = 184) = 12.77, p = .012$ (see Figure 1). In the surgery unit, caregivers quoted themselves and patients most often, followed by physicians, then colleagues. In the rehabilitation unit, caregivers quoted patients most often, followed by themselves, then colleagues. Only one quotation was from a physician.

Caregivers quote patients less often in the surgery unit than in the rehabilitation unit. In contrast, they quote physicians more often in surgery than in rehabilitation. These differences may reflect the different work situations of the units. Indeed, in the acute care context of the surgery unit, physicians intervene more often than in the rehabilitation unit. On the other hand, in the rehabilitation unit, patients typically stay for a longer period and, thus, potentially engage in more meaningful (and potentially problematic) interactions with the nurses. More of these interactions end up as quotations in the nurses' stories. The qualitative analysis will shed complementary light on these findings, showing that nurses accomplish different things by means of DRS depending on who they quote.

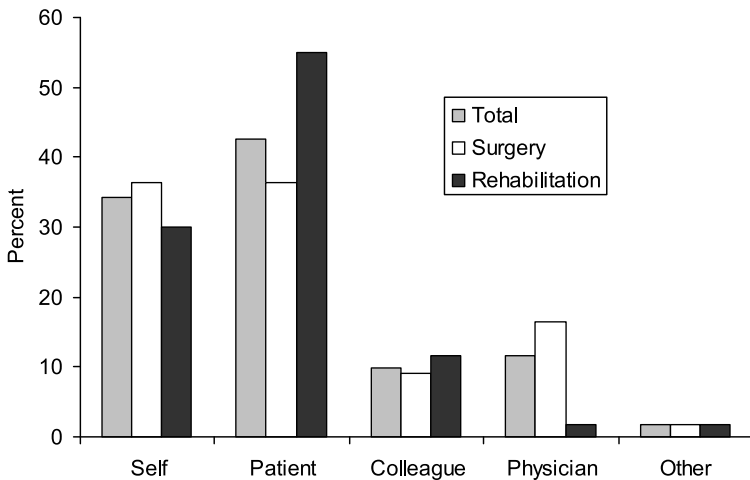


FIGURE 1 Distribution of sources quoted (bars of the same shading sum to 100%) in direct reported speech for each unit and in total.

Content of contextual utterances of DRS. We tested the association between the *content* of the contextual utterances, their relative *position* to DRS (1–3 utterances preceding a DRS utterance), and the *unit type* using loglinear analyses (Agresti, 1984). Loglinear analyses allow identification of the structure of multidimensional categorical data by testing the goodness of fit (G^2 likelihood ratio) of successive models. A nonsignificant G^2 value means that the tested model fits the observed data. In our data, models in which the main effects of unit type, position, and content were introduced alone or two by two did not fit the data, nor did models including only first-order interactions or models including the main effect of a factor and the interaction of the other two factors. The only model that fit the data included a main effect of unit and an interaction between position and content, $G^2(11) = 8.70$, $p = .65$. The main effect of unit reflects the fact that, as described earlier, the surgery unit produced more DRS than the rehabilitation unit. The interaction between position and content indicates that content of contextual utterances varies according to their position (see Figure 2). In the surgery unit, *situations/medical orders* and *actions* became less frequent immediately preceding the DRS utterance, whereas RS became more frequent. In the rehabilitation unit, *situations/medical orders* became less frequent immediately preceding the DRS utterance, whereas RS became more frequent.

In other words, there is a buildup of context preceding DRS. Roughly speaking, DRS tends to be *distally* preceded by narrations of situations and actions. It tends to be *immediately* preceded by other RS (both IRS and DRS)—RS often occurs in clusters of more than one utterance. This finding is a quantitative demonstration of the qualitative observation that background information is often provided prior to DRS, which constitutes the climax of a story (Drew, 1998; Holt, 2000). In our data, background information is provided in the form of a situation description, usually the patient’s diagnosis or symptoms, which is followed by the description of the actions undertaken (e.g., treatment administered). In conclusion, caregivers’ narrated situations and actions build up context for the production of RS (both DRS and IRS) and, finally, the focal DRS utterances. The sequential analysis that follows should shed more light on the details of this buildup.

QUALITATIVE ANALYSIS OF DRS SEQUENCES

In this section, we use conversation analysis to document how DRS (a) is produced in storytellings through the use of verbal and other means, (b) is embedded in jointly managed activities, and (c) serves as a resource for accomplishing both interpersonal and institutionally relevant jobs, like flagging non-routine events, displaying technical reasoning, or legitimizing the speaker’s

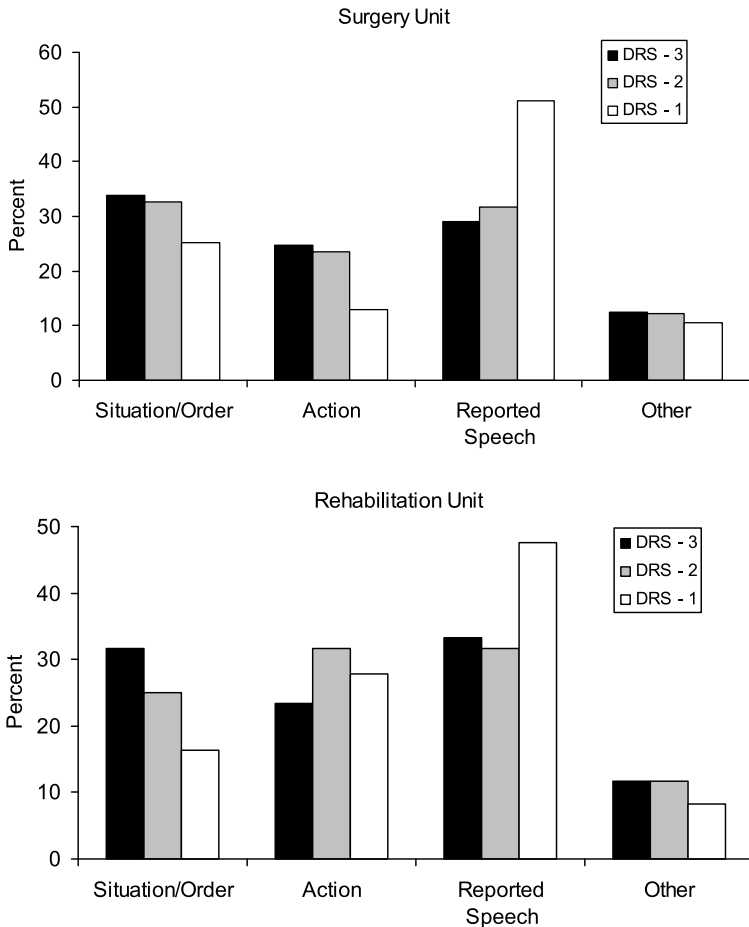


FIGURE 2 Content of the three utterances preceding direct reported speech (DRS; bars of the same shade sum to 100%) in the rehabilitation and surgery units. *Note.* DRS - 1 is the immediately preceding utterance, DRS - 2 is the second utterance back, and DRS - 3 is the third utterance back.

own recounted action. This qualitative study of selected data excerpts will extend the quantitative analysis, demonstrating in detail how the functions of DRS in our data differ depending on who is invoked as source, and also how narrators build up stories to a climax.

One recurrent feature of DRS in our data is its occurrence in reports of potentially problematic matters (i.e., episodes oriented to by the participants as going against normal expectations). Four such episodes, taken from the

rehabilitation unit, are analyzed, containing a total of 12 instances of DRS. Each excerpt features a situation deviating from the nurses' everyday practice: dealing with an unusual technical aspect of patient care (cleaning a wound; Excerpt 2), dealing with a patient's unreasonable request (Excerpts 3 and 4), or dealing with a deviation from a medical protocol (Excerpt 5). Seeking to account for the embeddedness of DRS in courses of jointly accomplished activities, we present a detailed analysis of a long interactional sequence in Excerpt 2, and are more expedient with the discussion of Excerpts 3 through 5.

Excerpt 2: Displaying Professional Conduct in Dealing With an Unusual Technical Aspect of Patient Care

Excerpt 2 involves three nurses seated at their computer-equipped desks (see Figure 3; the notes [A], [B], and [C] in the excerpt link the transcript to the appropriate panel of the figure): Lea and Ann are facing each other while Mag sits at the bottom end of the desk (with her back to the camera, slightly off the field of view). The excerpt presents a lengthy stretch of interaction where Ann recounts her cleaning of a patient's knee wound to Mag and Lea. We first look at the general organization of the narrative and then analyze the repeated use of DRS:

Excerpt 2

- 23 ANN je lui ai demandé (.)
I asked him
 <looks at MAG >
- 24 qu'il mette un antalgique avant la réfection des pansements? [A]
to put an analgesic before changing dressings
- 25 (1.5) <ANN lowers eyes to left knee, right hand on the knee> [B]
- 26 ANN .h euh ce qui était dégueulasse aujourd'hui c'est que de ce côté?
what was disgusting today is that on this side
 <-----left hand points to knee----->
- 27 (. . .)
 <----- looks at LEA, maintains point-----> [C]
- 28 LEA ouais
yeah
 <nods>
- 29 ANN euh j'ai commencé à tirer et puis j'ai dit à Daniel **regarde**
I started to pull and then I told Daniel look
 <-----looks at LEA----->
- 30 **je lui tire de la fibrine,**
I'm pulling fibrin
 ----->

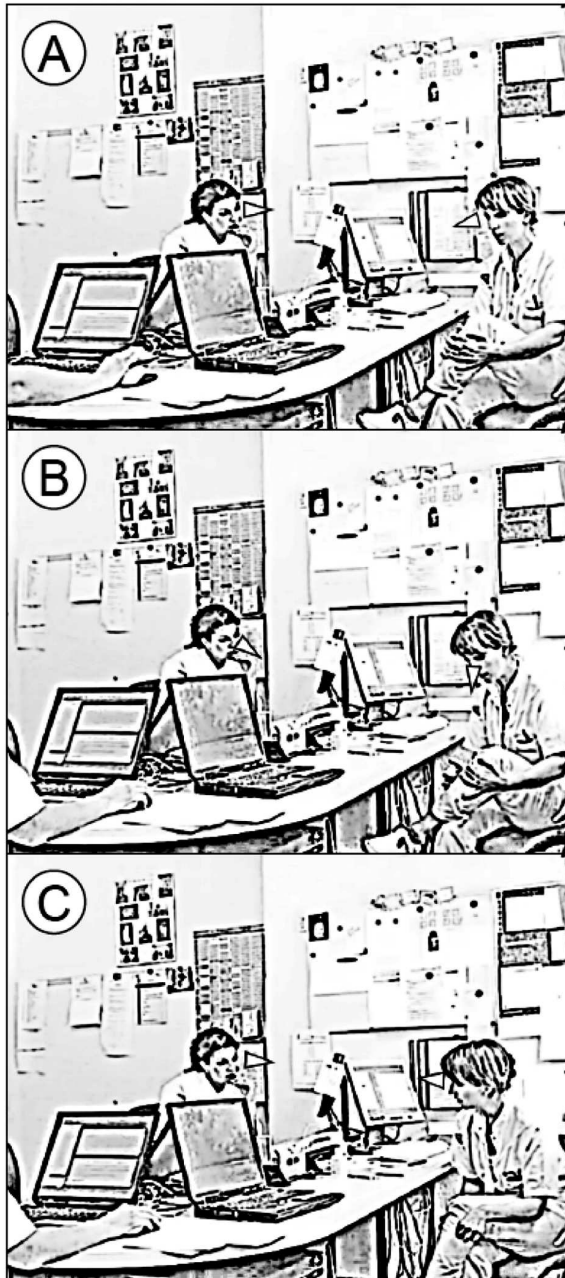


FIGURE 3 Multimodal actions in Excerpt 2. *Note.* Panel A: Ann's (on the right) gaze and posture are oriented toward Mag. Panel B: Ann points to her knee; Lea looks at it. Panel C: Ann's and Lea's gaze meet; Ann's body is reoriented toward Lea. Arrows indicate direction of gaze.

- 31 et puis je lui ai dit **mais t'es sûr que c'est de la fibrine,**
and then I told him but are you sure it's fibrin
 <-----looks away----->
- 32 parce que c'est d'une consistance
because it's got a texture
 <-----looks at MAG----->
- 33 asse:z (.) dure comme ça,
quite hard like that
 <----looks away---->
- 34 .h et j'ai dit **c'est un vaisseau qui: [qui a plus]**
and I said it's a vessel that that hasn't
 <looks at LEA> <----iconic gesture----->
- 35 MAG [qui part]
that's coming off
- 36 ANN **été irrigué, qui est loin,**
been irrigated anymore that's gone
 <iconic gesture of the left hand on the knee>
- 37 MAG qui part,
that's coming off
- 38 ANN et puis en fait il disait **non non continue à tirer,**
and in fact he said no no keep on pulling
 <----- looks away ----->
- 39 .h et puis tu tirais tu tirais,
and you pulled and pulled
 <looks at her knee, mimics pulling>
- 40 et puis c'est c'était vraiment dégueux,
and it's it was really disgusting
 <----continues the gesture, looks away ---->
- 41 y avait tout qui venait dessous,
everything was coming out underneath
 ----->
- 42 .h on coupait et puis en fait on pense que c'était un
we were cutting and in fact we think it was a
 <----- looks at MAG ----->
- 43 tendon=qui: qui était [dessous],
tendon that was underneath
- 44 MAG [°ah ouais°]
ah yeah
- 45 ANN qui qui était mort. enfin c'est vraiment d- °vraiment° dégue.
that that was dead anyway it's really really disgusting
 <-----looks at her knee, iconic gesture----->

Directly preceding the excerpt, Ann has been describing the patient's wound. In doing so, she progressively upgrades the dramatic character of her telling,

moving from a neutral identification of the patient's situation, to a more detailed assessment of the wound, of the patient's reluctance to receive pain medication, and finally to a vivid description of the wound-cleaning process (starting at line 25) that she accomplished together with Daniel, a senior colleague. DRS is used in the last, most dramatic phase of the story, which is reproduced in Excerpt 2. This is in line with earlier findings by Drew (1998) and Holt (2000), and also illustrates our findings in the quantitative analysis.

In Excerpt 2, several features of talk mark the segment starting in line 25 as the beginning of the peak of the story. First, the segment is demarcated by a pause of 1.5 s, followed by Ann's audible in-breath. Second, the segment shows a multimodal constitution of a virtual model of the patient's wound: In line 25, Ann gazes at her knee; starts to point at it; and then, in line 26, when she qualifies the wound as *disgusting*, she adjusts her gesture in order to point to a more specific location. She thereby uses a *local metric* in which "features of the current scene are used to describe the narrated one" (Goodwin, 2003, p. 323). Goodwin (2003) reported verbal uses of local metrics, such as, "Their dining room is about five times as big as ours" (said by a person at the table designated as *ours*). Here, Ann resorts to an *embodied local metric*: She uses her hand and knee as material to build a description of the patient's wound. The embodied use of local materials to which the current interlocutors have access is a way of making intelligible a scene the addressees did not witness, thereby augmenting the authenticity and the dramatic character of the depiction.

Third, the start of the story is also demarcated by means of a specific syntactic format in line 26, which opens the depiction of the wound-cleaning process—namely, a pseudo-cleft construction (or WH-cleft): "what was disgusting today is that." Pseudo-cleft constructions involve an "A is B" scheme, where A (*what was disgusting*) is underspecified, and B presents a specification of A. It is interesting to note that B can consist of a long stretch of talk in which case the A part projects something that will be elaborated on in what follows (Hopper & Thompson, 2008; Pekarek Doehler, 2011). Thus, *what was disgusting* projects a specification of "what was disgusting" as a relevant next action. The specification is provided by the subsequent segment of talk (lines 26–45). This device is instrumental in upgrading the dramatic character of the story. The effect is further enhanced by the lexical choice of *disgusting*, which echoes the preceding assessment of the patient's wound and further contributes to specifically demarcate the segment in lines 26 to 45 as the peak of the narrative. Indeed, *disgusting* is used again with the discourse marker *anyway* in line 45 to close the story.

The sequential ordering of the narrative buildup corresponds to the patterns found in our content analysis of the utterances immediately preceding DRS. This analysis showed a progression from the narration of situations and actions to RS immediately preceding a target DRS utterance. This pattern can be observed

in lines 26 and 29, where Ann narrates a situation (“what was disgusting”) and an action (“I started to pull”) before a DRS utterance in lines 29 and 30 (“look I’m pulling fibrin”), which is then followed by other DRS segments.

The transition between building the scene and reporting the wound-cleaning process is marked by a step-by-step reorientation of body posture and gaze, as shown in Figure 3: In the preceding talk, Ann’s gaze and whole posture was turned toward Mag (line 23; Figure 3A); now, Ann first gazes and points toward her knee (lines 25–26; Figure 3B) and then engages in a mutual gaze with Lea (line 27; Figure 3C), involving her as a co-addressee. In sum, then, Ann deploys a remarkable array of gestural, bodily, syntactic, lexical, and sequential means to create a virtual scene and, thus, set the stage for the peak of her story.

At this moment, once the attention of both colleagues has been captured, Ann’s actual recounting of her working on the wound starts: “I started to pull” (line 29); Ann uses a series of DRS utterances to do so. These show typical design features (Holt, 1996; Sidnell, 2006)—for example, recurrent use of enquoting devices (lines 29, 31, 34, and 38), shift of deictic space toward the place of the reported action (e.g., the exophoric use of the third-person *him* in line 31), and coordination between offset of DRS and gaze (line 31). Most important, the DRS itself is accompanied by iconic gestures that mime the events reported (lines 34, 36, and 39–40) and highlight their dramatic character. Together with the devices used to create the virtual scene in the preceding talk, Ann’s quotations constitute an embodied reenactment (Sidnell, 2006) of her experience, where gesture, talk, and gaze are coordinated so as to augment the authenticity of the events being reported. This “reassembly” (Schegloff, 2005, p. 463) of different modes is instrumental in *depicting* (Clark & Gerrig, 1990) the wound-cleaning process. This observation converges with previous accounts of DRS as augmenting the experiential realism of the scene depicted (Holt, 1996, 2000; Sidnell, 2006). It is, however, not the DRS alone, nor its combination with gesture, that does the job of augmenting the dramatic character of the narrative, but also its embeddedness in a specific course of action leading up to a climax.

This being said, the data allow us to carry the analysis one step further. Ann chooses quotations of concrete technical information that constitute successive conjectures about the possible nature of the substance pulled out of the wound. She reenacts a process of collaborative diagnosis through the reported interaction between Ann and Daniel. More specifically, the process is depicted according to an “At-first-I-thought-X-then-I-realized-Y” routine (Jefferson, 2004a), which involves the initial mention of reported thoughts positioned as mundane explanations of events that are subsequently revealed as incorrect. This routine constitutes a device for marking an event as extraordinary (Sacks, 1992). Here, Ann’s initial conjecture of “look I’m pulling fibrin” (lines 29–30) is followed by “but are you sure it’s fibrin” (line 31), which depicts a state of doubt and introduces an element of unexpectedness into the story. Her aside to Mag and

Lea in lines 32 and 33 (“because it’s got a texture quite hard like that”) delivers an account of that doubt. Her subsequent DRS, “it’s a vessel that hasn’t been irrigated anymore” (lines 34, 36) offers a second technical diagnosis of the tissue that is being worked on, and provides further qualification of the situation as unusual. Finally, in line 38, her quote of Daniel (“no no keep on pulling”) invokes a colleague’s voice as an authority whose reported go-ahead signal legitimizes Ann’s own subsequent actions (see also Excerpt 5), leading to the discovery of the nature of the substance being pulled and, ultimately, to the denouement of her story.

In sum, DRS is used to tell a story about an unexpected departure from a routine activity (cleaning a wound) and to show Ann’s dealing with it in a reasoned, expert manner. In doing so, Ann has her audience witness her actions as a thoughtful professional in what she presents as an unusual, critical moment. What we see her do is construct a rational accountability for their conduct. Her orientation to the normality of things (i.e., to what is habitual and what is exceptional) indexes Ann’s belonging to a specific membership category. As Sacks (1972a, 1972b) pointed out, membership categories activate alternative bodies of commonsense knowledge, perception, relevant conduct, and understanding of situations. Commonsense knowledge includes what Sacks (1972a, 1972b) termed “category-bound activities” (i.e., “kinds of activities or actions or forms of conduct taken by the common-sense or vernacular culture to be specially characteristic of a category’s members” (Schegloff, 2007, p. 470). Mentioning such a category-bound action makes relevant the category to which that action is bound. By using DRS and letting her colleagues “witness” (Holt, 1996) not only her actions but also her purported interpretations of the technical issues at hand, Ann orients to the category of “a professional nurse” without saying things like “I am a good nurse” (Schegloff, 2007). Also, her orientation to normal expectations and to what goes against normality is observably related to this membership category; what is enacted by means of the DRS is Ann’s understanding of the wound-cleaning process as a non-routine event and of herself as a conscientious nurse, in view of sharing this interpretation with other members of that same category (nurses). Ann’s story is similar to the “war stories” by which photocopy repair technicians share anecdotes about complex cases of machine failure diagnosis (Orr, 1996). Her use of DRS is instrumental in the enactment and sharing of a professional culture that involves dealing with and solving technical problems, as well as displaying and sharing relevant experience.

Excerpts 3 and 4: Dealing with Deviant Patient Behavior

We now analyze another recurrent use of DRS in our data: complaining (Buttny, 1997; Holt, 2000) about a patient’s deviant behavior. A first illustration is

provided in Excerpt 3. Lea recounts her interaction with a patient who claims to have paid for the entire day, but has actually only paid until 10 a.m. The room is needed at 3 p.m., but the patient wants to stay until 5 p.m.:

Excerpt 3

- 1 LEA elle pense qu'elle paie pour toute la::: toute la journée,=
she thinks that she's paying for the whole the whole day
- 2 =elle dit mais (.) puisque c'est comme ça, (.)
she says but since that's the way it is
- 3 ne vous en faites pas, je vai::s (.)
don't worry I will
- 4 je serai: (.) dehors à trois heures.
I will be out by three o'clock
- 5 PAM hhhh
- 6 LEA et puis après je lui ai fait un sourire,
and then I smiled at her
- 7 j'ai commencé à lui dire=
I started telling her
- 8 =mais vous savez si vous avez besoin de l'ai:de
but you know if you need help
- 9 je suis là, je peux vous °aid:er°,
I am here I can help you
- 10 j'ai commencé à faire une théorie,
I started to chat her up
- 11 et pour finir elle était elle était contente,
and finally she was she was satisfied
- 12 et pis elle a dit ouais, y a pas d'problème, (.) je °vais sortir°.
and then she said yeah there's no problem I will go

Lea starts her story by implying that the patient is wrong (line 1). She then uses DRS to depict the patient as annoyed by the situation (line 2: “since that’s the way it is”), but willing to comply (line 4: “I will be out by three o’clock”). Her use of DRS is a powerful means not only for highlighting the patient’s conduct as deviant from the norm, but also for getting her colleague’s alignment: Pam reacts with an audible out-breath (line 5), possibly a sign of exasperation. Once Lea has received her co-participant’s alignment to the picture she is painting, she sets out to recount her attempt to calm the patient: She reports smiling at the patient (line 6), and backs up the display of her conduct by using DRS to quote her own words (lines 8–9): “I am here I can help you.” She then tells Pam about the patients’ satisfied reaction (lines 11–12), using again DRS as evidence: She quotes the patient’s complying (“there’s no problem I will

go”). The juxtaposition of self-quotes and patient’s quotes within a reported dialogue (see also Excerpt 4) allows the speaker to provide evidence for her own professional conduct in the face of a patient that is depicted as difficult. Thereby, the change in the patient’s attitude, from uncooperative to complying, is presented as a result of the nurse’s attempts to mollify her.

Excerpt 4 provides another illustration of complaints about patients. It is taken from an interaction between Lea and Ann, who discuss the case of a patient leaving the hospital that very day. Two other nurses are present, but they do not participate in the interaction. The excerpt starts with Lea’s reporting the patient’s reaction to a question from Sara, another nurse, about whether the patient needs a nurse to assist her after her return home:

Excerpt 4

- 12 LEA [voilà alors euh]
so then
- 13 elle a: oui (.) parce que: Sara elle a demandé que:
she has yes because Sara she asked that
- 14 de lui dire qu’est-ce qu’elle avait besoin pour la: pour
to tell her what she needed for the for
- 15 rentrer à la [maison],
going back home
- 16 ANN [euh]
<writes and looks at her papers>
- 17 LEA si elle avait besoin d’infirmière:re. (.) puis elle a dit
if she needed a nurse and she said
- 18 **OH NON mais l’infirmière elle m’a dit que j’avais rien**
ah no but the nurse she told me that I didn’t need
- 19 **besoin, que : [(je XX)]**
anything that I
- 20 ANN *[non]
no
**<looks up from her papers, looks at Lea,*
signals ‘no’ with her index finger>
- 21 c’est pas vrai, je lui ai pas dit ça.
that’s not true I didn’t tell her that
- 22 LEA c’est vrai?
really?
- 23 ANN je lui ai dit elle [voulait]
I told her she wanted
- 24 LEA [(laughs)]

- 25 ANN que quelqu'un passe tous les jours. j'ai dit
someone to come by everyday I said
- 26 qu' y avait des gens qui étaient beaucoup plus mal qu'elle,
that there were people who were much sicker than her
- 27 et qui avaient pas une infirmière tous les jours,
and who didn't have a nurse everyday
- 28 LEA ouais voilà
yeah that's it
- 29 ANN qu'elle elle est capable de se laver un petit peu,
that she she's capable of washing herself a little bit
 <-----looking at LEA----->
- 30 de de s'faire- elle voulait quelqu'un pour lui faire
to to make herself she wanted someone to make her
 ----->< looks at LEA, beat gesture with index -
- 31 le petit déjeuner, j'ai dit **mai :s** [euh]
breakfast I said but
 -----><----looks at LEA-->
- 32 LEA [(laughs)]
- 33 ANN **vous êtes indépendante.** (.) °faut pas se foutre
you're independent what a nerve
 -----> <-lowers her head on her notes -
- 34 de la gueule du monde quoi°. alors je lui ai dit
really so I told her
 ----->
- 35 qu'on coupait la poire en deux, au lieu de l'envoyer
we'll compromise instead of sending her
- 36 quelqu'un <chaque jour>, (.) chaque deux jours.
someone every day every two days
- 37 et puis elle veut des douches deux fois par semaine
and she wants showers twice a week
- 38 LEA mhmm
hmm
- [15 seconds of talk omitted]
- 46 ANN [mais moi euh une dame] comme [ça]
but me a lady like this
- 47 LEA [(X ?)] [ouais]
yeah
- 48 ANN je suis pas d'accord qu'on lui envoie quelqu'un (.) euh
I don't agree to send her someone
- 49 tous les jours, parce que :: (.) c'est: euhm (.)
every day because it's

- 50 LEA oui
yes
- 51 ANN franchement elle a pas besoin de quelqu'un [tous les] jours.
frankly she doesn't need someone everyday
- 52 LEA [non non]
no no
- 53 ANN faut qu'elle s'bouge
she needs to pull herself together
- 54 LEA ouais
yeah
- 55 ANN >et puis c'est tout quoi<.
and that's it really
- 56 LEA ouais
yeah

Two cases of DRS are embedded in this episode where Lea and Ann recount separate dialogues with the patient. The excerpt shows a recurrent phenomenon in our data—namely, the proximity of DRS and IRS (see the previous quantitative analysis). The first DRS segment, occurring at lines 18 and 19, reports a patient quoting what Ann had purportedly told her, whereas the second, in lines 31 and 33, reports Ann's own words as addressed to the patient. The two DRS segments function as indexical tokens highlighting the authenticity of the dialogue that is being reported. They also create a tension between the patient's complaining stance as to Ann's purported statement, and Ann's own account of her words.

With “ah no but the nurse she told me that I didn't need” (lines 18–19), Lea reports the patient's verbatim remark: Purportedly, Ann had told the patient that she does not need someone to assist her after returning home. The DRS segment shows features that contrast with the self-quotes in Excerpt 3: It is a single quote, it is not accompanied by any noticeable gesture or shifts in gaze or posture, and it is introduced by an emphatic marker (“ah no”), produced with a markedly louder voice. These characteristics are significant. The use of a single quote and the absence of gesture suggest that this is not about enacting a whole scene, but rather about displaying the authenticity of a single assertion. The emphatic marker “ah no” indexes the patient's irritation, further highlighting the quote's authenticity (Holt, 1996).

In our data, mimicry of the original voice, as shown by change of pitch, loudness, and tokens such as *ah*, are typical of nurses' quotes of patients' talk. Such techniques are not just devices for demarcating DRS from one's own speech. Mimicry of patients has the effect of letting patients' words *depict* their attitude, rather than conveying it via the narrator's description. Suggestive mimicry (e.g., of a petulant tone of voice) can obliquely convey a negative

evaluation of the reported utterance (Buttny, 1997). Thus, nurses can use this practice to complain about patients by displaying their speech. Mimicry also allows the narrator to deemphasize her role and confront her co-participants with purported pure fact. This is particularly important in this case, as Lea's quoting of the patient's complaint as to what Ann said may constitute a reproach to Ann. This shows a powerful use of DRS to address, in an indirect way, a potentially complaint-worthy action of a co-participant (here, Ann).

Ann's subsequent talk shows that she indeed orients to Lea's remark as a potential reproach. She starts to report what she really said (line 23: "I told her"), then aborts and describes what the patient wanted ("she wanted someone to come by every day"). She then develops a story that alternates between examples of the patient's preposterous wants (recurrent use of *she wanted* or *she wants* in lines 23, 30, and 37) and her own indirect speech (repeatedly marked by *I said* or *I told her* in lines 25, 31, and 34). In doing so, she builds up a systematic contrast between the patient's unreasonable requests and her own efforts to reason with her. This sequence serves to discredit the patient's assertion (the first DRS segment, quoted by Lea in lines 18–19) about what Ann purportedly said, and to outline the absurdity of the patient's request. The story comes to a peak (lines 30–31) when Ann mentions that the patient "wanted someone to make her breakfast" while looking at Lea and accompanying her words with a beat of her index, possibly suggesting her impatience. Also, her "she wanted someone to make her breakfast" elicits laughter from Lea, who signals her endorsement of Ann's point of view as to the absurdity of the patient's request. It is now that Ann introduces her key diagnosis of the patient's needs, by means of a second DRS segment, "but uh you're independent," followed by an explicit evaluation, "what a nerve really" (lines 33–34), in a turn expansion. It is interesting to note that this evaluation, which contrasts with the matter-of-factness effect of the preceding storytelling enhanced by the DRS segments, occurs only once co-participants' alignment with the depiction of the patient has been secured (line 32). Also, it is produced as an aside, in a low voice, and with Ann's gaze withdrawn from Lea.

Ann's retelling of her interaction with the patient, from which both DRS segments are quoted, builds up a context allowing her to demonstrate the truth of her assertions, as well as the accuracy of her diagnosis of the patient's needs. Her narration also has the effect of shifting the issue at stake from what she told the patient to what the patient is like, thereby accounting for her subsequent negative assessment of the patient. The very orientation to a patient's behavior as deviant features a reference to shared knowledge by indexing a membership category. Ann's expression (line 46), "a lady like this," unambiguously classifies the patient as an exception, as a member of the category "patients" that is different from the others, thereby maintaining orientation to a shared understanding of the normality of the category.

Taken together, the use of DRS in Excerpts 3 and 4 accomplishes more than highlighting the authenticity of the reported dialogues. The use of DRS for quoting patients displays patients' attitudes, thereby depicting them as deviant from usual patients, without explicitly qualifying them as such. This shows the powerful indirectness of DRS to convey blame. These quotes build up a background against which the nurses display how they dealt with the deviant patient. Their self-quotes are instrumental in this: Self-quotes provide evidence for the professional character of the nurses' conduct on behalf of the patient, in a similar way as they provide evidence for the nurse's professional way of dealing with non-routine technical issues (see Excerpts 2 and 5). In both cases, the stories are sequentially built up to first describe the non-routine character of the situation, and then depict the nurse's conduct in the face of it.

Excerpt 5: Dealing with Deviation from a Medical Protocol

DRS is also used in non-routine episodes in administering medical treatment. Here we analyze a case where a nurse deviated from routine medical protocol. It features the use of DRS in quoting an authority to legitimize the nurse's actions (see also Excerpt 2), as well as self-quotes and reported thought to display the rationality of her actions. In Excerpt 5, the nurse (Ann) is explaining the situation to a colleague in a long narrative:

Excerpt 5

- 7 ANN j'arrivais pas à lui prendre les tensions,
I couldn't take her pressure
- 8 elle était dans les chaussettes
it was rock bottom
- 9 le pouls j'arrivais pas à le prendre. .h j'ai mis un sacré moment
the pulse I couldn't measure it took me a long time
- 10 pou:r euh arriver à prendre une tension et un pouls.
to manage to measure the pressure and a pulse
- 11 (0.2).h elle était pas symptomatique pourtant, et puis euh
she was not symptomatic though and
- 12 elle urine pas quoi. (0.2).h (alors on a appelé:, euh: elle nous a
she's not urinating so we called she made us
- 13 fait augmenter la perf= >ce qui était un peu bizarre,<
increase the perfusion which was a little weird
- 14 =elle a: doublé les les doses. (0.3) .h et puis euh:
she doubled the doses and
- 15 moi j'avais pas donné euh tout le traitement cardiaque
me I hadn't given uh all the cardiac treatment

- 16 ce matin, parce que je me suis dit euh *° **je vais la faire**
this morning because I told myself I'm gonna
- 17 **euh * crever**°. .h donc j'ai pas fait l'oedemex, j'ai rien faire
kill her so I didn't do the oedemex I did nothing
- 18 les comprimés, rien. ET euh ils (m')ont mis en suspens à la
the pills nothing and they postponed at the
- 19 visite. on m'a juste donné les prises, tout le reste ils ont mis
visit. I was only given the blood tests all the rest they
- 20 en suspens, et l'oedemex IV ils ont mis en pause aussi.
postponed and the oedemex IV they stopped it too
- 21 .h après: euh quand je l'ai: **dit**
afterwards when I told her
- 22 que: de venir voir la dame, euh **Daniel** a mis la dopamine,
that to come and see the lady, Daniel put the dopamine
- 23 =alors j'ai **mīs** (0.3).h +elle a (0.2) **quarante mille microgrammes**
so I put she has forty thousand micrograms
- 24 de dopamine sur vingt-quatre heures ((pronounced distinctly)),
of dopamine over twenty-four hours
- 25 .h donc j'ai dilué selon le protocole
so I diluted according to the protocol
- 26 >donc niveau glucose 5 pourcents<= j'ai **bien** posé la question
so glucose 5 percent I made sure to ask
- 27 à: (0.2) **Daniel** .h **la dame est diabétique est-ce que tu veux**
Daniel the lady is diabetic do you really want
- 28 **vraiment que je mette le glucose 5 pourcents,**
me to put the glucose at 5 percent
- 29 =il m'a dit **oui**. (0.2) donc je suis couverte à ce niveau-là?
he told me yes so I'm covered at that level
- 30 ça coule à 10 millilitres **heure**.
it's flowing at 10 milliliters per hour

Ann is narrating the case of a seriously ill patient, whose blood pressure and pulse were low. The first case we examine is an instance of reported thought in lines 16 and 17. Preceding it, several aspects of the patient's condition are reported as being unusual—notably, not urinating (line 12), the fact that a physician was summoned (line 12), and that she administered a procedure qualified as *weird* by Ann (line 13). Then Ann reports that her earlier action deviated from a prescribed treatment: “I hadn't given uh all the cardiac treatment this morning” (lines 15–16). The subsequent segment of reported thought, “I told myself I'm gonna kill her,” is presented as an account for that action, introduced by *because* (line 16). It provides a rationalization of her not administering the

cardiac treatment as being based on an assessment of its possible consequences—namely, the patient’s death. Her projection of the patient’s death is most likely a hyperbolic statement, which makes her reported thought all the more dramatic, thereby underscoring the key nature of her insight. Ann’s deviation from orders is, thus, presented as having been based on a rational decision-making process. At the same time, the DRS provides the justification for actions that are recounted subsequently (lines 17–18) and presented as consequences of that rationalization, introduced by *so* (“so I didn’t do the oedemex I did nothing the pills nothing”). As it turns out, Ann’s decision was vindicated by the doctors’ subsequent suspension of treatments (lines 18–20).

The second case of DRS (lines 27–29) is a piece of reported dialogue between Ann and Daniel (the same senior colleague as in Excerpt 1). It occurs in a context where accuracy is a high-stake issue—and where the transmission of precise information from Ann to her colleague is crucial. Ann recounts her administering of a precise quantity of medicine to the patient. What is oriented to as unusual by Ann is the fact that the patient gets glucose, although she is diabetic; this, in turn, implies that the treatment of a diabetic patient makes relevant a non-standard medical protocol. Ann first exposes technical information about the patient’s medicine as administered by Daniel (lines 23–24). She then presents that information as a basis (using *so* in line 23) for her own administration of a 5% glucose solution to the patient, which she claims to have diluted “according to the protocol” (line 25). Subsequently, she backs up the appropriateness of her action by letting her colleague “witness” a purported dialogue with Daniel that demonstrates how Ann had double-checked her decision by quoting her question to him (lines 27–28): “the lady is diabetic do you really want me to put the glucose at 5 percent?” Significantly, with “do you really want,” Ann demonstrates her awareness that such a dose is unusual for a diabetic patient. At the same time, she establishes Daniel as an expert and, hence, as the warrant for the legitimacy of her action: His reported “yes” (line 29) is presented as legitimizing the administration of that dose. The legitimizing function of DRS is made explicit by Ann’s subsequent meta-comment, “so I’m covered at that level.”

Excerpt 5 corroborates our previous observations. As part of a reported dialogue, DRS not only stresses the authentic character of the exchange, but allows the display of professionally appropriate conduct, staging the teller as a team member who asks relevant questions or brings up doubts based on analysis of the technical parameters at hand (Excerpts 2 and 5) or as a caregiver who deals with a patient in an understanding and empathic way (Excerpts 3 and 4).

In addition, Excerpt 5 also illustrates the use of direct reported thought. By publicly demonstrating how actions are based on rational thought, nurses respond to the specific institutional need for displaying expertise and accounting for their own actions as being professional. Our data do not allow us to check whether the DRS has actually been produced or not. However, this might not be relevant

in the first place. What is analytically relevant, however, is that talk addressed to oneself is selected to depict “thoughts appropriate to some situation and/or Membership Category” (Jefferson, 2004a, p. 136). Thereby, an institutionally relevant thinking-in-action gets depicted that functions as a display of the speaker’s mastery of the professional code of conduct, offered for collective recognition and ratification. By the same token, a particular professional culture is being enacted, as well as the speaker’s and the addressee’s belonging to it.

DISCUSSION

This study explored the use of DRS in conversational stories during handover in two nursing care units. We used quantitative content analysis to show what sources are typically quoted, as well as what kinds of content are brought up immediately preceding DRS. We used qualitative conversation analysis to document how DRS is sequentially embedded in stories, as well as what kind of purpose it accomplishes for participants. Our study contributes to the extant scientific literature on DRS and sheds light on how DRS is used in workplace storytellings.

Our findings converge with others showing that DRS in conversational stories has the effect of augmenting the authenticity of the elements being reported (Holt, 1996, 2000), by depicting rather than describing (Clark & Gerrig, 1990) selected aspects of speech produced earlier, thereby simulating direct access to the reported events. Our findings also converge with earlier work showing how the functioning of DRS is closely related to its local sequential environment and minutely coordinated with multimodal resources, such as the use of gaze, gesture, and body movement.

Our study also offers several new insights as to the use of DRS in an institutional setting. The most immediately recognizable way in which institutional order is apparent in the use of DRS is through the limited range of sources quoted, as well as systematic differences between the care units in this respect (see Figure 1). Microanalysis of selected excerpts revealed, in turn, that quoting different sources appears to accomplish different kinds of purposes.

Self-quotes and reported thought seem to account for the speaker’s professional rationality. They typically embody public displays of professional conduct and decision making in action, warranting peer recognition of the well-foundedness of the nurse’s analysis and conduct in non-routine situations. This is done, for instance, by indexing the technical phenomena on which an analysis is founded (Excerpts 2 and 5) or by depicting the nurses’ patience when dealing with patients (Excerpts 3 and 4). Self-quotes and reported thought allow direct access to decision-making processes and ways of dealing with (technically) complex tasks, similar to the “war stories” reported by Orr (1996).

Direct quotes of other nurses (and possibly of doctors) seem to be used as public displays of the legitimacy of one's own actions or decisions. In Excerpts 2 and 5, they occur when the nurse recounts non-routine actions that deviate from official protocol, but that are presented as being called for by the special circumstances reported, and as being in accordance with a colleague's assessment of that situation. Thereby, legitimacy of one's actions and sharing of responsibilities is enacted, as well as working in a team.

Direct quotes of patients, by contrast, are instrumental in complaint stories and can be powerful instruments for conveying potential blame about the person being quoted. Nurses use DRS to stage the patient's conduct as an exemplification of his or her mood; state of mind; or, more generally, character (another example of this can be seen in Excerpt 1, where DRS [line 8] is directly followed by an interpretation of a patient's attitude as expressing resistance to change [line 9]). By means of DRS, personal assessments can be implicitly conveyed in a way that is compatible with the shared professional code of conduct. Therefore, DRS of patients' talk allows nurses to compromise between a work ethic that calls for neutrality with regard to the patient and the need to share difficult, non-routine patient situations with other nurses. DRS constitutes an institutionally relevant technique in a professional context where a clear distinction between facts and their interpretation is a consequential issue.

The differential functioning of DRS described earlier is inscribed in some of its design features. For example, mimicry of voice tone in quotes of patients more vividly depicts their attitude, whereas mimicry of actions using gestures in self-quotes rather serves to enact physical aspects of a situation; and, the absence of mimicry in quotes of other nurses indexes a stance of neutrality and matter-of-factness with which their talk is being reported.

That DRS may have different functions depending on the source quoted points to another aspect of our findings—namely, how DRS indexes membership categories. DRS is *selected* speech. It is chosen to be reported as appropriate to a particular membership category, in two ways. It displays both the narrator's enactment of a membership category (e.g., as a nurse) and his or her orientation to the membership category of the addressee (e.g., co-members of the category of nurses). At the same time, depictions of patient's character and behavior also index shared expectations about what does and does not constitute normatively acceptable behavior of members of the category of "patients." Thus, DRS participates in what we might call *membership-bound tellings* (for membership-bound activities, see Sacks, 1972b). As such, they are a way for nurses to accomplish the category "nurse"—and even "good nurse"—through talk-in-interaction, without overtly stating their membership in that category (Schegloff, 2007).

Possibly the most interesting implication of this analysis is an account of how DRS is involved in recounting non-routine events (i.e., events that, in our case, go

against the normative expectations of the nurses' community of practice). That DRS indexes membership categories and their associated knowledge suggests that such knowledge is an important part of how people make sense of non-routine happenings. Indeed, part of the construction of such events as non-routine and newsworthy happens through the use of DRS, which allows a contrast with unspoken but shared expectations of what constitutes the norm, the routine. The experiential realism enabled by DRS and enactments may facilitate the collective sense-making that has been identified as a key element of well-functioning teams.

CONCLUSION

Storytelling is a recurrent practice of nurses accomplishing their everyday professional business in handovers. It is instrumental in the social sharing of knowledge and experience and in the updating of collective minds among care unit members. In DRS, we observe nurses "doing being professional"—that is, displaying the rationality and professionalism of their conduct and sharing it with others. This is a central part of the continual creation and consolidation of the nurses' community of practice. DRS is particularly instrumental as a device for constructing story events as non-routine and newsworthy by appealing to membership category knowledge, like shared patterns of reasoning or shared expectations about appropriate conduct.

Finally, from an organizational perspective, our analysis of DRS in handover storytelling opens an interesting window on what is at stake in these meetings. They are not only a standardized communicative routine for transmitting medical or technical information in a narrow sense. They are also a place for sense-making processes where the collective sharing and reconstruction of professional culture is materialized through stories (Orr, 1996). These stories are crucial in the transmission and conservation of the experiential dimension of the nursing profession; and, the use of DRS is instrumental precisely in enacting that experiential dimension.

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APPENDIX

Transcription Conventions

[]	onset and offset of overlap
=	intra- and inter-turn latching
&	turn continuation after overlap
(.) (..) (...)	unmeasured (micro-) pauses up to 1 s
(1.5)	measured pauses, in seconds
coul-	cut-off
ti:me	lengthening of preceding sound
tirer?	rising intonation
ordinateur.	falling intonation
j'achète,	continuing intonation
vraiment	stress
NON	loud voice
°ça fait tout°	soft voice
>et ça ça<	faster
<tout ça coûte>	slower
(du;de)	dubious hearing
(xx)	unintelligible stretch of talk

Gaze, posture, and gesture are annotated in a separate line in < > brackets. Direct reported speech utterances are annotated in bold.