

Ethnomethodological studies of nurse-patient and nurse-relative interactions: A scoping review

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A B S T R A C T

Keywords:

Nurse-patient relationship
Conversation analysis
Ethnomethodology
Review

Objectives: Researchers in nursing science interested in the study of nurse-patient and nurse-relative interactions have displayed an ever increasing interest in ethnomethodology and conversation analysis. This review assesses the scope of this literature. We categorize the papers in thematic categories determined both inductively and deductively and synthesize the main findings of this literature within category. Finally we discuss the interactional determinants of the lack patient participation, the limitations of the field, and focus on implications.

Design: A scoping review on nurse-patient and nurse-relative interactions.

Data sources: Forty articles focusing on nurse-patient interactions and nurse-relative interactions. All the articles relied on ethnomethodology and/or conversation analysis.

Review methods: A literature search has been carried out on Medline (all articles until June 2016; keywords were: nurs*.ab. and "conversation analysis"; nurs*.ab. and ethnomethodology). A similar search was performed on other platforms. The scope of the literature was identified by inductively and deductively analyzing the themes of the relevant articles.

Results: Six thematic categories emerged: Organization of nurse-patient interaction (eleven articles); Organization of mediated nurse-patient interaction (seven articles); Information, explanation and advice (eight articles); Negotiation and influence asymmetry (six articles); Managing emotions in critical illness (two articles); and Interacting with patients presenting reduced interactional competences (six articles).

Conclusions: Across most thematic categories it appeared that patient participation is far from ideal as interactional asymmetry was most observed in favor of nurses. When the encounters occurred at the patients' homes this pattern was reversed. Computer-mediated interactions were often reported as non-optimal as the standardized process constrained communication and delayed patients' presentation of their ailments. Micro-analyses of interaction present a clear potential for the development of guidelines for nurse-patient interactions. Implications for practice are described.

What is already known about the topic?

- Lack of patient participation in nurse-patient encounters leads to delayed care.
- Studies in nurse-patient interactions have indicated a lack of user-centered design in computer tools.

What this paper adds

- Nurse-patient interactions are asymmetrical over multiple institutional settings.
- Nurses exert more control over interactions, which limits patient participation.

- Interactions in home visits feature more balanced distribution of contributions between beneficiaries and nurses, i.e., social context affects how roles are instantiated.
- Computer-assisted communication tools should meet the needs of interacting parties in nurse-patient encounters.

Nurses' interactions with patients and patients' relatives are pervasive and essential in clinical settings (e.g., Fleischer et al., 2009; McCabe, 2004). These relationships have been studied for decades (e.g., Aguilera, 1967) under a variety of theoretical and methodological frameworks (Fleischer et al., 2009). While most studies have grounded their findings in quantitative aspects (e.g., quantification of observed actions, interviewees' statements or archived material; e.g., Hertzberg and Ekman, 2000; Sharac et al., 2010), some studies have relied upon hermeneutic approaches or other qualitative approaches (e.g., McCabe, 2004). Most literature

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on nurse-patient interactions has lacked proper investigation of patients' contributions to these encounters (Jarrett and Payne, 1995). And prior to 1990, most of this research program failed to examine the (re)production of social order through nurse-patient interactions (i.e., an interest in what is interpersonally accomplished; Bowers, 1992a). Therefore, the need to rely on ethnomethodology and conversation analysis to study nurse-patient interactions has been suggested by several authors (e.g., Bowers, 1992a; Dowling, 2007; Jones, 2003).

In this review, we examine the contribution of ethnomethodology and conversation analysis to the nurse-patient and nurse-relative literature. What are the thematic categories of research questions in this literature? What are the main findings, particularly with regards to patient participation and interactional asymmetry? What is missing in the literature? We provide answers to these questions after briefly introducing the theoretical and epistemological grounding of ethnomethodology and conversation analysis.

1. Ethnomethodology and conversation analysis

The study of interactions involving nurses is closely related to ethnomethodology and conversation analysis. Ethnomethodology aims to study the ways people coordinate and make sense of their everyday activities (Drew and Heritage, 1992; Hester and Francis, 2007; Ten Have, 2004). Ethnomethodology has produced significant knowledge about how people interact in clinical settings (e.g., Heath, 1986; Mondada, 2014). The approach is to carefully examine interactions, most of the time between people, but also with technology (e.g., Suchman, 1987). Conversation analysis emerged from ethnomethodology and focuses on the way people negotiate the social order in natural and institutional interactions (Goodwin and Heritage, 1990). Among the differences between the two traditions, it can be noted that ethnomethodologists do not require any specific method for the documentation of interactions (Garfinkel, 2002), whereas conversation analysts require naturally occurring data, such as recordings of conversations (Goodwin and Heritage, 1990). Another distinction is that conversation analysis has no interest in the motives of the participants (although accounts can be investigated), and takes an interest only in what occurs in the recorded interactions (Schegloff, 1987).

Regularities are present in the routines people use to understand and enact those understandings (Garfinkel, 1967) and in the context in which they are embedded (Drew and Heritage, 1992). The aim of ethnomethodology is to describe these routines. From this perspective, people's motives and understanding are constantly accounted for by their actions or words (Attewell, 1974). The social order is (re)produced at the level of the interaction by the co-participants (Hester and Francis, 2007). In other words, the meaning of a situation is never given, but always recursively co-constructed and negotiated by members of a community as a part of their process of understanding and acting in situation (Attewell, 1974; Zimmerman and Pollner, 1970). Any social situation can hence be described accurately by the inspection of routines – through visible and audible conduct, without a need for higher order theories. The ethnomethodologist can study the way members organize their actions by the observation of these practices (Adler et al., 1987). Ethnomethodology can also take into consideration the motives of the individuals, and insists on the importance of knowledge of their social context (Garfinkel, 1967). A concomitant weakness of ethnomethodology is that it deals with observations of actions that are necessarily indexical, i.e., related to the knowledge of the participants prior to the examined situation, which implies a requirement for context on the part of the observer (Garfinkel, 1967). This often leads to extensive fieldwork.

By repeated and 'unmotivated' (Sacks, 1984, p. 27) scrutiny of fragments of interaction, conversation analysis deals with the way participants structure the interaction in an orderly manner, according to the socially constructed rules they orient to (Schegloff and Sacks, 1973). The aim is to reveal these rules in everyday and institutional conversations from the scrutiny of multiple interactions (Sacks, 1984) and sometimes single cases (Schegloff, 1987). Interactional routines are often standardized, which makes frequently occurring types of interactions predictable (e.g., Coulmas, 1981). Conversation analysis aims at the discovery of regularities in talk-in-interaction through the exploration of the natural and sequential unfolding of events as they occur in everyday encounters. From an early interest in casual conversation (Sacks et al., 1974), conversation analysis has evolved to a method allowing the study of all kinds of institutional interactions with an interest in the way people routinely accomplish work-related activities collaboratively through conversation (for a review, see Drew and Heritage, 1992), including the study of clinical interactions (e.g., Maynard and Heritage, 2005).

Some approaches in conversational analysis have adopted a multimodal perspective to the study of naturally occurring interaction (e.g., Goodwin, 1994; Mondada, 2007). Human coordination relies not only on speech but also on bodily actions, posture, and prosody. Multimodal analysis is a subfield of conversation analysis that takes into account not only speech but also bodily conduct and their interplay (e.g., Goodwin, 2000). The importance of studying multimodal aspects in professional settings has been repeatedly shown in the literature (e.g., Heath, 1986; Maynard and Heritage, 2005; Goodwin, 1994; Mondada, 2007; Streek and Kallmeyer, 2001). However, this has been less frequent in the study of nursing (e.g., see González-Martínez et al., 2016; Mayor and Bangerter, 2015).

2. Nurse-beneficiary interactions

Interactions between nurses and beneficiaries (patients and relatives) have been studied for decades. In their thorough review, Fleischer et al. (2009) note that nurse-patient interactions are defined as mutual and intersubjective, and stress the importance of:

- patient participation,
- nurses' display of empathy, and
- the promotion of patients' competences.

We refer the reader to the aforementioned article for an excellent overview of the field, and focus on the contribution of ethnomethodology and conversation analysis.

The goals of our study are presented below.

- a) Our principal aim is to examine the main themes that are found in the international literature on nurse-patient and nurse-relative interactions relying on ethnomethodology and conversation analysis as methods.
- b) In the discussion, we aim to examine the extent to which the criteria mentioned above (Fleischer et al., 2009) are discussed in the literature on nurse-patient and nurse-relative interaction, and how well the criteria are attained in practice through the lens of the studies we review.
- c) We also aim at commenting on the limitations of the field (limitations in scope, sample size, diversity of methodological and analytic choices, regions where the data was collected), and describe implications for practice.

The type of study which best allows to meet these goals is the scoping review. Contrary to a systematic review, a scoping review

reports on publications featuring a wide range of study objects and designs (Arksey and O'Malley, 2005). Rather than examining the robustness of results of studies relating to specific research questions, scoping reviews can aim to explore multiple aspects of a specific field: "(...) examine the extent, range and nature of research activity (...), determine the value of undertaking a full systematic review (...), summarize and disseminate research findings (...), [or] identify research gaps in the existing literature" (Arksey and O'Malley, 2005, p. 21).

2.1. Method

Publications were identified by searching through a) electronic databases, b) the reference lists of the articles identified in electronic databases, and c) the articles citing the articles identified in electronic databases. We decided not to be specific in the search in order to avoid the potential risk of missing relevant articles.

Irrelevant articles were of course excluded at a later step, based on reading of titles and abstracts. The exclusion criteria are indicated on Fig. 1 which presents the overall process of identification of relevant publications.

2.1.1. Electronic databases

In June 2016, we performed a systematic and inclusive search of the literature on Medline, in a way similar to Jones (2003). Our search included the following terms:

- nurs*.ab. and "conversation analysis".af (41 records found)
- nurs*.ab. and ethnomethodology .af (13 records found)

We searched for *nurs* on the Ethnomethodology and Conversation analysis bibliography database (35 records found; http://emcawiki.net/EMCA_bibliography_database).

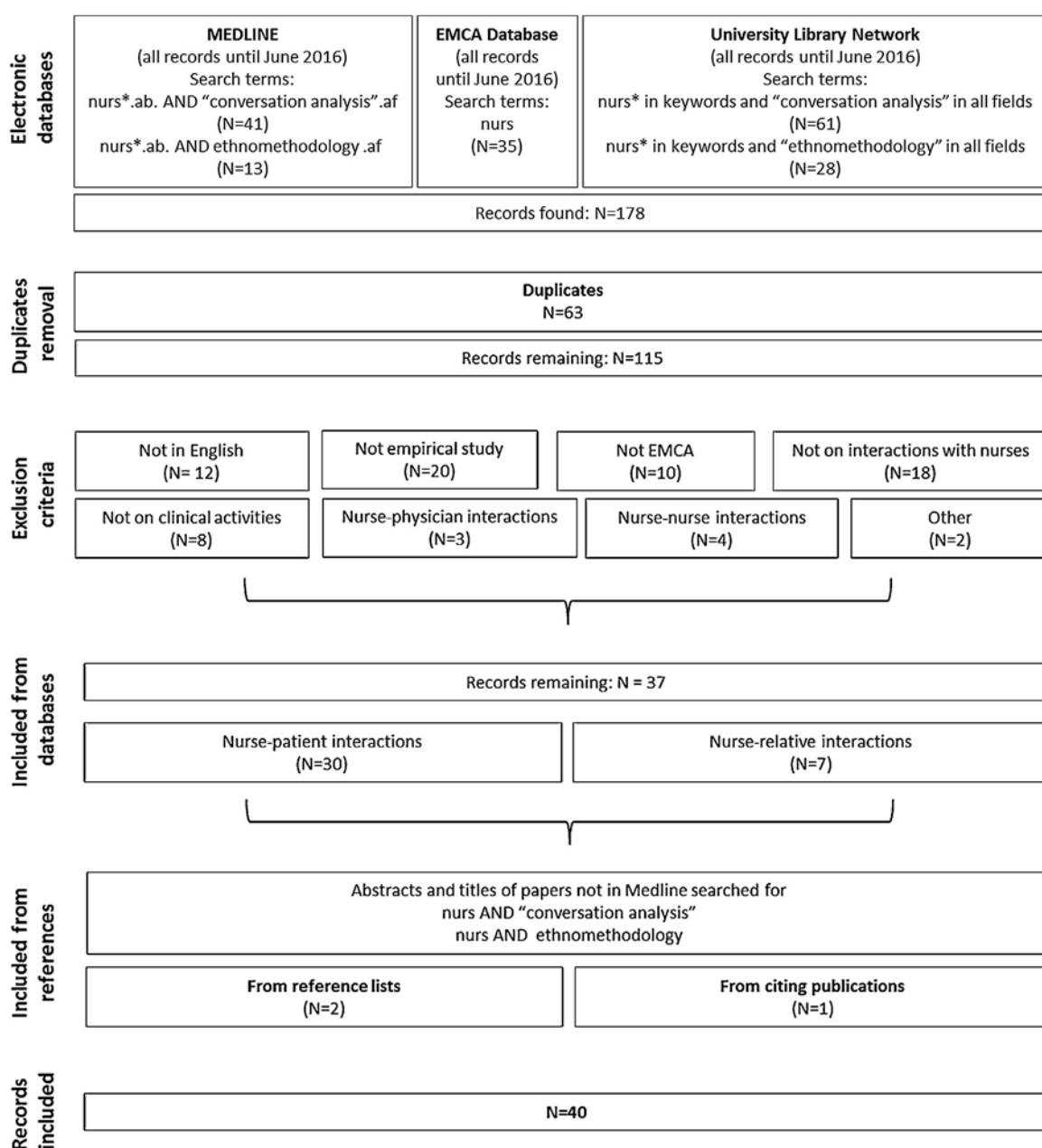


Fig. 1. Identification, exclusion and inclusion of studies.

Table 1
Descriptive information for the included studies.

Cat.	Focus	Country	Setting	Foundation	Interactions	Data	Linguistic resources	Non-linguistic resources	Tools	Main findings
1	Encounters between community psychiatric nurses and patients' relatives at their homes (Adams, 2001a)	UK	Home visits (psychiatry)	CA; DA	N-R: 48	A	S			Less interactionally asymmetric interactions between nurses and patients might help in creating bonds and promoting trust between the participants.
1	Conversational misalignments (Chatwin, 2008)	UK	Primary care	CA	N-P: 1	AV	S + P			Conversational misalignment can lead to delayed treatment.
1	Divulgence of symptom changes in COPD (Chatwin et al., 2014)	England	General practice	CA	N-P: 23 Ph-P: 16	(unspecified)	S + P			How nurses and physicians conduct the interview has potential clinical impacts in the consultation.
1	Patient admission (Jones, 2007)	UK	Medicine, surgery, neurology, cardiology	CA, EGR	N-P: 27	A + FN + AD	S + Wr + FN		Clinical records	Nurses' admission practices do not allow patients to initiate topics.
1	Patient discharge (Riva et al., 2014)	Switzerland	Rehabilitation	CA	N-P: 12	AV	S + P	G + Nod		Reciprocal interaction style from nurses enhances patient participation.
1	Patient and nurse participation in five identified phases of annual check-ups of Type 2 diabetes patients (Edwall et al., 2009)	Sweden	Diabetes clinics	CA	N-P: 20	AV	S + P	BM + Nod + Tou		Presents ways in which nurses can structure the physical examination that can lead discussions that allow patients to express their feelings and beliefs. The examinations promotes patients' understanding of diabetes.
1	Interactions during child immunizations (Plumridge et al., 2009)	New Zealand	General practice	CA	N-R-P: 10	AV	S + P	G + BM		Nurses and parents rarely verbally interact during immunization and rather address the child. Nurses might rely on baby talk to enrol mothers in helping the immunization.
1	Participation frames in interaction between nurses and taciturn patients (Kettunen et al., 2001, 2002a)	Finland	Anesthesia, surgery, gynecology, out-patient, physiotherapy, internal medicine	CA	N-P: 18	AV	S + P + Wr + L	Nod	Paperwork	Four different participation frames are linked with taciturnity patients: i) in the hands of professional frame; ii) compliant frame; iii) guilty frame; and iv) polite frame.
1	Progression of parent's expertise in their child's disease made explicit in interaction (Niedel et al., 2013)	UK, US	Diabetes consultations	CA	H-P: 55	A	S + P			Parents develop an expertise of their child's diabetes that is manifested in the organization of nurse-patient interactions. As time unfolds, they become attentive to two types of symptoms: symptoms of normal children, and symptoms that might be related to the worsening of their child's condition.
1	Conversational practices when talking about death (Wilainuch, 2013)	Thailand	District hospital, public health center, patient home	CA; EGR	N-P: 40 N-R: N/A	AV	S	G + Nod + BM		Nurses initiate discussions about death to inform and provide emotional support.
2	Helpline call openings (Leydon et al., 2013)	UK	Cancer helpline	CA	N-P: 52	A	S + P			Helpline calls are vastly led by the nurses. Authors provide a script for efficient call openings.
2	Interpreter mediated interaction (Estrada et al., 2015)	USA	Clinics	CA	N-L-P: 3	A + S	S + P + L			Interpreter mediated conversation can hinder or facilitate interaction. Interpreters can help in recognizing and solving miscommunication issue. But patients can misconstrue breaks in the interpreter's speech as turn completion points, which affects the unfolding of the interaction. Conversational strategies for meetings involving interpreters are provided.
2	Patient participation (Jones, 2009)	UK	Acute hospital sites	CA	N-P: 27	A + FN + D	S + P + Wr + Typ			Nurses' use of assessment documents as a way to organize the interview leads to low patient participation.
2	Computer-assisted telephone triage (Murdoch et al., 2015)	England	General practice	CA	N-P: 22	AV	S + P + L		Computer logs	Computer decision-support software leads to increased misalignments in conversation and reduced comprehension of patients' care needs.
2	Computer- and artefact-mediated nurse-patient	UK	Primary care	CA; TA	H-P: 50	AV	S + P + Typ	G		Computer check-lists structure the topics discussed and their order in consultations. This limits the

Table 1 (Continued)

Cat.	Focus	Country	Setting	Foundation	Interactions	Data	Linguistic resources	Non-linguistic resources	Tools	Main findings
	interactions in routine diabetes consultations (Rhodes et al., 2006)									possibilities for patients' interactional involvement in the encounters.
2	Constrains of electronic medical records in interactions about diabetes (Rhodes et al., 2008)	UK	General practice	CA	N-P: 18	AV	S + P + Typ	G + BM + Nod	Electronic medical records	Nurses look at the computer screen to disengage from the interactions. Patients participate more when nurses' gaze towards them.
2	Nurses' medical advice in nurse-parent phone conversations about child health (Butler et al., 2009)	Australia	Child health line	CA	N-P: 700	A	S + P		Electronic medical records	Although nurses acknowledge parents' accountability for the management of their children, they display their professional authority backed up by medical knowledge.
3	Explanations in consultations (Collins, 2005)	UK	Primary care diabetes consultations	CA	H-P: 38	AV	S + P			Nurses and physicians have distinct communication patterns. Both patterns perform useful actions. There are practical implications to combining nurses led and physician led consultations.
3	Role of 'what about' questions in self-management groups (Fasulo et al., 2016)	England	Self-management meetings	CA	Sessions: 24 (Nurse-led, 2 to 7 patients) N-P: 38	AV	S + P + Wr	Nod + BM + FE + MG		What about' questions are used by patients in groups as a device for selecting nurse as next speaker and obtain information.
3	The delivery and reception of advice in health counselling sessions (Poskiparta et al., 2001)	Finland	Health counselling sessions	CA	N-P: 38	AV	S + P	G + BM + Nod + MG + Sm	Guidebooks	Nurses alternate between patient-centred and nurse-centred communicative strategies. Such communicative strategies depend on nurses' goals in their interactions with patients.
3	The social construction of risk in nurses and psychiatric patients' relatives interaction (Adams, 2001b)	UK	Domiciliary meetings	CA; DA	N-P: 24	A	S			There are four stages in the social construction of risk during consultations: i) fishing stage; ii) identification stage; iii) risk assessment stage; and iv) risk management stage manage.
3	Nurse-parent interactions about child immunization (Plumridge et al., 2008)	New Zealand	Primary care practices	CA	N-R-P: 10	AV	S + P	BM		Parents accept and value nurses' medical knowledge and institutional role but often deny nurses any knowledge about their child.
3	Organization of the interaction between patients' relatives and health care workers with regards to shared information (May et al., 2001)	England	Rehabilitation	CA, EMG	H-R: 30	AV	S + P	G + Nod + BM + Point	Patients' notes	Even though health care workers remain in control of the interactions, relatives can present themselves in a way that minimizes knowledge asymmetry in interaction.
3	Questions and advice in health counselling sessions. (Poskiparta et al., 2000)	Finland	Health counselling sessions	CA	N-P: 38 groups	AV	S + P	G + Nod + BM + MG		Patient participation is enhanced by reciprocal counselling (e.g., recourse to future oriented and feeling oriented questions by nurses, and advice seeking questions by patients). Non-reciprocal counselling (e.g., the nurses provides standardized information) reduces patient participation. Health counselling sessions are generally characterized by both reciprocal and non-reciprocal counselling.
3	Empowering communication in health counselling sessions (Kettunen et al., 2003)	Finland	Health counselling sessions	CA	N-P: 38 groups	AV	S + P	G + Nod + L	Documents	Patient participation is facilitated by nurses' use of affective questions, tentative speech and continuers.
4	Chronic self-care management (Carr et al., 2014)	UK & Australia	Primary care	EMG	(3 focus groups: 10-15 participants each, 21 nurses in total; 36 interviews: including 5 nurses) H-P: 11	FG, I AV	S			Influence of client-centred models of care. Identification of facilitating factors and obstacles to self-management.
4	Motivational interview for smoking cessation (Codern-Bové et al., 2014)	Spain	Primary health care	CA, CoA	H-P: 11	AV	S			Identification of strategies that can improve patient engagement with smoking cessation. Most interviews didn't follow guidelines.
4		Finland		CA	N-P: 38	AV	S + P	G		

4	Power asymmetry in health counselling sessions (Kettunen et al., 2002b)	Health counselling practice	CA	H-P: 6	AV	S + P	G + BM	Documents	Power is actively negotiated in nurse-patient interactions. Nurses show their expertise while patients make use of their rights to interrupt, request clarifications, etc. Patients do not have much influence in goal setting. Nurses deploy much interactional effort in order to show that the proposed course of action is non-debatable. Nurses work with the patient to identify areas of life that can be improved. Most of the negotiation process is controlled by nurses. Patients are in interactional control when the interactions take place at their home, except for clearly medical matters. There is an interplay of nurses' and patients' contributions. Nurses rely upon interactional strategies to render bad news less threatening.
4	Interactional work during goal setting (Barnard et al., 2010)	Neurological rehabilitation	CA	N-P: 73	AV	S + P + L	G + BM + Nod + Sm	Documents	Participants use humour to accomplish interactional goals. Humour is collaboratively constructed. Use of humour by participants does not vary across occasions. Nurses focus conversation on nursing tasks when conversing with patients with communication disability. The interaction is highly asymmetrical (controlled by nurses). Nurses play a pivotal role in their assessment of patients' needs and the way they present patients with alternatives that fit their limitations. Nurses address requests of 'lucid' patients more readily. They try to display positive emotions in any circumstance, as ways to achieve interactional goals.
4	Negotiation in lifetime counselling (Karhila et al., 2003)	Primary health care	CA	N-P: 126	AV	S + P + L	G + Nod + BM + Sm	Documents	Nurses lack emotional availability to listen to end-of-life patients. They accompany the patients by providing high quality care and an environment as comfortable as possible. Nurses determine patients' level of consciousness from how they react to summons and requests. They adapt their interactional efforts to this assessment. When patients are unresponsive, the interactional order can still be maintained through conversations that mimic the usual conversational routines.
4	Interactions between psychiatric nurses and patients at their home (Bowers, 1992b)	Home visits	EMG	N/A	A	S			
5	Management of optimism in cancer care (Jarrett and Payne, 2000)	Radiotherapy and/or chemotherapy	EMG	N-P: 9/26 interviews with patients, 22 interviews with nurses, 2 interviews with relatives)	A	S			
5	Frequency of humour and its use (Mallett & A'hern, 1996)	Haemodialysis	CA, EMG	N-P: 126	AV	S + P + L	G + Nod + BM + Sm		
6	Interaction with communication disability (Gordon et al., 2009)	Stroke rehabilitation	CA	N-P: 5	AV + FN	S + P	G + BM + To		
6	Interactions with older people and their autonomy (McCormack, 2001)	Primary care	CA	N-P: 14	A	S + P + L			
6	Interactions with patients in palliative care (Li and Arbet, 2006)	Palliative care	CA, DA	8 team meetings, shift handovers (fieldwork only)	A + FN				
6	Accompanying and relating to patients in end-of life care (Haraldsdottir, 2011)	In-patient ward	EMG		FN				
6	Interactions with post-anaesthetic patients (Mallett, 1990)	Recovery unit	CA	N-P: 13	AV	S + P + So	G + BM		
6	Maintaining the social order in palliative care (Kelly, 1998)	Palliative care	CA, EMG	N/A	A	S			

Note: 1 = Organization of nurse-patient interaction, 2 = Organization of mediated nurse-patient interaction, 3 = Information, explanation and advice, 4 = Negotiation and influence asymmetry, 5 = Managing emotions in critical illness, 6 = Interacting with patients with reduced interactional competences. CA: Conversation analysis; CoA: Content analysis; DA: Discourse analysis; EGR: Ethnography; EMG: Ethnomethodology; FA: Thematic analysis; N-P: Nurse-Patient; N-R: Nurse-Relative; N-R-P: Nurse-Relative-Patient; Ph-P: Physician-Patient; H-P: Health professionals-Patient; A=Audio, AV=Audio-video, FG=Focus group (audio); FN=Field notes, AD=Assessment documents, I=Interview (audio), S=Speech, P=Prosody, W=Writing, So=Typing, So=Sobbing, G=Gaze, Nod=Nodding, BM=Body movement, Fe=Facial expression, MG=manual gesture, Sm=Smile, Tou=Touching.

We also performed a literature search of all articles available through our university library network (explore.rero.ch). The search platform does not allow searching specifically in abstracts:

- nurs* in keywords and “conversation analysis” in all fields (61 records found)
- nurs* in keywords and ethnomethodology in all fields (28 records found)

In total, 115 unique records were identified. From the reading of the titles and/or abstracts, we excluded records that were not in English (e.g. Korean, Portuguese, 12 records), were not the first report of empirical studies (e.g., literature reviews, editorials, study protocols, 20 records), did not focus on interactions including nurses (18 records), did not draw on the methods of ethnomethodology and conversation analysis (10 records), or were not based on data about nurses clinical activities or did not occur in clinical settings (8 records).

Forty-six records remained. Three records were classified as Nurse-to-physician interaction, and four as Nurse-to-nurse interactions. The remaining two were classified as “Other”. These records were excluded.

Thirty records were classified as Nurse-to-patient interactions, whether or not the interactions also included a third party. Seven records were classified as Nurse-to-relative interactions.

2.1.2. Reference lists

Relevant studies might have been published in journals that are not indexed in the electronic databases we used. We therefore examined the reference lists of papers we identified. As the objects of this study are nurse-patient and nurse-relative interactions, we chose to search through the publications reporting on these interactions only. We collated the reference lists of the relevant publications. Abstracts of journal articles from the resulting list that were not indexed in Medline were collected. We searched through the titles and abstracts of these publications using the same keywords as above. Two additional relevant publications were found.

2.1.3. Citing papers

The search through reference lists can not, obviously, inform on studies published after the papers we found. Therefore, we collected the references of the publications that cited the publications identified through electronic databases in order to identify potential additional studies. Abstracts of journal articles from the resulting list that were not indexed in Medline were collected. After a search through the titles and abstracts of these publications (same keywords as above), one more relevant publication was found.

2.1.4. Thematic analysis

We performed a thematic analysis of the included studies both deductively and inductively (see Vaismoradi et al., 2013). We paid particular attention to three potential themes of which the importance was stressed in the literature on nurse-patient relationships (e.g., Fleischer et al., 2009), as we mentioned above: the importance of patient participation in clinical situations, the importance of nurse’s display of empathy and the promotion of patients’ competences. As conversation analysis is primarily interested in the (re)production of social order at the level of the interaction, it is a privileged method for investigating these three potential themes (of which only the first is thoroughly discussed in the literature, as we will see). We also expected mediated communication to be an important theme in these publications, from previous research we carried out in clinical settings, and other settings as well (e.g., Bangerter et al., 2011; Bietti and Galiana-

Castelló, 2013; Bietti et al., 2016; Mayor et al., 2012; Mayor and Bangerter, 2015, 2016). We decided not to focus only on these aspects in preparing this review as the complementarity of deductive and inductive approaches leads to an enrichment of the understanding of the studied object (e.g., Vaismoradi et al., 2013). In other words, we were open to emerging themes.

We conducted the thematic analysis as described below:

- a) We prepared summaries of each publication. These are provided as Supplementary material, and a reduced version of the summaries is presented in Table 1.
- b) We made annotations of these summaries.
- c) We classified the summaries into thematic categories. This process was carried out iteratively until we were satisfied with the thematic categorization.
- d) We wrote a synthetic review for each category (see results section) along with a synthetic review of the field (see the discussion).

2.1.5. Coding of the studies

We were additionally interested in describing and commenting upon various characteristics of the studies (see the limitations subsection in the discussion). We took note of the following in Table 1 (also see our comments in the discussion section):

- the thematic category applied to the study
- the topic and the authors
- the year of publication
- the country of data collection
- the setting of data collection
- the methodological foundations
- the sample size (number of interactions)
- the type of data
- the reported linguistic resources
- the reported non-linguistic resources
- the reported tools used by participants
- the main findings

3. Results

The thematic categories of the papers that resulted from our analysis were: 1- Organization of nurse-patient interaction; 2- Organization of mediated nurse-patient interaction; 3- Information, explanation and advice; 4- Negotiation and influence asymmetry; 5- Managing emotions in critical illness, 6- Interacting with patients presenting reduced interactional competences. The thematic category membership of each paper is provided on Table 1. For each of the thematic categories, we provide a synthesis of the findings below, as well as summaries of each study as Supplementary material, as part of the results. The Supplementary materials also contain a particularly illustrating data exemplar reproduced from one of the publication in each thematic category. The data exemplar is commented in a way very similar to the analysis performed by the authors when reporting on the study. We standardized the transcription conventions for the readers’ comfort.

3.1. Organization of nurse-patient interaction

Eleven papers were categorized as discussing the general organization (e.g., turn-taking, topics discussed, and phases of the interaction) of nurse-patient or nurse-relative interaction. These studies particularly dealt with nurse-patient interactions. They included analyses of data taken from patient admissions (Jones,

2007) and discharge (Riva et al., 2014), check-ups (Edwall et al., 2009), child immunizations (Plumridge et al., 2009), and chronic obstructive pulmonary disease consultations (Chatwin et al., 2014). Despite the wide range of situations examined, the results reported in these studies highlight the importance and benefits of patient participation in nurse-patient interactions (Adams, 2001a) and the implications of the frequent lack thereof (Chatwin, 2008; Jones, 2007). Interactions between nurses and patients are often bureaucratic, at odds with recommendations for increased patient participation (Jones, 2007). But the structure of the consultation can increase patient participation and understanding of their conditions (Chatwin et al., 2014; Edwall et al., 2009), and that of their relatives (Plumridge et al., 2009). Embracing a reciprocal interaction style leads to increased participation of patients in consultations (e.g. Riva et al., 2014). But the initial behavior of patients is also related to their further participation and the progression of the encounter (Chatwin, 2008; Kettunen et al., 2001). When nurses participate in conversations outside a clinical setting (e.g. at the homes of relatives of psychiatric patients) their control over the interactions is limited to clinical topics only, and conversational topics not strictly related to the health care create the conditions for the strengthening of social bonds between the interacting partners (Adams, 2001a). Niedel et al. (2013) show that the development of parents' understanding of the illness (diabetes) of their child is visible in the organization of their interactions with nurses. Announcing (imminent) death to patients and relatives requires much interpersonal effort, deployed to alleviate suffering of the conversational partner (Wilainuch, 2013). These situations focus more on the recipients' feelings and less on clinical matters. Hence, conversational contexts may affect the interactional instantiation of pre-existing social roles.

3.2. Organization of mediated nurse-patient interaction

Seven papers were classified as discussing the organization of mediated (through documents, computer tools, or interpreters) nurse-patient or nurse-relative interactions. Research on mediated cases of nurse-patient interaction shows the role that other people (e.g. interpreters) and tools play in communication between nurses and patients. The topics covered by the articles ranged from phone-mediated interactions (Butler et al., 2009; Leydon et al., 2013), and the role of interpreters (Estrada et al., 2015), to the influence of medical records (Rhodes et al., 2008) and computer-assisted technologies (Murdoch et al., 2015) in nurse-patient interaction. These studies suggest that technological mediation hinders rather than facilitates nurse-patient interaction. For example, Leydon et al. (2013) show that missing elements in the opening of phone-mediated interactions have interpersonal consequences (Leydon et al., 2013). Nurses' use of documents to structure their consultations can reduce patient participation (Jones, 2009; Rhodes et al., 2008). Rhodes et al. (2006) have shown that the nurses' use of computer check-lists and electronic medical records significantly limits the possibilities for patients' interactional involvement in the encounters. Computer-assisted triage creates a conversational organization that increases misalignment between participants (Rhodes et al., 2006). Even though phone-mediated conversation can be an opportunity for nurses' displaying of expertise, this can reduce patient participant (Butler et al., 2009). In translator-mediated communication, Estrada et al. (2015) show that patients can misconstrue breaks in the translators' speech as turn completion points, which affects the unfolding of the interaction.

3.3. Information, explanation and advice

Eight papers were classified as discussing the request, reception and provision of information, explanations and advice. The

organization of nurse-patient or nurse-relative interactions (see above) has an effect on how information is communicated, and how the nurses give explanations and advice in clinical settings. Research on physicians and nurses' explanations has shown that these groups employ different communication strategies towards patients (Collins, 2005). In both cases, communication strategies prove to be useful and complementary when giving explanations in consultations. Examining nurses' communication strategies as they were giving advice to patients, Poskiparta et al. (2001) reported that the choice of strategies depends on the nurses' interactional goals. However, patients also have an active role: for instance, they choose specific types of questions (*what about* questions) to efficiently elicit information from nurses (Fasulo et al., 2016). Reciprocal (vs non-reciprocal) interaction styles promote patient participation in health counseling sessions, i.e., rigidly following a procedure reduces patients' participation (Poskiparta et al., 2000; Kettunen et al., 2003). With regards to nurse-relative interactions, studies have shown the active role of relatives in risk assessments (Adams, 2001b). Patient relatives are reticent accepting nurses' contributions on non-medical issues (Plumridge et al., 2008). As a result, relatives seem to challenge nurses' institutional role when it is not restricted to giving information, explanations or advice based on their medical knowledge (May et al., 2001).

3.4. Negotiation and influence asymmetry

Eight papers were classified as discussing negotiation and influence asymmetry in nurse-patient interactions. Research on interactions between nurses and patients has shown that nurses have a leading role when setting goals in consultations and are seeking to make their guidance and planned course of action non-debatable (Barnard et al., 2010). Institutional roles and expertise organize power relationships as these are acknowledged by co-participants, i.e., the control over the interaction is mostly exerted by nurses (Karhila et al., 2003). But still, patients often participate to interrupt, ask questions and request for clarifications (Kettunen et al., 2002b). Patient participation is higher when nurses "use reiterations, declarations, and open-ended questions" (Codern-Bové et al., 2014, p. 1). Interestingly, when interactions take place outside the clinical settings (e.g. patients' homes), the patients and not the nurses are in charge of the interactional management, with the exception of situations that require specialized medical knowledge (Bowers, 1992b). In cases in which strategies for patients' self-management of chronic care are discussed, the nurses' reliance upon rigid models of care (e.g., asymmetrical relations) is detrimental if the patients are to take on a more active role in their own care (Carr et al., 2014).

3.5. Managing emotions in critical illness

Two papers were classified as discussing the management of emotions in critical illness. Nurses craft communicative strategies to convey cancer diagnosis to patients in a less life-threatening fashion (Jarrett and Payne, 2000). In doing so, nurses' expertise plays an important role in mitigating the patient's pessimism about the future and the need for cancer care. Besides the management of expectations and optimism, the interactional mood between nurses and patients has also been a subject of study. In a study on mood in interactions between nurses and patients with renal failure on haemodialysis, Mallett and A'hern (1996) showed that the situational atmosphere is jointly and collaboratively constructed by nurses and patients in interaction in relation to the interactional goals (e.g., the management of the patients' anxiety).

3.6. Interacting with patients presenting reduced interactional competences

Six papers were classified as discussing interactions with patients whose interactional competences are reduced, temporarily or permanently. Patients' reduced interactional competences shape their interactions with nurses, as they increase interactional asymmetry (e.g., Gordon et al., 2009). How nurses assess the interactional competences of patients determines the interactional efforts they deploy in the interaction. Some of these assessments rely on nurses' perceptions of patients' reactions to summons and requests (Mallett, 1990). Even when patients are unresponsive, nurses manage to sustain the social order on the ward by talking to the patients and discussing with other caregivers (Kelly, 1998). Reduced interactional competences do not mean that patients are completely dependent. McCormack (2001) shows that through their stay, patients and nurses manage to collaboratively focus on both, the weaknesses of the patients where they require help (e.g., communicating and responding), but also their strengths, where they can be autonomous. Yet, patients' reduced interactional competences can affect cordiality in the interactions. Even though nurses still provide high quality care to terminally ill patients, their communicative efforts and emotional availability towards them can diminish considerably (Haraldsdottir, 2011). Nurses are also less personally engaged in their communication with disabled stroke patients (Gordon et al., 2009). Dying patients are also less cordial in their interactions with nurses. But this does not seem to be treated as a social transgression by the nurses, due to the patients' health conditions (Li and Arber, 2006).

4. Discussion

We further discuss the literature by providing an additional synthesis through the lens of Fleischer and colleagues' criteria and thereby confront the reality of nursing to these expectations. Fleischer and colleagues have set criteria for the opportunities that nurse-patient interactions should afford (Fleischer et al., 2009). These criteria included: i) opportunities for patient participation; ii) nurses' display of empathy; and iii) promotion of patients' competences. In the next sub-section, we will focus on patient participation, and will only briefly discuss nurses' display of empathy and promotion of patients' competences, as these have not been much studied yet in the literature on nurse-patient interactions relying on ethnomethodology and conversation analysis.

4.1. Patient participation

At odds with the ideal of increased patient participation, the heavy workload of nurses, notably, can lead to bureaucratic interactions, (Jones, 2007), even when guidelines meant to increase patient participation are in place (Codern-Bové et al., 2014). There is a distribution of labor where most topics are initiated by nurses, and answers are provided by patients (Jones, 2007; Leydon et al., 2013). This does not mean that patients are not active in the interactions, but that their contributions are mainly elicited by the nurses, and fulfill the instrumental needs of a procedure in which nurses are in power (Edwall et al., 2009). Nurses might voluntarily restrict patient participation as a means to render goals non debatable (Barnard et al., 2010).

Reciprocal interaction styles can promote patient participation (Poskiparta et al., 2000; Kettunen et al., 2003; Riva et al., 2014), but other interactional circumstances (participation frames) can inhibit deviation from a division of labor in which nurses are dominant (Kettunen et al., 2001, 2002b). External resources tend to interfere with the interactions and to lead to interactional

misalignment (Jones, 2009; Murdoch et al., 2015; Rhodes et al., 2006). Further, the alternation from less to more asymmetrical interactions between nurses and patients is determined by nurses' 'goals' (Poskiparta et al., 2001), as nurses adopt patient-centred and nurse-centred communicative strategies depending on these goals (Poskiparta et al., 2001).

The structuring role of nurses is even more visible in their interactions with patients with decreased interactional abilities. Nurse-centered communicative strategies are more frequent in interactions with patients with reduced autonomy (Gordon et al., 2009), patients in palliative care (Kelly, 1998; Li and Arber, 2006) and post-anesthetic patients (Mallett, 1990).

Despite the fact that nurses are vastly in control of their interactions with patients, power can be interactionally negotiated to some extent (e.g. Kettunen et al., 2002b). Verbal and bodily conversational devices can increase patients' participation. For instance, patients rely on 'what about' questions to request clarifications (Fasulo et al., 2016), and nurses' changes in gaze direction towards them can be treated by patients as opportunities to initiate new topics (Rhodes et al., 2008).

The physical context of nurse-patient encounters plays an important role in reinforcing or transforming the above described conversational asymmetries. When nurse-patient interactions occur at the patients' homes, patients are in interactional control – with the exception of highly specific medical matters (e.g. Bowers, 1992b). Not only the setting where nurse-beneficiary interactions occur shapes interaction styles and power relations, the identity and roles of the interacting partners are also crucial. Relatives can present themselves in a way that minimizes knowledge asymmetry in interaction (Butler et al., 2009; May et al., 2001; Plumridge et al., 2009). Although patients' relatives acknowledge nurses' medical expertise they often deny nurses any other general knowledge about their relatives (Plumridge et al., 2008).

Higher patient participation is consequential as it leads to the promotion of their competences (Kettunen et al., 2002b), and their better understanding of their disease (Edwall et al., 2009), whereas low patient participation delays the identification of pertinent information (Chatwin, 2008; Jones, 2009). Horizontal interactional styles between nurses and patients' relatives facilitate the collaborative identification of risk in psychiatric patients (Adams, 2001b), and parents' progressive understanding of their child's diabetes symptoms (Adams, 2001a).

4.2. Nurses' empathy

Nurses display empathy through verbal and non-verbal communication (Poskiparta et al., 2001). This happens when they initiate discussions about death to inform and provide emotional support (Wilainuch, 2013), when they use humor to reduce patients' anxiety (Mallett and A'hern, 1996) and foster optimism in cancer patients (Jarrett and Payne, 2000). Nurses readily display empathy at the patients' home (Adams, 2001b). But they can also display a lack of emotional availability towards patient's requests in palliative care (Haraldsdottir, 2011).

4.3. The promotion of patients' competences

The issue of the promotion of patients' competences was mostly discussed in studies conducted in the setting of health counselling and self-management groups (Poskiparta et al., 2000, 2001; Kettunen et al., 2002b, 2003), but of course empowering patients is important in all encounters with caregivers (Lashingerm et al., 2010). Several authors suggested that patient participation is a prerequisite to the promotion of patients' competences.

4.4. Limitations

This review has highlighted several limitations, some methodological, others relative to the scope of the studies considered as a corpus (geographical scope, disciplinary scope, limited objects). These are discussed below.

4.4.1. Limited use of multimodal analyses

Only about half of the reviewed articles included a transcription of non-verbal resources (e.g. gaze, body movements and nodding). Only a quarter examined the use of external resources (e.g. clinical records). Of the studies featuring multimodal transcripts, most have not conducted actual multimodal analyses, where the interplay of speech and bodily conduct is analyzed. Relying on multimodal analyses could benefit the understanding of nurse-patient interactions as much as it did for physician-patient interactions (e.g., Heath, 1986).

4.4.2. Limited diversity of settings

The setting of data collection was mostly primary care. The limited diversity of settings renders comparisons of interactions across settings difficult. We attempted to discuss interactional differences between primary care patients and other types of patients, but were confronted with the problem that in the first case we encountered a variety of studies, whereas in the other only a few.

4.4.3. Limited diversity of regions

Two thirds of the reviewed studies relied upon data collected in the UK, and most of the rest originated in Finland. This limitation does not allow studying whether there are universal patterns in nurse-patient communication, or if there exist cultural differences in these patterns.

4.4.4. Limited number of interactions analyzed

The median number of interactions studied was 25. This is hardly enough to propose rules of interactions as Schegloff (1979) did for phone interactions, relying on the scrutiny of 500 cases. Yet, the repetition of findings across different studies gives confidence in their accuracy.

4.4.5. The lack of study of other important interactional aspects

Neither nurses' display of empathy nor the promotion of patients' competences were much discussed in the studies reviewed here. The lack of studies on these essential aspects (Fleischer et al., 2009) might stem from the perception of a lesser importance among researchers, or from the influence of critical discourse analysis – which focuses on power relations – in qualitative nursing research on nurse-patient relationships (Traynor, 2006). This is discussed below.

4.5. The importance of critical discourse analysis

Critical discourse analysis focuses on the investigation of the ways in which social-power, dominance and inequality are practiced, reproduced, and sometimes resisted through the inspection of several forms of communication in relation to social and political contexts (van Dijk, 2015). Critical discourse analysis is not a particular method but rather a critical attitude towards the use of discourse practices to maintain the status quo in power relationships. Thus, critical discourse analysis integrates studies from different perspectives and methods in discourse studies, including conversation analysis, argumentation analysis, discourse pragmatics, multimodal discourse analysis, sociolinguistics, social semiotics, among several others (see van Dijk, 2015; for a general review; and Traynor, 2006 for a review of nursing studies). Critical

discourse analysis has provided a vast repertoire of studies focusing on the relationship of nurses with patients (Traynor, 2006). These are not bound to the study of recorded nurse-patient interactions as in conversation analysis. For instance, Horsfall and Cleary (2000) examined a policy for constant observation of patients in psychiatric wards and showed how this document reproduces asymmetrical power relationships between caregivers and patients. Wilson (2001) analyzed interviews with pediatric nurses and found that some forms of friendly social interactions can be construed as disguised surveillance practices. Heartfield (1996) analyzed nursing documentation. She shows that nursing documentation dehumanizes patients as it frames them as objects composed of body parts. According to her work, although the main goal of nursing is obviously curing patients' ailments, it is also used to reproduce power relationships through interactions and procedures. This type of research is complementary to what has been discussed here.

4.6. Implications for practice

This review shows that although nurse-patient interactions are often characterized by an interactional asymmetry, there is room for patient participation. The other main crucial aspects mentioned by Fleischer et al. (2009) are not sufficiently studied in this literature to be further commented upon.

Some of the reviewed studies have highlighted conditions that foster or inhibit patient participation. Several types of nurse-patient interactions share a tendency for control by nurses (whereas this is not the case at patients' home). But this control might be stronger in mediated interactions. Patient triage is an example of such interactions in which computer-mediation brings contingencies which enhance nurses control – this also applies to admissions and related interactions. Murdoch et al. (2015) has documented how nurses strictly follow the items on their screen when triaging patients, and how this structures their conversation, at the expense of patient participation – sometimes leading to misunderstandings as a consequence. The redesign of computer-assisted technology can be a straightforward way to solve such issues. Such redesigns should fulfil conversational and clinical needs – notably by taking into account studies in conversation analysis or other observational studies of clinical interactions (Coiera, 2000). Redesigns are obviously costly and may not be a main concern for administrators. Therefore, another way could be for the nurses to first encourage the patients to fully explain their ailments, and then to rely on the tool for processing. They would thereby avoid the reason for the patient's visit being delayed for a long time (see Excerpt 2 in the Supplementary materials where the reason for admission is discussed after 12 minutes, because of the rigid use of a standardized document, from Jones, 2009). We do not mean that no pre-established structure is better. Indeed, the outcome of interactions can be positively affected by the initial structure of conversation (Chatwin, 2008; Leydon et al., 2013). Our point is that the structure of conversation should be driven by interactional imperatives. Some guidelines for structuring interactions have been proposed. Leydon et al. (2013) have focused on the importance of openings of interactions in optimizing further interactional work. Poskiparta et al. (2000) and Kettunen et al. (2003) have discussed the role of reciprocal interactional styles in increasing patient participation. Poskiparta et al. (2001) have shown that verbal and bodily manifestations of understanding and interest promote patient participation.

4.7. Further studies

Future studies would need to further examine and systematize the communication strategies used by nurses and patients in

relation to their interactional goals, and material environments. Having a systematic and comprehensive understanding of how nurses and patients interact will create the conditions for promoting interventions in existing forms of communication and interaction to improve parents' care and well-being. In addition, a comprehensive understanding of nurse-patient interactions in most frequent communicative situations (e.g. phone consultations; face-to-face interactions in clinical facilities and patients' homes; and computer-assisted consultations either face-to-face or over the phone) may help create more solid theoretical, methodological and practical grounds to assess the costs and benefits of new hybrid modes of consultations (e.g. virtual consultations over Skype and/or other video-supported electronic media) and contribute to a more effective regulation of such novel practices (Greenhalgh et al., 2016). Such an understanding can be better accomplished by examining in depth the web of mutual dependencies between behavioral modalities in communication. Collections including a sufficient number of interactions should be systematically analyzed, contrary to what has been done in some studies so far (half of the ones we reviewed relied on 25 interactions or less). The literature would also benefit from studies in more countries. This would permit identifying cultural variations on the one hand, and the diffusion of good practices on the other.

Having a better insight into interactional practices as they occur in real-time is crucial to designing protocols aimed at improving communication strategies between nurses, patients and relatives (Poskiparta et al., 2001). Studying interactional practices in clinical settings might be of even greater importance as computer-mediated interactions are becoming a standard practice. The interactional impact of human-machine interfaces needs to be assessed, a step that is often forgotten during the implementation of information technology in hospitals (Coiera, 2000).

5. Conclusion

Higher patient participation results in better clinical outcomes (Chatwin, 2008; Chatwin et al., 2014; Elwyn et al., 2000). It also strengthens social bonds and promotes trust between nurses and beneficiaries of care (Adams, 2001a; Riva et al., 2014). This review has shown that nursing researchers relying on ethnomethodology and conversation analysis have studied the determinants and the consequences of patient participation, and the lack thereof across several types of nurse-patient encounters. Maybe the most important and recurrent finding in the literature is that, despite repeated calls for heightened patient participation, nurses still exert control over most of the progress of the interaction, including topic setting. Recommendations have been provided.

Fleischer et al. (2009) have reported that other aspects, such as nurses' display of empathy and the promotion of patients' competence are very important in nurse-patient interactions, but these have not been studied thoroughly in studies relying on ethnomethodology and conversation analysis.

Conversation analysis and ethnomethodology have already shown their potential for the understanding and improvement of nurse-patient interactions, opening up interesting opportunities for further research.

Conflict of interest

No conflict of interest.

Funding

None.

Ethical approval

None.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.ijnurstu.2017.01.015>.

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