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**INTERACTIONAL ACCOMPLISHMENTS BETWEEN NURSES AND DOCTORS IN A
MEDICAL CONTEXT**

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COMPULSARY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: _____ Date: _____

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ABSTRACT

The use of language is significant in co-constructing reality. This highlights the way that speakers relate to each other through talk with the available discursive positionings in a specific context. An institutional context with particular asymmetrical relations introduces how the construction of reality is an area accessible to explore the use of language in maintaining and creating power relations. This research study explores institutional talk through conversation analysis. The focus is on asymmetrical working relations in medical settings. This considers the implications on individuals with a differentiating status with how power is managed in conversations. Nurses and doctors represent asymmetrical relations and their conversations illustrate differences in the way that language creates reality in a medical context, in this case a public teaching hospital in South Africa.

Nurses and doctors were recorded during ward rounds, which spanned 22 hours of audio recordings. Approximately 40 ward rounds were followed where both a doctor and nurse were present. Ward rounds provided an opportunity to capture nurse-doctor conversations. The recordings were supplemented by ethnographic data that focused on the management of power. This focus is both at an individual interactional level and at a broader institutional level. Thus, showing how language coincides with the predominant subject positions available in a medical institution. The findings show how doctors do power overtly through various ways of speaking which show leadership in interactions. The findings also show how a doctor's subjectivity relates to qualities that continually build superiority in interactions. Nurses, on the other hand, manage power indirectly, by negotiating agency while enacting a passive actor role in conversations. Both doctors and nurses manage power and assertiveness, but continually show the sensitivity embedded in orienting themselves to one another. This aids in showing speaker support and is especially important for nurses, who are in a lower status, for managing their position in relation to doctors.

Keywords: Conversation analysis, power, discourse, subject positions, nurses, doctors

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CHAPTER ONE

INTRODUCTION

Why a study on nurses and doctors?

The aim of this dissertation is to explore the management of power between actors in an asymmetrical relationship. Power is relational and speakers continually attempt to influence and control each other in conversation. Language is thus important, considering that it provides a common resource for many speakers to enact influence and control. However, these attempts become complicated when asymmetry is present between speakers. Hierarchy introduces consistent patterns that enforce relations of domination (Thompson, 1984). This is keeping in mind that power relations are fluid and thus power can be negotiated between actors (Svensson, 1996). I therefore attempt to explore relations of domination with attention to actors negotiating a professional working relationship. This study is conducted in a medical institution and I have chosen relations between nurses and doctors to explore power relations. Asymmetry, power and language have been extensively studied in various settings, for instance in contexts such as courtrooms, schools and medical institutions (Atkinson & Drew, 1979; Fisher & Groce, 1985; Ng & Bradac, 1993; Wodak, 1996). These institutional settings have provided the starting points for this dissertation. Primarily, this is because of the gap in this literature in exploring asymmetry in working relations.

Asymmetrical relations are evident in medical settings and often doctor-patient interactions have been explored in these settings. There has also been a great deal of work in this area compared to other institutional settings (Sarangi & Roberts, 1999). Atkinson (1999) argues that there is a doctor-patient bias in exploring asymmetry and language use in medical settings. The use of language has been explored with how it constructs doctor-patient relations, considering the usual disparity in status and expertise in medical knowledge. Furthermore, ethical discussions within patient advocacy increase the 'marketability' of research in this area (Thompson, 1984). Patient-doctor or client-expert relationships are important in exploring how conversational dynamics construct issues of power and intersubjectivity. However, relationships amongst peers in the expert category serve as an opportunity to explore issues within working relations (Berger,

Ridgeway, & Zelditch, 2002; Sarangi & Roberts, 1999). Atkinson (1999) also argues that there are limits when exploring medical practice and knowledge from restricted perspectives. Medical discourse and power in collegial interactions are often neglected, but nevertheless sheds light on medical practice and knowledge, and on the implications of asymmetry in relations.

However, despite the bias on client-expert relations there has been an increase in workplace studies focusing on professional working relations. This is particularly with language use in constructing power relations. Atkinson (1999), for instance, explores language use between differing ranks amongst doctors. Kelly (1998) also stresses the importance of exploring talk with nurses, patients and others in accomplishing the everyday social order of a specific context. Ten Have (2001) also shows how an increase in workplace studies are highlighting issues of collaboration, coordination and negotiation amongst colleagues (Holmes, Stubbe & Vine, 1999). These studies have focused particularly on language use amongst colleagues and provide a resourceful base to compare nurse-doctor relations to general collegial relations.

Furthermore, workplace studies have methodological and analytical implications that contribute to the design of this research study on nurse-doctor interactions. Sarangi and Roberts (1999) show how literature in workplace studies is distinguished between two approaches. The one approach refers to a sociological approach which has an institutional and ideological analytical perspective. These studies focus on the relationship between knowledge and power, and relate power to issues of surveillance and control from a hegemonic perspective. The socio-historic elements of the context are important and ideology is explored without necessarily focusing on language use between actors. The second approach focuses on a sociolinguistic approach that highlights language use between actors. This is extensively explored within conversation analysis which claims that a detailed analysis of conversations show how institutional identities are accomplished through talk. The cultural scripts within the various discourses in a medical context are not a given, but rather conceptualised as practised and observable within text, i.e. in the minutiae of conversations (Seedhouse, 2004). A sociolinguistic approach which focuses on power has made attempts at integrating a sociological approach. However, the accomplishment of power in interactions is often the main focus. This distinction is useful, because I attempt to focus the analytical component of this dissertation on the second approach. I attempt to reference

a sociological approach by continually asserting that language use is informed by discourses, and especially by subject positions within discourses. The details of conversation will be complemented by drawing attention to issues of knowledge and power. Power will be related to the expectations which constrain nurse-doctor subjectivities. However, the interactional accomplishments of power based on asymmetries of language use will guide the methodology and analysis of nurse-doctor interactions.

For this reason, the key arguments of this dissertation focus on asymmetry and power in nurse-doctor interactions with attention to language use. This is complemented by addressing the various subject positions from which nurses and doctors draw. The literature that addresses nurse-doctor relations has guided my attempts at introducing a sociological approach. These studies have addressed nurse-doctor subject positions and the political nature of nurse-doctor relationships (Davies, 2003; Leonard, 2003; Sundin-Huard, 2001; Sweet & Norman, 1995). The literature in nurse-doctor relations has not often employed a conversation analytic approach, but language has been addressed, especially by discussing the conceptual shift in nurse-doctor studies. This is from an earlier unquestioning and deterministic approach of talk between doctors and nurses to a nurse's agency in the negotiation of talk between nurses and doctors (Hughes, 1988; Porter, 1991; Stein, 1968; Svensson, 1996). However, as Kelly (1998) argues, a fine-grained analysis of conversations, for instance in nurses' and doctors' talk; reveals how they routinely and rationally talk their context into being. Furthermore, how power is negotiated is said to be found in a larger and more detailed collection of conversations that allude to how nurses and doctors view each other. This methodological approach has not often been employed with nurse-doctor conversations, but has been attempted and advocated by Kelly (1998) in nursing care. I thus focus on a detailed analysis of conversations and then relate this to the various subject positions nurses and doctors use to relate to one another. Particularly, the question is on how language and subject positions interact with one another.

I therefore contextualise this study within medical institutions due to the gap in literature that use a sociolinguistic approach, and specifically conversation analysis, to analyse working relations. I pool trends in doctor-patient interactions to support my aims in using conversation analysis. This is related to working relations in order to construct an extensive discussion on nurse-doctor

interactions. Workplace studies are therefore used to draw attention to collegial interactions (Atkinson, 1999; McHoul & Rapley, 2002; Sarangi & Roberts, 1999). The studies which have explored nurse-doctor interactions have then been used to shift my perspective by using an applied conversation analytic approach that addresses both distinct traditions in workplace studies. I also use literature within nurse-doctor relations that explore language and power within interactions, and relate this with conversation analysis. This is if conversational analysis has not been directly related in those studies. I will focus on power and talk as an active process of constructing working relations.

Theoretical/conceptual framework and research questions

I have previously alluded to the theoretical underpinnings of this study by referring to conversation analysis and nurse-doctor subject positions. An overview of the theoretical and conceptual framework is needed to situate the specific research questions and to introduce the literature supporting these questions. I therefore briefly outline the central arguments of this dissertation in relevant theories and concepts.

The practical purposes in interaction

Social constructionist theories focus on the construction of ‘reality’ in everyday activities and practice. Garfinkel (1967) advocates an ethnomethodological approach highlighting the fact that interactions in practice are accomplished between people. This shows that actors in a relationship have particular goals and interests that facilitate how they interact with each other (Shotter, 1984). It is for this reason that context is essential to the interests of particular actors. The interests of nurses and doctors are inextricably linked to the institutional and societal knowledge and practices available to them. The way that actors construct themselves, to themselves and to others is by intersubjectivity. This introduces the importance of discourse and the presentation of self in interactions (Goffman, 1959). Nurses and doctors have cultural scripts that they can use to manage themselves in interaction. What defines a nurse and doctor is informed by what impressions a nurse and doctor are supposed to have, e.g. how a nurse is supposed to be, and how a nurse is supposed to be in relation to a doctor. Furthermore, various interests aim at

controlling or influencing another's interests amid presenting oneself to another. Cultural scripts are therefore important in showing how power is produced and reproduced between actors. However, social constructionist theories continually add to this by highlighting the (re)construction of practices, allowing for both active and passive actor roles.

An issue in highlighting institutional practice, such as within medical institutions, is that power can be illustrated among actors with differential statuses. Individual interests are extended along patterns given asymmetrical relations of dominance and authority. The presentation of oneself is tied to consistent patterns of one actor having power over another, i.e. doctors have power over nurses (Ng & Bradac, 1993). This is a common feature in working relations and introduces the implications of asymmetrical relations.

Asymmetry, power and relevance

'Ordinary' conversations are distinguished from conversations between speakers within institutions (Warren, 2006). Institutional talk introduces the relevance of workplace studies considering the specific expectations, goals and constraints associated with an institution (Atkinson & Drew, 1979; McHoul & Rapley, 2002; Ten Have, 1999). This is important when comparing talk with actors in a seemingly symmetrical relationship to an asymmetrical relationship. Expectations, goals and constraints become stratified along differences in symmetry. An actor with a higher or lower status is aware of these differences, whatever the level of consciousness may be, and this is reflected in their language use.

Power at the level of actors' expectations and language use are the two distinct areas of interest in this study. The expectations associated with nurse-doctor subject positions relate to patterns in language use. It is important at this point to be explicit about the concept of power, especially since I explore power at different levels between nurses and doctors. The concept of power is related to its use both in terms of discourse and knowledge, and to how it is practically accomplished in interactions (Hollway & Jefferson, 2000; Leonard, 2003). Unequal power relationships, given specific subject positions and discursive positionings, are continually related to language in interactions. This defines the achievement of power (Ng & Bradac, 1993). The

theoretical frames provided by social constructionist theories and ethnomethodology show how institutional talk is practically accomplished, especially since conversation is a common feature within interactions.

Language is therefore a key aspect in exploring the achievement of power. A significant question characterising the analysis of nurse-doctor interactions asks what these actors are trying to achieve in speaking to one another, and whether this achievement has anything to do with trying to control or influence each other. Language is seen as an important tool in exploring how actors meet their interests through conversation (Shotter, 2005). Again, these interests relate to the particular context and draw attention to both language and discourse.

Conversation and discourse

The concept of discourse is necessary to include, considering the research question and setting. Research within institutions often needs a broad scope. Actors' interests are linked to the expectations of the institutional roles they encompass (Ten Have, 2001). These expectations refer to general medical practice and knowledge as well as to the specific tasks at hand, which in this study are ward rounds (Sarangi & Roberts, 1999). Discourse is therefore important in establishing the asymmetry in a particular context by showing what it means to be a doctor and a nurse.

Asymmetry is also shown in language by exploring the interactional strategies of influencing and controlling others in conversation. Conversation analysis, with its premise on language use, guides the dominant aspects of the analysis in this dissertation. The attention to subject positions, however, aims to gain a comprehensive discussion on power and asymmetry in nurse-doctor relations.

Research questions

This study focuses on both discourse and language use. This is reflected in the methodology used to examine the implications of asymmetry between nurses and doctors. An ethnomethodological

approach that uses conversation analysis (CA) is used to gain an emic perspective of doctors' and nurses' patterns in managing power.

Approximately 40 ward rounds were recorded that amount to 22 hours of audio recordings. This takes place in a neurosurgery ward in a public teaching hospital in South Africa over a period of two and a half months. Recordings are a traditional source of data within CA and I attempt to gain a detailed transcription of conversations. The structural elements of language are related to individual interactional accomplishments. In addition to recordings, ethnographic data are used to supplement the recordings. This includes field notes, observations and conversations with nurses and doctors before and after ward rounds. Power is examined in the form of patterns and exceptions in language use. Language is then related to broader positionings of domination and subservience. In this way the following research questions are addressed.

The assumption is that doctors hold a privileged position that is constructed and reconstructed in discourse, and in language use. Conversations show the dominance of doctors in expressing control and influence. The question therefore lies in the specific ways doctors *do* power. This includes doing power at different levels of abstraction. Thompson (1984) argues that power can be illustrated at a conversational and institutional or structural level. Conversationally, power is related to turn taking and to specific linguistic strategies that show influence and control. Intersubjectivity is important and patterns in language use are inextricably linked to the discursive positioning of a doctor in a medical context. Therefore, how does discourse on doctor subjectivities interact with language use?

These research questions are compared to nurses who make up conversational and institutional roles that show submissiveness. Therefore, how do nurses show submissiveness?

At the same time, keeping the concept of power as fluid and relational, how do nurses manage power, resistance and agency? And how do doctors react to nurses in these situations? Again, what does this mean for nurse and doctor working subjectivities, i.e. what are the relevant nurse-doctor subject positions at work? Furthermore, nurses and doctors are sensitive to each other, and considering how power is managed, how are these actors enacting favourable or unfavourable impressions? What does showing support mean for managing power?

It is also important to continually ask about discourse in terms of space and other elements, including gender and race. It would be a disservice to a discussion on nurse-doctor interactions to exclude these relevant topics. It would also be further reinforcing the critique on many studies using conversation analysis which narrow the focus on discourse in favour of including specific (all too) detailed aspects of expressing influence and control (Parker, 2005; Sarangi & Roberts, 1999). This was a direction the analysis almost took and was corrected by giving due attention to subject positions at an institutional and structural level.

The contribution of this dissertation

Chapter One has introduced an overview of the central themes that will be fleshed out in the forthcoming chapter. The basis and rationale for this dissertation was discussed alongside the relevant theoretical and conceptual frames. These frames provide the departure point for the ongoing discussion on nurse-doctor interactions. This is explicitly expressed in the various research questions that will be grounded in the following chapters. Chapter Two develops the theoretical and conceptual framework previously introduced. The analytical and concluding arguments are therefore contextualised and justified by referring to previous research and literature. Specific studies that contribute extensively to the influence of this study will be explored and evaluated. Chapter Two is therefore divided by a theoretical and conceptual review followed by an empirical literature review. Chapter Three covers the research setting and methodology in detail. This includes the analytical background for Chapter Four, which constitutes the data analysis. Chapter Four is one section exploring how doctors and nurses manage power. This chapter is subdivided into six sections. The management of power is explored firstly with doctors and then with nurses, and then both actors are included to discuss speaker support and across type generalisations. Throughout Chapter Four, the conversational and institutional aspects within nurse-doctor interactions are related to one another. Language use is specifically related to discourse in terms of subject positions. The concluding chapter summarises as well as synthesises the key aspects of this dissertation. The findings are related to the research questions posed in this initial chapter, and these findings are also related to previous

literature. Lastly, within the concluding chapter, methodological issues and suggestions for further research are mentioned.

CHAPTER TWO

THEORETICAL/CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Theoretical and conceptual framework

This chapter will elaborate on the theoretical and conceptual framework discussed in the preceding chapter. This is followed by a presentation of the empirical literature that greatly influences the data analysis, and provides the groundwork for answering the research questions previously mentioned.

Ethnomethodology and the intertextuality of discourses

Social constructionist theories have been important in informing how social realities are shaped. Social realities are argued as being shaped by the interests of the people or actors in particular contexts (Shotter, 1984). Actors' interests create how interactions will be tactfully managed. Garfinkel (1967) advocated an ethnomethodological approach claiming that reality is practically accomplished between people. This suggests that people have particular interests and together co-construct reality. Interactions are not seen as disorganised and incomprehensible phenomena, and increasingly interactions became a key field of study together with individual interests in interaction. Garfinkel (1967) also proposed that individual interests in interactions were filled with structural characteristics. These characteristics could show an actor's goals achievable in interaction. Goffman (1959) for instance had earlier related goals in interactions to the presentation of the self. This highlighted the importance of impression management in interaction. Furthermore, as interactions are primarily characterised by conversations, language between speakers became a useful tool to explore how people achieve particular interests. Garfinkel (1967) also stressed that interests such as managing the self or subjectivity do not often occur consciously. It is therefore important to reflect upon interactional processes that are often 'taken for granted', but reveal much about individual investments and behaviour.

The social construction of reality is further supported by discourse research. Actors have both a passive and an active part in their context. They engage, in varying degrees, with the knowledge

or discourse available in certain settings (Hollway & Jefferson, 2000). Discourse is socially practised and is also informed by that practice (Fairclough, 1989). For this reason, there is significant literature within nurse-doctor relations that argue that nurses are not unquestionably subservient actors acting in accordance to the omnipotence of doctors (Wicks, 1998). The practice of discourse in working relations draws attention to the negotiation of subject positions (Svensson, 1996). Nurses are argued as having both a passive and an active part within their workplace, drawing from discourses that inform covert and overt forms of language use when interacting with doctors (Porter, 1991). Discourse is therefore not simply seen as a top-down approach in exploring power relations. Furthermore, the concept of discourse can be interpreted or defined in various ways, depending on a given theoretical approach (Fairclough, 1989; Parker, 1992; Thompson, 1984). Parker (1992) usefully conceptualises discourse by focusing on its methodological application. This draws attention away from understanding discourse within a theoretical or philosophical debate, but rather focuses on how discourse can be put to use to support an argument. I will not apply discourse analysis, but I use Parker's (1992) methodological approach to explore the various discourses informing nurse-doctor subjectivities from an ideological and interactional perspective.

The application of discourse in this dissertation is specifically relevant in its relation to intersubjectivity and power. As previously alluded to, actors may take on discourses that show how subject positions both empower and disempower actors in interactions. Shotter (1984) suggests how norms, roles and ideas in discourse become useful for managing subjectivity and meanings within interactions. Actors use discourse to make sense of their position in relation to others, to themselves and the world (Avdi & Georgaca, 2007). This makes up discursive positionings or subject positions which inform meanings to actors' experiences. These meanings are continually related to other subjects within and between discourses and therefore individuals are constructed with and through others. Parker (1992) also refers to the importance of intertextuality which points to discourse being maintained, produced and reproduced through the relationships it has with other discourses. Discourses may at once support and contradict meanings with other discourses. Leonard (2003) argues that there is a range of subject positions that nurses and doctors draw from that are complex, ambiguous and continually shifting among a number of different discourses. For example, a professional discourse impacts nurses and

doctors, but so does a changing organisational discourse. This can be extended to a discourse on gender difference or race. A number of discourses can be shown to relate to positioning nurses and doctors within a medical institution, including the medical discourse itself. This shows how various subject positions are socially practised with varying relevance for particular actors (Hollway & Jefferson, 2000). The various discourses discussed are important, but they will not be extensively explored. Rather, these discourses will be limited to how they impact, and especially how they achieve intersubjectivity, power and language between nurses and doctors.

Intersubjectivity, language, and facework

Subjects are not static, but are constituted in relation to other subjects (Parker, 1992). This is within a medley of discourses that, given a difference in status and hierarchy, may illustrate various dynamics within power relations. Intersubjectivity within various discourses impacts how both nurses and doctors see themselves in relation to each other. Leonard (2003) argues that different and competing discourses offer subject positions that may simultaneously constrain and attempt to liberate actors investing in those subject positions. Nurses and doctors may feel empowered or disempowered by the available subject positions. Within a professional discourse, nurses may feel empowered by having to be identified as a supportive nurse for doctors, but nurses may also feel disempowered within an organisational discourse that calls for nurse autonomy and independence. These positionings are informed by what it is to have a favourable or socially acceptable self (Goffman, 1959; Sundin-Huard, 2001). For instance, is a supportive nurse 'good' or is an independent or autonomous nurse better in working relations? The importance of presenting the self is involved with individual goals in conversation. These goals attend to issues of impression management and these impressions relate to actors' interests of influence and control in conversations.

Self-management in interactions or intersubjectivity is inextricably linked to power relations (Hollway & Jefferson, 2000). This is by relating individual goals to influence and control, and to multiple discursive positionings. Davies (2003) argues that subjectivities between nurses and doctors are performed. Manias and Street (2001) also show that gender difference and inequality is performed by doctors and nurses in 'everyday' interactions through talk. Power in terms of

institutional roles and impression management can therefore be related to language. Power relations are maintained, produced and reproduced through the medium of language in interactions.

Atkinson and Heritage (1984) note how the use of language, as a significant resource in interactions, became widely used in exploring the construction of reality. Feminist research explored this vein in social constructionist research, and uses the relationship between language and the notion of intersubjectivity or subject positions to explicate existing power relations (Davies, 2003; Hollway & Jefferson, 2000; Sundin-Huard, 2001). Nurses are often emphasised in exploring nurse-doctor relations, especially in the shift in literature exploring nurse agency (Wicks, 1998). Power is significant in various contexts, and has been shown with gender difference and patriarchy in institutions. Language, as a common feature in different contexts, is useful in exploring the purposes involved in managing conversations (Atkinson & Heritage, 1984; Kelly, 1998). This introduces the relationship between managing power while constructing oneself through language.

Norms within a specific context also inform and are informed by the notion of recipient design in accomplishing conversations (Ten Have, 1999). Speakers use language to orient themselves to others which is important for intersubjectivity and impression management. However, preference in exploring language use and impression management are different from each other. The former relates to specific preferred and dispreferred responses, while the latter relates to actors presenting appropriate or preferred impressions. I use both within this dissertation. I specifically attempt to relate impression management with preference organisation in language use. This is a distinction I will return to in discussing conversation analysis. Nevertheless, impression management characterises a significant approach in exploring power, language and subject positions. This approach has typically been related to examining power within institutions (Ng & Bradac, 1993; Seedhouse, 2004). This can be shown particularly by relating Brown and Levinson's (1987) concept of facework with impression management and recipient design.

Facework entails managing one's face, i.e. one's public self-image. The idea of being a 'good' or 'bad' actor relates to power by having actors meet interests of success. This shows how facework

is related to the expectations in a given context. Power in terms of self-empowerment or disempowerment creates the fluidity of power (Leonard, 2003). An actor's 'face wants' are associated with their interests in being socially approved and unimpeded by others. However, 'face wants' can be easily threatened and the term 'face threatening acts' (FTAs) is introduced alongside the management of power. The source of these threats varies, but norms which construct favourable subjectivities offers a departure point for relating impression management, power and language. Brown and Levinson (1987) argue that facework addresses the issue of recipient design where social approval and acceptance plays an important role in managing subjectivity and hence conversations. The notion of politeness within facework, for instance, explores power relations by highlighting the management of FTAs.

Facework and politeness are complicated by differentiating statuses. Brown and Levinson (1987) show that politeness is categorised as expressing solidarity as well as avoiding being an imposition. Speakership, i.e. patterns in speaking turns, shows how asymmetry allows certain speakers to initiate more FTAs, and therefore how this relates to politeness. Mitigation can also be used differently by nurses and doctors. Facework takes on particular patterns between stratified categories. Nurses, for instance, may encounter more FTAs than doctors given that they are in a lower status than doctors. Doctors are also decision-makers and have to give instructions. This is face-threatening as this impedes on a nurse's face by the mere 'telling' of instructions. Power is thus related to how language is used within patterns of FTAs. Furthermore, sensitivity to increased FTAs illustrates speaker support in language which makes for tactful management of conversations.

Speaker support is an essential concept in order to further contextualise facework, language and power. Seedhouse (2004) notes that showing others support during turn-taking illustrates the reciprocity of perspectives as well as politeness. Actors in conversation show that they are following the same norms in interaction and these norms relate to actors affiliating with another's perspective. This is illustrated when actors attempt to continually build rapport and common ground, and shows the bias towards cooperation within interactions. This relates to preference organisation in terms of language use rather than that of managing culturally preferred subjectivities, i.e. through subject positions. However, these areas are related as seen

within facework. For instance, doctors may not readily answer a nurse's question, based on a subject position that engenders them as the leader and not the follower of a nurse's speakership. This is face-threatening for a nurse. Conceptually, however, they are different, as the former instance relates to specific patterns of turn-taking that are affiliative or in this case disaffiliative, while the latter focuses on impression management relating to subject positions. Regardless of this example, a trend towards cooperation is relevant in working relations. Colleagues see each other frequently. For doctors and nurses, the success of ward rounds depends on establishing a cooperative relationship where both meet each other's interests. Uncooperative interactions between doctors and nurses during ward rounds may lead to breakdowns that are time-consuming and hinder the progress of ward rounds. The reciprocity of perspectives is useful to meet both actors' interests of success. It is useful to explore conversational breakdowns in relation to language and subject positions. This shows patterns in speaker support, and attends to facework.

It is important to uphold the significance of power in aligning one's perspectives with another, as shown in the previous example. Interests of support do not exclude the processes of enacting influence and control. On the contrary, speaker support is a means to initiate turns and inform impression management. These are interests that include actors exerting influence and control, albeit not with the assumption of relating power to negative controlling turns. Individual interests may be supportive and still show influence and control. Constraints within institutional talk are shown in the access and use of speaker support. This relates power at an individual level of action and at a hierarchical institutional level. The professional role of nurses may be more supportive. Doctors are to be followed and attended to. Thompson (1984) argues how patterns of asymmetry and domination can be shown through patterns in language use. Intersubjectivity and institutional realities are therefore a central place to explore power in asymmetrical relations. Power can in this case be shown to be examined most effectively by relating it to discourse and social interactions or relationships within the limits prescribed in a specific institution.

Power within the medical institution

Wodak (1996) advocates the importance of analyzing power relationships in institutional discourse. Atkinson and Heritage (1984) suggest that language within institutions can be systematically explored to show patterns in talk that may be specific for that context, and thus show the power relations and subject positions at work. There are particular demands within an institutional interactional setting (Wodak, 1996). These demands construct nurse-doctor relations given the various needs and problems that are encountered in managing healthcare. McHoul and Rapley (2001) note how talk within an institution is goal-oriented and this makes that talk relevant in that context. These goals also constitute norms within the medical setting and depict what Goffman (1959) argues as the working consensus. A working consensus shows the regulatory processes at work and helps make sense of that context (Wodak, 1996). In medical discourse and medical practice, the role of the doctor and the nurse is constructed differently. There are differences in the rights and obligations for nurses and doctors in managing healthcare, especially regarding issues of authority in work performance (Fagin & Garelick, 2004). For this reason, subject positions guides the relationship between language and power relations.

Nurse-doctor interactions show how talk in institutions varies from ‘ordinary’ conversations (Sarangi & Roberts, 1999). Atkinson and Heritage (1984) argue that the rules in ‘ordinary’ conversations help explore patterns in talk that reshape these rules, i.e. transformational rules. The conversational rules in symmetrical relations, as depicted by a conversation analytic approach, may be related to managing power and authority between speakers who, at the onset, have an imbalance of power. For instance, as previously mentioned, doctors may not readily answer nurses. This is a dispreferred response and does not often occur in ordinary conversations. However, this may occur routinely in conversations between doctors and nurses. This may be explored to further show why actors are speaking in certain ways that are relevant for that context. Language can show how managing power is verbally organised within institutions by showing actors’ interests in managing influence and control in conversations.

The use of language to achieve influence and control in conversations is achieving power (Ng & Bradac, 1993). However, power in this dissertation, is conceptually separated by different levels

of abstraction (Thompson, 1984). I apply the concept of power advocated by Ng and Bradac (1993) who consider power at one level as being the opportunity to realise one's goals or hinder another's goals. As mentioned, individual goals can be related to impression management or various interests within a medical institution. Power is shown by one actor controlling or influencing another, with control being more explicitly and forcefully expressed than influence. Power in language is also relational (Fisher & Groce, 1985). I reflect on how speakers reinforce and resist influence and control through the tactful use of language. The management of power is also important within managing agency and resistance. Nurses may show resistance given that they do not have power over doctors. Nurses may also show influence and control more overtly considering the shift in organisational discourse within nursing (Porter, 1991). Ng and Bradac (1993) also suggest a second approach in conceptualising power. One actor may have power over another which is relevant in asymmetrical relations. Power is related to broader processes of domination and resistance.

Therefore, levels of power are necessary to distinguish individual actions and interactional orders from more structural forms of domination (Thompson, 1984). Power can be related to institutional norms and hierarchy, as well as ideology in terms of consistent relations of domination. Dialogue between nurses and doctors is shaped by the discourse and disparity in status in a medical institution. The relationship between individual actions and dominant or subservient roles show how power is working at both levels of abstraction (Leonard, 2003; Sundin-Huard, 2001). Power is thus continually practised and reproduced and subverted in language, and works with the intuitively relevant positions and subjectivities (McHoul & Rapley, 2001). Ng and Bradac (1993) explore both approaches to conceptualising power from a theoretical and conceptual perspective. However, an extensive discussion on empirical literature is needed in order to ground such concepts. The following section attempts to cover empirical literature by relating this literature to the analysis of nurse-doctor interactions.

Empirical literature review: Subject positions and conversation analysis

Subject positions relate to differentiating, making and playing the roles of a nurse and doctor (Leonard, 2003). The performance of positionings associates language to discourse. Asymmetry in working relations also complicates the management of power. The following section will separate themes owing to the two distinct levels of abstraction discussed previously. Firstly, specific literature will be outlined exploring power with nurse-doctor subject positions. Secondly, power within strategic uses of language will be discussed.

Subject positions and power between doctors and nurses

Doctors and nurses can use various subject positions to relate to one another. A key issue is addressing how they use these positions to be empowered or disempowered in everyday working interactions.

'Good' and 'bad' subjectivities

Wodak (1996) suggests that the institutional and social authority of a doctor is embedded in discursive positionings which define doctors as infallible experts. Doctors have been extensively discussed in doctor-patient interactions, especially in the literature using a conversation analytic approach (Atkinson, 1999; Fisher & Groce, 1985; Swartz, 1991; Ten Have, 1991; Wodak, 1996). This aids the construction of doctor subjectivities within the medical institution. The social construction of doctors is further discussed in relation to nurses in literature that explores nurse-doctor interactions. The implications of asymmetry, and a doctor's authority and dominance are both shown within doctor-patient relations as well as collegial relations. For doctors, their professional and institutional role is characterised by rationality, authority, objectivity, decisiveness, mental strength and individualism (Atkinson, 1999; Davies, 2003; Wodak, 1996). The various characteristics associated with doctors inform an infallible subject position within the professional discourse. This is important when relating greater professional knowledge, credibility and responsibility with a doctor subjectivity (Sarangi & Roberts, 1999). The expectations related to doctors impact how they appraise nurses, and how others appraise doctors.

The expectations of certain types of actors introduce how 'good' and 'bad' subjectivities are constructed. 'Good' doctors do not make mistakes, because they are infallible experts. This is supported by a doctor's superior knowledge. Language uses can be explored to show how doctors maintain a subject position that is in control at all times. The construction of a doctor's subjectivity is a case example of the distinction between 'good' and 'bad' actors. The implications of such preferences within impression management were drawn by Fisher and Groce (1985) when they explored how cultural assumptions filter into medical practice. It is important to note that despite this construction of doctors, doctors may interact in ways that contradict this subject position (Svensson, 1996). It is important to continually draw attention to the fluidity of power in interactions. Nevertheless, dominant subject positions offers insight into patterns of behaviour that might often reconfirm what may be both an empowering and a favourable subjectivity, as shown in the study conducted by Fisher and Groce (1985) in exploring culturally preferred subjectivities.

Fisher and Groce (1985) analysed doctor-patient conversations in a medical setting in the United States. These conversations were during an initial medical interview between male doctors who diagnosed and treated female patients. In Fisher and Groce's (1985) study, it was the construction of 'good' and 'bad' patients or women that was significant for exploring asymmetrical relations and discourse. Culturally preferred subjectivities for women showed how doctors treated female patients differently. For instance, women who were more promiscuous were 'bad' women. Doctor-patient conversations illustrated that doctors showed a lack of reciprocity within conversations. Culturally preferred subjectivities may correspond with patterns in language use which are preferred or dispreferred. I will elaborate on this further when discussing preference organisation within studies using conversation analysis. However, it is important to note that I use preference in two distinct ways. Fisher and Groce (1985) address preference in terms of favourable subject positions. These subject positions impact interaction in terms of preferred and dispreferred responses in conversations. There was a considerable pattern of gaps, silence and misunderstandings in conversations with the 'bad' patient and woman in Fisher and Groce's (1985) study. These patterns are not preferred responses and specifically when in response to a question. Gaps, silence and misunderstandings when answering others are

not preferred. The doctor showed more of these patterns depending on which patient was judged as 'good' or 'bad'.

The doctor also showed conversational patterns that correspond to a doctor's subject position discussed earlier. The doctor showed that he knew best and would not be questioned by the 'bad' patient. The doctor did not address her concerns or suggestions as he did with the 'good' patient. Thus, showing how a doctor might enact an infallible subject position more so depending on the other speaker. Although Fisher and Groce (1985) separate this by discussing 'good' and 'bad' patients, numerous studies exploring doctor-patient interactions show how doctors generally do not favour patients asking questions. Ten Have (1991) shows how doctors show their dominance with informational need. Doctors ask questions and attend less to the concerns and questions of patients. This builds routine interactions where doctors question patients, and not the other way around. This draws attention to what a 'good' doctor is. A 'good' doctor is efficient, objective and decisive. These qualities assist in constructing an infallible subject position. Fisher and Groce's (1985) study focus on how patients and women fit 'good' and 'bad' subjectivities, but this concept, as shown, can be applied to doctors as well. Furthermore, although Fisher and Groce (1985) also focused on gender differences, a critical point in their study guides the analysis of this dissertation. Preferred subjectivities show how doctors and nurses can be seen as 'good' or 'bad' doctors and nurses. This relates to patterns in language use that may correspond to preferred and dispreferred responses. As shown, a culturally preferred doctor may increasingly use dispreferred responses, i.e. an infallible doctor may not readily answer a patient's question.

Culturally preferred subjectivities within nurse-doctor literature have been more comprehensively represented in nurse subject positions. Nurses draw from different subject positions than doctors. Sundin-Huard (2001) argues that subject positions constitute various norms. A professional discourse constructs both what it is to be a 'good' and a 'bad' nurse. Leonard (2003) explores discourse thoroughly with 60 doctors and nurses in the British National Health Service. Interviews showed that nurses draw heavily from a professional and organisational discourse which construct 'good' and 'bad' nurses. Leonard (2003) argues that a professional discourse on appropriate working relations constructs nurses as 'handmaidens' whose professional qualities centre on holistic hands on care. This is translated in medical

practice. A traditional ‘good’ nurse obeys doctors, because of their institutional authority. A ‘bad’ nurse complains and challenges a doctor’s medical expertise. A ‘good’ nurse subject position is also defined as being a useful follower who attends to doctors’ needs. Stein (1968) supports these nurse-doctor subject positions by describing a deterministic and top-down approach between doctors and nurses. Therefore, Stein (1968) shows that nurses unquestioningly obey doctors. Doctors are in power and nurses have to interact with doctors from a subservient position. Conversations between nurses and doctors show how power can be enacted, given asymmetry in relations. This points to how actors may manage dominance and deference in everyday working interactions.

A professional discourse, however, is not fixed and organisational and structural changes provide possibilities of role confusion and change (Sarangi & Roberts, 1999; Sweet & Norman, 1995). Hughes (1988) conducted a study in aims of arguing partially against Stein’s (1968) views on a top-down approach in exploring nurse-doctor relations. Hughes (1988) examined how organisational change has impacted how nurses and doctors interact. This is important as the social construction of relationships allows actors to take on a passive and an active role with empowering and disempowering subject positions. Hughes (1988) argues that nurses do not only submit and follow doctors, but actively make decisions that are often seen as a doctor’s work. Hughes (1988) conducted a study in a casualty department of a British district general hospital. Fieldwork consisted of participant observation and the findings showed that nurses had played a significant role in diagnosing patients before patients met a doctor. Nurses also gave advice and did not only remain silent or give minimal input to doctors. Nurses negotiated a more empowered position in decision-making (Svensson, 1996). Svensson (1996), like Hughes (1988), shows the importance of a nurse’s agency in nurse-doctor relations. Doctors are in a higher status than nurses, but this does not necessarily determine unproblematic and unquestioning obedience (Porter, 1991).

This point shows how subject positions through the intertextuality of discourses position actors. For instance, an organisational discourse with changing democratic ideas about working relationships, calls for teamwork (Qolohle et al., 2006). For doctors, they may acknowledge their institutional authority, but understand the concern for a nurse’s autonomy (Leonard, 2003).

However, this shows that an organisational discourse presents conflicting subject positions. This concerns notions of the 'new' nurse (Sweet & Norman, 1995). The role of nurse has increasingly included more managerial responsibility, technical skill and professional autonomy within the British National Health Service, as is the case in other contexts (Manias & Street, 2001; Qolohle, Conradie, Ogunbanjo, & Malete, 2006; Sundin-Huard, 2001). Nurses have to act with more initiative and question doctors if necessary. This is at conflict with a nurse's traditional subservient role (Hoekelman, 1975). Power is thus enmeshed in complex processes of intersubjectivity among multiple subject positions in discourse.

Generalising power relations

The subject positions impacting nurses and doctors influence the fluidity of power. Nurses have to manage a status which does not have power over a doctor, but a doctor's power is not necessarily rejected. The legitimacy of a doctor's power is at once accepted and rejected, based on nurses' subject positions being both subservient and assertive within a professional and organisational discourse. Nurses may support and feel empowered with their subject position in an organisational discourse (Leonard, 2003). This is based on more independence, authority and autonomy. However, nurses may also feel empowered by a traditional subject position. Nurses may feel disempowered by the tension and new responsibility in an organisational discourse which does not stress a traditional 'good' nurse role. A traditional professional role may appear subservient, but it is still a relevant subject position for nurses. This positioning may be understood as constructing a 'good' nurse and therefore an empowered nurse. Caution is therefore needed when attempting to explore the social construction of working subjectivities.

The fluidity and unevenness of power is important especially as subject positions have complex relations within different discourses. Leonard (2003) argues that individual agency is critical for examining power relations. Therefore, various factors impact the construction of 'good' and 'bad' actors, and should not be taken for granted. Leonard (2003) draws attention to hierarchical difference and individual experiences. Nurses may be more inclined to be a 'handmaiden' for doctors depending on a doctor's rank or perceived character. Nurses may also be separated by in-group status differences. Leonard (2003) shows how meanings within an organisational discourse become less powerful the lower the nurse is within the hierarchy amongst nurses.

Senior nurses use subject positions within an organisational discourse to empower themselves. Junior nurses tend to draw on the professional discourse to empower themselves. Generalising patterns in managing power need to be related to these factors in order to talk meaningfully about power relations.

Berger et al. (2002), however, focus on intergroup relations given the stereotypical expectations of nurses and doctors. They argue that asymmetry constructs status stereotypes. The perceptions and expectations of nurses and doctors define the relations between them. Self-management is continually linked to socially acceptable subject positions. The qualities that are associated with a 'good' nurse may become generalised and assigned to all nurses, and a particular status stereotype is constructed. The role of subservient nurse is therefore reinforced and constructs nurse-doctor relations. A traditional nurse-subject position, although used in cases to empower nurses, is generally associated with inferiority and powerlessness. Nurses follow, support and obey doctors. Reid and Ng (2000) also argue that there is an element of othering within stereotyping. Leonard (2003) notes how a senior nurse, though constructing herself as powerful through an organisational discourse, acknowledges powerlessness in comparison to doctors. Doctors and nurses begin to fit and constitute different groups and particular intergroup relations are constructed. Asymmetry in relations guarantees that doctors have power over nurses, and thus patterns relating subject positions to doing dominance and deference is important.

Doing discourse: gendered and racialised subject positions

Power imbalances between doctors and nurses are not only informed by professional and organisational discourses. Subjectivities relate to discourses that vary from an institutional level to a broader societal level (Fairclough, 1989; Thompson, 1984). The majority of literature on nurse-doctor relationships highlights a significant gendered subject position (Davies, 2003; Leonard, 2003; Porter, 1992; Sweet & Norman, 1995). Patriarchy in medical settings contributes to the representation of doctors as men and women as nurses. Furthermore, stereotypical representations of gendered categories interact with subject positions in a professional and organisational discourse. Subject positions within a discourse of gender are enmeshed with meanings comparing the authority of men as doctors with women as nurses.

Davies (2003) argues that individuals do not relate with one another as genderless beings. Subjectivities are related to doing gender and dominance or deference. Davies (2003) outlines the socio-historic context of nursing care in Sweden emphasising the ongoing relationship of caring with nursing. This is followed by a study with nurses and doctors in a Swedish general hospital. Davies (2003) relates power to stereotypical practices of gendered relations. Gender stereotypes interact with a professional discourse. Porter (1992) argues that the division of labour shows how a nurse does women's work through service. Doctors cure while a nurse cares. A subservient role of nurse and an infallible role of doctor relate to women as emotional carers and men as rational leaders (Leonard, 2003). This polarisation not only reinforces difference, but an imbalance of power characterising gendered relations (Reid & Ng, 2000).

The notion of caring and nursing represents women as dependent and subordinate, especially since nurses are still represented by women. Davies (2003) argues that the professional discourse interacts with discourse on gender equating the qualities of femininity to nursing. Women care for others while being lead by men. Meanings can be mobilised or served to construct patterns of domination (Thompson, 1984). 'Good' practice can be reinforced and associated with inferior practice. For nurses, this involves following and obeying doctors. In contrast, men and doctors are decisive, objective, rational and in control. Patriarchy within a medical institution therefore informs much of the research on nurse-doctor relations. The comparison of doctor and nurse qualities shows the subservience in feminine or nursing qualities. Though they can be construed as powerful, these qualities can serve to sustain relations where women are objectified or reified as inferior subjects (Gavey, 1997). Nurses and doctors are essentialised by gendered and professional subject positions. Ideological effects can be shown with women being treated weaker, less knowledgeable and skilled in comparison to doctors (Parker, 1992). Porter (1992) illustrates how nurses and doctors view their work. Nurses do service work, while doctors carry out important medical decisions. This is despite how Hughes (1988) argues that nurses play an important role in decision-making with diagnosing patients. Hughes (1988) shows how nurses did not view themselves as diagnosing patients. Gender difference thus illustrates how nurses and doctors may have qualities reinforcing inequality. As Leonard (2003) points out, a senior nurse still felt powerless in comparison to doctors despite having more status within an organisational discourse. However, it is important to understand the unevenness of power

especially with how actors use subject positions. Feminine qualities can also be constructed as superior qualities. These qualities may give nurses a leeway in managing power with doctors. For instance, how can doing women's work empower nurses? It is thus necessary to relate subject positions with managing power and resistance.

Doing dominance or deference shows how power relates to performance as shown in doing gender. Gender is, however, not the only positioning explored with nurse-doctor relations. Swartz (1991) explores the politics of racialised relations in medical settings. The perceived cultural difference between nurses and doctors influences interactions. Shared knowledge becomes devalued in interactions. There are implications for creating rapport and building common ground based on such differences (Brown & Levinson, 1987). At the same time, a doctor's knowledge takes dominance, because of a lack of mutual understanding on particular topics. This is based on the status attributed to a doctor's knowledge. In a South African context, the history of apartheid has made race and socio-economic status key markers in reinforcing difference in asymmetrical relations. Swartz (1991) explores this with doctor-patient interactions in a South African psychiatric hospital, and points to the importance of othering in racialised relations. Working relations reflect not only gendered, but racialised differences. Swartz (1991) focuses on doctors and patients, but othering is relevant with work colleagues. Swartz (1991), for instance, notes the implications of using nurses as translators and how shared knowledge becomes reduced. It is therefore important to explore the implications of racialised relations in the workplace. In fact, dominant external categories of difference and othering are important to relate to working relations. However, based on the limited scope in this dissertation, these categories will be addressed in relation to language.

Literature has therefore explored the representation of broader processes of inequality based on external categories of difference. This includes categories in an institutional and societal level. Ideological effects can be traced to subject positions within a discourse on gender or race. Furthermore, positionings which define 'good' or 'bad' working subjectivities inform how nurses and doctors speak to one another. As alluded to in previous points, performance can be shown through the use of language to (re)construct subject positions. Language may thus explore tendencies in interactions that show the subject positions and power at work. I turn now to

literature that informs nurse-doctor interactions with regard to a conversation analytical approach in managing power.

Conversation analysis in examining power

The predominant literature exploring nurse-doctor relationships has related language to the power dynamics between doctors and nurses. However, this literature has not directly explored language by using conversation analysis (CA). Kelly (1998) advocates the use of ethnomethodology and CA in order to grasp the conversational mechanisms by which doctors and nurses interact with one another. Kelly (1998) has therefore implemented the use of distinct interactional organisations, which will be shortly discussed, when applying CA to nursing care. CA explores the detail of naturally occurring talk and this draws attention to its use in providing highly empirical data (Seedhouse, 2004). Sacks, Schegloff and Jefferson (1974) also note that the significance of CA lies in how language is ordered in conversations. Orderliness in talk is illustrated in the detailed transcription process which is a significant process to analysing conversations. Furthermore, considering that order is important within talk, the accomplishment of power can be explored in relation to an actor's aims in conversation. This is considering that orderliness in talk suggests that actors engage rationally with each other to (re)construct relations with one another (Kelly, 1998). Ten Have (1999) suggests CA can apply order in talk to a particular theory and explain institutional relations. As previously mentioned, this has been in contexts such as courtrooms, schools and medical institutions (Atkinson & Drew, 1979; Fisher & Groce, 1985; Wodak, 1996). Ng and Bradac (1993), for instance, have related power to language use. The achievement of power highlights how speakers negotiate control and influence. Asymmetry in working relations can illustrate power in terms of conversational control and influence by referring to four related types of interactional organisation within CA.

Interactional organisations provide a platform for exploring institutional talk. Turn-taking, adjacency pairs, repairs and preference organisation constitute the interactional organisations. These function as templates which speakers can use to orient themselves to others (Seedhouse, 2004). Order in talk can therefore be structured along these templates by having actors organise their talk, and these templates can also serve as a reference point for which actors can interpret

what is spoken. In this way, by having power as the question of interest, CA can show how power is achieved according to patterns with these templates. I will now turn to explore these types of interactional organisation in relation to specific studies. These studies have either directly or indirectly referred to these structural templates in their analysis of either nurse-doctor relations, general working relations or doctor-patients relations.

Collegial interactions and doctors doing dominance

Workplace studies have addressed power and asymmetry in terms of collaboration and negotiation alongside language use. Wodak (1996) argues that there is no 'pure' unbiased talk. Asymmetry complicates power relations. Actors with a higher status show various strategies to control and influence others of a lower status. Sarangi and Roberts (1999) outline the relationship between workplace studies and language use. This is particularly relevant in addressing a significant and what may seem an obvious interactional organisation such as turn-taking. The exchange of turns seem to be a basic type of interactional organisation, but as Seedhouse (2004) notes, it occurs very efficiently with less than 5% of talk occurring with overlap and very brief pauses. Therefore, interruptions, overlap and gaps are important linguistic devices noteworthy to mention when they do occur. In addition to these devices, general patterns of turn-taking show who talks more. The power to have more turns is given by the rights to speaking. Turn-taking patterns have been shown remarkably in relation to general collegial interactions of asymmetrical relations. Holmes et al. (1999), for instance, explored asymmetry and language in a study that included 110 hours of recordings collected in four New Zealand government workplaces. Professional identity was continually related to actors' use of language and power. The study focused on conversations between actors in a managerial position with those of a lower status during work-related activities. The systematic analysis of conversations illustrated patterns in talk that showed the regulatory processes at play (Atkinson & Heritage, 1984). This study showed that managers also had more rights and opportunities to ask questions, open and close conversations, and evaluate another's performance. This is shown primarily with interactional order by exploring the rights of certain speakers in conversation (Ten Have, 1999). Turn-taking patterns are therefore shown with how often managers used direct strategies of influence and control. This is by using explicit assertions of authority, e.g. in giving instructions.

However, these were often mitigated or softened. Nevertheless, general turn-taking shows that managers speak more and guide the progress of conversations

Turn-taking refers to speakership in that dominance may be shown when one speaker controls the flow of the conversation by having more turns. Studies exploring doctor-patient interactions claim that doctors have far more turns when speaking than patients. Doctors guide the course of the conversation. Turn-taking is closely related to topic control and management in conversations. Seedhouse (2004) argues that topic is not a type of interactional organisation given that it is dependent on the context of what is being spoken rather than as being a template for how to speak. However, topic is still a significant part of CA based on how it relates to the control and influence of the conversation. The literature on CA and doctor-patient interactions is significant for showing how doctors do dominance through topic control and leadership (McHoul & Rapley, 2002; Pridham, 2001; Ten Have, 1991; Warren, 2006; Wodak, 1996). Collegial interactions in workplace studies can be compared to the literature using CA in a medical institution. Language relates to the authority of doctors to control topics and address their concerns. Ten Have (1991) draws findings from literature on doctor-patient interactions as well as his own work on general practice consultations in the Netherlands. Two significant trends are that doctors monopolise initiatives in conversations and withhold information. Therefore, doctors asks questions and start conversations, and they also have the rights to withhold topics. Doctors have the responsibility to run how patients will be managed.

Decision-making within the medical institution is often valued in and left to doctors. The right to control conversations is often legitimised and practised (Fagin & Garelick, 2004). The allocation and management of talk through repairs or preference organisation reflects issues of topic maintenance, and this has been extensively shown with doctors and patients (Sacks, Schegloff, & Jefferson, 1974). Turn-taking shows which speakers talk more or whose topics are being spoken about in conversation. This is a significant means of establishing influence and control through speaker and hearer roles (Ng & Bradac, 1993). Similarities may be drawn between asymmetrical relations of client-expert relations to collegial interactions. Asymmetry prescribes limits for actors in differentiating statuses. Comparisons may be made when exploring power and ideology in an institution. This is shown by highlighting control and influence in a number of

conversational strategies and practices. The rights to decision-making raises a significant type of interactional organisation, namely that of repairs in conversation.

The authority to evaluate others is significant in situations where managers have the right to give warnings, criticisms and challenges. Atkinson (1999) takes this point further by elaborating on speaker responsibility. Managers and doctors are shown to have similar trends in treating peers of a lower status. Atkinson (1999) explored collegial talk amongst physicians with junior colleagues and medical students during ward rounds, conferences and other sites where peers interacted. An ethnographic approach using CA was applied in teaching hospitals that stemmed from a large corpus of data examining medical practice and knowledge. Atkinson (1999) shows in a case study of peer interactions how doctors are constructed as fool-proof experts that are obligated to evaluate their peers. Speaker responsibility is termed as a key identity marker that is shown in language. Doctors guard their interests by influencing their peers (Brown & Levinson, 1987). Goffman (1959) had theorised this form of interaction as defensive practices. If doctors were attempting to accept and maintain another's interests, then this would be termed as protective practices. Atkinson (1999) showed that doctors continually check the turns of junior colleagues. Doctors supervise and teach their junior peers. Doctors are also responsible for the correct management of patients. Svensson (1996) argues that doctors are socialised to continually repair others' talk by checking information. Seedhouse (2004) states that repairs are relevant whenever there are problems in accomplishing talk. Conversational breakdowns and misunderstandings are managed by using repairs. This is a significant point in the analysis of nurse-doctor conversations.

There are four types of repairs, which I will relate to a doctor's use in conversation. There are self-initiated repairs where a doctor initiates a repair of their mistake in talk, other-initiated repairs where a nurse notices a doctor's mistake and initiates repair, self-repair where doctors correct themselves and lastly other-repair where a nurse corrects a doctor's mistake. For simplicity, I will focus on self-repair and other-repair. Atkinson (1999) shows that doctors continually correct junior doctors, i.e. they use other-repair. Doctors continually correct nurses for what should be done and they correct a nurse's information (Svensson, 1996; Wicks, 1998). Preference organisation is also related to repairs. Self-repairs are more preferred than other-

repairs. I will elaborate on this in framing nurses' talk, but a significant point is that exchanges of turns have a bias towards promoting the avoidance of conflict in talk, and correcting others is a dispreferred action. Wicks (1998) does not explore repairs as a source of conflict between nurses and doctors, but in the following analysis, I argue that repairs are a significant issue in conversational breakdowns and conflict between nurses and doctors. This is supported by Svensson (1996) when exploring the division of labour between nurses and doctors. Doctor may not want their toes to be stepped on, considering the division of labour between medical and nonmedical issues when managing patients. The medical issues are purely medical and scientific while nonmedical issues relates to nurses' work. This impacts who does the decision-making. Although Svensson (1996) argues that nurses are active in decision-making, as will be shown in later analysis, the predominant findings in this dissertation are closer to showing how doctors continually establish speaker responsibility by correcting, challenging and checking nurses' turns.

A further point relating repairs and conflict between nurses and doctors refers to unmitigated repairs. Doctors who check a nurse's turn may be polite and they may also soften their repair. However, because doctors have speaker responsibility, mitigation might be taken for granted. Patterns in language use may thus reflect a doctor's use of dispreferred repairs and show a doctor's dominance in conversations. This is shown in a study conducted by Manias and Street (2001) when attempting to highlight verbal communication in nurse-doctor interactions. Manias and Street (2001) conducted a study with nurses and doctors in a critical care unit of an acute care hospital in Australia. Ethnographic data was used to explore verbal communication with aims at changing nurse-doctor interactions. This was reflected in doctors' use of language that marginalised nurses' contributions in conversation. Doctors often interrupted or ignored nurses and invested in their positioning by protecting their interests of authority and managerial competence. Interruptions are considered a forceful strategy of achieving mutual understanding, i.e. other-repair. The rights to build mutual understanding are therefore different for different speakers (Boden & Zimmerman, 1991). Manias and Street (2001) also showed how nurses chose to be silent and accept doctors' interests given the legitimacy of their power. This showed a useful protective practice and illustrates how actors accept others in conversation.

Turn-taking and repairs have been the focus while prioritizing doctors in the previous literature using CA. Preference organisation has also been addressed, but I will elaborate on this together with adjacency pairs in the following section on framing a nurse's agency in nurse-doctor conversations. Doctors may be dominant while using certain conventions in language, but nurses negotiate power with various uses of language in conversations. The concept of power therefore enables nurses to construct agency while still being constrained by a lower status.

Framing nurses' agency

The literature on doctor-patient interactions and on the application of CA in different contexts helps draw similarities between nurses and patients. Nurses have been understudied regarding CA in workplace studies. Seedhouse (2004) supports the use of language to practically accomplish conversations by means of preference organisation.

In order to illustrate preference organisation, adjacency pairs are used to show the difference between preferred and dispreferred responses. Questioning is a common type of language use in doctor-nurse conversations. Wicks (1998) shows that doctors and nurses exchange information routinely when managing patients. Doctors need information and ask nurses for that information. Questioning is a type of an adjacency pair where a first part of the pair makes the second part "conditionally relevant" (Seedhouse, 2004, p. 19). Questions require answers. Sequence is important for this reason, because what comes before and after utterances builds mutual understanding. Adjacency pairs illustrate preference organisation in that an answer that is affiliative is required to be a preferred response. A dispreferred response would be giving no answer to a question or an answer that includes hesitation and delays. A dispreferred answer would also include an excuse or some form of mitigation to reduce the dispreference. Preference organisation is not the same as impression management, though these may be related. I have mentioned this distinction earlier when noting the difference between culturally preferred subjectivities and preference organisation. Nurses may not have an appropriate answer for a doctor's question. Nurses may give dispreferred answers. This contradicts their useful information-giver role as depicted in a 'good' nurse subject position. Thus, dispreferred responses relate to a dispreferred subjectivity. Seedhouse (2004) shows how adjacency pairs can offer insightful findings when exploring deviant cases, i.e. dispreferred responses. However,

preferred and dispreferred responses do not have to mirror culturally preferred subjectivities. As shown for doctors, doctors may correct nurses. Other-repair is a dispreferred turn, but doctors are shown to be responsible doctors. This shows that they are often sanctioned to take these dispreferred turns. For instance, doctors are legitimatised at taking these turns; they encompass a culturally preferred subjectivity.

In the discussion above, I have shown how doctors may be sanctioned to take dispreferred turns. In terms of framing nurses' agency, nurses employ strategies to manage a 'good' nurse role. Nurses manage this by employing the doctor-nurse game. Stein (1968) coined this term by referring to nurses' resistance to a doctor's dominance. Ng and Bradac (1993) have extensively explored issues of passivity with control and influence in turn-taking. In terms of relating power, subject positions and language, Ng and Bradac's (1993) conceptual framework provides the links that relate these topics. The depoliticisation of power is usefully related to framing resistance for those in a lower status. Nurses can use language to depoliticise the interests of doctors. This relates to interests of power and self-management in conversations. Ng and Bradac (1993) address the depoliticisation of power in strategies used to mitigate, mislead and mask actors' interests through language. Softening a speaker's words contributes to easier persuasion and therefore easier control of conversations. Masking or misleading others is illustrated in the doctor-nurse game. Distinctive patterns in language are used to illustrate trends in controlling or influencing others. The doctor-nurse game is used whereby nurses often strategically agree with and subtly advise doctors, but they still show passivity to their authority (Stein, 1968). Resistance is therefore tactfully managed by disguising a nurse's initiative. Wodak (1989) describes this process as a passive form of persuasion and control. The doctor-nurse game is shown to be routinely practised by nurses, and illustrates the routinisation of language dominance in a mitigated and passive form (Ng & Bradac, 1993). Wodak (1989) supports this in describing methods of manipulation and mitigation in talk. Power is managed covertly by having nurses enact an assertive role while being limited by passivity.

However, Wicks (1998) argues that this narrows the focus of exploring a nurse's agency. Nurses are shown to be passive, using covert forms of language use. Overt and more assertive forms of turn-taking are not addressed. Porter (1991) conducted a study in a hospital in Ireland where

participant observation was used. Nurse-doctor interactions were examined by drawing on principles of ethnomethodology. Informal, but overt suggestions to decision-making were frequently used. Furthermore, the doctor-nurse game was not always employed as more assertive and opinionated turns were used. The 'new' nurse role showed how silence, reactivity and passivity were not always the case within nurse-doctor conversations. Regardless of nurses taking both passive and overt forms of turn-taking, a significant point remains that doctors are in a higher position than nurses. This shows that nurses are constrained by a lower position, and throughout previous literature, including the forthcoming analysis; nurses often took a significantly more passive conversational and institutional role in relation to doctors.

This is shown in the way nurses negotiate a marginalised position. Impression management relates strongly to discourse. Manias and Street (2001) have attempted to relate language to nurse-doctor interactions despite not using CA. Manias and Street (2001) show how nurses are often assigned as information-givers and attend to doctors' concerns. A traditional nurse subject position coincides with such conversational patterns. These patterns are passive compared to doctors issuing instructions. A traditional nurse subject position is also passive. Resistance to this subject position allows nurses to question and challenge doctors. This is associated with a 'new' nurse role. However, Leonard (2003) argues that this positioning is at conflict with a traditional 'good' nurse role. Thus, passivity within a 'good' nurse role is often taken up rather than challenged. Agency is still constructed, but in a way which manages passive resistance in conversations. For instance, in addition to the doctor-nurse game, Sweet and Norman (1995) show how nurses tend to be passive in conversations rather than take initiative when interacting with doctors. Silence and reactivity relates to a positioning of the 'good' nurse who does not prefer to be disfavoured or critiqued (Manias & Street, 2001; Sundin-Huard, 2001). Silence is a useful strategy to manage facework. Nurses meet their own interests by avoiding or reducing face-threatening acts, i.e. nurses avoid doctors correcting them. This shows that though silence may be framed as powerless, as a strategy of facework it can be framed as a resourceful strategy. This is on order to avoid the negative side-effects of doctors taking dispreferred turns, i.e. the side-effects from repairs or forceful turns such as instructions (Ng & Bradac, 1993). A nurse's agency is constructed through language and intersubjectivity, but often in a passive way within asymmetrical relations.

Summary

This chapter has outlined the significant theoretical and conceptual frameworks underpinning this study. Social constructionist theories and discourse research guide the analysis on nurse-doctor interactions. In particular, an ethnomethodological approach highlights how reality is accomplished. This is in relation to the various subject positions offered by discourses. Furthermore, conversational analysis guides the analytical approach to language, power and intersubjectivity. Power is embedded in tactful processes of language use, but there is an ongoing relationship between language and subject positions. This addresses the central research question, which explores how nurses and doctors manage power in conversations.

Following this overview on theoretical frames and concepts, I have provided empirical studies supporting these frames. The literature has predominantly been international work on nurse-doctor interactions and conversation analysis. This has been separated by firstly exploring relevant nurse-doctor subject positions and secondly, studies relating language with power in conversations. Furthermore, throughout the presentation of literature, power is shown to be a fluid process. It is not neatly definable and what may seem powerful can be easily reframed to be powerless. This is shown in re-conceptualising the patterns in the management of power in nurse-doctor conversations. The theoretical framework and empirical literature provides the groundwork for this dissertation. This will be shown in the following chapter by relating the chosen methodology to the theoretical frames and literature discussed in this chapter.

CHAPTER THREE

METHODOLOGY

Design

This study is underpinned by social constructionist theories and discourse research that focus on language as an important resource in interactions. The framework thereof has implications for the design and methodology used in analysing nurse-doctor interactions. I combine conversation analysis with exploring nurse-doctor subject positions in conversation. The central research question on the management of power guides the analysis with methods owing to this theoretical and methodological focus. In the tradition of applying conversation analysis, audio recordings were used as samples of frequent collections of nurse-doctor conversations. The analysis is therefore based on comprehensive data treatment (Ten Have, 1999). Patterns are interpreted within a large body of data and are related to a specific theory such as the management of power in conversations. Ethnographic data that broadly includes unrecorded conversations and observations have also supported the use of conversation analysis.

The structural characteristics of language provide an emic perspective to discursive positionings in a medical institution. Applied CA has also been contrasted to ‘pure’ CA (Ten Have, 2001). The latter approach is focused on a formal science exploring talk within interaction. However, applied CA is more concerned with institutional interaction that uses the principles established in ‘pure’ CA. I make use of applied CA to explore subject positions within discourse. This has often been used in workplace studies. Individual goals and interests need a broader understanding of institutional practice. Institutional practice consists of goals related to a specific task, e.g. in ward rounds, but these goals are also relevant within discourses on nurse-doctor working subjectivities. Applied CA therefore guides data analysis drawing attention to nurse-doctor subjectivities.

In this way, I attempt to explore power in language and within subject positions by analysing recorded conversations and ethnographic data. The number of recorded conversations, however, was the benchmark in establishing an appropriate level of saturation. As the length in time and

number of recordings increased, so did the saturation level. This relates to the purposes of the research questions in exploring how language is used to manage power in conversations, i.e. do I have enough data to see how power is managed from a conversation analytic approach and from an ideological perspective?

The start of the study

The interest in conducting a study on asymmetrical working relations and language was initiated and encouraged by my relationships and involvement in the neurosurgery ward in the first place. I had volunteered in this public teaching hospital for a year prior to this study. I had regularly walked across the ward to the office of the organisation I had volunteered for. I did not work in the neurosurgery ward as most of the volunteers did. I had volunteered in the Intensive Care Unit (ICU) in the neurosurgery department. This voluntary work was exclusively with patients. I counselled patients and I therefore had minimal interactions with medical staff. Nevertheless, I had come to be familiar with certain doctors and nurses within the ward. I was also introduced to the politics within this hospital ward and ICU. This was between doctors and nurses, between medical staff and patients as well as medical staff or patients with other relevant third parties. The third parties included the organisation I had volunteered for. An interesting and recurrent pattern in the politics that I often heard and sometimes saw was between nurses and doctors. The issues that arose were associated with status, collaboration and tension between doctors and nurses. This initiated the inquiry into working relations and asymmetry.

As I had prior theoretical interest in language use and power relations, this study's focus was easily constructed, i.e. the focus being on the use of language to manage power in working relations. However, even with my interests in these areas, this study was largely motivated by the organisation I had volunteered for. I had numerous conversations with members of the organisation which made the link between power, asymmetry and language explicit and relevant. I did have initial reservations despite the direction this study was taking. I mentioned previously the various politics I was aware of which included the politics between medical staff and the organisation I volunteered for. I was sceptical about how both doctors and nurses would accept this study, a doubt later reinforced when I started the research proposal. There had been various

arguments between both doctors and nurses with the organisation. As a volunteer of the organisation, I had considered the implications of my relationship with them. I still continued this study and my relationship with the organisation seemingly did not create complications, but in fact aided the start of the study.

Prior to data collection, I had got to know the nurses well during a workshop planned by the organisation. Four of the nurses that worked in the ward attended the workshop. Two of the nurses later became participants, and more importantly one of the nurses who did not turn out to be a participant was the head nurse of the ward. I found this helpful in establishing common ground with the nurses, and that this facilitated my presence in the ward. Furthermore, based on my involvement with the organisation, I had significant conversations on a mutual topic with both doctors and nurses. This was especially with nurses and I found that this helped create collaborative conversations during and prior to data collection.

However, my presence was not only facilitated by my previous involvement within the ward. The general research interests of the head of the department of this ward and the nurse manager at the hospital supported the study. In presenting this study to both parties, and later to doctors and nurses, they were considerably supportive in welcoming me to the ward. The head of the department encouraged my research aims during a presentation to the doctors. The nurse manager also welcomed the study while I was gaining consent for the research study. This made the arrangements prior to data collection an uncomplicated process, and began what I consider is the crux of the research study, which is the data collection and analysis.

Research setting and participants

The medical context I had chosen was a neurosurgery ward in a South African public teaching hospital. It is important to describe the hospital ward and the participants in order to gain an understanding of the research setting. This is before the details of the procedural issues of data collection are discussed.

The neurosurgery ward was a 28-bed ward at the time of data collection. Data was collected

between January and March 2010. The characteristics of the patients in the ward relate to brain trauma. I collected data only in this ward. The influence of the particular goals within a neurosurgery ward on language was not compared to another site, but I will discuss this further in the concluding chapter. Returning to the research setting, the ward was a large and long room separated into two distinct sections. One section was the reception area and held a number of rooms down a corridor, from the family room to the senior nurse's office and doctors' rooms. Large double doors separated this section from another section which is what I refer to as the ward. This area held the beds and patients, and is where I found myself almost every morning for two and half months. There were a number of sections as well in this part of the ward.

There were six to four beds in four sections, with the last section with four beds being a high care area. These sections were at the back of this ward area and rooms with one bed were lined in front. The ward rounds I followed visited all these sections. In the centre, these sections were linked together by the nurses' station. At the end of this part of the ward was the office of the organisation I volunteered for. I visited the office almost daily during the data collection period, but I had stopped volunteering during this research study to prevent any confusion of my researcher or volunteer role in the ward or in the ICU.

The participants in the study consisted of nurses and doctors in the ward where the morning ward rounds were recorded. The nurses and doctors were chosen irrespective of the difference in status and responsibility within each category. In terms of external categories of gender and race, all the doctors and nurses that were recorded are male and female respectively. Furthermore, nurses were predominantly 'coloured' and 'black' South African nurses. The doctors were mostly 'white' doctors and those who were 'black' doctors were mostly not South African. Thus, broad categories differentiated nurses and doctors. This is in addition to their differences in status. I was similarly differentiated from nurses and doctors by external categories of gender and race. I was younger than the majority of doctors and nurses, and being a 'white' female differed from doctors and nurses in different ways.

The doctors in the study were those responsible for the morning ward rounds. This often consisted of two doctors for every ward round. In total there were eight doctors participating in

the study. Of those eight doctors, there was one doctor who was higher-ranking than the others, with at least one other doctor showing professional seniority as well. Despite these differences, the doctors in this study were generally of a similar professional status. The exception to such symmetry only occurred when a doctor was less familiar in working within the ward. High-ranking doctors such as professors and consultants were not recorded. These doctors were not seen during the ward rounds I joined, and on the infrequent occasion that they were present, they did not join the ward rounds. Doctors' rounds occurred later, but nurses were not involved in these rounds. The participants in this study were registrars as well as medical officers and I will continually refer to them as doctors.

The total number of nurses in the study was ten. These nurses can also be categorised further. Sisters and nurses are different, with nurses being of a lower status than sisters. There were two sisters who were of significantly higher status. Furthermore, of the sisters and nurses, the length of time in the ward and their relationships with other sisters and nurses influenced their rank. I will, however, refer to all sisters and nurses under the broad category of nurses. The implications of in-group status differentials will be discussed towards the end of the analytical component of this dissertation.

Generally, a ward round would consist of two doctors and one nurse. When there was a senior doctor, he was paired with a less senior doctor. Pairs of doctors did not change, and they were consistent throughout all ward rounds. This pairing would only change under exceptional cases, for instance if a doctor was on leave or was writing exams. Though an average ward round consisted of two doctors and one nurse, it was not uncommon for interns to be part of ward rounds. In fact, there are many ward rounds with an intern present. The interns, who are also doctors, were not included as participants within the study. This is based on the patterns within transcripts that showed the similarity in interns' language uses with nurses. This shows the importance of in-group status differentials amongst doctors and will be mentioned in later discussions in avoiding generalisations between categories. Ward rounds would consist of two doctors by a patient's bedside. One of the doctors would be at the foot of the bed where a patient's folder was often placed. The other doctor would be by the side of the bed. One nurse would be near the doctors, often behind them or at their side. An intern would be close to the

doctors, holding a book and also taking down a doctor's instructions. I would be close to the nurse and doctor, usually behind both of them. I would often be by the nurse's side, and would follow her with whichever doctor she would speak to.

In addition to the average appearance of a ward round, students and other staff would at times join ward rounds. I was initially often mistaken for a medical student considering the expected actors who joined ward rounds. Students and other medical staff, such as other doctors or nurses from other departments, were excluded from the use of conversation analysis in analysing data. Students were excluded, because of how little they spoke. They also did not fit within this study's focus. The other medical staff spoke mainly to doctors and not to nurses. They were also rarely present during ward rounds, and permission in gaining consent from these actors would be impractical.

Patients in ward rounds were not included in this study. I specifically focused on doctor-nurse conversations. Lastly, convenience sampling was used in recording nurses and doctors, and therefore participants could be recorded several times in the data collection period.

Procedure

Ward rounds were recorded almost every weekday morning for two and a half months. Four or five morning ward rounds were recorded per week. The participants were aware of my research purpose, i.e. that I was exploring the organisation of verbal interaction between nurses and doctors. They were informed by a presentation on the study. Consent forms were presented and signed. There were 44 morning rounds recorded which amounted to an average of 22 hours of audio recordings. This period of time was appropriate given that more conversations were seen as unnecessary showing that the research question had reached an appropriate level of saturation.

Thus, the primary form of data collection was the audio recording of ward rounds, of which the focus was nurse-doctor conversations. Ward rounds were initially chosen as the site for recordings based on how common they were for nurse-doctor interactions. In other sites in the ward, capturing nurse-doctor conversations would have been coincidental and time-consuming.

Ward rounds were therefore appropriate and have been a useful site for research in previous literature. Furthermore, at the start of the study, I was aware that in this ward, doctors and nurses conducted ward rounds separately from each other. The only ward round that had both doctors and a nurse together was at 7am.

An average ward round

In this medical context, the ward rounds I recorded would occur routinely every morning. These ward rounds generally started at 7am. I would arrive in the ward 15 minutes before 7, and usually waited 10 or 15 minutes within the nurses' station. This was a nurse's space, and this was illustrated in the personnel that often stood outside and inside the area. I had stood outside this area initially until I asked if it was appropriate for me to sit and wait inside the large cubicle. The nurses were welcoming and every morning I would find myself in this area listening to the stories, often humorous stories, of the nurses just before they swapped shifts. This was because at 7am, not only was it morning ward rounds, but the night shift nurses went home and the day shift nurses started to work. This was also the time when a nurse who would be working in the day shift had a round with a nurse from the night shift. Patients were reviewed and any pertinent information about the patient was given to the day shift nurse. This information also included concerns that needed to be brought to a doctor's attention. There was often activity around the nurses' station as the nurses swapped shifts, but in general the rest of the ward appeared calm and quite.

I did not record conversations between doctors and nurses during the night shift. Doctors and nurses did not speak to each other at night as they did during the day. The nurses emphasised that it would be pointless to come at night considering my focus on language, which I agreed. Thus, when it was almost 7am I would wait until a doctor would come in and go to a patient, the sign that the ward round had begun.

One or two doctors would come in the ward and start the morning ward round by approaching a patient's bedside. A nurse would see that a doctor was starting the round and pick up a file or a clip board and approach the doctor. There was no formal announcement of a ward round. A

nurse would see a doctor and go to his side. However, this did not occur all the time and exceptions did occur. Doctors would at times greet nurses before approaching a patient's bedside, but this generally did not occur for most doctors and in most occasions. When I saw that a nurse had the folder or clipboard in hand, I would follow the nurse to the patient's bedside. The recorder was on as the nurse joined the doctor/s on the round. The recorder was small as I held it beside a notepad inside a folder. Doctors and nurses knew that they were being recorded.

The morning ward rounds lasted approximately 30 minutes; with some being 15 minutes and others lasted up to 40 minutes. There would be three ward rounds occurring generally at the same time at 7am. Different ward rounds were responsible for different patients and one round would see on average between six to ten patients. The number of patients also changed every day as patients came in and out of the ward. There was a routine procedure to ward rounds, and this routine guides the analysis of nurse-doctor conversations.

One doctor would read and write in a patient's folder, while a second doctor would assist by asking the patient routine questions about how they were feeling. One doctor was usually responsible for writing notes in a patient's folder while another doctor assisted. These doctors would talk to each other a great deal about the patient. One of the doctors, usually the one writing in the folder, told the nurse what she needed to do for the patient. This was in one brief exchange of a few sentences. Ward rounds were about the decision of treatment for each patient at that point in time. Doctors would sometimes need to know more information about the patient and would ask questions. Nurses would sometimes need to know certain patient-related issues and would ask questions. This pattern also varied, but this will be discussed in the next chapter. At the end of each ward round doctors would informally acknowledge that the ward round was over. This was done either by doctors thanking the nurse. Alternatively the nurse would walk away or would ask if the ward round was over.

I preferred to record ward rounds from beginning to end to gain an understanding of the ward round activity, but decided that I would supplement a complete round with other rounds in one morning. This is when I had recorded a ward round earlier than the other two ward rounds. I would still have the recorder on, but I would join the rounds when the doctor/s and nurse were

already by a patient's bedside. In these cases they would have already seen patients before I joined the ward round. This process depicts the usual morning of recording ward rounds, and shows how nurse-doctor conversations were collected.

Transcriptions

I have mentioned how nurse-doctor conversations were dependent on audio recordings thus far. A sidestep is needed to explore the implications of using recordings. This relates audio recordings to problems with collecting data and the transcriptions thereof. The transcription conventions that help illustrate the structure of language are drawn from Ten Have (1999). The transcript symbols are found in the Appendix.

I used a small digital recorder to capture nurse-doctor conversations. The recorder was an appropriate size given that often participants were wary about being recorded. There were several comments about the implications of recordings while presenting the study to doctors and nurses. This occurred during data collection as well. The possibility of who would hear the recordings was an issue and I continually emphasised how the recordings were not significant for evaluating work performance. I also held the recorder in as unobtrusive a way as possible by holding it inside a folder while I took notes in a notepad next to it.

There were problems which arose based on the quality of the recordings. The recordings often had background noise and it was challenging to capture all nurse-doctor conversations. Over time, I began to realise that holding the recorder in a certain manner and standing in certain positions helped the quality of the data. However, group interactions in a setting with much background noise impacted audio quality. Background conversations were often important or they interrupted more relevant conversations. I continually wrote down any relevant details in conversations within field notes. This was in case the recordings did not reflect much detail. The quality of recordings further influenced the transcription process, a significant analytical process.

The recorder was not able to filter conversations and noise reduction methods were used in order to filter the data. I used software to reduce unnecessary background noise such as the humming

from background conversations. I also had to limit detail while transcribing, because of poorer quality in certain sections of recordings. Thus, specific detail in transcribing was not always possible. I also selectively chose when detail in transcribing should be used. This was when audio quality was clear. I generally attempted to be detailed when transcribing, i.e. with silences, emphases or audible breaths. However, I attempted to draw attention to broader processes of speakership and turn-taking as well. This is without sacrificing all the detail within transcriptions. At the same time, not all conversations were relevant to the research questions. This is especially in conversations between other medical staff such as students or interns with doctors and nurses. Detail within such conversations was limited. Lastly, certain doctors and nurses used different languages to communicate with each other. This was also with patients. However, nurses and doctors generally communicated in English. I transcribed conversations if they were Afrikaans and English, but not Xhosa, as I do not speak or understand Xhosa. I only noted down whether Xhosa was used to communicate in the transcriptions. Furthermore, the detail in transcribing was used only with English as I am most familiar and fully comfortable with English, and not any other language.

Audio recordings therefore had many implications for transcribing and analysing data. Within data collection, this is noticeable when I continually relied on field notes and observational data to supplement the recordings. The quality of the recordings was not always reliable. Therefore, I turn to the importance of using the ethnographic material used to complement the 22 hours of recordings.

Ethnography

Ethnographic material was used to analyse data. Observational data and field notes were essential for enriching the conversations that I recorded. The field notes consisted of notes before, during and after ward rounds. I had a folder with a pen and notepad at hand when I followed a nurse to a ward round. I held the folder open with the recorder on one side and the notepad on the other. I would write down any observational data that I considered useful and relevant. This included other nurse-doctor conversations in the background that I felt might not have been fully captured in the recording. I also took note of issues of space and nonverbal

interactions between nurses and doctors. These were written down during ward rounds. After each ward round, I would reflect and add any additional information that I considered useful.

Furthermore, these field notes consisted of conversations that occurred before and after ward rounds when I would speak to doctors and nurses. I considered one conversation with a nurse as a useful unstructured interview. There was an argument between a nurse and a doctor that I recorded. The nurse reflected this argument in great detail and length the following day. This was helpful as it related a conversational breakdown to issues of marginalisation and dominance. Therefore, several ad hoc conversations were important in answering this study's research questions.

Field notes were also an important part of data collection in terms of participant observation. This included my previous involvement in the ward. Notes were written down before I had started data collection. The notes reflected the perspective I had from the year of volunteer work in the ICU. I had encountered many nurse-doctor conversations prior to data collection. I noted down any issues I felt were important for exploring power and language between doctors and nurses. The issues that I had heard as a volunteer also left me with a particular view of both nurses and doctors. This focused on ethical issues relating to patient management, which is understandable given the organisation's aims at patient advocacy. The perspective I held prior to data collection changed as I became more immersed in daily ward rounds with doctors and nurses. I began to relate more with doctors and nurses. I was no longer at a patient's bedside as a counsellor, but as a researcher gaining an emic perspective of what it means to be a doctor and a nurse. Participating in ward rounds noticeably shifted my interpretations of doctors and nurses. I would initially find fault with the way a doctor or nurse seemed intolerant with a patient or each other, but then I would find myself understanding these intolerances. I therefore came to understand the norms within the ward, especially of how doctors, nurses and patients should act.

Norms for how others should act are critical for understating intersubjectivity. Participant observation allows for such an emic perspective. Impression management is shown in relation to my presence in ward rounds. Arguments between doctors and nurses occurred. I would evaluate and judge them, and in so doing would pick a side. I reflected on these situations while

arguments occurred and attempted to stay indifferent. Both parties at times rationalised their sides to me. Thus, I found myself being reasoned to understand what constituted a ‘good’ and a ‘bad’ doctor or nurse. Impression management may relate preferences for certain doctors and nurses to culturally preferred subjectivities. For instance, does a nurse like an infallible doctor or does a nurse like a doctor who breaks from this culturally preferred subjectivity? This shows the local rationalities informing doctor-nurse subjectivities (Ten Have, 1999). Ethnographic material was essential for this reason and therefore the recordings were complemented by my own participation in ward rounds. Field notes that referred to previous and ongoing conversations were important. An ethnomethodological approach which uses applied conversation analysis, i.e. in using ethnographic material, is used to explore power between doctors and nurses.

The analysis in the following chapter focuses on language use, but addresses nurse-doctor subject positions. This is necessary in order to explore the institutional conventions and goals within a specific context. In order to understand the use of CA and ethnographic data, a broad discussion on the analytical procedure is needed. I turn now to elaborating on the conventions used to interpret and analyse data. The analysis of data will be compared to the specific methods of data collection previously discussed.

Data Analysis

Interpreting data

I use conversation analysis (CA) to investigate how power is managed in conversations. The joint construction of conversations are highlighted to depict how power is both actively and passively negotiated between individuals (Hollway & Jefferson, 2005). The types of interactional organisation as indicated by CA are directly related to power. This refers to turn-taking, repairs preference organisation and adjacency pairs. These templates provide the basis for exploring the use of language for purposes of influence and control. Turn-taking explores speakership patterns, i.e. in being cast with certain speaker and hearer roles. Topic maintenance and various affiliative or disaffiliative language uses is also relevant for showing how power is accomplished. This is related to the rights of speakers throughout preference organisation and adjacency pairs

(Seedhouse, 2004). CA stresses the orderliness in constructing conversations which relates to particular functions of language (Ten Have, 1999). I therefore explore language by asking, “Why that, in that way, right now?” (Seedhouse, 2004, p. 16). The answer to that question is then related to broader theoretical frameworks exploring the function of language. This framework is guided by the central research question, which is the management of power in interactions. Intersubjectivity and facework are further frames exploring power. I continually attempt to consider what speakers are *doing* in terms of influence and control through patterns in language use. These patterns are made significant by frequency and placement in sequences. I do not specifically count across conversations, but analyse recurring themes across them. Contradictions and exceptions to patterns in conversations are also explored. This highlights the functions of themes at a particular point in conversation. Furthermore, the way that these functions are associated with particular subject positions are then used to explore patterns in language use.

In order to follow the analytical process I implement in the forthcoming chapter, I have mainly borrowed from the steps that Seedhouse (2004) uses to conduct CA. I list them below in relation to what I have previously discussed. There were several stages implemented in the analytical process. This was during and after transcription, namely: 1) I initially carried out ‘unmotivated looking’ whereby sequences and patterns were located and coded. This was based on its relevance for exploring issues of control and influence in conversation. Therefore, I suggest that an ‘unmotivated’ process refers to how open one is to new patterns in the data. This is rather than without a particular hypothesis in mind. However, any sequences that were of note were coded based on discovering new issues in nurse-doctor conversations; 2) the sequences located in the initial step was used to establish regularities throughout the transcriptions. Focal points were highlighted and began taking the shape of specific accountable processes that nurses and doctors made use of; 3) Regularities and focal points were further classified along types of interactional organisation. This is if they have not already been done. Deviant cases were noted. For instance, if nurses did not often repair doctors, what was revealed in the rare cases that they did? 4) a detailed analysis of sequences was then implemented. Particular linguistic devices that relate to the preceding points were explored, e.g. specific words and intonation was explored; 5) lastly, these patterns in conversation were related to the management of power. This is from an interactional perspective which was building from the preceding steps. Mitigation, politeness and

facework provide useful frames for exploring power and language. Furthermore, and which could be seen as a further step, was relating various subject positions to patterns in language use.

Throughout the steps I previously mentioned, the management of power was continually used as an anchor to direct the data. However, it is important to note that the theoretical and conceptual framework in this study requires a focus on an interpretative approach in exploring data (Hollway & Jefferson, 2000). Power is an interpretable phenomenon. Influence and control works back and forth between speakers. Persuading others by misleading them through language is not necessarily clear. Interpretation is needed to explain the functional use of language in relation to power. These functions, however, need to be warranted by appropriate claims and evidence using CA as a tool for interpreting language. Interpretations are also open to a multitude of alternative interpretations given appropriate support. It is thus important not to mistake interpretations of language use as simply based on intuition, but it has to be “methodologically, rhetorically and clinically convincing” (Hollway & Jefferson, 2000, p. 79).

A final point is needed to address the interpretation of data. Throughout data analysis, it is important to be explicit regarding what Garfinkel and Sacks (1970) (as cited in Boden & Zimmerman, 1991) refer to as ethnomethodological indifference. This refers to the ethical and moral judgments associated with exploring ideology in an institution. I do not intend to judge a doctor’s or a nurse’s language use as negative or positive. This is especially when I refer to negatively loaded phrases such as ‘tactful manipulation’ or the ‘depoliticisation of power’. Rather, I aim towards no moral judgment in the patterns within conversations between nurses and doctors. The focus is on the sense-making of a certain context between working colleagues of a differential status.

Summary

This chapter has covered the main design and methodology used in analysing data. The inception of the study was discussed in particular relation to my involvement within the ward prior to this study. The specific daily routine of data collection was also discussed while having presented the research setting to contextualise the specific methods of data collection. I also discussed

conversation analysis with the use of audio recordings. The implications of using audio recordings were then briefly mentioned. Ethnography also supplemented the use of conversation analysis, especially by applying conversation analysis in an institutional setting. The analysis in the following chapter was then introduced by explicitly referring to key themes within the data analysis in this chapter. Chapter Four is in this way related to the specific aims of conversation analysis. Language use will continually show the various subject positions. In the following chapter, I will make use of applied conversation analysis to analyse power between doctors and nurses.

CHAPTER FOUR

ANALYSIS

The following analysis is supported by continual attention to the implications of orienting oneself to another in interaction. Shotter (2005) argues that language is continually drawn upon as a useful resource to manage oneself in interactions. I will discuss various patterns in language by addressing its uses in constructing conversation. These patterns will be specifically related to the management of control and influence in conversation.

The analysis between doctors and nurses will be firstly addressed with doctors. This is by exploring the ways that doctors do power. This includes doctors mitigating or softening their power through language. An analysis will then follow into the ways nurses manage power and resistance. Despite analytically separating both actors in terms of their management of power, they will be continually related to one another. Lastly, I will explore the depoliticisation of power in terms of speaker support for both doctors and nurses. This includes sidesteps into broader issues of gender, asymmetry and discourse.

Speakership and casting: How do doctors do power?

Stereotypical ways of knowing about others informs working relations. This is associated with essentialising the differences of categories (Swartz, 1991). Doctors have power over nurses. Issues of difference and othering apply to asymmetrical relations in terms of status stereotypes (Berger et al., 2002). Language may show how othering is reinforced by differentiating patterns in language use. Professional and institutional roles of actors therefore inform transformational rules. This indicates the rights of those with a higher status or rank in working power relations. The general pattern of a doctor's right to influence and control conversations is consistently shown in nurse-doctor conversations. A significant theme throughout all doctor-nurse interactions is how doctors are the dominant actor, and therefore how they do power. I will show this primarily by illustrating how doctors do power in ward rounds through speakership and casting. The trend in issuing imperatives constructs doctors as leaders who are responsible and

knowledgeable. I turn at this point to relating leadership to specific language uses that control and influence nurses.

Leader emergence and issuing imperatives

Ward rounds are task-oriented activities within a professional discourse (Sarangi & Roberts, 1999). Task-oriented activities have routine goals that need to be met. Doctors decide how patients will be managed. In an asymmetrical relationship, doctors have the authority to tell nurses what to do for patients. This is necessary in order to create an efficient and practical ward round. Doctors meet their goals by giving nurses directives. A doctor's dominance is reflected in ward rounds by doctors issuing imperatives or directives in nurse-doctor conversations.

Nurses are present in ward rounds and are informed about patients. This enables nurses to meet their interests and therefore nursing role. A regular ward round consists of goals that guide the analysis on nurse-doctor interactions. Therefore, goals in ward rounds will be discussed firstly to establish doctors doing power and this will provide the background for nurses managing power. A nurse needs information about a patient's treatment and management during ward rounds. It is doctors who have the knowledge and who are responsible for making sure that treatment is known and carried out. Nurses are those who take that knowledge and put it into practice until the next ward round when treatment may be re-evaluated. Decisions about patients are updated and nurses have to know what relates to their job performance. The goals of ward rounds reflect decision-making. Doctors tell nurses what to do for a patient throughout the course of the patient's stay in the ward. The specific decisions mostly regard a patient's medication. A doctor lets a nurse know whether to continue or change medication. The medication depends on the patient's condition, and questions around the patient's eating habits and bowel movements inform a doctor's decision. Nurses also have to position patients in certain ways. The mobilisation of patients was a routine issue during ward rounds. In addition to various factors regarding the patient's condition, and with minimal nurse input, a doctor decides what is needed and gives instructions to nurses. For certain patients, imperatives regard the preparation for the patient to leave the ward. These are the main topics which guide nurse-doctor conversations in ward rounds.

The success of a ward round is meant to correspond with actors' goals in relation to one another and this places particular conventions between them. This is in order to establish a cooperative working relationship. Doctors decide what happens to patients and nurses carry out decisions. These conventions show that doctors lead and nurses follow. Doctors are often frustrated when they cannot make decisions or when their decisions are not carried out. Thus, when nurses do not help doctors with certain information, then arguments occur. For instance, if doctors ask nurses for information, nurses are expected to answer appropriately. An answer that is not relevant often introduces conflict. Furthermore, a doctor's authority is expected and legitimised otherwise nurses cannot do their job. When doctors issue imperatives, nurses may either accept or reject their request. This sequence illustrates an adjacency pair in that a nurse's acceptance becomes conditionally relevant. Nurses never rejected or challenged a doctor's instruction, because doctors are the primary decision-makers. A nurse rejecting a doctor's instruction and therefore giving a dispreferred response was unlikely and hardly occurred. I will return to this point when discussing more covert and overt forms of a nurse challenging doctors. Nevertheless, it is important to note that nurses continually accept and encourage doctors to give them instructions. This is illustrated when a nurse told me how she wanted and needed doctors to tell her what must be done with a patient. In fact, several occasions point to nurses telling me how rude, unhelpful and problematic a doctor's silence can be. Nurses, throughout the day, manage patient care and treatment. A nurse needs to know what to do with patients. This informs conversational patterns with respect to speakers' needs and demands within an institution. Issuing imperatives, in terms of conversational dominance, is therefore not necessarily resisted, but required, endorsed and accepted. Therefore, where the dominance of one speaker over another might not be favourable in symmetrical relations, it is expected within asymmetrical relations in medical settings. The purpose of ward rounds and difference in rank gives rise to the necessity of a doctor's dominance and leader emergence.

Leader emergence through language, as introduced by doctors issuing directives, refers to continuous speaker influence and control. Ng and Bradac (1993) argue that an important aspect within conversation lies in the opportunity to gain a speaking turn. Speakership refers to patterns in turn-taking, which illustrates who in conversation is speaking, and who has the floor at that particular moment. Despite the occurrence of simultaneous talk, a speaker will often let the other

speak, casting actors into specific speaker and hearer roles. Doctors are shown to be the primary speakers during ward rounds. Doctors initiate conversations by speaking first. This is done by telling nurses what to do, as shown in the extracts to follow. Continually self-selecting to speak shows the rights of doctors to initiate nurse-doctor sequences. Doctors therefore cast themselves as the primary speaker. It may also be beneficial for nurses to be silent, but the opportunity to gain a speaking turn is lost. This allows for easier leader emergence, because speaking in itself shows that talk is being used as a resource for rank and authority. A doctor's speakership also shows the precedence for doctors to meet their task oriented goals in comparison to nurses. The priority is given to a doctor's speakership and guidance by issuing imperatives

However, rather than attributing dominance to a general point on speakership and turn-taking, leader emergence is shown in the type of imperatives used by doctors. This is shown in the extracts below when doctors tell nurses what they should and need to do.

- 1 Doc4: give him his morphine and: get him out of bed

- 2 Doc13: um: give him his ten o clock dose and then let's stop the colistin (3)
um: and then: um we gona scan him today
Nur13: mm

As shown in the above extracts, brief and succinct imperatives characterise nurse-doctor conversations. A doctor uses turns in a manner which is time-saving and which helps create a short and efficient ward round. On average six to ten patients need to be seen in one round and brief imperatives are to the point and practically serve the purpose of a ward round. Doctors also write in a patient's folder what is required for them. The brevity in imperatives shows that imperatives are not always necessary for doctors to repeat. I often found nurses continually looking at doctors' notes during ward rounds and some ward rounds occurred with minimal imperatives. Nurses are, however, present during ward rounds and having nurses informed and carry out doctor's directives are an important demand. The expectation and convention is to inform nurses of the main instruction or situation of each patient. Power is, however, shown by doctors when they meet their aims of efficiency by giving brief instructions. This shows that it is

doctors, by speaking this way and especially while holding primary speakership, who hold the means of establishing the length and management of ward rounds.

I have mentioned that a doctor's dominance is not necessarily rejected but is maintained by nurses. This point relates a doctor's dominance to brief imperatives. Doctors can control and influence nurses by denying their interests. Porter (1991) argues that this shows unproblematic decision-making or subordination. Nurses unquestioningly accept instructions and have no input in this process. Unproblematic subordination occurred throughout ward rounds as illustrated by doctors when they issue brief imperatives, or alternatively when they issue inaudible and unclear imperatives. Interestingly, this latter use of language occurred consistently across ward rounds and shows that getting instructions across to nurses was not a significant priority.

Silence also creates impersonal interactions which nurses did not like. As previously mentioned, nurses need to know what doctors instruct for patients. Power is reflected in terms of asymmetry in nurse participation. For instance, a nurse claimed that she felt undervalued, because of impersonal interactions. The nurse felt inferior and unappreciated. This is because doctors are minimally including them in the decision-making process. In addition to the brevity in doctor initiated turns, doctors control the necessity to issue imperatives. Nurses are withheld information. This shows the restrictions placed for nurses in fulfilling their working subjectivity. Nurses are the ones in a position to be denied access to information. This shows exclusion and submissiveness, because nurses do not have information and are then compelled to ask for instructions. Nurses would have to give more of an effort in conversations by asking doctors questions in order to clarify instructions. Ten Have (1991) argues that doctors have rights to withhold information from patients and run the course of conversations. These patterns are strongly characteristic in nurse-doctor conversations.

Impersonal relations have further implications for nurse-doctor interactions. Doctors may not issue imperatives or they may take brief turns. Nurse-doctors relations and facework depend on the nature of turns being communicated. As a result, the abruptness and brevity of imperatives impact relations and rapport. Longer and more elaborated imperatives are associated with what doctors they like. I will return to this point later in exploring speaker support. But for the

purposes of speakership and leader emergence, brief imperatives help construct status and power. This is by adhering to formal and succinct imperatives which may exclude nurse participation.

However, longer imperatives can also serve the purpose of constructing status and power similar to that of brief imperatives. This is shown in doctors' use of imperatives within a longer turn, but which still shows how language, in different forms, is used as a resource for establishing authority. Longer imperatives establish doctors' authority by positioning doctors into a teaching and more knowledgeable role. This is shown in the extracts below.

- 3 Doc27: sh she was in *that* bed (.) with (inaudible) she has a shunt put in (.)
Nur27: mmhmm
Doc27: and then she developed a chronic (sydril) so she had her chronic (sydril) drained so (.) she needs just uh strict bed rest (.) um and no no sitting up or anything (.) ju jus she can sit up briefly to eat but then she must lie down again please
- 4 Nur38: he doesn't make a sound- like can't make out
Doc38: ya he's [if if
Nur38: <can't [even make out
Doc38: if if it's subarachnoid (.) that's what happens so at the end of [the day
Nur38: [mm
there is no guarantee with subarachnoid (.) you can't you can't say for subarachnoid (.) it's going to be 50/50
Nur38: mm
Doc38: subarachnoids do what subarachnoids do (2) he's been coiled (.) he's being protected but how do you recover and to what extent you will recover is (inaudible)

Extract 3 shows that although imperatives were often brief, there were exceptions to this rule. Imperatives could be issued within a longer turn offering a longer explanation. Longer imperatives often occurred explaining a patient's condition. A doctor is in a position to teach nurses while justifying their directives. Doctors have the knowledge and are able to be positioned in a teaching role. This is reinforced by the use of medical jargon in the diagnoses and explanations. Extract 4 illustrates that although the doctor is not giving an imperative, he is explaining the patient's prognosis to the nurse. The nurse has initiated the sequence by giving information about the patient. The doctor has continued to maintain and contribute to the topic by justifying the patient's situation. This is because of the nurse's assumed lack of knowledge

about the diagnosis. Decision-making is also supported by a doctor's knowledge. Ten Have (1999) argues that a key aspect in exploring asymmetry in interactions lies in the asymmetries of knowledge. Asymmetry in knowledge supports a doctor's right to influence and control interactions based on their superior knowledge. This is shown in their rights to primary speakership, for instance in issuing imperatives and using longer 'teaching' turns.

However, a significant point relates longer turns to unproblematic or problematic subordination (Porter, 1991). If decisions were unproblematic, then explanations of those decisions such as in extract 3 would not be needed. Nurses were not invited to contribute to the decision-making process, but Porter (1991) argues that if instructions were unproblematic then they would be given without explanations. Doctors often gave explanations while issuing imperatives. However, nurses are still not involved within turn-taking in this process. Furthermore, these conventions may be indicative of doctors exercising their superior knowledge and 'teaching' role rather than acknowledging instructions as problematic subordination.

Furthermore, a doctor's knowledge and authority to issue imperatives, which is reinforced by a doctor's teaching role, is also illustrated in self-reflective comments. Primary speakership and decision-making relates to unique trends in conversation. Doctors would continually repeat decisions and imperatives self reflectively without looking at anyone specifically. These turns were not aimed directly at nurses, because nurses would either ignore what they said or at times ask them to clarify. Doctors would be reading a patient's folder. Self-reflective thinking is common to whisper out aloud (Holmes et al., 1999). Repetition of imperatives in terms of self reflection also assists the management of decision-making. Repetition occurred often towards the end of visiting each patient and would serve to sum up an accountable imperative. Self reflective comments and repetition thus shows that doctors have the right to repeat turns and to speak, regardless of the presence of a second speaker. This is hardly present for nurses and shows that doctors are leading the round by fulfilling the role of decision-maker. Doctor's have the rights to control rounds through primary speakership by issuing brief directives. They also have the ability to impart superior knowledge, repeatedly and self reflectively. Primary speakership and decision-making thus shows how doctors are responsible for ward rounds.

Speaker responsibility

A doctor being responsible for ward rounds relates topic control, repairs and speakership. Doctors led ward rounds physically by walking from bed to bed with a nurse following. Consequently, doctors initiated and changed topics as soon as they left one bed to walk to another. Topics were changed in a doctor's use of language. Doctors initiated topics by issuing imperatives and likewise changed topics by giving different imperatives for different patients. Doctors had topic control and took on speaker responsibility (Atkinson, 1999). Speaker responsibility is illustrated, because a doctor has the ability to cast themselves in various speaking roles. These roles all indicate the conversational control and responsibility in a doctor's speaking turn. The casting of speakers shows how actors can be cast in different speaker roles. Ng and Bradac (1993) note that speaker roles may be categorised into animator, author and principal roles. Respectively, they denote that a speaker is uttering or animating the words, having composed the words themselves, and are expressing their viewpoint. Speaker roles may be enacted separately, but doctors show dominance and speaker responsibility when they take on all these roles. Doctors are not quoting others by animating others' words, and instead issue imperatives which are self-composed and express their needs.

Ownership of one's turn is therefore an important trend within conversation in asymmetrical relations. Doctors are decision-makers and their speaker responsibility is shown as they provide credible instructions. Instructions are formulated while placing the accountability on oneself when speaking. This shows the importance of a doctor's turn, and is further illustrated in the extracts below.

- 5 Doc9: can sit her out today for us please sister and she's- her (name) forms I believe were done yesterday so she's just awaiting on them (.)
- 6 Nur31: where is he going
Doc31: ya we're not sure where exactly yet but we- I'm gona chat to (name) again today (.) see how things are accumulating
- 7 Doc32: let's see what the (name) do today and then we decide as from

tomorrow if we start her on atrophin and then we just see how much she needs on a sliding scale (.) and: then tomorrow I'll prescribe her atrophin (.) coz we can't continue with the drip (1) she's up and down the whole time

Imperatives are made more accountable by doctors using self-repairs, as shown in extract 5 and 6. Self-repairs are used to rephrase initiatives in order for imperatives to be animated and packaged in a more suitable and effective way (Schegloff, 1992). A doctor takes on the responsibility of managing various speaking roles. Self-repairs are more preferred than other repairs. Doctors being corrected by others are dispreferred actions, especially since this shows that doctors are incompetent. Self-repairs may therefore show that doctors are attempting to avoid dispreferred turns. Self-interruptions, as shown in extract 5, were common and were used in the middle of a doctor's turn to formulate better instructions. This is denoted by the symbol ' - ' . Extract 6 also shows that self-repairs were often followed by doctors offering to take a particular action or check a situation. This is in order to be fully accurate while issuing an imperative and may occur without using self-repairs. Extract 7 shows a doctor taking on the responsibility of first checking a patient's need for medication before prescribing it. These situations show a doctor's responsibility in managing conversations and decisions. All speaker roles are used within turns. A doctor has control and institutional dominance, because they are the decision-makers who lead ward rounds. Wodak (1996) argues that doctors are also characterised as fail-safe experts. This is continually shown throughout speakership and casting and is especially relevant within self-repairs.

The institutional role of a doctor is important when constructing a doctor's subjectivity. Doctors are informed by subject positions of various discourses (Parker, 1992). A professional and medical discourse constructs an infallible actor. This constructs a doctor as the decision-maker, the leader, and the responsible and knowledgeable actor. The importance lies in the numerous expectations within a medical institution which construct what it is to be a doctor. These expectations are inextricably linked with the practice of these institutional expectations. Dominance is therefore shown both at an interactional and institutional level. Furthermore, by relating speakership and casting, power is viewed as a relational process. Doctors impact a nurse's speakership and casting by their own dominance in these areas. It is important therefore to understand how doctors do power by how they influence nurses into less powerful roles.

Casting nurses: The hearer roles

The power behind the opportunity to speak and being responsible for speakership often leaves the speaker able to cast the other into a particular speaking or hearing role. Doctors show how they do power in relation to nurses. This shows how actors of differentiating statuses take on speaker and hearer roles. Doctors, by issuing imperatives, cast nurses as the receiver of instructions. Turn-taking casts nurses into a hearer role. A main sequence during ward rounds shows regular sequences of turn-taking patterns (Warren, 2006). Nurses would give one-word acknowledgements to doctors. These acknowledgements consist of words such as 'okay', 'mmhmm', 'mm' and 'ya'. Sequences would take on the structure of doctors' initiation and nurses' acknowledgement. This also shows that a nurse is accepting a doctor's instruction. Adjacency pairs are being constructed as a doctor instructs or requests a nurse to accept their action. Doctors would also initiate and influence the course of the sequence, allowing the nurse to take a passive hearer role. Nurses showed this with brief acknowledgments showing that they were taking up a passive hearer role.

Nurses would also often be in a hearer position by being the person listening among doctors' conversations with one another. In addition to speaker roles, Ng and Bradac (1993) also note that hearer roles may be subcategorised to include casting within group conversations. Ward rounds were group activities. Dominance is not only represented by nurses being outnumbered in ward rounds. Dominance is also represented by nurses being cast as the more submissive actor during group interactions. The hearer role is not just defined when an actor is being directly addressed. There are also participant and overhearer roles. The former describes doctors casting a nurse as a supportive listener while they are speaking to another doctor. The latter is when the conversation is not meant to be heard by the nurses or turns are spoken indirectly to nurses. In group interactions, doctors would mainly cast nurses in the overhearer role. Doctors would have exclusive conversations with one another about patients. Nurses would at times accept this overhearer role by dismissing doctors' conversations. Nurses would watch elsewhere during these conversations. However, an important trend was that nurses would continually self-cast themselves in a participant hearer role. Nurses would self-initiate turns by giving information to

doctors. This is reflected in the below extract when doctors were speaking to one another about a patient.

- 8 Doc1a: ...coz he's still waiting he::s waiting to to go to (name)
Doc1b: why
Doc1a: no one is going there=
Nur1: =they went to (name) (.) the others (12)

The doctors do not look towards the direction of the nurse and do not request her input. The nurse is excluded and designated into an overhearer role. Conversations between doctors would also be very specific regarding a patient's treatment and diagnosis. They would often use medical jargon during the decision-making process. This reflects their knowledge, responsibility and authority in wards rounds. However, despite doctors casting a nurse into an overhearer role, nurses would often listen by watching them and at times interject, as in extract 8. Nurses would give information that they feel is beneficial or relevant, but which was not directly asked for. Interestingly, doctors' conversations attempt to cast nurses into a less participatory role, while nurses' attempt to change this by supporting their conversations. Casting by different speakers shows the exclusion placed on nurses and at the same time shows nurses negotiating exclusion. This can be further illustrated by a doctor's use of self-reflection, a common theme in ward rounds. Nurses are excluded as they are designated the hearer and especially the overhearer role. Nurses attempted to change doctor initiated casting through self-initiated turns. However, nurses are not the addressee and the alternative hearer roles, i.e. the overhearer and participant roles, are still more submissive.

Therefore, the way doctors do power can be seen with how they are constructed as responsible leaders in conversation and within an institution. Doctors issue imperatives, because this is a significant demand in ward rounds. Doctors also do dominance in relation to nurses which is evident when comparing speakership and casting roles. As seen, doctors use many uses of language to dominate nurses, but it is important at this point to emphasise that this goes hand in hand with attempts at doing deference. Doctors do power overtly within speakership and casting. However, working relations are often characterised by maintaining collaborative relations (Ten Have, 2001). Doctors regularly attempted to show less power while issuing imperatives. This is

shown in strategies of mitigation and politeness to avoid and minimise the force of a doctor's controlling turns.

Doctors mitigating their power

Doctors tell nurses what to do by issuing imperatives. This is a turn that impedes on a nurse's 'face' merely by being an instruction. Brown and Levinson (1987) argue that forceful turns such as giving orders threaten an actor's 'face wants'. A nurse has interests in being approved and unimpeded by others. Imperatives are face-threatening as they impose a doctor's needs onto nurses and obligate nurses to carry out another's interests. This gives rise to an important aspect in asymmetrical relations which addresses the sensitivity embedded in nurse-doctor conversations. Ng and Bradac (1993) consider risk and 'face' threats in conversations as the antithetical side-effects of enacting influence and control.

Leader emergence in nurse-doctor relations place nurses within a less dominant position. Doctors do power by continually having turns which control and influence nurses. The negative side-effects of such turns can be managed by changing the way turns are expressed. Doctors range from being indifferent to managing negative side-effects. However, doctors often minimise their imposition using language. Doctors take measures to manage power by depoliticising their influence and control. This is done by preventing or minimising the antithetical side-effects of imperatives. Power is still enacted, but is shown less forcefully. The depoliticisation of power is thus shown by tactfully managing assertiveness within speakership. A useful means to show less power is by using mitigation to avoid or minimise the negative effects associated with speaking turns. This strategy is used by doctors when they make their assertiveness and dominance more palatable. I turn now to exploring significant approaches within mitigation that focus on a doctor's use of indirectness and politeness.

An important trend within ward rounds is the dominance displayed by doctors. This is shown in various uses of language that show assertive trends in speakership and casting. There is a bias of face threatening acts (FTAs) in ward rounds as more are associated with nurses. As shown earlier, doctors' turns can be direct, succinct and abrupt. These serve to accomplish a successful

ward round, but they have negative side-effects. The abruptness of turns, however, does not mean that these are unmitigated turns. In fact, turns were regularly mitigated, but not to a point where there was an excessive use of indirectness or politeness. This is shown in the use of language to transform and soften imperatives, but without keeping the intention of the instruction lost. This helps actors in working relations to be cooperative. Doctors minimise their imposition while still imposing. Imperatives are therefore combined with tactful manipulation of speaking turns in order to mitigate a doctor's intention. An important point is that speakers are not necessarily aware of this tactful manipulation. This use of language is often taken for granted, but still shows conversation to be practically organised.

The way mitigation works relates directness with expressions, and more specifically relates measures of politeness and indirectness with mitigating speaking turns. Ng and Bradac (1993) define mitigation by suggesting that a speaking turn has force. This force lies within a continuum and a speaker may show varying degrees of imposing on another. Language is used tactfully to reduce the directness, as well as rudeness of turns. This may either strengthen or weaken the speaking turn and reflects degrees of mitigation. The force of turns can also be related to degrees of control and influence. This is similar to distinguishing between influence and control, with control being more forceful than enacting influence. Imperatives serve as ideal examples for indicating the degrees of force within turns. The below extracts, for instance, show how language can be used as an important resource to construct power tactfully.

- 9 Doc15: sit him out
- 10 Doc8: sit him out as well please
- 11 Doc29: alright can you sit him out on the chair
- 12 Doc26: okay (.) um: he needs to be out of bed

The extracts above are different versions of the same instruction. Imperatives are very threatening to a nurse's 'face', but there are different ways of issuing imperatives in order to manage antithetical side-effects. Extracts 9-12 show how imperatives can be delivered with different degrees of force. The placement and inclusion or exclusion of words transforms the imperative, and manages how it will be received by the hearer. A more acceptable interaction is

constructed given that a hearer interprets the turn more favourably. Power is managed as the intention behind the imperative is not lost, but only softened. This is reflected in the same intention in the different versions of the instruction in extracts 9-12, i.e. all instances tell nurses to sit the patient out of bed. The methods to soften a turn's force lie in two significant themes within mitigation, namely the use of indirectness and politeness to manage influence and control.

Indirectness and politeness

Ng and Bradac (1993) distinguish mitigation by separating indirectness and tentativeness. The latter focuses on the management of influence and control in a softer, but more polite way, regardless of directness. Actors may be direct, but still mitigate. This is contrary to the trend which associates mitigation only with indirectness. Extracts 9 and 10, for instance, are direct imperatives. These were commonly used, and at times were given within a series of similarly phrased imperatives. Direct imperatives clearly tell nurses what to do, but they are face-threatening as they have a strong forceful and therefore negative orientation. However, doctors issued direct imperatives that were not said in a loud or harsh manner. If extract 9 was combined with a strong authoritative and controlling tone then this would greatly threaten the other speaker. Power would be forcefully displayed. This did not occur and instead the tone in itself mitigated the imperative. Therefore, intonation is important in reducing the effects of enacting influence and control. Intonation was consistently used to mitigate turns. This also shows that unproblematic subordination is a concern in that force in turns show that direct imperatives are face threatening and therefore problematic (Porter, 1991).

Unmitigated or direct turns were mitigated through polite or tentative measures. This is further illustrated in extract 10 by combining directness with redressive actions (Ng & Bradac, 1993). Tentativeness in this extract relates to additive words showing consideration. The use of 'please' serves to add redress to the imperative by softening its force. Politeness manages influence and control, but still illustrates the management of power. The intention is still intact, but just depoliticised; showing the uses of politeness rather than indirectness to mitigate speaking turns. Politeness is therefore different from indirectness, but politeness is neither to be mistaken for mitigation. In using redressive actions, attention is drawn to the facework involved in managing

an imposing turn. This shows the sensitivity involved in issuing direct imperatives. This relates mitigation with facework, and includes the use of politeness. Conceptually, however, they are different, given that mitigation is only part of the broad spectrum within which politeness functions. Furthermore, mitigation may work independently from politeness by being used for impoliteness. Politeness, on the other hand, highlights the importance of speakers' attention to interactional offences, with or without mitigation.

Brown and Levinson (1987) suggest that attentiveness in conversations illustrates speaker support in conversations. Speaker support may or may not attempt to mitigate, but nevertheless aims to manage another's 'face' as well as one's own. This is illustrated when politeness is distinguished from mitigation by analytically separating an actor's 'face' as both positive and negative. Brown and Levinson (1987) argue that positive politeness is an expression of solidarity, whilst negative politeness is avoiding being an imposition. This shows how mitigation strongly relates to negative politeness rather than the former politeness, which will be later discussed with regard to speaker support and establishing common ground. Therefore, negative politeness has been significant in exploring processes of mitigation, and has often been particularly related to using indirectness. This has informed the trend of associating mitigation with indirectness, despite having shown that this is not exclusively the case as within extracts 9-10.

Regardless of the difference between politeness, mitigation and indirectness, they are closely related. Indirectness serves as a significant strategy within mitigation. This is shown significantly in extracts 11-12 and illustrates how an instruction's force is made considerably weaker by using different degrees of indirectness. The below extract illustrates how a potential direct imperative is transformed into a question.

13 Doc16: sister do you have a continuation sheet?
Nur16: ((she gives him 2 instead of 1))
Doc16: thank you

This extract, like extract 11, shows that instead of the doctor directly telling the nurse to sit a patient out or to give him a continuation sheet, he asks her if she can do it for him. The question

in extract 13 is unnecessary, given that nurses often have continuation forms with them, and even if they do not, they would have to fetch one for the doctor. This shows how nurses are obligated to do what a doctor needs. The question in extract 11 is also unnecessary, because it is not optional that a nurse sit the patient out as she is obligated to do so. The necessity, however, lies in the additional meaning set by transforming the instruction into a question. The nurse is capable of doing these instructions, and is given the opportunity to say no to the question, but that is if she interprets the literal meaning of the question. However, the indirect meaning is what the doctor is conveying and this is the meaning that the nurse is interpreting. This strategy makes the force of the imperative less harsh, because indirectness is used to weaken that force. The ‘telling’ part of the imperative becomes vague and makes the doctor’s imposition more palatable. This also meets the aims of negative politeness, because by being indirect, doctors are trying to minimise their imposition on a nurse’s ‘face’ (Brown & Levinson, 1987). Indirect imperatives still meet the purposes of dominance inherent in issuing imperatives, but by being posed as questions, reduce the harshness that comes with managing influence and control.

An instruction’s inferential meaning is further illustrated in extract 12. Turns such as those in extract 12 prioritises the indirect meaning rather than the literal meaning in issuing imperatives. This ideally displays indirectness by posing instructions not as an imperative or as a question, but as a statement of fact. The doctor is implying that a nurse needs to sit the patient out by phrasing it as a task that needs to be done. The doctor suggests at telling the nurse that she needs to do it. This is further illustrated in the extract below which places emphasis on the object, i.e. the patient’s drip. The focus is on the necessity for the drip to come out rather than on directing the removal of the drip.

- 14 Doc16: um: his drip can come down (2) unless are we- are we still giving him
a cocktail (1) actually leave it as long as he tolerates it
Nur16: so I can:=
Doc16: =ya if he pulls it out and then uh: his drip can come down

The doctor does not refer to the nurse specifically and refers only to the task that needs to be done. This task is not directly aimed at anyone, but is spoken to the nurse and is meant for her to understand. The removal of the drip is a nurse-related task and the convention is that she knows

that statements such as these relate to her nursing role. This is shown in the above extract when the doctor shows he is referring to the nurse by changing his mind and asking the nurse to leave the drip up. The mitigated words in the above and below extract also support mitigation through indirectness.

- 15 Doc15: °prepare to give him something orally and see if he'll tolerate it °
Nur15: we gona- what you say↑
Doc15: you can try and give him something orally and see if he'll tolerate it=
Nur15: =okay

The way mitigation has been shown thus far has been primarily by relating indirectness and politeness to the structure of the imperative. That is either by posing turns as a direct imperative, a question or a statement of fact. Mitigation, however, has been significantly explored with regard to the use of mitigating words. Mitigated words reflect indirectness and at times hedging, and illustrate usefully placed words in order to reduce a turn's harshness. This is shown in a significant pattern of language use where doctors added further meaning to imperatives by continually including words such as 'can' and 'try'. In extracts 14 and 15, the word 'can' is usefully placed in order to soften the instruction. The word 'can' was used substantially within issuing imperatives. In extract 15, this is illustrated by a doctor saying that the nurse *can* feed the patient rather than she *must*. The nurse is capable of doing this task, but 'can' insinuates that there is an option of not carrying out the task. In extract 15, the doctor has changed his phrase from 'prepare to give him something' to 'you can try and give him'. The word 'prepare' limits the nurse's options of carrying out the task, while 'can try' leaves the doing of the task open. This also shows that the nurse may not necessarily carry out the task, because the word 'try' implies the possibility of failure. These indirect meanings continually weaken the force in executing the instruction.

The responsibilities of a nurse are, however, continually called on. A nurse's role tends to doctors' needs for the management of patients. This role attends to doctors' concerns and further reflects a 'traditional' nursing subject position; a subject position that will be discussed later in exploring a nurse's management of power. For now though, this position reflects a nurse that

obeys doctors and manages a patient's care by carrying out the basic maintenance of patients, i.e. moving a patient, taking out a drip or changing certain medication. The discourse on nurses' working subjectivities informs that she answers to the indirect meaning rather than the literal meaning of imperatives. The use of indirectness serves to introduce ambiguity, but relies on discourse in everyday practice to keep the control and influence intact. The force of the instruction can be vague and weak, but still shows how power is managed through mitigation. This relates discursive norms with inferential meanings in conversations. Doctors may continue to be indirect without having their directives misunderstood. This is typically the case for those in a higher status and shows the usefulness in being indirect (Ng & Bradac, 1993). The use of mitigation does not apply equally for nurses who are in a lower status and fulfil a different conversational and institutional role. Nurses can be misunderstood and conversational breakdowns occurred from a nurse's use of indirectness. Furthermore, a nurse's use of indirectness also relates to a dispreferred response, i.e. a nurse's answer that included indirectness. This is not the same for a doctor who issues imperatives. A nurse's use of indirectness in a dispreferred response is part of an adjacency pair, and draws attention to dispreference in a nurse's use of indirectness. This shows how it is a nurse's use of indirectness that may cause conversational breakdowns. I will return to this point when addressing a nurse's use of indirectness.

Returning to doctor's use of indirectness, and in order to present a comprehensive discussion on a doctor's use of indirectness and politeness, I will elaborate further on mitigated words. The means of indirectness and politeness have been included in the analysis of doctors managing power, because they are extraordinary trends in nurse-doctor conversations. These patterns are therefore not at times used, but were consistent over all conversations. Thus, a final point on a doctor's use of mitigation is needed to cover the main uses of indirectness and politeness in conversation.

A useful strategy to meet indirectness in relation to politeness has been alluded to in previous strategies of mitigation. An important means to avoid directly relating the instruction to the hearer is by omitting or replacing significant pronouns, namely 'you' and 'I'. These pronouns have often been omitted, because they have become unnecessary in issuing imperatives. The use

of pronouns is not essential for directing instructions. However, the use of omitting these words, in addition to being a practical form of expression, relates to politeness and mitigation. The omission of pronouns shows that a doctor does not want to impinge on the nurse. This is shown in the previous extracts and is further represented in the below extract.

16 Doc14: know why he's on the oxygen
Nur14: ((nods)) don't know

This extract impersonalises who the instruction is aimed towards and also impersonalises the speaker. This makes the question less direct and mitigated. However, including 'you' may be mediated by tone. Turns are therefore mediated by strategically placing or omitting words to transform the negative side-effects of speaking turns. The aims of omitting personal pronouns can, however, be managed by other means. These means can also be seen as more favourable given the additional interests it serves within facework. An alternative means to omitting personal pronouns such as 'I' and 'you' is in replacing those pronouns with 'we'. The use of 'we' implies that both parties are involved in the instruction, i.e. both doctor and nurse. This was a recurrent trend in speaking turns, both for doctors and nurses to a point where turns did not often occur without the use of 'we'. Brown and Levinson (1987) suggest that using 'we' includes both actors as co-operators. In terms of politeness, both positive and negative politeness is established, i.e. solidarity is constructed and a doctor avoids being an imposition. The harshness is reduced by using 'I' and 'you' in turns, but also 'we' builds support for the receiver of the imperative or question which is shown in the below extract.

17 Doc16: can we get her out of bed or not
Nur16: yeah
Doc16: °haven't seen him out of bed yet°
Nur16: mm?
Doc16: haven't seen him out of bed yet
Nur16: he's been on the chairs
Doc16: oh↑ has he
Nur16: ya

Extract 17 shows the continual use of 'we' in issuing an imperative. The use of 'you' in this instance would be impolite and it would have shown the influence and control of the doctor

forcefully. The doctor is not responsible for getting the patient out of bed as this is a nurse-related task. However, by using 'we' he is distancing his involvement in the speaking turn by including both him and the nurse within the content of the turn. At the same time, the doctor is repairing a nurse's response when checking whether the patient did in fact get out of bed. The doctor therefore mediates dispreference by impersonalising himself in the turn.

A further point of note in extract 17 thus relates to the use of 'we', speaker support, indirectness and repairs. This extract ideally represents a doctor mitigating their power, and thus concludes this section before I address nurses managing power. In extract 17, the doctor does not directly question the nurse to see if the patient has been out of bed. Doctors often repair nurses by questioning and challenging a nurse's information. This is very 'face' threatening. Other-repairs are also dispreferred. However, in the above extract the doctor is using many strategies to considerably repair the nurse's turn by omitting 'I' and 'you'. Furthermore, the implication of saying 'Haven't seen him out of bed yet' is that the doctor is challenging her information. The doctor phrases his turns tactfully so that it is not a direct question or challenge, but a less confrontational observation. The challenge is therefore indirect as it is impersonalising the speaker and illustrates that the doctor is checking the nurse's information politely. This draws attention to the negative side-effects of repairs.

Repairs can be tactfully managed by those issuing it as shown in extract 17. Mitigation is at times used to fulfil a doctor's role of checking information, and therefore depoliticises their power to check and repair nurses' turns. Tactfully managed repairs introduce the trend in conversations to lean to cooperation, politeness, mitigation and indirectness. This is a significant point I will return to later in exploring speaker support in conversations.

Doctors therefore use various uses of mitigation to show less power. This is by softening the force of imposing turns, i.e. in issuing imperatives. Indirectness and politeness reduce the harshness associated with giving orders. Nevertheless, power is still present by having the intention of the order intact. Doctors are showing less power even though they are still dominant, both conversationally and institutionally. In fact, the way they depoliticise their power shows their rights to do so and shows how doctors do power in often mitigated ways. The use of

mitigation has also been significant with nurses. This is by relating a lower status with assertiveness. I therefore focus mitigation more significantly with nurses in the following section. However, it is necessary to explore a nurse's management of power in order to understand a nurse's use of mitigation.

How do nurses manage power?

The focus up until this point has been on a doctor's use of language to manage power in conversations. I turn now to elaborating on a nurse's use of language to manage power, specifically with how nurses do deference as well as manage resistance at a conversational and institutional level.

The useful information giver

Doctors need to ask nurses questions during ward rounds in order to issue an accountable imperative. A doctor would need to know how a patient was eating so that he could prescribe medication. A nurse was responsible for that information. As part of an adjacency pair, an answer that is relevant and useful would be a required and a preferred turn for nurses. Nurses would have to give an answer. An answer that is absent or consisted of delays, excuses and mitigation would indicate dispreference. Seedhouse (2004) notes that this unit of arrangement in conversation has expected or predictable second turns. Doctors expect nurses to provide helpful information in order to fulfil their position as a responsible doctor and speaker. Doctors, by posing questions, select nurses as information givers for the second turn of conversation. This also shows doctors' authority and right to influence turn-taking. Sarangi and Roberts (1999) note that a speaker in a higher status is often delineated as the speaker asking the questions, and that this is a trend in asymmetrical relationships. The extracts below illustrate such questions which are followed by a nurse's input and assistance.

- 18 Doc7: was he admitted yesterday
Nur7: no no no he: uh: he when he went for an op (.) and then he was in
(name) and then he came back to us yesterday (2) he had a blocked
shunt first

- 19 Doc11: uh you haven't heard about- from (name) hey
Nur11: no
Doc11: let's find out okay (.) she's been waiting for a long time
- 20 Doc21: sister (.) just ask him for me how he's doing (.) ask him how he is
<how is his bowel

Doctors ask questions to better understand a patient's situation. Nurses would follow with relevant information which helps a doctor decide what to write in a patient's folder. The above questions help to build up knowledge and manage uncertainty for doctors. Nurses would serve as a resource to assist doctors. This is especially shown in extract 20. A nurse was often asked by doctors to serve as a translator. Doctors would have trouble communicating with patients based on language differences. Nurses would often be familiar with a patient's language. Doctors would also ask other doctors or interns similar questions that were at times posed for nurses. However, translation was a unique resource that nurses possessed and was therefore an important characteristic within their role and speaker contribution. This embodies the role of nurses as useful information givers.

A nurse's speaking contribution was also reflected within topic maintenance. Doctors would initiate topics by issuing imperatives and initiating adjacency pairs. Nurses would maintain these topics by listening when receiving an instruction, i.e. in the hearer role. This is a more passive form of topic maintenance as a doctor's topic is not overtly rejected. However, nurses would be more assertive in maintaining topics while being a useful information giver, especially when being asked questions. In extracts 18-20, nurses follow a doctor's turn by maintaining and contributing to a doctor's topic. Topic maintenance is expected with adjacency pairs, and defines a nurse's interest to be relevant and useful. In extracts 18-19, this is also a preferred response to a question, i.e. an answer that addresses what the doctor is asking. In extract 20, the nurse accepts the doctor's request by translating for the doctor. These preferred turns are affiliative and avoid conflict. These responses also show that nurses are framed in a role that is supportive.

The management of control and influence in nurse-doctor conversations therefore draw from a nurse's supportive role. The expectations found in topic maintenance in information giving are

such an important trend in defining nurse subjectivity that giving information is often self-initiated. Self-initiated information consisted of sequences that were supportive and helpful to doctors. Nurses predicted the need for relevant information. Extract 21 below shows a short sequence illustrating a nurse giving a doctor information about a patient.

- 21 ((doctor paging patient's folder))
Nur37: she's for angio on Thursday (1) °that's what it still says°
Doc37: okay

In extract 21, the doctor is unfamiliar with this patient as he is paging through the patient's folder. This takes longer than is usually expected and the nurse gives information explaining the patient's situation. The doctor recognises this with a brief acknowledgement. In this instance, the nurse values her role as information giver especially as she recognises the benefit of offering useful information. A doctor's routine questioning creates a nurse subjectivity that is useful in information giving. This can be shown in various uses of language besides that of nurses answering questions. In the extract above, it is with self-initiated information. The nurse felt that the doctor was in trouble and that he needed assistance. She told me immediately after this sequence that it is beneficial for her to work an entire week, because she still has the updates of each patient. I recall the nurse expressing how, despite the working hours, at least she can provide consistent information to doctors. This illustrates the relationship between self-initiated information giving and personal achievement.

Furthermore, self-initiated information giving is supported by additional strategies of language use that continually support doctors and therefore meet the role of nurse as a useful information giver. This is shown in the following extracts.

- 22 Doc35a: they done that for him already
Doc35b: for who
Doc35a: for that patient mistuh: mistuh:
Doc35b: I actually [don't
Nur35: [was mistuh (name)
Doc35b: ah okay

- 23 Doc35: okay so we waiting for (.) um (.) (name) is trying to get the family
 [together
 Nur35: [there was someone who came here was it [Wednesday who was
 Doc35: [yeah
 prepared to take her but [then I don't know=
 Doc35: [mm mm
- 24 Doc19: (name) did I take blood from you last night (1) I can't remember if I if
 I (.) took blood (1) it's amazing it was only a couple of hours ago and I can't
 remember
 Nur19: ((looks on arms)) there's no=
 Doc19: =oh isn't there=
 Nur19: =there no uh: (.) there's no marks on-I can't see anything (1) well
 unless they took it and they washed it

Extract 22 is similar to extract 8 at the beginning of this chapter. Both examples depict a nurse giving information to further aid topics while doctors are talking to each other. A nurse's exclusion in group conversations and passive overhear role is negotiated and resisted through self-initiated information giving. Turn-taking and speakership are also renegotiated by assertively casting oneself as a speaker rather than a hearer. Furthermore, while doctors were speaking to each other about a patient, nurses would at times simultaneously speak with one of the doctors. The overhearer role would be renegotiated when a nurse would competitively speak with a doctor for rights to information giving. Overlapping turns were not common, but when giving information, the need to give useful information would inform a nurse's speaker contribution. Overlap and interruption was also illustrated in extracts 22-24. Nurses show continual speaker support for doctors. These are overtly managed rather than showing nurses passively taking turns in response to a doctor's turn. In the extracts above, the nurses are also repairing doctors by correcting their information, but this is done to support the doctors rather than challenge them. Extract 24 shows a continuous flow from one speaker to another. This illustrates support whereby nurses readily contribute to the conversation. In extract 22-23, a nurse also deliberately interrupts a doctor's turn in order to take on the role of useful information giver. The nurse potentially has information and knowledge that a doctor does not have. A nurse's useful working subjectivity would take precedence and therefore self-selecting to speak and repairs were used in favour of silence. These various instances of information giving illustrate a nurse role that is knowledgeable and competent, and 'good'. Thus, I turn to showing

how this relates to discourse on nursing. This represents a significant relationship between language and a nurse's working subjectivity.

The traditional 'good' nurse and facework

The construction and reconstruction of working subjectivities is important in institutions. The usefulness found in meeting certain speaking or hearing roles in conversation leads to a continual preoccupation with meeting discourse related expectations. Language aims to meet individual goals based on personal use. Nurses take on the information giver role and inform patterns in conversation that relate to expectations within this role. A nurse's speaking contribution is reflected in topic maintenance through self and other-initiated information giving. Language therefore aids in defining what a 'good' nurse is. A 'good' nurse provides useful information and this informs a nurse's discursive positioning within a professional discourse. Nurses have been represented as actors attending to doctors imperatives and being useful information givers. Discourse on appropriate nurse subjectivities provides conventions of a traditional 'good' nurse subject position. A nurse within this positioning obeys doctors' instructions and gives information to assist them. This is also defined as a 'good' nurse, because a 'bad' nurse does not obey a doctor. Throughout data collection, a nurse did not explicitly challenge a doctor's instructions. In one situation, a doctor asked a nurse to carry out a nurse-related task. The nurse did not comply and remained silent. When asked again, a more senior nurse challenged the doctor by saying that they could not do what he asked right at that moment. In both instances, the nurse gave a dispreferred answer by rejecting the doctor's request. Dispreference can therefore be related to an understanding of what it means to fulfil a 'good' nurse role. This instant turned into a considerable argument between nurses and a doctor. Nurses avoided such arguments by accepting doctors' requests. If a nurse attempted to reject a doctor's request. Mitigation was used and at times more overt forms of rejection were implemented. However, generally nurses attempted to continually provide useful information and be supportive aides to doctors, including providing preferred responses. Language is therefore seen, in various strategies, to be informed by, sustain and reproduce a traditional nurse subject position.

Furthermore, a traditional 'good' nurse has also been shown to be a subservient role in comparison to doctors (Hoekelman, 1975). Nurses show assertiveness in managing information and therefore influence the course of topics. However, this can be reframed by arguing that a nurse tends to a doctor's topic and not their own. The doctor is the decision-maker and has topic control. A nurse also has to renegotiate the casting of an overhearer role rather than being cast by doctors from the onset in a participant role. Group conversations between doctors exclude nurses. Asymmetries of participation are illustrated in nurses' passive and reactive participation (Manias & Street, 2001; Ten Have, 1991). A conventional nurse working subjectivity shows nurse passivity. This is not to say that nurses did not take more assertive turns, but I will return to this later in discussing how nurses give more opinionated suggestions in conversation.

However, it is important to note that the relationship between language, subjectivities, and passivity shows the construction and implications of asymmetry in nurse-doctor relations. The importance of language and self being relational emphasises the expectations between speakers in conversation. As illustrated, a nurse's 'good' impression is associated with expectations on providing useful information. However, anxiety is introduced for nurses to meet these expectations. This shows how topic maintenance in information giving can be threatening. A nurse's anxiety includes the demands placed on embodying a lower status in asymmetrical relations. A nurse's 'face' consists of nurses being valued as a useful information giver within a traditional 'good' nurse subject position. At the same time, nurses do not impose on doctors.

Anxiety in conversations introduces how face threatening acts (FTAs) are related to information giving. A nurse's speakership would often consist of brief turns. At most times, only one turn was given after a doctor's question. This is shown in one word answers or brief statements. Extracts 21-24, with extract 15-16 consist of one to two words. Brief turns show the threatening nature of answering a doctor's question. The shorter and less elaborated a turn is the less of an imposition the information is likely to be (Brown & Levinson, 1987). It is important not to mistake dispreference in language use with FTAs. Dispreference may be related to a break in norms in conversations, for instance not answering a doctor or rejecting his request. This is also face threatening, but this is not the case in all situations. A nurse gives a doctor a preferred answer by answering his question in giving brief answers. However, the brevity in the answer

might be more indicative of the FTAs present in taking a longer and perhaps unnecessary turn. Nurses often say only what is required, which shows the threat present for nurses in conversation. There is the potential for being irrelevant and unhelpful, especially with inadequate information giving. It would be the contribution of the nurses that would be on display, ready for criticism, and clarification. Sarangi and Roberts (1999) note this as a significant theme characterising actors in a lower status in asymmetrical working relations.

At this point, it would be useful to elaborate on the relationship between FTAs in information giving to the principle of preference within CA (Seedhouse, 2004). Preference organisation helps speakers orient themselves to others through talk. Nurses and doctors can show that they are affiliating and disaffiliating with each other through language. In instances where doctors ask information from nurses or give them requests, adjacency pairs introduce a potential dispreferred second turn. A preferred response to a doctor's question would be affiliative and help construct social solidarity. A dispreferred second turn would consist of a nurse not answering or rejecting a doctor's question or request. In this case, anxiety is related to a dispreferred response. A nurse is also shown to fail at her nursing role by giving dispreferred responses. Furthermore, the way doctors interpret their response, preferred or not, may introduce dispreference in terms of repairs. Doctors may devalue a nurse's response. Nurses may also self-initiate information, but the attempt at topic maintenance may fail to be relevant, and a doctor might repair them. Nurses may fail to be accountable in responding or a doctor might interpret their unaccountability unfavourably.

Breakdowns in information giving show that if information is not accountable then conflict arises. Preferred responses occur often unnoticed as they become normative in conversation. However, dispreferred responses are noticeable as they break the affiliative norm within nurse-doctor conversations in ward rounds. This is further related to speakers' working subjectivity and therefore 'face'. This is shown in the below extracts when nurses fail to maintain a doctor's topic and fail to be a useful information giver. At first this relates to giving a dispreferred response to a doctor's question or request.

25 Doc21: did he have a fit
Nur21a: hey who take over here ((nurse asking other nurse a question))

- Doc21: did he have a seizure last night
 Nur21b: ya but it wasn't for long
 Doc21: but he had one
 Nur21b: he had one ya but it wasn't for long they said (.) only once
- 26 ((patient says something in Xhosa))
 Doc21: what's he saying
 ((nurse and patient speak)) (6)
 Nur21: he didn't know what-
 ((nurse talks to patient))
 Doc21: °what's he saying°
 ((nurse and patient continue talking)) (7)
 Nur21: h[hh
 Doc21: [what is he *saying* ((impatiently))
 Nur21: he says he didn't know that there is also a book here like this (.) he noticed from (name) so: (.) ya (2)
- 27 Doc15: okay he is not suppose to be on nil per mouth (.) I don't know why they (.) it is not nil by mouth sister (3) and I can't find his notes=
 Nur15a: =who the one there in the corner
 Doc15: yes=
 Nur15a: =I think it's still in the room check the folder
 Doc15: no they not in the folder↑ (.) I have checked ((self reflective mumbling))
 Nur15a: yesterday he was nil per mouth
 Doc15: no it's not about the nil per mouth (.) his notes are not in the folder [I need: I] need to find it because
 Nur15a: [ya I know I know]
 Doc15: who put him nil per mouth (.) mistuh (name) is nil per mouth
 Nur15b: ((nurse a and nurse b simultaneously say something)) no no is not mistuh (name), what is mistuh (name)=
 Doc15: mistuh (name)(3) it's it's not- I'm not worried the nil per mouth I'm worried about [his notes]
 Nur15b: [no they said] he was cancelled yesterday so: (.) he's not
 Doc15: I'm concerned about the notes
 Nur15b: is there no notes there
 Doc15: no notes

Doctors have speaker responsibility and need useful information. They have the responsibility and the authority to have their topic maintained by asking questions. In the above extracts, a theme in all breakdowns is that doctors ask questions for information, but a nurse's response is not useful enough. In extract 25, the nurse did not have the answer for the doctor and aimed to rectify her lack of knowledge by asking another nurse. The nurse therefore gave a dispreferred

response by not answering the doctor's question. The other nurse responded and added extra information that could be more useful. The nurse adds 'ya but it wasn't for long'. The doctor interprets this as unnecessary despite her attempt at giving a well-rounded answer. This breakdown could have also been initiated by the initial dispreferred response. The doctor has been disaffiliated with based on the nurse's initial response.

In extract 25, the doctor also questions and checks the validity of her answer. Repairs are a common use of language for doctors in order to check a nurse's information. Doctors have professional responsibility to direct the course of a patient's treatment. In this extract, the nurse eventually repeats her response more assertively and clearly in response to the doctor's unfavourable interpretation. Dispreference in terms of repairs is further shown in extract 27. The doctor challenges the nurse's information by correcting her and saying 'no they not in the folder'. Seedhouse (2004) argues that these other-initiated repairs are highly dispreferred as correcting another's response impedes on their 'face'. This is shown in extract 27 by the nurse changing the topic rather than continuing to justify where the folder is. A nurse's answer is open for clarification, and again may not be suitable or useful. This latter point is also illustrated in extract 26 through a dispreferred response. The nurse does not immediately answer the doctor, even after his repeated questions. He impatiently repeats the question a third time and emphasises the word 'saying', showing that his need for translation has not been met. In this instance the nurse has failed to be a useful translator. These extracts show that attempts at information giving can be threatened and may be explained through facework.

The useful information giver role is inextricably linked to a traditional working subjectivity. Providing relevant information is threatening for nurses given the potential of FTAs with how doctors interpret their information. The presence of many FTAs in conversation shows the limits in conversation within an institution. The goals of ward rounds and the discourse on nurse and doctor working subjectivities constrain nurses. A significant point on influence and control is that nurses encounter FTAs more than doctors in ward rounds. Doctors were rarely repaired by nurses and thus their infallible subject position was maintained. This is keeping in mind that the dispreference in other-repairs is disaffiliative. When nurses repaired doctors, in one occasion, an argument occurred and in other, the repair was softened by a nurse's humour or indirectness.

Doctors, however, have the rights and responsibility of continually checking and repairing nurses' responses. This constrains nurse-doctor relations as nurses have limited control over the presence of FTAs and have to work harder to avoid them. Nurses also show these constraints in self-initiated information giving by continually preserving their 'face'. Nurses maintain their self image as information givers. Therefore, their public self image as a traditional 'good' nurse is being attended to.

Facework and the presence of FTAs are further illustrated in extract 27. Breakdowns of information giving show that a nurse's 'face wants' are not met. The nurse's face is open for evaluation as the doctor in this extract questions the nurse regarding a patient's situation. He places pressure with maintaining the topic by having her answer competently. However, both nurses are not able to provide useful information, because they do not know where the patient's folder is and they are also not certain why the patient is still on 'nil per mouth'. They are not answering his questions properly. This is face-threatening. There is a lack of facework in terms of politeness being carried out by the doctor. The doctor's questions are repeated and direct. The nurses are being corrected and rejected. The doctor is also insinuating fault by referring to an error in carrying out a nurse related task. He is continually repeating his question about the folders and directly suggesting that he cannot complete his goals without the aid of the nurses, who at this point are unhelpful. A significant nurse subject position is compromised as the nurse failed to provide useful information. The conventions and success of a normal and expected ward round have been broken. Importantly, extract 27 shows the reason behind managing a nurse's 'face'. Therefore, nurses encounter FTAs and dispreference within repairs regularly. Nurses need measures to minimise and avoid FTAs.

Nurses' use of verbal self-defence

There were not many conflicts during wards rounds, but when they did occur this could be solely designated to nurses failing to meet their working subjectivity, i.e. by failing to be a useful information giver. The pressure and responsibility to continually tend to 'face' is placed on nurses. Doctors evaluated nurses regularly by acknowledging a nurse's response as 'no problem' or 'that's fine'. There is an important difference attributed to differentiating statuses. As

illustrated previously in extract 27, conflict arises when nurses fail to maintain a doctor's topic and therefore fail to be a traditional 'good' nurse. Nurses come across negative consequences and therefore measures would be appropriate to ease these consequences.

In light of FTAs in nurse-doctor conversations, a recurrent theme in language use was used by nurses. Nurses continually attempted to minimise or avoid potential breakdowns in conversation. Ng and Bradac (1993) cluster strategies to avoid the negative side-effects of turns under verbal self-defence. Ng and Bradac (1993) argue that in order to continually manage oneself in conversations, verbal self-defence is necessary. These strategies are shown amid failing adjacency pairs and are illustrated in the below extracts.

28 Doc7: okay so sit him out today continue with his *feeds* and: what is he getting iv's?

Nur7: (4)

Doc7: is he just getting fluid (inaudible)

Nur7: (2) °um: well I'm not sure what the: (inaudible)°

29 Doc29: is he eating↑

Nur29: I don't know doctor uh=

Doc29: =< okay well then can (.) you find out please ((nods his head like no))

Nur29: (4) his getting a soft diet (.) I'm just reading the notes here

Doc29: and is he tolerating it

Nur29: °I'm not sure° let me just check quickly with the chart here

Doc29: yeah on the 4th (1) tea given water given and: ((quick and abrupt))

Nur29: =it looks like he's taking it=

Doc29: =well there's nothing written here so how can you [make that

Nur29: °it looks [like here°

deduction

Doc29: [no thats coffee=

Nur29: =and the [porridge

Doc29: yes but the actual [*diet* (.) that's why I'm asking whether he's actually

Nur29: [mmm

[tolerating it if if I can from here I would have read from there but its

Nur29: [mmm

insufficient that's why I'm asking

Nur29: ya let me find out for you

Doc29: will you find out because we need to know what's the (how to feed the patient) ((nods his head like no))

((nurse gets other nurse))

In the above extracts, strategies of verbal self-defence are employed. In extract 28, silence and mitigation are used to answer a doctor's question. Silence is used rather than answering the question, as shown in the four second delay. The nurse may have not heard the question, but this is unlikely given her response to his repeated question. After the question is repeated the nurse pauses for two seconds before answering reluctantly and softly. Hedging is shown through hesitation and delays before speaking. This shows that the nurse's self image needed maintenance (Brown & Levinson, 1987). The nurse response is also dispreferred and conversational breakdowns are easily arisen within these instances. This is despite showing the use of mitigation to avoid further disaffiliation.

Generally however, silence as verbal self-defence is illustrated in many ward rounds when nurses had very minimal turns. Nurses minimised giving information and did not ask many questions. Ng and Bradac (1993) stress the importance of silence as passive resistance. FTAs are managed through silence. Therefore, even if nurses forfeit the opportunity to talk, silence is a useful strategy to reduce disaffiliation. However, silence may be problematic given its potential to stop the flow of conversation (Schegloff, 1992). Questions are positioned so that they require responses. These need to be spoken and silence impedes this process. A strategy to better reduce disaffiliation is shown in indirect phrases and responses.

Mitigated words or indirect phrases such as 'I don't know', 'maybe' and 'I think' allow nurses to soften their response. Extract 28 shows reluctance in the nurse's answer in the phrase 'I'm not sure'. The nurse continues her statement, but allows it to be vague. This often occurred within breakdowns, as further illustrated in extract 29 by 'it looks like he's taking it'. Excuses, hesitation and mitigation are often present while taking dispreferred turns, i.e. the nurse does not have a direct answer for the doctor. Turns are packaged more palatably in response to doctors. Mitigation by being indirect helped to minimise a nurse's imposition on doctors, while at the same time allows nurses to admit uncertainty. The latter point has implications regarding how doctors interpret mitigated responses.

Dispreferred responses are noticeable as they break from the affiliative norm, and therefore they are accountable. This is shown immediately after the interaction in extract 29. The more senior

nurse accounted for her disaffiliation in her dispreferred response. The nurse presented the doctor with excuses and rationalisations which often accompanies dispreferred responses (Seedhouse, 2004). Dispreferred responses may however be sanctionable or not. This draws attention to a doctor's reaction to a nurse's dispreferred response. Indirectness is interpreted as being part of a dispreferred response and it illustrates failure in providing clear supportive information. Doctors also make the responses sanctionable by continually repairing and showing that a nurse's response is unhelpful.

In extract 29, the doctor did not want the nurse to be indirect in her responses. Extract 29 is similar to extract 27, because both reflect the doctor's frustration with the lack of a direct and suitable answer. Therefore, mitigation often failed to meet the aims of reducing disaffiliation. In fact nurses exacerbated a doctor's annoyance with insufficient and indirect answers. Extract 29 shows uncertainty being expressed through mitigation. The nurse is continually showing assertiveness by maintaining the doctor's topic rather than going to fetch another more knowledgeable nurse. This is after the doctor asked her to find out if the patient was eating in the beginning of the sequence. The nurse was about to fetch a more senior nurse, but instead took turns to influence and control the course of the topic herself. However, the doctor eventually abruptly repeats the question with his reason for asking. The doctor firmly says 'yes but the actual *diet* that's why I'm asking'. The nurse's roundabout answers were not useful and therefore her role as useful information giver failed. This also shows how status impacts how indirectness will be taken up by different speakers. Verbal self-defence is a useful strategy for nurses, but it can backfire depending on a doctor's interpretation of the response. Ng and Bradac (1993) argue that speakers may want clarity of expression. This is important for planning and decision-making. Nurses are expected to be clear and assist in a doctor's decision-making process.

Therefore, the use of indirectness as a resourceful strategy to manage power has more risk with reducing disaffiliation within dispreferred responses for nurses than for doctors. This shows how asymmetry constrains relations through biases in FTAs. This relates to norms within discourse. Unequal power relations represent imbalances in risk and facework in relation to different professional roles.

It is also important to note that dispreference and FTAs are informed by the difference in the way doctors use mitigation in comparison to nurses. A doctor's use of mitigated words contrasts a nurse's uses of them. A nurse's use of mitigation within verbal self-defence include many words such as 'maybe', 'perhaps' and 'I think'. These words show uncertainty and reduce the force of turns. They were however not often used by doctors. Doctors hold speaker responsibility and a common trend for those in a higher status are that they use mitigation to soften their imposition, but without compromising their speaker responsibility (Atkinson, 1999). Doctor's invest in positions that construct them as responsible and infallible actors (Wodak, 1996). Doctors' infallibility has often been discussed with doctor-patient relations. A doctor's investment in this subject position also shows its applicability in working relations. A doctor's discursive positioning in relation to a nurse's positioning shows that uncertainty in mitigation is not acceptable. Mitigation is used to soften a doctor's force, but not to the extent to which their positioning is not managed. This differs from nurses who do not invest in this positioning. Nurses often absolve their responsibility and show uncertainty in order to avoid giving incorrect information. This meets their positioning as a useful information giver, which is a role that is not relevant in the same way for doctors.

Nurses therefore use mitigated words and show more indirectness than doctors. Doctors, on the other hand, use a weaker form of indirectness by excluding very uncertain and indirect words. Doctors do not reflect uncertainty, but rather indirectly infers the instruction in a less controlling form. Furthermore, nurses often use mitigation within dispreferred turns as part of adjacency pairs. Nurses are reducing the disaffiliation within dispreferred turns. Doctors are not using mitigation in the same way. Doctors are not being asked to give answers or carry out instructions. For doctors, redressive words were used to reduce the forcefulness of imperatives. Redressive words are also not used excessively, because too many mitigating words would show increased vagueness, uncertainty and language incompetence. Politeness in terms of redressive actions is also not always necessary given a doctor's right to issue imperatives. The use of mitigation was therefore understated in order to avoid compromising the dominance and knowledge of doctors. Ng and Bradac (1993) note that language users may use powerful and powerless styles of speaking. The differentiating patterns in mitigation, speakership and casting

in relation to discursive positionings reflect these styles between doctors and nurses. A nurse's use of mitigation can be excessive as shown in extract 29 compared to doctors.

Returning to strategies of verbal self-defence, an additional strategy also shown in extract 29 illustrates another form of mitigation which relates to earlier discussions on speaker responsibility. When nurses took on the speaker role, a remarkable theme in nurse-doctor conversations was that they would speak from the animator role. This is by quoting and blaming a third party for the words they were speaking (Ng & Bradac, 1993). In extract 23, the nurse absolves responsibility by quoting the information from the notes, i.e. 'his getting a soft diet (.) I'm just reading the notes here'. This influences the course of the topic without taking on personal responsibility. This is a significant pattern that occurred in nurse-doctor conversations as illustrated in the below extract.

- 30 Doc25: ...you must give it routinely then please sister (1) so even if if she
[complains that she's vomiting we need to give this to her (1) okay
Nur25: [mm °I see° (1) but the night sister said um um the patient doesn't
want to stomach it
Doc25: they they must give it to her because if she vomits then...

Assertiveness is negotiated by the nurse who self-initiates information. This can also be framed as a challenge. The nurse rejects the doctor's request and therefore dispreference is introduced. Again, dispreferred responses are often followed by excuses and reasons for their accountability. In order to minimise the effects of dispreference in a challenge, the nurse refers to the night sister, a third party to take the blame for her statement. For nurses, strategies to show assertiveness palatably reinforce the need to absolve speaker responsibility. This is further informed by the difference of dispreferred turns for speakers, as shown in the prevalence of FTAs for nurses.

Verbal self-defence has primarily been shown with nurses attempting to empower themselves while being limited by a 'powerless' role compared to doctors. This has been shown in a nurse's dispreferred turns and in their failure at managing their nursing role. This has also been shown in repairs, i.e. in the correction of a nurse's turn. FTAs are relevant and measures to avoid or reduce the negative side-effects of turns are necessary. This is closely related to the next section in this

chapter which explores nurses managing resistance and agency. Thus, I join the rest of the discussion on verbal self-defence by relating measures of verbal self-defence with resistance.

Nurses doing resistance

Strategies of language use emphasise how and why nurses use mitigation. This draws attention to asymmetrical relations. The asymmetry and hierarchy within institutions has implications for working subjectivities (Sarangi & Roberts, 1999). Nurses show participation by taking assertive turns. This introduces FTAs given the expectations with a nurse's institutional and professional role. This is shown in being a traditional 'good' nurse and reinforces the need for verbal self-defence as their turn is open for repair. For nurses who have a lower status, mitigation is a good strategy to show assertiveness in turns that may be challenging and threatening to both a doctor's and a nurse's face. Absolving responsibility addresses this issue in extract 30, and is further shown in the use of mitigation in the extract below.

31 ((doctor asks patient to move his arm))
Nur16: I think he's restrained doctor

The nurse uses indirectness to tell the doctor that his request is inappropriate. The nurse repairs the doctor which is disaffiliative and this is a potential problematic action. The nurse sees that the patient cannot move his arm. The nurse takes a turn that corrects the doctor, but this is in order to rectify as well as assist the doctor. The dispreference in taking such a turn is however softened by using mitigation. The use of 'I think' in this extract shows false uncertainty, because the nurse knows and sees the patient has restraints. The nurse's turn implies that she knows better than the doctor. A doctor's positioning suggests that he is more knowledgeable than nurses. Therefore, mitigated or indirect words helped reduce the force of a nurse's challenge. The nurse's duty to assist and support the doctor is accomplished, but just in a more mitigated form.

Verbal self-defence can therefore be explained within a range of passive and assertive uses of language. However, despite self-selecting to speak, mitigated strategies were used to cast the nurse in a more passive role amid assertiveness. Passivity was therefore common among turns

that attempted to show assertiveness. This is also illustrated in conversations where assertiveness was managed by rationalising a nurse's turn.

The use of language is important to avoid disaffiliation while maintaining a nurse's useful information giver role as shown in extract 29. The nurse attempts to answer the doctor by rationalising what she said. She refers to the patient's chart. Passive turns were however not always the case and at times nurses would take turns that showed defence through direct rationalisation. This is shown in the below extract.

- 32 Nur37: he's for resus?
 Doc37: if he's for
 Nur37: resuscitation
 Doc37: (no not not yet) please
 Nur37: I'm *just* ask:ing
 Doc37: °ya ya as a nurse°

Arguments between nurses and doctors often occurred when doctors and nurses rationalised their turns. Extracts 27 and 29 illustrate nurses and doctors continually defending their turn. The doctor in extract 27 does not except the nurses' justifications by repeating several times his concerns about the folder and the 'nil per mouth'. In these instances, rather than being silent or taking very indirect turns, nurses rationalised their answers by defending and justifying their response and information. This is in aims of showing their competency and usefulness. This is again briefly shown in extract 32 above when a nurse justified her turn by saying 'I'm *just* ask:ing'. This was a direct turn, but mitigation was still used by using the word 'just' which attempts to minimise her imposition. The nurse rationalises her turn as 'merely' a turn that did not mean to be forceful (Brown & Levinson, 1987). However, nurses are still getting their opinions and questions across, such as within extract 32. The nurse questions the doctor and accounts for her question after being repaired. Porter (1991) shows that nurses do not simply obey doctors and remain silent. Nurses ask questions and if necessary offer overt suggestions. As in extracts 30-32, the nurse, despite the level and use of mitigation, is still taking an assertive turn. She informally voices her opinions.

Rationalisations and excuses are common in dispreferred turns. Extract 32 shows the dispreference given the doctor's interpretation of the nurse's turns. The doctor undermined and rejected her contribution by insinuating that her question was irrelevant. This is when he repeats 'no no no'. The doctor also impeded on her face directly by insinuating that her assertiveness in her questioning was further irrelevant, as she is only a nurse. This illustrates the FTA in the nurse's turn as it may be seen as challenging and irrelevant. This shows that a nurse's turn would often be open to repairs. This impedes on a nurse's face as a useful contributor to the conversation and justifies the use of various strategies to 'save face'.

Verbal self-defence has therefore been justified as a necessary means to minimise or avoid negative consequences in turn-taking. Again, this is shown in using passive forms of language such as silence and mitigation in one's turn. Nurses avoid the negative side-effects of taking turns, and at the same time potentially influence doctors. Verbal self-defence introduces a broader discussion on how nurses attempt to construct their agency, and therefore resistance to subservience in nurse-doctor interactions. I will now turn to elaborating on issues of verbal self-defence more explicitly with nurses' use of mitigation in questioning doctors.

Mitigation in nurses' questioning

FTAs were shown during ward rounds when nurses would ask interns questions or look at a doctor's notes. These alternate means of gaining better information are safer than directly asking a doctor for information which would need facework. Nurses would at times need to know what the main instruction is for each patient, e.g. should nurses mobilise the patient or feed them in certain ways. When nurses asked questions, mitigation was used to soften their initiative. The use of mitigation is therefore used to ease conversation and to create socially agreeable working interactions.

Questions came in various forms, and distinguishing questions from challenges shows the difference in the risk and management of dispreference. Nurses would ask questions and this was acceptable given that nurses need to know the main instruction for each patient. This was a similar pattern to issuing imperatives. Nurses would ask questions and these turns are made

unsanctionable, because of the goals permitting these turns within a task-oriented activity. Nurses would ask specific questions relating to the basic treatment of patients. These types of questions were of minimal imposition to doctors. For this reason, questions were asked directly or they were accompanied by strategies that showed a minimal use of indirectness. Nurses were not overly invasive as is shown in the brevity of questions. This is illustrated in the extracts below which show nurses asking short questions, of which extracts 34-35 show particular uses of mitigation.

- 33 Nur37: what's the plan for this patient
 Doc37: continue: (.) antibiotics and sit her out today
- 34 Nur6: still want the drip up doctor
 Doc6: we can remove the drip thanks=
 Nur6: °remove the drip°
- 35 Nur5: must we feed him or must we stop
 Doc5: you can feed him

Extract 33 shows that nurse initiated questions were not always indirect. Nurses needed to carry out nurse-related tasks which made brief questioning tedious and rudimentary. These questions also often served as a substitute to or a clarification of doctors' imperatives. Porter (1991) argues that these questions can serve as shorthand for suggesting and alluding to tasks relating to patient management. This introduces the relationship between asking questions and issuing imperatives. This relationship also lies in the use of mitigation to manipulate the force of turns. Nurses' brief questions are similar to a doctor's use of mitigation. Extract 33 is direct, while not having a commanding tone. Extracts 34-35 are all similar in tactfully managing the omission, exclusion or placement of words to weaken the force of turns. These similarities are shown in the use of pronouns. Nurses also use a redressive action in extract 34, though not in the form of 'please' or 'thank you'. Nurses used the title of 'doctor' as redressive actions. Titles were similarly used by doctors by referring to nurses as 'sister'.

However, certain strategies of language use are different even though the management of the force is similar. This is expected considering the difference between asking questions and issuing

imperatives. Interestingly, doctors used more redressive actions than nurses in mitigating turns by including words such as 'please' and 'thank you'. Nurses would also use a substantial use of indirectness compared to doctors, as already shown by absolving responsibility. Nurses continually use verbal self-defence and rely on indirectness to avoid rather than minimise the antithetical side-effects of imposing turns.

The function of mitigation also relates a nurse's usefulness with language. Nurses would attempt to construct agency by being relevant. Nurses would show agency without sounding imposing or incompetent. Extracts 33 and 34 are phrased to continually support a doctor's turn. Extract 34 for instance uses the word 'still' which was regularly used by nurses. Nurses are showing that their question is relevant by suggesting that they are using a doctor's previous turn. The sequential organisation of turns is therefore important in showing how actors attempt to be relevant within turn-taking (Seedhouse, 2004). Previous information is used to inform and validate their question and this also supports doctors through topic maintenance. Ward rounds are not isolated events as they are informed by previous ward rounds and information. Nurses have prior knowledge about patients which informed a recurring pattern in asking questions. Nurses would often ask doctors if certain treatments would be continued or they would remind doctors of previous information. This shows that ward rounds are not stand alone activities. Nurses continually attend to the relevance of their turn by making it accountable.

Instances resembling extract 34 show how language is used to show nurses being supportive and relevant. Turns can have multiple intentions, and rather than directly asking a question, other meanings can be attributed to turns. Turns are made more palatable. Influence and control is also done more agreeably. Extract 35 asks an open-ended question. A doctor is given options for answering. Nurses are not shown to assume either answer. The nurse in this extract provides an option in order for doctors not to feel that she has insinuated or assumed an instruction in asking a question (Brown & Levinson, 1987). This occurred frequently in questions and is similar to doctors' use of mitigation to make imperatives more open-ended. This illustrates how subtle insinuations through indirect meanings are functional and useful. These meanings relate to various strategies emphasising open-endedness, supportiveness and relevance.

However, questions came in various forms and were not always simple or straightforward as shown in the above extracts. Questions that are more forceful represent stronger uses of mitigation rather than the minimal strategies discussed above. This is because questions may insinuate and suggest a nurse's interest more forcefully as shown in questions that veer away from the normal routine of ward rounds. Thus, turns are not specifically task-oriented where patients' instructions need to be clarified or received from imperatives. This relates to unconventional turns which stop the progress of ward rounds. Nurses encounter FTAs by changing the topic and showing assertiveness. This is shown in various mitigating strategies showing hesitation. This also relates to a 'bad' nurse, i.e. in not fulfilling a traditional 'good' nurse subject position. A 'bad' nurse shows dominance and not subservience to a doctor's leadership. Nurses hesitate to ask more challenging questions. Stronger uses of mitigation reflect a greater presence of FTAs. This is illustrated in the following extracts.

36 Nur19: there's a call for doctor (name) there (.) I don't know if you want to
take it
Doc19: sure thanks sister

37 Nur20: doctor (name)
Doc20: mm?
Nur20: it's a patient
Doc20: ok (5)
Nur20: °um: doctor°
Doc20: ei?
Nur20: no there's a family of mistuh (name) [on] the line
Doc20: [yes] (1) what do they want
Nur20: information about him=
Doc20: there's no information today (.) so: (2)
((doctor writes something in folder and then goes to answer phone))

A stronger use of mitigation is shown in extract 36. The nurse hedges and uses indirectness tactfully to avoid being an imposition. The nurse acknowledges that the phone call is for another doctor and does not presume that the doctor will answer it. The nurse also uses indirectness in the words 'I don't know' which shows she is hesitating and recognising the issue of her relevance and right to take that forceful turn. The nurse's question is mediated by not taking for granted the doctor's action (Brown & Levinson, 1987). In this extract the doctor gives a preferred answer by accepting her indirect request. There is a strong link between relevance and

self-initiated turns. This is also ideally represented in a longer sequence in extract 37. The nurse shows considerable hedging through silence and indirectness. The nurse was speaking to another nurse about a family member who was on the phone. This lasted for about five minutes. The nurse also mentions to the other nurse the concern about the doctor speaking to the family member himself. The nurse's turn is very threatening as the ward round may be stopped. The nurse is also introducing a time-consuming activity for the doctor.

There is an unusually long silence in extract 37. The delay lasts for 5 seconds. Indirectness and uncertainty stop the flow of conversation. The nurse does not press the doctor forcefully and speaks softly when repeating her concern. The nurse also does not directly ask the doctor if he will answer the phone. She gives short statements about the family member and the need for them to be informed. The nurse is suggesting the doctor answer the phone. The doctor does not immediately attend to her indirect suggestion. Unlike extract 36, this instant shows the doctor giving a dispreferred response through pauses, clarifications and rejection, i.e. 'there's no information today' and does not at first answer the phone. This shows considerable threat in veering away from specific task-oriented topics. The goals in ward rounds can be shown by dispreferred turns.

Dispreference and threat in extract 37 is also reflected importantly in the length of the sequence. The nurse shows assertiveness and this is reflected with how nurses use language to build up to a particular suggestion. This contrasts earlier questions which did not consist of a particular build up. Nurses build up to a suggestion in order to get doctors to do acts without telling or asking them directly. The nurse's purpose was to get the doctor to answer the phone or to at least give information to tell the family. This was not directly said which shows continual attention to inferential meaning. Nurses enact influence and control without causing trouble or letting their turn become sanctionable. This is further represented below by a long winding sequence which is made up by many indirect and repetitive questions. The sequence eventually boils down to the nurse's main concern and indirect suggestion.

38 Nur37: she wants to know when are u coming
 Doc37: okay um:: for her today let me put it in my phone so I don't forget I'll
 come at about 11

Nur37: tell me doctor are we to phone them there or they- do they know about her

Doc37: uh we just make the application that's: what I usually ask for and uh: (name) takes care of it from there (2) so then we just wait

Nur37: so we don't have to phone them to come and fetch her=

Doc37: it doesn't actually matter (.) okay let's see the patients

Nur37: th that's why I also ask [because yesterday you said doctor yesterday

Doc37: [I don't know okay..

you say she's for (name) today (.) now normally- although they know but we still *phone* them but now my worry is if you coming to explain [to her at 11 what if they fetch her at 9 o'clock

Nur37: [she's going to

Doc37: no she's going for (name) and she also needs to go to (name) they aren't mutually exclusive (.) we are awaiting (name) we don't know when it will come through=

Nur37: =no no I'm talk-leave alone (name) I'm talking about (name)=

Doc37: =yes=

Nur37: =my point is you said you gona come and talk to her at 11 what if the (name) fetches her at 9=

Doc37:= no no↑ that's no problem I'll talk to her *now* then (.) we'll just finish the round and then I'll come back

Initially, the nurse is speaking to a patient in Xhosa. She translates the patient's concern to the doctor. The nurse begins asking questions relating to a concern that the doctor might fail talking to the patient before the patient leaves. However, instead of immediately raising this concern, the nurse refers to third parties. The nurse does not directly ask the doctor when he will speak to the patient. The nurse asks questions relating to phoning other parties. The nurse indirectly attempts to get an idea of the times of each party so that the doctor does not miss talking to the patient. The doctor, however, misunderstands the relevancy of the nurse asking about the phone calls and the third parties. The doctor becomes impatient with her questions about procedural topics. He shows this by rationalising the direct insinuation of her questions, and says 'it doesn't actually matter (.) okay let's see the patients' and '<I don't know okay'. Therefore, the nurse's use of roundabout questions is causing trouble rather than serving to palatably bring up her concern. The nurse is eventually more direct with her concern, especially since the doctor misunderstood her indirect meaning. The doctor then realises her point by saying in a high tone 'no no↑ that's no problem'. The nurse eventually communicates her concern about the doctor not speaking to the patient in time. She indirectly communicates a suggestion to speak to the patient at a more suitable time. In this extract, the nurse initially asks a question, but towards the end of this

sequence, this question is shown to be a prequestion to the main issue at hand (Seedhouse, 2004). These prequestions pre-empt the need for future dispreferred responses. Nurses use prequestions regularly. This extract therefore shows a significant point in the nurses build up and use of indirect questions to illustrate an indirect concern and suggestion.

The doctor-nurse game

Stein (1967) (as cited in Porter, 1991) coined the term the doctor-nurse game to describe the characteristics in extracts 37 and 38 that show the uniqueness of nurses being indirect. Nurses subtly bring up concerns and offer suggestions to doctors indirectly (Sweet & Norman, 1995). Nurses show influence and control, but in a passive way in order to stay within the limits of assertiveness. These limits are prescribed by encompassing a lower status in an asymmetrical relationship. Their initiative and dominance is disguised, and shows how power can be managed in a more palatable way. Resistance is therefore managed, because doctors have power over nurses. This relates social acceptance to the norms prescribed within professional working relations. It is important to note that Wicks (1998) argues that nurses are not only passive actors in relation to doctors, and argues that the doctor- nurse game is often over emphasised. There were, however, numerous examples indicating that in this context, nurses made extensive use of the doctor-nurse game to offer suggestions to doctors. This does not represent shorthand to what doctors already know (Porter, 1991). Rather, this shows that nurses attempt to give suggestions indirectly, and if this does not work they become more assertive or persistent towards the end of the sequence. I will elaborate this further in the below discussion.

Nurses manage assertiveness by going against the conventions of dominance in ward rounds. Questions like those in extract 37 and 38 are posed indirectly, because the purpose of the doctor-nurse game is to allow nurses to raise a concern or suggestion. These turns can run the risk of imposing on a doctor's leadership role. In extract 37 the nurse stopped the ward round. Topic change challenges a doctor's topic control. Furthermore, a nurse rarely repairs doctors explicitly. Indirect turns can be seen to show nurses preventing this very dispreferred action. Therefore, topic change and challenges were managed in order to sensitively negotiate interests relating to dominance. Sensitivity to dispreference is also shown in extract 38. The nurse is attempting to

suggest the implications of the doctor's timing. This is with the possible mismanagement of a patient. The nurse runs the risk of contradicting the doctor's positioning as a responsible and fail-safe expert. The use of indirectness in her roundabout questions safeguards the nurse against the threat of insinuating that she knows better than the doctor. The nurse also pre-empts a dispreferred response, for instance by avoiding the rejection of her request to see the patient at that moment. The nurse also prevents telling him how to do his job, which is a severe FTA. The doctor-nurse game therefore depoliticises the nurse's interests without compromising her obligation to bring up a concern or offer a suitable suggestion. This is more clearly illustrated in the below extract which further illustrates the doctor-nurse game.

- 39 Doc25: (drop to) tramadol=
Nur25: you know the tramadol actually made him vomit doctor
Doc25: (inaudible) intake
Nur25: I think (.) it makes them very nauseous (.) < the night sister said that she wouldn't stop vomiting
Doc25: it's just the: we use the tramadol especially to relieve the pain (.) she complains of pain still (3)
Nur25: you know what they use also um: for the pain can be also the morphine=
Doc25: =morphine is more more vomiting (.) than the tramadol
- 40 Nur25: doctor are we gona continue the tramadol or we just leave it
Doc25: no we gona continue with it please sister
Nur25: think like coz she was complaining about vomiting sometimes, she doesn't want it
Doc25: you must give it routinely then please sister (1) so even if if she [complains that she's] vomiting we need to give this to her (1) okay
Nur25: [mm (.) I see] but the night sister said um um the patient doesn't 'want to stomach it'
Doc25: they they must give it to her because if she vomits then...

In the above extracts, there are numerous mitigating strategies that show how nurses use indirectness to manage their concerns and suggestions. Extracts 39 and 40 show the use of assertive turns insinuating the change of medication. Assertiveness is managed by the nurse using considerable and repetitive means to absolve responsibility. This is by referring to the night sister and in using the word 'they' during the nurse's suggestion to change to morphine. Various strategies show how the doctor-nurse game is implemented in order to continually attend

to a nurse's concern about the patient's vomiting. A nurse gives a mitigated recommendation. It is part of a nurse's duty to be a supportive aid for doctors. Face-threatening turns have to be done, but in order to avoid FTAs and dispreferred responses; the doctor-nurse game is used to soften these duty bound turns.

The duty in a nurse's position can be illustrated before a ward round with doctors. Extracts 39 and 40 are part of one ward round. The nurse in this round did a round previously with another nurse. There are concerns that are brought up and some are noteworthy of mentioning to the doctor. This is shown repeatedly when the nurse refers to the night sister in her turns. Responsibility is not only absolved, but a nurse shows the relevancy and duty within her assertive turns. The issues that nurses raise are largely unavoidable, because they are obligated to bring up concerns. In extracts 39 and 40, there is a problem with the patient's vomiting. The nurse manages her concern by repeating it twice in this ward round as shown first in extract 39 and then in extract 40. Therefore, assertive turns that may be challenging are not simply unnecessary turns, though it may be interpreted that way, but rather they are required turns in order to fulfil a nurse role. This relates the doctor-nurse game with the various obligations associated with the professional discourse on nursing.

The doctor-nurse game can be further related to the expectations and subject positions of a nurse. This concerns the notion of the 'new' nurse who takes on more responsibility as a professional actor (Leonard, 2003). A nurse's autonomy is related to assertiveness. However, as shown, nurses are often invested in a traditional nursing role. The doctor-nurse game has been a significant means to manage the negative side-effects associated with these obligatory turns. Furthermore, a nurse's expectations relates to the discourse of a caring nurse (Davies, 2003, Wicks, 1998). A nurse's assertive turns are often about the care of patients. The doctor-nurse game was used to raise concerns about bettering the care and management of a patient. Extracts 39 and 40 shows the nurse's concern about the patient's vomiting. This is an important expectation defining a nurse role.

However, because of the constraints in a nurse's status, there is anxiety in enacting assertiveness and therefore anxiety within role enactment. Doctors hold the authority to make decisions about

patients. Nurses therefore use indirectness in the doctor-nurse game to enact influence and control. The doctor repeatedly justifies his decision in extracts 39 and 40 and therefore enacts power. Thus, even though the nurse enacts her assertiveness in a mitigated way, this instant can be recognised as a failure, considering that she made her suggestion known, and it was rejected by the doctor. Doctors manage the assertiveness of nurses by directly refuting or accepting their concerns and suggestions. This introduces the point on doctors' awareness of nurses' assertiveness. The depoliticisation of power relates to a doctor's awareness or lack of awareness of a nurse's interests. This also relates to adjacency pairs being more direct and eliciting a yes/no response, which makes a dispreferred answer more likely.

Indirectness in the doctor-nurse game is useful, because indirectness may be used to an extent where a nurse's interests are realised without doctors necessarily being aware of the influence and control involved. The doctor-nurse game has thus far illustrated how mitigation minimises a nurses imposition, but this strategy can be significant in avoiding FTAs and dispreference altogether. This is by allowing nurses to insinuate a concern that becomes taken for granted and taken up by doctors. Doctors can take ownership of nurse initiated concerns (Sweet & Norman, 1995). This is best illustrated below when a nurse advised doctors of a patient's poor condition. The nurse fulfilled her role as a useful information giver and at the same time indirectly introduces her worry about a patient.

- 41 Nur17: it *oozes* it oozes but that is how the dressing and the bleeding looks every [day
Doc17a: [(serous fluid) (.) it's not fresh blood
Nur17: no it's not blood it's just that but I mean it's been like a *week* now
Doc17a: mm hmm it's a one week now
Nur17: since Friday (.) it's another Friday
Doc17b: I have a bad feeling
Doc17a: can u tell me has has he walked
Nur17: his leg is broke compared to his head that I know
Doc17a: (inaudible)
Doc17b: I have a bad feeling
Nur17: say again
Doc17b: I *have* a bad feeling
Nur17: are u gona do something about that feeling
Doc17b: (he repeats the wound's condition) the way he's bleeding
Nur17: yes that's why hh I'm asking are u gona do something about it

In this extract, the nurse raises the point that the patient is bleeding in a troubling way and that this is not a good sign. The nurse has communicated her concern to the doctor. This is directly shown in the last line when she asks what the doctor will do about her concern. She shows her intention by pointing out an important problem that needs the doctor's attention. Interestingly, her concern has been taken up by the doctors as being of importance, but one of the doctors has taken ownership of this concern. This was initially the nurse's issue, but this doctor repeatedly mentions 'I have a bad feeling'. The doctor's opinion prioritises his anxiety about the patient and not the nurse's anxiety. The doctor also personalises the observation whereas the nurse impersonalised herself by stating facts and observations. The nurse does claim back this concern by directly asking if the doctor will do something about that feeling. This shows her intention of what she indirectly meant in this extract, i.e. she communicated her worry and suggested at some kind of recommendation or instruction about the patient. The nurse eventually overtly questions the doctors about the patient's management. Thus, the doctor-nurse game often shows itself in assertive suggestions later in the sequence (Porter, 1991). These instances have broader implications as nurses further construct themselves as competent nurses and information givers.

The doctor-nurse game is useful in disguising interests to a point where doctors may not recognise the influence and control being practiced. I have thus concentrated a great portion of nurses' doing resistance in the doctor-nurse game. Wodak (1989) argues that mitigation introduces easier persuasion and therefore easier control of conversations. If assertiveness is enacted in a subtle way then hidden meanings suggest to doctors to pay attention to certain problems. Indirect meanings are alluded to by using mitigation in the doctor-nurse game. Indirectness was therefore used and shown safely to enact influence and control without overtly imposing on a doctor's dominance. This shows how a nurse often negotiated power and resistance alongside the limits established by asymmetry. Indirectness points to the trends associated with actors in lower status in a working relationship. Power can be (re)negotiated within an unequal power relationship. Ideologically, this shows the impact of the routinisation of agency through various patterns in language. This contributes to the differences in managing power between actors in an asymmetrical working relationship. Nevertheless, it is important to note that nurses may still directly assert their suggestions if the doctor does not express his opinion or decision within the doctor-nurse game. This shows nurse agency more overtly than

the doctor-nurse game suggests. As shown in extracts 38 and 41, nurses overtly stated their suggestions towards the end of the sequence, but indirectness was still helpful in establishing those suggestions.

Differences in strategies of language use show how discourse and language interrelate to create asymmetry. The doctor-nurse game is used by nurses. This is characterised by nurse passivity and indirectness, though overt uses of language are not excluded. Doctors also use language differently to orient themselves to nurses. Mitigation has been a central concept within the following analysis. Differences in language use can be further shown in themes relating mitigation to support within working relations. This has been touched upon in noting indirectness with depoliticising doctors' and nurses' interests. For instance, a nurse uses mitigation while attempting to be supportive to a doctor. A doctor also attempts to minimise the force of their turns. However, mitigation was the focus in discussing such supportive strategies. I turn now to a considerable discussion on speaker support in nurse-doctor conversations. I will not separate this section between doctors and nurses, and rather focus on the co-construction of speaker support between actors. This is further explored by relating intersubjectivity with building rapport and more specifically with language use.

Speaker support and creating rapport

An important aspect to managing influence and control relates to speaker support. Speaker support has been previously introduced by relating mitigation to interests of creating supportive relations. Indirectness and tentative measures are used to avoid or minimise the antithetical side-effects of turns. This relates avoiding being an imposition and helps create supportive relations. Mitigation therefore relates strongly to negative politeness. It is however the alternative of negative politeness that is associated with building common ground and speaker support. Positive politeness focuses on social solidarity and rapport between actors. The use of language to influence and control another can be analytically separated between negative and positive politeness. The relationship between speaker support and power is with the asymmetry in supportive languages uses. This can be further related to facework drawing attention to language use and discourse. I will also avoid confusing speaker support with preferred responses within

turn-taking. Preference organisation may relate to speaker support, but I adhere to positive politeness when using the concept of speaker support. In this section on speaker support, I will relate differences in speakership and casting between nurses and doctors with speaker support. I will explore specific strategies addressing intersubjectivity and power in nurse-doctor conversations.

Humour and laughter

The use of humour and laughter occurred during ward rounds. This is not say that they were overly used throughout ward rounds, but that they occurred during many ward rounds in different ways. The use of humour or laughter also depended on which nurse or doctor was in the ward round and which situation or patient was being discussed. Furthermore, different ways of expressing humour were used more often than others. For instance, jokes between nurses and doctors seldom occurred. If humour did not occur often then exploring the meaning to these exceptions are important. CA explores focal points and not only frequent patterns of language use (Ten Have, 1999). Doctor initiated jokes that did not directly include nurse participation occurred more often. This point is critical for showing exclusion in group conversations. Regardless of these trends, nurse-doctor jokes illustrate how humour was used to build positive politeness and create rapport.

Glenn (2003) argues that the use of humour and laughter serves functions that manage rapport in interactions. Speaking turns can be forceful and 'face' threatening as seen when issuing imperatives or when a nurse shows assertiveness. Eiggins and Slade (1997) note that humour allows speakers to do serious work while distancing themselves through laughter. FTAs represent the seriousness in nurse-doctor conversations. Speaker support softens the negative effects and seriousness of turns, and builds on the reciprocity of perspectives by constructing social solidarity.

The reciprocity of perspectives is usefully shown when both actors joke with one another. The togetherness in joking shows how humour and laughter creates speaker support and rapport (Norricks, 1993). The function of laughter and joking is represented when both are accepted,

endorsed and maintained by doctors and nurses. Glenn (2003) claims that the reciprocity of perspectives is shown within shared laughter. Laughter and humour is invited and accepted by one another. Shared laughter and joking aligns perspectives despite who may have started first. As an adjacency pair, shared laughter is accepted and constitutes a preferred turn. Norrick (1993) shows how joking strongly aligns actors' interpretations of the joke and humour. Jokes and bantering were common during ward rounds. This led to laughter and illustrated how shared joking between a nurse and a doctor created speaker support. This is shown in the extract below.

- 42 Doc17: ...it was the night before he was carrying on hey
Nur17: (still swearing) still making noises
Doc17: ((doctor swears in Xhosa)) hey
Nur17: excuse me↑
Doc17: ((doctor swears in Xhosa))
Nur17: a un u hh your masa hhh
Doc17: hh he was swearing yesterday
Nur17: na you were swearing *worse* than that (.) you people and newspaper
(1) he's looking for a newspaper
Doc17: hh

Extract 42 shows how affiliation can be created through a sharing of laughter. Doctors and nurses align their perspectives by understanding and maintaining the topic of the joke. The doctor has initiated a crude joke. The nurse hedges in response which shows she is surprised. The nurse continues to support the joke by carrying on the joke with her own swear word. She laughs and continues teasing the doctor by scolding him. The nurse does so by saying 'na you were swearing *worse* than that'. The doctor then laughs and turn-taking shows how both speakers accept and endorse the humour.

The vulgarity of the joke also creates a sense of comfort and casualness between actors. Doctors and nurses are in positions of formal working relations, but the inappropriate joking strongly constructs rapport. Actors are constructed as friendly parties and not strictly work colleagues who adhere to the specific task at hand. Conversations that veered away from the routine tasks of ward rounds built supportive relations. Topic can therefore be a significant factor in building rapport between actors. This is by leaning towards supportive, cheerful and non-related work topics. Instances like extract 42, however, seldom occurred which showed that ward rounds were

not fit the basic stereotype of 'whiteness' as he translates competently. The nurse reveals this unconventional response by laughing and joking with the doctor. The doctor accepts the humour and smiles at the nurse's compliment, i.e. 'you know very well'. Extracts 42 and 43 illustrate how topics may be used for establishing symmetry through mutual topics. This is further reinforced by humour and laughter.

Status is still important in limiting relations, but it is renegotiated when making ward rounds informal and personal. Thus, task-related goals are not only being met as other cooperative goals are included. Personalisation does not relate to the use of personal pronouns as discussed earlier. Personalisation here refers to speakership which makes ward rounds more social and informal. Rapport is created as actors feel positive rather than negative about conversations or ward rounds and this lead to feeling positive about each other. This shows the relationship between language and the social construction of working relations through the use of supportive language devices. This is both within preferred turns and within turns that are supportive in content.

Status and power are nevertheless significant in working relations, and can be illustrated through frequent patterns of a differentiating use of humour and laughter. I will thus relate humour and laughter to managing power within conversations.

Power in humour and laughter

In extracts 43 and 44 to follow, the trend shows that jokes and humour are initiated mainly by doctors. Power is embedded in the authority of doctors to initiate topics and self select as the speaker. It is doctors who initiate support and common ground between themselves and nurses. Doctors have the rights to make a ward round seem 'good' or 'bad' by initiating humour and laughter. This is similar to the rights of doctors to repair nurses and initiate breakdowns by challenging nurses. A 'bad' ward round is created especially if several breakdowns occur in one ward round. Doctors instead initiate humour and help create 'good' ward rounds or at least 'good' sequences. The notion of 'good' ward rounds or sequences refers to language uses that create speaker support, affiliation and rapport between nurses and doctors, while 'bad' ward rounds refers to arguments and disagreements. Thus, doctors can initiate dispreference by using

repairs and they can also initiate speaker support by initiating humour and laughter. This shows how influence and control is constructed by doctors initiating turn-taking with humour or laughter. One ward round in particular stands out showing a doctor continually joking with a nurse. The jokes were all initiated by the doctor. This ward round also showed that most ward rounds rarely occurred with humour and laughter. A doctor commented on how social ward rounds were rare, but 'nice'. The doctor in this ward round said that it was 'surprisingly a social round today'. The nurse jokingly agreed and confirmed that it should be social all the time. Speaker support can therefore construct 'good' ward rounds, but these ward rounds hardly occurred as they were often task-oriented.

Doctors initiated jokes, but nurses also show influence and control. Nurses construct 'good' or 'bad' interactions by influencing humour or breakdowns. This has been shown with nurses giving useful information and carrying out nurse related tasks. When nurses give preferred responses they are fulfilling their duties to avoid being repaired. However, the 'good' sequences and ward rounds can also be created by maintaining doctor initiated jokes. Nurses contribute to humour through topic maintenance. Nurses are constructing their agency even though they did not initiate the humour. Nurses acknowledge a doctor's humour by using turn-taking to add to humour. Speaker support helps nurses build affiliation by accepting and endorsing humour. This works to a nurse's favour as her 'face' is being accepted. Topic maintenance is thus important for nurses and is shown in the structure of jokes. A doctor initiates a joke and a second turn is expected. This is because the success of a joke depends on how others react to the joke (Norrick, 1993). A nurse helps doctors by acknowledging and maintaining jokes and humour. This is illustrated below.

44 Nur26: MRI or MRA
Doc26: I I I
Nur26: I
Doc26: I I
Nur26: I
Doc26: aye captain
Nur26: hh

45 Doc28: we will wave a flag when he's allowed to go home okay

Nur28: a white flag I will I will look out for that flag hh

Extracts 44 and 45 are initiated by doctors. The nurses are carrying the jokes by acknowledging the humour and supporting the doctors' turns. This is shown in extract 44 when the nurse repeats the letter 'I'. The nurse also laughs at the doctor's explicit expression of the joke, i.e. 'aye captain'. In extract 45, the nurse reflects and supports the doctor's joke by saying 'I will look out for that flag'. These instances show how a doctor often initiates humour, but nurses acknowledge and help maintain the humour. A dominant nurse subject position also requires nurses to be supportive. Nurses have been shown to be supportive active listeners. Nurses also give useful and supportive information. Doctors are not characterised as an overly supportive aid to nurses. Doctors lead ward rounds by topic control rather than topic maintenance. Thus, topic maintenance is useful for nurses in managing power, but the support is still for a doctor's topic. Submissiveness is embedded in being restricted to initiate humour. Glenn (2003) argues that a pattern in asymmetrical relations shows the implications of status regarding humour and laughter. Glenn (2003) claims that actors in a lower status laugh more at humorous remarks of those in a higher status than vice versa. Nurses make more of an effort to show speaker support through topic maintenance. This is in contrast to how a doctor manages a nurse's humour.

Nurses initiated jokes even though doctors initiated jokes more often. Doctors would not carry or maintain nurse initiated jokes. Doctors accepted nurse initiated jokes and this constitutes a preferred response, but this was minimally done. Furthermore, doctors would end nurse initiated jokes by not taking a turn to contribute to the humour. Interestingly, this occurred in doctor initiated jokes. In extracts 44 and 45, the humour ended with nurses laughing, acknowledging or maintaining the joke last. Doctors therefore determine when humour is enough. In extract 44, the doctor started and maintained the joke, but ended it with an explicit expression of the joke. In extract 45, the nurse reflected the joke back to the doctor. The doctor did not self-select to speak again. Doctors therefore control humour by initiating and terminating it. For nurse initiated jokes, doctors control topics by minimally acknowledging a nurse's humour. Doctors end the sequence by minimally maintaining the nurse's topic. This is shown in the following nurse initiated jokes.

- 46 Nur17: he's ours ((said to another doctor, but he didn't hear)) (2) hhh he's
 looking at the wrong one
 Doc17: ei?
 Nur17: ours
 Doc17: mm ((smiles))
 Nur17: h the x-rays (.) °we just had them° hh
 Doc17: ((looking at notes))
- 47 Nur9: the-res-a-mi therethesami
 Doc9: oh
 Nur9: its f u I hh not frusit mi hh thresa(hh)mi yesterday they ask me sister
 what is this now rasics I say its suppose to be but doctor was thinking about fruit
 hh
 Doc9: ((smiles))

Extracts 46 and 47 illustrate doctors minimally acknowledging a nurse's joke and humour. The doctors do not add turns to flesh out the joke. The doctors are showing that they are listening, but they also end the joke. In both cases, the doctor either smiles or uses one word answers such as 'mm' and 'oh'. This reaction contrasts how a nurse interprets a doctor's jokes. Power can therefore be shown in terms of how doctors use humour differently from nurses. Ward rounds are also group activities. It is important to show how the differentiating use of humour relates beyond the one on one examples presented thus far.

Group interactions and humour

Asymmetry and humour can be explored by discussing the casting of nurses in relation to the group dynamic of ward rounds. This was shown in earlier discussions on the casting of nurses. A recurrent pattern in group interactions reflects power and humour in terms of nurse exclusion.

Doctors would be joking and laughing amongst each other during ward rounds. This shows nurse exclusion by having doctors show speaker support with one another. Doctors also talk and joke with other actors in ward rounds, for instance with interns, students or patients. Nurses were cast many times by doctors in an overhearer or participatory role. Nurses would not pay attention to or minimally acknowledge a doctor joking with other actors. This is shown in the extracts below when doctors were joking with one another and with patients.

- 48 Doc2a: there's that favourite guy of yours (.) mistuh (name) hh
 Doc2b: ah hh he's coming here
 Doc2a: h he'll be the last one to see
 Doc2b: ya h the image I'll leave with h
 Nur2: ((watching doctors talk))
- 49 Doc14: that's a strong grip you get there h hey hh
 Nur14: ((smiles))
 ((patient and doctor joke while nurse continues smiling))
- 50 Doc28a: don't want you to stand there and feeling useless
 Doc28b: there's no danger of that [h
 Doc28a: [hh
 Nur28: hh

In extracts 48-50, nurses were not included in the joking as they were not directly addressed. The nurses were excluded from creating social solidarity and were not given the opportunity to build rapport. Asymmetry is reflected in the differentiating access to contribute to joking. Extract 48 shows no nurse involvement. The doctors are not suggesting any participatory involvement. However, nurses were not always ignoring conversations, because humour often requires acceptance from others. Nurses may support humour, as shown in extract 49, by minimally contributing to the humour. The nurse smiles and therefore acknowledges the humour. A nurse's participation was more common than a nurse ignoring humour. This is further shown in extract 50 when the nurse laughs while the doctors joke with each other.

Extracts 48-50 show that doctors often joke with other actors besides nurses. In these cases, nurses are excluded as they are not directly addressed, but nurses show involvement by having a participatory role. Nurses laugh and support a doctor's humour. Furthermore, group interactions and humour occurred more so than one on one joking between nurses and doctors. Doctors also held primary speakership with patients, interns and students. There was more opportunity for humour and joking between doctors and other actors. This introduces a significant point where doctors would share humour, build rapport and have mutual understandings with several actors besides nurses. Doctors therefore shared more occurrences of speaker support than nurses.

Separate teams are easily created in ward rounds and the use of speaker support becomes biased. Doctors have more actors that are affiliating with them, not only through humour, but through general speakership and turn-taking. Nurses do not speak to interns, students and patients as often as doctors. Therefore, nurses do not have as many actors whom they can have separate conversations with during ward rounds. The dominant trend shows doctors speaking and joking with others. Power is embedded in casting differences and speakership which places nurses in more submissive conversational roles.

Language can therefore be used to manage power between actors. I have discussed power in this section on speaker support by relating support to its differential use and access. Doctors use humour and laughter differently from nurses. However, the broader and ideological implications of power can be related to speaker support. Power is inextricably linked to discursive norms which inform power through intersubjectivity. I have previously discussed how professional subject positions are related to speakership and casting in conversation. I turn now to elaborate on humour with a specific subject position relevant within a societal and institutional level (Thompson, 1984).

Power, discourse and gender

Power has been related to discourse by drawing attention to nurse-doctor subject positions. Language shows how dominant trends in speakership and casting relate to subject positions. Impression management draws from broader conventions of working subjectivities. As shown, nurses give useful information in various ways to help construct a traditional 'good' nurse. Similarly, humour and laughter can relate speaker support with processes of influence and control. Language use is often taken for granted, but shows how discourse filters through in conversation. These conversations show how nurses use subject positions to empower themselves and construct agency (Leonard, 2003). However, this is within the limits prescribed by asymmetry in nurse-doctor working relations. Humour and laughter are useful strategies to manage power, especially since these strategies are affiliative and depoliticise the negative side-effects of turns. I turn now to exploring speaker support by relating a broader institutional and structural subject position with language use. Specifically, gender will be shown with how often

it was practised using speaker support. In extract 52, I focus on how language shows the gender discourse at work.

- 52 Doc26a: ...patient's hand is there
Doc26b: it's a primitive reflex
Doc26a: yes yes that's it
Doc26b: hhh
Nur26: yes they can be in a coma and their hand will still go there
((scolding and sarcastic tone))
(all laugh)
Doc26b: [no [no no I'm not joking
Nur26: [no its not a
Doc26a: [scratching different things=
Doc26b: =we are not saying (.) we are saying we *know* hh
Nur26: we moved it alright but [still
Doc26b: [no no but hh I mean=
Nur26: =he could be how out of it but he'd [go near it
Doc26b: [but but if we give him- someone
(name of antibiotic) what's the *first* thing they do
Doc26a: they cover their=
Doc26b: =yes exactly
(all laugh)
Doc26b: it's a primitive reflex
(all laugh)
Doc26a: it could true hey
Doc26b: ya like when they suck their thumbs
(all laugh)
(2)
de: which is a sign of health
Nur26: hhh ah uh
(all laugh)

Humour and laughter is used strongly in extract 52 to build affiliation and speaker support through a sharing of laughter and topic maintenance. There is also common ground being constructed. Doctors and a nurse are speaking about a patient and are jokingly speaking about his situation. This involves crudeness about the topic of his hand at his groin. However, the bantering and teasing between the actors draws attention to a broader ideological subject position. This is by relating conversational joking to norms within discourse. The management of control and influence is shown alongside the functions of speaker support to construct social solidarity.

In extract 52, the structure of the sequence and humour relates specifically to a nurse teasing the doctors. This point is similarly shown in extract 42 when initially exploring speaker support and humour. The doctors in both extracts mention an inappropriate topic. The nurses in both these instances are acting like women or mothers scolding their naughty boys. In extract 42, the nurse scolds the doctor by saying 'na you were swearing *worse* than that'. In extract 52, the nurse jokingly reprimands the doctor. She contradicts the doctors' rationalisations by using a mocking and sarcastic tone. This is shown when the nurse says 'yes they can be in a coma and their hand will still go there' and 'he could be how out of it but he'd go near it'. The nurse also breathes in a jokingly reprimanding way in the last line by saying 'ah uh' which is similar to saying 'oh no'. The nurse is scolding the doctors and this shows how nurses use the gender discourse to construct themselves as women or mothers reprimanding misbehaving men or boys. Gavey (1997) supports this by arguing that gender is practised. For instance, women are socialised to practise gender through language in everyday interactions. Gavey (1997) notes how a nurse practices gender by embodying this subject position. In extract 52, the nurse uses the gender discourse to construct agency. Scolding doctors gives nurses leeway as they take controlling turns. The nurse in extract 52 reprimands the doctors and jokes along with them. The gender discourse serves as a useful resource for enacting agency.

However, the majority of literature focuses on women practicing a disempowered gendered positioning. Gavey (1997) shows how women act more 'feminine', i.e. women act more vulnerable and weaker than men. It would have been inadequate to explore nurse-doctor communication and relations, and not talk about the most prominent theme in these relations. This refers to the gender discourse and disempowerment. Gender has been touched on by showing how a traditional 'good' nurse is a supportive aid for doctors. Extract 52 shows how gender can be used to empower nurses through speakership and casting. The nurse however is still yielding the floor to the doctors' opinions. Turn-taking and topic control prioritises the doctors' turns.

The nurses in this study were all female and the doctors were male. Doctors and nurses can therefore be categorised respectively as masculine and feminine. Previous examples show doctors having speaker responsibility. Doctors also have leadership and are positioned as

knowledgeable teachers. Doctors enact dominant characteristics that strongly relates to masculine characteristics (Davies, 2003). This is also shown in extract 52. The doctors jokingly rationalise their statements by referring to medical knowledge. Doctors represent themselves as knowledgeable and authoritative actors. A doctor's qualities are in contrast to a nurse's qualities. Nurses are supportive and obedient. This is shown in language and in nurse subject positions. The difference within nurse-doctor qualities also relates doctors as men and nurses as women. Patriarchy is relevant in working environments. Language use and subject positions relate strongly to broader structural limits and conventions. Doctors are showing qualities of dominance and masculinity. Asymmetry and dominance interacts with gendered and professional subject positions.

Nurses are constructed as emotional caregivers while doctors are constructed as infallible experts. Nurses fulfil the traditional nurse subject position more than the 'new' nurse subject position within this medical context. Nurses continually support doctors and do not directly challenge doctors. Gender relations similarly show women as the caring and supportive actors in gendered relations. This is despite changing conventions and discourses. Nurse-doctor relations show that men have power over women. Doctors/men have powerful styles of speaking and express powerful qualities (Ng & Bradac, 1993). Nurses may be empowered by gender, but a doctor's dominance is entrenched in nurse-doctor relations. This point is briefly illustrated in the below extract. A doctor yields to a nurse by showing that she can walk ahead of him. This is a polite gesture showing how femininity can be empowering for nurses.

53 Doc6: excuse me sister (.) ladies first
 Nur6: no its okay hh
 ((doctor walks first))

The above extract shows how nurses are reminded of their gendered position. Politeness is associated with prioritising women to walk ahead of men. Interestingly, these instances hardly occurred, but show how the discourse on gender can filter through to institutional working relations. Intersubjectivity and discourse are involved in impression management and communication. However, as shown in extract 53, status and power override prioritising women. This is similarly shown in extract 52 when the nurse scolds the doctors, but still defers to their

opinions. Multiple subject positions inform power relations (Hollway & Jefferson, 2000, Leonard, 2003). The gender discourse interacts with institutional discourses in relevant ways, and thus gendered and professional positions are made compatible in a specific context. In extract 53, the doctor accepts his dominance by walking first and thus shows his interpretation of various discourses and practice.

Power is thus important at various levels of abstraction (Thompson, 1984). Language shows how the structural characteristics of turn-taking relate to empowered and disempowered subject positions. Nurses may use humour and laughter to empower themselves through topic maintenance, but the gender and professional discourses also shows the dominance of doctors. Throughout previous discussions, patterns in language use have helped generalise patterns in nurse-doctor relations. However, patterns in conversation were continually met with contradictions and exceptions. For instance, various means of creating speaker support and rapport were not always the same for all doctors. Leonard (2003) argues that there are factors which contribute to the unevenness of power. In-group status differentials and preferred subjectivities are factors which influence language use. For the rest of this chapter, I will present concluding remarks on avoiding generalising patterns between nurses and doctors. I will specifically refer to speaker support to address differences in enacting influence and control.

Avoiding across type generalisations

There are two important issues to consider when generalising language uses between doctors and nurses. The liking of certain doctor-nurse subjectivities and in-groups status differentials impact how generalisations are made.

Liking certain doctor-nurse subjectivities show how actors interpret what may be professionally appropriate or inappropriate, but to like certain doctors or nurses is not the same as culturally preferred nurse-doctor subjectivities, though this may be related. Professionally, 'good' doctors may be different from what nurses like. Preference organisation also relates to the structure and affiliative norm within language. This is different from liking certain actors, though often those who give preferred responses will be liked more than those who do not. However, this is not

necessary. It is important to explore how constructions of certain positive or negative subjectivities inform conversations, i.e. how does one present and manage who they are to another person. Identities are flexible and manageable between actors. Goffman (1959) explored this issue by discussing the presentation of self in interactions. Subjectivity is accomplished by attempting to present a socially acceptable self. This relates to facework and may relate to 'good' and 'bad' professional roles, but I will focus primarily on what nurses and doctors consider 'good' and 'bad' nurses or doctors in terms of liking certain types of co-constructed subjectivities.

Nurses and doctors express preferences for certain doctor and nurse subjectivities. These preferences can be related to generalisations as well as contradictions in language use. For nurses, a doctor's language strongly constructed preferred doctor subjectivities. I have a number of field notes supported by conversations with several nurses that express preferences for certain doctors. These doctors were generally 'polite', 'sweet' and 'caring'. Preferred doctors can be compared to their language uses. These patterns can then be contrasted to a doctor who is less preferred.

Patterns in language showed that preferred doctors showed a greater use of turns between themselves and nurses. Conversations were more collaborative which involved nurse participation. This contrasts impersonal interactions, i.e. when doctors were silent and strictly issued imperatives. Preferred doctors used longer turns, humour and laughter. Preferred doctors also made personal and unnecessary comments. Preferred doctors supported nurses by giving information, a role that is not often associated with doctors the same way it is for nurses. These uses of language move away from adhering to the formality of ward rounds. Preferred doctors also showed more mitigation and politeness, and more supportive language uses. This shows the importance of constructing oneself through language, a tool not only for communication, but for intersubjectivity. I also became aware of the preference for certain doctors during particular group ward rounds. In specific ward rounds, there were distinct preferences for certain doctors. In one ward round, a doctor showed considerable turn-taking with nurses. This was in contrast to a second doctor in the same ward round.

The second doctor had a higher status than the first doctor. As soon as the senior doctor arrived the first doctor and nurse drastically reduced turns that showed speaker support and rapport. The first doctor was also more liked. This is because the second and dispreferred doctor did the opposite of the affiliative language uses discussed in the preceding section. The doctor's turns were minimal and task-oriented. There was little collaborative turn-taking. This is further illustrated when this doctor walked ahead of both the first doctor and nurse. The doctor made his decision and walked to the next bed. The doctor left the first doctor behind with the nurse. The nurse told me how disrespectful this gesture was, because he was not showing collaboration. An issue that was relevant within this example also relates to in-group status differentials.

Doctors are categorised by status differences. Less senior doctors can be grouped more similarly to nurses. This is similar to grouping interns with nurses. The importance of language use and symmetry also relates othering within working relations. A lower status doctor and nurse are associated with a similar rank. Speakership and casting was similar for these actors. A doctor may contradict a status stereotype. In the previous example, the more senior doctor represented a status stereotype. This stereotype constitutes an infallible and 'good' professional doctor. This stereotype has been discussed with doctors doing dominance. A doctor veering away from status stereotypes seemingly helps create a 'good' relationship with nurses. Status stereotypes in this medical context continually constructed difference between doctors and nurses. The closer symmetry was constructed, then the more preferred the doctor was. This is an important issue considering that Hughes (1988) argues that overseas doctors or new doctors are not familiar with the routine practices of a particular context. Doctors therefore rely on nurse input. Nurses voice their opinions more. In this study, similarities are drawn in that symmetry is constructed based on factors that reduce an infallible doctor subject position. This is shown significantly with one doctor who had not been in the ward long. Furthermore, Porter (1991) shows in his study that it was with more senior doctors where nurse input was rare. These nurses listened on the sidelines and gave brief factual statements when requested. This is a significant issue when relating preferred doctor subjectivities to in-group status differentials.

The issue of symmetry and common ground between actors is further explored within in-group identity markers. In-group identity markers created preferred doctors. Othering was minimised

by associating doctors and nurses within one group rather than two separate groups (Brown & Levinson, 1987). This created togetherness and disguised the asymmetry in relations. Nurses also felt a shared knowledge with these preferred doctor subjectivities. Doctors were not often familiar with certain languages, but nurses were familiar with these languages. This is shown when using nurses as translators. However, in-group identity markers helped establish preferred working relations. A lack of mutual understanding contributes to othering and difference. Doctors and nurses do not represent a mutual background which is reinforced by differences in gender and race. Doctors are predominantly 'white'. The doctors who were 'black' were mostly foreign 'black' doctors. Nurses were, however, 'black' or 'coloured' South African nurses. These external categories reinforce difference and othering in nurse-doctor interactions. Swartz (1991) argues that othering in intergroup relations makes it more difficult to construct shared knowledge. This is shown in the few instances where nurses and doctors spoke personally with one another. A recurrent theme was difference. Difference is found in the various nurse-doctor subject positions, but there was one significant example showing shared knowledge.

A doctor and nurse were familiar with a certain language. This was a strong in-group identity marker as several comments were made by nurses about the preference with such a commonality. This led to a number of conversations between a doctor and nurses with humour and laughter, and all the affiliative language devices previously mentioned. Personal topics were also shared based on this identity marker. Nurses would comment on how 'nice' and 'wonderful' this doctor's knowledge was. The doctor was also constructed as a preferred doctor who contradicts an impersonal doctor subjectivity. Status stereotypes therefore impact nurse-doctor interactions. Doctors and nurses generally shared little personal knowledge about each other. However, personalisation and in-group identity markers increased the similarities between nurses and doctors. Despite status and other discourse-related differences, preference was explicitly expressed by nurses for doctors who did not fit a status stereotype.

The discussion up until this point has focused on preferred doctor subjectivities, but doctors showed preference for certain nurse subjectivities. For doctors, preferred nurse subjectivities do not relate strongly to the use of politeness and mitigation. On the other hand, mitigation is seen often to construct 'bad' nurse subjectivities. Preferred nurse subjectivities relate more to a

nurse's ability to be an informed and capable worker. Thus, a traditional 'good' nurse is liked by doctors. Nurses are preferred if they give useful information which is characterised by relevant and necessary turns. Thus, a nurse's speakership depends on topic maintenance and provides expectations that construct a 'good' nurse. However, this does mean that nurses who showed assertiveness were disliked, as implied by encompassing a traditional subject position. A nurse who is well informed and gives useful information is related to a more assertive nurse. However, assertiveness was defined by usefulness and not a nurse who challenges a doctor's authority. Doctors asked on many occasions for a more senior nurse. This often occurred out of breakdowns when nurses failed to give useful information. Nurses were often indirect and doctors at times misunderstood a nurse's turns. Doctors also got frustrated at the uncertainty embedded in using indirectness. Doctors wanted clear and relevant information. Thus, in contrast to the above preferences for doctors, nurses were more preferred if they did their job, not if they were more personable, though this was not the case in all instances. Nurses who were very useful information givers also had a higher status than other nurses. This is particularly relevant with one of the nurses who doctors favoured. Ward rounds with this nurse showed more nurse participation and thus doctors do not necessarily prefer nurse exclusion, but relevant nurses. This nurse was also personable.

Status is therefore important in relating language use, not only to preferred subjectivities, but to in-group status differentials. This has been shown with doctors, but the strength of this argument would be best constructed with further examples. Therefore, I will prioritise status differentials for the rest of this section with nurses rather than with doctors.

Doctors and nurses can be reclassified within each group. In previous discussions, I have used the term nurses to relate to all nurses and sisters despite the fact that sisters are in a more senior position than nurses. Doctors showed a preference for nurses who were well informed. They do not like silence as shown when a nurse would not answer a doctor. This is especially during disagreements. Doctors did not like dispreferred responses which break from the affiliative norm. This is illustrated when a lower status nurse was timid and silent during a doctor's confrontational turns. A doctor prefers to have a nurse fulfil a traditional nursing subjectivity. A nurse is 'good' when she is giving useful information and if she accomplishes nurse related

tasks. On several occasions a doctor was more personal and showed more speaker support and rapport with two senior nurses. Interestingly, this doctor did not often speak with any nurses. The occasions that he did were recorded with senior nurses. Doctors also sought senior nurses during breakdowns with less senior nurses. Nurses, however, were not only seemingly more knowledgeable and capable, but they were more assertive. One senior nurse showed more assertiveness through language. The nurse self-initiated turns and used much more affiliative language uses, i.e. she joked and laughed. Interestingly, this nurse also used the doctor-nurse game well by using indirectness that did not cause uncertainty. She also did not directly challenge doctors. Doctors acknowledged her assertiveness by taking more turns with her rather than repairing or ignoring her. This shows how intersubjectivity and language is relational. How one speaker acts impacts how another speaker will act. Thus, patterns in language use have to be considered against a backdrop of factors in order to avoid generalising across nurses and doctors.

In-group status differentials and preferred subjectivities show what doctors and nurses expect and prefer from each other. Influence and control, at a conversational level, is associated with hierarchy. Hierarchy not only constructs asymmetry between nurses and doctors, but differences are also found within these categories. A trend for both doctors and nurses is that preferences have been associated with status differentials, but this is based on limited data. However, I do consider nurse-doctor preferences to relate closely to conversational patterns showing speaker support and minimising difference between actors. Thus, it is important to note that nurse-doctor categories are not neatly fixed by specific boundaries, and patterns between categories should not be taken for granted

Summary

This chapter has covered the central themes and findings by applying conversation analysis to nurse-doctor conversations. I will briefly summarise the main components of the analysis and in so doing introduce a more detailed summary and synthesis in the concluding chapter. The analysis has been separated into six sections. The first section has explored how doctors do power. This is followed by the ways doctors mitigated their power in order to depoliticise their control and influence. The third section explored how nurses manage power while being

constrained by the limits of a lower status. The fourth section related closely to the previous section by showing how nurses attempted to show resistance and agency. Section five departed slightly from previous sections as nurses and doctors were not analytically separated by how they manage power. This section explored power by relating various themes within speaker support. Section six concludes this chapter by showing how the patterns discussed in the data analysis should not be taken for granted. In many ways this section also introduces suggestions for further research. The present data analysis has therefore explored power by focusing on how nurses and doctors accomplish power, but these findings will be best summarised in the following chapter.

CHAPTER FIVE

CONCLUSION

This chapter summarises and synthesises the arguments presented in this dissertation by presenting and pooling together the arguments in the previous chapter. I will attempt to do so by continually relating key arguments to previous literature, and thus show the relevance and contribution of this study. A broad discussion on the limitations of this study will then follow introducing suggestions for further research.

Summary and synthesis

The preceding analysis supports the notion that conversations are not haphazard phenomena. On the contrary, conversations are embedded in complex cultural settings that inform its construction. In this concluding section, I will address the central research question on how power is managed between nurses and doctors during ward rounds. I have distinguished between two distinct approaches in exploring power. This is at an interactional and institutional level. The focus of this dissertation has been on the interactional level of accomplishing power by exploring language between doctors and nurses. However, as Sarangi and Roberts (1999) point out, focusing on one theoretical or methodological approach restricts the scope of the findings. For this reason, I have continually attempted to compare language use with nurse-doctor subject positions. This needs to be further explored within studies that attempt to focus on the relationship between language and discourse. Furthermore, I have encountered few studies that use conversation analysis to analyze data in nurse-doctor interactions. The exception to this being Kelly (1998) who argues for an ethnomethodological approach in examining nursing care. I have thus attempted to provide a comprehensive discussion on nurse-doctor power relations by focusing on language use in conversation analysis.

Language use and nurse-doctor subject positions have been related in order to explore the management of power. I will firstly represent the ways doctors do power. Asymmetry in nurse-doctor interactions also show that doctors have power over nurses. Therefore, I turn to the ways nurses manage power in conversations. Particularly, this relates to doing deference and resistance through language. Again, ideology will be addressed in terms of nurse-doctor subject positions.

Doctors doing power

The expectations and goals in ward rounds in a medical setting show how language coincides with institutional goals. Doctors are dominant actors compared to nurses. This shows considerable patterns, alongside exceptions, in language use. Previous literature shows how doctors are constructed as infallible experts, in relation to patients and to nurses (Stein, 1968; Wodak, 1996). This study supports the dominant understanding of doctors as omnipotent actors. This is by relating speakership and casting to control and influence.

Doctors show more explicit control and influence. Ward rounds regularly show that doctors issue imperatives and fulfil a dictator role in conversations. Doctors continually support their dominance by having the authority to control ward rounds. Doctors are leaders, because they have the right to tell nurses what to do. Holmes et al. (1999) have explored the ways managers do power with employees of a lower rank. This study supports workplace studies such as these by showing the similarities of language use between doctors and managers. The process of doctors doing power is thus supported by workplace studies as similarities are drawn from actors in a higher rank with others in a lower rank. Asymmetry enables certain allowances in conversation. Actors who have power over others show that they open and close conversations. Turn-taking patterns show that doctors hold primary speakership. They control topics and their dominance is continually constructed and legitimised by lower-ranking actors. There is literature that relates a person of a higher rank, such as a doctor, with ethical issues regarding patients or nurses, but this study veers away from such an approach by addressing the 'local rationalities' in collegial interactions (Ten Have, 2001).

Furthermore, Atkinson (1999) explores workplace studies by conducting a study similar to this research study. The goals associated in working relations relate language use with what is known about doctor-nurse interactions. This shows the importance of applied conversation analysis in a medical context. Atkinson (1999) argues that doctor-patient interactions are important, but medical practice and knowledge is usefully addressed by drawing attention to collegial interactions. Atkinson (1999) explores peer relations between senior doctors and junior doctors. The findings in this study are similar to the findings in doctors' interactions. Doctors have more

technical and medical knowledge, and are the decision-makers when it comes to patient management. Literature relating language use to a doctor's interests is supported by various strategies discussed in the previous chapter. Trends in speakership and casting illustrate that a doctor holds speaker responsibility. Doctors have the right to constantly repair nurses, and if a nurse's information is unsatisfactory then they have the right to challenge nurses. Doctors take on dispreferred turns by issuing other-repairs. Doctors are therefore not following the affiliative norm in conversations. Doctors initiate face threatening acts and nurses have to manage these threats, either to pre-empt, avoid or minimise them. A doctor's use of repairs is commonplace with peers and with patients (Ten Have, 1991). Doctors often self-repair as well. Atkinson (1999) shows how doctors are continually guarding their interests of being responsible actors. Conversational breakdowns were initiated by doctors, because nurses failed to be relevant and useful. A doctor does power by legitimising their institutional role as an infallible expert. The practice of their discursive positioning in turn manages that practice. Doctors defend their interests by having the rights to useful information. In so doing, they attempt at not making mistakes in order to make appropriate decisions. Therefore, doctors prefer nurses who are capable and knowledgeable as this supports them. Holmes et al. (1999) and Atkinson (1999) stress the importance of higher-ranking actors to question others. Therefore, a significant theme within data analysis relates to dispreference.

Workplace studies explore asymmetry with language and this has strongly supported the findings in this study. Thus, this dissertation does not modify the literature relating workplace studies with conversation analysis (CA). Studies using CA have provided the framework for analyzing nurse-doctor conversations. Seedhouse (2004) provides four related interactional organisations in conversation. These interactional organisations structure the analysis of nurse-doctor conversations. Turn-taking patterns show that doctors initiate talk and topic control. Doctors initiate adjacency pairs and there are many antithetical side-effects for nurses. For instance, nurses may give dispreferred answers and doctors may also repair nurses. Preference organisation is embedded within adjacency pairs and repairs. This is by showing how actors might affiliate or disaffiliate with one another. Doctors initiate repairs and this is part of their working subjectivity which can be seen as a significant transformational rule in nurse-doctor conversations.

Ten Have (1991) also shows how doctors and patients manage power and asymmetry. I have shown the similarities of this study by relating patients to nurses. Ten Have (1991) outlines the implications of asymmetry. The findings in this study show how asymmetry in patient participation and agency reflects nurse exclusion in nurse-doctor conversations. Studies focusing on patriarchal relations have highlighted a doctor's dominance (Wicks, 1998). Nurses are made 'powerless' by often encompassing a passive actor role during ward rounds.

This study also supports workplace studies which focus on collaboration and negotiation (Allen, 1997; Svensson, 1996; Ten Have, 2001). Ng and Bradac (1993) explore power extensively by showing the depoliticisation of power. Workplace studies highlight collaboration and not just dictatorship in collegial interactions. This is shown when doctors depoliticise their interests by softening their forceful turns. Mitigation and speaker support illustrate how doctors show less power. In working relations, overt expressions of forceful dominance are highly face-threatening. The depoliticisation of power and politeness are therefore key aspects in exploring working relations. This is a significant theme that would benefit from studies exploring mitigation and politeness in nurse-doctor relationships. However, workplace studies have drawn attention to the depoliticisation of power in nurse-doctor relations. The framework that Brown and Levinson (1987) introduce through facework is central in contextualising collaboration between colleagues. This may relate to preference organisation as well as politeness. However, it is shown that doctors mitigating their power still enact dominance. A particular trend is that doctors initiate speaker support, especially through humour, laughter, and personalisation. Glenn (2003) argues that speaker support shows dominance, because of constraints in institutional talk. Nurses do not have the same allowances in using speaker support. Nurses are continually reminded of their subservience, because doctors have more allowances than nurses.

Nurses doing deference and resistance

Earlier literature in nurse-doctor interactions explores the marginalisation of nurses (Porter, 1991). This is shown in various subject positions that show deference. Manias and Street (2001) for instance show how language is used to construct power relations. Manias and Street (2001) do not apply CA and thus this study aims to extend this literature by using CA to explore detail

within turn-taking in conversations. The findings showed that nurses differed from a doctor's role given the legitimacy of a doctor's leader emergence, topic control and speaker responsibility. Asymmetry constrains nurses. Nurses were cast as the listening and more passive actor during ward rounds. Nurse exclusion and asymmetry in participation with the use and access to speakership patterns showed nurses doing deference. For instance, nurses did not show or start as much humour and laughter. Furthermore, nurses used various ways of using language to minimise or avoid the antithetical side-effects of turns. Nurses defended themselves by not explicitly challenging or repairing doctors which is a dispreferred turn. Therefore, doctors were allowed to take dispreferred turns, but nurses were not. This is shown in the use of repairs, but can be seen when nurses fail adjacency pairs, i.e. fail in answering a doctor's questions or requests. This points to power in terms of influence and control in language use, and to the implications of power and dominance at a hierarchical or institutional level.

Regardless of doctors doing dominance and nurses doing deference, the distribution of agency is often taken for granted. There is literature that argues against the overemphasis of nurse passivity in nurse-doctor relations (Hughes, 1988; Porter, 1991; Svensson, 1996; Wicks, 1998). I have supported the notion of power as being a fluid process. Doctors may enact power, because of their status. Nurses may be complicit in this process, but nurses are very active in managing power and agency in relation to doctors. A doctor's dominance within a conversational and institutional role does not exclude a nurse enacting influence and control. Nurses were shown to take assertive turns especially within the doctor-nurse game. When indirectness was shown to increase misunderstanding in talk, nurses would overtly offer suggestions towards the end of the sequence in the doctor-nurse game. Nurses would also at times be more assertive by being persistent with their recommendations throughout the ward round. This is despite recommendations being delivered with the use of indirectness. Nurse agency would also be shown throughout turns where nurses would maintain topics, self-initiate turns and joke with doctors.

Nurse agency was also shown in literature in nurse-doctor interactions highlighting the intertextuality of discourses. This relates nurse subject positions with agency. Leonard (2003) explores power between doctors and nurses among various discourses. I have supported this by

comparing the findings in Leonard's (2003) study to this research study. A 'new' nurse role indicates more influence and control. However, it is important to point out that throughout data analysis; the findings in this medical context show that there is a strong relationship between a traditional nurse subjectivity and language use. Thus, though nurse agency should be considered under the negotiation of subjectivities, asymmetries in status and passivity in a traditional nurse subject position constrain nurses. There is not as much emphasis on a 'new' nurse subject position in this medical context, but I will return to this point when suggesting possibilities for further research. Subject positions have often been the focus in nurse-doctor relations, but again there is a need for an explicit discussion on a nurse's use of language to manage power in relation to doctors. This has been alluded to in previous literature and Kelly (1998) examines patterns in turn-taking, but there are few illustrations of these patterns across all studies. The various strategies of language use, for instance in avoiding face threatening acts, need detailed examples, of which I have attempted to illustrate in this study. It is therefore useful to relate instances of nurses managing power through language. This has been done for doctors with patients and other doctors, but not as much with nurses and doctors.

I therefore summarise the following section on nurses managing agency by relating language back and forth with nurse subject positions. Nurses manage power by attempting to be useful and supportive aides to doctors. Nurses used language in this way to manage influence and control. This is in order to meet various relational goals, i.e. to help make imperatives more accountable and especially recognising a doctor's speaker responsibility. Information was often needed from nurses. The need for useful information allowed nurses to be information givers through topic maintenance and relevancy. Furthermore, both doctor and nurse conversational roles go hand in hand with the predominant professional subject positions in medical settings. For a nurse, this relates strongly to a traditional 'good' nurse subject position. This supports previous literature on nurse subjectivities showing the way nurses construct themselves in a medical context.

Preference organisation and impression management were key themes throughout data analysis. Fisher and Groce (1985) framed this study's findings by showing how cultural assumptions of preferred and dispreferred subjectivities filter into conversation. Though their focus was with doctors and patients, the principle of 'good' and 'bad' subjectivities were related to empowered and disempowered subjectivities.

Working subjectivities are therefore constructed and reconstructed from practices in language use. Nurses show resistance while being limited by their status. A nurse, who is a useful information giver, is shown to be this way by attempting to give useful information. A nurse's professional 'face' is at stake. A nurse's language supports facework through various strategies to be assertive amid a passive actor role. This relates facework and face threatening acts (FTAs) to a nurse's turn-taking. Facework has been discussed as a theoretical approach to understanding power relations, but not with nurse-doctor interactions. I attempted to explore differentiating patterns in language use with the bias of FTAs that nurses encounter. This is also related to dispreference. Nurses may fail to give answers or carry out a doctor's request. This is dispreferred and thus strategies are used to manage dispreference. This is explored in verbal self-defence and in the doctor-nurse game.

The doctor-nurse game is a significant illustration of the way nurses manage resistance while not having power over doctors. Workplace studies have yet to significantly explore nurse-doctor interactions by using CA. I attempt to extend previous literature by focusing on specific working relations between doctors and nurses. The doctor-nurse game was therefore shown in detail to illustrate 'unique' patterns between work colleagues. Nurses were consistently indirect, not only to avoid challenging a doctor, but to challenge in a covert way.

Thus, nurses could best meet their interests by showing deference to doctors in a mitigated way. This study explicitly relates the doctor-nurse game to detailed transcriptions of conversations. The specific linguistic conventions of the doctor-nurse game has been understudied and poorly illustrated in previous literature. A general corpus of detailed examples of the way nurses play this game is needed, and I attempted to provide such examples. Furthermore, what a nurse says impacts what a doctors says and does. I have thus continually related the way nurses speak to a doctor's reactions. While the doctor-nurse game has shown its use for nurses enacting influence, it has been shown that it is often at odds with what a doctor prefers. A nurse's indirectness led to all breakdowns in conversation. Nurses failed to be useful for doctors. As previously mentioned, this has related to preference organisation as well as culturally preferred subjectivities, and the types of nurses doctors prefer.

Lastly, a concluding point on nurses doing deference and agency is needed in relation to the distinction I made between exploring power at an interactional and institutional level. The literature on nurse-doctor interactions has often illustrated gender difference and patriarchy in the medical institution. Davies (2003) shows how doctors are constructed as masculine actors in contrast to nurses who are feminine. This reinforces a doctor's dominance. Furthermore, race difference reinforces othering in nurse-doctor interactions. Swartz (1991) argues that a lack of shared knowledge reinforces the power of dominant actors. I support and extend this by showing how facework relates to creating support and common ground between nurses and doctors. However, I have focused on language use. External categories have been limited to what is shown in nurse-doctor conversations. Gender difference has been shown by a nurse scolding doctors and racialised relations have been shown by a lack of shared knowledge. Both these instances show how othering occurs within speaker support and creating rapport. I also attempt to show the unevenness of power by broadening the literature that relates power within a top-down approach, i.e. from doctors to nurses. Gender was for example shown to provide nurses with a leeway in managing power. Leonard (2003) continually argues that subject positions can be used to empower and disempower actors, and this study strongly adheres to this approach. However, turn-taking patterns need to be considered with who is initiating speaker support. It is shown that nurses are often reacting to a doctor's turn.

Limitations and further research

The previous section in this chapter introduces limitations and thus opportunities for further research. This is owing to a theoretical and methodological focus. However, these limitations in focus are more restrictions or boundaries rather than significant limitations in this study. I therefore turn to particular limitations that compromise the data with its chosen framework, before I address possibilities for further research within a different framework.

Data was collected primarily by using audio recordings that amounted to 22 hours of recordings. A larger corpus of data would be needed in order to support the generalisations discussed in the analysis. Literature using conversation analysis often uses extensive hours of recordings. Holmes et al. (1999) for instance use recordings that amount to 110 hours of recordings. Thus, further

research is needed to explore the data I have presented. The audio recordings that I collected were also limited in terms of audio quality and thus several sequences were inaudible. I discuss this within Chapter Three, but repeat that in group interactions audio quality is often compromised. I note one occasion where I could not significantly transcribe a disagreement between nurses and a doctor. There was not much detail in these transcriptions. Further ward rounds and a longer time period aided the data collection, but nevertheless certain recordings were not able to be suitably transcribed.

An important point regarding patterns of language, discourse and power is that patterns have to be considered against a backdrop of contradictions and alternatives. The issues discussed in the concluding section in the previous chapter attempts to avoid generalising among all doctors and nurses. In-group status differentials and what actors liked in terms of working subjectivities impact the patterns within the findings. I continually attempt to generalise patterns of doing power and deference, but address certain factors that provide exceptions to these patterns. However, I did not record significantly senior doctors. Thus, further research can explore in-group status differentials in nurse-doctor interactions. Avoiding generalisations based on in-group status differentials and subjectivities also has implications for generalising within one particular context. I did not collect data or observe nurse-doctor interactions in another ward or in another medical institution. Interpretations in this instance should be related to this context, rather than generalising findings to all doctors and nurses. This is shown for instance with reference to an organisational discourse. The notion of a 'new' nurse subject position is not highly relevant within this context compared within other literature. The data shows this in the lack of explicit challenges to a doctor's authority in comparison to other contexts.

Furthermore, doctors and nurses were male and female respectively. It is important to explore female doctors and male nurses. I did not record any male nurses or female doctors. Language could show how these factors relate to discourse. The ward itself can also be compared to other wards, for instance to show if conventions within a neurosurgery ward depart from other sites, e.g. an emergency unit or intensive care unit. Thus, cross-cultural comparisons and further research is beneficial for exploring power in nurse-doctor interactions.

Lastly, before I trace theoretical and methodological restrictions, I point to the issue of my own presence in ward rounds. It is important to note that the sensitivity in orienting oneself to another includes how participants oriented themselves to me. My presence has many implications for how doctors and nurses speak to each other. Doctors and nurses knew of my research questions. They also knew they were being recorded. The management of power, especially with issues of politeness and mitigation could be increased due to an audience. I represent that audience. Furthermore, a premise of this dissertation is the notion of 'saving face'. This aspect is equally important for doctors and nurses orienting themselves to me as an 'evaluator'. In many occasions, I felt that doctors and nurses were wary of my presence. It should not be taken for granted that this is reflected in their language use. Several nurses and doctors commented on the ethical issues of this study's research aims. This is shown in comments where doctors could be judged negatively considering their power over nurses. I was also continually persuaded to join particular sides or 'teams' within conversational breakdowns. Doctors and nurses rationalised and defended their position within disagreements. I was associated as an evaluator despite expressing ethnomethodological indifference.

I turn now to concluding comments about this study's scope and restrictions owing to its theoretical and methodological focus. The central research question explores power between nurses and doctors, and although focus is needed to guide research, a wider framework offers an opportunity to answer the research question more comprehensively. I have focused on a conversation analytic approach in analyzing data. External categories are continually related to language by drawing parallels between discourse and conversations. However, CA has been criticised for neglecting issues of discourse and limiting ideology and power to what can be directly seen in transcriptions (Parker, 2005). An alternative approach could show the relevance of discourse within a broader discussion on knowledge/power systems. For instance, Davies (2003) explores the socio-historic context of a medical institution. This is in order to explore patriarchy in nurse-doctor interactions and addresses power relations from a sociological perspective. Gendered and racialised relations are salient in a South African context. Ward rounds showed differences in external categories. The background to the public hospital in this study could show how conventions have been established over time. These conventions could contextualise nurse-doctor subject positions in that specific context.

Furthermore, throughout data collection there were issues of space and body. I very briefly point to doctors walking ahead of nurses during ward rounds, but there are various instances showing how nonverbal interactions show dominance and deference. This could be better articulated in alternative studies within a medical institution. Previous literature has addressed issues of space and nonverbal communication (Davies, 2003; Manias & Street, 2001). This is an important point in exploring power in nurse-doctor interactions.

From a methodological point of view, the ethnographic data used in this study could have been supplemented by interviews or different sites other than ward rounds. Furthermore, I have not extensively referred to field notes throughout data analysis. Previous literature shows how interviews and ethnographic data shed light on subject positions and facework. Nurse subject positions can also be explored without focusing on nurse-doctor interactions. Leonard (2003) explores how nurses construct themselves within a 'home' discourse. A nurse's subjectivity could be explored in relation to other discourses besides those that directly relate them to doctors. The various subject positions that inform a nurse subjectivity could then be related back to working relations (May, 1992).

In conclusion, I have attempted to summarise the findings in this research study by relating it to the previous literature guiding the framework of the data analysis. I have emphasised that nurse-doctor relations are constructed through language. This is continually reconstructed in everyday practice. Power is accomplished between speakers in various ways highlighting the interests of actors in working relations. Doctors and nurses are active despite doctors having power over nurses. It is important to note that asymmetry provides restrictions and allowances for managing power. However, the findings in this study can be (re)conceptualised in other contexts as well as reproduced given the implications of changing discourses on nurse-doctor subject positions.

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APPENDIX

Transcription conventions

[]	Square brackets	This indicates overlapping or simultaneous talk. Brackets bridging two lines indicates a point of overlap onset, whether at the start of an utterance or later
=	Equals sign	Equal signs ordinarily come in pairs, one at the end of a line and another at the start of the next line or one shortly thereafter. If the lines connected by two equal signs are by different speakers, then the second followed the first with no discernable silence between them, or was "latched" to it.
(.), (1), (2), (3)	Delays or silences	(.) Indicates of a brief delay that is under a second long. The numbers in the brackets show the number of seconds the delay took.
word::	Colons following a word	Indicates the prolongation or stretching of the sound just preceding them. The more colons, the longer the stretching.
?	Question mark	Indicates rising intonation, which often coincides with asking a question.
-	Hyphen	A hyphen after a word or part of a word indicates a cut-off or self-interruption

<u>word</u> or <i>Italics</i>	Underlining or using italic formatting on parts or whole words	Indicate some form of stress or emphasis, either by increased loudness or higher pitch.
°word°	Degree sign	When there are two degree signs, the talk between them is markedly softer than the talk around it.
↑ ↓	Up arrow or down arrow following a word	Marks sharper rises or falls in pitch or may mark a whole shift, or resetting, of the pitch.
<	Less than symbol	Indicates that the immediately following talk is "jump-started," i.e., sounds like it starts with a rush.
hh (hh) .h	'h' represents hearable aspiration	With the full stop before it, it indicates a breath in. Otherwise it indicates laughter. This is either on its own or it can be within words, which it is then enclosed with brackets within words.
(())	Double round brackets	These are used to mark transcriber's description of events, rather than representations of them, e.g. ((coughs))
(word)	Word in brackets	The words in the brackets indicates uncertainty on the transcriber's part, but represents a likely possibility.
(name)	The word name inside brackets	This occurs when there is a person's or a party's name in the transcription. The word 'name' is used to keep the person's anonymity.

...	Ellipsis	I use this symbol not in the conventional CA transcriptions, which indicate speakers 'trailing off'. I use this to indicate that there are words before and after this symbol, but they have been excluded due to their irrelevance for the particular claims being discussed.
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