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Title

Voices used by nurses when communicating with patients and relatives in a department of medicine for older people - An ethnographic study

Abstract

Aim: To describe how nurses communicate with older patients and their relatives in a department of medicine for older people in western Sweden.

Background: Communication is an essential tool for nurses when working with older patients and their relatives but often patients and relatives experience shortcomings in the communication exchanges. They may not receive information or are not treated in a professional way. Good communication can facilitate the development of a positive meeting and improve the patient's health outcome.

Design: An ethnographic design informed by the sociocultural perspective was applied.

Method: Forty participatory observations were conducted and analyzed during the period October 2015 to September 2016. The observations covered 135 hours of nurse-patient-relative interaction. Field notes were taken and 40 informal field conversations with nurses and 40 with patients and relatives were carried out. Semi-structured follow-up interviews were conducted with five nurses.

Results: In the result, it was found that nurses communicate with four different voices: a medical voice described as being incomplete, task-oriented and with a disease perspective; a nursing voice described as being confirmatory, process-oriented and with a holistic perspective; a pedagogical voice described as being contextualized, comprehension-oriented and with a learning perspective; and a power voice described as being distancing and excluding. The voices can be seen as context-dependent communication approaches. When nurses switch between the voices this indicates a shift in the orientation or situation.

Conclusion: The results indicate that if nurses successfully combine the voices, while limiting the use of the power voice, the communication exchanges can become a more positive experience for all parties involved and a good nurse-patient-relative communication exchange can be achieved.

Relevance to clinical practice: Working for improved communication between nurses, patients and relatives is crucial for establishing a positive nurse-patient-relative relationship, which is a basis for improving patient care and healthcare outcomes.

Keywords:

communication, ethnography, nurses' voices, older patient, relative, sociocultural perspective

What does this paper contribute to the wider global clinical community?

- The study presents an original description of how nurses communicate with patients and relatives in a department of medicine for older people. The study identified three 'voices', medical, nursing and pedagogical, that can be used by nurses during communication exchanges with older patients and their relatives, in order to increase care satisfaction.
- The study highlights that the three voices can enable nurses to obtain a process-oriented and holistic view with a learning perspective of the patient's life situation. As a result, the communication exchanges can become a more positive experience for all parties' involved and good nurse-patient-relative communication can be achieved.
- The findings can be used during nurse training interventions as tools for improving the communication exchanges between nurses, older patients and their relatives. The training can be carried out, for instance, in reflecting teams. In a wider perspective, this knowledge can be used in general nursing education as regards communication with all patients and relatives.

Introduction

Communication exchanges between persons with highly diverse life and professional backgrounds take place in the healthcare sector every day. The quality of communication is important for achieving care satisfaction and safety. Nurses spend about half of their working time in direct patient care, during which they communicate with patients and their relatives (Furåker, 2009; Lundgren & Segesten, 2001). The Swedish Patient Safety Act (SFS 2010:659) stipulates that nurses should promote high patient safety and nurse-patient communication built on trust.

From a patient perspective, the ability to communicate successfully, including speaking, listening, reading and writing, is a critical factor for achieving good healthcare. Complaints from patients and relatives worldwide often concern the communication exchange (Harrison, Walton, Healy, Smith-Merry, & Hobbs, 2016; Jangland, Gunningberg, & Carlsson, 2009). Communication is therefore a central aspect of patient care in general and is fundamental for achieving a good relationship between nurses and older patients. A positive communication exchange is a prerequisite for mutual understanding and cooperation. With normal aging, communication skills generally deteriorate due to cognitive and physiological changes, affecting in particular hearing and speech, which entail communication difficulties during healthcare communication exchanges involving older patients (Le May, 2005). Due to the complex nature of multiple morbidities, nurses caring for older patients may at times have a negative attitude towards the patients, which in turn can negatively affect the communication exchange and the care provided (Hanson, 2014). A lack of knowledge about the specific requirements for providing care to aging and older patients can be a factor behind any negative attitudes displayed (Holroyd, Dahlke, Fehr, Jung, & Hunter, 2009). By increasing the awareness and knowledge of nurses about the specific nature of communicating with older patients, nurses can improve the quality of the communication exchanges between them and

said patients and their relatives, and thus achieve greater insights into how the older patient's individual needs can be met. Effective nurse-patient-relative communication is important for the discipline and profession of nursing. It is important to know which communication styles are appropriate at different points in a patient's lifespan and in given clinical situations. The present study focuses on how nurses communicate with older patients and relatives in a department for older people in western Sweden.

Background

Sociocultural perspective and communication

Communicating means sharing an existence with others (McCabe & Timmins, 2013). Communication is therefore a social activity seeking to develop common understanding. In a sociocultural perspective, language and thinking have an impact on the ability of individuals to understand the outside world and to act in it (Vygotsky, 1987). The function of language is to convey messages. By learning to use the language the individual becomes able to understand specific situations. This process takes place in a social system where the participants' attitudes and expectations shape the exchanged information. Nurses use the language as a tool to communicate with patients and their relatives (McCabe & Timmins, 2013). The communication exchange can take the form of both verbal and non-verbal acts, such as exchanges of words, voice tone, and attitudes conveying feelings and thoughts (McCabe & Timmins, 2013). How nurses communicate depends on the culture and the institutional orientation in which they find themselves and on their previous experiences of the activity (Wertsch, 1998; Vygotsky, 1978). Charlton, Dearing, Berry and Johnson (2008) mention two traditional healthcare communication styles: the biomedical style and the biopsychosocial style. The biomedical style of communication focuses on signs and symptoms that bother the patient; nurses ask closed-ended questions, provide instructions, and expect little or no patient

involvement. The biopsychosocial style of communication actively strives to involve both patients and relatives in the discussion and decision-making.

What is known about communication exchanges between nurses, older patients and relatives

The World Health Organization (WHO, 1998) defines older persons as people who are 65 years or older. As this group comprises persons of widely varying ages, it can be divided into three groups according to age: 65-74 years, 75-84 years and 85 years or older (Swedish National Board of Health and Welfare, 2008). In this study, the two last groups are relevant.

The communication exchanges between nurses, older patients and their relatives have been studied from different perspectives. Studies from the perspective of patients and/or relatives have found that they experience shortcomings in the communication exchange, for instance that they do not receive information or are not treated in a respectful and professional way (Harrison et al., 2016; Jangland et al., 2009). Older patients have described that nurses use medical terminology, are authoritarian and can suddenly change the topic during a communication exchange (Park & Song, 2005). Patients are sometimes apprehensive of disturbing the nurse and therefore fail to fully understand what the nurse is talking about (Le May, 2005). Research also shows that older patients want to participate in their own care by receiving regular information through follow-up communication that may facilitate their ability to cope with pain and discomfort in their daily lives (Nygren Zotterman, Skär, Olsson, & Söderberg, 2016). Patients want nurses to be attentive, competent, friendly and understanding in the meeting (Finch, 2005) and say that good communication makes them feel like the nurses are interested in them and like they are confirmed and seen. Patient recovery is promoted when nurses take a holistic approach to patients (Nygren Zotterman et al., 2016). One literature review shows that the thoughts, feelings and behavior of relatives and nurses can create positive or negative patterns of communication (Bélanger, Bourbonnais, Bernier, & Benoit, 2017).

Negative patterns of the communication exchanges between relatives and nurses may be due to the nurses behaving in an authoritarian or controlling manner. Such negative patterns can be detrimental to the quality of communication and reduce care satisfaction.

Nurses are often stressed by the large number of older patients with substantial care needs and physical constraints, such as impaired hearing, which complicate communication even under normal hospital noise conditions (Ruan & Lambert, 2008). Research from a nurse perspective describes how nurses experience that they speak too fast and present different kinds of information at the same time (Park & Song, 2005). Nurses describe that they are interrupted in their work by, among other things, colleagues and telephone calls, which hampers their communication exchanges with older patients and relatives (Furåker, 2009; Olsen, Østnor, Enmarker, & Hellzén, 2013). By creating communication strategies for care, nurses can minimize misunderstandings and reduce complaints (McCabe, 2004). In this way, the work-related stress of nurses can be reduced and the well-being and care of older patients can be enhanced (Harrison et al., 2016; McGilton, Sorin-Peters, Sidani, Boscart, Fox, & Rochon, 2012). McCabe (2004) found that nurses are more concerned with their tasks than talking with patients, and that even when they have the skills for talking with patients, they are too busy to do so. Research shows that it is important for nurses to recognize the value of using a distinct and efficient communication style, characterized by short and iterative interactions combining chit chat and professional communication, in order to get to know their older patients and build a relationship with them (Chan, Jones, Fung, & Wu, 2012). Chit chat communication helps bridge the gap between nurse and patient (Millard, Hallett, & Luker, 2006).

In summary, communication and language are powerful tools for nurses when interacting with older patients and their relatives (McCabe & Timmins, 2013). Studies identify both shortcomings and ways to overcome them (Harrison et al., 2016; Nygren Zotterman et al., 2016; Olsen et al., 2013; McGilton et al., 2012; Chan et al., 2012; Furåker, 2009; Jangland et

al., 2009; Ruan & Lambert, 2008; Millard et al., 2006; Finch, 2005; Le May, 2005; Park & Song, 2005; McCabe, 2004). Previous research on the communication between nurses and relatives in geriatric care has focused on the participants' thoughts, feelings and behavior (Bélanger et al., 2017).

The data in the present study was drawn from a larger project focusing on communication between nurses, older patients and relatives in a department of medicine for older people. This specific communication situation had not been studied previously and the research project was initiated upon the request of the department in question.

Aim

The aim was to describe how nurses communicate with older patients and their relatives in a department of medicine for older people in western Sweden.

The following research question guided this study: How do nurses communicate with older patients and their relatives?

Method

The study design was ethnographic, using participatory observations, and was informed by the sociocultural perspective (Vygotsky, 1978; 1987). Ethnography strives to systematically observe, document and analyze lifestyles and patterns in a culture or subculture (Hammersley & Atkinson, 2007; Walford, 2009).

Setting, participants and recruitment

The study was conducted in two wards in a department of medicine for older people in western Sweden. The department focuses on multiple morbidity patients, with a minimum age 75, and believed to be in need of regular medical inpatient care. Healthcare centers or healthcare hotlines can refer such patients directly to the department, bypassing the normal emergency

care department. Most of the patients have been treated in the department several times because of their multiple chronic conditions. The wards are expected to run diagnostic tests, treat actual illness and plan future care needs in collaboration with other healthcare providers such as physicians, nurses, occupational therapists, physiotherapists, counselors, enrolled nurses, healthcare centers and municipalities. Each ward has a total of 24 beds, located in rooms with one, two or four beds.

The two wards employ a total of 42 nurses. All of the nurses were considered appropriate to participate in the study because of their work with patients and relatives. The recruitment of participants was initiated after obtaining written permission from the managers of the hospital and the two wards. At ward meetings, detailed information was provided about the study and the nurses were given the opportunity to give their informed consent. Following these meetings, informed consent forms were left openly available on staff room tables in the two wards for several days so that nurses could take their time to decide whether or not to participate. A specific and freely available folder was kept on the ward's administrative desk so that nurses could hand in their consent forms at their leisure. Twenty-four nurses, aged 23 to 63, volunteered to participate (i.e. 57% of all the nurses working at the two wards). The 18 remaining nurses did not volunteer and were not further involved in the study; consequently, 'their' older patients, i.e. the patients in their care, as well as their relatives were not involved in the study either. Their professional experience as nurses ranged from three months to 36 years and their presence in the wards ranged from three months to seven years. All participants were registered nurses and four of them had undergone specialized training in nursing for older persons (60 additional higher education credits after completing their basic nursing education).

The ward managers provided the work schedules of each of the 24 participating nurses. During their working passes, these nurses were individually responsible for about eight patients. Based on the participating nurses' work schedules, the researcher contacted the

relevant patients and visiting relatives, in order to present the study and eventually obtain their written informed consent. The patients and relatives received information about the research focus, i.e. the communication exchange between nurses, patients and relatives, and were assured that their care would not be affected if they declined to participate in the study. Patients identified by the ward manager as being critically ill or in palliative care were not invited to participate in the study. Four of the patients gave their informed consent on tape because of paralysis.

Data collection

The data collection consisted of participatory observations, field notes, field conversations and individual interviews with nurses. To get to know the ward, nurses and routines, the first author worked alongside the wards' nurses for two weeks full-time prior to commencing the actual field work. Forty observations were carried out from October 2015 to September 2016 and were recorded with a dictaphone.

The participatory observations covered the nurses' everyday communication with older patients and their relatives, and lasted until the phenomenon repeated itself and confirmed the earlier analysis (Hammersley & Atkinson, 2007; Walford, 2009). To reduce the risk of observing only part of the whole and to promote variation in the observations, a selective intermittent time model was selected with a flexible approach to the frequency and times of the researcher's site visits (Hammersley, 2006; Jeffrey & Troman, 2004), meaning that the participatory observations took place on different days, times and places in the wards. To harmonize with the environment the author was dressed like the wards' regular staff. The observation periods ranged from three to five hours. The total observation time was 135 hours. A total of 40 field conversations with 24 nurses and 40 older patients and their relatives, which lasted for 5 to 15 minutes each, were carried out towards the end of every observation. Field

conversations with nurses took place in a room adjacent to the ward and were tape-recorded. Field conversations with patients and relatives were held in the patient room.

Semi-structured interviews (Silverman, 2006) with five nurses were conducted after 30 participatory observations had been completed. The purpose of these interviews was to gain a deeper understanding of what emerged during the observations. The interviewed nurses were recruited on a voluntary basis at a ward meeting subject to two eligibility criteria: permanent employment at the ward and experience of working with older multiple morbidity patients. An interview guide was drafted based on the patterns and potential themes that emerged from the analysis and field notes made during the observations. The tape-recorded interviews lasted for 20 to 40 minutes and took place in a room adjacent to the ward.

Data analysis

In ethnographic studies, data analysis is a continuous process which begins at the same time as the participatory observations and field conversations (Hammersley & Atkinson, 2007). Field notes on the observations and field conversations formed the basis for the questions used in the subsequent individual interviews with nurses.

The first author carried out the research work in the wards and started the data analysis process. As more data was gathered, the other authors became actively involved in the analysis of all the gathered data. The field notes about the communication exchanges contained information on times, locations, parties involved, postures, body language and movements, and were transformed into narratives. The field note narratives and the verbatim transcripts of the recorded observations and field conversations were repeatedly read as a whole to get a sense of how nurses communicate with older patients and relatives in a department of medicine for older people. From the analysis, it emerged that nurses communicate in different ways and working hypotheses were formulated which became tools for the continued data collection and

analysis of field notes, field conversations and interviews. At this stage, tentative themes, such as illness, learning, interpersonal closeness and distance, relating to how nurses communicate with older patients and their relatives emerged.

In the next step of the analysis, the field note narratives, field conversations, observation transcripts (from the recorded observations) and the interview transcripts were analyzed separately for further testing and understanding of the tentative themes. Differences and similarities were compared and tentative categories were identified. To this end, questions were put to the different observation situations to test the tentative themes illness, learning, interpersonal closeness and distance. After the analysis of the field conversations, the interviews were read as a whole to get a sense of their content. The entire data was read again on the basis of the tentative themes identified in the analysis of the field notes. Meaning units relating to the identified themes were identified and related to the categories (Silverman, 2006) and different communication 'voices' were identified. A voice corresponds to a particular relationship between the nurse, older patient and relative.

Continuous discussion within the research group during the analysis process provided opportunities for continuous and in-depth understanding of the subject studied, which is an essential part of the ethnographic method (Hammersley & Atkinson, 2007). During the process all data and emerging categories were considered and discussed by the researchers until they were in complete agreement.

Ethical considerations

The study was approved by the regional ethical review board (Ref: 584-15). The participating nurses, older patients and relatives received verbal and written information about the study. In particular, they were informed that participation was voluntary, that they could cancel their participation at any time and that the results would be presented in a manner protecting their

identity, in agreement with the Declaration of Helsinki (World Medical Association, 2013). All participants signed an informed consent form. All confidential information is stored in such a way that unauthorized persons cannot access the content.

Results

The ethnographic analysis resulted in four different ‘voices’ describing how nurses communicate with older patients and their relatives in a department of medicine for older people. The voices are metaphoric and can be seen as communication approaches or communication styles. The four voices identified were a medical voice, a nursing voice, a pedagogical voice and a power voice (Table 1). The medical voice is incomplete, task-oriented and based on an illness perspective. The nursing voice is more confirmatory, process-oriented and based on a holistic perspective. The pedagogical voice places the patient’s situation in a context, is comprehension-oriented and is based on a learning perspective. The power voice is more distancing and excluding. The voices are reinforced by using body language and form patterns that constitute approaches that change depending on the situation and orientation. The voices can vary in importance during communication exchanges. When nurses switch between the voices, this indicates a shift in the orientation or situation. A nurse can use different voices in a given communication exchange and change voice depending on the social orientation and subject matter.

Table 1. Voices used by nurses in communication exchanges with patients and relatives.

Voice	Focus	Body language	Tone of voice
Medical voice	Incomplete Task-oriented Illness perspective	Remains standing Eye contact	Monotone tone and speaking fast
Nursing voice	Confirmatory Process-oriented Holistic perspective	Kneels down or sits Nods Eye contact	Friendly tone
Pedagogical voice	Contextualized Comprehension-oriented Learning perspective	Kneels down or sits Uses body to show and describe Eye contact	Friendly tone
Power voice	Distancing Excluding	Remains standing Maintains physical distance Limited eye contact	Greater emphasis on selected words

Medical voice

The medical voice was the most prevalent and was present in both scheduled and unscheduled communication exchanges between the nurse, older patient and relative. The medical voice is enhanced with different body movements, voice tone or attitude. When nurses use the medical voice they remain standing and their eyes sweep between patient and relative during the communication. They speak faster and the tone is monotone.

The medical voice was incomplete, meaning that the nurses informed the patient and relative of several things at the same time and that the information did not place the patient's medical condition in relation to the patient as a person. The following is a field note describing a nurse who is about to remove a blood bag, while also giving the patient an injection of diuretics. The nurse stands in front of the bed table, puts her hand on the patient's arm and starts to unwrap the bandage protecting the peripheral venous catheter:

Nurse: You have received blood now. The patient nods. Nurse: And now you will get some diuretic, Furix, from me soon and then you get a bag of blood. You have low hemoglobin. Patient (laughing): Yes, it's very driving. Nurse (laughing): Yes it is. (Field Note 9).

Generally, test results arrive in the afternoon, which means that patients and relatives are informed of the results by the nurses who work the evening shift. The information is task-oriented. The following field note shows how a nurse gives information about test results. Before she goes to the patient, she reads through the patient's journal and writes down the facts. The nurse stops some distance from the bed:

Nurse: You know what kind of test we took, right? The patient nods. Nurse (turning to the relative): She has been treated with antibiotics. Relative (nodding): Yes, exactly. Nurse (turning to the patient): We have received the results of the X-ray and it shows that you have pneumonia. The nurse points to the patient's arm where the peripheral venous catheter is located. There is liquid on the right hand side and you are being treated with diuretics and antibiotics intravenously. Patient: Yes. (Field Note 6).

When nurses are communicating from an illness perspective they bring out the illness in the patients and the focus is on the older patient's incapacity. The following scenario describes how the nurse talks to the patient from an illness perspective. The nurse is standing by the bedside:

Nurse: They found that you have an infection. Your infection tests were a little high. Patient: OK. Nurse: You had a wound on the left leg. We found that there were bacteria present. Patient: OK. Nurse: You have received treatment for it. Patient: Yes. Nurse: And you have prostate cancer and chronic atrial fibrillation for which you are taking Waran. Patient: Yes, I'm taking Waran. Nurse: And you have kidney failure. Patient: Do I? Nurse: Yes, it is noted in your journal. Patient: OK. Nurse (turning to the relative): Are you aware of the fact? Relative: Yes, he has been given a diuretic. (Field Note 19).

Nursing voice

The nursing voice was amplified with the tone of voice, facial expressions and body movements. Eye contact was made with the patient and nurses often knelt down in front of the patients. *"I very often sit down so my position is lower than the patient"* (Interview 2).

To show that they had understood what the patient and relative had said, the nurses confirmed the message by listening, repeating the information and nodding. In the following field note the nurse confirms that the patient can manage to medicate himself. The nurse comes into the room to show the patient how he should use the oxygen mask. The patient is half-

sitting in the bed. The nurse stops next to the bed, sits down on her knees and meets the patient's eye:

Nurse (facing the patient): This is not the first time you use this mask. Patient: No, it's the third time now I think. Nurse (nodding): Third time. Well, then I'll put it on. Patient: Yes you do it like this. The patient takes the oxygen mask and shows how he puts it on and then points at the button so the nurse can start the oxygen machine. Nurse (nodding): Good, that's right. (Field Note 5).

The nursing voice is characterized by being process-orientated, which means that nurses create conditions for planning and implementing healthcare activities with patients and relatives. The nurse tries to create conditions for planning a good home return for the patient, enters the room and sits down on her knees in front of the patient who is sitting in a chair:

Nurse: What are you thinking about? You'll soon be going home. Patient: Yes. Nurse: Do you think that you need more help? We should have a care plan ready before you go home. Patient: Yes, I do. Nurse: You want more help? Patient: Can it be arranged? (Field Note 18).

With the nursing voice, nurses are communicating from a holistic perspective where the patient's entire life situation is focused on, here and now. In the holistic perspective nurses open up for a trusting meeting by being friendly and positive and by encouraging patients to see their own abilities. The following field note describes how nurses proceed. The patient is lying in the bed; her legs are swollen and wrapped with bandages. The nurse is standing next to the bed and kneels in front of the patient:

Nurse: How are you today? Patient (looking at the nurse): I have problems with my legs. Nurse (pointing to the legs): Have you had any help at home with the legs? Patient: The only help I have received is one person who vacuum cleaned my place for me. Actually, another person wrapped my legs also every other day. Nurse: Where did you get your legs wrapped? Patient (nodding): At the health center. Nurse: How are things working at home? Patient (raising his hands): I'm on my own. Nurse: So you cook your own food? Patient: Those who shop for me often buy ready-made dishes. Nurse: And you wash yourself? Patient (smiling): No, I don't have the energy for showering, but I have always been able to wash myself, although not very often or as well as I would want to. (Field Note 38).

Pedagogical voice

When the pedagogical voice was identified in communication exchanges, nurses wanted the patients and relatives to increase their knowledge. In these situations, the nurses usually sat down on a chair and used a friendly tone. They closed the door to the patient's room so that nothing could disturb the communication exchange. Nurses could also consciously use body language as a teaching tool to clarify what they had just said. "...and then I try to show with the body what I mean" (Interview 5). The following field note shows a nurse using body language when giving medicine. The patient is lying on the bed and wiggling his toes. The nurse moves the bedside table away and kneels by the side of the bed:

Patient: Have I had a fungus infection? Nurse: Yes, it seems so. That's why you are getting this. The nurse points to the syringe, taps on it and nods. Patient: I have not thought so much about it, but... The patient points to the plate on the table. Nurse: No. When you have fungus in your mouth, the food does not taste at all and you do not notice. The nurse points to her own mouth and then to the plate. The patient looks at the nurse, blinks and nods, then takes the syringe and swallows the contents (Field Note 5).

When nurses communicated in a contextualized manner and with a learning perspective they placed the patient's illness and treatments in a context. The following field note demonstrates how the nurse contextualizes urinary tract infections with catheter use to help the patient understand the illness. The nurse sits on a chair beside the bed:

Patient: Would it not be better to have a catheter and a bag hanging? (Pointing to a diaper lying on the bed). Nurse: There is a risk of infection also when using a catheter. Patient (sighs): Yes, but would it not be better to run that risk? Nurse: Yes, but it's also good if you get up and move about, try to walk, so that the whole body can get well. Patient: Yes, but I cannot move about half the day because I'm on a diuretic. It's very difficult having a commode by the bed that I cannot reach. Lately, I haven't been able to handle it myself. Nurse: Let's see what the physiotherapist and occupational therapist can do to help. They'll be here tomorrow. It's important that you get up. Patient: Yes, I've read about a bacteria and they've written in the papers that one should go back to the old antibiotics for urinary tract infections. But I think this is a bit tough and hard to handle. (Field Note 39).

In order to increase the patients' and relatives' understanding, nurses communicated in a learning-oriented manner. They asked the patient or relative to retell information to achieve

better understanding, *“If one cannot get through to them [the patients], one must ask follow-up questions”* (Field conversation 21). The nurses repeated the information when they noticed that the patient had not understood. They also used reminder notes both for the patient and for themselves. *“Sometimes one must repeat, leave a message. It depends on the person. I mean write reminder notes to them”* (Field conversation 26).

Power voice

The power voice was the least used voice in the communication exchanges between nurses, older patients and relatives and was characterized by an excluding and distancing attitude. The nurses' body language became distant with the nurse placing herself away from the patient and relative, gazing at the wall or out the window. The nurses spoke louder and with greater emphasis on selected words. When the nurses excluded the patients and relatives, there was no real conversation and their questions went unanswered and their concerns were ignored. In this situation, the nurses showed their hierarchical position and the patients and relatives had no opportunity to influence the care. The following example shows how a nurse excludes the patient and just talks to the relative. The patient and relative have asked for a conversation with the nurse. The patient is lying in bed and the nurse and relative are standing on each side of the bed. The nurse looks either out the window or at the relative:

Relative (turning to nurse): How is she? What is she being treated for right now? Nurse: It's an infection without focus. We don't know from where it comes. Patient (raising her hand and waiving): What? Nurse (talking to the relative): But she is receiving antibiotic treatment ... It wasn't you I had on the phone, was it? Relative: No, it was my sister. Nurse: Yes. Well, she [the patient] was sent to do an ultrasound test of the heart and it showed that the right part of the heart, the right chamber, is functioning poorly. Patient (looking back and forth between the nurse and relative): My breathing is bad. Nurse (ignoring the patient's words and talking to the relative): We are trying to correct this with diuretics among other things. (Field Note 13).

When nurses distance themselves, they referred the patient to the physician without explaining the care situation to the patient or relative. Nurses distanced themselves from the

patient when they had doubts about the causes of the patient's disease, had difficulty explaining the meaning and usefulness of diagnostic tests or treatments, or felt that it was the physician's job to discuss the issue. *"It's easy to start talking about things that come under the physician's remit."* (Field Conversation 13). Another reason for nurses to distance themselves from patients and relatives was lack of time. *"It can be very stressful; sometimes one can't take the time to talk more."* (Interview 3). However, when resorting to distancing communication, the nurses' demeanor towards the patient and relative remained friendly and positive. In the following example a nurse transfers the responsibility to the physician. The patient has had cough and itching after starting a new medicine:

Patient: It itches and I cough. Nurse: Okay. Patient: Yes, I sat in here and coughed. Yes, how I coughed. I was sitting here for at least 30 minutes. I almost threw up. Nurse: Tomorrow it's Monday again and the physician will be here as usual. The physician can examine you then. (Field Note 17).

Discussion

The aim of this study was to describe how nurses communicate with older patients and their relatives in a department of medicine for older people. Four 'voices' were identified: a medical voice, a nursing voice, a pedagogical voice, and a power voice. The voices differ in their characteristics in terms of the nurse's closeness or distance to the patient and relative and the voices are enhanced by corresponding non-verbal communication.

The communication exchanges between nurses, older patients and relatives take place in an institutional environment formed by culture, history and people's social activities. When a sociocultural perspective is taken to explain the communication exchanges between nurses, patients and relatives, the use of language, dialogue and social and cultural contexts is important for creating meaning and understanding (Vygotsky, 1987). The fact that the communication exchange between nurse, patient and relative is dominated by the medical voice is unsurprising considering the activities and purpose of departments of medicine for older

people. This communication is shaped by the institutional context where culture and history, according to the sociocultural perspective, are a major part (Wertsch, 1998; Vygotsky, 1978). How the nurses communicate depends on the institutional context and their previous experiences of the activity. In this respect, nurses can be described as creators and definers of meaning. The nurses' attitude shapes the conversation and thus the interaction in the communication exchanges. When attempting to understand a workplace culture, one must understand its beliefs, values and constraints (Wilson, McCormack, & Ives, 2005). Nurses work against time. They want to provide as much information as possible in a short time. This entails a risk that patients and relatives have difficulty finding meaning and understanding, which may explain why they have been found to be dissatisfied with the communication exchange (Harrison et al., 2016). A stressful working environment also hinders a successful implementation of person-centered care (Elfstrand Corlin, Kajonius, & Kazami, 2017).

In the course of communication exchanges between nurses, patient and relatives, nurses may shift between the nursing voice, the medical voice, the pedagogical voice and the power voice. Each shift indicates a new focus of the exchange. According to Berg, Hedelin, and Sarvimäki (2005), nurses alternate between a biomedical communication style and a biopsychosocial communication style depending on the context and situation. The biomedical communication style (Charlton et al., 2008), which is similar to the medical voice, may or may not entail patient participation, which in turn affects the interaction between nurse and patient. From a sociocultural perspective, communication is an active and creative process in which there is interaction between the parties involved (Vygotsky, 1987) and the interaction between nurses, patients and relatives affects how the voices change and the outcome of the communication. According to Bakhtin (1981) a voice never exists alone and embrace how an individual situationally orient toward others in a social communication process. Different voice means different perspectives, intentions, interaction and world view.

Nurses in this study attempted to create a positive atmosphere during the meeting with the older patient and relatives by, for instance, smiling, being supportive, and showing interest in the patient as a person. According to Timmermann et al. (2017), the nurse's ability to be attentive is crucial for inspiring positive emotions in the patient. Furthermore, when a ward is characterized by a positive atmosphere, the patient feels that the healthcare professionals are genuinely interested in him or her as a person. Nurses who maintain a positive attitude have more social conversations with their patients, are more humorous towards them, and are less authoritarian (Caris-Verhallen, de Gruijter, Kerkstra, & Bensing, 1999). Humor is a valuable tool for achieving a relaxed atmosphere and a positive relationship with the patient (Schöpf, Martin, & Keating, 2017). From a sociocultural perspective, words and actions contribute to mutual understanding in a cultural context, which is a prerequisite for understanding the other party's perspective (Vygotsky, 1987).

Nurses in the study consciously used their body language as a pedagogical tool when they needed to provide or explain some kind of information. Nods, smiles, body position and physical contact become important communication tools (Caris-Verhallen et al., 1999). If the communication is handled poorly, it can reduce the patient's well-being; if it is handled well, it can promote both patient well-being and person-centered care (Draper, 2014). A good communication approach not only benefits the patient, it can also improve the cooperation between healthcare professionals (Gray, Ross, Prat-Sala, Kibble, & Harden, 2016; Edvardsson, 2015; Slater, 2006). Body language can be seen as a mediating tool that helps individuals understand the outside world and act in it (Vygotsky, 1987).

The nurses in the study also stated that time constraints made them focus on immediate medical matters and practical care, and not on communication with patients and relatives or on longer-term issues. This hampers their opportunities for reflection and for applying a process-oriented and holistic perspective of the patient's well-being. Despite their often good

communication skills, nurses are forced to adopt a task-centered approach (Chan et al., 2013; Hemsley, Balandin, & Worrall, 2012; McCabe, 2004) in order to deal with all the items on their work agenda. In such situations nurses can feel a greater need to use the power voice in order to exclude and steer the communication with the patients and relatives.

Communication is a constantly ongoing process that cannot be shut down and how nurses communicate affects patients' well-being (Nygren Zotterman et al., 2016). A good nurse-patient-relative communication exchange needs a balance between the medical voice, the nursing voice and the pedagogical voice, which, if achieved, reduces the need for the power voice and promotes the emergence of good nurse-patient-relative communication.

Trustworthiness and limitations

The choice of ethnography as a methodological approach, with the combination of different data collection methods, enhanced the study and made it possible to gain greater insight from different perspectives. The ethnographic research method gave the researcher the opportunity to be present in the activities and to study actions, exchanges, interactions and cultural phenomena in natural situations (Silverman, 2006), which strengthens the study's dependability as the observations were made at different times and places in the wards. Field notes, field conversations and interviews provided rich descriptions of the nurses' communication exchanges with older patients and relatives. Detailed descriptions of the participants, setting, method and results have been provided, which strengthens the credibility, and quotes have been provided in the results to strengthen the confirmability (Silverman, 2006; Fangen, 2005). In order to ensure response validity (Hammersley, 2006), the preliminary results were reported to some of the nurses, who confirmed the researchers' conclusions.

The first researcher, who conducted the actual observations and interviews, had only limited prior experience of older care and therefore had no particular preunderstanding of the

subject at hand. Two of the remaining members of the research group had professional experience of providing care to older people. All analyses and research decisions were discussed and agreed by all the members of the research group.

To be present as a researcher in the situation that is being observed requires awareness of the fact that the situation can change and/or be affected in different ways by the researcher's presence. There is always a risk that individuals modify their behavior in response to their awareness of being observed (Silverman, 2016). To reduce this risk, the researcher worked alongside the nurses for two weeks prior to commencing the actual fieldwork, in order to get to know the nurses and their work, and to become a familiar face in the wards.

The study was limited by the collection of data from only two locations. The findings are therefore more appropriate for achieving conceptual understanding than for generalization.

Conclusion

The study's findings serve as a description of how nurses communicate with older patients and relatives in a department of medicine for older people and of how communication is a tool for nurses in their profession. Effective nurse-patient-relative communication exchanges are important for the discipline and profession of nursing. The nurses used four voices when communicating with patients and relatives: a medical voice, a nursing voice, a pedagogical voice, and a power voice. If nurses plan their communication exchanges and are successful in combining the voices, while limiting the use of the power voice, the communication exchanges can become a more positive experience for all parties involved and patients and relatives can become more satisfied with the care.

Relevance to clinical practice

Working for improved communication exchanges between nurses, older patients and relatives is crucial for establishing a positive nurse-patient-relative relationship, which is the basis for enhancing patient care and can improve the patient's healthcare outcome. The findings can be used by nurses in training interventions as tools for improving nurse-patient-relative communication. The training can be done in for example reflecting teams in hospital wards. In a wider perspective this knowledge can be used in the context of nursing education when training nursing students to communicate with patients and relatives.

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