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BY
BETTINA SLETTEN PAASCH

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AALBORG UNIVERSITY
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CV

Bettina Sletten Paasch received her master's degree in clinical nursing from the Department of Nursing Science, Aarhus University in 2008. She graduated in 1995 as a registered nurse, after which she worked for six years in an intensive care unit specialising in neurosurgery and traumatology. Subsequently, she worked in an oncological department for eight years, before becoming a lecturer at the University College of Northern Denmark. In 2013 she was enrolled as a Ph.D. student at Department of Communication and Psychology, Aalborg University. In her thesis, she uses video ethnography to study how interactions between nurses and patients unfold when a mobile work phone rings.

ENGLISH SUMMARY

This Ph.D. thesis focuses on key aspects of the use of mobile work phones in hospitals. In recent years, demands for efficiency improvements have been predominant in the Danish healthcare system; implementing mobile work phones has been one way of complying with this mandate. Sensitivity to and caring for the patient are core values in the nursing profession, and they are grounded in the relationship between nurse and patient. The aim of this thesis is to explore if and how nurses are able to enact care in patient interaction when a mobile work phone also enters the encounter.

In studying interactions between nurses, patients, and mobile work phones, this thesis draws on several strands of practice theories to alternate between zooming in on the concrete situated actions performed and zooming out on the broader issues that help shape them. The overall theoretical and methodological framework is nexus analysis, which allows this thesis to connect the situated interactions recorded on video with the social, cultural, and historical currents influencing them. To zoom in on the situated accomplishment of interactions, nexus analysis is complemented with insights and methods from ethnomethodology and the related discipline of interaction analysis.

The main data obtained for this thesis is 144 hours of video footage recorded in a Danish hospital. Nurses were shadowed with a mobile video camera throughout their daily work, so the resulting recordings encompass naturally occurring interactions between nurses, patients, and mobile work phones. These data were supplemented with participant observations, interviews, photos, documents, and webpages. In the process of logging the video data, only the persons participating in events and the actions being performed were coded. Seven cases in which a single nurse was performing actions in close proximity to a patient as the mobile work phone rang were selected for analysis. In mapping the nexus of practice, the discourse of being efficient and the discourse of patient-centred care were both exhibited as ubiquitous. In this light, an interactional analysis focusing on the way nurses distribute orientations and how they organise activities was performed on each of the seven cases. These analyses were subsequently connected with discourses circulating in the nexus of practice and with other times and places.

The analytical sections of this thesis demonstrate how experienced nurses are able to foreground the discourse of patient-centred care and postpone their enactment of the discourse of being efficient when mobile work phones ring during close interactions with patients. It further reveals that experienced nurses continue to enact the discourse of patient-centred care through the use of tactile resources and embodied orientations while they attend to the phone call. Experienced nurses thus

perform multiactivity by distributing attention towards both the patient and the phone, and the analysis shows that their concrete ways of doing so depend on the complex features of the on-going situation.

Additionally, this thesis demonstrates that the strategies used by nurses do not occur naturally, but are acquired over time. Finally, it shows that the strategies developed by nurses in the hospital ward investigated to enact the discourse of patient-centred care when they are telephoned during interactions with patients are not universal. Indeed different strategies have evolved in other hospital departments.

Not only does this thesis contribute insights into the way nurses manage phone calls during interactions with patients, but by subscribing to a growing body of embodied interaction studies it also demonstrates the potential of interaction analysis and video ethnography for nursing research more broadly. Furthermore, it offers a perspective on how a research framework combining nexus analysis and interaction analysis can provide nuanced understandings of the complexity of human interaction.

DANSK RESUME

I denne afhandling udforskes brugen af mobile arbejdstelefoner i det danske sundhedsvæsen. De senere års krav om effektiviseringer på danske hospitaler har ført til implementeringen af adskillige teknologier, herunder mobiltelefoner. I sygeplejen er omsorg og nærvær bærende værdier som er funderet i et respektfuldt samarbejde med patienten. Det er imidlertid uvist, hvordan mødet mellem patient og sygeplejerske udspiller sig, når sygeplejersken bærer en mobil arbejdstelefon. Formålet med denne afhandling er derfor at udforske, hvorvidt og hvordan sygeplejersker kan udøve omsorg i interaktioner med patienter, når en mobil arbejdstelefon også deltager.

Denne afhandling trækker på flere praksisteoretiske perspektiver i sin undersøgelse af interaktioner mellem sygeplejersker, patienter, og mobile arbejdstelefoner. Det overordnede teoretiske perspektiv, nexus analyse, sætter afhandlingen i stand til at forbinde konkrete videooptagede handlinger med de sociale, kulturelle, og historiske cyklusser som influerer dem. Nexus analyse komplementeres med etnometodologi og dens relaterede disciplin interaktions analyse med henblik på detaljeret at studere den lokale intersubjektive opnåelse af betydning og meningsdannelse i interaktionerne mellem sygeplejersker, patienter og mobile arbejdstelefoner. Analysen i afhandlingen veksler således mellem en optik hvor der zoomes ind på hvordan der lokalt opnås fælles forståelse i de videooptagede situationer, og en optik hvor der zoomes ud for at forbinde deltagernes handlinger i interaktionerne med de diskursive strømninger som cirkulerer i situationerne.

Afhandlingens empiriske grundlag består hovedsageligt af 144 timers videooptagelser fra et dansk hospital. Optagelserne blev foretaget ved at følge sygeplejersker i deres daglige arbejde og omfatter således naturligt forekommende interaktioner med patienter. Som supplement til videooptagelserne blev der udført deltagende observationer, interviews, billeder, dokumenter og hjemmesider.

I arbejdet med at logge videomaterialet blev optagelserne opdelt i hændelser hvor deltagende aktører og deres handlinger blev kodet. Gennem en udvælgelsesproces blev syv interaktioner hvor en sygeplejerske udfører handlinger i tæt fysisk kontakt med en patient idet den mobile arbejdstelefon ringer, udvalgt til analyse. I arbejdet med at kortlægge de diskursive strømninger som cirkulerede det undersøgte neksus af praksisser, blev diskursen ”at være effektiv” samt diskursen ”patient-centreret omsorg” identificeret som allestedsnærværende. I lyset af dette var fokus for interaktionsanalyserne af de syv udvalgte cases, måden hvorpå sygeplejerskerne kropsligt orienterede sig og hvordan de organiserede aktiviteter. Efterfølgende blev disse næranalyser forbundet til centrale diskurser samt til andre steder og tidspunkter.

Gennem denne analyse viser afhandlingen, hvordan erfarne sygeplejersker kan sætte diskursen om patientcentreret omsorg i forgrunden og udsætte udøvelsen af diskursen "at være effektiv" når deres mobile arbejdstelefon ringer, mens de er i tæt interaktion med en patient. Afhandlingen viser desuden, hvordan erfarne sygeplejersker fortsætter med at praktisere diskursen "patient-centreret omsorg" under telefonsamtalen ved brug af berøring og kropslige orienteringer. Erfarne sygeplejersker udfører således multiaktivitet ved at dirigere kropslige orienteringer mod såvel patient som telefon, og analysen viser, hvordan deres konkrete handlinger afhænger af de komplekse detaljer som indgår i den igangværende interaktion. Analysen viser også, at de strategier erfarne sygeplejersker anvender ikke mestres af nytilkomne sygeplejersker men tilegnes over tid efterhånden som nyansatte deltager i og tilegner sig afdelingens arbejdspraksisser. Afhandlingen afslører ydermere, at strategierne som anvendes af sygeplejersker i den hospitalsafdeling hvor videooptagelserne blev foretaget, ikke er generelle. I andre sygehusafdelinger anvender sygeplejersker andre strategier for at praktisere patient-centreret omsorg i interaktioner med patienter, når mobile arbejdstelefoner ringer.

Denne afhandling bidrager ikke kun med viden om, hvordan sygeplejersker håndterer telefonopkald under interaktioner med patienter. Ved at skrive sig ind i et interaktionsanalytisk felt bidrager afhandlingen også med et perspektiv på det potentiale som denne forsknings optik i forening med videooptagelser har for sygepleje forskning. Endvidere afslører afhandlingen hvordan en forskningsramme som kombinerer nexus analyse og interaktions analyse kan medvirke til at skabe nuanceret indsigt i den kompleksitet som kendetegner menneskelig interaktion.

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This dissertation would have never been possible without the tremendous support and assistance I have received during the process. I am thus deeply indebted to a many, many people.

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Last but not least, I owe my deepest gratitude to my family. From the bottom of my heart, I thank my father and mother for always being there to help and my husband for his patience and love. Finally, I would like to thank my two boys for being all-pervading reminders that there are more important things in life than a Ph.D. dissertation. You are my world.

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CHAPTER 1. INTRODUCTION

In recent years, demands for efficiency improvements have been predominant in the Danish healthcare system, and implementing mobile work phones has served as one way of complying with this demand. This Ph.D. thesis is a study of the ways in which nurses use mobile work phones during interactions with patients. In the nursing profession being sensitive and caring towards the patient and establishing a nurse-patient relationship are core values. The aim of this thesis is thus to explore if and how nurses are able to enact care in interactions with patients when a mobile work phone rings. Theoretically and methodologically, it draws on nexus analysis and interaction analysis combined with an extensive empirical base.

The inspiration for this thesis has roots in my career as a nurse and in a specific occurrence that I happened to witness. I therefore commence this chapter with a narrative of the event which initially aroused my curiosity and eventually prompted me to commence this study, after which I will outline the purpose and research frame of this thesis and clarify its structure in a reading guideline.

1.1. ON A DAY LIKE ANY OTHER

My journey into this field of research was triggered by an observation I made in a hospital ward on a warm spring day. Working as an associate professor at University College of Northern Denmark, I was assigned as an external examiner for a nursing student who was finishing her clinical practicum in a hospital ward. For the exam, her clinical supervisor (a nurse working in the hospital department with additional pedagogical training) and I had to observe her work for two hours. We followed her as she attended to her tasks that morning; at one point we all went into a two-patient room. While I was observing the nurse student treating and caring for one of the room's patients, I could not help but notice another nurse talking to the other patient. The patient was frightened about a major surgery she was going to have, and the nurse was working to soothe her and give her information about the precautions of which the patient needed to be aware. During their conversation the nurse's mobile work phone rang three times. The nurse answered the phone when it rang the first and second times, engaging in brief conversations and returning to the discussion with the patient when the phone conversations ended. When the phone rang the third time, the nurse left it ringing in her pocket and kept talking to the patient about fasting procedures, while the patient's gaze kept flickering towards the pocket with the ringing phone. Once the exam was finished, I asked the clinical supervisor about the phones. "How peculiar that you mention it. When we first got the phones, we

were all wound up about them, but now I never think about them anymore. They are just there."[1]

1.2. OUTLINING THE THESIS

This thesis encompasses 18 chapters including this introductory chapter, in which the first step of the research process is described, an overview of the thesis is provided, and reading guidelines are offered.

In Chapter 2, the background on which this thesis builds is sketched. It begins with a short description of some organisational and strategic aspects of the Danish healthcare system, continues with a presentation of central aspects regarding the nursing curriculum and the work of nurses, and then offers a brief sketch of the history of mobile phones. An exposition of relevant research literature on the use of mobile phones is provided and Chapter 2 closes with sections describing the scope and foci of this thesis.

In Chapter 3, the research framework tailored for this thesis is presented. Initially, the main characteristics of practice theories are outlined. After this, the toolkit approach that Nicolini (2009, 2013) proposed to study the complexity of human practices and from which this thesis takes inspiration is introduced. Subsequently, the theoretical and methodological perspectives on which it relies are described. Drawing on two strands within practice theories, Chapter 3 first presents the perspective of ethnomethodology and the related disciplines of conversation analysis and interaction analysis. The overall research framework of this thesis, nexus analysis, is presented next, along with the related perspectives of mediated discourse analysis, critical discourse analysis, and multimodal analysis. Chapter 3 ends with a description of the assumptions guiding this tailor-made research framework.

Chapter 4 provides a thorough exposition on the overall research framework, nexus analysis, beginning with a discussion of some of its central concepts: discourse, circumferencing, and mediational means. It continues with an introduction to the way social action is analysed, after which the activities of a nexus analysis are outlined. The closing sections discuss the ethnographic strategy, the generation of a data archive, and video ethnography as a method for gathering empirical data.

Chapter 5 describes the first activity of the nexus analysis conducted for this thesis: engaging the nexus of practice. It describes the process of gaining access and obtaining permissions from participants, describes how the video ethnography was conducted, offers relevant ethical reflections, and how I came to be a participant in

[1] "Det er sjovt du siger det. Lige da vi fik telefonerne var vi helt oppe at køre over dem, men nu tænker jeg aldrig over dem mere. De er der bare".

the nexus of practice. Chapter 5 continues with sections describing the hospital department which was the site of investigation and the communication system of which the mobile work phones are part. It ends with sections providing insights into the work unfolding in this nexus of practice.

In Chapter 6, the process of mapping the nexus of practice is described and persistent discourses circulating it are subsequently exposited. The chapter continues with sections outlining how trajectories to other places and other points in time were followed and describing the practices carried out by nurses working in the nexus of practice when they use mobile work phones. Chapter 7 describes how the video recordings that comprise the main data of this study were logged, transcribed, edited, and collectively analysed. Chapter 8 describes the two analytical manoeuvres of zooming in and zooming out and introduces the presentation of analyses in the subsequent chapters.

Chapter 9 presents the full analysis of the case "The work of a thumb", beginning with the close interactional analysis of the video recording and its subsequent connection to persistent discourses circulating in the nexus of practice. In similar ways Chapters 10 and 11 present full analyses of the cases "Anything important" and "Just a moment".

Chapter 12 presents résumés of the analyses performed on the three cases "The blanket", "The arterial blood gas", and "Removing a catheter". In Chapter 13, the analyses of the first six cases are summarised and salient analytical discoveries pointed out. In Chapter 14, the full analysis of the case "The newcomer" is presented, while in Chapter 15 connections to other times and places are outlined and a summary of the analysis as a whole is provided.

In Chapter 16, reflections on changes taking place in the nexus of practice during my research activities are offered, with potential for change highlighted. Chapter 17 offers reflections on the construction and utilisation of the research framework constructed for this thesis; the findings of the thesis are discussed in relation to existing research. Chapter 18 concludes and offers suggestions for further research.

1.3. READING GUIDELINES

The data for this Ph.D. thesis was gathered in and around a Danish hospital department; consequently all communication was conducted in Danish. The original Danish utterances are represented first in the transcripts with the pertinent English translations below. When quotations are made inside the text, only the English translations of the spoken utterances are represented in order to ease reading. The original quotations in Danish are however made available in footnotes. When citing

persons, the quotations are followed by parentheses that indicate which person produced the utterance and at which date, although precise time-codes are omitted in order to ease reading. Where available, I refer to English versions of Danish websites and translate the website name and author accordingly.

To ease reading further, nurses are referred to with feminine pronouns and adjectives in chapters concerning the specific hospital department where the inquiries of this thesis were made, as there happened to be no male nurses working there. When referring to nurses in this thesis I refer to registered nurses who have completed a bachelor degree in nursing, in accordance with Danish legislation. I do not evaluate their individual levels of proficiency; when referring to experienced nurses, I mean those who have been working in the hospital department under investigation for more than two years.

In writing this thesis, I lean on the insights of many past and present scholars, some of whom share the same surnames. As some of these authors recur throughout the thesis, initials for all of them are provided in text citations to avoid confusion.

CHAPTER 2. SETTING THE SCENE

In this chapter, the broader context of the introductory narrative is detailed. The organisation and some central trends of the Danish healthcare system are touched upon briefly, after which the historical and theoretical currents constituting the Danish nursing profession is presented. The work of Kari Martinsen, Katie Eriksson, and Patricia Benner is highlighted, as these prominent theorists are required reading in every Danish nursing school. Indeed, their perspectives are so embedded in the Danish nursing curriculum as to constitute the normative values of Danish-trained-nurses. This leads to the next section on the nurse-patient relationship, because the fundamental perspective of nursing as a caring science is grounded in the relationship between nurses and patients. This section is followed by an overview of the characteristics of nurses' work and how it unfolds.

2.1. INTRODUCING THE DANISH HEALTHCARE SYSTEM

The public hospital in which the introductory narrative took place is part of the Danish healthcare system, in which governance is largely decentralised. Public hospitals are owned and run by the regions, domiciliary care is run by the municipalities, and general practitioners are self-employed. Some central regulations are enacted by the Danish Ministry of Health, which is the foundational legal authority for the Danish healthcare system. The Danish Ministry of Health is "in charge of the administrative functions in relation to the organisation and financing of the healthcare system" (Danish Ministry of Health, 2016), and compiles the necessary acts and regulations (Krasnik, Vallgårda, Christiansen, & Høyer, 2010). Legislation is enforced by the Danish Health Authority, the Danish Medicines Agency, and the Danish Patient Safety Authority, which together oversee the Danish healthcare system and act as advisor to the government ministries (Danish Health Authority, 2016).

The main task of the five regions in Denmark is the governance of the Danish healthcare system (Danske Regioner, 2013); the regions also have responsibilities for social services and regional development. The regions are managed by regional councils whose members are democratically elected politicians. The decentralised organisation of the Danish healthcare system imposes a risk of inconsistency in expenses and services (Krasnik et al., 2010), so efforts have been made in a number of areas to promote quality and ensure efficient resource utilisation (Danish Health Authority, 2014). In 2005 the Danish Health Authority founded the Danish Institute for Quality and Accreditation in Healthcare (IKAS) with the purpose of developing a model for quality in the Danish healthcare system. Their efforts led to the Danish Healthcare Quality Programme (DDKM) (Danish Institute for Quality and

Accreditation in Healthcare, 2014b), which uses accreditation to determine the minimal level of acceptable quality and monitors it in all sectors of the healthcare system (Danish Institute for Quality and Accreditation in Healthcare, 2014a). The model has played an important part in unifying and structuring quality development throughout the system, but the model has also been criticised for its substantial demands in terms of documentation and monitoring. All Danish healthcare institutions and places of healthcare treatment or service must be repeatedly accredited in accordance with the programme. IKAS develops, plans, and manages the Danish Healthcare Quality Programme with the goal of achieving:

- A consistent and high level of quality across the full range of healthcare services.
- Coherence in the patient experience.
- Transparency in relation to the services and benefits of the Danish healthcare system.
- A culture of on-going mutual learning to generate and facilitate continuous quality development (Danish Institute for Quality and Accreditation in Healthcare, 2014c).

In April 2015, the National Quality Programme of Healthcare 2015–2018 superseded the Danish Healthcare Quality Programme in all public hospitals, with the goal of further promoting quality improvements (Ministeriet for Sundhed og Forebyggelse, 2015). The core of this newer programme is threefold:

- To make the patient the centre of attention: the patient should be the focal point in order to improve patient experience and provide value to the patient.
- To support the continuous development of quality: the aim is ensuring that Danish healthcare ranks among the world's best performers of quality.
- To use resources as efficiently as possible: healthcare and improved quality should be delivered at the lowest cost per patient without sacrificing quality (Ministeriet for Sundhed og Forebyggelse, 2015).

One yardstick in the achievement of quality is good communication; there is a general interest concerning interpersonal communication and communication skills in and around the healthcare sector (Horsbøl & Sørensen, 2010). Although the primary purpose of hospitals is not communication but the treatment and care of ill patients, it is recognised that quality in this core mission cannot be achieved without appropriate communication, and international studies have demonstrated how communication in healthcare has a profound influence on patient compliance, patient satisfaction, patient safety, and success of treatment (Alvarez & Coiera, 2006; Jangland, Gunningberg, & Carlsson, 2009; Verhaak, Bensing, & van Dulmen, 1998). On the basis of statistics from the Joint Commission (2015) the Danish Society for Patient Safety estimates that up to 70% of reported serious adverse

events in the Danish healthcare system are wholly or partly caused by communicative issues (Dansk Selskab for Patientsikkerhed, 2007). This is supported by a Danish study which reports communication problems to be a major cause of adverse events (Pedersen & Mogensen, 2003). On the basis of medical record audits Pedersen and Mogensen stress the vital importance of communication both among staff and between staff and patients and relatives in order to achieve quality in treatment and care.

Given that the fundamental task of the Danish healthcare system is the examination, treatment, and care of patients, its focus has always been directed towards the patients. However, in recent years the patient's perspective on the healthcare system has been emphasised, and an increased awareness of patient integrity and autonomy has resulted in patient-course policies, waiting-time warranties, and free choice of treatment for patients (Krasnik et al., 2010). The focus on how patients actually experience the healthcare system has been further stimulated by increased competition between public and private hospitals in Denmark. The national survey on patient experiences "Den Landsdækkende Undersøgelse af Patientoplevelser" (LUP) is carried out every year (Enhed for Evaluering og Brugerinddragelse, 2015). Results from the LUP consistently point out that communication is vital to how patients experience their treatment and care (Enhed for Evaluering og Brugerinddragelse, 2014); communication is also essential if resources are to be efficiently utilised in hospitals. Poor communication can result in invalid or missing examinations and procedures, insufficient treatment, and reduced patient compliance, all of which result in prolonged patient admittance (Vinge & Vikkelsø, 2004).

The communicative practices of healthcare professionals working in a hospital are thus of vital importance to the achievement of the objectives laid out in the National Quality Programme of Healthcare 2015–2018 (Ministeriet for Sundhed og Forebyggelse, 2015). Efficient use of resources, improvement of patient experience, and world-class quality cannot be achieved without expertise in communication practices. Understanding communication as fundamentally multi-modal means that expert communication is actually expert interaction with all the different modes and contextual configurations used. As Sarangi points out, the communicative practices of healthcare professionals working in a hospital are complex expert manoeuvres which rely heavily on embodied tacit knowledge in interactions (2010). What they do and how they act is a response to the pressures of the situations in which they are engaged, and the unfolding interactions play a significant part in the communicative process, as is evident in the opening narrative of this thesis. The actions of the nurse in that scenario impacted the efficiency and quality of the treatment and care the patient received, affected the patient's experience of being admitted to hospital, and helped shape the hospital as institution. Engaging in this micro level of interaction can thus provide insights significant for the macro level strategies and management of the Danish healthcare system.

2.2. A CARING SCIENCE – THE CURRICULUM OF NURSING

Florence Nightingale laid the foundations for modern nursing during the 19th century, establishing the first secular nursing training school in London in 1860 (Bullough & Bullough, 1979). When secular nursing education began in Denmark in 1876 (Glasdam & Bydam, 2008), nursing was strictly limited to completing tasks and assisting doctors, not about interacting with patients (Hall, 1997).

In the 1950s, academic nursing began to develop, with the aim of distinguishing nursing from medicine and stressing the independent function of nursing (Alligood, 2014). Early theorists such as Henderson (Harmer & Henderson, 1955; Henderson, 1966), Peplau (1952), and Travelbee (1966) focused on the basic needs of patients and interaction with patients, moving nursing away from tasks and procedures towards a patient orientation. From the late 1960s and well into the 1970s, nursing theorists strived to legitimise nursing as a discipline through the development of abstract concepts, theories, and models such as Orem's self-care deficit theory (1971), Roy's adaptation model (1976), Levine's conservation model (1969), and the Neuman systems model (1974). Inspiration from phenomenology and existential philosophy was reflected in the late 1970s, when nursing theorists began addressing ontological issues and describing the essence of nursing. Examples include Rogers's development of a philosophical theory on the wholeness of human beings (1983), Newman's theory of health (1979), and Parse's theory on human becoming (1981), all of which contributed to the evolution of a human science perspective on nursing. At the same time other scholars were developing a perspective on nursing as a caring science, as reflected in Watson's nursing: the philosophy and science of caring (1979), and in Leininger's theory of culture care (1978). Together, these perspectives formed the beginning of a paradigm shift away from a bio-medical towards a holistic perspective, and they have had profound impacts on the work of subsequent nursing theorists. During the 1980s, a growing number of midrange theories explaining concepts of relevance to nursing emerged: Pender's theory of health promotion (1982), Benner's theory of skill acquisition (1984), and Mishel's theory of uncertainty in illness (1988). As an answer to the gap between grand theories and the practices of nurses, scholars turned to the substance of nursing, explaining subjects or analysing concepts to develop nursing's knowledge base. However, philosophical questions regarding ethical, aesthetic, epistemological, and ontological issues continue to be of interest to nursing theorists with focal points such as the values guiding the relationship between nurse and patient (Bishop & Scudder, 1996; Gadow, 1989), the character of nurses (Gadow, 1989; Pinch, 1996), and caring as an ethical value (Bradshaw, 1996; Condon, 1992). The philosophies of unitary humans and care as the essence of nursing developed in the late 1970s and early 1980s shaped a moral ideal and imperative for nurses and nursing theorists which remains in force. Caring as an ethical value has had a major impact on nursing curricula in Scandinavia, forming a moral, relational, and practical ideal for

nursing propagated by prominent Scandinavian nursing theorists like Kari Martinsen and Katie Eriksson.

In her philosophy of care, Martinsen (2010) builds on the Danish philosopher Løgstrup (1956, 1978). She emphasises care as basic to human existence operating from the central ontological assumption that human life is interdependent: "Care is to be concrete and present in a relationship with our senses and our bodies. It is to always be in a movement away from ourselves and towards the other" (Martinsen, 1991, p. 11). Martinsen depicts perception as essential in nursing, in which senses and emotions work together to understand the other (Martinsen, 2006). She considers perception to be a crucial part of clinical judgement that opens itself up to the wholeness and complexity of the patient, and avoids an objectifying and categorizing perspective which reduces the patient to little more than symptoms and diagnoses. Martinsen worked in Denmark in the 1990s, playing an important role in the establishment of Danish nursing research. Although she has been criticised for downplaying scientific, evidence-based knowledge and for her altruistic perspective on care (Nortvedt, 2000), she remains the leading philosophical figure in Danish nursing, and her perspectives are a required element of the curriculum at Danish nursing schools (Petersen, 2013).

The Finnish-Swedish scholar Katie Eriksson is another pioneer in Scandinavian nursing; she has worked to develop the substance of caring and to shape caring science as an independent discipline. Reflecting the thoughts of Aristotle (1935) and the Swedish theologian Anders Nygren (1966) on *ethos*, *eros*, and *agape*, Eriksson regards *caritas* as the basic motive of care:

> True caring is not a form of behaviour, nor a feeling or state. It is an ontology, a way of living. It is not enough to "be there" – it is the way, the "spirit" in which it is done; and this spirit is caritative.
>
> (1998, p. 4)

Caritas is love and charity, and care without caritas will cause the patient to suffer (Eriksson, 1998). Eriksson depicts how caring is constituted by a communion, an intimate relationship between nurse and patient in which respect for the patient's dignity and wholeness are the guiding elements and a conscious effort to be with him or her is essential. Inspired by hermeneutics, Eriksson outlines how the nurse must interpret and understand patients and the values that are important to them. Eriksson draws on Gadamer (1994) to argue that theory can enable a deeper participation and communion among nurses, and thus advocates for basic research. She has been criticised for her axiom that humans are fundamentally religious and for the self-sacrificing attitude of her theory, but her perspectives are still part of the basic curriculum in Danish nursing schools.

Both Martinsen and Eriksson ground care in the relationship between nurse and patient. This relational perspective is also evident in the work of the American scholar Patricia Benner, who also emphasises care and describes nursing as a "caring relationship" in which the primacy of caring is the enabling condition of nursing practice: "Caring is primary because caring sets up the possibility of giving help and receiving help" (Benner & Wrubel, 1989, p. 4). Benner et al. describe how nursing practices are guided by the moral art and the ethics of care and responsibility, but at the same time highlight the skills, knowledge, and complexity required for successfully establishing a caring relationship: "The term 'ethical comportment* is used to refer to the embodied, skilled know-how of relating to others in ways that are respectful, responsive, and supportive of their concerns" (Benner, Tanner, & Chesla, 1996, p. 233).

Considering the nurse-patient relationship as fundamental for nursing care and critical to patient outcome dates back to Peplau (1952), one of the earliest nursing theorists. Although others have subsequently built on her work, the underlying assumption remains that the nurse-patient relationship is not a personal relationship in which stories of lives and dreams are shared, but a therapeutic relationship built on trust and essential for desirable patient outcomes (Fleischer, Berg, Zimmermann, Wüste, & Behrens, 2009; Morse, 1991; Peplau, 1952; Travelbee, 1966). That the nurse-patient relationship is pivotal in nursing is underlined by the fact that the interpersonal skills and emotional work required to accomplish a therapeutic relationship are an important part of nursing curricula. Nurse students are not only examined in the theories of interaction but also have to demonstrate interactional skills and achieve a therapeutic relationship with patients to pass their clinical exams (Undervisningsministeriet, 2008).

From these normative perspectives that establish the nursing profession as a caring science grounded in the nurse-patient relationship, I turn now to empirical studies on the nurse-patient relationship.

2.2.1. PHENOMENOLOGICAL AND HERMENEUTICAL STUDIES ON CARING RELATIONSHIPS

Research on nurse-patient interaction is dominated by a nursing science perspective, with the preferred approaches being hermeneutic and phenomenological, and the preferred methods being life word interviews and ethnographic observations. Benner et al. use observations and interviews in an intensive care unit to demonstrate the complexity and here-and-now orientation of nurses in interactions with patients, as they test and modify their understanding in actual situations, challenging and refining their preconceived assumptions (1996). In collaboration with Wrubel, Benner depicts how the presence of the nurse, both physically and psychologically,

is significant for sustaining and deepening the relationship with the patient, and how shared humanity allows nurses to feel for their patients, adding to the qualitative dimension of expert care for both patient and nurse (Benner & Wrubel, 1989).

Studies on the nurse-patient relationship from perspectives other than nursing are limited, though a sociological study by Weinberg uses observations and interviews to show how it is a relationship in which getting to know the patient means getting to know the patient's medical needs, progress, resources, physical and emotional state, and how treatment is managed and responded to (2006). In accordance with nursing literature, she reveals how it is the fundamental therapeutic groundwork through which nurses gather the rich information about patients that enables nurses to assess their condition and plan relevant actions:

> Just checking on a patient is an extremely complicated thing. And most of it you're doing unconsciously… Because if you're looking for response to illness, which is what nursing is doing, then those responses are very subtle and very wide ranging.
>
> (Weinberg, 2006, p. 37)

Weinberg documents how nurses use their expertise to sense subtle phenomena and disparate pieces of information and assemble them in meaningful ways. She further shows how this complex groundwork is essential not only to patient experience but also to quality in treatment and care. However, nurses find it difficult to put into words what they do, so the therapeutic relationship is often disregarded as a personal choice of doing a little extra rather than as a necessity for professional work (Weinberg, 2006).

The literature also reveals how nurse-patient interaction is vital to patients' experience of their hospital admittance. On the basis of phenomenological life-world interviews, Shattell reports how patients longed for more and deeper connections with nurses and how physical distance from caregivers made them feel insecure (2004). In a Grounded Theory study, Irurita reveals how patients do not prioritise the technical competence of nurses; rather, it is expressive factors like demonstrating empathy or compassion that make a substantial difference to their hospital experience. Patients identified building a relationship as central to the phenomenon of high-quality care and expressed how nurses "being there" for patients enhanced their sense of security and safety (1996). In contrast to nurses being available and dependable, nurses rushing by and being unavailable made patients feel vulnerable. In a meta-synthesis, Kitson and her colleagues describe how psychosocial components like empathy and compassion are mediated through each encounter between nurse and patient, and how the skills and competences of the nurse are essential in order to integrate these dimensions with technical skills (Kitson, Muntlin Athlin, & Conroy, 2014).

Studies also point to the fact that the increased workload of nurses, which demands that they take care of more patients with fewer resources, can interfere with nurses' ability to accomplish the ideal nurse-patient relationship described by nursing theorists. In Irurita's study, nurses reported feelings of frustration and guilt when reductions in staff forced them to prioritise physical care, leaving them unable to provide compassionate care consistently (1996). Weinberg documents how "doing the little things" – the complex and often unconscious expressive elements of forming relationships and delivering compassionate care – are not acknowledged as part of professional work and consequently do not enjoy the appropriate allocation of resources (2006). McQueen argues that because engaging in interpersonal interaction is a common feature of everyday life, the skills required to develop a nurse-patient relationship are overlooked and disregarded (2000), so the formation of trusting relationships in nursing is overshadowed by more observable nursing activities.

In the interviews referred to above, nurses reported feeling of guilt and frustration because they did not have enough time to talk to patients in order to develop a "positive relationship" and "understand their individuality" (Irurita, 1996). These feelings reveal that nurses themselves did not feel that they were meeting their own and their profession's expectations. Patients presumably do not regard the nurse-patient relationship as therapeutic and do not fully grasp the complex information-gathering that occurs throughout their interactions with nurses. However, those same life-world interviews with patients indicate that building of close and deep relationships with nurses is essential (Shattell, 2004). Although they engage in these relationships for different reasons than nurses, their values and expectations are substantially similar.

2.2.2. INTERACTIONAL STUDIES ON CARING RELATIONSHIPS

Patients' and nurses' feelings about nurse-patient relationships may be revealed in interviews, but understanding what actually takes place in those relationships and how they are developed by concrete interactions requires additional methods.

Ethnomethodology (Garfinkel, 1967) has the capacity to uncover the aspects of social order that are taken for granted and to reveal how ordinary, every-day interaction is accomplished jointly. However, ethnomethodology has rarely been used to explore nurse-patient interaction. Jarrett and Payne did use audio recordings and participant observation to analyse nurse-patient interactions (2000). In an analysis inspired by ethnomethodology, they reveal how seemingly superficial, positive, and chatty interaction was ably achieved by the nurses in their study. Nurses were willing to discuss difficult and negative topics and encouraged patients to do the same, while at the same time deploying multiple methods to sustain hope

and build a realistic optimism that would benefit patient treatment and recovery (Jarrett & Payne, 2000). The study illustrates how ethnomethodology offers a window into the interpersonal actions and reactions which are rarely reflected on and to the shared creation of meaning in nurse-patient interactions.

Although conversation analysis has been used comprehensively to study communication between physicians and patients (e.g., Heritage & Maynard, 2006) and is commonly used within the field of heath communication (e.g., Drew & Heritage, 1992) it has not entered the mainstream of research on nurse-patient interactions. In a study by Jones, audio recordings of conversations from assessment interviews were used to analyse nurse-patient interactions (2003). She demonstrates how nurses orient to the bureaucratic function of the hospital using a chain of scripted questions to "get the job done". The distribution of turn-taking is managed such that patients have little opportunity to take the floor for any purpose other than providing answers, with the nurse controlling the agenda and restricting it so as to facilitate the desired institutional outcome. In another study, Gordon et al. use video recordings of interactions between nurses and patients with aphasia or dysarthria as the basis for a conversation analysis (Gordon, Ellis-hill, & Ashburn, 2009). They found an overall asymmetry in the conversations, with nurses controlling openings and speaker change and with patients frequently using one-word replies. Although aphasia or dysarthria can be contributing factors to this organisation of talk, the study documents how nurses perform institutional talk (Drew & Heritage, 1992).

In these conversation analysis studies, the interactions of nurses are shown to be strongly influenced and structured by the institutional context of the hospital, to be oriented to tasks, and to be constrained by the formal character of the interactions. Although both studies contribute valuable insights about nurse-patient interaction, they focus exclusively on verbal communication. In interviews, patients pointed to embodied conduct such as the use of touch, a compassionate stance, and "the little things" as important to nurse-patient relationships (Irurita, 1996; Weinberg, 2006; Williams & Irurita, 2006). Understanding communication as fundamentally multimodal means that therapeutic communication is better described as therapeutic interaction and that analysis should include all modes and contextual configurations used by nurses (C. Goodwin, 2000). This is reflected in the embodied turn in research on language and social interaction, and the rising interest in the embodied involvement in interactions (Nevile, 2015). This interest also prevails in studies of interactions in hospitals, such as Nishizaka's demonstration of how midwives use subtle touch to accomplish reference in their interactions with patients (2007). In an observational study on nurse anaesthetists, D. Goodwin reveals how they use their own bodies to become sensitive to the intricacies of their patients and elaborate on digitized information provided by technologies with the use of touch (2010). However, in nursing research the interest in embodied conduct during interactions with patients remains embryonic, and its potential for nursing research has not been realised.

2.3. A COORDINATING PIVOT – THE WORK OF NURSES

Today, fast-paced healthcare has been suggested by nursing researchers to cause superficial, routinized, and task-oriented engagement with interpersonal interactions rather than presence, empathy, and compassion (Irurita, 1996; Williams & Irurita, 2006). Nurses work in a health care system that is evolving rapidly and in several ways: continual implementation of medical and technological improvements; increased co-morbidity of patients; shortened lengths of hospital stays; increased demands for organisational accountability; cost reductions; and an increasing number of tasks that cross professional boundaries (Iedema, 2006). In pressure situations when nurses have to care for many patients, the heavy workload can constrain their ability to develop the nurse-patient relationship described as ideal by nursing theorists.

In the complex work environment of hospitals with multiple professions, specialisations, and technologies, the ethical aspects of nurses' work are traditionally emphasised and their practice referred to as a "caring science" (Nelson & Gordon, 2006). Even though care is central to the self-understanding of nurses, the emphasis on ethical aspects has been contested, partly because this traditional perspective tends to leave little acknowledgement of the skills, knowledge, and complexity involved in actual practice of nurses (Nelson & Gordon, 2006). Some argue that nursing has not been able to claim responsibility for any specific realm other than the function of care, and that there is no encompassing area of expertise that summarises the contribution of nurses (Booth & Waters, 1995). Nursing has been constituted for decades as a combination of altruistic care for the patient and self-sacrificing service to doctors, as a virtue discipline rather than as a knowledge discipline (Nelson & Gordon, 2006). Nursing is thus often described in terms of virtues or in terms of specific tasks in alignment with the medical profession (Booth & Waters, 1995). One reason for this may be that the focus of nursing is the patient as a whole. Taking this generalist perspective causes the role of nurses to overlap with those of several other professions, so that nursing can be defined as "the undifferentiated other" (Bowker & Star, 2000) that is made up of whatever is not specifically included in the purview of other professions. Another reason might be that caring for the patient as a whole entails several undefined and tacit tasks which are not easily documented and are not included in quality regulation and resource allocation (Blomgren, 1999; Bowker & Star, 2000). Thirdly, nurses have been subordinate to the medical profession for 150 years; nurses use skills and deliver care, while it is doctors who possess knowledge. This emphasis on virtues is reflected and reinforced by public opinion and in mass media that laud nurses as "angels" who are "touching hearts" and providing "devoted care" (Nelson & Gordon, 2006).

2.3.1. WORKPLACE STUDIES ON NURSING

Empirical studies on the actual work of nurses is characterised by methodological homogeneity, with the preferred methods being quantitative measurements, observations, and interviews. An English action research study using observations and interviews reveals how nurses become coordinating pivots because of their focus on the patient as a whole and because they are in close contact with the patient (Booth & Waters, 1995). This coordinating function of nurses in the inter-professional collaboration of a hospital ward leads to frequent interruptions in their work flow, as members of the multidisciplinary team involved in patient treatment rely on them for information and coordination. Interruptions are thus an inevitable feature of nursing practice, and an immense amount of research has examined the frequency and types of interruptions, their consequences for patient safety, and possible ways to reduce them (Anthony, Wiencek, Bauer, Daly, & Anthony, 2010; Brahe & Elgaard Sørensen, 2010; Freeman, McKee, Lee-Lehner, & Pesenecker, 2013; Laustsen & Brahe, 2015; Palese, Sartor, Costaperaria, & Bresadola, 2009; Raban & Westbrook, 2014; Relihan, O'Brien, O'Hara, & Silke, 2010; Westbrook, Woods, Rob, Dunsmuir, & Day, 2010).

Literature from several countries reports that the work of nurses is characterised by rapid task-switching, multiactivity, and a high level of complexity, unpredictability, and mobility. In an American study that observed nurses working in an oncology ward, Cornell et al. (2011) reported 2061 different task during 35.7 hours of observation, with a mean task length of 62.4 seconds. This study also documents how nurses rarely complete one activity before switching to another, which is consistent with a human factor study using mixed methods to examine the work of nurses in acute care wards. On the basis of quantitative data, observations, and interviews the authors found that the work of nurses has a high level of complexity, discontinuity, and unpredictability (Ebright, Patterson, Chalko, & Render, 2003). These findings are confirmed by a Joint Commission study that involved conducting observations in wards across seven different hospitals; it reported the work of nurses to be fragmented, unpredictable, and interrupted (Kalisch & Aebersold, 2010). The authors further document how nurses engage in multiactivity during 30–40% of their work time. An American study exploring the work of nurses similarly reveals a high level of complexity and multitasking. On the basis of focus group interviews, the authors reported the unpredictable nature of nurses' work and the increased responsibilities that nurses have to bear in a condensed time that exacerbates this uncertainty (Krichbaum et al., 2007). Yet another study confirming that rapid activity-shifting and a high level of complexity and unpredictability are features of nurses' work also documents the high degree of mobility in the profession (Redding & Robinson, 2009). Using a combination of quantitative and qualitative observational data, Redding and Robinson map the travel patterns of nurses during their work. Mapping the motions of nurses during work in great detail had been

previously conducted by Potter et al., who reported a high degree of mobility among nurses (Potter et al., 2004).

After this brief glimpse into the American literature on the work of nurses, I turn to Scandinavian literature, because the region's healthcare systems are comparable, as are their historical and cultural roots. In a Norwegian study, Vareide et al. described the working procedures of Norwegian nurses as the "the glue" holding everything together (Vareide, Hofseth, Norvoll, & Røhme, 2001); similarly the working procedures of Danish nurses in a medical in-patient ward are described as the "putty" cementing it all (Svenningsen, 2004). These studies indicate that nurses compensate for bad internal hospital organisation and continue to take on additional tasks and functions, a service that is also reported in studies outside Scandinavia (Booth & Waters, 1995; Cornell et al., 2011; McGillis Hall, Pedersen, & Fairley, 2010). In a call to change working procedures, the head of the Danish Nurses' Organization, Grethe Christensen, compared nurses to octopuses with all-round functions, keeping the everyday work of hospital departments running (Søndergaard, 2009).

Several studies of nurses' work describe an ingrained culture of availability, with nurses being constantly at hand and called upon to allow patients, colleagues, and collaborators to interrupt their activities (Hallin & Danielson, 2007). Observations of nurses working in a Swedish medical ward documented how nurses tend to interrupt their activities immediately in response to the desires of other team members (Hedberg & Larsson, 2004). Similarly, a Danish study of interruptions in nurses' work practices revealed how nurses strive to be available to everybody as a way to ensure that patients receive the best possible treatment (Brahe & Elgaard Sørensen, 2010). In this study, nurses stressed how they must be available and accommodating, receptive, and friendly to both patients and collaborators. This constant availability may have its roots in nursing as a caring discipline in which sensitivity towards the other is emphasised (Martinsen & Eriksson, 2013). It may also have roots in the historically subordinate role of nursing to medicine (Hedberg & Larsson, 2004; K. Larsen, 2003; May & Fleming, 1997), in collegial obligations and loyalty (Andersen, Dybbroe, & Bering, 2004; Sygeplejeetisk Råd, 2004), and in historical patterns of gender roles (Dickson, 2000; Muff, 1988; Wiener, 2000). The coordinating function of nurses in which other team members rely on them for information, may further prompt nurses to be more tolerant of interruption and to encourage communication at all times.

2.3.2. STUDYING NURSING FROM OTHER PERSPECTIVES

In addition to the many workplace studies that use quantitative measurements, observations, and interviews, a few interactional studies have also explored the work

of nurses. In the study by D. Goodwin mentioned previously, the author not only shows how nurses use their bodies become sensitive to the intricacies of patients and to elaborate on digitized information drawn from technologies (2010). Her study also revealed the collaborative nature of nurses' practices, with discussions circulating continuously amongst them and thus co-constructing their assessments, their understandings and their actions. Mesman, on the basis of observations in a Dutch hospital, has analysed the interactional diagnostic work of nurses and the spatial configuration of their collaborative work, showing how nurses constantly monitor the conduct of others and align their bodily and technical actions accordingly, distinguishing when and how customisation is needed (2012). Despite their spatial dispersal across different places within the ward, nurses are thus performing a multi-sited collaboration that makes parallel lines of work possible.

In an interactional study, Kjær and Raudaskoski used video recordings from a hospital to describe how the demands on nurses consist of continuous diagnostic work as they move between patients and spaces and treat every sensed stimulus as potentially relevant for their next actions (2014). In performing diagnostic work, nurses continuously shift their levels of attention, their engagements, and their activities, deploying several trajectories of action and the performance of multiactivity.

The work of nurses has also been studied from discursive perspectives. Employing a multimodal-organisational discursive approach focused on concrete actions, Iedema et al. used video recordings to map the work of clinicians, including nurses, in a hospital clinic. As with the studies cited above, they report the work of nurses to be highly coordinative and communication-based, with frequent corridor interactions being vital to diagnostic work and decision-making (Iedema, Long, Forsyth, & Lee, 2006). Adopting a classic Anglo-Saxon discursive perspective drawing on pragmatics, Sarangi has investigated communication in healthcare in several studies. He depicts how verbal interactions are knowledge systems laminated with expertise and authority and with a dynamic frame that shifts constantly between gathering information, accessing, explaining, diagnosing, evaluating, discussing, treating, caring, predicting, etc. Hence, the communicative practices of healthcare professionals are complex expert manoeuvres which rely heavily on embodied tacit knowledge and constantly unfolding interactional context (Sarangi, 2010). This is an appropriate point at which to introduce into the present study the mobile work phone, which forms part of the interactional context in the introductory narrative.

2.4. MOBILE PHONES

The use of mobile phones has spread with dramatic speed in the last two decades to even the remotest villages in developing countries; its rapid expansion has outpaced

the dissemination of all prior technologies (Agar, 2013; Castells, Fernandez-Ardevol, Qiu, & Sey, 2009; Srivastava, 2008). Eventually the mobile phone also found its way into hospital wards. The focus in this thesis is on the actions that nurses undertake with mobile work phones, so an introduction to this central means of mediation (R. Scollon & Scollon, 2004) is appropriate. I begin with a brief glimpse into the history of the mobile phone.

2.4.1. OUTLINE OF THE HISTORY OF MOBILE PHONES

The idea of mobile telephony was proposed by D.H. Ring at Bell Laboratories during the late 1940s, although the idea was left undeveloped for several decades (Agar, 2013). In 1969 the Nordic Mobile Telephone Group was established with representatives from Denmark, Sweden, Norway, and Finland, in order to develop a mobile phone system. This resulted in the analogue NMT standard, which defined how elements of a mobile phone system were to interact and was launched in 1981 (Agar, 2013). Representatives from 11 European countries gathered in 1982 to inaugurate the digital Global System for Mobile (GSM) standard, which aimed to ensure comparable mobile phone systems in all participating countries. The GSM standard, which was launched in Finland in 1991 made it possible to use the same phone across national borders, thus encouraging the development and mass production of such devices. The initiative was an immediate success, with the standard soon adapted in countries outside Europe. By 1996 the system was used in 103 countries (Agar, 2013). Mobile phone systems debuted in the United States in 1983, but political decisions to encourage competition resulted in several incompatible network systems that made cross-network communication difficult (Agar, 2013; Castells et al., 2009).

Concurrently, the Digital European Cordless Telecommunications (DECT) phone system was developed and launched in 1987; it has underdone regular developments since. DECT technology enables the mobile phone to access a fixed phone network through a base radio link. This system has high capacity and is thus ideal for constricted areas with many phone users, especially in larger buildings where standard phone system coverage may be lacking (Rappaport, 2002).

Mobile phones were initially intended for businesspeople. During the 1990s, however, mobile phones became diffused throughout into the private sphere with dramatic speed, becoming a mainstream technology (Agar, 2013; Castells et al., 2009). The penetration of mobile phones continues to rise, and regular advances in the phones have resulted in the incorporation of multiple functionalities. Similarly, data transfer has been improved through the development and dissemination of more advanced phone systems such as the now predominant 4G.

2.4.2. THE USE OF MOBILE PHONES

The ringing of a phone is a signal of a caller's intention to make contact and a summons to the person being called (Schegloff, 2002). It initiates the appearance of another and is thus a potential first move in an interactional sequence (Goffman, 1974). The appearance of another is intended to capture attention, and the first landline phones were originally designed to produce a repetitive disturbing sound that only ceased when the correspondent answered. Ignoring the appearance of another can be a source of embarrassment (Honneth, 2006), so the ringing of a phone incorporates a strong normative expectation that the correspondent should answer the call. Adopting a conversation analysis point of view, Schegloff describes how the summons-answer constitutes an adjacency pair in which the first pair part imposes a normative obligation to perform a type-fitted response at the first possible opportunity (Schegloff, 1968). The person calling produces the summons for a purpose, having assessed the relevance of making a call, and the person being called ordinarily relies on this assessment and considers the summons appropriate (Schegloff, 2002). This makes answering the summons the next appropriate thing to do, and failure to do so is oriented to by others. With land-line phones, people are only summoned when they are near the location of a phone, whereas mobile phones expose people to being summoned everywhere, leaving no room for excuses like "I was not home". As mobile phones make it possible for widely separated people to contact each other without being tied to specific locations or stationary positions, the capacity to answer a call is disengaged from the specific physical location of the person being called: "The mobile phone means that for those who have come into our sphere of friendship we are always available" (Ling, 2000, p. 10).

The portability of the mobile phone thus enables constant contact, and exposes carriers of mobile phones to expectations of always answering the phone, leaving them accountable if it is not answered. In experiments resembling the classic breaching experiments of Harold Garfinkel (1967), Katz demonstrated how people become angry with those who do not answer their mobile phones (2006). Licoppe, meanwhile has demonstrated how the ringing of a phone establishes a sequential order that projects expectations and preferred responses which, if they do not occur, are marked and justifications warranted (2012). Sociological studies on the use of mobile phones consistently report how people tend to prioritise answering the mobile phone at the expense of the physical situation in which they are engaged. Ling demonstrates how people emphasise the interaction mediated by their mobile phone so as to make it superior to co-present interaction (2004). Srivastava describes how an unanswered mobile phone is frowned upon (2008), while Turkle depicts how constant responsiveness and connectedness has become an expectation that requires people to be "always on": "These days, turning away from a person in front of you to answer a cell phone has become the norm" (2008, p. 130).

Hans Geser, a foundational thinker about the sociology of mobile phones describes how, even when circumstances are unfavourable, norms dictate that the phone is answered, causing the phone call to interrupt local interactions or activities (2004). When local activities require little involvement and no verbal resources, it is possible for the call recipient to continue on-going activities in parallel with the phone conversation. However, if the phone rings during interaction with others, the person being called has to become involved simultaneously in two front stages (Goffman, 1969). A study by Plant demonstrated how mobile phones create a "simultaneity of place": a physical space and a virtual space of interaction (2000). Having to manage two sets of geographic locations and two sets of social environments is quite complex, especially as strategies of self-presentation may conflict between the face consonant with the local/physical situation and the face consonant with the conversational space of the phone call. This simultaneously visible acting out of different roles may result in uneasy moments of anomie when the phone call has ended and interaction with the others present must be resumed. Several studies on mobile phone use have explored how people manage these highly demanding and complex stage activities concurrently. Ling reports that people often retract themselves from the physical situation, literally distancing themselves from others present, turning their bodies away, and staring into mid-air (2004). Local interaction is disengaged, and the others present are left waiting in a back-stage position for the phone conversation to end. This coheres with Murtagh's findings that people avoid eye contact and move their heads and bodies away from others present when on mobile phones (2002).

Fortunati describes how people talking on a mobile phone are only bodily present; their attention, minds, and senses are drawn to the mediated conversation on the phone: "…they suspend their flesh and blood interlocutor while they talk into the mobile, with the effect that they give the person at the other end more attention than the person in front of them" (2002, p. 519).

She goes on to describe how people's presence in the social space that they physically occupy is so limited that they are immaterially absent. This can be a signal to others present that they are not significant enough to deserve the attention of the person being called. Turkle documents how people talking on a mobile phone can treat physically proximate individuals as disembodied and anonymous by not speaking to them and using non-verbal signals to exclude or even ignore them (2008). From a psychological perspective, Gergen details how conversation on a mobile phone actively excludes others present from participation, defining them as secondary and non-significant (2002). When people engage in conversation on a mobile phone they cease to be full participants in the immediate context and a tension between the promise of presence and the actual state of absence arises. Although physically present, the person is absorbed by a technologically mediated world elsewhere, a state that Gergen calls "absent presence" (2002). Geser, in his sociological analysis of the mobile phone describes how the focused attention on the

caller and the disengaged in-person interaction can easily make the subject of talk evaporate and make it difficult to resume the thread of talk. However, he also notes that people talking on a mobile phone can intensify non-verbal communication towards others present to signal that they are still considered important and that interaction with them will be resumed after the call (Geser, 2004).

Several researchers point to the fact that mobile phones do not determine what an individual does; rather, how they handle the phone is embedded in social interaction and meaning-making (Arminen & Weilenmann, 2009; Katz & Aakhus, 2002; S. Raudaskoski, 2009). Understanding mobile phones within the complex realm of interaction means that how people act with a mobile phone in a concrete situation is influenced not only by their own body of experience but also by other actors present, the circumferences and historicity of the situation, and the unfolding interaction (Katz & Aakhus, 2002). People communicating on a mobile phone consider norms and resources from both their proximate context and from the context mediated by the phone, negotiating claims from multiple sources (Arminen & Weilenmann, 2009). The way mobile communication is conducted is thus interwoven with the personalities of both those communicating and the situational conditions, as it is linked to multiple social practices (S. Raudaskoski, 2009).

2.4.3. MOBILE COMMUNICATION IN HOSPITALS

The need for intense collaboration and coordination between spatially distributed and highly mobile healthcare professionals has urged hospitals to support communication by implementing mobile phone and other information and communication technologies (Toussaint & Coiera, 2005; Wu et al., 2012). Mobility is a distinctive feature of hospital work, as the on-going subdivision and specialisation of hospitals requires healthcare professionals to oscillate constantly between patients, collaborators, and equipment in several physical locations to perform their work (Vallgårda, 1992; Vinge & Vikkelsø, 2004). Nurses walk a substantial number of kilometres in every shift to engage in knowledge exchange and collaborative problem solving, to move equipment from storage rooms to patients, and to contact specific individuals who possess central information or authority. (Bardram & Bossen, 2005).

The literature on nurses' communication reveals a preference for synchronous communication (Alvarez & Coiera, 2005; Alvarez & Coiera, 2006; Edwards et al., 2009; Toussaint & Coiera, 2005), due to their multifaceted workflow that involves the rapid task-switching and frequent multiactivity described above. The management of large amounts of information requires nurses to relieve themselves of information frequently, due both to the limited capacity of short-term working memory and because passing the information on means they can mark one in a long

list of tasks as completed. Finally, the communication of nurses is oriented to the here and now, meaning that they cannot perform the task at hand until communication has been accomplished; a nurse cannot give analgesics to a patient having pains until she has established contact with a doctor who has the authority to prescribe the medicine, while a nurse who is uncertain about the appearance of a wound cannot dress it until she has made contact with a colleague who can help her assess the wound and select the appropriate bandage.

2.4.3.1 Two-way hands-free communication

Early research suggested that wireless communication technologies could support effective and efficient communication and coordination in hospital wards, with benefits for patient outcome (Minnick, Pischke-Winn, & Sterk, 1994; Spurck, Mohr, Seroka, & Stoner, 1995). Testing a two-way hands-free communication device, Minnick et al. reported reduced noise levels, improved coordination, and greater ease in locating nursing staff which resulted in shorter walking distances and time savings, leaving nurses to devote more time to direct patient care (1994). Another American study evaluated the implementation of a wireless communication system in hospital wards, reporting significant time savings (Spurck et al., 1995). Later quantitative research on two-way hands-free communication devices found that they significantly improved the response rate of nurses to communication queries but also raised concerns regarding voice recognition and reliability (Breslin, Greskovich, & Turisco, 2004; Jacques, France, Pilla, Lai, & Higgins, 2006).

In a grounded theory study involving observations and interviews in three American hospitals, nurses reported that a two-way hands-free communication device was beneficial in providing improved communication access to others (Richardson & Ash, 2008). The nurses emphasised that they no longer had to search for collaborators; instead they were able to call and determine their location, while they could easily call for assistance if they needed help. The study, however, did express concern about the multiple interruptions that the two-way hands-free communication device induced during face-to-face interactions, requiring nurses to manage simultaneous and sometimes conflicting communications. Nurses described how the multiple interruptions were annoying and frustrating, leading to a love-hate relationship with these devices. Other concerns such as breaches of confidentiality and lack of etiquette when using the two-way hands-free communication device were also noted.

2.4.3.2 Mobile phones

Similar findings have been in research on mobile phones. A Danish Computer Supported Cooperative Work (CSCW) (Greif, 1988) study evaluated the implementation of mobile phones in operating rooms, using quantitative data like questionnaires and statistics. The healthcare professionals reported the phones to reduce walking distances and improve communication and coordination (Hansen & Bardram, 2007). An American study analysed statistical measurements of mobile phone use in a hospital, such as response rates, communication interference, time of problem solving, etc. It reported that mobile phones improved communication time and accuracy and thus enhanced patient safety (Ortega, Taksali, Smart, & Baumgaertner, 2009). A Canadian study employing observations, interviews, and quantitative measuring of frequency, location, etc. in medical wards documented how mobile phones enhanced coordination between clinicians and increased their availability (Wu et al., 2011). However, this study also reported a substantial volume of interruptions induced by the phones, with residents feeling overwhelmed by constant interruptions. It was noted in particular that numerous patient interactions were interrupted, while unprofessional behaviour when attending to mobile phones during patient encounters was reported. The study concluded that while mobile phones increased the overall availability of clinicians, they also reduced their local availability due to constant distractions and interruptions.

Other research has similarly pointed out the disadvantages of using mobile phones in hospitals. A Norwegian study explored the adoption and usability of mobile work phones among attending physicians from a CSCW perspective (Scholl, Hasvold, Henriksen, & Ellingsen, 2007). On the basis of participatory observations and interviews in an oncology department, mobile work phones were reported to cause multiple interruptions in the work practices of physicians. The study describes how the mobile work phone made the physicians "over-available", as people tended to call about minor matters that could easily wait, and to call back repeatedly if the phone were not answered. Some practitioners called the phone "the interrupter" which was constantly "nagging" them. Furthermore, the physicians reported that the mobile phone caused a greater cognitive disturbance than a pager, as they had to make an immediate decision as to whether to answer a given call.

In a Norwegian Human Computer Interaction (HCI) study using observations and interviews, mobile phones were also found to be interruptive (Card, Moran, & Newell, 1983). However, some nurses reported the benefits of being available everywhere. In the findings, a concern about the patient-nurse relationship was expressed by nurses who considered it inappropriate to answer a mobile phone when with a patient: "a phone has nothing to do inside a patient room" (Kristiansen, 2011, p. 4).

Observations from a Canadian workplace study conducting observations and interviews in hospital wards similarly documented how mobile work phones interrupted nurses during activities with patients (McGillis Hall et al., 2010). In focus group interviews nurses described how often the phone appeared to ring at the worst possible time, causing patients to refrain from further conversation:

The patient will even say, [be]cause the phone's ringing over and over, they'll just be getting into telling me something important, and they'll stop and they'll say, it's ok, answer your phone, and then you've lost the moment.

(McGillis Hall et al., 2010, p. 173)

The study also indicated that nurses felt unable to get away from the phone and that they never had uninterrupted time with patients, as they had to abandon patient interaction to attend to incoming calls. A Norwegian HCI study based on observations in hospital wards also reported how mobile work phones increase the frequency of disruptive interruptions in nurses' work (Klemets, Evjemo, & Kristiansen, 2013). The mobile phones were connected to the patient call system and the phone system, and when activated the nurses had to opt between dismissing their current activity and attend to the call or ignore the call and continue the activity. Dismissing the call deactivated the ringtone. However, the phone continues to produce a humming sound which the nurses found hard to ignore. If they dismissed the call and continued their immediate focus, the nurses explained that the humming made them feel "out of it" and that it "takes out the communication" between themselves and the patient (Klemets et al., 2013, p. 331). Following the observation, videotaped scenarios and subsequent focus group interviews were conducted in order to clarify further nurses' experiences when using the phones. The nurses reported in the interviews that the continuous ringing of the phone was "stressful" and "irritating", making it hard to concentrate on what they were doing (Klemets & Evjemo, 2014). Several factors were identified as influencing the nurses' decisions as to whether to abandon their activity and answer the phone: the situation and the nature of their current activity; the context of the call; the relationship with the patient; and the patient's condition. For instance, if the phone call were from a person whom the nurse had been trying to reach, the nurse was more likely to answer that call for fear of missing the opportunity. When a call was from a patient in serious condition, the nurse was more likely to abandon the current activity and answer it. The decision to answer was also influenced by colleagues' activities, as nurses frequently used the phones to coordinate tasks and to ensure redundancy. It is evident from the study that the answering decision relied on a number of subtle contextual complexities, all of which had to be weighed in a few seconds.

Recent developments in this line of research address the interruptive nature of mobile phones. In response, CSCW studies and HCI studies have directed their attention to ways of supporting social awareness and enable healthcare professionals

to tacitly and unobtrusively align and integrate their activities (Bardram & Hansen, 2010). A CSCW study reported that the use of mobile phones with location tracking to increase social awareness and efficiency in an operating department (Bardram, Hansen, Mogensen, & Soegaard, 2006). An HCI study designed and evaluated a prototype system with presence, availability, and location query features. However, nurses made little use of call management features (Sammon, Brotman, Peebles, & Seligmann, 2006). An HCI study designed and evaluated a context-aware communication device that monitored a person's availability for communication but found that the feature was used as a display of presence and being contactable rather than to assess actual availability (Fogarty, Lai, & Christensen, 2004).

Another recent line of research investigates the use of personal mobile phones by healthcare professionals at work. A Canadian survey revealed that 86% of the participating medical students had used their personal mobile phone to exchange patient information, and that personal phones were used to answer and make phone calls, text, or email during patient encounters (Tran et al., 2014). In addition to potential breaches of confidentiality the authors problematize this increased connectivity of employees which have a negative impact on professionalism and cause "distracted doctoring" (Tran et al., 2014).

In 2012 I conducted a minor ethnographic study in the same hospital department that serves the site of investigation for this thesis (Paasch, 2014). At that time, the present study had not been conceived or planned, and the data from this prior study is not included in the present analysis. The findings of that study do however reinforce the studies discussed above, as mobile work phones were observed to cause frequent interruptions, on which one nurse commented: "those days when it rings all the times I just want to throw it out the window. It stresses me out. Even in the bathroom one does not have silence" (Paasch, 2014, p. 26).[2] Nurses further voiced the opinion that mobile work phones could disturb interactions with patients and restrict communication. This was articulated by nurses describing that: "but as it [the phone] rang I thought: oh no not now",[3] and "it is just that when one hears it ring to begin with then the conversation stops right there" (Paasch, 2014, p. 28).[4]

[2] "De dage, hvor den ringer hele tiden, der har jeg bare lyst til at smide den ud af vinduet. Den stresser helt vildt. Ikke engang på toilettet har man ro".

[3] "Men da den [telefonen] så ringer, tænker jeg: åh nej ikke nu".

[4] "Det er bare det med, at man overhovedet hører den ringe til at starte med, at så stopper samtalen ik'os".

2.5. SCOPE OF THESIS

The literature review above reveals that studies on mobile work phones in hospitals have been conducted from a narrow if valuable array of approaches: work place studies concerned with the way mobile phones feature in the situated organisation of clinicians' collaborative activities, CWSC studies concerned with how mobile phones can support collaborative activities and coordination among clinicians, and HCI studies evaluating and designing the interface between clinicians and mobile phones. From the results of these studies, it can be concluded that mobile phones do enhance the availability of nurses and other healthcare professionals and improve communication access between them. The studies also demonstrate that mobile phones increase efficiency and coordination. However, they point to strains between availability and interruptions, and between physical presence and social absence that may affect patient confidentiality and even patient care.

In several studies, concerns regarding mobile work phones were forcefully expressed by nurses. In the study by Klemets et al., a nurse describes how the mobile phone "takes out the communication" between her and the patient (2013, p. 331), while Kristiansen reports a nurse voicing the opinion that the mobile phone "has nothing to do inside a patient room" (2011, p. 4), and in McGillis et al. a nurse talks about "losing the moment" when interaction with a patient is interrupted by her mobile phone (2010, p. 173). Finally, in Richardson et al.'s study, a nurse echoed these concerns: "…it's like an invasion of what you're trying to do" (2008, p. 623). However, none of the studies examine the utterances in depth or what motivates them. Social science research, as outlined above, suggests that communication on mobile phones can change the way we interact with people in close physical proximity. In conjunction with the concerns raised by nurses, this opens up serious questions about what happens when mobile phones are implemented in the practices of nurses working in a hospital.

Despite the fact that hospital practices are technology-intensive, technology is often categorised as cold and opposed to the warmth of human care. Technologies are regarded as rational and purely instrumental, capable for instance of measuring blood pressure but unable to place a reassuring hand on the patient's shoulder during that process (Gammon, Sorlie, Bergvik, & Hoifodt, 1998). A general fear that technology is implemented at the cost of humans and will replace human contact is common (Pols & Moser, 2009). As described above, nursing is a "caring science" that is grounded in the relationship between nurse and patient. When with a patient, a nurse must be sensitive and responsive (Benner & Wrubel, 1989; Martinsen, 2010) and be fully present, using their senses and bodies to make a conscious effort to be with the patient (Martinsen & Eriksson, 2013). This theoretical background and the values of this relational perspective are embodied in nurses as they interact with patients. As Goffman advices, the nurse-patient relationship is like any relationship constituted by a series of interactions that each reaffirm and reconfigure the

relationship (Goffman, 1971); in every interactional sequence with a patient the nurse thus aims to construct and reinforce that relationship in accordance with nursing values.

Several of the studies above show that in every-day interactions people tend to respond immediately respond to the summons of the phone and retract themselves from the physical situation in order to manage the simultaneous conflicting demands for attention (see e.g., Ling, 2004). In doing so, they exclude others present from participation, defining them as secondary and non-significant (e.g., Gergen, 2002). It seems reasonable to assume that these findings are to some extent transmissible to other interpersonal interactions, including nurse-patient interactions. If that is indeed the case, nurses may find themselves acting in ways that make patients lose significance, which conflicts with nurses' core commitment to relational values. This tension might be what is reflected in the utterances by nurses in the studies on mobile phones; they find that their actions when handling mobile work phones impede successful therapeutic nurse-patient interactions. However, scholars have not yet explored whether these experiences accord with what actually takes place in such interactions. How nurses distribute their attention between physically present patients and mobile work phones has not been investigated, nor has it been revealed how nurses coordinate linguistic structures and bodily resources to execute coherent, intelligible courses of action in such situations. Hence, it remains unknown whether nurses add a secondary web of meaning to the interactions as they recreate them during interviews conducted after the interactions. Their utterances in interviews are processed representations of the actual interactions reconstructed by the nurses through a variety of interpretative devices that import meaning into the event. They may be influenced by normative values of nursing, by contrasting conceptions of cold technologies and warm care, and by their fragmented, unpredictable, and interruptive working conditions. There may also be a schism between what nurses think they do and what they actually do, as a large part of our embodied conduct is unconscious. The patients' perspectives on this issue have also not been obtained, although their experiences could reveal how they interpret and co-accomplish interactions between themselves, nurses, and mobile phones. There is a lack of knowledge about the concrete situated actions that take place when nurses, patients, and mobile phones interact; this thesis strives to help fill this gap in existing knowledge.

2.6. RESEARCH FOCI

The normative values of a caring relationship inherent in the nursing curriculum are clear; when caring for a patient, nurses need to make a conscious effort to be with the patient in a caritative spirit (Eriksson, 1998). They must be oriented towards the patient, use their senses perceptively (Martinsen, 1991), and be respectful of and

responsive to the patient (Benner et al., 1996). The empirical studies presented in Section 2.2.1 point to features that constitute a caring relationship, such as physical presence, demonstrating empathy or compassion, and building deep connections. They also point to features that make patients feel unsafe, like physical distance, rushing, and being unavailable. The issues around if and how nurses develop caring relationships with patients have not been adequately explored in studies taking actions rather than lived experiences as their point of departure. What happens when a mobile work phone becomes part of the interaction? Does the notion of care influence the way nurses use mobile work phones in interactions with patients? Does the involvement of a mobile work phone in interactions between nurses and patients hinder or even prevent nurses from displaying attributes that constitute care? Answers to these important questions from an interactional perspective are not yet available, so this thesis aims to answer them.

In exploring if and how nurses are able to enact care in interactions with patients and mobile work phones, this thesis studies the concrete, situated actions performed. The methods that nurses and patients use to create social order and accomplish interactions include an array of embodied communicative resources such as verbal production, gestures, posture, gaze, etc. Studying how nurses and patients choreograph their bodies in interactions with mobile work phones, how they distribute orientations, how they display attention and participation, etc., can provide insights about the intersubjectivity that they interactively accomplish. Hence, this thesis focuses on the micro actions that take place in interactions between nurses, patients, and mobile work phones in a hospital, with particular interest in the actions performed by nurses as on-going accomplishments of their practices.

A caring relationship constitutes a complex groundwork that is essential to patient experience, patient outcome, and to quality in treatment and care. Insights about how interactions unfold between nurses, patients, and mobile work phones can thus prove vital for on-going efforts to improve communication, patient compliance, patient satisfaction, and consequently to achieve the national goals of enhancing quality, improving patient experience, and operating efficiently.

In its efforts to generate knowledge about these concrete actions in clinical practices, this thesis is informed by ethnomethodology and nexus analysis, both of which seek to understand action and practices. As part of the field of practice theories, they provide the tools for this thesis to understand how the practices of nurses unfold in interactions with patients and mobile work phones. To generate this kind of knowledge, emergent actions of naturally occurring interactions between nurses, patients, and mobile phones are analysed in detail. A data corpus consisting of approximately 140 hours of video recordings from a Danish hospital was obtained for the analysis. In the following chapter, I elaborate on the theoretical and methodological deliberations of the research framework.

CHAPTER 3. A MULTIDISCIPLINARY RESEARCH FRAME

This chapter places this thesis within a theoretical and methodological frame. Initially I simply asked the question, "What happens when mobile work phones are introduced in the practices of nurses working in a hospital?" This question opened up a diversity of possible theoretical and methodological ways of studying the use of mobile work phones in hospitals. My focus is not to explore the possible inherent affordances and limitations of these devices, but rather to explore in detail how they participate in the building of interaction. From the very beginning I have been aware of the bias that my experience as a nurse could impose on the analysis in this thesis. It has thus been important to me not to impose any theoretical or methodological presumptions, but rather to favour an emic (Pike, 1967a) perspective with an analysis based on participants' situated understandings and what they, rather than I, consider relevant in the situation. In doing so, I found it necessary to construct a combination of theories and methods, proposed by Nicolini as a "package of theories and methods" (2012, p. 216). Theories and methods have thus been carefully selected on the basis of their capacity to analyse how interactions between nurses, patients and mobile phones unfold. However, as no interaction occurs in a vacuum, theories and methods with the capacity to analyse the historicity and sequence of interactions have also been chosen in the interest of understanding practices. Hence, I deliberately shift between theoretical and methodological sensitivities, which allows me to straddle the heterogeneous and subtle aspects involved in the complex, multi-actor, technology-mediated practices of nurses' use of mobile work phones.

Nursing science is a relatively young and limited academic discipline characterised by methodological rigor, which has been noted internationally (Freshwater & Rolfe, 2001; Rolfe, 1995) and nationally (Dreyer, Martinsen, Norlyk, & Haahr, 2014). As Chapter 2 revealed, phenomenological and hermeneutic perspectives are prevalent in nursing science, while ethnographic observations and interviews are commonly used methods. The two key phenomenological influences Edmund Husserl (1964) and Martin Heidegger (1962), aim to describe the lived experiences of everyday life as the consciousness encounters the world. The prevailing interpretative approach is hermeneutics, with Gadamer (1976) and Ricoeur (1981) serving as central figures. The analysis relies on the hermeneutic circle proceeding from naive understandings to explicit understandings that emerge from data interpretation. Hence, the analysis is a process that relies on the researcher's impressions, interpretations and reflections without having to bracket preconceptions and theories. This is incongruent with the emic perspective of this thesis, which explores how interactions between nurses, patients and mobile work phones are accomplished from the participants' perspective. To overcome this conflict a focus on the here-

and–now, moment-to-moment actions and the situated practices in which they occur is essential. I turned to practices theories, with their central interest in everyday practices; there I found the tools for understanding the practices of nurses from the participants' perspective, and for zooming in on the embodied intersubjectivity of their interaction. Practice theories have served as an epistemological mind-set, as a way of seeing the practices of nurses and making them visible.

3.1. PRACTICE THEORIES

Practice theories constitute a broad family of theoretical approaches taken by a multitude of social theorists with varying theoretical origins. Reckwitz (2002) and Nicolini (2013) outline how elements of practice theories can be found in the work of Schatzki, Bourdieu, Giddens, the late work of Foucault, Garfinkel and Latour, among many others, and show how these theorists, despite their differences, form a conceptual alternative to more classical types of social theory: "they all highlight the significance of shared or collective symbolic structures of knowledge in order to grasp both action and social order" (Reckwitz 2002, p. 246).

Practice theories understand human action and social order as embedded in a common knowledge which enables a socially shared way of ascribing meaning to the world. Inspired by Mead's critique of methodological individualism, they take the position that social action is not the product of the individual mind: "[…] throughout the entire process of an interaction, we analyse the incipient actions of others by our own instinctive reactions to changes in their posture and other signs of developing social actions" (Mead, 1909).

Practice theories are thus fundamentally processual and tend to see the world as an on-going accomplishment. This thesis stands opposed to more purpose-oriented or norm-driven ways of explaining human action as a product of single interests or mutual normative expectations. The scope is to explore the practices of nurses through the actual doings of nurses, and as an on-going collective accomplishment.

Practice theories also highlight the crucial role which the body and material things play in this accomplishment:

> A "practice" (*Praktik*) is a routinized type of behaviour which consists of several elements, interconnected to one other: forms of bodily activities, forms of mental activities, "things" and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge.
>
> (Reckwitz, 2002, p. 249)

The routinized actions constituting a practice are themselves bodily performances, which are connected with knowledge, interpretation, aims, emotions, etc. Hence, the body is not an instrument which an agent uses to act; rather, practices are routinized activities inscribed in the habituated body of the person carrying out the practice (Bourdieu, 1977). Furthermore, practice theories understand the relationship between practices and their material conditions to be reciprocal, with objects participating in the accomplishment of practices and connecting them with other practices through time and space (Schatzki, 2002). Hence, practice theories offer a remedy for endurable dualisms between mind and body and between the social and the material.

In line with practice theories, this thesis understands practices as routinized activities of the body so that nurses' practices are routinized ways in which they move their bodies, handle objects, treat subjects, describe things, and understand the world. Each practice is a multitude of single actions reproducing that practice and forming patterns, and each practice depends on the specific interconnectedness of the actions constituting it. Every nurse is a carrier of practices, a unique crossing point of multiple bodily and mental routines, and a nexus of multiple practices with a focus on the horizon of intelligible actions made available to him or her.

3.2. ZOOMING IN AND OUT

In order to achieve nuanced understandings of the complex, multi-actor, technology-mediated practices of nurses, I mobilize several strands of practice theories to explore nurses' practices and bring the power of multiple perspectives into a coherent, practical package of theory and method. Switching between theoretical sensitivities and exploiting the strengths of various theories allows me to analyse the many dimensions and complex interrelationships of the interactions between nurses, patients, and mobile work phones. This line of thought is inspired by Nicolini, who advocates that researchers employ a package of theories and methods to provide richer understandings of practices (2009, 2013):

> Put another way, to the extent that practice is a multifaceted and multidimensional phenomenon, it can only be empirically approached through toolkit logic and a collage or heteroglossia, or even carnivalesque, approach.
>
> (Nicolini, 2013, p. 215)

Nicolini proposes a theory-method package as a way for the researcher to be able to shift analytical lenses, foregrounding certain aspects of a practice as others are backgrounded to achieve richer understandings and thicker accounts of the practice (2009, 2013). Therefore, interactions between nurses, patients, and mobile work

phones cannot be understood by inspecting solely concrete actions in their local ecology; rather, they can only be understood as material and human agencies that form interdependencies in a nexus of connections. To understand practices, Nicolini offers the concept of zooming in and zooming out to describe how analytical lenses are switched, zooming in on the local accomplishment of practices and zooming out on the ways in which they are associated in time and space (2009, 2013). This means that to generate understandings about the practices of nurses' use of mobile work phones, this thesis must capture not only the actual work that goes on, but also appreciate that the actions of nurses do not happen in isolation. To enrich my understanding of the practices of nurses, I follow Nicolini by alternating between zooming in on the situated interactions between nurses, patients, and mobile work phones and zooming out to transcend the boundaries of the incidental and look at the influences shaping the interactions.

Zooming in on the situated accomplishment of interactions between nurses, patients, and mobile work phones requires theories and methods that are sensitive to their material and embodied nature. To get close to the interactions, I draw on the wisdom and toolkit of ethnomethodology (Garfinkel, 1967) and ethnomethodologically inspired approaches such as conversation analysis (Sacks, Schegloff, & Jefferson, 1974) and interaction analysis (Jordan & Henderson, 1995; Streeck, C. Goodwin, & LeBaron, 2011). A data corpus consisting of approximately 144 hours of video recordings in a Danish hospital was obtained to achieve this goal.

Zooming out on the relationship between practices in time and space demands theories and methods that are able to trace their interconnectedness. For this, I rely on nexus analysis (R. Scollon & S. W. Scollon, 2004), a theoretical and methodological research framework based on ethnographic and discursive perspectives. Like Nicolini's approach, nexus analysis aims to connect the situated social action with the elsewhere-and-then by including the many dimensions and complex interrelationships of social action in the analysis:

> We believe that the broader social issues are ultimately grounded in the micro actions of social interaction and, conversely, the most mundane of micro-actions are nexus through which the largest cycles of social organization and activity circulate.
>
> (R. Scollon & S. W. Scollon, 2004, p. 8)

Nexus analysis thus not only entails a close empirical examination of the moment under examination, but also performs a widening ethnographic circumferencing that includes historical, discursive, and cultural analyses of the trajectories intersecting the moment. The ethnographic and discursive tools of inquiry provided by nexus analysis permit the researcher to shadow the practices under study and uncover connections by mapping the semiotic cycles circulating in the moments of interaction. This has similarities with the way that Nicolini follows the

intermediaries of practices in time and space, and to perform this analytic manoeuvre, the data corpus was augmented with photos, documents, webpages, interviews, observations, etc.

My package of theories and methods thus draws on two stands within practice theories. For the manoeuvre of zooming in, this thesis takes its origin in Garfinkel and ethnomethodology, following this thread into conversation analysis and interaction analysis. For zooming out, this thesis takes Ron Scollon as a point of departure and follows him through critical discourse analysis, mediated discourse analysis, nexus analysis and multimodal analysis. In order for theories and methods to work together, they obviously must share coherent ontological and epistemological assumptions, and I account for the internal consistency of my research package in the following sections. I begin by introducing ethnomethodology, followed by conversation analysis and interaction analysis. Subsequently, I describe nexus analysis as the culmination of Ron Scollon's lifelong work. This is followed by a section on mediated discourse analysis being the precursor of nexus analysis, after which come sections on critical discourse analysis, and multimodal analysis to which Scollon's work has also contributed.

The following sections are not to be seen as comprehensive expositions of approaches informing this thesis; rather, for the sake of clarity, they are confined to brief introductions of their theoretical origins and inter-connectedness. For instance, neither Parson's thinking nor Wittgenstein's language games are discussed in the section on ethnomethodology, although they both had substantial influence on Garfinkel's development of ethnomethodology.

3.3. ETHNOMETHODOLOGY

Ethnomethodology was coined by the American sociologist Harold Garfinkel, who undermined the prevailing preoccupations with scientific explanations of how social order was constituted. Inspired by phenomenologists such as Schutz and Husserl (Husserl, 1964; Schutz, 1962; 1964), Garfinkel shifted the attention from the problem of social order to the production of social order. Proposing that members are not simply *in* social settings but rather *do* those settings, he developed ethnomethodology as a way of studying people's methods for performing everyday social order (Garfinkel, 1967). Hence, ethnomethodology attempts to describe how social order is mutually accomplished on the basis of members' experience, without developing or becoming bogged down in causal theories of explanation:

> I use the term "ethnomethodology" to refer to the investigation of the rational properties of indexical expressions and other practical actions as contingent ongoing accomplishments of organized artful practices of everyday life.
>
> (Garfinkel, 1967, p. 11)

Garfinkel takes as his focal point the practices of everyday life, emphasising an empirical rather than a philosophical approach to analysis. He echoes Schutz in bridging phenomenological philosophy and sociology (Heritage, 2013). Empirical data is not understood as empirical evidence of an external world; rather, it is understood as an intelligible constituent of a world inhabited by both actors and analyst. Ethnomethodology takes an interest in the practical and common-sense elements of every-day interactions which are often neglected or "seen but unnoticed". The inherent features of "accountability" and "intelligibility" are central to Garfinkel's empirical work on everyday practices (Heritage, 1984, p. 5). In Garfinkel's understanding, accountability not only entails that actors are responsible for their actions and may be called upon to provide an explanation, but also means that all behaviour is designed to give an account of that action (Garfinkel, 1967). The actions that people take in order to produce and manage a social setting are thus identical with the actions they perform to make a setting accountable. Actions produce their own sense, as they are designed to be recognisable for what they are, and their interpretation rests on the co-actor's ability to infer their sense: "when I speak of accountable my interests are directed to such matters as the following. I mean observable-and-reportable, i.e. available to members as situated practices of looking-and-telling" (Garfinkel, 1967, p. 1).

Members' production of accounts is observable and available for analysis when they show each other through their actions how they understand the situation and how their actions are meant to be understood. According to Garfinkel, the accomplishment of sense in everyday practices consists of: "[…] members' uses of concerted everyday activities as methods with which to recognize and demonstrate […] the rational properties of indexical expressions and indexical actions" (Garfinkel, 1967, p. 10). Ethnomethodology thus understands members' methods as encompassing both spoken and unspoken elements, so the methods with which members accomplish understanding in interaction include bodily performances (Cicourel, 1974; Psathas, 1977). Heritage makes a similar point: "Social actions do not have to be baptised with language for their intelligibility and implicativeness to be available to the participants" (Heritage, 1987, p. 249). In other words, accountability does not necessarily refer to verbal acts, but is also manifest in bodily movements and the manipulations of objects, tools, and technologies. Heritage outlines how interaction cannot be analysed by applying a predefined set of rules; rather, analysis must take participants' methods of practical reasoning as its point of origin (1984, p. 6). Ethnomethodologists thus frequently use audio or video

recordings in their empirical investigations of human activities, because permanent records of members' actions allow for extended, careful analysis. However, ethnomethodology does not provide a strict social scientific methodology with an obligatory set of methods. Rather, it emphasizes that any research method can be used, as long as it is adequate to the phenomenon under study.

Ethnomethodology has informed my approach to zooming in on the actions of nurses and patients in interactions. It has guided my way of seeing and analysing their interactions by providing me with valuable insights on how social order is accomplished, recognized, and made visible. I rely on ethnomethodology to make visible what nurses and patients do in concrete interactions, the methods they use when acting, and the patterns that emerge. Hence, the epistemological assumptions of ethnomethodology have served as a guide to uncover aspects of interactions between nurses, patients, and mobile work phones, that may be taken for granted, and to make visible the perceptible but unnoticed subtleties, all in accord with the emic perspective of this thesis.

3.4. CONVERSATION ANALYSIS

Ethnomethodology forms the basis of the sociological method known as conversation analysis, developed by Harvey Sacks, Emmanuel Schegloff, and Gail Jefferson (Sacks et al., 1974). In addressing the perspective of intersubjectivity, conversation analysis also takes inspiration from Goffmann's work on interaction order (Goffman, 1974) and his approach to studying sense-making and social organization without making claims about what is in an individual's mind. Conversation analysis built on Garfinkel's work by showing how it is possible to analyse the situated achievement of intersubjectivity by focusing on the sequential organization of talk. The analysis relies on the moment-to-moment verbal and embodied conduct of participants to demonstrate their understanding of a prior action in their next action (Schegloff, 2007). Actions are shaped by the actions that precede them and shape the actions that follow. By analysing how participants orient themselves to such details of interaction and how they are consequential for their conduct, conversation analysis reveals how actions are locally situated and produced, as Garfinkel advocates.

Conversation analysis has grown into a broad multidisciplinary field encompassing a wide range of topics and interests within linguistics and sociology. Traditionally, conversation analysis emphasised the spoken word in studying the methods of shared meaning and action in human interaction. This emphasis was not adopted in ethnomethodology, in which the accomplishment of sense in everyday practices consists of both indexical expressions and indexical actions, as described above. Although some linguists using conversation analysis continue to focus their research

on talk, verbal exchange is no longer considered to be the sole or even primary component of meaningful interaction:

> Conversation analysts cannot disassociate themselves from language or culture or gesture or posture or facial displays without violating the integrity of their undertaking. Their undertaking is defined by a domain of naturally occurring events – talk and other conduct in interaction; that undertaking is committed to the study of any observable doings that are treated as relevant by the parties to those interactions.
>
> (Schegloff, 2005, p. 456)

In order to study social action, it is necessary to include not only the full array of visible and audible communicative resources such as gesture, grammar, prosody, and pragmatics, but also other features which the participants may orient to such as culture, social structure and material surroundings. This perspective has both enriched and complicated investigations and understandings of social interaction within branches of conversation analysis research, contributing extensively to the interdisciplinary field of interaction analysis.

Analysing nurses as they interact with others and with objects in their environment is not merely a matter of understanding what is said. Rather, the analysis of their interactions should uncover their methods for accomplishing intersubjectivity, including body movements or the manipulations of objects. In studying nurses' interactions, this thesis thus rejects the traditional exclusive focus on spoken language and includes the full range of representational and communicational semiotic resources for making meaning.

3.5. INTERACTION ANALYSIS

The interdisciplinary field of interaction analysis has developed into a distinctive method for the empirical investigation of human interaction (Jordan & Henderson, 1995; Streeck et al., 2011) from its roots in ethnography, sociolinguistics, ethnomethodology, and conversation analysis. The influence of linguistics, with its prioritising of language, and the artificial separation between verbal and non-verbal behaviour has been challenged since the 1970s. Goffmann in his frame analysis (1974), Kendon with his F-formation system (1976), and Goodwin with his study on gaze (C. Goodwin, 1979) are just a few of the early scholars who began to establish empirically how talk and embodied behaviour are interdependent phenomena. Understanding interaction as being inherently embodied renders visible the many crucial forms of semiotic fields, shaping communication and meaning-making in human interaction:

> Every single utterance using speech employs, in a completely integrated fashion, patterns of voicing and intonation, pausings and rhythmicities, which are manifested not only audibly, but kinetically as well, and always, as a part of this, there are movements of the eyes, the eyelids, the eyebrows, the brows, as well as the mouth, and patterns of action by the head. And there are, in addition, from time to time, variously conspicuous hand and forearm actions or "gestures" (as they are called – and which tend to receive the lion's share of academic attention), and also postural and orientational changes. All of these are produced in a fully integrated fashion and must be seen as inseparable components of the utterance as the utterer produces it.
>
> (Kendon, 2009, p. 363)

There has been a growing recognition of embodiment as a significant feature of social interaction, contributing to an "embodied turn" in the development and direction of research in social interaction (Haddington, Mondada, & Nevile, 2013; Nevile, 2015). Pioneering studies conducted by Goodwin (C. Goodwin, 1981), Heath (Heath, 1986), and Kendon (Kendon, 1990) draw attention to the way that body comportment is essential to the interactive organisation of participation. Numerous scholars since have demonstrated how different modalities work together to establish coherent courses of action. Representative influences are Schegloff, especially his term "body torque" (1998), Streeck's extensive research on gestures (2009) and Mondada's work on the relationship between language, embodiment, space, and mobility (2007a, 2009, 2011, 2012). Charles Goodwin has made a life-long contribution to the increasing awareness of embodied conduct in human interaction in several studies that elucidate the importance of including embodied features in analysing interaction (1981, 1994, 1995, 2000, 2007a, 2007b). Moving beyond the coordination of talk and embodied behaviour he considers the entire "contextual configuration" which also includes the social, cultural, material, and sequential structure of the environment. Understanding interaction in this vein, as outlined by Streeck, Goodwin and LeBaron (2011), demands that the interacting body cannot be separated from the material world, which also renders visible how environmental sources of meaning are drawn into the production of inter-subjective understanding: "[…] embodied interaction *in the material world*, which includes material objects and environments in the process of meaning making and action formation, is primary" (Streeck et al., 2011, p. 9).

Acknowledging that interaction is always intertwined with the environment means grasping that communicative acts can structure the semiotic and material environment and that environmental resources can be drawn into the production of intersubjective understanding. A pioneering study by Suchman demonstrating how users interact with a copy machine (1987) spurred a line of research into interaction with and through technology. Further inspired by workplace studies and science and technology studies, a growing body of research examined the accomplishment of

accountable actions in workplaces (Heath, Knoblauch, & Luff, 2000). The investigation of complex technological environments has turned out to be a substantial element in this line of research (e.g., C. Goodwin & M. H. Goodwin, 1996; Heath & Luff, 2000; Mondada, 2007b; Nevile, 2004), as have the ways that objects constitute and are constituted through interaction (e.g., Koschmann, LeBaron, C. Goodwin, & Feltovich, 2006; Nevile et al., 2014; Streeck, 1996; Turkle, 2007). However, very few of these studies have examined the practices of nurses.

Reflecting its foundation in practice theories, scholars within embodied interaction analysis reject meaning-making and intersubjectivity as products of the individual. As with the perspectives of ethnomethodology and nexus analysis, embodied interaction analysis taxes as axiomatic that knowledge and action are social in origin (Streeck et al., 2011). The self is mediated by interaction and is inextricably embedded in a community (Mead, 1934), which means that the knowledge and actions of nurses are situated in their interactions with others. As embodied interaction analysis grounds the theories of action and knowledge in empirical data and aims to identify regularities in the way people use interactional resources, the basic data for studying interactions between nurses and patients is consequently their naturally occurring interactions in all their detail. The present thesis subscribes and contributes to a growing body of embodied interaction studies as it explores the complexity of the nursing profession with a focus on how nurses and patients accomplish interaction when mobile phones are present and how nurses make use of material resources in changing contextual configurations (C. Goodwin, 2000).

3.6. NEXUS ANALYSIS

Nexus analysis, an approach to practice theory that takes action as the unit of analysis, was developed by Suzie and Ron Scollon, who drew on their own experiences of pioneering computer-mediated communication in Alaska in the late 1970s and early 1980s (R. Scollon & S. W. Scollon, 2004). With their interdisciplinary backgrounds in linguistic anthropology, interactional sociolinguistics, critical discourse analysis and intercultural communication (McIlvenny & Raudaskoski, 2009), Scollon and Scollon developed their theory in an attempt to connect the minutiae of everyday actions with the historical and sequential currents underlying those actions.

Scollon and Scollon perceive each action as a unique phenomenon which is always carried out via mediational means. They understand practices as the perception that an action is the repetition of another action, so that mediated actions realise a recognisable practice – a nexus of practice – which in nexus analysis is constituted by three semiotic cycles: interaction order, historical body, and discourses in place

(Scollon & Scollon, 2004), through which the inherent processual and interactional lens of Practice Theory becomes evident. Using the ethnomethodological understanding of interaction as a contingent ongoing accomplishment, this means that with nurses and patients acting in concert with each other (interaction order), with their bodies as an interactional resource (historical body), while circumferencing the social, cultural, material, and sequential structure of the environment (discourses in place), the nexus of practice I am studying is being continuously and recurrently accomplished.

As an ethnographic discursive theory of practice nexus analysis diverges from other discursive disciplines by not taking language as its central focus; rather, it is heavily influenced by Vygotsky's perspectives on socially, culturally and institutionally mediated actions (1978). Scollon and Scollon refer to Wertsch in explicating Vygotsky's work (Wertsch, 1998); Wertsch's thoughts have inspired their development of several central terms such as "mediated action" and "mediational means" (R. Scollon & S. W. Scollon, 2004, p. 181). In their development of nexus analysis, Scollon and Scollon are also indebted to numerous other theorists: Goffman on interaction order (1983), Gee on discourse (1996), Fairclough regarding technology (1996), Nishida for the term "historical body" (1958), Burke for his theory on motives (1945), Iedema for the term "resemiotization" (2003b), Lemke on timescales (2000), and Kress and van Leeuwen (2001) on multimodality. While the sheer number of theorists involved in inspiring the development of nexus analysis might seem chaotic Scollon and Scollon manage to reconcile these genealogies into a consistent theoretical, methodological, and empirical focus on mediated action as the unit of analysis:

> Indeed, one of the reasons for choosing mediated action as a unit of analysis is that it does not carve up phenomena into isolated disciplinary slices that cannot be combined into a more comprehensive whole. Because mediated action is grounded in an irreducible tension between elements, it is a unit that at least has the possibility of operating at the crossroads of various academic disciplines.
>
> (Wertsch, 1998, p. 179)

I follow Wertsch in considering the interdisciplinary origin of nexus analysis to be a strength in a framework that sets out to understand the many dimensions and complex relationships of social action. The pluralistic approach of nexus analysis resonates well with my aim to achieve nuanced understandings of what actually happens when nurses, patients, and mobile work phones participate in interaction. Nexus analysis takes in situ actions as its point of origin and strives to reveal all the aspects embedded in a situation to achieve the widest possible view of the historical, social, and cultural trajectories that shape it. This approach is highly compatible with Nicolini's analytical manoeuvre of zooming in and zooming out (2009, 2013), because the idea that different angles of interpretation frameworks are required to

appreciate why a practice is carried out in a certain way, how it came to be practiced this way, and what its effects are is implicit in the metaphor of zooming in and zooming out. Nexus analysis stands out for its willingness to incorporate an eclectic set of sensitizing concepts to zoom in on the situated accomplishment of interactions and zoom out to capture the interconnectedness of interactions, thus providing a multi-layered perspective which serve as the overall research framework of this thesis.

In Ron Scollon's understanding action is always mediated through semiotic resources that they call "mediational means", which can be either singular or plural and "is defined as the semiotic means through which a mediated action, that is any social action, is carried out" (2002, p. 148). Mediational means include not only abstract and cognitive systems of representations but also material objects; a virtually endless list of mediational means can be appropriated in any social action. These mediational means are always multiple in any given action and carry historical affordances and constraints, with Scollon pointing to the fact that, given the multiplicity of mediational means involved in any action, it is impossible to know a priori which mediational means are appropriated (R. Scollon, 2002). Scollon further insists that the characteristics of the mediational means appropriated in the interaction should be analysed with the relevant theories and methods (R. Scollon, 2002):

> The variety of things in the world which may be appropriated as mediational means is, in fact, nearly limitless and so there is, as I have said, no a priori means of knowing what kind of analysis or analytical framework will be most useful in analysing the mediational means in any specific case.
>
> (R. Scollon, 2002, p. 173)

As with the ethnomethodological freedom of analytical methods, this means that in a mediated discourse analysis or nexus analysis it is not possible beforehand to know what kind of analytic framework will be most useful for examining the relevant means of mediations. Mediated discourse analysis investigates the site of engagement to determine which mediational means are significant and thus relevant to include in the analysis; their semiotic characteristics then determine what analytical tools to use. The inherent multidisciplinarity and openness towards methodological issues makes nexus analysis a valuable framework for a variety of academic disciplines; reflected in the wide range of phenomena which nexus analysis has been used to study, including how young people use social media (M. C. Larsen, 2010), language acquisition in schools (Kuure et al., 2015), and identity making during phone calls (P. Raudaskoski, 2010). Further, nexus analysis resonates well with the emic perspective of this thesis; Scollon emphasises how it is impossible to know a priori what is relevant for analysis and which methods should

be applied. In nexus analysis it is the perspectives of the participants which determine what semiotic cycles are significant for study (R. Scollon & S.W. Scollon, 2004, p. 171), as the researcher works closely with the participants and focus on issues they find relevant. The perspective in ethnomethodology is slightly different; it studies how actors accomplish interaction and what is relevant to study in interactions is what the participants themselves treat as relevant (Garfinkel, 2002, p. 259).

3.7. MEDIATED DISCOURSE ANALYSIS

Nexus analysis is an advancement that builds on the mediated discourse analysis coined by Ron Scollon in the late 1990s. In their work, Scollon and Scollon have proven unafraid to revisit their own earlier work critically, so nexus analysis can be seen as an analytical tool of improved sensitivity, which transcends the boundaries of the incidental and addresses the structural issues and layered influences affecting it. Jones and Norris, both former students of Ron Scollon, have contributed to the development of mediated discourse analysis as an overarching interdisciplinary approach to discourse inspired by conversation analysis, ethnomethodology, linguistic anthropology, psychology, and sociolinguistics (Norris & Jones, 2005, p. 204). Nexus analysis was subsequently developed by Scollon and Scollon as a methodological enhancement of mediated discourse analysis, and has been adopted by Norris and Jones as "The method mediated discourse analysis uses to attempt to answer the theoretical questions about discourse and social action…" (Norris & Jones, 2005, p. 201).

Mediated discourse analysis was developed as an alternative to discursive approaches regarding social action as secondary and to social action approaches regarding discourse as secondary (R. Scollon, 2001b). Rather than privileging one or the other, mediated discourse analysis sees discourse as one of many tools available for taking action and aims to preserve the complexity of social situations (R. Scollon, 2001a): it "takes as its unit of analysis the *action*, more specifically, the *mediated* action, which is the real time moment when mediational means, social actors and the sociocultural environment intersect" (Norris & Jones, 2005, p. 5).

Mediated discourse analysis is influenced by James Wertsch (1998), the American psychologist who built on Lev Vygotsky's (1978) perspectives on social, cultural, and institutional mediated actions. Wertsch emphasises that all actions are mediated through "cultural tools": objects, technologies, practices, identities, social institutions, communities, language, and other semiotic systems (1998). All of these tools come with a history which shapes what can and cannot be done with them. The affordances and constraints embodied in the tools, however, do not and cannot determine what social actors do with them or how they are appropriated:

> The essence of mediated action is that it involves the tension between the mediational means as provided in the sociocultural setting, and the unique contextualized use of these means in carrying out particular, concrete actions. In this view, any attempt to reduce this basic unit of analysis to the mediational means or to the individual in isolation is misguided.
>
> (Wertsch, 1994, p. 205)

Wertsch underlines the unresolvable dialectic between action and mediational means by which actions are accomplished. Focusing on the tension between an agent acting with mediational means stands opposite methodological individualism, as this perspective includes other elements, dimensions, and relationships by linking the action with the historical, cultural, and institutional context in which the action occurs. Wertsch is informed by Vygotsky (1978) in his description of how the actions that people take are transformed by the tools they use, while the tools are transformed by the actions in which they are used. Wertsch also cites Bakhtin to make clear that we never speak with a voice of our own, but borrow and ventriloquate the voices of others (1981). While mediated discourse analysis shares the broad outlines of these perspectives on the relationship between discourse and action, it moves further in the attempt to develop a theory that can account for the complex role that discourse plays in social action. To do so, mediated discourse analysis draws on theories focusing on discourse as action, such as Wittgenstein's theory of language as series of games (1958), speech act theory (Austin, 1962; Searle, 1969), systemic functional grammar (Halliday, 1973), and ethnomethodology (Garfinkel, 1967).

Both mediated discourse analysis and nexus analysis hold that if we analyse only the discourse – the written text or the spoken word – we will understand very little of what is actually going on in social situations, because "meaning" does not reside solely in discourse, but encompasses the actions that people undertake with it (Norris & Jones, 2005, p. 4). Reflecting Nishida (1958), Bateson (1972), and Bourdieu (1977), Scollon and Scollon believe that social action is based in the habitus, will, and judgement of practice, not in rational and logic analysis:

> MDA takes the position that whatever it is that people say in and about their actions, these discourses are not likely ever to grasp the bases in habitus for these actions which are largely outside of the awareness of social actors.
>
> (R. Scollon, 2002, p. 145)

Ron Scollon thus takes the position that we cannot take a piece of text like a transcript of a conversation and draw any direct interpretation of the social actions

that led to its interpretation. He criticises theories of language and discourse such as interactional sociolinguistics and critical discourse analysis for beginning with an interest in social action but ending up analysing text in practice (R. Scollon, 2002, p. 143). Other aspects of social action and other mediational means than language and discourse are backgrounded as part of the "context" rather than being included in the analysis. Ron Scollon emphasises that, although we might need to use text as a means to represent an action, these descriptions will always under-represent the meaning present in the actions (R. Scollon, 2002, p. 144). This perspective makes sense when we observe nurses' interactions with patients and mobile work phones. A nurse answering the phone in the midst of an interaction with a patient is performing a mediated action, which itself depends on several other mediated actions: the summons produced by the phone, the way the phone was designed, the patient's response to the ringing phone, the person making the call, etc. Nexus analysis puts the focus on the mediated actions that are part of multiple practices that intersect in a unique moment in time while still accounting for how discourse is relevant to these actions. If we look only at discourse, as in transcripts of what nurses and patients say in and about their interactions, we would miss out on mediational means and actions that are not part of that discourse but are nevertheless an important part of the way that nurses produce the habitus and histories of their daily lives. Hence, routinized micro actions may be significant in order to link the dialectic between the actions themselves and the mediational means with which they are accomplished.

3.8. CRITICAL DISCOURSE ANALYSIS

Despite his concerns about critical discourse analysis, Ron Scollon did consider it to be related to mediated discourse analysis and nexus analysis (2002, p. 141), as critical discourse analysis also takes the position that social action and discourse are inextricably linked (Fairclough & Chouliaraki, 1999). It regards discourse as a form of social action, not focusing solely on the written or spoken text but also including the social processes and structures of its production and interpretation (Fairclough, 1993b). Mediated discourse analysis and nexus analysis share many of the goals of critical discourse analysis and conform to most of the eight-point programme put forward by Fairclough and Wodak (1997) to define critical discourse analysis:

1. It addresses social problems;
2. Power relations are discursive;
3. Discourse constitutes society and culture;
4. Discourse does ideological work;
5. Discourse is historical;
6. The link between text and society is mediated;
7. Discourse analysis is interpretive and explanatory;
8. Discourse is a form of social action.

Ron Scollon, however, does not agree with the claim in critical discourse analysis that power relations are discursive; rather, he sees them as grounded in practice (2002). This means that discursive practice is just one form of social practice, not a fundamental practice through which society is constituted. Mediated discourse analysis thus also departs from the critical discourse analysis claim that discourse constitutes society and culture.

Another divergence between critical discourse analysis and mediated discourse analysis is their difference in focus. The former concentrates on discursive events as instances of language use, discursive practice, and social practice (Fairclough, 1993a). Mediated discourse analysis, meanwhile, takes mediated action as its point of departure and only includes discourse in analysing an action if it is understood to be involved as a means of mediation:

> A [*sic*] MDA view would not assume a priori that any particular texts or any particular mediational means, speaking more generally, are significant, but use the overall research problem to guide the selection of mediational means for analysis.
>
> (R. Scollon, 2002, p. 173)

Hence, mediated discourse analysis is by no means merely a branch of critical discourse analysis because it does not share the purpose of critically analysing discourse. However, there are many cases in which the two disciplines will be closely related as discourse is often used to take action and is thus relevant for inclusion as a mediational means in mediated discourse analysis. Advocates of mediated discourse analysis criticise critical discourse analysis for not being able to establish the links between discourses and social actions (Norris & Jones, 2005; R. Scollon, 2001b), a problem of mediation that has also been acknowledged by scholars of critical discourse analysis themselves (Meyer, 2002; Wodak, 2002). What can be analysed from the discourse may have very little to do with the way it is being used to take action so it is not always possible to read social actions from discourse. In response mediated discourse analysis takes it as its central task to elucidate the complex linkages between discourse and action by analysing the dialectic relationship between the action and the multiple mediational means that are appropriated to accomplish the action.

3.9. MULTIMODAL ANALYSIS

Efforts to make discourse analysis sensitive to multiple modalities of meaning-making are growing worldwide (Iedema, 2003a; Jewitt, 2014; Kress & Van Leeuwen, 2001; Norris & Jones, 2005). Nexus analysis also contributes to the interdisciplinary discursive field of multimodal analysis, which has developed

around the assumptions that all communicative events are discursively shaped and that all modes offer means for the expression of discourse. Although language often plays a central role, multimodal analysis insists that all modes are considered juxtaposed in the analysis of human interaction, and that the interplay between them is central to meaning-making (Jewitt, 2014). Hence, multimodal analysis is not simply a rephrasing of non-verbal communication and an attempt to place language on the side-line. By contrast, scholars of multimodal analysis have amply demonstrated that language is a rich source of analysis within multimodality (Kress & Van Leeuwen, 2001). Understanding human interaction as more than language and rejecting the traditional conjunction of language and communication, multimodal analysis incorporates the full range of semiotic and communicative modes in the analysis of interaction, and treats the choice of mode as itself significant: "The meanings in any mode are always interwoven with the meanings made with those of all other modes co-present and 'co-operating' in the communicative event." (Jewitt, 2014, p. 16).

Kress and Van Leeuwen (2001) have made a substantial contribution to this interdisciplinary field in studies mapping and describing semiotic resources and their use for articulating discourses: "Semiotic resources are the actions, materials and artefacts we use for communicative purposes […] together with the ways in which these resources can be organized" (Van Leeuwen, 2005, p. 285). Hence, multimodal analysis differs from traditional semiotics in the way that semiotic resources are understood; they are not a stable system of rules but are socially made and changeable in interaction, reflecting the influence of social semiotic theory (Halliday, 1978). Multimodal analysis also links to critical discourse analysis, especially through the work of Chouliaraki, who investigates the multimodality of new media discourses (2010). It is also linked to mediated discourse analysis and nexus analysis through the work of Norris. As a co-developer of mediated discourse analysis she has moved on to incorporate discourse analysis, interactional sociolinguistics and multimodality in her development of a methodological framework for multimodal analysis of human interaction (2004). In this framework, Norris analyses embodied (language, gesture, etc.) and disembodied (the material world) modes of communication in conjunction with modal density, levels of attention, and semantic structuring devises. In her distinction between embodied and disembodied modes Norris emphasizes that all modes are of equal value and can each play a subordinate, equal, or superordinate role depending on the specific case of interaction (2004).

3.10. RESEARCH PERSPECTIVE

Most discursive traditions are grounded in social constructionism, assuming that the way we understand the world is historically and culturally specific and that knowledge is constructed in social processes (Burr, 2015). This means that language plays a central role in constructing both knowledge and the social world; in the most relativistic perspectives, nothing exists except as it exists in discourse (e.g., Gergen, 1985; Laclau & Mouffe, 1985). Early conceptualisations of discourse analysis focused mainly on language as text, but the focus has now shifted to language in use. Building on efforts from several countries to make discourse analysis sensitive to multiple modalities of meaning-making (Haddington et al., 2013; Iedema, 2003a; Kress & Van Leeuwen, 2001; Norris & Jones, 2005; Streeck et al., 2011), this thesis moves beyond a linguistic perspective on language in use and focuses on discourse as action in a social context.

To achieve this goal, the thesis relies on two strands of discourse analysis approaches which regard language in use to be constructed across multiple modes of embodied communication and to include contextual phenomena, such as objects or physical spaces, in which discursive actions are carried out. For zooming in on the situated accomplishment of interactions between nurses, patients, and mobile work phones this thesis draw on ethnomethodology and ethnomethodologically inspired approaches that take an interest in the practices of conduct. As we are always doing things with our words, it is not so much about analysing what people say they do, but rather analysing their actual doings in interaction with the surroundings. Hence, these approaches disassociate themselves from a linguistic emphasis on discourse as language structure, regarding discourse instead to be a kind of social action. For zooming out on the relationship between practices in time and space, this thesis further relies on mediated discourse Analysis and nexus analysis, in which the object of study is reformulated from a focus on discourses of social issues to a focus on social action. This refocus is significant because the discourses which are relevant to a moment of action are often displaced from that action across a variety of times, places, persons, and objects (Bhatia, Flowerdew, & Jones, 2008). Mediated discourse analysis and nexus analysis understand discursive practices to be merely one out of several forms of social practices that shape the social world, and conceive the relationship between discourses, actions, and materiality to be contingent:

> MDA sees discourse as “cycling” through social actions: verbal and textual tools working their way into practices, material objects, and the built environments in which we interact. Those same practices, objects and environments then reproduce spoken and written texts.
>
> (Norris & Jones, 2005, p. 9)

It follows from this that discourse and the social world inevitably shape each other and that phenomena must be understood as both discursive and physical constructions. Although discourses are part of the construction of reality, there is also a physical reality that plays an important role. Approaches informed by Ethnomethodology regard embodiment and the material surroundings as meaningful, constitutive elements of interaction, which means that places, objects, and bodies are understood to be both already existing and in situ emerging in a cooperative accomplishment of action.

This thesis acknowledges the emergent nature of any situation, with entities such as culture, society, organisations, and identity appearing through entangled and layered practices that take place in concrete circumstances. From this, it follows that detailed empirical descriptions are basic, so this thesis relies on ethnographic investigations of natural occurring social action. It further takes the position that embodied participation in material settings is not just accomplished locally but transcends the here-and-now situation and connects to different times and places. This is coherent with approaches informed by both ethnomethodology and mediated discourse analysis which appreciate that what we do in a moment of action depends on what has gone before, which in turn entails that what we do shape future actions. Interactions between nurses, patients, and mobile work phones are thus approached as situations in which material settings and embodied actions enable or constrain possibilities for participation by building on the past and making of closing off possible futures.

The basic ambition of this thesis is to study the heterogeneous and subtle aspects involved in the complex, multi-actor, technology-mediated practices of nurses using mobile work phones in hospitals. Reflecting on the toolkit logic of Nicolini (2009,2013), made it necessary to construct a research framework drawing on multiple theories and methods in order to reveal multiple dimensions and give voice to more aspects of these interactions. By this I do not mean to insinuate that I as a researcher uphold a distanced and objective analytical perspective on the empirical data and regard the phenomenon under study as a discovery to be made in a one-way process. Rather, following Scollon and Garfinkel, I acknowledge a dialectic relationship between the real world and the human, epistemological construction of it (R. Scollon, 2003) and the researcher as an integral feature of the creation of "one out of alternative [*sic*] empirically possible worlds" (Garfinkel, 1967, p. 274). Hence, the theories and concepts constituting my research frame are continuously constructed in my interaction with the phenomenon I study, and their construction changes as I bring them into use and reflect on practice. This means that as a researcher I am contributing to the phenomenon of interactions between nurses, patients, and mobile work phones, as is detailed below when my participation in the practices under study is described.

The specific combination of theories and concepts that frame this have been shaped by my research practice for this particular inquiry. In order to create a clear overview, I have avoided going into too much detail when it comes to mutual interrelationships between theories and methods. Instead, the interconnectedness of central understandings and concepts are touched upon in the next chapter, as I provide a thorough exposition of nexus analysis as the overall research framework of this thesis.

CHAPTER 4. NEXUS ANALYSIS

In this chapter I present nexus analysis in greater detail outlining how its positions and concepts relate to other scholars and to the present study. Scollon and Scollon situate action in a unique historical moment and material space, a "site of engagement" where separate practices come together in real time to form an action (2004, p. 12). In these sites of engagement, they observe social actions and explore which mediational means are at work and how specific systems of relevance and rules of attention make certain practices more prominent while putting others in the background:

> Our interest as ethnographers is in social action and so for us a nexus analysis is the mapping of semiotic cycles of people, discourses, places, and mediational means involved in the social actions we are studying.
>
> (R. Scollon & S. W. Scollon, 2004, p. viii)

The task in nexus analysis is to identify the crucial mediated actions and then to map the cycles of the people, places, discourses, and mediational means circulating through that unique historical moment and material space in which the social action takes place.

4.1. DISCOURSE

Despite taking social action rather than discourse as the a priori base of mediated discourse analysis, Scollon does have an abiding interest in discourse, as is clear by the middle word in his term mediated d*iscourse a*nalysis (R. Scollon, 2002, p. 145). He considers the actions of individuals to be nexuses in which everything relevant about the realities of being human are joined and transformed from mere potential to actual occurrence (R. Scollon, 2013, p. 192). Hence, the majority of social actions involve discourse in some important way. In the narrowest sense, Scollon and Scollon take discourse to mean "the ways in which people engage each other in communication" (2004, p. 4), but in recognition of Gee's insights, they understand discourse at two levels of meaning: lower-case *d* discourse as situated language in use and the higher-level upper-case *D* Discourses:

> "Discourses" with a capital "D," that is, different ways in which we humans integrate language with non-language "stuff," such as different ways of thinking, acting, interacting, valuing, feeling, believing, and using symbols, tools, and objects in the right places and at the right times

> so as to enact and recognize different identities and activities, give the material world certain meanings, distribute social goods in a certain way, make certain sorts of meaningful connections in our experience, and privilege certain symbol systems and ways of knowing over others.
>
> (Gee, 1999, p. 13)

Although in significant agreement with Gee, Scollon and Scollon do not differentiate between discourse and Discourse in their work, as they regard confusion about the levels of discourse to be rare (R. Scollon & S. W. Scollon, 2004, p. 4). Instead they unify the two levels of discourse analysis, as they believe that the broader social issues are ultimately grounded in micro actions and that even the most mundane micro action is a nexus through which the largest cycles of social organisation ultimately circulate (R. Scollon & S. W. Scollon, 2004, p. 8):

> When we try to focus on these broader discourses – academic discourse and legal system discourse – we find that there are very complex differences in actual practices depending on either the historical bodies which come into these interactions or the technological mediations, or, in fact both of these factors as well as many others we have not had the space to discuss.
>
> (R. Scollon & S. W. Scollon, 2004, p. 90)

This does not contradict Gee, who also understands lower-case *d* discourses and upper-case *D* discourses to be linked (1999); however, Scollon and Scollon rely on Blommaert, who prefers the more general term "semiotics": "Discourse to me comprises all forms of meaningful semiotic human activity seen in connection with social cultural and historical patterns and developments of use" (Blommaert, 2005, p. 3). Like Blommaert and Scollon and Scollon, this thesis is interested in both discourse in the sense of multiple modalities of concrete here-and-now meaning-making and in discourse as broader social and cultural resources of meaning-making. Nurses working in a hospital, for instance, are influenced by the discourses of the nursing curriculum and the healthcare system. However, their practices are also influenced by their historical bodies and the numerous other factors shaping their actions. In understanding the concrete ways in which patients, nurses, and mobile work phones engage each other in communication to be constituted by broader social cultural and historical patterns, this thesis aims to analyse the linkages and relationships between the various levels of meaning-making.

Regardless of level, Scollon and Scollon understand all discourse to rely on some enabling technology (2004, p. 3). By technology they refer not only to obviously technical artefacts but also to a wide range of material supports, extensions from the structures of the built environment, and the media with which communication moves across time and space. New media technologies such as computers and mobile

phones remain very visible in our lives, as they are still fairly new and rapidly evolving. Technologies like pens or printed texts, by contrast, are naturalised to the point where we have lost our memory of implementing these technologies, a process Bourdieu calls "genesis amnesia" (1977). Technologies of face-to-face interaction such as eye gaze or exchange of turns are even more fundamental and are not even recognised as such. Both the discourse of situated language use and discourse in the broader sense are inseparable from the underpinning technologies, which means that a change in any of them entails a change in the other (R. Scollon & S. W. Scollon, 2004, p. 7). As the mobile work phone has only recently made its way into hospitals, it is therefore highly visible in the practices of nurses, as for instance I noticed it in the opening narrative. This change in a supporting technology will, according to Scollon and Scollon's understanding, inevitably lead to a change in the discourse itself.

4.2. CIRCUMFERENCING

In nexus analysis microscopic observations and analysis of action are placed against social, cultural, and historical currents. This entails mapping the semiotic cycles of people, discourses, places, and mediational means involved in the social action under study. These semiotic cycles are each followed both backwards and forwards in time on the various timescales on which they are based. Drawing on Burke (1945), Scollon and Scollon use the term "circumferences" to describe these contexts of varying scope: "The idea of 'circumferencing' the action you are studying is to try to follow the circumference for each cycle far enough that you can include the most important elements that give meaning to the action" (2004, p. 171). By timescales, Scollon and Scollon do not refer to the objective time of a calendar, but ask the discursive question of how the timescales on which the semiotic cycles operate are constructed by the participants in an action. This analytical manoeuvre opens up a wide range of interests around the action being studied that are more comprehensive that would be possible for any researcher to investigate fully. Hence, the researcher must focus on crucial points in the cycles of discourse where changes or linkages occur, while at the same time remaining alert to cycles of discourses being invisible in the moment of action. Seen in a broader scope, cycles of discourses may be active moments in the overall semiotic ecosystem.

Scollon and Scollon emphasise how no action takes place in a social and political vacuum (2004, p. viii); consequently, they aim to include the widest possible circumferences in their analysis. They join Blommaert in criticising other discursive disciplines such as critical discourse analysis for their tendency to ground analysis in concrete texts despite claiming to include sociocultural or historical contexts (R. Scollon & S. W. Scollon, 2001, p. 538). Furthermore, from the perspective of

critical discourse analysis, context is separate from the analysed text, relegating it to being a background or a frame described in the analysis:

> "We are not informed about where such crucial ethnographic information comes from. This is the "context" for the rest of the analysis, and this context is offered as an unquestionable, untheorized set of "facts". The source of such contextual accounts is often obliquely referred to as on-site observation and interviewing (again, untheorized and without discussing any explicit procedures). Their function, however, is crucial: they are central contextualizing features that allow for claims about an "insiders' perspective" (Wodak, 1997, p. 178) on the communication patterns studied in CDA.
>
> (Blommaert, 2001, p. 16)

Blommaert's critique of the ethnographic basis of claims being placed outside the scope of critical discourse analysis underpins the benefits of a theoretical and methodological framework like nexus analysis, which combines discourse analysis with a strong emphasis on ethnographic fieldwork and the gathering of empirical data. Scollon and Scollon do not use the word "context" themselves, but speak instead about circumferencing the sites of engagement by asking about its past, its direction in the future, and its expanding circles of engagement with others near and far (R. Scollon & S. W. Scollon, 2004, p. 10). Rather than understanding actions to take place in a separable, stable, delineating context, they consider the circumferences in which the action operates to be interactively constituted and arising from that action.

Like nexus analysis, the ethnomethodological perspective understands context not as a stable entity but as shaping the interaction while the interaction is itself shaping the context (Heritage, 2013). Goodwin terms this "contextual configurations", which is the full array of local semiotic fields (cf. Scollon & Scollon's "mediational means") made relevant by participants by orienting to them. As participants take action, semiotic fields are added as relevant while others are treated as no longer relevant, from which it follows that contextual configurations change continuously as they frame and constitute actions. The ethnomethodological approach thus understands context not as a describable setting but rather as an accomplishment in which members of an interaction draw on background knowledge and common-sense understandings to achieve intersubjectivity.

The analytical implication for this thesis is that interactions between nurses, patients, and mobile work phones do not take place in a definable context that is described and used as a frame for the analysis. Rather, the thesis consists of two analyses that zoom in and zoom out on interactions between nurses, patients, and mobile work phones. In zooming in, this thesis uses interaction analysis to analyse videotaped interactions between nurses, patients, and mobile work phones. These analyses rely

on nurses' and patients' sequential production and interpretation of situated actions, thus including only the here-and-now actions from moment to moment. In accordance with the ethnomethodological perspective, these analyses are based on the contextual configurations made relevant by the participants themselves in every case of interaction. When zooming out, this thesis relies on nexus analysis to analyse the recorded moments of actions with all the trajectories circulating through them. This analysis thus encompasses also the elsewhere-and-then by including the semiotic cycles of participants, discourses, mediational means, etc. In this analysis, the circumferences of the interactions were interactively constituted by participants both amongst themselves and with me. As I participated in the nexus of practice, I followed the semiotic cycles of people, discourses, places, and mediational means emerging from moments of action. I initially mapped all of the semiotic cycles circulating in the moments of action and expanded the circles of engagement with others near and far. Following all semiotic cycles to the full extent would of course have been an impossible task, so in the process of circumferencing the interactions between nurses, patients, and mobile work phones, choices and delimitation thus had to be made. I sought to let the actions of the participants point me to the most significant cycles and then follow these far enough on their timescales to include the most relevant points. Naturally, the process of circumferencing was also guided by my focus of research, which for example necessitated that the cycles of the mobile work phones be kept within the scope. Delimitation caused me not to follow the cycles of every piece of furniture, every element of the built environment, or every piece of equipment present in the hospital department backwards and forwards in time on their own inherent timescales. Neither did I follow the semiotic cycle of every person who frequented the department, such as medical laboratory assistants, physiotherapists, porters, occupational therapists, carpenters, cleaning personnel, etc. However, this is not to say that these necessary omissions from my deepest analysis did not contribute to the moments of action under study; by contrast in a particular situation, they may be crucial to the way that interaction is accomplished.

4.3. MEDIATIONAL MEANS

Objects can be drawn on to build action and understanding, so they have a certain social potential in interaction. Reflecting Vygotsky (1978) and Wertsch (1994, 1998) Scollon and Scollon hold the position that any action is accomplished by the use of semiotic resources which they term "mediational means" (2004, p. 12):

> A mediational means (a term in either the singular or plural) is defined as the semiotic means through which a mediated action, that is any social action, is carried out (communicated). In this definition 'semiotic' is intended to convey not just abstract or cognitive systems of representation such as languages or systems of visual representation, but

> also any and all material objects in the world which are appropriated for the purposes of taking a social action.
>
> (R. Scollon 2002, p. 148)

Vygotsky's claims about mediation imply that language and tools do not simply facilitate human action, but mediate its flow and structure (1978). Wertsch refines this view to assert that human action "employs 'mediational means' such as tools and language, and that these mediational means shape the action in essential ways" (1991, p. 12). Wertsch understands the essence of mediated action to be a tension between the mediational means provided and the contextualised use of these means in concrete actions (1994), so both the actor and the mediational means must be included in any analysis of the action. Scollon echoes this requirement by noting that all human action is carried out by means of tools. Actions and tools are used together, which means that tools mediate the actions that people undertake:

> I must pay attention to how objects are used in human actions because those objects shape those actions. And further I had to really come to think that objects and the actions in which they are used are inseparable units.
>
> (R. Scollon, 2013, p. 185)

To analyse this nexus of action and object, Scollon proposes that the unit of analysis is the use of objects through action, rejecting the placement of the intentional human agent as the centre of orientation (R. Scollon, 2013). Here, he agrees with Gibson's denial of any ontological primacy of humans over material reality; rather, people belong to the same ecology of representations (1979). The originator of the term "affordances", Gibson emphasises that affordances and perception are always interlinked, and that possible functions are perceived directly when we look at an object, not through cognitive processing. Gibson understands perception to consist of experiences of the environment surrounding the body (2002, p. 77), which not only entails that various actors perceive affordances differently but also that objects become affordances only when engaged with an actor and an action. Scollon echoes this view by emphasising how "an object has merely a current or present potential meaning, not an actual meaning, until it is used by a human to do something" (R. Scollon, 2013, p. 194). Latour also considers objects to be more than an inert background for human action rather they possess agency. He understands objects as an "actant in its own right" (1996, p. 239) that has meaningful ties with both other objects and with humans. Without distinguishing between human and non-human actors, Latour in his actor-network theory (2005) follows the actors and identifies connections between them. Scollon takes inspiration from Latour (1996) in the way that objects can give and take meaning through their juxtaposition and in the way that inference can be drawn from their spatial proximity. Any object has an irreversible material entity that is independent of human action and allows for a

wide range of historical readings and potential actions (R. Scollon, 2013). Parting from Latour, Scollon distinguishes between humans as social actors and things as mediational means, but both scholars understand human practices to be formed by a chain of agencies embodied in and enacted by multiple entities with different ontologies. Furthermore, rather than focusing on the effects of connections between heterogeneous actors, Scollon focuses on the practices of social actors and the intimate relationship between actions and materials described above (2013).

By studying interactions between nurses, patients, and mobile phones, this thesis cuts across the dichotomy of object-subject and assigns both objects and subjects the competence of originating courses of action. Both human and non-human actors set constraints and create possibilities which generate trajectories of actions, so interactions between nurses, patients, and mobile phones are considered to be joint accomplishments of human practices and object affordances.

Ethnomethodology and related approaches also consider material objects and environments to be included in the process of meaning-making and action formation. The emphasis within interaction analysis has been on how objects feature in the moment-to-moment conduct of social interaction. However, a growing interest in how objects in and of themselves are significant for building interaction is underway, analysing embodied conduct as relative to their material environment (Nevile et al., 2014, p. 5). As resources, objects are situated in and contribute to the development of trajectories of action; things make a difference in the unfolding of social interaction not as extra interactional objects but as genuine inter-actants. Understanding material sources of meaning to be drawn into the production of intersubjectivity in interaction the perspective of interaction analysis resonates with the way that nexus analysis considers all interaction to involve mediational means. To Scollon, mediational means are “any semiotic object used to mediate social action” (R. Scollon, 2001, p. 7), which not only includes objects but also discourses, multi-modal communication, etc. (R. Scollon, 2001, p. 8). Consequently, mediational means are inherently polyvocal and include the materiality of the social actors, their bodies, and movements.

Scollon and Scollon understand these heterogeneous and intertwined semiotic resources to display and distribute meaning while building intersubjectivity in interactions (2003). However, from an ethnomethodological perspective semiotic resources need to be displayed as relevant by participants in order for their agency to become evident. Garfinkel thus takes a more human-centred perspective and relies on members’ perspective to make the agency of objects visible in interactions as they use them and assign meaning to them in accordance with their frames of relevance. Ethnomethodologically, material aspects are embodied in the way people perform their practices, and the agency of objects is assumed to be visible as people design their actions. Thus the relevant features of the world are those selected and used as relevant by human beings in interactions. Following Bourdieu (1977),

Scollon and Scollon remind us that mediational means can be so deeply naturalized in the process of use that they become invisible to us; we use them as part of our selves (2004, p. 3). This means that as people use things repeatedly they become naturally and routinely implemented in their practices, and people may not be aware of the agency of things and may not mark their constitutive role. Even when unmarked, however artefacts still project certain courses of actions and define crucial dimensions of any interaction.

In zooming in by analysing videotaped interactions between nurses, patients, and mobile work phones from the perspective of interaction analysis this thesis investigates the agency of objects from members' perspectives, revealing how they refer and orient to things. In zooming out, this thesis follows the semiotic cycles circulating in the moments of action, which includes the cycles of objects present, whether marked or not. It is however impossible to map the cycles of every object present in the premises of the hospital department, and attention is thus focused on mobile work phones as a natural consequence of the research questions.

4.4. ANALYSING SOCIAL ACTION

Analytically, Scollon and Scollon aim to connect the concrete events of social action with the layered influences which, with varying force and from various sources, offer different orientations and possibilities to actors. Consistent with approaches informed by ethnomethodology, Scollon and Scollon refuse to determine in advance which categories or discourses are significant for the social action under study. Rather, they favour a bottom-up analysis in which it is the ethnographic analysis of the mediated action occurring in a site of engagement that identifies the crucial discourses operating in the scene. Figure 1 shows how Scollon and Scollon understand social action to take place as an intersection between three main elements: the historical body of the participants, the interaction order that they mutually produce, and the discourses in place which are used by the participants as mediational means or in other ways enable the action (R. Scollon & S. W. Scollon, 2004, p. 19).

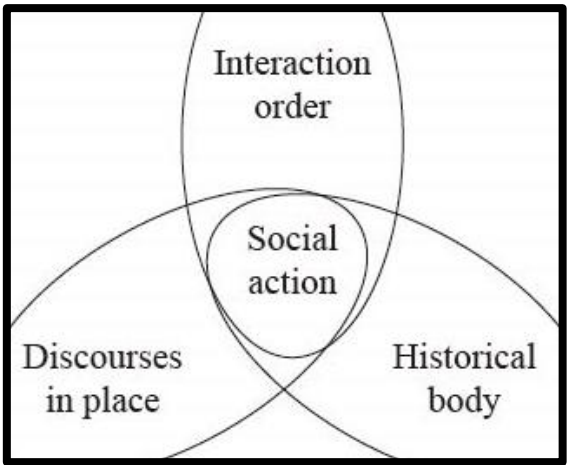

Figure 1: Analysing social action (R. Scollon & S. W. Scollon, 2004, p. 20)

4.4.1. HISTORICAL BODY

Scollon and Scollon use the term "historical body" to refer to a person's history of personal experience (2004, p. 13). The term was originally coined by Nishida (1958); it resembles Bourdieu's "habitus" (1977), which has also inspired their work. Scollon and Scollon, however, prefer "historical body" as it more precisely situates bodily memories within the individual body (2004, p. 13). Whenever we engage in social interaction, we draw on previous experiences of social interaction and use our historical bodies as we learn to use various mediational means. By adopting Nishida's term, Scollon and Scollon also adopt the instability, ineffability, and collective relationship which are inherent in the term. The historical body is dynamic and is in continuous interaction with the environments a person encounters (Jones, 2008, p. 247). Rather than being a stable set of experiences, it is an ever-changing basis for the ontogenesis of new practices, which Suzie Scollon describes as a compost heap of social practices preparing the soil for new growth (2003, p. 168). The analytical implications for this thesis are that the historical bodies of nurses interacting with patients and mobile work phones are not considered to be the same in all situations analysed. Rather, they continuously evolve, and as nurses draw on their individual historical body in dynamic interaction with the situations they encounter, new practices develop.

This manner of analysing social action differs from ethnomethodological approaches. As noted in Section 3.3.1, conversation analysis and interaction analysis rely on the moment-to-moment verbal and embodied conduct of participants to display their understanding of a prior action in their next action (Schegloff, 2007). This approach does not move beyond the situation itself to include the elsewhere-

and-then. Scollon and Scollon, on the other hand, consider it important to include all trajectories involved in the moment of social action in the analysis, and thus include historical trajectories of persons, discourses, mediational means, etc. in their analysis. They believe that a person brings sociocultural and psychological knowledge, a history of experience, motives, interests, and dispositions into the moment of action, all of which makes a difference in how the person takes action (R. Scollon & S. W. Scollon, 2003, p. 15). In zooming in, this thesis uses interaction analysis to analyse videotaped interactions between nurses, patients, and mobile work phones, relying on the nurses' and patients' sequential production and interpretation of situated actions, and thus including only the here-and-now, moment-to-moment actions. Zooming out, the thesis relies on nexus analysis to analyse the recorded moments of actions, with all the trajectories circulating in them. This analysis thus encompasses also the elsewhere-and-then by including the historical bodies of participants, discourses, mediational means, etc. The two analyses are each conducted in accordance with the theories and methods that inform them; the thesis as a whole combining analytical tools without compromising the epistemological assumptions guiding them. It goes without saying that in zooming out, it is neither possible to reveal nor to include the instable and ineffable historical bodies of the participating nurses and patients in full. This is also true for Scollon and Scollon; they for instance analyse the conduct of pedestrians in a street, without knowing the individual pedestrians and their historical bodies. Echoing Goffman (1959), Scollon and Scollon depict how any action displays aspects of the historical body of the actor; those aspects are available for others to infer and respond to (R. Scollon & S. W. Scollon, 2003, p. 199). As I participate in the nexus of practice the actions of nurses and patients thus display aspects of their historical bodies in both their embodied conduct and in interviews and conversations, which can be included in an analysis.

4.4.2. INTERACTION ORDER

The term "interaction order" was coined by Erving Goffman (1983), who has also been a general source of inspiration to Scollon and Scollon in their development of nexus analysis. Exploring how people make external displays to others present in social situations, Goffman itemised several interaction arrangements such as singles, withs, contacts, meetings, etc. (1983). Scollon and Scollon refined interaction order to mean "any of the many possible social arrangements by which we form relationships in social interactions" (2004, p. 13). Such arrangements of the interaction order constitute semiotic units on the basis of which discourse is organised and inferences are drawn. Taking further inspiration from Goffman and Edward T. Hall (1966), Scollon and Scollon outline how the study of interaction orders should comprise analysis of perceptual spaces, sense of time, interpersonal distances, and personal fronts (2003, p. 64). They understand people to behave

differently depending on the social setting, acting out different roles and role expectations that depend on their mutual relationship (R. Scollon & S. W. Scollon, 2004, p. 13). The roles that nurses and patients perform in interactions and their inherent role expectations are thus part of the way the interaction order is constituted. Consequently, the term "interaction order" is used in this thesis to analyse the social roles and relationships between the nurses and patients during videotaped interactions in the hospital department.

4.4.3. DISCOURSES IN PLACE

All social action occurs in a material place; Scollon and Scollon regard all places as complex aggregates of many discourses that circulate through them (2004, p. 14). Some discourses, such as conversation topics between nurses and patients have rapid cycles, while others like the built environment of patient rooms circulate slowly. Some of the discourses might be distant, with little relevance to the particular social action under study (e.g., the design specification of the ceiling), while others are more directly relevant (e.g., the design specifications of the mobile work phone). Scollon and Scollon term these discourses that circulate in a site of engagement "discourses in place" (2004, p. 14). As any social action can be mediated by the discourses in place, they need to be identified and studied empirically to determine which are relevant and foregrounded in the social action under study, and which are irrelevant and backgrounded. When a nurse interacts with a patient and a mobile work phone she selects, among the discourses in that place, the ones most relevant to the action she is taking and uses them to carry out the action. Although the design specifications of the mobile phone may be relevant in one interaction between a nurse, a patient, and the phone, they may not be foregrounded relevant in another. Analytically, the discourses in place are followed back and forth in time to see how the site of engagement is constituted out of past actions and how they in turn lead to new actions. This suggests that each interaction between a nurse, a patient, and a mobile work phone is not analysed as an isolated instance of interaction; rather, it is situated in its historical origin and its future trajectories.

4.5. ACTIVITIES IN A NEXUS ANALYSIS

Conducting a nexus analysis consists of three activities: engaging, navigating, and changing the Nexus of Practice (R. Scollon & S. W. Scollon, 2004). In engagement, the researcher conducts ethnographic participation in the nexus of practice under study and gathers data. The navigation activity involves the researcher organising and analysing the data, while in the activity of change, the researcher analyses trajectories of change. By a nexus of practice, Ron Scollon refers to practices being linked to other practices and recognised by social actors in the actions of others

(2002, p. 150). This means that any linkage between practices which is recognised by social actors as a repeatable linkage may form a nexus of practice:

> Whenever there are a number of people who share practices and the linkages among them, that is, to the extent that there is a *we* who know how to have a cup of coffee, how to catch a bus, or how to send an email message, there is a nexus of practice. A nexus of practice is any group who can and do engage in some action.
>
> (R. Scollon, 2002, p. 150)

A nexus of practice is thus a rather loosely structured, recognisable grouping of a set of mediated actions. As mediated actions are an indissoluble dialect between actors and mediational means, a nexus of practice thus simultaneously points to a genre of activity and a group of actors engaged in the activity. It thus diverges from the term "community of practice" (Wenger & Lave, 1991) which Scollon uses to refer to a relatively fixed and bounded "group of people who regularly interact with each other to achieve some common purpose or goal" (2002, p. 151).

Although outlined in a field guide, Scollon and Scollon do not consider the activities of nexus analysis to be a strict methodology; rather, they understand it to be organic research (2004, p. 148), where each step is a reflective process involving a multitude of contingencies and interactive decisions made by the researcher. As every nexus of practice is different, researchers must chart their own course, developing structure as they progress and applying whatever means seem appropriate given the knowledge they have at any given point (Norris & Jones, 2005, p. 201). Hence, Scollon and Scollon advocate a flexible methodology that grows from a reflective research process making room for any data collection or analytical tools deemed useful. This reflective process is mirrored in my way of doing research for this thesis. The nexus of practice I am studying require constant adjustments due to its unpredictable nature and my continuously situated ethical considerations, which I touch upon later. I also had to find my way in research disciplines unfamiliar to me and construct a research framework carefully tailored to the phenomenon under study. In this process, the recommendations of Scollon and Scollon have not only served as a way of working empirically and analytically; their conceptual framework has also formed shaped my method of being a researcher, as become apparent below where I describe my journey through the activities of this nexus analysis. For now, I briefly introduce the three activities.

4.5.1. ENGAGING THE NEXUS OF PRACTICE

The first activity in nexus analysis, engaging in the nexus of practice, is preliminary to the actual analysis. The researcher aims in this phase to establish the social issue under study, observe the interaction order, find the crucial social actors, determine the most significant cycles of discourse, and establish a zone of identification (R. Scollon & S. W. Scollon, 2004, p. 154). The social issue under study was identified in a preliminary form on the day I went to the hospital department as an external examiner. I became interested in interactions between nurses, patients, and mobile work phones and wanted to find out what happens when mobile phones are introduced in the practices of nurses working in a hospital. This was subsequently established as the social issue of study after I scrutinised the literature, spoke to numerous people, and raised the funding for this Ph.D. project. As I began my inquiries and my engagement with the nexus of practise, the focus of the thesis remained relative open to underpin its emic perspective. During the process of research it, however, did prove necessary to limit this openness at certain points so as to manage the complexity of interactions between nurses, patients, and mobile work phones taking place in a hospital department.

With the focus of this thesis being interactions between nurses, patients, and mobile work phones, the crucial social actors in the mediated actions of interest were nurses working in a hospital department where mobile work phones were used and the patients admitted to that department. The actual nurses and patients who were studied as crucial social actors were identified and negotiated through a lengthy process of gaining access and engaging a nexus of practice. The phase of engagement further aims to establish the researcher within a zone of identification, which means that the researcher takes a place as an accepted legitimate participant within the nexus of practice. As Scollon and Scollon emphasise “there is no study from afar in nexus analysis” (2004, p. 153). Nexus analysis begins once the social phenomenon under study is enacted in the experience of real social actors. Hence, my inquiry began with their actual situated actions and probed from there. I had to engage in a hospital department where mobile work phones were used, to observe the typical interactions orders within which the interactions between nurses, patients, and mobile work phones occur, and to observe the discourses in place and follow their cycles to other means or sights. In the process of doing so I also had to establish a zone of identification and be recognised by the people working in the hospital department as a participant in their nexus of practice.

4.5.2. NAVIGATING THE NEXUS OF PRACTICE

The activity of navigating the nexus of practice begins with mapping and navigating the cycles which circulate through it:

> Now the task is to map the cycles of people, places, discourses, objects and concepts which circulate through this micro-semiotic ecosystem looking for anticipations and emanations, links and transformations, their inherent timescales, and to place a circumference of relevance around the nexus of practice.
>
> (R. Scollon & S. W. Scollon, 2004, p. 159)

Scollon and Scollon understand an action to be a moment in time and space in which historical bodies, interaction orders, and discourses in place intersect, each with a cycle leading into and away from the moment of action. Hence, mapping the nexus of practice includes the cycles of persons, semiotic aggregates, overt discourses, discourses internalized as practices, mediational means such as objects and concepts, etc. Given the complexity of interactions between nurses, patients, and mobile work phones taking place in a hospital, countless semiotic cycles circulate in the moments of action. Although they strive to preserve the complexity of situations, Scollon and Scollon acknowledge the total complexity to be unmanageable (2004, p. 160). This is one reason for the researcher to engage in the nexus of practice:

> In thinking of these cycles do not try to map all the semiotic cycles of every person, discourse, or object that occurs within the place where the action is occurring. The purpose of your activities in engaging the nexus of practice was precisely to make a selection so that you can focus your inquiry.
>
> (R. Scollon & S. W. Scollon, 2004, p. 160)

When mapping the semiotic cycles I thus had to restrict the initial openness and refrain from mapping semiotic cycles of every piece of furniture, or every element of the built environment. I also had to omit the semiotic cycles of every piece of equipment used in the hospital department and every person frequenting it. This delimitation was made in a process of assessing which cycles are more significant on the basis of my engagement in the nexus of practice. The maps of significant semiotic cycles are presented in Chapter 6 and make evident that the complexity of interactions between nurses, patients, and mobile work phones is still substantial, despite the omission of less significant cycles.

Each semiotic cycle has a history that leads into the moment of action and a future leading away from the moment of action. These past and future trajectories are followed backwards and forwards in time on their own inherent timescales in order to circumference the moment of action. As outlined in Section 4.2, this process means following each semiotic cycle far enough to include the most important elements that give meaning to the moment of action and far enough to include points where semiotic transformations or resemiotizations occur (R. Scollon & S. W. Scollon, 2004, p. 171). Circumferencing thus opened up a wide range of analytical

interests around the interactions between nurses, patients, and mobile work phones. Following the semiotic cycles circulating among the interactions not only entails following them to other situations occurring in the nexus of practice, but also following them to other places and persons working there, and to virtual places and texts residing there. As the semiotic cycles were followed back and forth in time and connections were trailed, the complexity once again became massive. In order to manage this issue I had to make analytical cuts on the timescales at points where I considered significant relations and transformations to be encompassed. This was a process guided by my engagement in the nexus of practice, as I felt my way along trajectories and reflected on their elements and the meaning they contributed.

After circumferencing the semiotic cycles, the next task is to analyse each on the basis of anticipations and emanations, points and intervals, links and interactions, and transformations and resemiotizations (R. Scollon & S. W. Scollon, 2004, p. 166). This is an analysis not only of the ethnographic content but also of discourses in the broad sense. Scollon and Scollon also propose an analysis of discourses in the narrow sense, as language in use, present in the speech of participants, in semiotic systems used as mediational means, submerged in historical bodies of participants or in the design of the built environment. To examine such discourses, Scollon and Scollon suggest using tools from critical discourse analysis, interactional sociolinguistics, or linguistic anthropology (2004, p. 173). Reflecting their ambitions for change, Scollon and Scollon further add a discursive analysis of motives, taking inspiration from Burke's grammar of motives (1945), in which any action can be described from one of five explanatory positions: the scene, the actor, the mediational means, the mediated action, and the purpose, while each perspective forms a discursive motive for the action (2004, p. 175). Using a motive analysis aims to understand how participants position themselves in relation to the action under study, and then to engage in their explanatory positions and see if taking a different position might change the action.

For the analysis of discourses in the sense of people communicating with one another, this thesis departs from the recommendations of Scollon and Scollon. Section 3.4.2 detailed how mediated discourse analysis faults critical discourse analysis for not being able to establish the links between discourse and action. Section 3.4.1, meanwhile, outlined Scollon's criticism of both interactional sociolinguistics and critical discourse analysis for starting out with an interest in social action but actually ending up analysing text (2002, p. 143). Although interactional sociolinguistics is primarily interested in interpersonal relationships, positioning, and alignment, this work is carried out mostly on speech phenomena rather than other modes of communication (Gumpertz, 2001), which is also true of linguistic anthropology (Duranti, 2009). Hence, motivated by an understanding that all modes are juxtaposed in human interaction this thesis instead takes inspiration from interaction analysis to examine discourses in the sense of the ways people communicate with each other. Section 3.3.2 revealed how interaction analysis

understands interaction as being inherently embodied and renders visible the many forms of semiotic fields that shape communication, while also situating the interacting body in the material world. Not including such basic features of human practical conduct in the analysis of interactions between nurses, patients, and mobile work phones would make this thesis unlikely to grasp how these multimodal phenomena are accomplished.

Scollon and Scollon regard nexus analysis to be organic and adjustable in order to meet specific research needs. Hence, incorporating a complementary research perspective to enhance the sensitivity of the analysis is in harmony with their intentions and beliefs. Furthermore, Ron Scollon indisputably considers discourse to be inherently multimodal. In a collaboration with LeVine, he acknowledges the significance of making discourse analysis sensitive to multiple modalities of communication, abandoning a mono-modal concept of discourse. As language in use "is always and inevitably constructed across multiple modes of communication" (LeVine & R. Scollon, 2004, p. 2), they advocate for discourse analysis to open up the lens and develop a fuller perspective of how humans communicate, analysing social actions as multimodal phenomena. Incorporating perspectives from the field of multimodal discourse analysis, such as the methodological framework developed by Norris (2004), could be a way of making the analysis of interactions between nurses, patients, and mobile work phones sensitive to multiple modalities. For several reasons this thesis however relies on interaction analysis to achieve this goal: it underpins the emic perspective of this thesis as it takes participants' situated understandings as basis for the examination of interactions, and the way it demonstrates claims empirically helps prevent that my career as a nurse guided the analysis (see Section 4.6) .

4.5.3. CHANGING THE NEXUS OF PRACTICE

This thesis does not have a priori intentions to change the practices of nurses; rather, it aims to describe what happens when mobile work phones are introduced into the practices of nurses working in a hospital. The activity of changing the nexus of practice does not necessarily entail critical ambitions about change, nor do I consider myself to be in any privileged position to bring about change. However, Scollon and Scollon make clear how conducting a Nexus analysis in itself brings about change (2004, p. 177). As a researcher participates in a nexus of practice the research activities become part of the activities of that nexus of practice, which inevitably changes the trajectories of both the researcher and the participants: "By your actions of analysis you are altering trajectories for yourself and for the others in the nexus of practice and that in itself is producing social change"(R. Scollon & S. W. Scollon, 2004, p. 178).

Intentionally or not, by becoming a participant in a nexus of practice, the researcher also becomes part of a process constructing the social world within that nexus of practice. Furthermore, if the analysis conducted by the researcher is brought back into the site of investigation, unnoticed features may become visible to its participants. This then also becomes an action in the construction of the nexus of practice which inevitably has social consequences. Although nexus analysis might have the potential to be used for action research (R. Scollon & S. W. Scollon, 2004, p. 149), this is not the aim of this thesis. The activity of change in this thesis entails reflections on changes taking place in the nexus of practice during the course of research. Subsequently, the findings of this thesis will be brought back into practice as they are refined into articles, presented at conferences, and incorporated in the education of nurses.

4.6. ETHNOGRAPHIC STRATEGY

Practice theories understand knowledge and action to be fundamentally social in origin, which entails that the data for studying practices is to be found in interactions, not in the minds of individuals. Consequently, approaches informed by mediated discourse analysis and ethnomethodology rely mainly on ethnographic investigations of naturally occurring situated social actions. Scollon argues that although actions are based on people's habitus and situated understandings they are rarely able to grasp or verbalise that fact as they talk about their actions (2002, p. 145). Studying discourses about social action rather than the social actions themselves is methodologically precarious, so nexus analysis operates by observing concrete situated social actions. The opening task of nexus analysis is to engage in ethnographic participation in the nexus of practice under study. A central task in this first stage of a nexus analysis is to recognise the main mediated action by identifying the crucial social actors, observing the interaction order, and determining significant cycles of discourse. Another central element in the phase of engagement is to establish a zone of identification, which means that the researcher takes a place as an accepted legitimate participant within the nexus of practice:

> Ethnography is not simply a methodology for getting rich data for objective analysis but a theoretical position that takes it that it is important for the analyst to be identified within the nexus of practice under study.
>
> (R. Scollon & S. W. Scollon, 2004, p. 13)

In their ethnographic approach, Scollon and Scollon are inspired by the "ethnography of communication" proposed by Hymes as an approach to analysing language use (1972, 1974). In developing this ethnographic method, Hymes was inspired by Burke (1945, 1950) who has also been a major source of inspiration to

Scollon and Scollon in their development of several other concepts such as "zone of identification", "circumferencing", and "motive analysis" (2004, p. 180). Nexus analysis departs from traditional ethnography within anthropology or sociology by not taking an interest in a specific group of people who are then selected for study. Rather as nexus analysis takes social action as the centre of study, ethnography in this sense means to actively participate in the lives and actions of people. Reflecting Burke, Scollon and Scollon use the term "zone of identification" to emphasise that a researcher should not maintain an observational stance. Rather, the researcher must be present in the field of action and actively participate in the lives and actions of the people being studied, in order to gain an inside perspective:

> In order to do a nexus analysis you must establish a zone of identification with a nexus of practice. That is, you must find a nexus in which you have or can take a place as an accepted legitimate participant.
>
> (R. Scollon & S. W. Scollon, 2004, p. 11)

Scollon and Scollon thus argue for an extended study of actions undertaken in the course of living life (2004). This resembles the inherent stance of ethnomethodology that there is no study from afar; indeed Garfinkel insists on a strong participant observation requirement:

> The unique adequacy requirement of methods is identical with the requirement that for the analyst to recognize, or identify, or follow the development of, or describe phenomena of order in local production of coherent detail the analyst must be vulgarly competent in the local production and reflexively natural accountability of the phenomenon of order he is "studying".
>
> (Garfinkel, 2002, p. 175)

The particulars of accounts are built step by step as they are used and referred to, and the identification of such distinctive features requires the capacity for competent performance and actual participation by the researcher. Especially when investigating specialised settings, the fusion of local and analytical knowledge and competencies is required (Lynch, 1993). The unique adequacy needed to understand the workings of sophisticated practices are thus only assessable through the in-depth experience of a competent practitioner (Garfinkel & Wieder, 1992). The focus on process and dynamic interaction as a means to gain understandings and insights from an inside perspective underpins the emic perspective of this thesis. While there is resemblance to auto-ethnography (Ellis & Bochner, 2000), this however places more emphasis on the voice of the researcher. Other ethnographic traditions employ various degrees of participation. For instance, Spradley describes various levels of participation, from non-participation in which the researcher strictly observes and avoids involvement to complete participation, in which researchers study social

settings that they are already participating in (1980). Similarly, Hammersley and Atkinson describes various field roles and advocate for a position as "marginal native" (2007, p. 89), which requires the researcher to participate in the social setting under study from a position that combines familiarity and a certain remove from those being observed. Like Scollon and Scollon, they regard researcher participation to be essential in order to obtain subjects' perspectives, but caution that in familiar settings it may be difficult for the researcher to suspend preconceptions (Hammersley & Atkinson, 2007).

In engaging the nexus of practice I undertook three weeks of participatory observations, in which I followed nurses throughout their shifts and assisted them in their activities. For reasons of insurance I could not participate fully, but I worked with them to the extent permissible. When I later returned to the nexus of practice I carried a video camera, which restricted my participation as it occupied my hands, although I put the camera down when a nurse was in need of an extra pair of hands. As I strived to establish a zone of identification and achieve unique adequacy I benefitted from my historical body as a nurse; knowing how hospitals are organized and how work is structured, understanding technical terminology and sharing professional knowledge, sensing what nurses do and talk about and why actions are carried out. I also knew how to contact specific people in different levels of management in order to gain access; finally I knew how to talk to nurses and patients in order to participate in the department's practices. Without a background as a nurse this process would have required more efforts on my behalf and consequently would have been considerably prolonged. However, having never worked as a nurse in this particular hospital and having never used a mobile work phone as a nurse, I still needed to engage in a process of dynamic interaction with the nexus of practice I was studying, in order to become a legitimate participant and establish a zone of identification, which is detailed in Chapter 5.

Although Garfinkel and Scollon and Scollon do not consider it problematic for a researcher to conduct research from an inside perspective, other ethnographic traditions point to possible disadvantages (Hammersley & Atkinson, 2007; Spradley, 1980). My historical body as a nurse can make nurses' actions and practices so naturalised to me that they might become invisible and remain unnoticed in the analysis. Furthermore, my experience as a nurse can lead me to presumptions, guide my way of looking, and steer my analysis of the nexus of practice. The interaction analysis used in this thesis to zoom in on the situated interactions between nurses, patients, and mobile work phones addresses these concerns, as the claims made are demonstrated empirically in the videotaped data, making them substantiated in an intersubjectively available way. As a further precaution, I hosted several data sessions where colleagues proposed observations and questions which I could later pursue analytically. The data sessions are described in greater detail in Section 7.3.

4.7. DATA TRIANGULATION

Where traditional ethnography usually relies almost exclusively on field notes as empirical data (Hammersley & Atkinson, 2007; Spradley, 1980), nexus analysis recommends triangulation of multiple types of data. As nexus analysis takes situated moments of action as its point of departure, it is not possible a priori to know what empirical data is needed for analysis. Rather, the researcher must remain open, follow the participant lead and collect as much data as possible on the way:

> To put it crudely, a nexus analysis would like to document or record everything that might be relevant to understanding the historical antecedents of a social action as well as the unfolding outcomes of that action.
>
> (R. Scollon & S. W. Scollon, 2007, p. 621)

This approach to data collection resembles Rapley's, who suggests that the researcher generate a "data archive" (2007). Like Scollon and Scollon, he proposes that collecting and managing an array of different materials enables the researcher to engage with and think about the research question and to interrogate contrasts and contradictions (Rapley, 2007; R. Scollon & S. W. Scollon, 2004). Rather than confining data collection to include only data generated by the researcher, they all advocate that the researcher generate a diverse collection of materials, including any existing data gathered during the research process. Scollon and Scollon consider data gathering to be an on-going documentation in an engagement surrounding the actions under study, where the researcher must remain inherently open while following the participants and gathering as much data as possible on the way: "It is not only practically difficult to know what one will need to study next and where, or with whom, it is theoretically limiting to make such decisions in advance of becoming engaged in the actual research" (2007, p. 620).

This open approach to data collection is similar to connective ethnography (Hine, 2000), in which experiences in the field open new possibilities for the researcher to follow in what is known as a "snowballing technique" (Biernacki & Waldorf, 1981). Like nexus analysis it relies on active engagement and interaction with the participants, and results in a multitude of empirical data that sheds light on the phenomena under study. With the complexity of mapping all the semiotic cycles circulating through moments of social action, it seems only natural that a wide range of data types are relevant. Hence, as I participated in the practices of the hospital department, I not only pursued connections between people and workplaces but also continuously gathered as much data as possible. This led to an enormous data corpus, much of which has not yet been analysed. However, the amount of data in itself does not ensure the quality of the analysis; in their open approach to data gathering Scollon and Scollon focus on ensuring that the data answers more perspectives, in order to achieve more nuances understandings of the phenomenon

under study. Following Ruesch and Bateson (2006 [1951]), they thus suggest that four types of data are included in a dialectic analysis:

Members' generalizations: What do participants say they do?
Neutral observations: What does a neutral observer see?
Individual experience: What does an individual describe as his or her experience?
Interactions with members: How do participants account for your analysis?

(R. Scollon & S. W. Scollon, 2004, p. 158)

In order to explore how nurses, patients, and mobile work phones participate in the accomplishment of interaction, the present study had to generate a data archive encompassing all four types of data, to allow for close interrogation of this complex, multi-actor, technology-mediated hospital work setting. To allow for detailed analysis of the interactions, video recording was conducted, preserving not only the temporal and sequential structure of the interactions, but also visual, acoustic, and kinaesthetic information. As it could not be known at the time of taping what the analysis would identify as relevant, the mobile video camera recorded continuously throughout the day including not only all the nurses' actions, but also conversations amongst themselves and collaborators, conversations with me, etc. The video recordings thus also provide information regarding the historicity and trajectories of situations, however, in order to zoom out and map the semiotic cycles circulating in the recorded situations additional data was required.

Prior to the video recordings, as a way of entering the nexus of practice, I initially conducted participatory ethnographic observations and interviews with a number of nurses and patients. Besides being a discrete way of entering this also provided me with valuable data. Furthermore, during my participation in the nexus of practice I made a conscious effort to remain open and pursue connections to other people, places, times, etc., while gathering as many kinds of empirical data as possible. Hence, in addition to the video recordings the data corpus of this study consists of participatory ethnographic observations, interviews, photos, documents, and webpages. Formal and informal interviews were not only conducted with patients, nurses, doctors, and managers at the hospital where the study occurred, but I also interviewed nurses and managers working at another hospital in the region, employees at the regional construction department, managers at the international technology company Ascom, along with engaging nurses at a hospital in another region. The data corpus as a whole provides data on members' generalizations, members' individual experiences, neutral observations, and interactions with members, as recommended by Scollon and Scollon. Although this thesis does not claim to include all four types of data to the full extent, nevertheless, the analysis will rely on a triangulation of all four types of data.

4.8. VIDEO ETHNOGRAPHY

Video technology is vital for interaction analysis, as only this kind of audio/visual recording produces a data corpus which allows for close interrogation of the subtle aspects of human interaction (Jordan & Henderson, 1995). The capacity of video recordings to replay moments of interactions repeatedly is especially crucial to the analysis. Video technology is thus also vital for this thesis to explore how nurses, patients, and mobile work phones participate in the accomplishment of interactions. I thus conducted approximately 144 hours of video recordings during which I shadowed nurses with a mobile camera that recorded continuously. The video recordings provide detailed permanent accounts of interactions, including a wide range of multi-sensual and sequentially ordered elements such as speech, embodied conduct, artefacts and the semiotic structure of the environment. This enables a detailed analysis of micro actions performed in interactions between nurses and patients; field notes could not have provided anywhere near the same level of detail.

Besides the fact that field notes would lack essential details of micro actions, they would also be constructions of my interpretations of the interaction. Retrospectively produced accounts such as field notes or interview transcriptions are representations of the interaction constructed through a variety of interpretative devices which assign secondary meaning to the event (Jordan & Henderson, 1995). Video recordings provide a shared resource for analysing what happened, rather than analysing accounts of what happened. They consequently have the capacity to bridge the gap between what people say they do and what they actually do. In this regard, video recordings have the potential to produce data closer to the situation itself as it happened. However, even video recordings are merely representations of the interactions; what is not captured on the recording is not available for analysis and it is the operator of the camera, who decides what is recorded and in what ways in terms of focus, angle, etc. Actions happening around the recording may be pertinent to the people participating in the interaction recorded and may be in the periphery of their attention. What I as an analyst see and hear on the recordings is not what the nurses saw and heard; the camera is also restricted in its representation, as it does not capture smell, heat radiation, etc. On balance, though video recordings do offer a complexity captured which includes bodily behaviour not easily described in words. As mentioned above, the possibilities of repeated and slow-motion viewing are crucial for invisible or taken-for-granted phenomena to emerge in the analysis and for the analysis of interrelationships between micro actions.

Lomax and Casey scrutinise various perspectives on the validity of video-based ethnography as it has evolved over the years (1998). Especially in the early years of video ethnography, the position that a video camera has a distorting effect on the social reality was raised, with the claim that people change their behaviour when they are aware of the camera (Erikson & Schultz, 1982; Heider, 1976). Others take the position that as participants become engrossed with what they are doing, they

become unaware of both camera and researcher (Bergstrom, Roberts, Skillman, & Seidel, 1992). Yet another position claims that the embodied conduct of participants is not under their conscious control and thus remains unaltered by video recording (Weimann, 1981). Ultimately, Lomax and Casey demonstrate how a video recording does not represent a situation as it would have occurred had the video camera not been there, but also that the camera does not contaminate the scene in a way that makes the recording invalid (1998).

Rather than discussing whether a situation being recorded with a video camera is authentic, Raudaskoski focuses on how the video camera is perceived as part of the situation (P. Raudaskoski, 2010). Ethnographic studies have demonstrated how video recordings can provide the means for analysing participants' orientation to both researcher and camera, which may lead to insights about participants' construction of their social world. Mohn demonstrates how participants' gazes into the camera can reflect important aspects about the situation and the constitution of relationships (2009). Likewise, Lomax and Casey demonstrate how the presence of a researcher with a video camera can provide insights about how participants organise their activities (1998). Following this perspective, the way nurses and patients orient themselves to the camera may be part of how they construct something as problematic or valuable, an analysis of which may reveal insights about their motives or priorities. This perspective also means that the process of conducting video recordings is part of the construction of the social situation being recorded and thus part of the production of the data being collected, which reinforces the dialectic relationship between the world and the researcher's construction of it. This means that the interactions between nurses, patients, and mobile work phones are not there as an independent phenomenon to be captured on tape; rather, my practice of recording is embedded in each interaction. Conducting the video recordings with a mobile camera required me to be present in all the recorded situations. However, the camera and I were not only present in the situations but also became part of those naturally occurring situations as they unfolded. As recommended by Scollon and Scollon and other ethnographic scholars (e.g., Hammersley & Atkinson, 2007; Spradley, 1980), I did not avoid participation or attempt to minimise the cameras' or my own:

> You should not seek to stay aloof from the nexus of practice. On the contrary, it is your goal to become a full-fledged participant so that your "research" activities merge with your "participation" activities.
>
> (R. Scollon & S. W. Scollon, 2004, p. 156)

Being a participant in the situated activities while they were recorded, the video data also provides the means for reflections on the socially constitutive nature of the research process. As the video camera recorded continuously, it generated data on the way that I as a researcher participated in interactions. The recordings permit the analysis of how my participation in the situations generated talk about the research

project which was unrelated to the situation itself, how I became interactionally involved during delays, and the way I participated in the organisation of a non-formal environment.

CHAPTER 5. ENGAGING THE NEXUS OF PRACTICE

In this chapter, the activities of engaging the nexus of practice are described in more detail. While some of the activities have already been touched upon, this chapter offers a thorough account of my engagement and generation of data. The hospital department where the introductory narrative took place later became the site of my interrogations. In the first few sections I describe the process of engaging this nexus of practice, from preliminary manoeuvres to becoming a full-fledged participant. In subsequent sections I introduce the hospital and the specific department which constitute my nexus of practice. After this, the communication system of which the mobile work phones are part is presented; the chapter ends with a description of working processes in the hospital department.

5.1. BRINGING A VIDEO CAMERA TO A HOSPITAL

My engagement with the nexus of practice began on the day in 2010 I went to the hospital department as an external examiner, as described in the introductory narrative. On this day my curiosity was piqued and initial inquiries began. Approximately 17 months later, in November 2012, I was granted the permission by the director of nurses and the head nurse to conduct participatory observations and ethnographic interviews in the department. The data obtained in this minor study is not included in the present analysis, but my presence in the department as I conducted the study made me familiar with some of the people working there and with the way their work was organised. This knowledge was useful when later I commenced the present dissertation and reengaged the department. My earlier presence in the department meant that managers knew me and had a sense of my ethical conduct as a researcher, which may have been significant in the process of achieving their permission to enter the department with a video camera. Figure 2 shows when research activities have been conducted in the nexus of practice for this and the previous study.

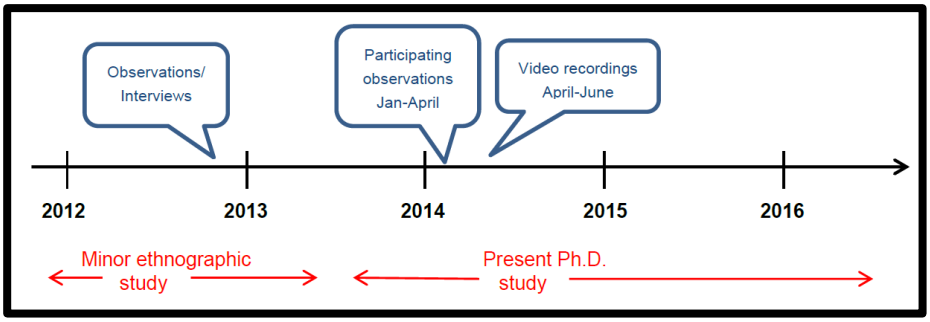

Figure 2: Chronology of research activities in the nexus of practice

5.1.1. OBTAINING PERMISSIONS

To obtain permission to engage the hospital department and conduct observations, interviews, and video recordings for the present study, I arranged a meeting with hospital management: the hospital director, the director of doctors, and the director of nurses. Although puzzled about my desire to conduct a qualitative study rather than obtaining quantitative data, they acceded to my request. The management of the medical sector and the management of the department also had no problem with my conducting video recordings in the department and readily granted me the permission to proceed. Additionally, the study was registered at the Danish Data Protection Agency and the required permission obtained.

I then began visiting the department around lunch time, sitting down with the nurses in the staff room while eating my lunch. During a two-month period I visited regularly, chatting with them and telling them about the study I was going to conduct in the department, in order to become a familiar face to them. After this period, formal information meetings were arranged in which verbal and written information about the study was supplied to the nurses. Because of a large staff turnover only a few nurses in the department knew me from earlier, and I considered it essential that the nurses gained confidence in me as a researcher before I started recording. I thus began by asking for their permission to conduct participant observations by shadowing them during their work. Any involvement in the participant observations was voluntary and consent could be withdrawn at any time. Five nurses came forward and allowed me to shadow them. I conducted participatory ethnographic observations for three weeks by following the five nurses during all their working activities. Concise field notes were obtained during each observation period and elaborated upon later the same day. In the mornings, before nurses began work, patients were asked for their consent to participate in the ethnographic observations. Oral and written information was given and precautions

taken to ensure that patient participation was entirely voluntary. No patients declined to participate in the observations.

My presence in the department during these participation observations provided nurses with the opportunity to assess my ethical conduct as a researcher and get to know me as a person. This, I believe, was significant in the subsequent process of achieving their permission to videotape them during their work. Entering the department with a video camera was the next step of my engagement with the nexus of practice. I had previously been worried about whether any nurses or patients would allow me to record them. After having conducted three weeks of participant observations in the department, I participated in a staff meeting during which I approached the nurses with my request to videotape them. To my surprise, most of the nurses working in the department had no reservations and instantly agreed to participate, while some had to think about it first. Participation in the study was voluntary and the nurses could withdraw their consent at any time. Only one nurse eventually declined to participate and was consequently not recorded. All participating nurses signed written consent forms on which they specified how I was allowed to use recordings of them. Each nurse has thus indicated whether I am allowed to show the recordings of them to colleagues on my research team, whether I am allowed to show anonymised videos featuring them at conferences, etc.

As patients were admitted to and discharged from the department on a daily basis, I had to approach them every day before commencing videotaping. I arrived at the department each morning, well before the day shift began, and visited every patient room to talk to all the patients admitted to the department that day. Written and oral information was provided regarding the study; patients had to sign a consent form if they agreed to participate. On this they, like the nurses, specified how I was allowed to use the recordings of them (Appendix A). Participation was voluntary and consent could be withdrawn at any time. All the patients were ill, some more seriously than others. When I sat down with patients to inform them about the study, I thus attempted to be very perceptive towards them and strove to sense any uncertainty or hesitation. If I did feel concerns in this regard, I changed the subject of the conversation to explore whether their uncertainty and hesitation was an indication that they were upset, confused or in other ways cognitively vulnerable. If continued conversation with them gave that indication, I did not asking them to participate, as they might accept without fully understanding what they accepted. If I, in the continued conversation with the patient, did not sense any such impairment, I interpreted their uncertainty and hesitation as a display of reservations about participation, and asked those patients to take some time to think about it. However, to avoid putting pressure on them, I did not approach the patients to ask again, as they might then have found it difficult to decline. In some of these cases, the patients later approached themselves to offer their permission to record them. Given their potentially sensitive and stressful situations and the limited time they had to consider

their decision, all patients who agreed to participate were approached again after the shift ended and asked to reaffirm their participation orally.

Six patients declined participation in the study. A number of patients were not asked to participate for ethical reasons (e.g., they were dying or in severe pain or distress), while several patients were not capable of understanding the given information: e.g., they were unconscious, confused, or cognitively impaired. These patients were thus not recorded. A total of 85 patients were admitted to the respiratory in-patient ward on the 18 days I conducted video recordings on the premises. Additional patients were admitted to the geriatric ward or seen in the out-patient clinics. 23 patients were not asked to participate in the study for the reasons listed above. By coincidence 14 patients were not video recorded as the nurses I happened to shadow did not approach them while I was recording. Consequently 42 patients were video recorded for longer or shorter periods of time. Doctors working in the department constantly engaged in interactions with the nurses during recording. The medical director informed all the doctors about the projected video recordings, and they were instructed to demur if they did not want to appear in the recordings. Two doctors did so and were thus not included in the recordings.

5.1.2. CONDUCTING THE VIDEO RECORDINGS

Given the highly mobile nature of nurses' work, as they walk constantly to locations all over the department, using stationary cameras would have required me to select positions for video recording. Scollon and Scollon recommend that the collection of data takes the participants as the point of departure and follows them, as it is impossible and theoretically limiting to make any advance decisions as to what data should be collected (2007, p. 620). I thus used a mobile camera and shadowed nurses throughout their entire shifts; the camera recorded continuously throughout the days of participation. In addition, I carried a miniature camera in my pocket, which was used to supplement the recordings in situations where limited physical space constricted the angle of the primary camera.

Prior to each day of recording, I made arrangements with a specific nurse to follow her. I arrived at the department in plenty of time before the nurses' shift started to prepare the equipment and speak with patients. From the moment the nurses entered the department I shadowed her with the camera during all activities until her shift ended. If she walked to a patient who was not participating in the study, I waited in the corridor outside the patient room with the camera still running. Other nurses passing by would then invite me to follow along, and I would do so until that nurse had to attend to a patient I could not record, yet another nurse invited me to follow along, or we met with the designated nurse, whichever happened first. This way of

working generated a data corpus with video recordings of numerous nurses and numerous patients, in all kinds of interactions.

Conducting the recordings required continuous attention towards battery times, light, sound, etc. All recordings were made at the widest angle feasible to include as much as possible in the frame. The full bodies of all participants were included, along with as much of the surrounding environment as possible. When limited physical space restricted the angle feasible, the recording was supplemented with the miniature camera. The designated nurse I was following carried a wireless microphone to ensure good sound quality recorded in close proximity to each interaction. Whenever I followed another nurse, I unplugged the wireless receiver and had the camera record the sound instead. This proved unproblematic regarding quality of sound. While recording video I also carried an audio recorder that served as a backup should the primary audio source fail. At the end of each day, all audio and video recordings were transferred to a secured drive in the IT Department at Aalborg University. While the files were uploading, I wrote notes regarding the day to secure information which could not necessarily be derived from the video recordings.

Interactions between patients and nurses in a hospital can involve extremely sensitive information and exposed genital organs. Before engaging the nexus of practice I had numerous reflections on how to conduct the videotaping in an ethically sound way, and consulted several ethical guidelines of research conduct (American Sociological Association, 1999; British Sociological Association, 2002; Sykepleiernes Samarbeid i Norden, 2003) to raise my awareness of ethical responsibilities. Planning the study was done with careful considerations of patients' autonomy, dignity, integrity, and vulnerability. As is clear from the description above, for example I took meticulous precautions to ensure that patients who were upset were not pushed to participate. In the situated conduct of the video recordings I also attempted to safeguard patients' dignity and integrity by turning off the camera in highly vulnerable or exposed situations. In some of these situations patients actually insisted that I turn the camera back on, meaning that I had to make a split second decision regarding the right course of action: stay true to my own sense and keep the camera turned off in order to protect the integrity of the patient or to comply with the patient's request and turn the camera on out of respect for the patient's autonomy. Navigating ethical considerations in concrete, here-and-now situations proved complicated at times, and continuous situated ethical reflections were required to ensure conscientious data gathering. When returning to each of the patients at the end of the shift to ask them to confirm that they still wanted to participate in the study, I also asked for their opinion of my ethical conduct during the day. I also consulted nurses regarding their views of concrete situations in moments when it did not disturb the recordings, as when they were waiting, or were on a break. These tactics permitted the participants' perspectives to contribute to the

qualification of my ethical reflections and the continuous development of my ethical conduct.

5.2. ESTABLISHING A ZONE OF IDENTIFICATION

In Scollon and Scollon's understanding, establishing a zone of identification means, that the researcher gradually enters more and more into the life-worlds of the participants (Norris & Jones, 2005, p. 202). As I engaged in the nexus of practice, I did indeed become increasingly involved with both employees and patients. I did not confine my involvement to professional issues, striving instead to encompass their entire life-world. After spending days and days with the nurses, it felt only natural to ask about sick children or how moving into a new house was progressing. Over my months of participating in their everyday activities, they came to recognise me as a participant in their nexus of practice. The first indication of this development came from an anthropologist who entered the department with a colleague to conduct ethnographic observations. They were there to observe documentation practices as part of a central initiative to reduce the amount of time spent on that task. Like me, the anthropologists were dressed in hospital wear and followed nurses throughout their shifts, although carrying a notepad rather than a camera. On their second day of observation, one of the anthropologists approached me in the staff's room to ask "What is it that you do differently than me? Whenever I enter a room everybody looks at me, but when you enter no one notices it. It seem as though you just blend in with them" (anthropologist 2, 11.06.14).[5]

It can be inferred from her remark that, from an outsider's perspective, I was recognised as a participant in the nexus of practice, though this does not mean that I was acknowledged as an accepted, legitimate participant by the members of the nexus of practice I was studying. As I participated in the nexus of practice, my ability to fit in was demonstrated in the way that nurses shared both personal and professional information and concerns with me, and became apparent when they started asking for my advice. They might ask for my assessment of a patient or a test result ("what do you think about this a [arterial] gas", nurse 8, 30.05.14),[6] how to conduct a specific procedure ("how do I make a greasy slice [a dressing used when a drainage tube is removed from a lung]", nurse 4, 05.06.14),[7] ask me to clarify the reasons for decisions ("how low does pH need to drop before she goes on NIV [non-invasive ventilation]", (nurse 21, 23.06.14)[8], help them make decisions ("do you

[5] "Hvad er det du gør anderledes end mig. Hver gang jeg kommer in i et rum kigger alle på mig men når du kommer ind er der ingen som lægger mærke til det. Det er som om du går i ét med dem".
[6] "Hvad tænker du om den her a [arterie] gas".
[7] "Hvordan er det nu jeg laver en fedtemad [forbinding som bruges når et lungedræn fjernes]".
[8] "Hvor lav er det pH skal være for at hun skal på niv [non invasiv ventilation]".

think with the spillage I should give him another dosage", nurse 14, 13.06.14)[9] or find out what is wrong ("why can I not withdraw any [fluid] from this tube", nurse 18, 25.06.14)[10]. That I managed to establish a zone of identification was reinforced when, after a certain amount of time, the nurses began to criticise colleagues, managers, or doctors openly in my presence, and to discuss mistakes without any attempt to conceal them from me.

5.3. THE SITE OF INVESTIGATION

The hospital where the data for this study was gathered is situated in the North Denmark Region which has approximately 580.000 inhabitants (Region Nordjylland, 2015a). Located in the northern part of Demark, the region governs three somatic hospitals and one psychiatric hospital, with approximately 14.500 employees in total (Region Nordjylland, 2015c). Each hospital has a management led by a hospital director (Region Nordjylland, 2013a). The data was recorded at a hospital situated in a town with approximately 25.000 inhabitants. It is the second-largest hospital in the region with an average of 23.866 patients admitted annually and 185.364 outpatients treated in its clinics. The hospital has regional responsibilities for several areas of specialisation, thus drawing patients from the entire region. Branches of the hospital are located in three other towns in the region with approximately 1600 employees spread over its four physical locations (Sygehus Vendsyssel, 2015). The hospital is run by a hospital director and a hospital vice-director and consists of six organisational units.

The hospital was established in 1822; the first buildings on the current premises were constructed in 1891. Buildings have been added regularly since then, along with on-going renovations. In 2008 a building housing several medical wards was inaugurated, colloquially called "the medical building". The video recordings for the present study were conducted at a medical respiratory inpatient ward, a medical respiratory outpatient clinic, a geriatric ward, and a geriatric outpatient clinic, all in this building. Organisationally the two wards and two clinics comprise a department managed by a head nurse. Physically, the department occupies one floor of the medical building with an entrance hall flanked by two wings (Figure 3). One wing houses the medical respiratory inpatient ward and offices for department management, while the other wing has the geriatric inpatient ward, the geriatric outpatient clinic, and the medical respiratory outpatient clinic.

[9] "Tror du der er løbet så meget ved siden af at jeg skal give ham en ny portion".
[10] "Hvorfor kan jeg ikke trække noget tilbage på det her kateter".

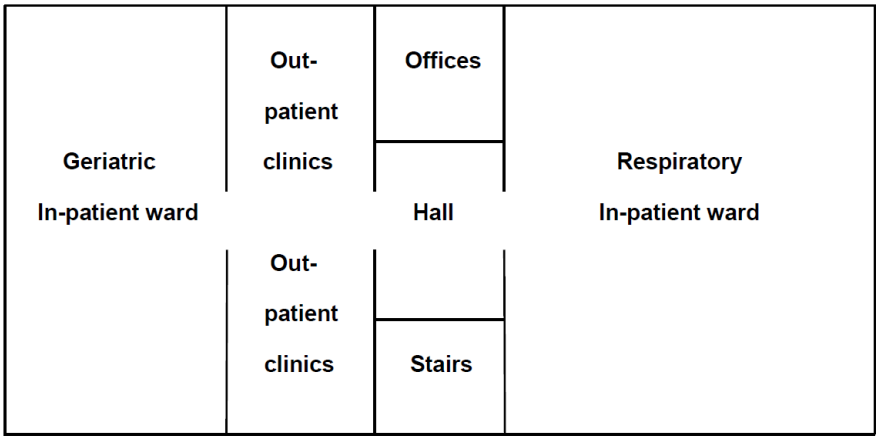

Figure 3: Plan of department

The department is managed by a head nurse with two assistant managers, one of whom is in charge of the geriatric ward and the geriatric outpatient clinic, while the other is in charge of the medical respiratory inpatient ward and the medical respiratory outpatient clinic. The medical respiratory ward and the medical respiratory outpatient clinic have been situated at the premises since the building was inaugurated in 2008, but the geriatric ward and geriatric outpatient clinic were only established four months prior to my engagement with the nexus of practice, as part of a large organisational restructuring of all medical departments in this and other hospitals. Before that, a medical cardiology inpatient ward was situated on the premises. The organisational restructuring caused wards and clinics to be merged or relocated, and employees' work places to shift across hospitals or even cities. Hence, a substantial number of the nurses working at the department had started there only a few months prior to my investigations.

Figure 4: Photo of medical respiratory inpatient ward

The organisational changes and the recent establishment of the geriatric inpatient ward caused me to spend most of my time recording in the medical respiratory inpatient ward (Figure 4). However, video recordings were conducted throughout the department to allow for interrogations into variations and resemblances. Of the 48 nurses employed in the department six worked in the outpatient clinics, 22 in the medical respiratory inpatient ward, and 20 in the geriatric inpatient ward. The respiratory inpatient ward has 13 patient rooms, each intended for two patients. Patient rooms are located on one side of a long corridor, with rooms for equipment and other necessities of care located on the other side (Figure 5).

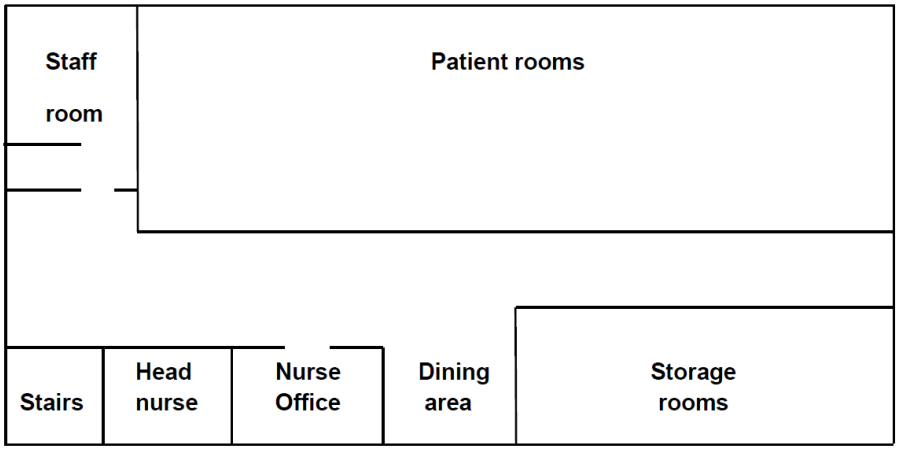

Figure 5: Plan of medical respiratory inpatient ward

5.3.1. THE COMMUNICATION SYSTEM

All personnel working in the department carry mobile work phones: managers, doctors, nurses, nurse assistants, secretaries and cleaning personnel, as do staff who are not assigned to a particular department, such as porters, occupational therapists, physiotherapists, and medical laboratory assistants. The phones used in the hospital are Ascom d62s (Figure 6), which uses the DECT standard (Ascom, 2016a).

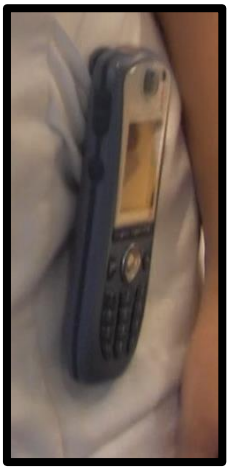

Figure 6: The mobile work phone

The phones can be used to place internal and external phones calls and to receive calls from any phone inside or outside the hospital. An incoming call is signalled by a ringtone, with the caller's number displayed. It is possible to designate seperate ringtones for various types of calls in order to differentiate between them. However, as the nurses do not carry the same phone every shift, the settings depend on previous users, the preferences and skills of the nurse carrying the phone, and whether the nurse has the time to make adjustments. The phones also receive alarms from electronic surveillance equipment like electronic cardiac monitors and from emergency buttons placed in all rooms in the department. When an emergency button is pressed all activated phones in the ward repeatedly produce a loud tone and display the bed number of the emergency. The phones also receive nurse calls that patients place by pulling a drawstring. When a patient issues a nurse call, all phones in the group of nurses assigned to a certain number of patients will display the patient's bed number and produce a beep every 30 seconds until someone attends to the call. The patient room is also displayed on screens in the corridor, in the office, in the staff room, and in patient rooms where the presence button is activated. If the call is not attended to within two minutes, the phones in the other group of nurses will also display the bed number and produce a beep every minute until a response occurs. When nurses respond to a nurse call, they must deactivate the call by

pressing a button inside the patient room. Pressing the button once marks the nurse as present in the room, which is indicated by a green light above the door. When leaving the room, the nurse has to press the button again to deactivate the presence function. If a drawstring is pulled while the presence button is on, an emergency alarm will sound.

The phones are linked by a software system which the nurses can access from any computer. At the start of a shift, each phone must be activated by logging on to the software system and designating which nurse is carrying that phone. At the end of every shift, nurses must deactivate the phone in the software system.

5.4. WORKING IN THE NEXUS OF PRACTICE

The nurses employed in the medical respiratory inpatient ward when the building was first occupied received a brief introduction to the phone system. Nurses hired subsequently have not received any such introduction, and there has been no follow-up training. When nurses begin working in the department, they are told by a colleague to carry one of the phones. How much the individual nurse knows about the functionalities of the phone system depends on what their colleagues tell them and how much they find out on their own. When newcomers enter the nexus of practice, they may ask specific questions and receive answers about the functionalities of the mobile work phones or the communication system. Occasionally, nurses who have been working in the department for some time also ask a colleague about a specific functionality of the phone, such as how to redirect a call. Thus, the extent to which staff members explore and use the functionalities of the phones varies a great deal. Some use it only for making and answering calls, whilst others use the phones' directory and are able to redirect calls. The short message system (SMS) was only observed to be once. To avoid disturbing a conversation between a doctor and a patient, an experienced nurse (nurse 17) sent a message to a nurse colleague (nurse 4) rather than calling (26.06.14). The colleague receiving the short text message immediately called back, completely confused about the message. Even though the nurse at this point in time had been working in the department for 18 months, she did not know it was possible to send text messages on the phones.

5.4.1. BEGINNING A SHIFT

When the phones are not in use they are placed in a charging rack next to the staff room (Figure 7). When nurses begin their shifts they place their personal belongings in a locker and grab a phone from the charging rack. The number of phones does not

equal the number of nurses and nurse assistants working in the ward. Hence, they do not each have a phone permanently assigned to them. Some nurses simply grab a random phone when they begin a shift, while other nurses prefer to have the same phone when they are at work and thus team up with another nurse who works the opposite shifts. On most days they can then hand the phone to each other as one ends and another begins a shift. They attach a label with their names to the charging rack in front of the phone to display their preference for the phone. Colleagues try to avoid taking a phone with such labels but this is not always possible due to the limited number of phones.

Figure 7: Charging rack

After taking a phone from the charging rack, nurses and nurse assistants go to the office, where they each take a printed paper overview of the patients admitted to the ward. The overview lists the name, diagnosis, treatment plan, bed number, etc. of every patient. The patient rooms are divided into two groups, red and green, and the nurses and nurse assistants are similarly divided into two groups. Each group is responsible for half the patient rooms, in an effort to distribute the number of patients and workload evenly between the two groups. However, as patients do not require the same amount of treatment and care, the workload allocation between the two groups is regularly negotiated and resources are reallocated if necessary. As a shift commences, the two groups gather around their table in the office, while a nurse from the previous shift passes on relevant information regarding the patients in the group. Then, the group allocates the responsibility for each patient among themselves, discuss treatment plans, and assign various tasks and functions such as ward rounds, medicine rounds, meetings, etc.

After the group decides which nurse is responsible for which patients, they write the name of the nurse next to the patients' names on the printed paper overview, also noting the names of each group member and the number for the phone they are carrying that day. Nurses carry the printed overview with them at all times, adding information during the work day and consulting it for any information that they have not memorised. If the printed patient overview is mislaid nurses search desperately for the paper until it is found. They refer to the printed paper overview as "my other brain" (nurse 8, 30.05.14), "my extra brain" (nurse 1, 21.05.14), "my reserve brain" (nurse 39, 26.06.14), or "the third half of my brain" (nurse 19, 02.06.14).[11]

Whichever nurse is sitting close to a computer logs on to the phone software system. To avoid having every nurse spend the time logging into the system, she then activates all group members' phones and assigns them to the appropriate nurses.

5.4.2. WORK FLOW

Nurses leave the office and begin their tasks at locations all over the physical premises of the ward. As they all have their own patients and tasks to attend to, the majority of work is performed without colleagues being physically nearby. Exceptions arise when they are accompanied by a nurse student or have to perform tasks which require two people. When working individually, however, they regularly call each other on the phone, as an individual nurse cannot perform the task at hand if information is lacking, if she has doubts or lacks knowledge, if activities have not been performed or documented, etc. Nurses are this hampered in completing their duties until they have established contact with a colleague or collaborator who can provide the essential information or action. Their reasons for calling are mainly coordination, distribution of information, and supervision. This echoes findings in studies presented in Section 2.3.1 and 2.4.3, which reported nurses to be coordinating pivots, managing and distributing large amounts of information and preferring synchronous communication as their work is oriented to the here and now (Alvarez & Coiera, 2005; Alvarez & Coiera, 2006; Booth & Waters, 1995; Edwards et al., 2009; Toussaint & Coiera, 2005). If a call is not answered, nurses are observed to call back repeatedly, as was reported in a study presented in Section 2.4.3 (Scholl et al., 2007). How often nurses call one another or are called varies a great deal. It is influenced by the experience of the nurse, as recently qualified nurses and newly appointed nurses frequently have to call more experienced nurses for supervision. It also depends on the assignments of the nurse on a particular day, as nurses responsible for wards rounds and discharging patients have to coordinate with numerous other actors. Of course, the frequency of calls is influenced by the sheer number of patients admitted to the department, whether the

[11] "min anden hjerne", "min ekstra hjerne", "min reserve hjerne", "min tredje hjernehalvdel".

department is overcrowded, and by the conditions of the patients. If a patient is in poor condition, the nurse responsible for that patient calls other nurses and doctors more frequently to adjust treatment, report deterioration or ask for assistance.

When nurses are called, they almost always answer the phone. In only two situations in the 144 hours of video recordings does a nurse not answer a ringing phone. In both situations the nurse is wearing gloves contaminated with urine or vomit when the phone rings. The ringing of the mobile work phones are thus strong summons, confirming Schegloff's earlier demonstrations (1968, 2002). As nurses answer the phone, the number calling is displayed regardless of whether it is an internal or an external call. Most nurses recall the phone numbers of frequent external collaborators like community nurses and the company that installs oxygen in private homes. They also memorise numbers of internal collaborators such as the x-ray department or the laboratory. However if a colleague from within the department calls, the nurses only know who is calling before they answer the phone if they know who is carrying the number displayed on that particular day. They may recall this from the morning gathering, or they may remember if they are called several times by the same colleague.

When nurses answer the phone they generally identify themselves, although if two nurses have communicated on the phone several times within a short time frame they omit this step. The numbers for the phones which the nurses carry are not made available to people outside the healthcare system. However, when nurses call the relatives of patients their number is displayed, and relatives can then use the number if they need to contact the nurse later. If they call the next day, another nurse who knows nothing about the patient may be carrying the phone.

When information regarding a patient is to be delivered or obtained, nurses refer colleagues and collaborators to the nurse assigned to the patient. If another nurse is approached, that nurse will then provide the number for the correct nurse, either from memory or by consulting the printed overview. This means that all knowledge and responsibility concerning each patient rests with the assigned nurse. Before mobile work phones were implemented, nurses received information about other patients and then passed it on to the assigned nurse when they encountered that nurse in person.

The phones are attached to pockets near the hip on nurses' uniforms (Figure 8). The phone display is not visible to the nurses by a simple glance; rather they need to tilt or grab the phone in order to read the display. They frequently do so without disinfecting their hands. On rare occasions their hands are so contaminated that they avoid touching the phone. If the phone then produces a beep to indicate a patient call they bend their hip backwards in order to make the display visible to them. When an emergency alarm sounds, all phones produce a loud repeated sound and every nurse immediately drops everything and runs to the patient room displayed. Most of the

alarms are false, caused by a nurse call button being activated in a patient room where a presence button is also activated. Consequently, a large number of nurses avoid activating the presence button when they enter a patient room.

Figure 8: Position of phone

In observing the interaction order, it becomes evident how nurses not only constantly move around the physical premises of the department, but also how they continuously move their bodies, with one activity followed by the next in a continual flow without pauses. When nurses talk on a mobile work phone, this pace is continued, and they are almost never observed to be standing still. While speaking on the phone, they simultaneously walk to position themselves for their next task or perform multiactivity, using bodily resources not required to manage the phone call to perform other activities. For longer conversations, rather than standing in the corridor, they frequently walk to a storage room to finish the call. Only if the nurses are walking to a patient room and the call is not finished when they reach the door do they stand still outside the door and finish the call before they enter. Furthermore, it is observed how nurse tend to not initiate calls when they are inside patient rooms, instead waiting until they leave the room before calling. At the end of their shifts, nurses deactivate their phones as they finish their tasks and leave the office. As they do not finish simultaneously, several nurses have to log in to the software system to deactivate their phones within a short time span.

5.4.3. COLLABORATING WITH DOCTORS

Doctors also carry different phones every day, depending on which duties they are assigned to. The number of the phone they carry is linked to the assignment, which

means that if nurses need to call a specific doctor, they have to know what assignment the doctor has that day or consult the doctors' work schedule. However, as the ward only has a copy of the schedule on which updates are not reflected, they frequently call the wrong doctor. They then need to ask others who might know what assignment that doctor has, and nurses and doctors frequently call each other to inquire about a number.

When nurses and doctors are engaged in activities in patient rooms, they take over courses of actions for each other if one is summoned by a phone. Doctors engaged in conversation with a patient are seen to hand their ringing phone to the nurse and asking her to answer it. As the doctors' phones are linked to their assignments, the doctor with the phone also hands over the responsibility of assessing the call and any response required. This demonstrates that doctors rely on the ability of nurses to carry out this task competently.

With this description of working processes, I leave the activities of engaging the nexus of practice and commence the analysis of the data. In Chapter 6 the analysis begins by mapping the numerous semiotic cycles circulating the nexus of practice.

CHAPTER 6. MAPPING THE NEXUS OF PRACTICE

In this chapter the semiotic cycles circulating in the nexus of practice are mapped and described, however, as detailed in Section 4.5.2, I had to refrain from including all. Mapping the semiotic cycles entails following the cycles of persons, places, discourses, objects and concepts (R. Scollon & S. W. Scollon, 2004, p. 159). This means that I have followed semiotic cycles to other hospitals and nurses working at them, to virtual places such as the region's document management system, to various websites, to people working at Ascom and the regional construction department, etc. In mapping the semiotic cycles, I thus draw on my participation in the nexus of practice during which I followed connections and gathered as much data as possible on my way, as outlined in Section 4.7.

Each of the cycles followed has a history which leads into a moment of action; each also has a future leading away from the moment of action. These past and future trajectories were followed backwards and forwards in time in order to encompass interactions between nurses, patients, and mobile work phones. In circumferencing the interactions, I strove to include the most important elements that gave them meaning, which, for example, entailed following the semiotic cycle of the mobile work phones back to the point of their acquisition. Needless to say, it would be an impossible task to follow all semiotic cycles in the full length of their own inherent timescales. According to Scollon and Scollon, this would also not be relevant (R. Scollon & S. W. Scollon, 2004, p. 171). Following the timescales of the semiotic cycles circulating in the nexus of practice, I thus did not follow the historicity of the design of the phone, trajectories to private mobile phones, to various other phone companies and other phone systems, etc.

In the following sections semiotic cycles are mapped in various ways, taking inspiration from Clarke (2005). On the basis of this process connections between elements of the maps are reflected on and central orientations of the nexus of practice identified. The discursive constructions emerging from this process then delimit the description of semiotic cycles in subsequent sections.

6.1. MAPPING

Mapping the nexus of practice was carried out by literally producing maps of pertinent semiotic cycles circulating in the nexus of practice, which serves as a way to enter the analysis of the immense complexity which nurses have to navigate in

interactions with patients and mobile work phones. In composing the maps, I was inspired by the way Clarke works with maps in situational analysis (2005), and the way Larsen uses maps in a nexus analysis study of youth and online social networking (2010). In developing situational analysis, Clarke is rooted in Grounded Theory and Symbolic Interactionism, aiming to understand the situatedness and relations of actions in a case being studied (Clarke & Friese, 2007). However, as this thesis merely takes inspiration from the way Clarke configures maps without subscribing to other elements of the theoretical and methodological framework of situational analysis, I will not explain it further. For the same reasons, I refrain from collocating situational analysis and Nexus analysis, but recommend Larsen for an elaboration on this issue (2010). In this thesis maps are not used to form final analytic products but to articulate the countless semiotic cycles circulating in the nexus of practice and to stimulate reflections on that complexity. The maps serve as an entrance into the analysis of the complexity. Given the large amount of elements included in the maps they are hard to read in the figures below; the maps are thus available on the enclosed USB stick.

6.1.1. MESSY MAP

The first map is a "messy" situational map (Clarke, 2005, p. 87); it includes all the pertinent human and non-human actors, mediational means, discourses and concepts circulating in the nexus of practice (Figure 9). The purpose was to articulate the countless semiotic cycles circulating in moments of interaction between nurses, patients, and mobile work phones, and to open up a wide range of analytical interests around the moments of action. This reflects the way that Scollon and Scollon approach the study of social action, taking into consideration the broader discourses in which the action operates (R. Scollon & S. W. Scollon, 2004) and aiming to preserve the complexity of social situations (R. Scollon, 2001a).

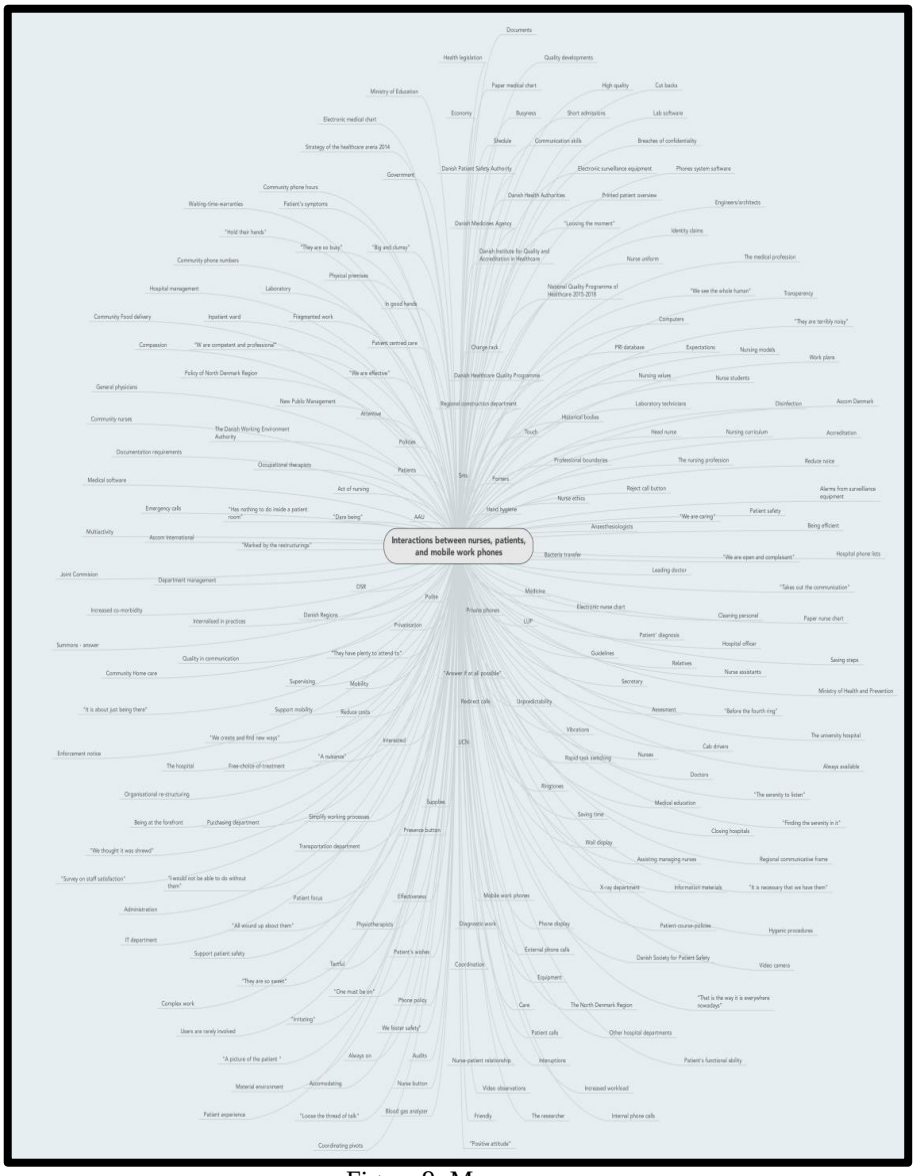

Figure 9: Messy map

The messy map is the result of a long-term brainstorming process during which pertinent semiotic cycles circulating in the nexus of practice were regularly added. The map is produced by means of the online mapping software Mindmeister (2016), with the elements included in the map positioned in random order. The citations included in the map are quotations from people or documents encountered during my participation and circumferencing of the nexus of practice. Even though the map does not include all semiotic cycles circulating in the nexus of practice it nevertheless demonstrates the immense complexity involved as nurses, patients, and mobile work phones interact. For example; the patient's diagnosis and symptoms influence what the patient is able or allowed to do, and thus influence the way nurses take action in concrete situations. Another example is the restricted availability of community home care nurses; when they call, it may not be possible to call them back later.

6.1.2. ORDERED SITUATIONAL MAP

Mapping the complexity of interactions between nurses, patients, and mobile work phones visualised the countless entangled elements contributing to the interactions, thus allowing for more conscious reflections on them. Taking inspiration from Clarke (2005) and Larsen (2010), the numerous elements constituting interactions between nurses, patients, and mobile work phones were subsequently categorised in what Clarke has termed an "ordered situational map" (Clarke, 2005, p. 89). Categorising in this case is not used in the sense of forming analytical products. Rather, categorising the elements of the messy map as it is performed here means to group the elements as actants, actions, discourses, etc. (Figure 10). Some elements fitted into more than one category, in which case they were placed in the category that seemed most pertinent. This pragmatic solution was applicable as the production of the ordered map in this thesis is not an analytical manoeuvre, but merely a way of establishing an overview of complexity.

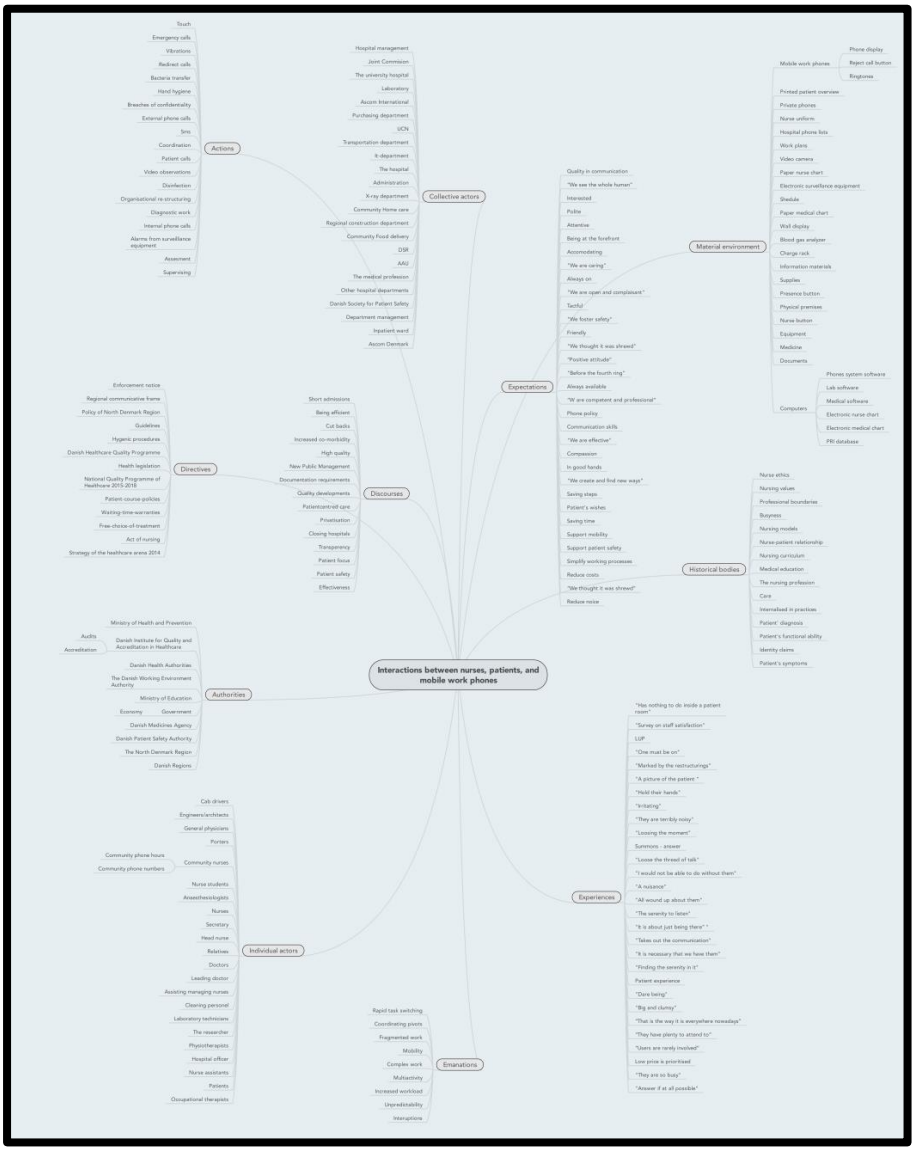

Figure 10: Ordered situational map

The ordered map displays more clearly the pertinent semiotic cycles circulating in the nexus of practice. The elements featured are identical to the elements included in the messy map, but provide an overview of the individual and collective actors, expectations and emanations, actions, mediation means, etc., which all circulate in the nexus of practice.

6.1.3. RELATIONAL MAPS

Although numerous cycles have already been omitted, including all the elements of the ordered map in the analysis of this thesis would lead to too much ambiguity. Rather than attempting to include everything, I thus needed to narrow my inquiry further. After mapping the semiotic cycles circulating in the nexus of practice, Scollon and Scollon suggest that their mutual connections be identified (2004, p. 158). In doing so, I again took inspiration from Clarke and the way she draws up "relational maps" (Clarke, 2005, p. 102). Each element on the map was systematically considered in relation to other elements on the map, and their mutual connections were plotted. With this manoeuvre the complexity again became apparent; numerous relational maps were produced to be able to distinguish between patterns of connections. Clarke further proposes that the nature of each connection be described. However, as the aim of producing the maps in this thesis is not to form final analytic products, I refrain from this, knowing it might preclude further reflections from being triggered.

In plotting the links between semiotic cycles circulating in the nexus of practice, two patterns of connections emerged as ubiquitous (Figure 11 & 12). The connections between elements of the maps visualise how various role expectations manifest in different elements of the nexus of practice. For now, an initial contemplation of the maps is presented in order to point to the central orientations and normativities that circulate in the nexus of practice. These will delimit the detailed descriptions of expectations and the ways in which they are manifest presented below. To ease reading the brief outlines of the maps, appropriate citations appear from the detailed descriptions.

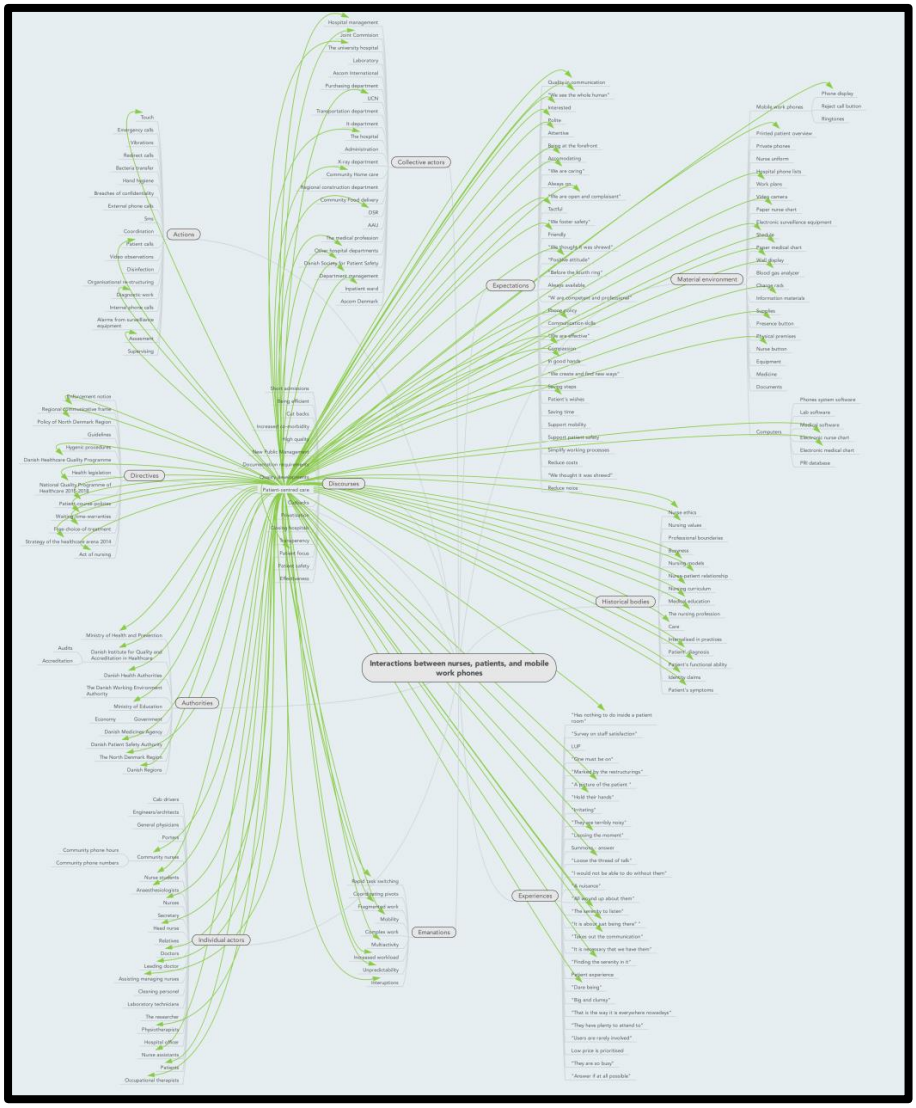

Figure 11: Relational map – patient-centred care

From the relational map presented in Figure 11, it can be seen how central documents of the ministry articulate that "the patient should be the focal point" and that the patient should be "the centre of attention". It connects to Danish regions aiming for a healthcare system in which "the individual is in the centre". This connects to the North Denmark Region's assertion that "patient focus is one of the leading values" and that nurses are expected to be "caring". This is discursively constructed as being "in good hands" and visualised by pictures of a hand holding a heart. In its documents the region links care with being "attentive" and "open and agreeable", with seeing "the whole human" and with "security". The hospital also articulates expectations of patient focus which are manifested in phrases such as "do it attentively and well" and "with the patient as point of departure". Guidelines expect nurses to be "accommodating", "interested" and "sensitive", while satisfaction surveys ask that they are "friendly and agreeable" and "available for needs of care". This connects to care being central in the nursing curriculum, linking it to being "attentive" and "sensitive" towards the patient and relating to the patient in a respectful and responsive way. It also connects to utterances produced by nurses working in the nexus of practice, who talk about the importance of "just being there", "holding their hands" and having "the serenity to listen". Finally, it connects to patients articulating how nurses are "so sweet". (Danske Regioner, 2016b; Ministeriet for Sundhed og Forebyggelse, 2015; Region Nordjylland, 2012, 2013b, 2014a, 2014b; Sygehus Vendsyssel, 2014)

In these ways, role expectations circulating in the nexus of practice are manifested in various terms used by different actors. The terms are interconnected by semantic meaning, which indicates that they are not solitary terms used in isolation but form a coherent orientation and way of thinking. The expectations circulating in the nexus of practice constitute and discursively construct a discourse of "patient-centred care", which is substantiated in Section 6.2.1 by describing the discourse in more detail.

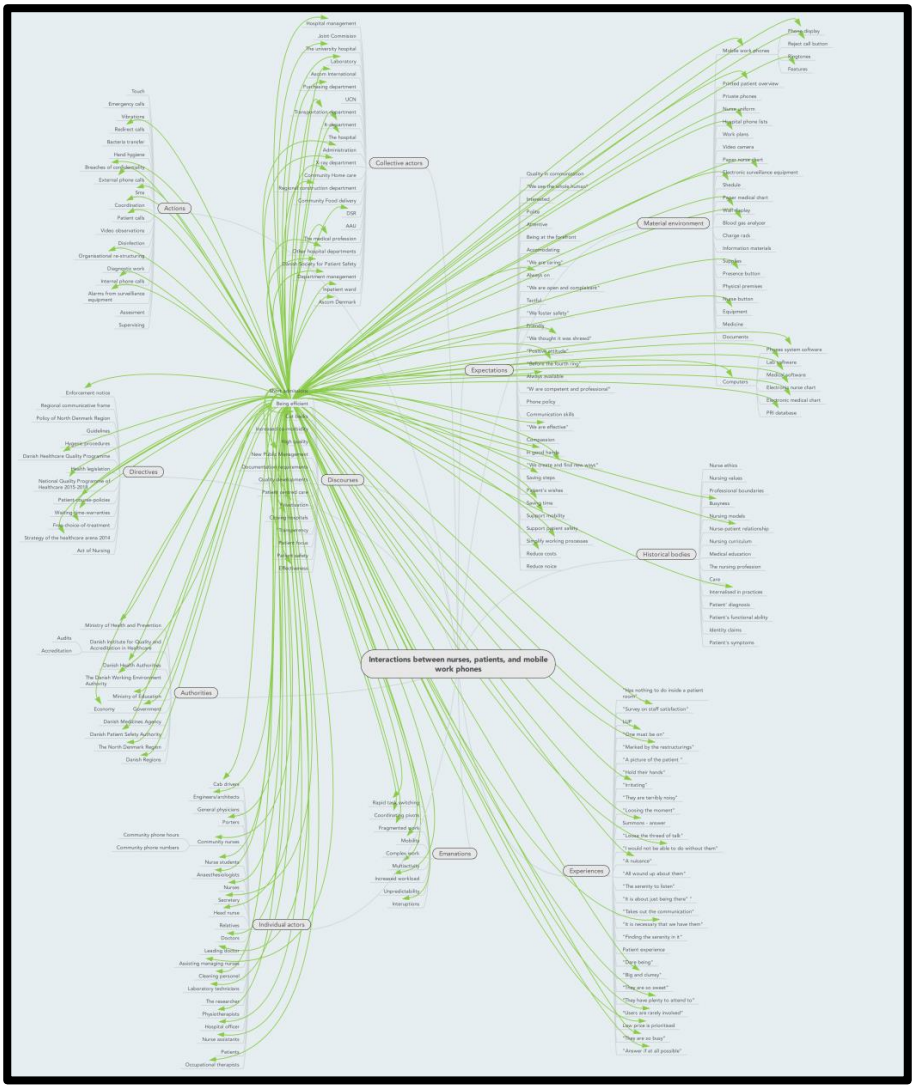

Figure 12: Relational map – being efficient

The relational map presented in Figure 12 illustrates how central documents of the ministry insist that resources are used "as efficiently as possible" and that healthcare services should be delivered "at the lowest cost per patient". This connects to continuous cost reductions, layoffs, and overcrowded hospital departments, which further connects to nurses experiencing heavier workloads and increased time pressure. This connects to restructurings in the nexus of practice motivated by issues of economy and efficiency and to a contract between the hospital department and the

hospital management that defines the demands of economy and efficiency. It also connects to the North Denmark Region's articulation that "we are efficient" and to nurses working in the nexus of practice who in their actions exhibit themselves as "always available". Nurses articulate this sentiment in phrases such as "one must always be on" and "be available", and "I would like to answer my phone at all the times that it is at all possible". It also connects to patient expressing that nurses "have plenty to attend to", etc. (Danske Regioner, 2016b, 2016c; Hansen, 2016; Ministeriet for Sundhed og Forebyggelse, 2015, Region Nordjylland, 2012, 2014).
The map in Figure 11 display role expectations circulating in the nexus of practice and how they are manifested in various terms used by different actors. As in the previous map, the terms used are connected by semantic meaning indicating that they are not solitary terms used in isolation but form a consistent orientation in the nexus of practice. Expectations circulating in the nexus of practice constitute and discursively construct a discourse of "being efficient", which is substantiated in section 6.2.2 by describing the discourse in more detail.

6.2. PERSISTENT DISCOURSES CIRCULATING IN THE NEXUS OF PRACTICE

The process of mapping the semiotic cycles circulating in the nexus of practice has served as an entrance to the analysis by providing an overview of the complexity involved and by delimiting where to focus my inquiry. From the connections between elements in the maps, a discourse of patient-centred care and a discourse of being efficient have emerged. These discourses are substantiated below as the semiotic cycles constituting the discourses are described.

6.2.1. THE DISCOURSE OF PATIENT-CENTRED CARE

The National Quality Programme of Healthcare 2015–2018 dictates that "the patient should be the focal point"[12] and that healthcare professionals should "put the patient in the centre"[13] (Ministeriet for Sundhed og Forebyggelse, 2015). In the "Strategy of the healthcare arena 2014"[14] the North Denmark Region names patient focus as one of six values guiding the development of the healthcare system (Region Nordjylland, 2014a). "Danish Regions", which is an association of the five regions in Denmark that govern the healthcare system, describes on its website how the regions aim for a healthcare system in which "the individual is in the centre" (Danske Regioner,

[12] "patienten skal være omdrejningspunktet".
[13] "sætte patienten i centrum".
[14] "Strategi på sundhedsområdet 2014".

2016b).[15] In the policy of the North Denmark Region, "Involving patients and relatives in the healthcare system in the North Denmark Region" (Region Nordjylland, 2013b),[16] it is articulated that patients are to be involved in and influence their own course of treatment. The policy states that, "patient focus is one of the leading values in the health strategy of the North Denmark Region".[17] To achieve this, a communicative frame of the North Denmark Region is presented, requiring that "all communication must be attentive, simple, focused, and trustworthy" (Region Nordjylland, 2013b).[18]

The North Denmark Region webpage lays out what patients, relatives, partners, and citizens can expect when in contact with the region: "security, professionalism, competences, care, and much more" (Region Nordjylland, 2015b).[19] These aims are consolidated in the motto "In good hands at the North Denmark Region",[20] which is illustrated by a hand holding a heart or a group of people (Figure 13). This illustrated motto is promoted on webpages, banners and posters, on cars, in printed leaflets, staff magazines, etc.

Figure 13: In good hands

[15] "patienten sættes i centrum"
[16] "Inddragelse af patienter og pårørende i sundhedsvæsenet i Region Nordjylland".
[17] "er patientfokus en af de bærende værdier i Region Nordjyllands sundhedsstrategi".
[18] "al kommunikation skal være nærværende, enkel, målrettet og troværdig".
[19] "tryghed, professionalisme, kompetencer, omsorg og meget mere".
[20] "I gode hænder hos region Nordjylland".

Furthermore, a collection of "good stories" has been published by the North Denmark Region in a document called "The good hands – in words and photos" (Region Nordjylland, 2012).[21] It relates positive narratives from patients, relatives, and employees, which are accompanied by photos of hands belonging to specific, named employees. The multiple photos "show a selection of the good hands of the North Denmark Region",[22] and display hands holding various artefacts like a red thread, an oxygen mask, a bag of blood, etc. Written headlines in the publication assert that "we are competent and professional", "we are caring", "we see the whole human", "we foster safety", "we are efficient", "we create and find new ways", and "we are open and agreeable" (Region Nordjylland, 2012).[23]

On banners in the entrance hall of the hospital[24] the motto of the Region is reformulated to "In good hands at Hospital Vendsyssel".[25] This motto is also present on the hospital webpage, along with a repetition of the values of security, professionalism, competences, care, and much more which is featured in the motto. The hospital further promotes itself as "Large enough to be among the best and small enough to do it attentively and well" (Sygehus Vendsyssel, 2014).[26] By being "among the best", the hospital refers to a high level of quality in its treatments. Doing it "attentively and well" means that the hospital wishes to articulate that delivering a high level of quality is not done without human considerations but in a way that is attentive to each individual patient. The vision of the hospital is presented on the hospital webpage: "With the patient as point of departure, to perform coherent and efficient patient courses characterised by up-to-date, quality-controlled professional expertise in diagnostics, treatment, care, and rehabilitation" (Sygehus Vendsyssel, 2014).[27]

The North Denmark Region thus emphasises hands in internal communication (staff magazine) and in external communication (banners, posters, cars, leaflets, webpages, publications, etc.). The hand holding a group of people or a heart has strong connotations of "warm hands" taking "care". In the publication with photos of hands belonging to specific employees, the text is structured as if it is uttered by the employees themselves: e.g., "*we* [emphasis added] are caring", "*we* [emphasis added] are open and agreeable". In this way the employees working within the healthcare system are regularly described as individuals with caring hands. The

[21] "De gode hænder – i ord og billeder".
[22] "viser et udpluk af Region Nordjyllands gode hænder".
[23] "vi er kompetente og professionelle", "vi er omsorgsfulde", "vi ser det hele menneske", "vi skaber tryghed", "vi er effektive", "vi skaber og finder nye veje", og "vi er åbne og imødekommende".
[24] As of March 2nd 2016 the name of the hospital changed from "Sygehus Vendsyssel" to "Regions hospital Nordjylland". However, as the name change was not implemented on the websites of the Region as this thesis was composed, the name is not changed in this thesis.
[25] "I gode hænder på Sygehus Vendsyssel".
[26] "Store nok til at være blandt de bedste og små nok til at gøre det nærværende og godt".
[27] "Med udgangspunkt i patienten præsterer Sygehus Vendsyssel sammenhængende og effektive patientforløb, som er karakteriseret ved høj ajourført kvalitetssikret faglig ekspertise i diagnostik, behandling, pleje, genoptræning og rehabilitering".

formal policy of the North Denmark Region has different wording: "patient focus is one of the leading values in the health strategy of the North Denmark Region" and "all communication must be attentive, simple, focused, and trustworthy". The policy is accessible to everyone from the region's webpage, as it is a directive document for the Region's employees. By explicating patient focus as one of its leading values, the North Denmark Region thus displays to its employees that they are expected to place the patient at the centre of treatment and care. The policy, however, also has an external signalling effect and promotes externally that this is what can be expected under the auspices of the Region. The policy is concretised in the communicative frame dictating that "*all* [emphasis added] communication must be attentive, simple, focused, and trustworthy" (Region Nordjylland, 2013b), which leaves no room for exceptions. The demands on the employees of the region to act accordingly are thus clear, repeated frequently, and inescapable.

Section 2.2 revealed that patient focus was introduced into the nursing curriculum by early nursing theorists in the 1960s (Henderson, 1966; Peplau, 1952; Travelbee, 1966). Since then, patient focus has been manifested in almost every nursing theory, articulating the patient as focal point, and the nurse-patient relationship as fundamental (Alligood, 2014). Care was introduced into the nursing curriculum during the 1970s (e.g., Leininger, 1978; Watson, 1979) and has since formed nothing short of a moral imperative for nurses that remains in force. Nursing theorists like Benner, Eriksson and Martinsen have strongly influenced the Danish nursing curriculum by describing care as caritative (Eriksson, 1998), as skilful perception (Martinsen, 2006), and as a responsive and supportive relating (Benner et al., 1996).

In the Nursing Act of 2008, "care" is only mentioned once, which make clear how a respectful collaboration with the patient is basic to the conduct of care. Patient focus, on the other hand, is mentioned repeatedly, and described as a "focus on both the patient's basic needs as well as special needs", "focus on the individual human", "focus on the individual's experiences, conditions and actions", and "focus (…) on the relation between patient, relatives, and nurse" (Undervisningsministeriet, 2008).[28] In the Nursing Act of 2016 which became effective August 1st 2016, it is added that nurses must be able to use, assess, and reflect upon technologies in relation to care and treatment (Undervisningsministeriet, 2016).

Expectations of care and patient focus also appeared in the utterances of nurses as I participated in the nexus of practice. As the video camera recorded continuously the conversations between nurses and colleagues, patients, the collaborators and I were also recorded, although in some cases only in audio format. Speaking about their practices, one nurse expressed how, in interactions with patients, it is important that

[28] "fokus på både patientens grundlæggende behov og de særlige behov", "fokus på det enkelte menneske", "fokuserer på menneskets oplevelser, vilkår og handlinger", "fokuserer (…) på interaktion mellem patient, pårørende og sygeplejerske".

one "dare to be".[29] She had experienced that what she does can be "of great importance" to the patients,[30] and admires patients for "letting one in".[31] The nurse concluded by saying that interacting with patients is about "finding the serenity in it" (nurse 1, 21.05.14).[32] Another nurse reported that "it is hard to know what one should do",[33] but subsequently articulated how a nurse can achieve a lot by just sitting down next to patients and "holding their hand".[34] She explains how one can gain great insights simply by "having the serenity to listen"[35] to the patient and summarises by saying that "it is about just being there" (nurse 12, 13.06.14).[36]

A third nurse described how in interactions with patients, she needs to create "a picture of the patient inside my head". It is the insights into the patients' life-world and how they speak about themselves that determines how the nurse "reacts to what the patient feels"[37]. This nurse pointed out that even though two patients might feel the same, the action she takes could well vary; therefore, she finds it difficult to take action without such insights (nurse 13, 05.05.14).

The requirements placed on nurses are not simply idle words; rather, the nurses' activities are being evaluated and assessed continuously. The extent to which nurses meet patient expectations is evaluated in a national survey of patient experiences, which charts how patients experience their visits to hospital departments. The results from all of the clinics and wards in the medical unit are analysed as a whole, which means that results are not calculated for the specific inpatient ward where the video recordings were conducted. In 2014, when the video recordings were conducted, 198 patients who were acutely admitted to one of the inpatient wards answered a questionnaire asking them to evaluate communication, information, patient involvement, availability of staff, errors occurring, rest, food, etc. (Enhed for Evaluering og Brugerinddragelse, 2014). On a scale from one to five, with one indicating "not at all" and five indicating "to a very high degree", patients were asked to state their agreement or disagreement with statements such as "The staff was friendly and agreeable" (score 4.35), "Verbal information was intelligible" (score 3.95), "Questions asked were answered" (score 3.98) and "Staff was available for needs of care" (score 3.86). In general, this hospital has been evaluated well in national surveys on patient experiences, and in 2012 it was chosen as the best minor hospital in Denmark. This election was based on results from the national survey of patient experiences, measurements of quality in patient treatment, and a vote among

[29] "turde være".
[30] "har stor betydning".
[31] "lukke én ind".
[32] "finde ro i det".
[33] "svært at vide hvad man skal gøre".
[34] "holde dem i hånden".
[35] "have roen til at lytte".
[36] "det handler jo om bare at være der".
[37] "jeg skal have et billede af patienten inde i hovedet for at afgøre hvordan jeg skal reagere på det de mærker".

healthcare professionals (Johansen, 2012). In participating in the nexus of practice patients often described nurses along the lines of "they are so sweet" (patient 33, 24.06.14).[38]

6.2.2. THE DISCOURSE OF BEING EFFICIENT

Other expectations circulating in the nexus of practice centre around efficiency. In addition to the demand that patients be the centre of attention, the National Quality Programme of Healthcare 2015–2018 requires that efforts be undertaken to promote efficient resource utilisation. As Section 2.1 outlined, resources are to be used "as efficiently as possible" and healthcare "should be delivered at the lowest cost per patient" (Ministeriet for Sundhed og Forebyggelse, 2015). For at least a decade Danish hospitals have had to deliver a 2% cost reduction every year, while still abiding by maximum wait time regulations (Danske Regioner, 2016c; Hansen, 2016). In this same time frame, expenditures for new types of medicine have skyrocketed and an increasing proportion of the Danish population is older, which augments their need for treatment and care (Danske Regioner, 2016d; Oxvig, 2016). Layoffs have been implemented and bed numbers reduced, with medical departments in particular experiencing overcrowding and high staff turnover (Christensen, 2016; Danske Regioner, 2016a; Pedersen, 2016; Pedersen & Jensen, 2016). On the Danish Regions website, the Danish healthcare system is described as "marked by efficiency" (Danske Regioner, 2016b).[39] In the "Strategy of the healthcare arena 2014" the North Denmark Region articulates "cost-effectiveness"[40] to be one of six values guiding the development of its healthcare mandate. Money and personnel are to be used at the "lowest effective level of care"[41] as "society must have as much health as possible for the money"[42] (Region Nordjylland, 2014a). The Region's health finances department is responsible for drawing up budgets and signing contracts to ensure economy and efficiency with the hospitals under its jurisdiction. The department is also responsible for registering and measuring effectiveness of the hospitals and for efficiency developments (Region Nordjylland, 2016b).

In the collection of good stories published by the North Denmark Region, employees are described as "efficient" and able to "create and find new ways" (Region Nordjylland, 2012). On the hospital website issues of economy are also

[38] "de er så søde".
[39] "præget af effektivitet".
[40] "omkostningseffektivitet".
[41] "laveste effektive omsorgs niveau".
[42] "samfundet skal have mest mulig sundhed for pengene".

addressed; it aims to deliver the best treatment and care "within the given political frames" (Sygehus Vendsyssel, 2014).[43]

According to the head nurse of the department, the organisational restructuring just launched as I entered the nexus of practice was motivated by issues of economy and efficiency. During my participation the head nurse and the two assistant managers had several meetings to prepare for forthcoming negotiations with hospital management, as the collective agreement defining specific demands of quality, efficiency, and economy was up for renewal. When following the head nurse for a day with the video camera, I participated in one of these meetings, in which the working environment was described as "marked by the restructurings" (head nurse, 23.06.14).[44] Agreements also existed between hospital departments regarding how patients were allocated. These agreements were frequently violated when patients were admitted to the hospital during evening and night shifts. Frustrations over this were expressed by nurses in the respiratory inpatient ward almost daily, as when the number of patients on non-invasive ventilation exceeded the agreed-upon norm, when patients with no pulmonary diagnosis were allocated to the department, or when the department was simply overcrowded with patients.

These frustrations may indicate that nurses working in the department find it difficult to balance all their tasks. By the end of 2013, a survey on staff satisfaction in the North Denmark Region was conducted (Ennova, 2014). A questionnaire was sent to all employees with questions regarding management, workload, well-being, attachment, etc. This survey also included the hospital under study, with results being calculated specifically for every department. In general, nurses and nurse assistants at the medical department indicated below average scores than other departments in the hospital, especially on questions regarding workloads. On a scale from zero to one hundred, nurses were asked to evaluate statements such as: "In general, time and workload is well balanced" (score 25), "It is possible for me to deliver good quality in my daily work" (score 31), and "I thrive on the workload I experience" (score 37). These scores may reflect a tension between the many demands placed on nurses by themselves, their colleagues, patients and relatives, central regulations, employers, etc. and the ultimately finite resources available. The Danish Working Environment Authority inspected the department in April 2014 and spoke to management and employees. After this inspection, an enforcement notice on the work environment was issued regarding workload, time pressure, and unclear demands. Concrete plans of action to ensure the health and safety of the employees working in the department were demanded by February 2nd, 2015. A printed document from the Danish Working Environment Authority announcing the enforcement notice hung in the staff room during my participation in the nexus of

[43] "Sygehus Vendsyssels mission er, inden for de politisk givne rammer, at levere den bedste: diagnostik, behandling, pleje, genoptræning og rehabilitering, sygdomsforebyggelse og sundhedsfremme, udvikling, uddannelse og forskning".
[44] "mærket af omstruktureringerne".

practice. Similar enforcement notices have been announced for numerous hospital departments in Denmark (Dansk Sygeplejeråd, 2015), and heavier workloads and increased demands for efficiency are recurrent topics permeating all issues of Danish nursing periodicals over the last five years (Dansk Sygeplejeråd, 2016).

Nurses working in the nexus of practice are shown by their actions to be efficient, as they frequently perform multiactivity by conducting several tasks simultaneously. Furthermore, nurses are rarely seen to stand still; rather, they continuously move their bodies in a constant flow of activity. Nurses are also being efficient by consulting the printed patient overview and noting essential information on it throughout the day (Figure 14).

Figure 14: Passing on information using printed patient overviews

If they did not use the sheets, nurses would have to walk to the office and log on to a computer every time they needed or had obtained information. A nurse in a conversation explains how it is increasingly a demand that "one must always be on" [45] and "be available" when working (nurse 13, 05.05.14).[46] The nurse adds how in her experience these demands are difficult to manage for recently qualified nurses, and that the nursing curriculum does not prepare them for these requirements. Another nurse articulates how she "would like to answer my phone all the times it is at all possible" (nurse 3, 02.06.14).[47] Patients occasionally commented on the busyness of nurses; one patient articulated how "they have plenty to attend to" (patient 7, 22.05.14), another said "they are so busy" (patient 26, 24.06.14). One

[45] "man skal være på".
[46] "stille sig til rådighed".
[47] "vil gerne tage min telefon alle de gange det overhovedet kan lade sig gøre".

patient asked me to show the video recording to hospital management "so that they can see how they run around" (patient 33, 30.05.14).[48]

6.2.3. PERSISTENT DISCOURSES AND PHONES

The previous two sections have described how various actors in and around the nexus of practice articulate expectations that nurses be efficient and conduct patient-centred care. These expectations are articulated in various terms, which are connected by semantic meaning to form two consistent orientations in the nexus of practice. Expectations circulating in the nexus of practice in this way constitute and discursively construct a discourse of being efficient and a discourse of patient-centred care. These discourses are ubiquitous in the nexus of practice, as they are consistently referred to by the majority of actors. By contrast, a discourse of high quality, which is frequently articulated by the ministry and the regions along with efficiency and patient focus, is only occasionally explicit among actors within the nexus of practice.

By consistently orienting themselves to the discourses of being efficient and patient-centred care, the nurses demonstrate that they are highly relevant for this study to pursue analytically. As the focus of this thesis is interactions between nurses, patients, and mobile work phones, it is thus relevant to explore how these two discourses are constituted in relation to the phones. Even though the discourses are exhibited as ubiquitous, they are not articulated in relation to mobile work phones. For example, expectations that nurses conduct patient-centred care are exhibited as strong, but how these expectations relate to mobile work phones is not articulated. To explore how the discourse of being efficient and the discourse of patient-centred care are constituted in relation to mobile work phones, the next section traces the trajectories of the mobile work phones. Subsequent sections will explore how nurses navigate the discourses of being efficient and of patient-centred care as they use mobile work phones.

6.3. THE TRAJECTORIES OF MOBILE WORK PHONES

The mobile work phones used in the nexus of practice were designed, produced, and sold by the international technology company Ascom. Ascom develops wireless communication solutions for a number of settings, with the Ascom d62 phone being intended for use in hospitals and healthcare settings (Ascom, 2009). The functionalities of Ascom d62 were designed to "support the work flow in a hospital"

[48] "de har nok at se til", "de har så travlt", "så de kan se hvordan de løber rundt".

and "simplify a number of work processes" with the intent to "save time" and "reduce costs" (Ascom, 2009, 2016a).[49] On its webpage, Ascom describes how the functionalities of the phones "support mobility and patient safety" (Ascom, 2016b).[50] Through its choice of these words Ascom alludes to issues of economy, safety, availability, and efficient work processes, which are mainly managerial concerns in hospitals. When I asked Ascom portfolio manager Jesper Mathiesen about this, he said, "in our experience users are rarely involved in decisions regarding the phones" (ascom 2, 29.12.14).[51]

Ascom describes how the company continually develops new features to support work practices, such as a top display which is visible without touching the phone, coding functionalities that manage communication flow, compatibility with other electronics systems, etc. The phones are produced in various models from standard through very advanced, with features varying accordingly. The features are selected or declined when the purchaser chooses a particular phone model. A portfolio manager and a marketing manager from Ascom both made clear that when phones are purchased by the public sector, low price is prioritised above features, and that follow-up service are commonly declined for budgetary reasons. This is reflected in the nexus of practice, so it is the hospital's IT and service departments that are responsible for maintaining and servicing the phones. However, the people in those areas have little or no specific knowledge of the Ascom system; during my participation in the nexus of practice I was unsuccessful in trying to locate a person with genuine expertise in the department's communication system. The consequences are that the nurses working with the system have no support if adjustments are requested and limited support if the communication system malfunctions.

6.3.1. PROCESS OF ACQUISITION

To pursue the process of purchase, I contacted the construction department of the North Denmark Region to talk to the people involved in acquiring the phones. It was engineers and architects working at the construction department who, as the medical building in which the nexus of practice is located was planned and constructed, decided to incorporate the phones into the building's infrastructure. The first time that the construction department incorporated mobile work phones in a hospital department was in 2005, when a new building at the university hospital was planned and built. At this point the employees of the construction department suggested to hospital managers that mobile phones be incorporated into the infrastructure of the building. This was agreed to and the construction department subsequently made

[49] "at understøtte arbejdsflowet på et hospital", "letter en lang række arbejdsgange", "spare tid", "gøre det billigere".
[50] "styrker mobilitet og patientsikkerhed".
[51] "det er vores oplevelse at brugerne sjældent involveres i beslutninger vedrørende telefonerne".

inquiries to various phone companies before a contract was signed with Ascom to deliver their d62 model. In planning and constructing the medical building that was the site of this study, the construction department of the North Denmark Region incorporated the same phones into the building's infrastructure without further examination. No experiences from the departments that used the phones at the university hospital were solicited; nor were the future users of the building and its phones involved in the acquisition process.

Asked about the reasons for incorporating the phones, an engineer replied, "we thought it was smart" (engineer 1, 03.09.14).[52] He further explained how they expected the phones to reduce the number of steps that healthcare professionals had to take during work hours by enabling them to call each other rather than having to find and walk to each other. They also expected the phones to improve the work environment by reducing the level of noise made by speakers in the corridors whenever a patient activated the nurse button. The engineer also pointed out the features that are available manage how the phones ring, such as the silence button and the grouping of patient calls. Once made aware of the fact that the mobile work phones still produce a loud vibration sound when silenced and the fact that patient calls are frequently dispatched to all nurses when the response time is longer than one minute, the engineer responded: "but that is adjustable" (engineer 1, 03.09.14).[53]

In its marketing of the mobile work phones, Ascom addresses issues of work flow, economy, and efficiency. In this way the discourse of being efficient is explicit and used as a reason for purchasing the phones. Similar terms were used by the engineer to explain why the phones were acquired. In both cases, the phones were described to support and ultimately constitute the discourse of being efficient.

6.3.2. GUIDELINES

Following the trajectories of the mobile work phones also led me search for the guidelines regarding their use. All hospital directive documents in the region can be obtained from a joint electronic document management system entitled "Politics, Guidelines, and Instructions" (Region Nordjylland, 2016a). After being compiled, the directive documents are approved by the management responsible for the unit or department to which they apply before being entered into the system. Some documents are directives for a single department, whilst others are general and apply to all departments within a hospital or region. Procedures may vary between departments due to their functions, patient groups, etc. Personnel are advised not to use printed versions of the documents, as updates are regularly made that may not be reflected in previously printed versions.

[52] "vi syntes det var smart".
[53] "jamen det kan jo justeres".

To access a guideline in the electronic document management system, personnel are required to log on to a computer and search for the document. Given the number of documents, this may be time-consuming and require skills in filtering the search. In one recorded situation (23.06.14) a nurse (nurse 21) cannot find a procedure regarding subcutaneous fluid supply, and asks the head nurse for assistance. The head nurse is not able to find the document either; only after involving a third nurse (nurse 18) and spending a substantial amount of time is the document found. Subsequently, the nurse is not able to print the document and again has to find the head nurse and ask her to print it on her personal printer.

Searching the electronic document management system using the word "phone" resulted in 1431 documents, as all documents containing the search word appear in the list of results. These are directive to various personnel and hospital departments. Filtering the search so that only documents applicable to the specific hospital appear resulted in 139 documents, which were mostly user manuals but also included numerous documents with no apparent relevance to phones other than the fact that the word appeared in them. Using the search term "DECT phone" resulted in 140 documents consisting of user manuals, procedures in case of phone system breakdown, and procedures to ensure that personnel on call are always reachable. One result of the searches is a general procedure regarding disinfection of equipment entitled: "Cleaning keyboard, mouse, phones, and similar equipment (8.14)".[54] This procedure dictates that all DECT phones must be disinfected at the end of every shift to prevent microbial contamination transmission (Region Nordjylland, 2015). The procedure was developed by the region's hygiene department, which has directive authority, and the guideline thus applies to all regional personnel. In the medical respiratory inpatient ward an additional instruction has been composed, printed, laminated, and pasted to the wall next to the phone charge rack. It is not a printed version of the procedure but a brief instruction stating: "Remember to disinfect the phone at the end of every shift".[55]

No documents in the electronic document management system regulate how to use mobile phones in this specific medical unit, but a guideline regulating the conduct of phone communication was compiled by a quality coordinator at the university hospital. It was approved by the management of the medical unit and thus applies to all medical personnel at all medical departments of the university hospital. The guideline dictates how phone communication in general is to be conducted and states that "you should always answer yours or your colleague's phone when it rings. No calls are to be lost. You should answer the phone as quickly as possible and before the fourth ring".[56] The guideline also specifies how personnel should always be "polite", "tactful", "friendly", "accommodating", and "interested" when

[54] "Rengøring af tastatur, mus, telefoner og lignende udstyr (8.14)".
[55] "Husk at disinficere telefonen ved afslutningen af hver vagt".
[56] "Du skal altid besvare din telefon eller din kollegas telefon, når den ringer. Ingen opkald bør gå tabt. Du bør besvare telefonen hurtigst muligt og inden 4. ring".

communicating on a phone.[57] Further, personnel are always to be "sensitive" towards the needs of the person at the other end of the phone, and display a "positive attitude" towards him or her (Region Nordjylland, 2014b).[58]

The search in the electronic document management system makes it apparent that there are no guidelines that advice nurses working in the nexus of practice on how to use the mobile work phones. The general guideline concerning phone communication articulates the discourse of patient-centred care, at least in relation to the person at the other end of the phone. However, it does not take into consideration the fact that the phone may ring when nurses are involved in interactions with a patient and thus potentially have two patients to whom they are to be attentive and accommodating. The guideline does not apply to this specific department, but even if it did, it does not indicate to nurses how they are to act during simultaneous interactions with patients and mobile work phones.

It thus appears to be up to the nurses themselves to take action and navigate the discourse of being efficient and the discourse of patient-centred care in relation to the use of mobile work phones. How they do so, is the topic of the following sections.

6.4. A SILENT PRACTICE

When I engaged in the nexus of practice the mobile work phones had been used for six years. The strategies for and the practices of using them are not discussed at this point in time, even when newly appointed nurses and nurse students begin to work in the ward. On their first day, they are told to carry a mobile work phone, but nothing more. In one videotaped situation, a nurse commencing her first shift in the department is standing by the lockers with a nurse who has just greeted her. The latter grabs a phone and says: "you need to grab a phone" (nurse 29, 02.06.14).[59] The newly appointed nurse says "okay" (nurse 37),[60] grabs a phone, and follows the other nurse to the nurse office, with no further discussion of the phone.

In another situation, three nurse students enter the nurse office at their first day of work. A nurse asks them: "Did you grab a phone" (nurse 14, 08.05.14),[61] and they reply in the negative; they turn around and walk back to the staff room. As they return with a phone each, neither the students nor the nurse mention the phones. In

[57] "høflig", "taktfuld", "venlig", "imødekommende", "interesseret".
[58] "lydhør", "positiv holdning".
[59] "du skal tage en telefon".
[60] "ok".
[61] "har I taget en telefon".

this way the mobile work phones are exhibited as a natural feature for which newcomers apparently need no introduction.

However, the utterance produced by the nurse in the introductory narrative suggests that this was not always the case: "When we first got the phones, we were all wound up about them, but now I never think about them anymore". By the words "all wound up about them" the nurse indicates that the phones were formerly discussed and not treated as a natural feature of their practices. This latter phenomenon of the two is also reflected in a conversation with a nurse who has been working in the department since the building was inaugurated and the phones came into use, "I have gotten used to it [the phone]" (nurse 11, 07.05.14).[62] The two nurses thus describe a process of internalising the mobile work phones into their practices. Two other nurses who have been working in the department for three and four years respectively say: "It is necessary that we have them [the phones]"[63] (nurse 17, 26.06.14) and: "I would not be able to do without them [the phones]"[64] (nurse 13, 03.06.14). While nurses were "all wound up about them" when the phones were implemented, they are now used to them and even consider them to be indispensable.

The video recordings also reveal how experienced nurses handle the mobile work phones without looking at them. When nurses are engaged in interaction with a patient and the phone rings, they do not orient themselves towards the phone ringing in their pocket by turning their head or directing their gaze towards it. Rather, they move their hand to the pocket and grab the phone without searching for it; then, without looking, they press the button to accept the call. This embodied way of handling the phone is a general feature observed in situations in which a nurse who has been working in the ward for some time is a participant. The embodied knowing of exactly where to move their hand, how to grab and hold the phone, and where to place their thumb to press the "accept call" button, all classify their actions as well-practiced or even automated. Nurses with less experience in handling the mobile work phones do shift their gaze to see where the phone is positioned and where to move their hand. Likewise they shift their gaze to the phone to see the position of the "accept call" and determine where to place their thumb.

With the strategies for using the phones and the practices of using them not being discussed, with no introduction to newcomers, and with the handling of the phones being displayed as automated actions, the mobile work phones are exhibited as internalised in the practices of the nurses working in the ward. The fact that mobile work phones are treated as a natural feature that is not talked about makes it even more relevant to explore what nurses do to navigate the discourses of being efficient

[62] "Jeg har vænnet mig til den [telefonen]".
[63] "Det er nødvendigt at vi har dem [telefonerne]".
[64] "Jeg ville ikke kunne undvære dem [telefonerne]".

and of patient-centred care as they use mobile work phones. This is pursued in the upcoming sections.

6.4.1. SHIELDING PATIENT ROOMS

Nurses who have been employed in the ward for some time never place a phone call from a patient room. They answer incoming phone calls in patient rooms, but they postpone dialling a number themselves until they are out of the room. Similarly, they postpone entering patient rooms when engaged in a phone conversation. Rather than continuing their characteristic flow of movement, they pause outside the patient room until the call is finished (Figure 15).

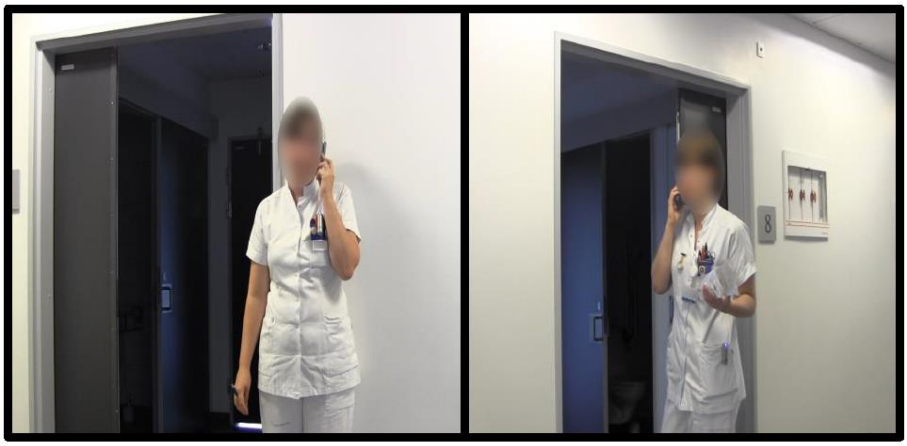

Figure 15: Waiting outside patient rooms until phone conversation is finished

Newly appointed nurses and nurse students do not participate in the accomplishment of this practice, as they initially do make phone calls from patient rooms and enter them while talking on the phone. On the video recordings, this is never addressed verbally; however, when experienced nurses are present, they mark this behaviour by gazing at the newcomer. Over time, the newly appointed nurses and nurse students adopt the practices of not dialling from a patient room and of postponing their entrance into patient rooms until calls are finished.

When they answer a phone call in a patient room, nurses strive to keep the conversation short. If the topic of the conversation seems like it will be resolved quickly, nurses engage in the conversation. However, if the topic is projected to require more turns (Sacks et al., 1974) or is otherwise complicated, then nurses propose postponing the discussion. In the case “Anything important”, which is

analysed in Chapter 10 the nurse proposes sequence closure (Sacks & Schegloff, 1973) by saying: "Well, er, I am in room nine so I will speak to you soon, I will call you" (nurse 1, 23.05.14).[65] This pre-closure is produced in her third turn on the call, which is preceded only by a self-identification turn and a greeting turn (Schegloff, 2002). This serves as an example of how nurses, when being called on the phone in a patient room, quickly propose closing the sequence and resuming it later. In the case "The arterial blood gas" analysed in Chapter 12, the nurse similarly proposes sequence closure on only her third turn by saying to the caller: "I will be out in just soon" (nurse 8, 30.05.14).[66] In contrast, nurse students doing their clinical training in the ward are observed to have long conversations on the phone in patient rooms. This behaviour is not observed to be verbally marked; if nurses are also present in the room, they frequently shift their gaze from the activity at hand to the student. In the case "Just a moment" analysed in Chapter 11, where a nurse is called by a nurse student who continues to ask questions regarding a patient, the nurse proposes sequence closure by saying: "Yes you know what I will pop down before long" (nurse 25, 22.05.14).[67] In this way the nurse manages to both shorten the phone conversation in the patient room and meet the student's request for supervision.

The strategies used by the nurses to keep phone conversations short in patient rooms, to not enter patient rooms while talking on a phone, and not to initiate calls from within patient rooms all demonstrate that conversations on the mobile work phones are troublesome in patient rooms. The nurses are seen to put the discourse of patient-centred care into practice by minimising phone conversations in the presence of patients.

6.4.2. ALWAYS AVAILABLE

At the same time, however, nurses facilitate the active participation of mobile work phones in interactions with patients as they almost always answer the phone when it rings. In only two of the numerous recorded interactions is a nurse observed not answering her phone; in both cases the nurse is wearing gloves contaminated with vomit or urine when the phone rings. By always answering the phone, nurses make themselves available for others to contact at all times and make their collective knowledge always accessible. Colleague nurses and collaborators are not obstructed from advancing the activities at hand, when these activities require information, coordination, or supervision from a nurse engaged in interaction with a patient.

[65] "Jamen øh jeg er lige inde på stue ni, så vi kan lige snakkes ved her, jeg ringer lige".
[66] "Jeg kommer ud lige om snart".
[67] "Ja ved du hvad jeg kigger lige ned her inden så længe".

Nurses working in the nexus of practice demonstrate how they expect nurse colleagues to always answer the phone when they say it is "odd"[68] if a phone is not answered (nurse 5, 22.05.14). They further display the expectation that nurse colleagues and other collaborators are available for contact by calling back repeatedly when a phone is not answered. In two videotaped situations repeated calls are observed to cause nurses, who initially did not answer the phone, to remove their gloves and abort a procedure in order to answer the phone. In one situation the nurse comments, "well apparently it is important"[69] (nurse 28, 30.05.14); in the other, the nurse produces a despondent gesture and facial expression (nurse 1, 23.05.14).

By making themselves available for exchange of information at all times, nurses prevent the obstruction of work processes and thus put the discourse of being efficient into practice. They also do so by calling each other on the phone rather than walking to speak to each other in person. Furthermore, they enact the discourse of being efficient by being mobile or by performing multiple activities. While speaking on the phone, nurses frequently walk to position themselves for their next task or use the embodied resources not required to manage the phone call to perform other activities. The hand not used to hold the phone is used to simultaneously write, gather utensils, tidy up, inspect, close drips, prepare procedures, etc. (Figure 16). Nurses are rarely observed to be standing still talking on a phone, thus realising the discourse of being efficient. Whether they are able to simultaneously put the discourse of patient-centred care into practice in interactions with patients remain to be explored.

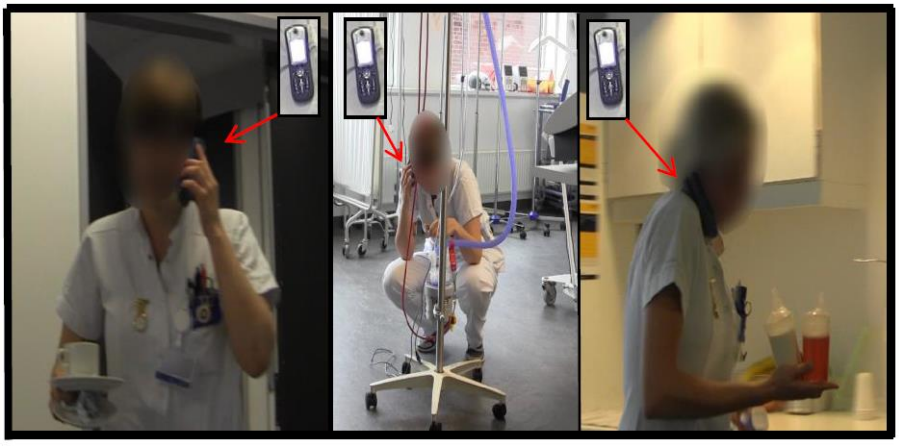

Figure 16: Performing other activities while speaking on the phone

[68] "mærkeligt".
[69] "nå det er åbenbart vigtigt".

6.4.3. OTHER PRACTICES OF USING MOBILE WORK PHONES

Following the semiotic cycles of the nexus of practice prompted me to contact medical departments at the university hospital where the phones were adopted in 2006. In one inpatient ward, I found that the nurses refused to use the phones. With management's consent, I visited the ward and interviewed a nurse and the assistant manager about their reasons for not using the mobile work phones. The nurse reported several reasons: "They must be activated in an IT system which often has error messages and it takes a long time to log on and register in the programme"; "They are terribly noisy"; "They are too big and clumsy to carry in your pockets" (nurse u1, 28.11.14).[70] When asked about the guideline regarding phone communication, the nurse was not aware of its existence. The assistant manager of the department was also interviewed and offered the following reasons for not using the phones: "They cause disturbances inside patients' rooms"; "Then you sit there in the middle of a conversation and you need to pick up the phone to see who is calling and then it might not be one of your own patients"; "They were a nuisance so we stopped using them".[71] Asked about the guideline regarding phone communication, she replied, "It does not make sense" (nurse u3, 26.11.14).[72] This inpatient ward at the university hospital is only half the size of the inpatient ward that is the site of my investigation, which means that the distance nurses have to walk to get from one end of the ward to the other is much shorter. Visiting another ward at the university hospital where the mobile work phones were in use, I soon noticed that the nurses there did not answer all incoming calls. One of them explained why she did not always answer the phone: "But I can't, if I am with a patient I can't".[73] Asked about the guideline dictating that phones are always to be answered, preferably before the fourth ring, the nurse laughed and said, "I certainly don't" (nurse u2, 17.12.14).[74]

Nurses working in departments at the university hospital indicate that the phone software system is not effective and thus does not constitute the discourse of being efficient. The nurses further express how they cannot answer the phone when with a patient and how the phones cause disturbances inside patients' rooms. These nurses articulate the discourse of patient-centred care, making clear that the phones conflict with that discourse.

[70] "De skal kobles på via et it-system hvor der så tit er fejlmeldinger og det tager lang tid at gå ind og registrere sig i programmet". "De larmer helt vildt". "De er for store og klodsede til at have i lommerne".
[71] "De giver forstyrrelser inde på patientstuerne". "Så sidder man der midt i en samtale og så skal man have telefonen op for at se hvem det er der ringer og så er det måske slet ikke en af ens egne patienter". "De var til gene så vi holdt op med at bruge dem".
[72] "Det giver ikke mening".
[73] "Det kan jeg jo ikke, hvis jeg står med en patient så kan jeg ikke".
[74] "Det gør jeg i hvert fald ikke".

6.5. NAVIGATING DISCOURSES

I now end the description of the semiotic cycles of people, semiotic aggregates, overt discourses, discourses internalized as practices, and mediational means such as objects and concepts, etc. circulating in the nexus of practice. As detailed in Section 6.2, describing the semiotic cycles has centred on the discourses of being efficient and of patient-centred care, as these discourses were revealed to be significant in the process of mapping the nexus of practice. This has focused my enquiries but also means that numerous semiotic cycles were not described, such as hygiene, patient safety, quality developments, etc. Following these cycles would have led to other analytical points and conclusions which must remain unexplored for now.

Nurses working in the nexus of practice almost always answer the phone during interactions with patients. They are mobile and perform multiactivity during phone calls, thus enacting the discourse of being efficient. Nurses working in departments at the university hospital enact the discourse of being efficient in other ways, as they either do not use the phones or do not answer them during interactions with patients. In their words and actions they display that answering the mobile phone during patient interactions is in conflict with enacting the discourse of patient-centred care. In parallel, nurses working in the nexus of practice minimise phone conversation in the presence of patients. In their actions they thus similarly display the use of mobile work phones to be in conflict with putting the discourse of patient-centred care into practice. Whether answering the mobile work phone precludes nurses from enacting the discourse of patient-centred care in interactions with patients is however not revealed in any of the wards. It may be that nurses, as they put the discourse of being efficient into practice by answering the phone during interactions with patients are unable to enact the discourse of patient-centred care simultaneously. It is also possible, though, that they do manage to reconcile these two seemingly conflicting discourses and put them both into practice, as they answer mobile work phones during interactions with patients.

How nurses navigate the two discourses in situated interactions with patients and mobile work phones is the focal point of the continued analysis below. The presentation of the analysis is preceded by two chapters leading into and framing the analysis. The next chapter describes how the video data that comprises the bulk of the data corpus of this thesis was logged and transcribed, how situations were selected for analysis, and how the videos were made available for collaborative analysis. In Chapter 8, the manoeuvres of zooming in and zooming out are accounted for so as to frame the analysis.

CHAPTER 7. WORKING WITH VIDEO

Section 4.5.2 detailed how the close analysis of the recorded interactions between nurses, patients, and mobile work phones is guided by the concepts and methods of interaction analysis. Section 4.8 described how the analytical methods of interaction analysis rely heavily on video recordings, which thus comprise a major part of the data corpus of this thesis. This chapter describes how the video data was logged and transcribed, how situations were selected for analysis, and how the videos have been made available for collaborative analysis.

7.1. LOGGING VIDEO DATA

The first step of working with the video recordings was reviewing the entire data corpus and producing a content log of the events on the recordings. Reflecting the emic perspective of this thesis and the positions of ethnomethodology and nexus analysis not to make a priori assumptions, it was important not to impose any presumptions or theoretical concepts as the video data was logged. Hence, data-driven open coding (Gibbs, 2008) was called for in order to allow phenomena to emerge from the data. Open coding as an approach to data is advocated by grounded theory (Glaser & Strauss, 1967), but my way of using open coding is not identical with this approach. Grounded theory emphasises how open coding should not be mere descriptions; but consist of theoretical or analytical codes (Strauss & Corbin, 1990). However, given the emic perspective of this thesis, only the actions of the situations (the interaction order) and the participating actors (the crucial social actors) were coded, in order to keep an open mind and to not impose interpretations onto the data. Because mobile work phones are of central interest to this thesis, and in accordance with the stance taken in Section 4.1.3, the phones were regarded as actants in their own right and included as actors along with nurses, patients, doctors, etc. in the process of logging the video data. As nurses always carry a mobile work phone, a phone is present in all situations where a nurse is present and has agency in these situations by its mere presence. However, logging the mobile work phone as actor in all situations would lead to an immense number of situations having to be analysed in detail, and the phones were consequently only logged as actors when they actively participated in interactions e.g., by producing a sound or by being marked or oriented to orally or gesturally.

In the process of logging the video recordings ethnographic chunks or events were identified. I not only drew upon my own cultural knowledge, but also took inspiration from Jordan and Henderson and Pike on how to structure events (Jordan & Henderson, 1995; Pike, 1967b). Events often have official beginnings and endings which are perceived as externally imposed, but beginnings and endings are in fact

collaboratively achieved by participants through their preparatory and disengaging activities. De facto beginnings and endings are not easily identified without thorough analysis, which calls for the researcher to begin recording prior to the official beginning of an event and to keep the camera running after its official ending. In this regard it was an advantage that the video recordings obtained for this thesis were recorded continuously without pauses.

The process of logging the video data was carried out with Transana, a software program designed for analysing and transcribing video data (Woods & Fassnacht, 2014). The software built upon certain beliefs and understandings of human interaction, which structures the way video footage is worked with in the program. Organising and systematising the video data in Transana consists of labelling video segments with key words and categorising them into collections. In respect of the emic perspective of this thesis I did not use Transana to categorise events into collections. Instead, the software was used to label events with the actors participating and the actions being performed. Keywords used to label events were thus the specific actors present, for example: "nurse 1", "patient 3", "doctor 7", "mobile work phone", "physiotherapist 4", "nurse student 2", etc. and the actions being performed, for example: "rings", "beeps", "speaks", "touches", "sits", "stands", etc. (Figure 17). The keywords were not predetermined, but were applied during the labelling process when persons appeared in the video data and when dynamic terms were needed to describe actions being performed.

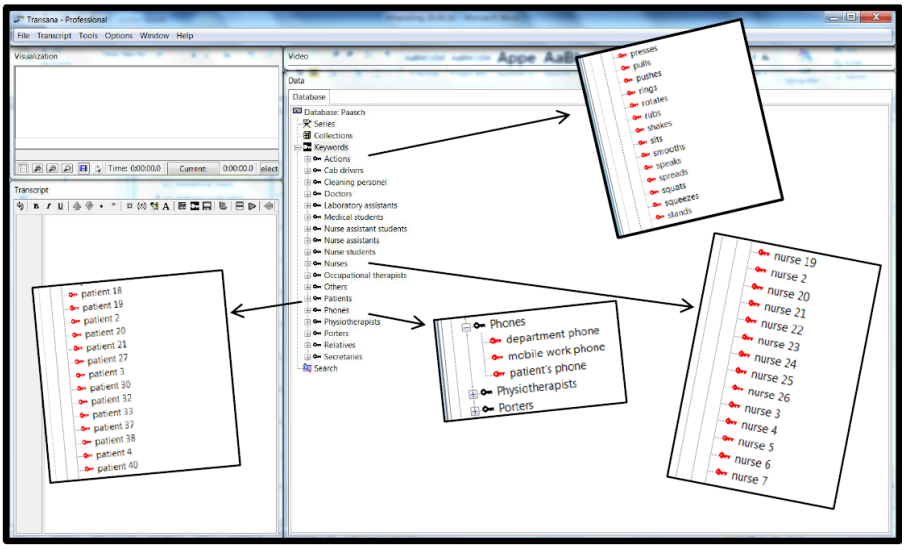

Figure 17: Labelling events with keywords

From the process of labeling the video data with keywords a collection of 334 events in which a mobile phone participated by producing a sound or being oriented to by the words or actions of persons emerged. A large proportion of these events involved no patient participation. Given the central interest of this thesis in the interactions between nurses, patients, and mobile work phones, a collection of 73 events in which all three of these categories of actors participated was generated. Conducting a detailed interactional analysis on that number of interactions would however have been impractical in a dissertation context, so a thoughtful process of winnowing had to be carried out (Figure 18).

In 26 of the events in which a nurse, a patient, and a mobile work phone participated, additional actors such as doctors, students, nurse assistants, or other nurses also participated. In interactions where more people participate they are seen to take over courses of actions for one another, allowing the person summoned by a phone call to withdraw from patient activities and attend to the phone. This also means that when several people participate in interactions with patients and mobile work phones, they can each enact various discourses simultaneously. In situations where only one nurse is participating in interactions with a patient and a mobile work phone, the nurse has to organise activities singlehandedly. When a mobile work phone participates in the interactions by producing a ring or a beep, the nurse thus has to navigate the dual involvements without assistance. The collection of events in which only one nurse participated in interactions with a patient and a mobile work phone was thus selected for further inquiry. This is not to say that situations with additional actors cannot contribute valuable insights about interactions between nurses, patients, and mobile work phones. These, however, remain to be explored in later studies.

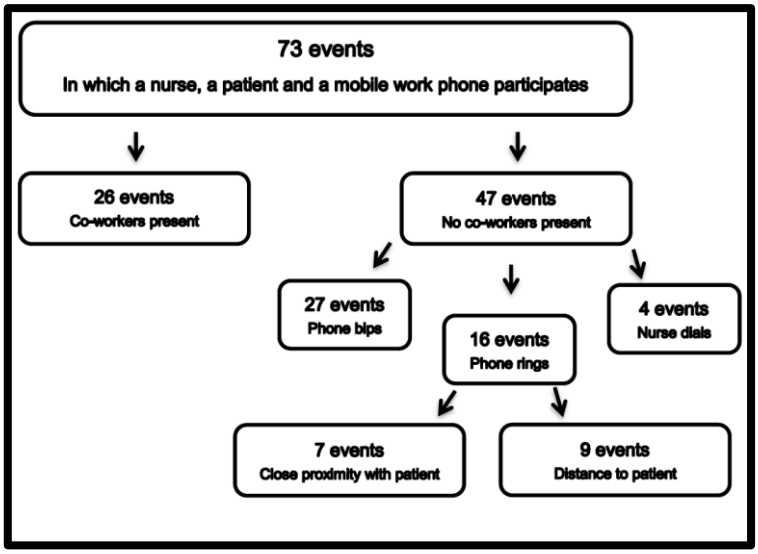

Figure 18: Process of selecting events for analysis

In the remaining 47 events, only one nurse interacts with both a patient and a mobile work phone; the phones participate in these situations in various ways. In 27 situations, the phone produces one or more beeps to indicate that a patient has activated the nurse call button in request for contact or assistance. A beep signal does not require the same rapid response from the nurse as a ringing phone; the nurse can finish the on-going activity before attending to the phone's summons. The activity of the phone in these situations therefore does not impose the same time constraints on the nurse's organisation of activities and involvement. In 16 situations a mobile work phone participates by ringing, which means that the nurse has to reorganise courses of action rapidly in order to answer the summons. For this reason, the 27, events in which the phone beeped were deselected in favour of the 16 situations in which the phone rang. In the remaining four situations the nurse uses the phone to place a call, which imposes few time constraints on the nurse. These situations are notable exceptions from the general pattern described in Section 6.4.1, which makes clear that nurses do not initiate phone calls inside patient rooms. It is the same newly appointed nurse who places the four calls; for this and the aforementioned reason these four events are left uncharted.

The collection of 16 events in which the phone participates by producing a ringtone was consequently selected for further inquiry. In nine such cases, the nurse was involved in activities at some distance from the patient when the phone rang, such as disinfecting equipment, tidying up, washing hands, writing on the printed patient overview, etc. In these situations the nurse and the patient did not constitute a close embodied participation framework and the demand for the nurses to sustain their

commitment to the patient was thus less pressing. In the other seven situations, the nurse was performing actions in close proximity to the patient, which included them touching the patient. When the phone rings in this context, the nurse and the patient constitute a close embodied participation framework which presumably makes handling the summons of the phone a greater challenge. In these events the rules of turn-taking become operative, meaning that nurses cannot appropriately terminate the interaction with the patient simply by stopping talking or walking away. As the possible completion of a turn is a point in time where turn transfer is relevant, this would be considered accountable behaviour (Dersley & Wootton, 2000; Schegloff & Sacks, 1973). In order for the nurse to stop the interaction with the patient without violating interactional norms, the nurse has to work collaboratively to suspend the transition relevance of possible turn completion. Being involved in close physical contact likely requires more effort from the nurse to handle the dual involvements in a morally sound way. These seven situations thus form the basis of the detailed analysis of situated actions.

7.2. TRANSCRIBING THE VIDEO DATA

Analysis of interactions recorded on video requires transcripts to be produced, not only as a means to present the recorded situations to others, but also as a resource for the analysis:

> Transcription is not simply a way of presenting aspects of the activity, but provides an important resource in developing observations and getting to grips with the characteristics and organisation of the actions in which the participants engage.
>
> (Heath, Hindmarsh, & Luff, 2010, p. 67)

Needless to say, transcripts are not objective or complete representations of recorded situations. First of all, it is not possible to include the full complexity of recorded situations in transcripts, as speech and body movements have far more detail than any transcription system could ever capture. Secondly, as noted by Bergmann (1985) and Jordan and Henderson, a transcript "fixates what is essentially fluid and ephemeral. It holds talk up for repeated inspection, the very impossibility of which is central to the lived experience" (Jordan & Henderson, 1995, p. 48). According to Ochs, full representations are not even desirable, because "a transcript that is too detailed is difficult to follow and access. A more useful transcript is a more selective one" (1979, p. 44). Ochs encourages the transcriber to be selective and make conscious choices in the process of filtering what is relevant to the research focus. Rather than attempting to represent complexity in its totality, she advocates for transcripts to make selected aspects of interactions visible. Goodwin also addresses

this point, describing the tension between producing transcripts which present relevant and clear descriptions and are accurate enough to recover the endogenous structure of the event under investigation (2001, p. 161).

During the process of transcribing, it became clear to me that a transcript is never to be regarded as final. Rather, the repeated viewing and listening led to continuous refinements of the transcripts, which in turn led to additional reflections and insights. Transcripts are thus not only analytic resources after they have been produced; the very process of transcribing substantive can lead to analytic insights. Duranti compares the production of transcripts to "a classic hermeneutical circle, or actually a spiral, in which each loop gives us a new listening, a new viewing, exposing us to the possibility of new interpretation, which happens at a different time" (2006, p. 307-308). This is the reason why I, despite the substantial time commitment, chose to produce all transcriptions of the videotaped data myself.

In the tradition of conversation analysis the practices of transcription rely heavily on the conventions developed by Jefferson (2004). Any transcription convention embodies a theory of what is relevant in interaction, and Jefferson's transcription convention emphasises speech and features of speech rather than multimodal communication. Despite the recognition within the interdisciplinary fields of interaction analysis noted in Section 3.3.2 that embodiment is a significant feature of social interaction, the representation of nonverbal phenomena in transcripts is still in its infancy (Heath & Hindmarsh, 2002). Although researchers from a variety of disciplines have proposed and developed ways of transcribing embodied features (e.g., Cowan, 2014; Davidsen, 2014; Norris, 2004), there is little consensus about the ideal approach to transcribing multimodal and embodied interaction (Heath et al., 2010). Following Garfinkel (1972), a transcriber should abstain from describing the subtle aspects of embodied conduct in general terms. This is echoed by Sheets-Johnstone (2011), who points out that there is a difference between describing movements in wholes, such as eating, defending, threatening, etc., and in dynamic terms of postural orientation, direction of movement, etc. Cowan's recent study contrasted various ways of transcribing interaction and suggested that transcripts including visual elements such as video stills allow for patterns in the interaction to become more prominent (2014). This is in line with Goodwin, who in his transcripts uses a mix of written speech and frame-grabs with effects added (2000, 2001). Likewise, Norris in her transcripts uses a photo stream to which effects and speech are added (2004).

As this thesis takes the position that all modes should be considered in studying interactions between nurses, patients, and mobile work phones, emphasising speech in transcripts of the recorded interactions is thus unintentional but reflects the challenges outlined above of transcribing embodied features. When studying embodied interactions, I consider transcripts without video stills to be difficult for others to follow and comprehend. Consequently, in my practices of transcribing I

use a selection of written speech, embodied phenomena described in dynamic terms, and video stills added effects. Nevertheless, the transcripts of course do not represent the complexity and details of the video recordings, which reinforces the importance of analysing the video recordings themselves, not the transcripts.

Transcribing the collection of situations in which nurses, patients, and mobile work phones interact, I reviewed Transana but quickly discovered that it did not provide the means for the detailed level of transcription and analysis of embodied interaction that I demanded. It was not possible in Transana to zoom in or to scroll the video frame by frame, which is essential for precise and accurate transcription of embodied conduct, especially where the goal is the analysis of interrelationships between micro actions and for unnoticed phenomena to emerge (Section 4.5). Consequently, I started using Adobe Premiere Pro video editing software (Adobe Systems Software, 2016) to view the videos and transcribed them in Microsoft Word. Adobe Premiere Pro not only allowed for frame-by-frame viewing, but also backwards viewing, zoom, lighting improvements, etc., all of which led to accurate and detailed transcription and subsequent analysis.

7.3. DATA SESSIONS

Given my background in nursing science, working with transcripts and video was new to me. As a novice learning the craft of video analysis, my participation in a multidisciplinary group of people meeting for data sessions every second week was crucial. It allowed me to see how others work with video-recorded data, to benefit from their experiences, and to discuss methodological issues. The multidisciplinary group in which I participated consists of people with various theoretical interests, affiliated with different departments, and possessing various levels of experience, ranging from Ph.D. students to professors. Despite their different backgrounds, the group members shared an interest in collaborative analysis of video data from a discourse, interaction, and practice-based perspective. At each data session one person brought a few minutes of video data and the relevant transcriptions. A little information about the data might be given; however, no topics of interest were revealed. The video excerpt was played several times to allow for group members to get a grasp of the data. After this a shorter piece of data on which to focus was selected by consensus among the group members. This piece of data, which was usually less than a minute long, was then played repeatedly. Meanwhile, group members consulted the transcript and might ask for passages to be played in slow motion. Then, each group member had some time to work on their own with the transcript. At the end of the session, a round occurred, in which each group member offered their observations and thoughts. Assertions about what was happening in the data were not to be ungrounded speculations but had to be grounded in the data.

Furthermore, no conclusions were drawn; rather, it is up to the person bringing the data to pursue analytically what was noticed by group members.

I hosted several data sessions where I presented excerpts of my video data. Erickson demonstrated that what we see or do not see in a video is not only a matter of what is contained in it, but also a matter of our sense making constructions (2007). The collaborative viewing of the data worked to diminish preconceived notions on my part, and to discourage tendencies to see what I wanted or was conditioned to see. Most participants in this study consented to research colleagues participating in the analysis of the video data which made the embodied conduct of participants available for collaborative analysis.

In prolongations of the data sessions, group members frequently exchanged information about hardware and software for recording, editing, transcribing, and analysing video data, and shared experiences in using these products. The software package "Praat" (Boersma & Weenink, 2016) has been used to analyse timing, pitch, and intensity. Subtitles for video excerpts were produced in Inqscribe (Inquirium, 2016), a software for transcription and subtitling. To anonymise and edit video recordings when excerpts were prepared for data sessions, or presentations I used Adobe Premiere Pro, a package of software for video and audio editing (Adobe Systems Software, 2016). This software makes it possible to anonymise subjects by blurring their faces or using a solarising effect. Blurring the faces of the participants also conceals facial expressions, gaze directions, and other elements which are vital to the analysis, while solarising allows facial expressions and gaze directions to be visible to some extent. However, in my experience solarising does not make participants completely unrecognisable in all video recordings; thus it has not been used.

CHAPTER 8. ANALYSING CASES: ZOOMING IN AND ZOOMING OUT

Section 7.1 described how seven situations in which a nurse performs actions in close proximity to a patient and a mobile phone participates by producing a ring tone were selected for detailed analysis. Navigating the nexus of practice in this thesis includes zooming-in and zooming-out manoeuvres. The analysis of the seven selected cases alternates between zooming in on the situated accomplishment of interactions in the here-and-now and zooming out by moving beyond the situation itself to include the elsewhere-and-then. The two analytical manoeuvres are framed in the following sections.

8.1. THE MANOEUVRE OF ZOOMING IN

In close interactional analyses, the selected cases are analysed using principles from interaction analysis. This means that the analysis of the actions nurses perform takes as its basis the way they through their actions show how they understand the situation, and how their actions are to be understood. In conducting close interactional analyses, certain aspects are included in the field of attention while others are not. The interactions between nurses, patients, and mobile work phones are analysed in the light of Chapter 6, in which the nexus of practice was mapped. In the process of mapping, the discourse of patient-centred care and the discourse of being efficient were displayed as ubiquitous, and the potential tension between the two highlighted. In the situations selected for close analysis, nurses have to navigate the two discourses singlehandedly, as they are engaged in close interaction with a patient when the mobile work phone rings, with no colleagues present to assist. The close analyses performed on the cases thus investigate how nurses distribute orientations and how they organise activities. These analyses do not move beyond the situation, but includes only aspects of the situated interaction itself. Hence, the analytical discoveries of the close interactional analyses are then linked to the discourse of patient-centred care and the discourse of being efficient in the zooming out manoeuvre.

In the excerpts a nurse (N), a patient (P) and a mobile work phone (T) interact. The transcriptions draw from conventions developed by Jefferson (2004) with added visuals of embodied conduct. Orange arrows indicate gaze direction, blue arrows indicate direction of movement, and red arrows are used to highlight features. To protect the privacy and identities of nurses and patients their names have been changed and their faces blurred.

The mobile work phones do not produce a uniform, repeated tone when ringing, but produce a string of tones which is repeated (Figure 19).

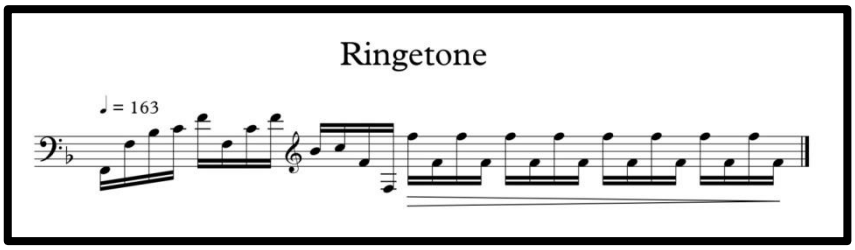

Figure 19: The ring tone represented as musical notes

Regrettably, for technical reasons it has not been possible to incorporate the musical notes into the transcripts; the ring tone is instead represented by lines (–).

8.2. THE ZOOMING OUT MANOEUVRE

As nurses accomplish interactions, they are oriented towards what ought to be done and the meaning that their practices carries (Nicolini, 2009), which means that interactions between nurses, patients, and mobile work phones are never accomplished in a vacuum (R. Scollon & S. W. Scollon, 2004). Chapter 6 mapped the semiotic cycles circulating in the nexus of practice, which made clear that the discourses of being efficient and of patient-centred care were exhibited as ubiquitous and highly significant. In the manoeuvre of zooming out the analysis thus transcends the incidental and connects the analytical implications of the close interactional analyses with these ubiquitous discourses that circulate in the nexus of practice.

Ideally, the manoeuvre of zooming out would place interactions between nurses, patients, and mobile work phones within the complete nexus of connections in which they are immersed. However, this proved an insurmountable task for this thesis to undertake (Chapter 6). In the analysis of the selected cases, the manoeuvre of zooming out is thus confined to analysing how the discourses of being efficient and of patient-centred care are put into practice in the situated actions of nurses as they interact with patients and mobile work phones.

8.2.1. BEING EFFICIENT

The nurses operating in the situated interactions with patients and mobile work phones do so within the scope of on-going cost reductions (Section 6.2.2.) This means that the number of patients and tasks that each nurse has to attend to are both increasing and that they need to be ever more efficient. The demands for efficiency are not only derivable from the workload that nurses experience, but is also made explicit by the Ministry of Health and Prevention and the North Denmark Region. The National Quality Programme of Healthcare 2015–2018 stipulates that resources are to be used as efficient as possible (Ministry of Health and Prevention, 2015), while the Region portrays employees as effective (Region Nordjylland, 2012). To reduce the number of steps that nurses have to walk during their work, employees at the regional construction department added mobile work phones to the nexus of practice. As the phones were intended to improve efficiency, they in a sense materialise the discourse of being efficient. When nurses interact with patients and mobile work phones, they do not consciously attempt to be efficient in every action. However, as they are participating in the interactions, nurses are aware of the patients and tasks that await them elsewhere in the ward. They are also aware of the activities of colleagues, and the possibility that a colleague may need information from them. In the close analyses of interactions between nurses, patients, and mobile phones, the discourse of efficiency is enacted when nurses answer the phone. This makes them available to provide the necessary information for the advancement of other activities and to avoid obstructing the working processes of colleagues. The practice of always answering the phone if at all possible thus embeds the discourse of efficiency.

8.2.2. PATIENT-CENTRED CARE

The notion of patient-centred care is ubiquitous in the mapping of the nexus of practice. It appears in the annual national survey on patient experiences (Enhed for Evaluering og Brugerinddragelse, 2015), in patient course policies, waiting-time warranties, and in the patient's free choice of treatment (Krasnik et al., 2010). It appears in the National Quality Programme of Healthcare, which insists that the patient should be put "in the centre" and that "the patient should be the focal point" (Ministeriet for Sundhed og Forebyggelse, 2015). It can be found in the policy of the North Denmark Region, which calls "patient focus is one of the leading values" (Region Nordjylland, 2013b), and in the Region's publication "The good hands – in words and photos" which advertises that "we see the whole human" (Region Nordjylland, 2012). The notion of patient-centred care is also present on the hospital webpage explicating the vision of the hospital to take "the patient as point of departure" (Sygehus Vendsyssel, 2014), and last but not least it is prominent in the nursing curriculum. Patient-centred care is a crux in the theoretical and clinical

training of nurses, with the nurse-patient relationship being pivotal. Nurse students are not only examined in the theories of patient-centred care and the nurse-patient relationship but also have to demonstrate these skills on their clinical exams (Undervisningsministeriet), 2008). To think that the notion of patient-centred care is not embedded in the historical bodies of nurses would be pure fantasy. While nurses may never have read the National Quality Programme of Healthcare or the policy of the North Denmark Region, they still experience the discourse of patient-centred care as omnipresent. Nurses know that it is expected of them and there is no debate on this matter. If a nurse were to propose some other approach, this would be considered reprehensible; the discourse of patient-centred care is thus exhibited as completely naturalised throughout their practices.

8.2.3. STRATEGIES OF USE

Mobile phones are not mentioned in the National Quality Programme of Healthcare or in the policy of the North Denmark Region. There are no phones in the Region's photos of good and caring hands, and mobile work phones have no role in the nursing curriculum. The hospital does not address mobile work phones on its webpage, however, they are discussed in a guideline on disinfection. At the university hospital a guideline concerning the use of mobile work phones formulates how "no calls are to be lost" and that the phone is to be answered "as quickly as possible and before the fourth ring" (Region Nordjylland, 2014). This general guideline however does not take the individual situation into consideration.

Mobile work phones appear to have entered the nexus of practice without reflections about their participation in interactions between nurses and patients. At the initiative of employees at the regional construction department, they were imposed on the practices of nurses, who then had to find their own ways of incorporating the phones in a practical manner. For example, they solved the problem of linking a phone number with the person carrying it by writing names and numbers on the printed overview every morning. Their practice of using mobile work phones thus depends on this age-old technology and the practice of its use.

As mobile work phones entered interactions between nurses and patients, nurses also had to solve the practical problem of how to meet the expectations of both patient-centred care and of efficiency. The strategies used by the nurses to pursue both objectives are investigated in the manoeuvre of zooming out. This is done by analysing how the discourses of being efficient and of patient-centred care are put into practice in the situated actions of nurses. Zooming out builds on the analytical discoveries made in zooming in, by connecting the analytical discoveries made on the basis of interaction analysis with the prevailing discourses that circulate throughout these interactions.

8.3. PRESENTING ANALYSES

The following chapters present analyses performed on the seven selected cases. The full analysis of cases one, two, and three is provided, describing the analytical manoeuvres of zooming in and zooming out separately to provide transparency into the analytical process. This manner of presenting the analyses necessarily includes a great deal of repetition. It also requires that the points of the close interaction analyses performed on each case in zooming in are not directly and immediately evident. The analytical points do become apparent as the analysis of each case zooms out and connect the close interactional analysis with the discourses circulating in the nexus of practice. Describing the two analytical manoeuvres separately improves transparency of the analytical process by providing clarity in the way various theories and methods are employed. Making the video-recorded interactions available for viewing would further improve transparency of the analytical process, but distributing the data, even in anonymised form, would not only violate my ethical beliefs but would also contravene data protection laws.

Chapter 12 presents résumés of the analyses performed on cases four, five, and six; the analytical process is identical with the process performed on cases one, two, and three. However, in order to prevent the presentation of the analysis becoming too protracted, full bipartite analyses of cases four, five, and six are not presented. This reduces transparency to a degree but is enough to demonstrate that the analytical findings from the first three cases also appear in cases four through six. The analytical products of case seven breaks from this pattern, so it is also presented in full in Chapter 14 to provide transparency into the analytical process performed. After analysing all cases sequentially, connections to other places and other points in time are examined. This analysis, which is presented in Chapter 15, zooms out further to study the interconnectedness and evolution of the practices of nurses using mobile work phones.

CHAPTER 9. ANALYSIS OF CASE ONE: “THE WORK OF A THUMB”

Chapters 9–11 present the analyses of cases one, two, and three. The analytical manoeuvres of zooming in and zooming out are described separately to provide maximum transparency into the analytical process. This inevitably leads to some repetition and also means that the analytical points of the close interactional analyses are not immediately evident. However, as the analysis of each case subsequently zooms out and connects the close interactional analyses with discourses revealed in Chapter 6 as omnipresent in the nexus of practice, the analytical points become apparent.

In case one, “The work of a thumb”, a nurse has been called to a patient by a nurse student because the nurse student cannot convince a patient to take her medications. The nurse talks to the patient for several minutes about this; during their conversation the patient explains that she wants to die but does not know how to. She feels that she is not allowed to join people that she knows are waiting for her “on the other side”, and is troubled that the reason for this is that she “has not been good”. The patient is sitting in a chair next to her bed with her eyes closed for the entire conversation. As we enter the situation, the patient opens a new sequence regarding her eyes.

9.1. INTERACTIONAL ANALYSIS OF CASE ONE, “THE WORK OF A THUMB”

The patient is sitting in a chair with her arms and hands resting on pillows on top of the armrests. The nurse is standing next to the patient’s chair, with her upper body bent towards the patient, her left elbow leaning on the patient’s table (Figure 20). Their faces are close together and oriented towards each other. The nurse is holding the patient’s hand and is gently stroking the back of her hand with her thumb. With their bodies directed towards each other and their distribution of orientations towards each other, the nurse and the patient constitute an embodied participation framework (C. Goodwin, 2000).

Figure 20: The work of a thumb – intro

The patient launches a new topic as she produces the utterance, “why can why can you not open my eyes” (excerpt 1).

Excerpt 1:

```
 1   P    hvorfor ka’ hvorfor kan du ikke lukke mine øjne op
 2        why can why can you not open my eyes
 3        ((turns face towards N))
 4
 5   N    det ved jeg ikke
 6        i do not know
 7        ((moves bottom backwards, bends knee, gaze P, holds P’s left
 8        hand with right hand, strokes it with thumb))
 9
10   P    ((shaking head))
11
12   P    er der kli- (.)[er der
13        is there any pa- (.) is there
14   N                   [klistrer de
15                       [are they sticky
16
17   P    er der klister på dem
18        is there any paste on them
19        ((turns head to mid position))
20
21   N    det ser det ikke ud til
22        there does not look to be
23
24   N    prøv at se om du selv kan lukke dem op
25        try to see whether you yourself can open them
26   P    ((turns head towards N))
27
28   P    ((moves head down and sideways, smacks lips, moves mouth))
29
```

```
30          (11)
31
32    N     gerda
33
34    P     ja
35          yes
36          ((lifts head towards N’s face))
37
38    N     prøv at lukke øjnene op
39          try to open your eyes
40
41          (14)
42
43    P     ((moves head, lifts eyebrows))
```

The utterance “why can why can you not open my eyes” (line 2) could be ascribed to be an existential question; however, it is treated by the nurse as the first pair part of an adjacency pair (Sacks, Jefferson, & Schegloff, 1992; Schegloff, 1968) requesting information. This imposes a normative obligation on the nurse to perform a type-fitted response, which she does with the utterance “I do not know” (line 4). The nurse thus claims an unknowing stance, upon which the patient poses an additional informative request. However, in her utterance “is there any pa is there” she aborts the word “paste” in the very production of it (line 13). The nurse recognizes the incomplete word that is underway and projects how the rest of the patient’s turn was to develop. With her utterance “are they sticky” (line 15) she works to minimize the gap and display what she anticipated in the patient’s truncated turn. At the same time, the patient initiates self-repair and repeats the first two words of that turn, overlapping with the nurse’s utterance. The patient again stops short (line 13). As the nurse’s turn reaches completion, the patient initiates self-repair by producing the utterance, “is there any paste on them” (line 18). The nurse responds to the patient’s request for information with the utterance “there does not look to be” (line 22). The nurse then makes a request for action when she produces the utterance “try to see whether you yourself can open them” (line 25). The request is designed as a soft instruction that makes reference to whether the patient has the bodily ability to perform the action. The nurse’s request for action is the first pair part of an adjacency pair for which the conditionally relevant next (Schegloff, 1968) is for the patient to perform the requested action that constitutes the second pair part of the adjacency pair. The patient moves her head around and smacks her lips but does not open her eyes. After approximately 11 seconds, the patient has not produced the conditionally relevant next action – opening her eyes – and the nurse addresses and summons the patient by uttering her name (line 32). The patient then produces the type-fitted second-pair part response to the nurse’s summons by answering it with a “yes” (line 35) while turning her face towards the nurse. The nurse subsequently officially recognizes the non-occurrence (Schegloff, 1968) of the obligated action by repeating her previous request. Noticing the patient’s trouble, the nurse in her repeating of the request replaces the deictic term “them” with “eyes”. She thus designs the utterance, “try to open your eyes” (line 39) to be intelligible without the patient having to refer back to their previous turns of

talk. The repeated request for action is designed as a more direct instruction. Because the nurse uses the word “try”, she is however still making reference to whether the patient has the bodily ability to perform the action. The patient moves her head around slightly and raises her eyebrows but does not open her eyes. Her face remains oriented towards the nurse and the nurse maintains her own gaze direction towards the patient’s face. After approximately 14 seconds, the patient turns her head to the left and coughs (excerpt 2).

Excerpt 2:

```
44   P    [coughs
45        [((turns head to the left))
46   N    [((closes eyes, straightens body, [releases P’s hand,
47        slides hand up P’s arm))
48   P                                      [°ja°
49                                          [°yes°
50                                          [((turns head towards N,
51                                            lifts hand/arm))
52
53   N    det er svært
54        it is hard
55        ((gaze P, places right hand on P’s shoulder, strokes it))
56
57   N    ((gaze table, places left hand on table))
58
59   P    mm
60        ((lifts arm further, holds it in mid-air, hand shakes))
61
62   N    ((gaze on P’s hand, removes right hand from shoulder))
63
64   P    hvis du-
65        if you-
66        ((turns face towards N))
67
68   N    ((takes P’s hand, places both their hands on table,
69        gaze hands/table))
70
71   N    [((bends upper body to a stooping posture, bends right knee,
72        puts weight on right leg, slides hip right))
73   P    [((turns head to mid position))
74
75   P    er det er det et bord
76        is this a table
77
78   N    ((turns head towards P, gaze P))
79
80   N    [mm det er et bord det her
81        [mm this is a table
82        ((turns head towards table, gaze table))
83   P    [((lowers head))
84
85   N    [der står lidt yoghurt foran dig
86        [there is some yoghurt in front of you
87        ((turns head towards P))
88   P    [((raises head, turns it towards N))
```

As the patient produces a cough, the nurse immediately retracts her head from its close proximity to the patient’s face, straightens her body to the upright position, releases her grip on the patient’s hand, and briefly slides her hand up the patient’s wrist (Figure 21).

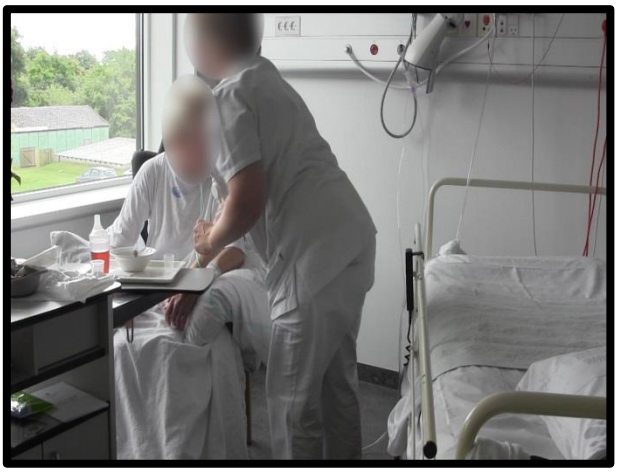

Figure 21: Nurse retracts as patient coughs

Through her movements, the nurse is withdrawing from the close embodied participation framework (C. Goodwin, 2000) with the patient, but still displays a basic orientation (Goffman, 1971; Kendon, 1990) towards the patient by keeping her lower body directed towards her. As the nurse releases the patient’s hand (line 46) there is no longer any physical contact between them; with her eyes closed, the patient is not able to see the nurse’s display of continued basic embodied orientation towards her. As the nurse releases her grip around the patient’s hand, the patient immediately displays an increased acute orientation towards the nurse by turning her head towards her and producing a soft “yes” (line 49). Her utterance is a display of alignment, either in response to the nurse withdrawing her embodied orientation or as a confirmation of her receiving the nurse’s request for action. Simultaneously the patient lifts her left hand and arm from the pillow on which it was resting. As the nurse straightens up, her eyes are closed. She then turns her head slightly and looks at the patient as she moves her right hand to the patient’s shoulder and places it there.

While she gently strokes the patient’s shoulder with her hand, the nurse produces the utterance “it is hard” (line 54). By her utterance the nurse is orienting to the non-occurring action from the patient and combined with her stroking gesture, displaying an affiliative stance (Heritage, 2011) towards the absent action (Schegloff, 1968). She is treating the patient as not having the bodily ability to perform the non-occurring action, and the nurse’s utterance can be ascribed as negotiating the pre-

closing of the sequence. When she places her hand on the patient's shoulder, the nurse re-establishes an embodied participation framework with physical contact, but not with the same close proximity as before. Still stroking, she shifts her gaze to the table and places her left hand on it (line 57). The patient lifts her left arm a little more while she produces an "mm" utterance (line 59) and the nurse shifts her gaze to the patient's hand. The nurse ascribes the patient's sound and gesture to be an orientation towards the lack of touch of her hand, and in an effort to re-establish their contiguity, she takes hold of the patient's hand (line 68) (Figure 22).

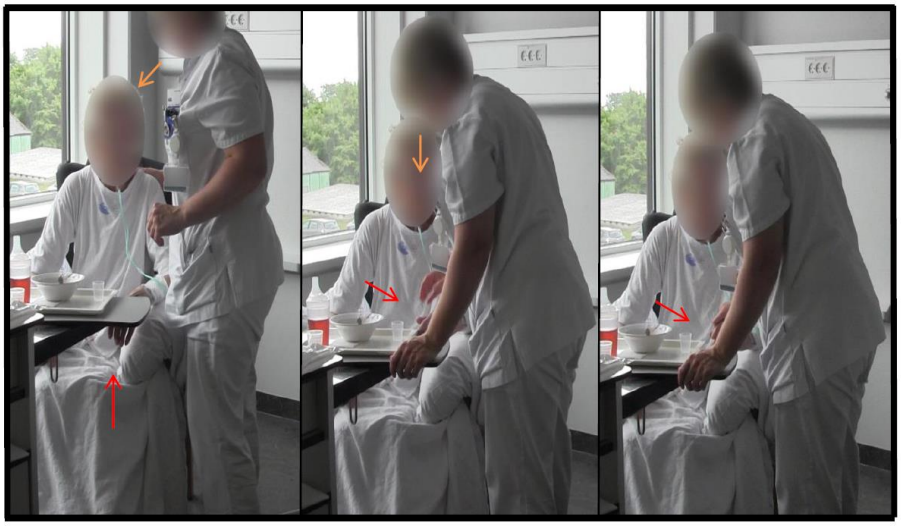

Figure 22: Re-establishing contiguity

The nurse's gaze then shifts to the table, as she places both their hands on the table with a shepherding movement (Cekaite, 2010). The nurse is distributing her orientation towards both the table and the patient. She bends her upper body to a stooping posture with her hands and gaze on the table. Simultaneously, she slides her hip to the right to display a strong basic orientation towards the patient; through their holding hands they establish a mutual orientation within the collaborative accomplishment of their interaction.

As the nurse takes her by the hand the patient produces the utterance, "if you" but aborts and leaves the turn incomplete as her hand is placed on the table. She turns her head to mid-position and produces the epistemic question "is this a table" (line 76). The nurse shifts her gaze to the patient and produces the utterance "mm this is a table", shifting her gaze back to the table. By her utterance the nurse confirms that the object their hands are touching is a table. The patient lowers her head, and the nurse again directs her gaze towards the patient as she produces the utterance "there is some yoghurt in front of you" (line 86). The nurse does not treat the patient's

question “is this a table” as an epistemic question, but uses the object to build action in her elaboration of the turn, treating it as the activity of eating. The patient raises her head and turns it towards the nurse. At this point the phone starts ringing (excerpt 3).

Excerpt 3:

```
89    T     [-----------------------------------------------------]
90    N     [gaze P]
91
92    T     [-----------------------------------------------------]
93    N     [((straightens up, grabs phone with left hand, gaze P))]
94
95    T     ------------[------[------------]
96    N                       [((gaze phone, pushes button]))
97    P                 [((lowers head, mid position))
98
99    N     ((moves phone to right ear, rotates shoulders and head to
100         the left, gaze mid-air))
```

As the phone rings the nurse sustains her orientation towards the patient for the duration of the first pulse of the ring tone (duration: 2.4 seconds). As the second pulse of ring tones sounds, she then distributes embodied orientations towards the summons of the phone (line 93). In doing so the nurse displays multiple distributions of orientations; her gaze on the patient’s face is sustained as she straightens her upper body, slides her hip to the left, and grabs the phone from her left pocket with her left hand (Figure 23).

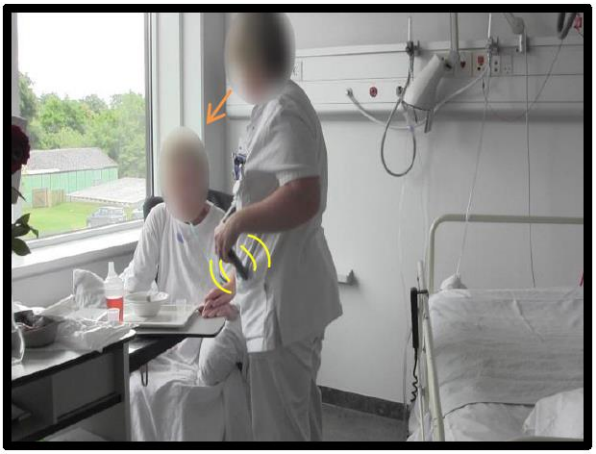

Figure 23: Sustained orientation towards patient while phone rings

Not having to look where to move her hand to grab the phone, the nurse demonstrates that the phone is internalized in her practices. Schegloff has demonstrated how a phone ringing is a strong summons, projecting a strong normative expectation of answering the phone at the first possible opportunity (Schegloff, 2002). The summons from the phone is audible to the patient as well as the nurse, and the patient can project from the sound of the phone ringing that the nurse’s next action will be to answer the summons. The patient may also sense the nurse’s distribution of orientations towards the phone, may hear the movements of the nurse, and feel them through the embodied interconnectedness of their holding hands. The patient at this point turns her head to mid-position and lowers it (line 97). By doing so she withdraws her facial orientation towards the nurse, displaying that she is withdrawing from their mutual embodied participation framework (C. Goodwin, 2000). The patient treats their mutual activity as ceased. As the nurse answers the phone, she redistributes her orientations, turning her head and directing her gaze at the phone as she pushes a button. She then moves the phone to her right ear, turning her head and her shoulders slightly towards the left, away from the patient. Holding the phone by her right ear with her left hand, her arm is positioned across her chest. Meanwhile, she is still holding the patient’s hand with her right hand, observably maintaining an orientation towards her.

The nurse does not verbally account for her answering the phone or mark the phone call as a side sequence (Jefferson, 1972) or an inserted sequence (Schegloff, 2007). The nurse is thus exhibiting that the patient is capable of hearing the summons and from that being able to project that the nurse will answer it. As the patient is not able to open her eyes, she is not able to see the nurse’s distribution of orientations. The nurse uses the tactile sensation of holding her hand to display her continued orientation to the patient and to show that their mutual activity is not terminated but will be resumed. In doing so, she treats the activity with the patient as the main activity (Sutinen, 2014) and observably marks the activity of answering the phone as inserted into this activity.

The nurse opens the phone conversation with a self-identification sequence (Schegloff, 1986), stating her name (excerpt 4).

Excerpt 4:

```
101  N    det er heidi
102       heidi speaking
103       ((rotates shoulders, turns head right, gazes P))
104
105  N    hej
106       hi
107       ((gaze hands/table, squeezes p’s hand))
108
109  P    ((raises head))
110
111  N    ((strokes p’s hand with thumb))
```

```
112
113  P    ((turns head towards nurse))
114
115  N    hh jeg er ikke begyndt (.) jeg står lige inde på otte
116       hh I haven’t started (.) i am just in eight
117       ((gaze table, ceases strokes))
118
119  N    ja (h)okay
120       yes (h)okay
121
122  N    jeg har fo- jeg har forberedt det (.) det ligger klar
123       derinde
124       i have pre- i have prepared it (.) it is lying ready
125       in there
126
127  N    ja godt hej
128       yes okay bye
```

Opening the phone conversation the nurse simultaneously turns her head and shoulders towards the right and gazes towards the patient (line 103). By her gaze the nurse is displaying an acute orientation towards the patient, monitoring her while engaged in the phone conversation. Gazing at the patient, the nurse notices that the patient is no longer displaying current commitment towards her. Their hands are still connected but the patient is not recognizably displaying that she understands that their mutual activity is not finished but will be resumed. The nurse treats the patient’s lack of orientation towards her as troublesome, and works to fix the trouble through subtle use of tactile resources. Because she is using her verbal resources to manage the phone conversation, using them to address the patient as well would interfere with the topic under way in the phone conversation. Instead, the nurse increases the tactile sensation on the patient’s hand by squeezing it gently with her thumb (line 107). Increasing the tactile sensation highlights it so as to make the patient notice it. As the patient observably does so by immediately lifting her head (line 109), the nurse begins to move her thumb back and forward, gently stroking the back of the patient’s hand. The movement is designed as a gesture of affiliation (Heritage, 2011), and the patient in continuation of her head lift turns her head towards the nurse, displaying an acute orientation towards her (Figure 24).

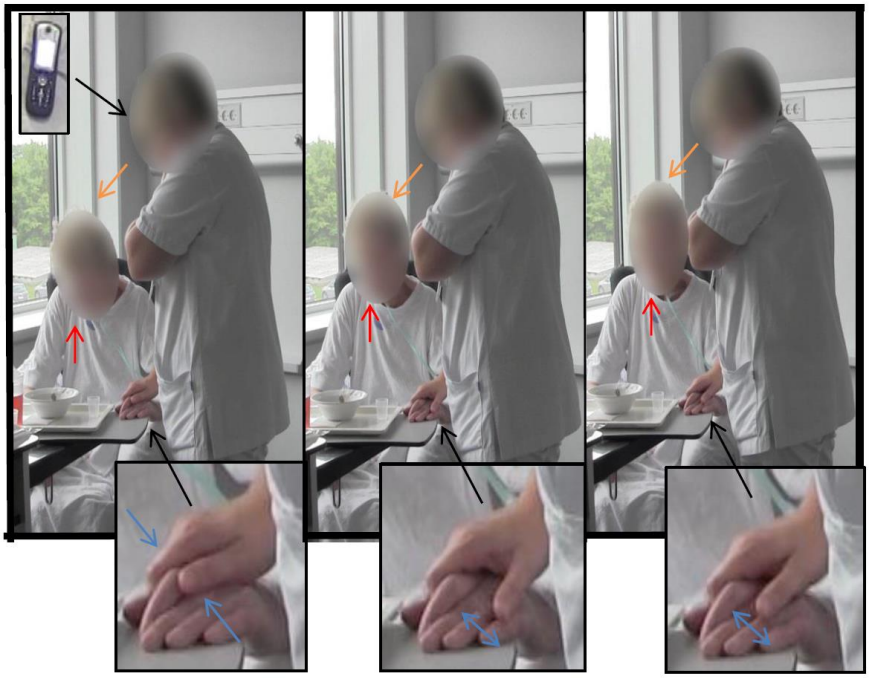

Figure 24: Squeezing and stroking patient’s hand during phone conversation

The caller presumably reciprocates the self-identification, and the nurse in her second turn initiates a greeting exchange (Schegloff, 1986) by saying “hi” (line 106). As she produces her greeting the nurse’s gaze shifts to a midpoint down position towards the table. The nurse uses a middle-distance stare (Lofland, 1973) to demonstrate her non-availability even though her involvement shield (Goffman, 1969) is not visible to the patient. The caller asks how much of the IV medicine the nurse has administered. The nurse answers the informative request by producing the utterance “I haven’t started”, prefaced by an audible outbreath (line 116). By her sigh, she is treating the fact that she has not yet started the IV as troublesome. She continues her turn with the utterance “I am just in eight” (line 116). The physical location of the nurse and the activity she is performing is not known to the caller. By telling the caller where she is, the nurse is not simply giving information about her physical location; the activity she is performing and with whom can to some extent be projected from this information. Her utterance is thus not only designed for the caller to determine her location, but also as an account of not having started administering the IV. By her utterance the nurse is indicating to the caller that her activity in room eight has kept her from that task. At this point the nurse stops stroking the back of the patient’s hand with her thumb (line 117), but she continues to hold the patient’s hand, and the patient maintains her face turned towards the nurse. By maintaining an acute orientation towards the nurse, the patient is treating

their mutual activity as not finished; without taking their mutual activity forward or pursuing progression of their talk, the patient is recognizably waiting for the nurse to finish the phone call. She is thus displaying her understanding that their mutual activity is only temporarily suspended, and is displaying herself as available to the suspended activity once the nurse has finished the phone call.

The caller informs the nurse that she will begin the administration because she has finished her other assignments. The nurse produces the utterance “yes okay” with an interlacing laughter particle (line 120). Laughter can work to indicate that there is trouble but that the trouble is manageable (Jefferson, 1984). By inserting the laugh particle the nurse is marking the trouble of her not starting the IV, but at the same time exhibiting that she is taking the trouble lightly. In her next turn the nurse informs the caller that she has made preparations for the task of administering the IV and that the commingled drugs are ready in the medicine room. The caller then presumably proposes closure of the sequence, which the nurse accepts with her utterance “yes okay bye” (line 128).

As the closure of the phone conversation is accomplished, the nurse uses her left hand to move the phone away from her ear and replace it in her pocket, simultaneously pressing a button twice (excerpt 5).

Excerpt 5:

```
129  N    ((presses button on phone twice, moves phone to pocket,
130         gaze mid-air))
131
132  N    ((squats, leans left elbow on table, gaze P))
133
134  N    har du svært ved at åbne øjnene gerda
135       is it difficult for you to open your eyes gerda
136       ((gaze P’s face))
137
138  P    ja
139       yes
140       ((turns head towards N))
141
142  N    ja
143       yes
144
145  P    jeg t jeg tror d tror der er noget der klister
146       i t- i think there is something sticky
147
148  N    skal vi lige prøve at vaske dem lidt
149       shall we try to wash them a little
150
151  P    er jeg er jeg blevet vasket
152       have I been washed
153
154  N    du er lige blevet vasket nu ja men vi kan lige prøve og (.)
155       og vaske øjnene igen
156       you just had a bath now yes but we can try to (.) to wash
```

```
157       your eyes once more
158
159  P    ((moves head right, smacks lips, moves head left))
160
161  N    ik os (.) jeg henter lige lidt (0.3) en klud med lidt vand
162       på
163       right (.) i will fetch a little (0.3) a cloth with a little
164       water on it
165
166  N    så prøver vi og ser
167       then we will see
168       ((stands up, turns body away from P))
169
170  P    ((turns head right))
171
172  N    [((starts walking, left hand and leg slow as movement is
173       stopped by right hand being stuck in P’s hand))
174  P    [((holds nurse’s hand))
175
176  N    ((turns towards P, gaze hands, slips right hand out of P’s
177       hand))
178
179  N    ik os
180       right
181       ((places hand on top of P’s hand))
182
183  P    °ja°
184       °yes°
185       ((turns head left))
186
187  N    ((turns away, starts walking))
188
189  N    jeg er tilbage lige om et øjeblik
190       i will be back in a minute
191       ((walks towards door))
```

Once again the phone is exhibited as internalized in the practices of the nurse; without looking she disconnects the call and replaces the phone using only one hand. Before the action of replacing the phone is completed, the nurse begins to bend her knees and assumes a squatting position next to the patient’s chair. All these actions are performed at the same steady pace, merging them into one smooth movement. As the nurse squats down she is still holding the patient’s hand with her right hand; she places her left arm on the patient’s table. The nurse is positioning herself lower than the patient, having to lift her head slightly to look at the patient face (Figure 25).

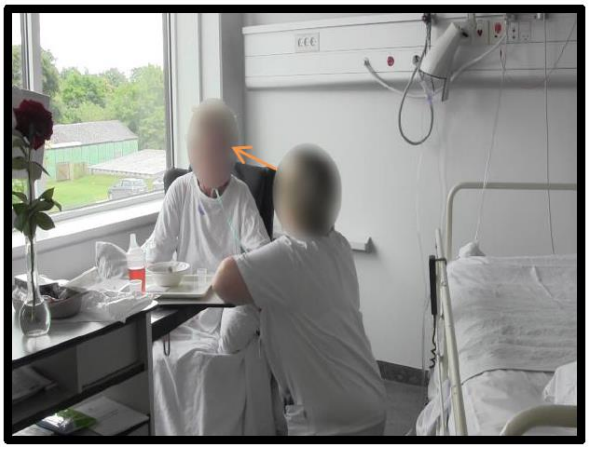

Figure 25: Resuming suspended sequence

The nurse addresses the patient by saying her name and initiates the opening of an interactive sequence between them as she producing the utterance “is it difficult for you to open your eyes Gerda” (line 135). With her utterance the nurse returns to the topic of their previous sequence, and initiates the resumption of their mutual activity which was suspended by the phone ringing. She opens the sequence with an informative request to which the answer is projectable from the mutual interactional sequence they were engaged in prior to the phone call. The patient responds with a “yes”, seemingly effortlessly resuming the topic of this interaction sequence. The nurse acknowledges the patient’s turn with a “yes”, and the patient then produces an elaboration of her previous turn by her utterance “I t- I think there is something sticky” (line 146). On the basis of this informative answer, the nurse in her next turn makes an offer by producing the utterance “shall we try to wash them a little” (line 149). By using “we” the nurse is marking that the patient is not herself capable of washing her eyes. She will need the nurse to help her do so and the nurse is offering to assist her. The patient does not produce an acceptance or declination as would be the expected type-fitted response to the nurse’s offer. Instead, the patient breaks the contiguity between the first- and second-pair parts of an adjacency pair, and inserts a pre-second expansion (Stivers, 2012) producing the informative request: “have I been washed” (line 152). Her inserted expansion exhibits her as having difficulties remembering that she just finished her bath, and she therefore requests further information about the contingencies on which her response hinges.

In her next turn the nurse not only provides the requested information but also re-produces her offer to the patient by uttering “you just had a bath now yes but we can try to to wash your eyes once more” (line 156). This is exhibited as a transition relevant place with a salient possibility for the patient to take the speakership as the nurse’s precious turn has reached possible completion. However, the patient does

not respond verbally to the nurse’s repeated offer to wash her eyes, and her silence suggests that the preferred yes response is not forthcoming. The patient turns her head away from the nurse and makes a smacking sound with her lips before turning her head back to face the nurse. The nurse treats the patient’s embodied response as a display of dis-alignment, as she again takes the floor and prefaces her next turn with “right” (line 163). As the preferred response to the nurse’s utterance is an acceptance of her offer, she is working to accomplish the patient’s alignment with her proposal for action. When she continues her turn, she says “right I will fetch a little a cloth with a little water on it” (line 163) and thus makes the patient’s alignment prerequisite by informing her of her next action. The patient does not produce any verbal response to the nurse’s utterance but turns her head slightly to the left. Her silence again suggests that the preferred acceptance response is not forthcoming. By not responding to the nurse’s turn the patient is violating the basic rules of turn-taking, which can be considered a breach of social norms and thus accountable behaviour (Robinson, 2013). The nurse marks the non-occurrence of the normative obligated type-fitted response as officially absent (Schegloff, 1968) by producing the utterance “then we will see” (line 167) as she stands up and starts to turn away from the patient.

The patient again turns her head to the right, and the nurse starts to walk away. The nurse’s left hand and leg slow as her walking movement is stopped by her right hand being stuck inside the patient’s hand (Figure 26). She turns her body around towards the patient and directs her gaze towards the contiguity between her right hand and the patient’s hand (line 176). She gently slips her hand out of the patent’s grip and places it on the back of the patient’s hand while she utters, “right” (line 180).

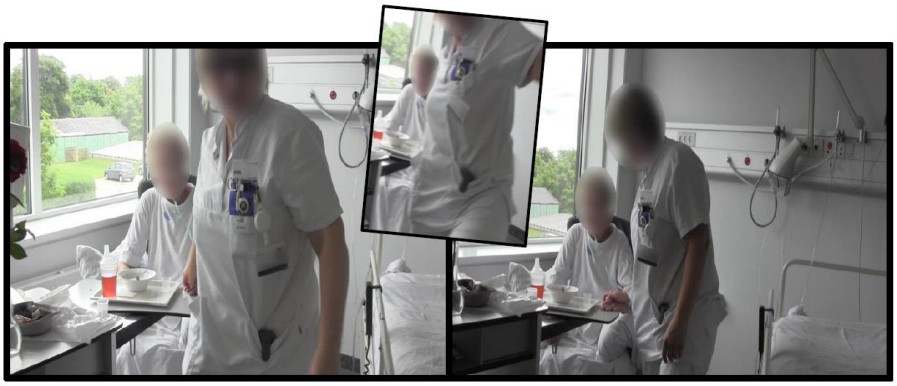

Figure 26: Patient holding on to the nurse’s hand

Not replying to the nurse's utterances about walking away and not letting go of her hand as she starts walking, the patient is exhibited as reluctant to let the nurse go. The nurse displays her understanding of the patient's preference for physical contact and her orientation towards touch; she places her hand on top of the patient's hand, marking the closure of the contiguity between their hands. With her simultaneous verbal production she adheres to the planned trajectory of action and again requests the patient's acceptance of her offer. The patient produces a soft "yes" (line 184), accepting the nurse's offer and aligning with the proposed action. The nurse removes her hand and again turns her body away from the patient and starts walking. As she is walking away she produces the utterance "I will be back in a minute" (line 194). Her utterance is designed to reassure the patient that she will return, and the patient is thus exhibited as reluctant to let her go.

9.2. STRATEGIES IN CASE ONE, "THE WORK OF A THUMB"

In case one, "The work of a thumb", the nurse and the patient constitute a close embodied participation framework, as the nurse talks to the patient about her dying wish for an extended period of time. In this moment of action, the nurse is putting the discourse of patient-centred care into practice by distributing all orientations towards the patient and by being sensitive towards the patient's slow pace, her need for physical contact, and her debarred vision. When the phone rings, the nurse keeps her body oriented towards the patient and sustains her gaze towards the patient's face. The nurse, having just produced a turn as the phone rings, is in this way addressing the patient as the next speaker and displaying adequate attention towards her. She thus foregrounds the discourse of patient-centred care and postpones her enactment of the discourse of being efficient. As the nurse recognizes that the patient is refraining from producing a next turn, possibly because she hears the phone ring, the nurse distributes embodied orientations towards the phone. She thereby puts the discourse of being efficient into practice. However, as she answers the phone, the nurse continues to hold the patient's hand, and in this way makes her sustained orientation perceptible to her. The nurse uses the tactile sensation of holding hands to show her continued orientation towards the patient, and to display that their mutual activity is not terminated but will be resumed. In doing so, the nurse continues to enact the discourse of patient-centred care while she simultaneously enacts the discourse of being efficient by speaking on the phone. In this moment of action the nurse thus combines a new semiotic field (the phone) with the on-going contextual configurations (C. Goodwin, 2000).

As the nurse is talking on the phone she simultaneously monitors the patient, who has lowered her head. The nurse treats the patient's lack of orientation towards her as troublesome, and works to fix the trouble through subtle use of her embodied resources. As she is using her verbal resources to manage the phone conversation,

simultaneously using them to address the patient would interfere with the topic in the phone conversation. Instead, the nurse increases the tactile sensation on the patient's hand by squeezing it gently with her thumb. The patient observably notices this, immediately lifting her head. As the trouble of non-orientation is fixed, the nurse recognizably achieves the success of her action formation; she changes her movement to a stroking gesture of affiliation by moving her thumb back and forward and gently stroking the back of the patient's hand.

Given their capacity to interdigitate, hands are the means of togetherness (Ingold, 2015, p. 6). By holding the patient's hand the nurse is displaying that "we are here together". The patient is not displaying that she recognises their togetherness, and the nurse observably treats the patient's withdrawn orientations as other than the preferred response. The nurse highlights the tactile sensation by gently squeezing the patient's hand to emphasise the interconnectedness of their hands and to mobilise another response from the patient. The nurse is thus demonstrating sophisticated perceptual awareness towards the patient, using subtle gestures to make sure that her display of togetherness is understood. Ensuring that the patient recognises their togetherness during the phone call is treated as relevant by the nurse, and in this way she is displaying it to be significant. The nurse's gesture mobilises an acute facial orientation from the patient, which is maintained as the patient is observably "doing waiting". As she continues to distribute commitment towards the nurse, without taking their mutual activity forward or pursuing progression of their talk, the patient is observably doing waiting; demonstrating that she understands their mutual activity to be only temporarily suspended and demonstrating herself as available to the suspended activity once the nurse finishes the phone call.

The discourse of patient-centred care is put into practice as the nurse in this situation sustains embodied orientations toward the patient and displays the patient to be the main activity. It is further enacted when the nurse uses subtle embodied resources to demonstrate to the patient that they are still together during the phone call and when she makes sure that her display of togetherness is understood by the patient. At the same time, the nurse is enacting the discourse of being efficient by answering the phone and coordinating tasks with a colleague. Speaking to a colleague on the phone the nurse says with a sigh, "I haven't started I am just in eight" and "I have prepared it, it is lying ready in there". Prior to the situation under study, the nurse by the caller was assigned the task of handing out medicine to all patients. The colleague now calls to inquire about the progress of this activity. By her sigh, the nurse is treating the fact that she has not yet started administering the medicine as troublesome. She continues her turn with the utterance "I am just in eight". By displaying her location to the caller the nurse is not simply giving information about her physical location; the activity she is performing and with whom can to some extent be projected from this information. Her utterance is thus not only designed for the caller to determine her location, but also as an account for not having started to administer the medicine. By her utterance the nurse is indicating to the caller that her activity in room eight

has kept her from the task, and it is at this point the nurse stops stroking the back of the patient’s hand with her thumb. However, she continues to hold the patient’s hand for the duration of the phone call.

The discourse of being efficient is enacted in the situation when the nurse answers the phone. It is also put into practice as the nurse with a sigh tells the colleague that she has not yet attended to the activity of administering medicine. The colleague then offers to begin that process; as the nurse accepts this, she inserts a laughing particle, exhibiting that she is taking this trouble lightly. The nurse exhibits her stance to be that patients are to be prioritised and that some tasks can be postponed for the benefit of patients. By her words she thus also enacts the discourse of patient-centred care. The discourse of patient-centred care is further put into practice as the nurse in the situation continues to attend to the conversation with the patient rather than taking any actions to close their interactive sequence and attend to the task of administering medicine. The discourse of being efficient is thus backgrounded until the phone rings and materialises this discourses within the interaction. By answering the phone and attending to the discourse of being efficient the nurse however simultaneously manages to enact the discourse of patient-centred care through her embodied display of togetherness.

CHAPTER 10. ANALYSIS OF CASE TWO: “ANYTHING IMPORTANT”

In case two, “Anything important”, a nurse is assisting a patient in washing and being dressed in clean clothes. Because of her illness, the patient is not capable of doing this herself, nor is she capable of going to the bathroom. The patient is thus sitting in a wheelchair in front of a sink in a patient room, with her bed and table next to her. As we enter the situation the nurse has just finished washing the patient and grabs a clean shirt to begin dressing her (Figure 27).

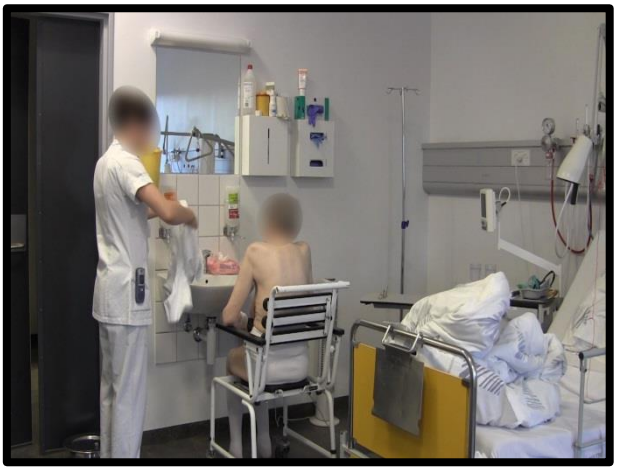

Figure 27: Anything important – intro

10.1. INTERACTIONAL ANALYSIS OF CASE TWO, “ANYTHING IMPORTANT”

The nurse turns the right side of the shirt out and rolls it up to make it easier for the patient to put it on. She then holds the shirt with her arms stretched towards the patient while producing the utterance, “there” (excerpt 6).

Excerpt 6:

```
192  N    så
193       there
194       ((steps forwards, holds shirt towards P, gaze shirt)
195
```

```
196  P    ja
197       yes
198       ((puts hands inside shirt, gaze shirt))
199
200  P    åh ja (h)
201       oh yes (h)
202       ((puts arms through sleeves of shirt))
203
204  N    ((touches shirt, pulls it gently with right hand, releases
205        shirt, gaze shirt, moves hand to P’s face, gaze P’s face))
206
207  N    vi skal lige have den her af et øjeblik
208       we need to remove this for a moment
209       ((removes oxygen catheter from P’s nose and ears))
```

In Danish the stand-alone “så” (line 192) can have various meanings. It can be used to express that something is completed, that a person is ready for something, or that an expected or dreaded moment has occurred (Det Danske Sprog- og Litteraturselskab, 2015). With her utterance the nurse might display that she is done preparing the shirt for the patient, that she is ready for the patient to put it on, or that putting it on is a dreaded moment, as the patient’s respiratory problems makes every movement an exertion. The nurse’s turn is exhibited as the first pair part of an adjacency pair (Schegloff, 2007), because the patient treats the nurse’s utterance as an offer, which she accepts with the verbal production “yes” (line 197). Simultaneously, she aligns herself bodily by placing her hands inside the shirt (Figure 28).

Figure 28: Assisting patient with shirt

As the patient begins to slide her arms through the sleeves, she produces the utterance “oh yes” with a sigh (line 201). “Oh” is a change of state token which has been found to index a change of awareness or attention and to indicate a self-attentive course of action (Heritage, 1984; Heritage, 2002). By her oh-preface the

patient is displaying her orientation towards the activity of putting on the shirt, while her subsequent “yes” displays her acceptance of undertaking the task. Along with this utterance the patient produces a sigh. Sighing has been shown to serve as a public display of orientation towards a task and to demonstrate that the task is accepted and will be started. However, the sigh also displays a resigned posture towards the task and negatively evaluates it as onerous (Hoey, 2014). With her sigh, the patient treats the accepted activity of putting on the shirt as burdensome.

The nurse with her right-hand fingers gently pulls the shirt a little but then releases it (line 204). Through this gesture the nurse acknowledges the patient’s display of the activity as onerous and responds with an initial willingness to assist her. However, when she refrains from completing it, the nurse is demonstrating to the patient that the patient must perform the task herself. The nurse moves her hand to the patient’s face and begins to remove the oxygen catheter attached to the patient’s face by her nose and ears (Figure 29).

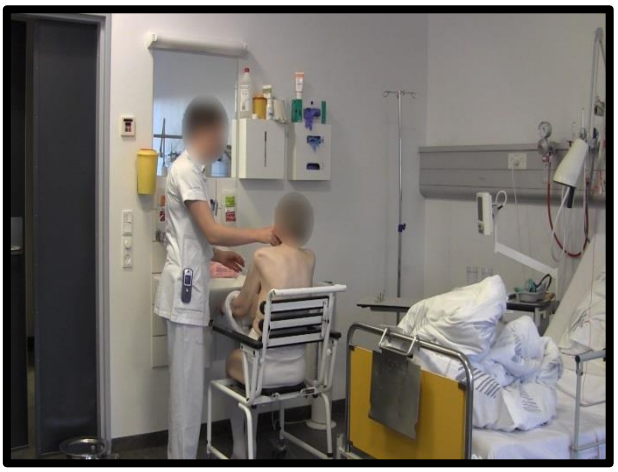

Figure 29: Removing oxygen catheter

Reaching for the oxygen catheter the nurse produces the deictic utterance “we need to remove this for a moment” (line 208). The nurse does not explain verbally to the patient why they need to remove the catheter, but by using “we” she orients the situation towards their joint activity of putting on the patient’s shirt. The reason for removing the catheter is projected from the trajectory of their actions; the shirt cannot be donned with the catheter in place. The nurse adds “for a moment” to her deictic reference to display to the patient that the catheter will be replaced shortly. In her recipient design (Sacks, Schegloff, & Jefferson, 1974), the nurse demonstrates her understanding of the patient as being dependent on the supply of oxygen. The patient makes no verbal response to the nurse’s turn; instead she continues the activity of sliding her arms through the sleeves. By not responding to the nurse’s

turn the patient is violating the basic rules of turn-taking, which can be considered a breach of social norms and thus accountable behaviour (Robinson, 2013). The nurse does not however treat the patient’s lack of verbal response as troublesome. The patient continues the trajectory of actions and thus aligns with the removal of the catheter, treating the account and actions of the nurse as intelligible and acceptable. While the nurse removes the oxygen catheter, the phone starts ringing (excerpt 7).

Excerpt 7:

```
210  T    [-------------------------------------------------------
211  N    [((untangles oxygen catheter from shirt, gaze shirt))
212
213  P    åh
214       oh
215       ((gaze shirt))
216  T    [---------------------------------------[-----------
217  N    [((untangles catheter))                  [((pulls shirt))
218  P                                             [((lifts arms))
219
220  T    [--[-----------------------------------[---------[---
221  N    [((lifts shirt over patient’s head))    [((grabs catheter))
222  P       [mm                                           [(.hh)
223
224  T    [---------------------------------------[-----------
225  N    [((untangles oxygen catheter, gaze catheter))
226  P    [åh (h)
227       [oh (h)
228       ((gaze forward mid-air))
229  N                                             [så får du lige
230                                                [now you just get
231                                                ((lifts hands))
232
233  T    [------------------[---------------------------------
234  N    [den her på]
235       [this one on]
236       [((replaces catheter in P’s nose))
237  P                      [ja
238                         [yes
239
240  T    [-------------------------------------------------------
241  N    [((replaces oxygen catheter around P’s ears))
242                                                [jeg tager lige
243                                                [I will just
244
245  T    [-------------------------------------------------------
246  N    [telefonen her [og hører om det er noget vigtigt
247       [answer the phone to hear if it is anything important
248       [((moves right hand to pocket, grabs phone))
249  P                   [°ja°
250                      [°yes°
251                      [((turns head right))
```

When the mobile phone begins to ring, the nurse does not orient towards the phone, but continuous her course of actions. Her gaze stays fixed on the patient and oxygen catheter and she sustains a body posture leaning towards the patient (Figure 30).

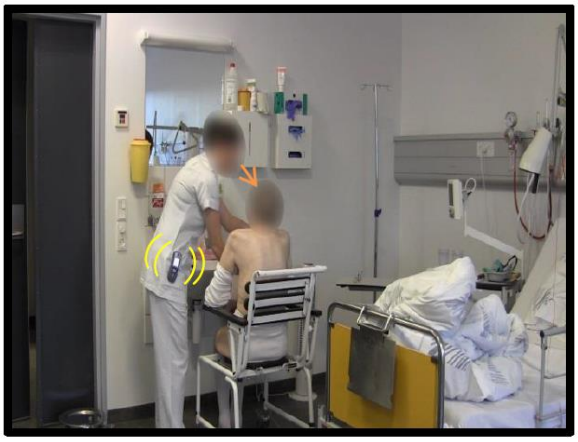

Figure 30: Sustained orientation towards patient while phone rings

By not orienting towards the summons of the phone (Schegloff, 2002), the nurse displays the activity of putting the shirt on and replacing the oxygen catheter as the main activity (Sutinen, 2014), which is prioritized over the activity of answering the phone. The patient also shows no sign of orientation towards the phone. After the first string of tones from the phone the patient produces the utterance “oh” with an audible expiration (line 214). The phone then produces the second string of tones. Producing her utterance at a salient transition moment between strings of tones, the patient seems to coordinate her verbal production with the rhythm of the ringtone (Figure 31).

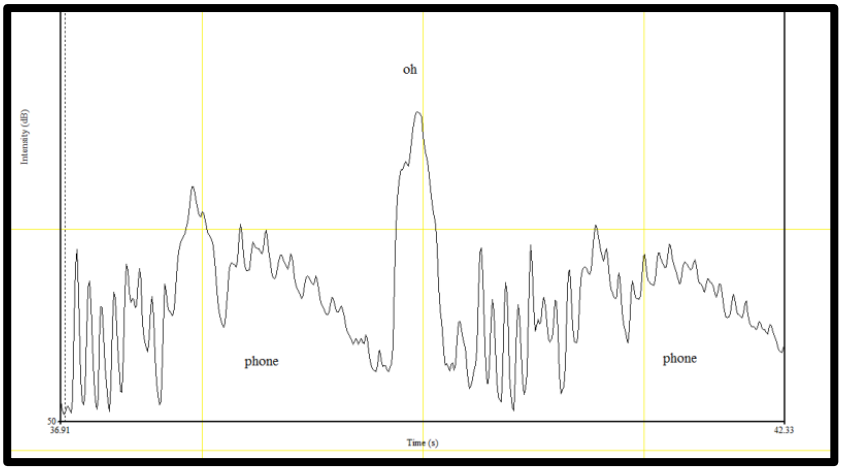

Figure 31: Verbal production in gap between ringtones

The patient’s utterance is exhibited as a repetition of her previous display of the activity as burdensome. As neither the nurse nor the patient orients towards the phone, the utterance is not exhibited as a response to the phone ringing.

The nurse and the patient continue the activity of putting on the shirt by pulling it over the patient’s head (Figure 32). This action is exhibited as a coordinated jointly achieved bodily movement in which the patient lifts up her arms as the nurse pulls the shirt. This joint movement is performed without the use of verbal resources to synchronize the action. However, as the movement is performed in the gap between the second and third string of tones, the rhythm of the ring tone is exhibited as a shared rhythmic framework coordinating the action (Erickson, 1992).

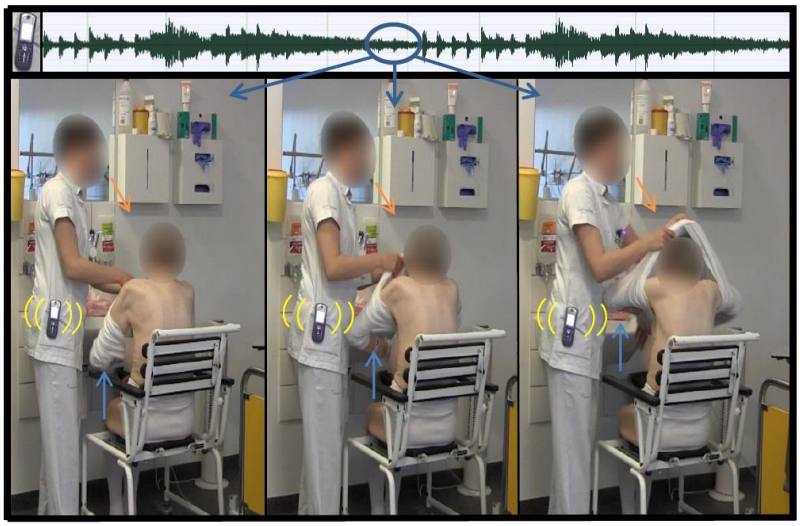

Figure 32: Coordinating jointly achieved body movement

As they pull the shirt over the patient’s head the patient produces an “mm” utterance (line 222) to demonstrate to the nurse the strain that she is experiencing from this movement. The nurse then immediately grabs the oxygen catheter and begins to untangle it. In the pause between the third and fourth string of tones, the patient generates a prolonged in-breath (line 222) and produces the utterance “oh” (line 227) with a sigh. The prolonged in-breath demonstrates that putting on the shirt has left her short of breath, while the utterance displays her distress. Producing the in-breath in the gap between two strings of tones from the phone, the patient again seems to coordinate her action with the rhythm of the ring tone. The prolonged in-breath takes up most of the gap, so the “oh” utterance overlaps the onset of the fourth string of tones. As the fourth string of tones fades, the nurse produces the

utterance “now you just get this one on” (line 230 & 235), seemingly coordinating her utterance with the rhythm of the ring tone. Her deictic utterance refers to the oxygen catheter which she is simultaneously attaching to the patient’s nose (Figure 33). The patient responds with a “yes” (line 238), as a free-standing receipt marker (Beach, 1995) that displays her understanding of the nurse’s previous turn.

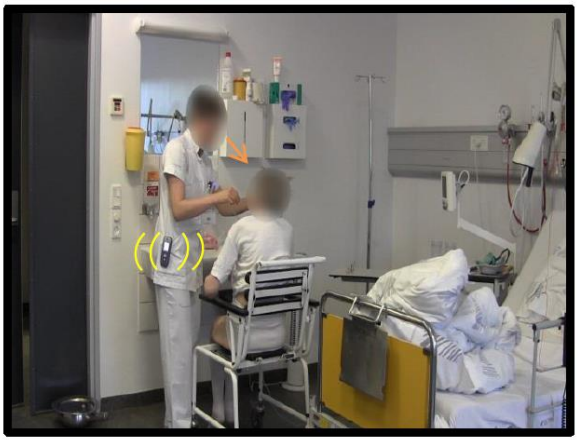

Figure 33: Planned course of action is pursued and orientation towards patient is sustained while phone rings

The nurse replaces the oxygen catheter by attaching it to the patient’s nose and ears. As the fifth string of tones is fading she produces the utterance “I will just answer the phone to hear if it is anything important” (line 243 & 247). The nurse is verbally orienting to the activity of answering the phone, while she is still bodily attaching the catheter around the patient’s ears. Her gaze is not directed towards the phone nor towards the catheter and patient, but in mid-air. She relies on tactile sensation to replace the catheter around the patient’s ears, as the rear of the patient’s ears is not in her visual field. Her utterance is designed as an account to the patient for suspending their mutual activity. By inserting the word “just” and maintaining her body orientation towards the patient, she is displaying to the patient that their mutual activity is not terminated but will be resumed. She thus treats the activity with the patient as the main activity (Sutinen, 2014), and marks the activity of answering the phone as a side sequence (Jefferson, 1972). The patient acknowledges and accepts her account by uttering “yes” as a free-standing receipt marker (line 250), but produces when overlapping with the nurse’s turn. The onset of the patient’s “yes” marks a possible completion point of the nurse’s turn, but the nurse produces further talk beyond what the patient anticipated. As the patient produces her overlapping “yes”, she turns her head away from the nurse, disaligning herself with the nurse and their mutual embodied participation framework (C. Goodwin, 2000). She maintains her lower body in the same position, displaying a basic orientation (Goffman, 1971;

Kendon, 1990) towards the nurse. By her head turn the patient displays an acute orientation away from the nurse and demonstrates her understanding that their mutual activity is being suspended. By her body torque (Schegloff, 1998), the patient exhibits her understanding that their mutual activity is the main activity, which is temporarily suspended and will be resumed when the inserted activity of the phone call is finished.

The nurse demonstrates the transition to the activity of answering the phone to be delicately coordinated into the activity of dressing the patient. Rather that responding immediately to the summons of the phone and abandoning the on-going activity, the nurse in a skilled way mobilizes multimodal resources to organize the two activities and pursue the planned trajectory of actions. Her movements are designed not to orient herself towards the phone; she does not increase her pace, instead she maintains the same tempo in her verbal and bodily conduct. The nurse thus in a skilled way combines a new contextual configuration (the phone) with the on-going contextual configuration. Furthermore, the nurse directs her talk towards spaces between the ringtones. The way that the patient and the nurse coordinate their verbal productions into salient transition gaps of the ring tone resemblances the basic turn-taking organization of interpersonal conversation (Sacks et al., 1974), and the ringing of the phone is exhibited as constructing a rhythmic framework (Erickson, 1992) in the interaction.

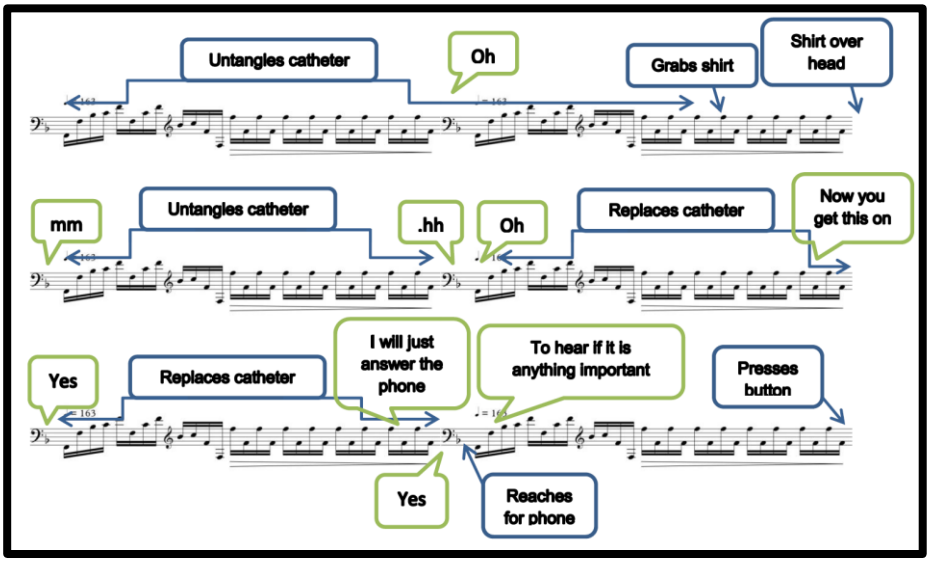

Figure 34: Overview of actions while phone rings

The nurse has embodied knowledge of the duration of the activity she is performing with the patient. She also has embodied knowledge about the general duration of the phone’s ring, and she exploits the length of the ringing to pursue her planned course of actions (Figure 34). She thereby risks that the caller disconnects, which indicates the importance of the activity she is performing. This is further indicated by the utterance “I will just answer the phone to hear if it is anything important”, indicating that the activity she is performing with the patient is already deemed important, because only something important can suspend it.

As the nurse accepts the phone call by pressing a button, she opens the conversation with a self-identification sequence (Schegloff, 1986) stating her name (excerpt 8).

Excerpt 8:

```
252  N    [de:t anna
253       [anna speaking
254       ((walks to P’s back))
255  P    [((turns head forward))
256
257  N    hej
258       hi
259       ((bends, pulls shirt with left hand))
260
261  N    jamen øh(.) jeg er lige inde på stue ni så vi kan lige
262       snakkes ved her
263       well er (.) I am just in room nine so I will speak to you
264       soon here
265       ((straightens up, slides hand over P’s back))
266
267  N    jeg ringer lige
268       i will call
269       ((walks to P’s side, gaze midair))
270
271  N    godt hej
272       okay bye
273       ((gaze mid-air, small step sideways))
274
275  N    ((attaches phone to pocket, gaze pocket)
276
277  N    og så var det sengen
278       and then it was the bed
279       ((steps forward, places right hand on P’s shoulder, gaze P))
280
281  P    hva
282       what
283       ((turns head towards nurse))
284
285  N    så var det sengen
286       then it was the bed
287
288  P    ja
289       yes
290       ((turns head forward))
291
```

```
292  N    ja
293       yes
294
295  N    ((removes hand from P’s shoulder, walks behind P, grabs
296       handle of wheelchair))
```

The caller presumably reciprocates the self-identification, and the nurse in her second turn produces her part of a greeting exchange (Schegloff, 1986), saying “hi” (line 258). While she verbally engages in the self-identification sequence and the greeting sequence, the nurse moves to the patient’s back and continues the activity of dressing the patient. As the nurse moves behind her, the patient turns her head back to a forward position. The nurse answers the phone at a point when it is possible for her to embed the activity of answering the phone into the activity of dressing the patient. Moving behind the patient’s back, she continues the activity while talking on the phone (Figure 35).

Figure 35: Continuing the activity of dressing the patient

The nurse is deploying several body segments (Schegloff, 1998) to manage more than one course of action at a time, as she uses her right hand to hold the phone while she gently pulls the shirt and smooths it with her left hand. While performing this multiactivity (Haddington, P., Keisanen, T., Mondada, L., & Nevile, M., 2014) the nurse’s body is tuned towards the patient, displaying the activity of answering the phone as inserted (Schegloff, 1998) into the activity of dressing the patient. With her smoothing movements, the nurse prolongs the activity of dressing the patient and shows that the nurse is not absent (Figure 36).

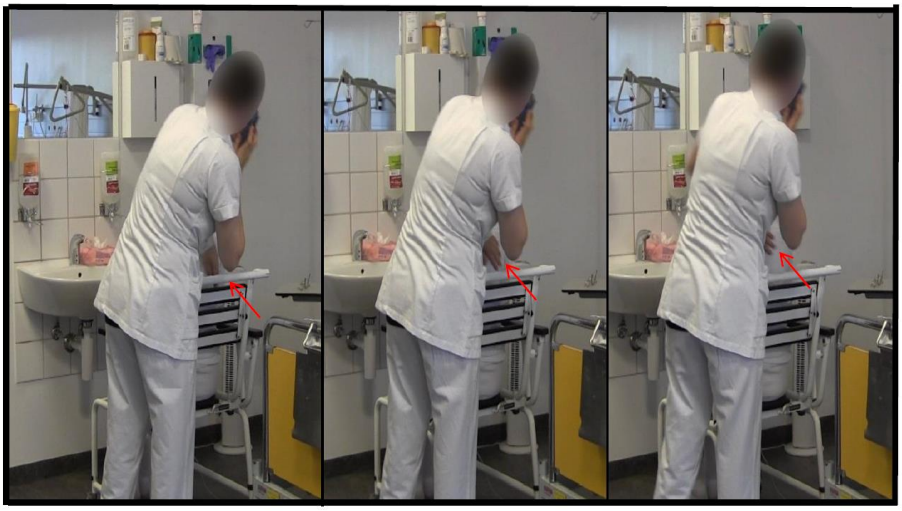

Figure 36: Smoothing movements

The nurse proposes sequence closure to the caller on the phone by uttering: “Well er (.) I am just in room nine so I will speak to you soon here” (line 263). By telling the caller where she is, the nurse clearly gives information about her physical location; the activity she is performing and with whom can to some extent also be inferred from this information. Her utterance is thus not only designed for the caller to determine her location, but also as an account for the proposed closure. As the nurse finishes her adjustment of the shirt, she positions herself next to the patient with her body turned towards her (line 269). The caller presumably accepts the nurse’s proposal of sequence closure as the nurse simultaneously utters: “I will call” (line 268). The nurse is recognizably putting the activity of dressing the patient on hold. The bodily and verbal resources required to manage the phone call are similarly required for the continuous activity of dressing the patient. This means that the two activities can no longer be performed simultaneously, so the nurse suspends the activity of dressing the patient. Standing next to the patient the nurse orients her body towards the patient, but with her gaze fixed in a middle distance stare (Lofland, 1973), she demonstrates that she is not available to the patient.

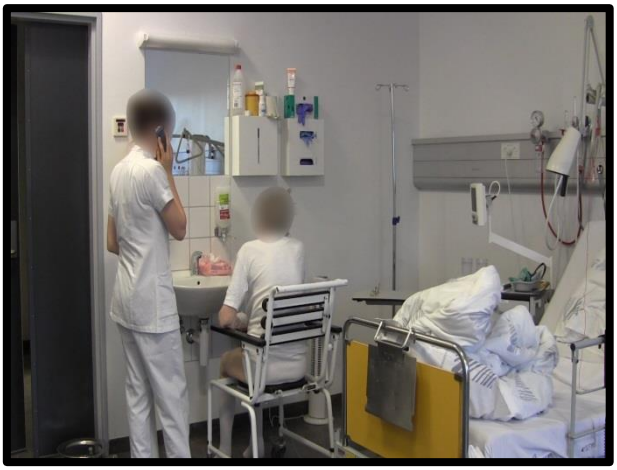

Figure 37: Awaits closure

Up to this point of the interaction, the nurse has been constantly moving, performing a continuous flow of actions. As she is negotiating closure with the caller, a disjunction occurs when she is standing still next to the patient (Figure 37). The caller presumably accepts the proposed closure as the nurse then closes the sequence with an “okay bye” (line 272) while she takes a step backwards. This step can be a way to recreate her tempo after the disjunction of standing still. She disconnects the phone by pushing a button without looking at the phone. She then bends her head and directs her gaze towards her pocket, while attaching the phone to it. The nurse then takes a step forward and places her right arm on the patient’s shoulder while producing the utterance, “and then it was the bed” (line 278). The nurse orients her body and gaze towards the patient in order to re-establish a mutual embodied participation framework. However, as the patient is not looking at her, the nurse actively works to secure the orientation (C. Goodwin, 1981) of the patient, using the gesture to display to the patient that the utterance is addressed to her (Figure 38).

Figure 38: Resuming activity with patient

The utterance, combined with the gesture, marks the opening of an interactive sequence between the patient and the nurse and the resumption of their mutual activity. The nurse prefaces her past tense utterance with an “and” as a deictic utterance which back connects (Local, 2004) to an earlier sequence in which the nurse promised that the patient could return to bed after washing herself. The patient turns her head towards the nurse and produces the repair-initiating turn (Schegloff, 2000) “what” (line 283), displaying that she either did not understand the previous turn produced by the nurse or that she did not hear what the nurse said. The nurse treats the repair initiated by the patient as a display of her not hearing the turn, as the nurse in her repair turn produces an almost identical utterance, “then it was the bed” (line 286), without adding any additional information or deictic features. Following the repair turn produced by the nurse, the patient accepts her request for action with a “yes” (line 289). The nurse then uses “yes” as a free-standing receipt marker displaying confirmation of the patient’s acceptance (line 293). The nurse subsequently walks behind the patient to grab the handle of the wheelchair and roll the patient to the bed.

10.2. STRATEGIES IN CASE TWO, “ANYTHING IMPORTANT”

In case two, “Anything important”, the nurse does not orient to the summons of the phone for an extensive period of time. Instead, she exploits the lengths of each occurrence of ringtone to continue the activity of assisting the patient in putting on a shirt. The patient suffers from a lung disease which makes it very hard for her to breathe, and she is dependent on the supply of oxygen. As the phone rings, the nurse has just removed the oxygen catheter from the patient’s nose, as this will otherwise

tangle up with the shirt when it is pulled over the patient's head. The nurse needs to replace the oxygen catheter before she answers the phone. If she replaced it immediately in order to answer the phone, the patient would be sitting with no shirt on for the duration, as yet unknown to the nurse, of the phone conversation. This would leave her exposed and would, because of her gaunt condition, cause her to freeze. The nurse thus postpones her response to the summons of the phone for 16.5 seconds to pursue the planned trajectory of actions involved in assisting the patient in pulling the shirt over her head and replacing the oxygen catheter. Meanwhile, the phone rings seven times. Suppressing any distribution of orientations towards the summons of the phone is not easily accomplished. As Schegloff notes, the demand for a summons from a phone to be answered promptly is strong, and not doing so is considered a failure (2002). Orienting oneself to a summons from a phone is thus normatively expected and forms a "presupposed underlying pattern" (Garfinkel, 1967, p. 78). The nurse in this situation demonstrates sophisticated perceptual awareness towards the patient by not orienting herself towards the summons of the mobile work phone for an extended period of time. Having worked in the department for several years, the nurse has developed habitual knowledge of the length of time that a caller generally lets the phone ring. By postponing her response to this extent, she risks the caller's hanging up. Knowing that the patient's breathing will deteriorate if she is put under pressure, the nurse refrains from speeding up the activity. Rather, in her actions she is seen to maintain a calm and steady pace, despite the ringing phone. Not rushing, despite this repeated summons, the nurse is exhibited as being extremely sensitive and responsive towards the patient.

In this moment of action the nurse, by postponing her response to the ringing phone, assigns a lower priority to the discourse of being efficient. She foregrounds the discourse of patient-centred care in her actions by, instead of rushing, complying with the patient's need of a slow pace. Talking about the interaction afterwards, the nurse describes how she felt inclined to speed up the situation and how it was hard to control herself, but that she knew she had to, as she on a previous occasion "saw what happened when one pressured her [the patient]" (nurse 1, 23.05.14).[75] Her description reveals how the discourse of being efficient and the discourse of patient-centred care came into conflict in this moment of action, and that the nurse was not able to enact both simultaneously. The nurse's actions foregrounded the discourse of patient-centred care and backgrounded the discourse of being efficient, which might have been realised by answering the phone immediately.

While replacing the oxygen catheter with her hands, the nurse produces an account for answering the phone with her body still tuned and oriented towards the patient. Only after the verbal account has been produced does the nurse bodily orient towards the summons of the phone by moving her hand to grab it. The nurse thus works to suspend the activity with the patient by preparing her verbally for the shift, while she is still distributing all other embodied orientations towards the patient, and

[75] "så hvad der skete da man pressede hende [patienten]".

before ending the previous activity. In doing so, the nurse accomplishes a smooth transition to the activity of answering the phone, and in a respectful way suspends the activity with the patient, without violating norms of social conduct. By the wording in her account, “I will just answer the phone to hear if it is anything important”, she displays to the patient that the phone call has to be about something important for her to suspend the activity with the patient. She thereby demonstrates the activity with the patient to be the main activity. By her choice of words she shows to the patient that she is significant, as only something important is allowed to disturb their interaction.

Having dressed the patient and replaced the oxygen catheter, the nurse is able to put both the discourse of patient-centred care and the discourse of being efficient into practice. She enacts the discourse of patient-centred care by performing a respectful transition, by displaying her continued orientation towards the patient, and by demonstrating the patient to be significant. Simultaneously, she enacts the discourse of being efficient as she orients herself to the summons of the phone. When the nurse answers the phone, she moves behind the patient, removing herself from the patient’s field of vision. Although positioned behind the patient’s back, the nurse continues the activity of dressing the patient, which makes her perceptible to the patient. The nurse prolongs the activity of dressing by repeatedly pulling on the shirt to straighten it and by sliding the palm of her hand across the patient’s back to smooth the shirt. With the palm of her hand sliding across the patient’s back, the nurse is displaying a strong perceptible orientation towards the patient, showing to the patient that she is still with her. While performing this multiactivity, the nurse’s body is directed towards the patient, displaying the activity of answering the phone as inserted into the activity of dressing the patient. As the phone conversation continues, the nurse ends the activity of dressing and walks to the patient’s side, making herself visible to the patient again. Standing next to the patient, the nurse orients her body towards the patient and re-establishes a participation framework which displays her as being “with” (Goffman, 1971) the patient and displays the patient to be her relevant next.

The discourse of being efficient is put into practice when the nurse answers the phone and makes herself available to colleagues. It is also enacted as the nurse continues the activity of putting on the patient’s shirt during the phone call. In performing this multiactivity, the nurse is displaying herself as efficient, although a close analysis also reveals how the nurse prolongs the activity of smoothing the patient’s shirt with the palm of her hand. Here, she is simultaneously enacting the discourse of patient-centred care by displaying a strong perceptible orientation towards the patient and show that she is still “with” her. The analysis of this interaction demonstrates how the nurse manages the multiple expectations circulating in the situation as she foregrounds the discourse of patient-centred care at certain points while still being able to enact the discourse of being efficient by not ignoring the call completely.

CHAPTER 11. ANALYSIS OF CASE THREE: “JUST A MOMENT”

In case three, “Just a moment”, a nurse is doing a round to see all her patients before ward rounds. She speaks to every patient, asking about their condition and the like. As we enter the situation, the nurse is approaching a patient lying in his bed with his eyes half-closed (Figure 39).

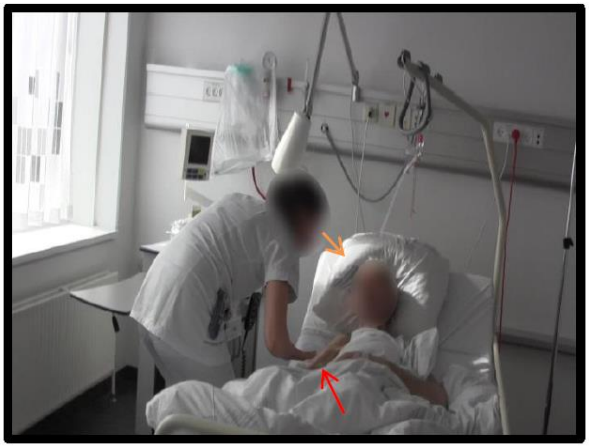

Figure 39: Just a moment - intro

11.1. INTERACTIONAL ANALYSIS OF CASE THREE, “JUST A MOMENT”

The nurse walks besides the patient’s bed and pushes his table away to allow herself to approach him. Greeting him, the nurse assumes a squatting position next to the patient’s bed (excerpt 9).

Excerpt 9:

```
297  N    godmorgen
298       good morning
299       ((bends, squats, puts right hand on P’s arm, gaze P))
300
301  P    °morn°
302       °morning°
303       ((head nod, turns head towards N, gaze N))
304
```

```
N    hvordan har du det i dag
     how are you today

P    hva
     what
     ((lifts head))

N    hvordan ha:r du det
     how a:re you

P    der er sgu ingen forandring
     there is no damn change
     ((shakes head))

N    der er ingen forandring
     there is no change

P    ja
     yes

N    nej
     no

P    det det er lige varmt
     it it is equally warm

N    det er lige varmt↑
     it is equally warm↑

P    ja
      yes

N    har du det varmt
     are you warm
     ((strokes P’s arm with palm of right hand))

P    °ja°
     °yes°

P    men det det de:t osse for va- de:t osse for koldt bare med
     tæppet på
     but it it i:t is also to wa- it is also too cold with just
     the blanket on
     ((turns head, gazes towards foot of bed, points towards foot
     of bed with left hand index and long finger))

N    ((turns head, gaze P’s left hand, retracts right
     hand from P’s arm, gaze P’s right arm, gaze P))

N    det er for koldt med tæppet
     it is too cold with the blanket
     ((gaze P)

P    det det er for koldt det har [jeg opdaget
     it it is too cold that i found out
     ((turns head, gaze N))
N                                 [((nods head, tightens lips,
                                   raises eyebrows, gazes down))
```

```
364  N    ja
365       yes
366       ((gaze P))
367
368  P    jeg vil helst [ha'dynen på
369       i prefer to use the duvet
370  T                  [---------------[------------------------
371  N                                  [ja
372                                     [yes
373
374       (3.7)
375
376  T    ---------------------------------[--------[-----------
377  N                                     [((withdraws torso, moves
378                                         right hand towards phone))
379  N                                              [lige et øjeblik
380                                                 [just a moment
381                                                 ((gaze P))
382
383  T    [---------------------][
384  N    [((gaze phone, moves phone in front of torso))]
385                             [((presses button))
386  P                          [((turns head, gaze midair))
```

The nurse opens an interactional sequence with the patient by producing the first part of a greeting sequence in her first turn. As she produces her utterance, “good morning” (line 298), she has her upper body bend towards him while squatting beside his bed. This movement positions her face in close proximity to the patient’s face as she produces her utterance. She has her gaze fixed on the patient’s face during her movement, while also resting her right hand on his right arm. With her upper body bent towards the patient and her whole body tuned towards him, the nurse is working to establish an embodied participation framework (C. Goodwin, 2000) with the patient. The patient is lying on his back with his eyes half-closed, and does not make any observable reaction to the nurse’s approach. As the patient does not observably orient towards her, the nurse employs several multimodal resources at the same time to address the patient. She produces a verbal greeting, she gazes at him with her face in close proximity to his, she bends and orients her body towards him, and she rests her hand on his arm. The patient then produces the second pair part of the greeting sequence, as he very softly utters, “morning” at a very low volume that resembles a whisper (line 302). Producing a shortened version of the word used by the nurse to greet him, the patient is required to carry out less articulatory work (Fowler & Housum, 1987), without sacrificing any communicative efficiency. The patient simultaneously performs a small head nod, briefly lifting his head from the pillow. His head nod is designed to complement his minimal verbal production in displaying adequate attention towards the nurse. The patient then turns his head towards the nurse, and shifts his gaze to her face, observably distributing an acute orientation towards her. He does not move his body, however; by lying on his back, his postural configuration displays a basic orientation towards the environment surrounding his bed and any persons that might approach it. The nurse shows a strong basic and acute orientation towards the patient (Goffman, 1971; Kendon,

1990; Schegloff, 1998) as she sustains her squatting position with her hand still on the patient’s arm, her upper body leaning towards him, her head turned towards him, and her gaze on his face. They thus observably constitute an embodied participation framework (C. Goodwin, 2000) with close mutual facial orientation (Figure 40).

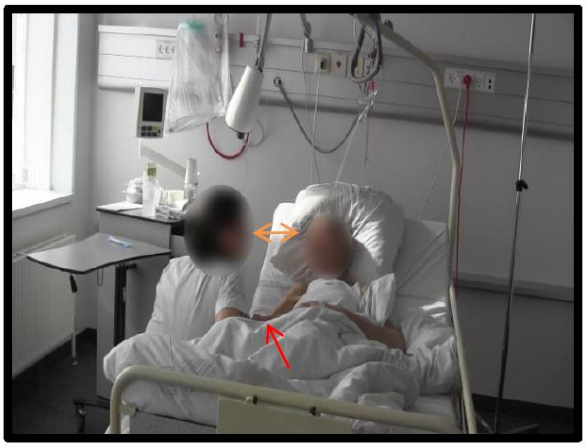

Figure 40: Embodied participation framework with patient

The nurse in her second turn produces the utterance, “how are you today” (line 306), to which the patient in his second turn responds with the utterance “what” (line 309). By his utterance the patient displays that he has trouble hearing or understanding the nurse’s previous turn, and thus initiates an open-class other-repair (Drew, 1997). The nurse then produces a repair turn: “how are you”, doing a near-repeat of her previous turn but eliminating “today” (line 313). Through her repair production the nurse displays her analysis of the trouble source as being not an unintelligible turn-construction, but that the patient is having trouble hearing it. Producing her near-repeat, she thus lengthens and stresses the verb, making it more distinct.

The nurse’s utterance is not exhibited as the first part of a “how are you” sequence (Sacks, 1975; Jefferson, 1980), which would call for a reciprocal inquiry by the patient. Rather, the nurse’s “how are you” turn is exhibited as an actual, interrogative question about the patient’s well-being, as the patient produces the informative answer, “there is no damn change” (line 316). As the patient is ill and admitted to a hospital, the nurse is displaying her epistemic status (Heritage, 2011) by asking about his condition. The circumferences of the situation do not make it relevant for the patient to ask about the nurse’s condition, as he could then be interpreted as claiming to possess the epistemic domain (Stivers & Rossano, 2010) of a healthcare professional. The epistemic gradient (Heritage, 2011) is thus exhibited as a steep slope between the knowing nurse and the unknowing patient.

The nurse repeats the patient's informative answer to her request as she produces the utterance, "there is no change" (line 320) eliminating only the profanity. In doing so, she acknowledges the information provided by the patient and demonstrates her receiving and understanding it. As a response to the nurse's utterance, the patient produces a "yes" (line 323), but as the nurse's utterance is designed to prefer a "no"-answer, the patient's "yes" is displayed as not conforming to the principle of preference (Sacks et al., 1992). The nurse orients herself to the patient's not producing the preferred answer by producing the preferred "no" answer herself (line 326).

The patient then produces the utterance, "it is equally warm" (line 329). The nurse repeats his utterance using the exact same words, "it is equally warm", but with a rising prosody (line 332). By reproducing the utterance with rising prosody, she is designing it as a question, initiating other-repair (Schegloff, Jefferson, & Sacks, 1977; Schegloff, 2000) and displaying that the patient's utterance is not intelligible to her. The patient however does not work to provide a repair solution of the trouble source, instead producing the utterance, "yes" (line 335). The nurse thus produces a second repair initiation by reformulating her previous turn as, "are you warm", offering her candidate understanding of the patient's trouble source turn (line 338). While producing her candidate understanding, the nurse gently strokes the patient's arm with the palm of her right hand, displaying to the patient that her utterance refers to his body. The patient confirms her understanding with a "yes" produced with a very low volume (line 342). He then continues his turn by elaborating on the topic, producing the utterance, " but it it it is also too wa- it is also too cold with just the blanket on" (line 346). In his turn the patient initiates self-repair (Schegloff et al., 1977; Schegloff, 2000) as he aborts in the middle of the production of a word, and then re-launches the turn and replaces the trouble source word. The aborted trouble source word could be "warm", which is replaced with the word "cold" in his second production of the turn. As he produces his utterance the patient turns his head and gazes towards the foot of his bed, while he lifts his left hand and points towards the foot of the bed with his index and middle fingers (Figure 41). His environmentally coupled gesture (C. Goodwin, 2007) is connected with his utterance and refers to the blanket lying in the foot end of the bed.

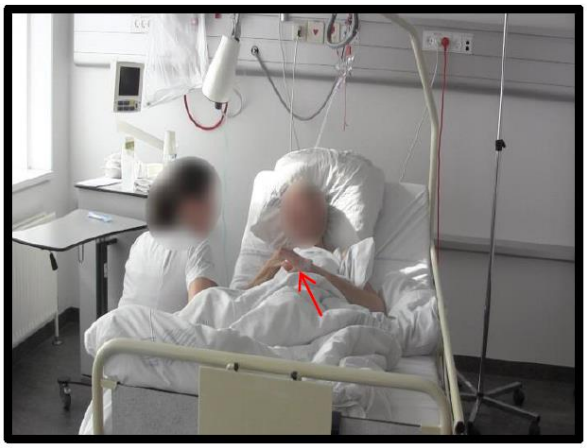

Figure 41: Patient’s environmentally coupled gesture

The nurse turns her head and briefly gazes at the patient’s left hand while removing her right hand from his right arm. She briefly shifts her gaze to his right arm and then back to his face. The patient’s pointing gesture towards the foot of the bed, designed to direct her orientation towards the blanket lying there, does not make the nurse distribute her orientation towards that area. As her gaze returns to the patient’s face, she produces the utterance, “it is too cold with the blanket” (line 355), displaying that she understands his previous turn without orienting herself to the foot of the bed, thus exhibiting his self-initiated repair as successful. The patient then elaborates on his claim about the blanket, as he produces the turn, “it is too cold that I found out” (line 359). By his reformulation, the patient displays that the claim he is making about the blanket being too cold is based on his own experience of trying to use the blanket. After the patient produces the word “cold” the nurse performs an exaggerated head nod, shortly shifting her gaze downwards in mid-air, tightening her lips, and raising her eyebrows (line 361). Her facial expression is produced at a possible completion point of the patient’s turn but as the patient produces further talk beyond what the nurse projected, it is performed as the patient produces the words, “I found out”. The nurse’s facial expression is designed to be in alignment with the patient’s story. As his turn reaches completion, she supplements her gesture with the aligning verbal utterance, “yes” (line 365). The patient then produces further talk on the topic, as he utters, “I prefer to use the duvet” (line 369). As the patient produces this utterance, the phone starts ringing, overlapping with the words “use the duvet”. The nurse maintains her strong orientation towards the patient and keeps her gaze on the patient’s face as she produces the utterance “yes”, displaying alignment and appropriate attention to the patient’s utterance (line 372). Her response is coordinated with his turn and delivered precisely at the transition relevant place (Sacks et al., 1974) with a minimum of silence between their turns. The nurse is observably not orienting herself towards the summons of the phone that

overlaps with their talk. Instead the finely tuned coordination exhibited by the nurse as she achieves an unmarked transition between turns, displays her continued orientation towards their mutual turn constructional units. After producing her utterance, the nurse keeps her gaze on the patient’s face, displaying her continued involvement in their mutual conversational sequence (Figure 42).

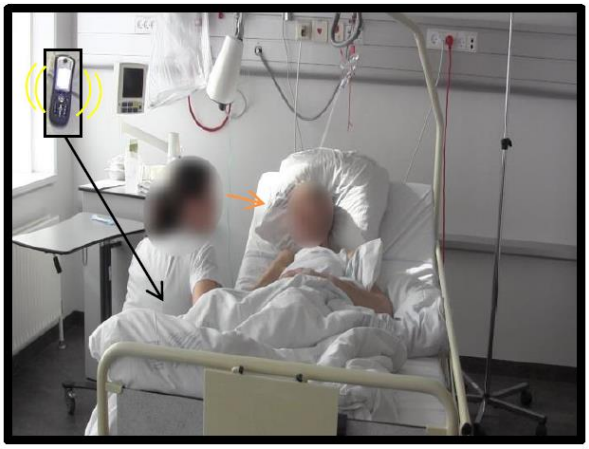

Figure 42: Displaying adequate attention while phone rings

The nurse squints her eyes and everts her lips, using non-verbal resources to display observably that she notices the summons from the phone. By producing a non-verbal noticing, the nurse does not interfere with their collaborative construction of a sequence; instead, by sustaining her gaze on the patient’s face, she addresses him as the next speaker (Lerner, 2003; Rossano, 2013) and recognizably postpones her treatment of the summons. She continues to displays adequate attention towards him, as they uphold a mutual gaze for approximately 3.7 seconds. The patient in this transition relevant place desists from producing a turn constructional unit, thus refraining from taking the floor as next speaker. After approximately 3.7 seconds of silence, the nurse distributes orientations towards the summons from the phone, recognizably attending to the summons. She withdraws her upper body, retracts her right arm, and moves her hand to grab the phone in her pocket. She then produces the utterance, “just a moment” (line 380), while she shifts her gaze back to the patient’s face to address the utterance to him. Simultaneously, she moves the phone from her pocket to the front of her torso and then shifts her gaze to the phone. The nurse produces her utterance as the second pulse of tones is fading; it is timed to be delivered in the gap between two pulses, when the intensity of the ring tone is low. By withdrawing her upper body and producing the utterance “just a moment”, the nurse displays to the patient that she is suspending their mutual activity temporarily. She thus she marks the activity of the phone call as a side sequence (Jefferson, 1972) or an inserted sequence (Schegloff, 1998) in their mutual interactional sequence.

Her distribution of acute orientations is displays her allocated involvement to the activity of answering the phone; her head is bent over the phone with her gaze directed towards it while her hands are handling the phone. Meanwhile, her lower body is sustained in the same posture, maintaining her basic orientation towards the patient and exhibiting their mutual activity as the main activity (Sutinen, 2014) to which she will return when her involvement in the inserted activity of answering the phone is finished.

Having moved the phone in front of her torso, the nurse shifts the phone to her left hand and presses a button on it with her right hand. The patient at this moment turns his head away from the nurse to a mid-position where his face and gaze are no longer oriented towards her. In withdrawing his orientation, the patient displays his understanding that their mutual activity is suspended. When the nurse accepts the phone call by pressing a button, she opens the conversation with a self-identification sequence (Schegloff, 1986), stating her name (excerpt 10).

Excerpt 10:

```
387  N    det er sarah
388       sarah speaking
389       ((gaze mid-air))
390
391  N    hej
392       hi
393
394       (4.7)
395
396  N    ja
397       yes
398
399  P    ((rubs face with left hand))
400
401       (2.5)
402
403  N    ja
404       yes
405
406       (6.4)
407
408  N    ja
409       yes
410
411  P    ((snorts))
412
413       (5.2)
414
415  N    ja
415       yes
417
418       (2.1)
419
420  N    ja ved du hvad jeg kigger lige ned her inden så længe
421       yes you know what i will pop down before long
```

```
422       ((turns head, gaze P))
423
424  N    godt hej
425       okay bye
426
427  N    ((removes phone from ear, replaces phone in pocket, gaze
428       phone))
429
430  N    så må vi regulere lidt frem og tilbage som det passer med
431       dynen
432       then we will have to regulate a bit back and forth with the
433       duvet as it suits
434       ((lifts head, tunes upper body towards P, gaze P, places
435       right hand on P’s left arm))
436
437  P    ((turns head, nods, closes eyes))
438
439  N    hvordan har du det ellers ud over at du har det varmt
440       how are you otherwise apart from being warm
441
442  P    hva
443       what
444       ((opens eyes, gaze N))
445
446  N    hvordan har du det ellers udover at du har det varmt
447       how are you otherwise apart from being warm
448
449  P    jamen så har jeg det som jeg har
450       well then i feel the way i do
451
452  N    så har du det som du har det [og hvordan er det
453       then you feel they way you are and how is that
455       ((smiles))
456  P                                 [ja
457                                    [yes
458
459  P    der er ingen forandring
460       there is no change
461
462  N    der er ingen forandring
463       there is no change
464
465  P    nej
466       no
```

The caller presumably reciprocates the self-identification, and the nurse in her second turn produces her part of a greeting exchange (Schegloff, 1986), saying “hi” (line 392). While she verbally engages in the self-identification sequence and the greeting sequence, the nurse’s face is turned straight ahead towards the wall and her gaze direction is downwards and in mid-air displaying a middle-distance orientation (Heath, 1986). As gaze direction is an indicator of availability (Goffman, 1969), the nurse is displaying herself as not available to the patient. However, as she simultaneously sustains her squatted position next to the patient’s bed, with her shoulders twisted slightly towards the patient, the nurse continues her display of

basic orientation (Kendon, 1990) towards the patient. The nurse thus holds a mid-point body posture (Nishizaka, 2014) as she distributes her orientations towards both the patient and the phone, exhibiting her involvement in both activities (Figure 43).

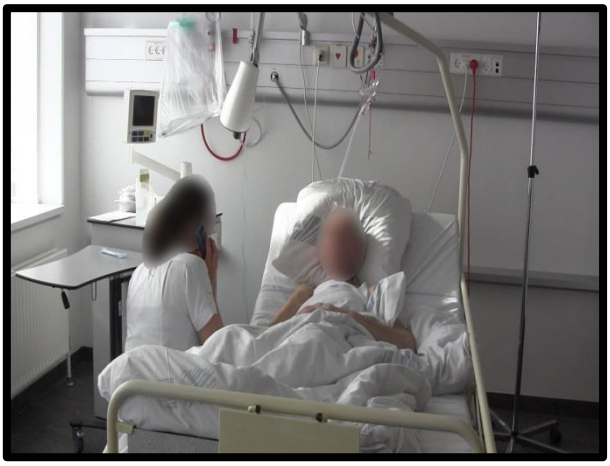

Figure 43: Displaying dual involvements

The person at the other end of the phone is a nurse student calling about the deteriorated condition of another patient and asking for advice and supervision. The nurse student is explaining her reason for calling, describing the patient’s condition, and asking about the correct action for her to initiate. The nurse repeatedly answers to her turn constructional units by saying only the word, “yes” (lines 397, 404, 409, 415). Keeping her verbal production to a minimum and speaking in a low voice, the nurse uses her vocal modality to distance herself from close proximity to the patient, thus constituting the phone conversation as a “backstage” (Goffman, 1969) conversation, although she does not spatially distance herself. The patient does not orient himself towards the nurse at any point during her phone conversation. He is observably doing waiting, as he refrains from speaking or engaging himself in other activities (apart from performing body maintenance such as snorting or rubbing his face with a hand) and displays his ongoing availability to the suspended activity, once the nurse has finished her summoned engagement.

After the nurse has produced a responding “yes”-utterance five times, she produces the utterance, “yes you know what I will pop down before long” (line 421). By her utterance the nurse is initiating the closure of the sequence, exhibiting the topic as difficult to resolve through their phone-mediated interaction. The phone connects the nurse and the nurse student across space (McIlvenny, Broth, & Haddington, 2009), but they do not share the same place and experience the same materiality in their interaction. The mobile contextual configuration allows for the nurse and the nurse student to share salient aspects of context and to orient each other to the

semiotic resources relevant to the action in question. The nurse, however, only has access to the nurse student’s description of the materiality of her place, but cannot herself experience the materiality with her embodied resources. The nurse thus announces to the nurse student that she will join her at her physical location shortly; reflecting than she wants to keep the inserted activity short or that they need to share the same physical place to resolve the topic. The nurse presents a face-to-face encounter in the near future as a compromise between her current unavailability due to being involved in an interaction with the patient and her obligation to supervise the nurse student. As the nurse student presumably accepts this, the nurse turns her head towards the patient and shifts her gaze to his face. She observably projects the closure of the phone conversation and orients herself towards the patient before the activity is brought to an end. The nurse then closes the sequence by her utterance, “okay bye” (line 425) and removes the phone from her right ear, by lowering her right arm. She turns her head further to the right, shifts her gaze to the phone, and presses a button on the phone with her right thumb. She shifts the phone to her left hand, bends her head, and directs her gaze towards her pocket. She attaches the phone to the pocket with her left hand while holding the hem of the pocket with her right hand.

After repositioning the phone in her pocket the nurse lifts her head and leans her upper body towards the patient. She directs her gaze towards the patient’s face and places her right hand on his left arm to address him and mark the resumption of their mutual sequence (Figure 44). Simultaneously, she produces the utterance, “then we will have to shift back and forth with the duvet as it suits” (line 432). The patient turns his head towards the nurse and directs his gaze towards her face.

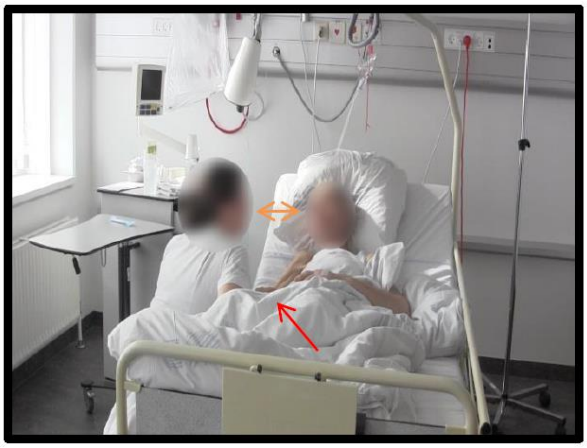

Figure 44: Resuming suspended sequence

Using the word "then" as a preface, the nurse back connects (Local, 2004) to their previous turn constructional units, and offers a solution to the topic that the patient was feeling warm. The reference to their previous talk is exhibited as intelligible to the patient, as he performs the obliged type-fitted response (Schegloff, 1968; Schegloff, 2007) by accepting the nurse's offer with a head nod (line 437). The patient underlines his acceptance by closing his eyes as he nods his head. He thereby employs several body segments to make his acceptance intelligible to the nurse without using verbal resources.

The nurse then closes the sequence about the patient's being warm and opens a new sequence as she produces the utterance, "how are you otherwise apart from being warm" (line 440). She treats the topic of the patient being warm as closed, and reformulates her initial question about the patient's condition. The nurse orients towards the non-occurrence of an answer to her informative request by re-launching her question. The patient then produces an open-class other-initiated repair by producing the utterance "what", displaying that he either did not hear or did not understand the nurse's question (line 443). The nurse displays her analysis of the trouble source as not being that the turn-construction is unintelligible but that the patient is having trouble hearing it. She thus produces a full repeat of her previous turn (line 447) which is exhibited as successful as the patient produces a type-fitted response to her informative request by his informative utterance, "well then I feel the way I do" line 450). The nurse produces a near-repeat of the patient's turn, but treats his informative answer as insufficient, as she then elaborates her informative request in her utterance: "You feel the way you do and how is that" (line 453). The patient confirms the nurse's understanding of his previous turn by uttering "yes" (line 456) after her near-repeat, though he produces it as an overlap, as the nurse expands her turn beyond projected completion. The nurse orients towards the patient's not producing a relevant answer to her request, but it is not exhibited as troublesome, as she smiles at the patient when she reformulates her informative request. The patient then produces the utterance, "there is no change" (line 460), which is a re-launch of his third turn in their mutual interactional sequence. After acknowledging the patient's informative answer, the nurse shifts the topic by opening a new sequence about the patient's food intake. At this point we leave the interaction.

11.2. STRATEGIES IN CASE THREE, "JUST A MOMENT"

In case three, "Just a moment", the nurse and the patient constitute a close embodied participation framework when the mobile work phone rings. The nurse is in a squatting position with her upper body oriented towards the patient. She does not distribute any orientations towards the phone as it rings and maintains all of her body segments oriented towards the patient. The ringing of the phone is produced as

overlapping with a turn construction unit produced by the patient. The nurse maintains her strong display of orientations towards the patient, sustaining her gaze on the patient's face as she produces the receipt-marker "yes". Subsequently, she keeps her gaze on the patient's face, addressing him as the next speaker, and displaying her continued involvement in their conversational sequence. In this moment of action the nurse is enacting the discourse of patient-centred care as she continues to display adequate attention towards the patient and demonstrate their mutual interactional sequence to be the main activity. By postponing her response to the summons of the phone, the nurse also postpones putting the discourse of being efficient into practice. She thus assigns lower priority to this and foregrounds the discourse of patient-centred care, as she upholds adequate attention towards the patient as the next speaker for approximately 3.7 seconds.

While maintaining her gaze on the patient's face and her body oriented towards the patient, the nurse squints her eyes and everts her lips, to display that she is noticing the summons of the phone. As the patient refrains from taking the floor as speaker, the nurse attends to the summons by observably distributing orientations towards the phone. She withdraws her upper body slightly and moves her right arm to grab the phone. She then produces the utterance "just a moment" with her gaze on the patient´s face to address the utterance to him. By her utterance, the nurse is displaying to the patient that their mutual sequence will be only momentarily suspended. She thus marks the phone call as an inserted activity and displays the activity with the patient to be the main activity (Sutinen, 2014). This is further demonstrated as she maintains her squatting position and her basic body orientation towards the patient. Attending to the summons of the phone the nurse is putting the discourse of being efficient into practice. Doing so, she explicates to the patient that this discourse will only momentarily be enacted.

While she is talking on the phone the nurse upholds a middle-distance gaze, displaying herself as unavailable to the patient. However, she sustains her squatting position in close proximity to the patient, and her shoulders twisted towards him. Maintaining a squatting position will inevitably make muscles in the legs ache, so by not standing up during the duration of the phone call and maintaining a close embodied participation framework with the patient, the nurse continues to enact the discourse of patient-centred care during the phone conversation. Simultaneously, she puts the discourse of being efficient into practice by supervising a nurse student on the phone. However, as the nurse student continues her inquiries, the nurse proposes closure of the phone conversations by uttering: "yes you know what I will pop down before long". The nurse thus works to limit the duration of the inserted activity and return to the main activity with the patient. In this way the nurse is seen to favour the discourse of patient-centred care over the discourse of being efficient. As the phone conversation ends, the nurse returns the mobile work phone to her pocket and resumes the interactional sequence with the patient, thus continuing to enact the discourse of patient-centred care.

CHAPTER 12. RÉSUMÉS OF ANALYSES: CASES FOUR, FIVE, AND SIX

The previous three chapters present a full analysis of cases one, two, and three. The analytical processes conducted on cases four, five, and six are identical with the analyses carried out on the first three cases, but to prevent the description of the analysis becoming too protracted, this chapter provides only merged résumés of the analyses performed on cases four, five, and six. Each case contributes unique insights about the accomplishment of interactions between nurses, patients, and mobile work phones. The résumés do exclude much of the detail of the full analyses that were conducted. They also do not include the full events with beginnings and endings, but are delimited around the phone call. Additionally, the analytical manoeuvres of zooming in and zooming out are not separated in the résumés, which reduces transparency. The résumés do, however, serve to demonstrate that the analytical discoveries made in the first three cases – "The work of a thumb", "Anything important", and "Just a moment" – are not isolated observations but salient features that appear in more cases.

12.1. CASE FOUR: "THE BLANKET"

In case four, "The blanket", a nurse is assisting a patient in returning to his bed and making him comfortable for a nap. As we enter the situation the patient is lying in the bed on his back with his face turned towards the ceiling. The nurse is spreading a blanket over the patient's legs, and grabs hold of the top end of the blanket with both hands (Figure 45).

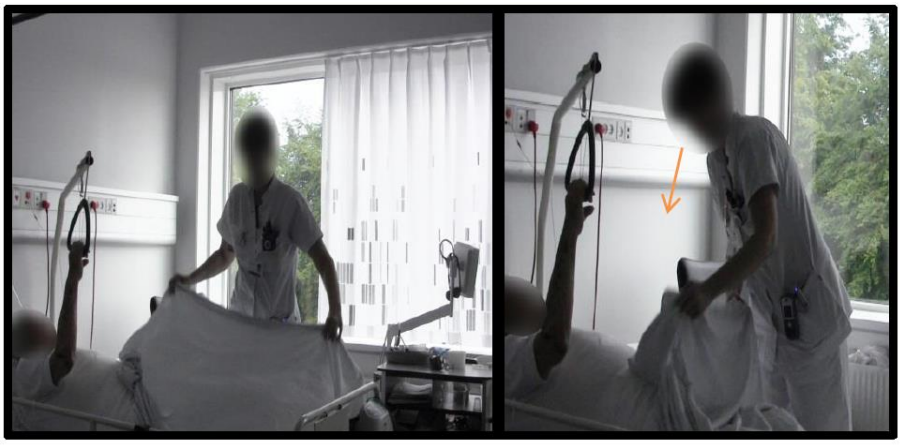

Figure 45: Covering patient with blanket

The nurse pulls the blanket towards the patient's abdomen, but stops the movement and releases the blanket with her right hand. She bends her upper body over the patient with her gaze fixed on the urine tube. Still holding the blanket in her left hand, she grabs the urine tube with both hands, displaying an acute orientation towards it (Goffman, 1971; Kendon, 1990; Schegloff, 1998) towards it. The nurse is exhibited as sensitive and attentive towards the patient by noticing the urine tube and aborting the activity of covering him with a blanket to inspect it. In this way, she is enacting the discourse of patient-centred care.

The patient lifts his left arm and his head and gazes down the length of his body. He recognizably senses that the nurse has abandoned the projected course of action and therefore lifts his head to include her within his visual field. He directs his gaze towards her hands, displaying an acute orientation towards them, and again lowers his head and gazes at the ceiling. By standing with her upper body bent over the patient, the nurse is displaying a strong basic orientation towards the patient (Figure 46) (Goffman, 1971; Kendon, 1990; Schegloff, 1998). Distributing all orientations towards him and using some of her embodied resources to inspect his urine tube, the nurse is putting the discourse of patient-centred care into practice.

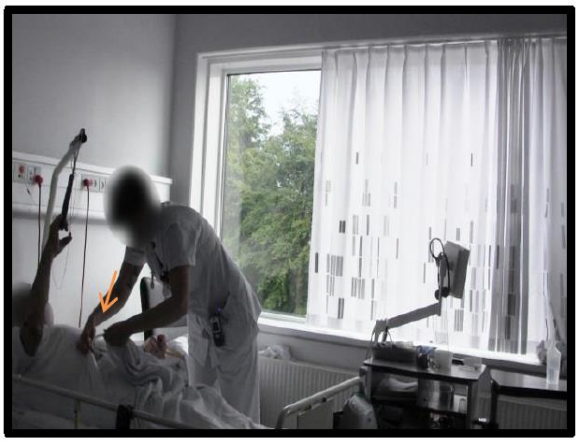

Figure 46: Inspecting tube

While the nurse is inspecting the tube, her mobile work phone rings, however, neither the patient nor the nurse distributes any immediate acute orientations towards the summons of the phone. The nurse, however, continues to twist and squeeze the tube during the first pulse of the ringtone for approximately 2.4 seconds. She then retracts her hands and uses her right hand to pull down the patient's shirt (Figure 47).

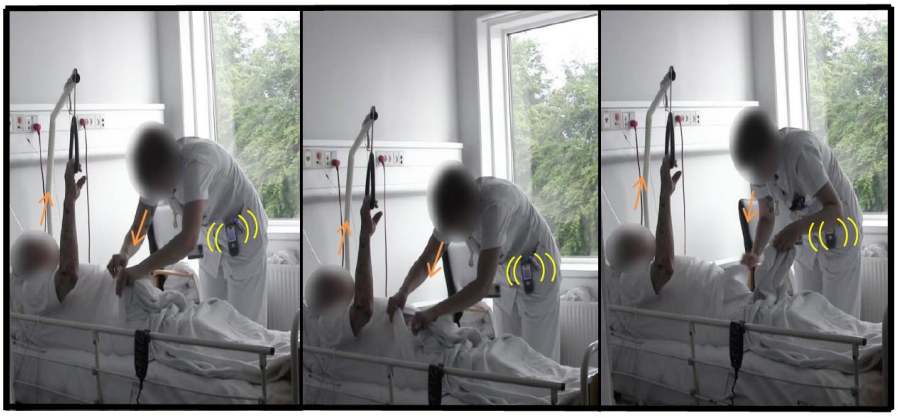

Figure 47: Sustained orientation towards patient activity while phone rings

Pulling the shirt down, the nurse covers the patient's groin. It also marks the end of the activity of inspecting the tube, as it is then covered and unavailable for

inspection. In managing these intersecting activities, the nurse is displaying appropriate timing by delaying her response to the summons from the phone. This allows her to finish her on-going course of action and cover an intimate part of the patient's body. She constitutes a transition relevant gap (Sacks, Schegloff, & Jefferson, 1974) for her to abandon accountably the on-going activity and favour the activity of answering the phone. The nurse thus foregrounds the discourse of patient-centred care and postpones putting the discourse of being efficient into practice. She assigns higher priority to the discourse of patient-centred care as she takes the time to cover an intimate area of the patient's body before attending to the phone.

The nurse does not verbally notice or orient herself to the summons, nor does she mark the phone call as a side sequence (Jefferson, 1972) or an inserted sequence (Schegloff, 2007). The summons makes salient a moral obligation for the nurse to attend to the remote caller (Licoppe & Tuncer, 2014). She does not produce an account for answering the phone; rather, she treats the sound of the summons as an account in itself. The nurse straightens her upper body and moves her left hand to her left pocket to grab the phone. She moves the phone to a position in front of her stomach and uses her right hand to press a button. She then shifts the phone to her right hand and moves it to her right ear. The nurse initiates the phone conversation with a self-identification sequence (Schegloff, 1986), stating her name (excerpt 11).

Excerpt 11

```
467  N    squeezes the tube using fingers on both hands
468
469  T    [-----------------------------------------------------
470  N    [((twists tube with left hand))
471
472  T    [-----------------------------------------------------
473  N    [((pulls shirt down with right hand, straightens upper body,
474         shifts blanket from left hand to right hand, right hand
475         releases grip of blanket and drops it on to the bed))
476
477  T    [--------------------------------]
478  N    [((moves left hand to pocket, grabs phone, moves phone
479       in front of stomach, gaze phone))]
480  P    [((moves bottom to the left))
481
482  N    ((pushes button, shifts phone to right hand, moves phone to
483         ear, gaze mid-air))
484
485  N    de:t charlotte
486       charlotte speaking
487       ((bends upper body over patient, gaze patient´s lower body))
488
489  N    ((pulls shirt up with left hand, grabs tube, moves tube))
490
491  N    hvad tænker du på
492       what do you have in mind
493       ((squeezes tube with left hand fingers))))
494
```

```
495  N    ((slides tube to palm of left hand, slides left hand along
496       hem of shirt))
497
498  N    hvem
499       who
500       ((rotates hand, grabs tube))
501
502       ((lifts tube))
503
504  N    var det ikke mig du skulle ri(h)nge til
505       was it not me you were going to call
506       ((pinches tube between left hand thumb and index finger,
507       twists tube, squeezes tube))
508
508  N    ((releases tube, pulls shirt down))
509
510  N    går vi ned nu her
511       are we going down now
512       ((straightens upper body, grabs blanket))
513
514  N    ((moves blanket towards patient´s stomach))
515
516  N    det er bare i orden ja hej hej
517       that is okay yes bye bye
518       ((releases blanket over patients upper body))
519
520  N    ((moves phone in front of torso, gaze on phone, holds phone
521       with both hands, pushes button, replaces phone in pocket))
522
523  P    ((lifts upper body from madras, moves it left, lowers it))
524
525  N    ((steps towards patient's head
526
527  N    kan du lige løfte hovedet lidt
528       can you lift your head a bit
529       ((moves both hands towards pillow))
530
531  P    [((lifts head))
532  N    [((adjusts pillow))
```

As the nurse answers the phone she puts the discourse of being efficient into practice. Simultaneously, she bends her upper body over the patient and continues her display of a strong basic orientation (Goffman, 1971; Kendon, 1990) towards him. With her left hand she pulls the patient's shirt up to expose the tube, and with her gaze fixed on the tube she grabs it and lifts it (line 489). Here, the nurse is adhering to the initially planned trajectory of actions, and resuming the activity of inspecting the tube (Figure 48). She is exhibiting the activity with the patient to be the main activity (Sutinen, 2014), which is not suspended for the benefit of the phone conversation, and the nurse thus continues to enact the discourse of patient-centred care.

Figure 48: Resuming inspection of tube

Resuming the activity of inspecting the tube, the nurse deploys the body segments (Schegloff, 1998) that are not needed for the activity of the phone call to pursue the activity of inspecting the tube. She uses her right hand, her hearing, and her verbal resources for the activity of the phone call and her left hand, and her vision for the activity of inspecting the tube. The nurse is combining a new contextual configuration (the phone) with the on-going contextual configuration, allowing her to engage in two courses of action simultaneously. In doing so, she is performing multiactivity (Haddington et al., 2014) and is in this way putting the discourse of being efficient into practice.

The caller's launch into the topic of conversation is exhibited as unintelligible to the nurse; her second turn, "what do you have in mind", initiates repair (line 492). The caller's response to the nurse's first repair initiation is inadequate, as the nurse in her third turn produces a second repair initiation, this time a category-specific interrogative (Schegloff et al., 1977), with the utterance "who" (line 499). While producing her utterances, the nurse keeps her gaze fixed on the tube. With the tube inside her palm, she slides her hand along the hem of the patient's shirt to make the shirt cover her fingers (line 495). She then rotates her hand to pull the shirt over the tube, but aborts the movement and grabs the tube again. The nurse produces her next utterance: "was it not me you were going to call" with an interlacing laughter particle (line 505). Laughter can serve to display that there is trouble, but that the trouble is manageable (Jefferson, 1972). The nurse in her utterance reveals the source of trouble, which is that the caller had intended to call someone else but called her by mistake. While producing this utterance the nurse is observably inspecting the tube, holding it pinched between her left hand thumb and index finger, twisting it and squeezing it, her gaze fixed on it (Figure 49). She then releases the tube and pulls the patient's shirt down to cover it, thereby marking the activity of inspecting the tube as finished (line 508). The nurse is thus seen to

manage the continued progression of both lines of action simultaneously; each activity continues to advance without significant interference from the other.

Figure 49: Inspecting tube during phone conversation

With the source of trouble resolved, the nurse launches a new topic with the utterance "are we walking down now" (line 511). The deictic term "down" refers to the staffroom at the end of the corridor, and her utterance is designed to coordinate the activity of eating lunch with her colleague. While producing the utterance, the nurse grabs the blanket with her left hand and subsequently moves it towards the patient's upper body (Figure 50). The nurse is thus resuming the activity of covering the patient with a blanket, which was suspended when she noticed the urine tube. As she produces her closing utterance, "that is okay; yes bye-bye", (line 517), the nurse releases the blanket over the patient's upper body to cover him. Abandoning one activity (inspecting the tube) in favour of another (covering the patient with a blanket) while performing a third (speaking on the phone), the nurse is thus managing three intersecting courses of action, constantly adjusting to the contingencies of the situation and the temporality and complexity of its sequential organisation.

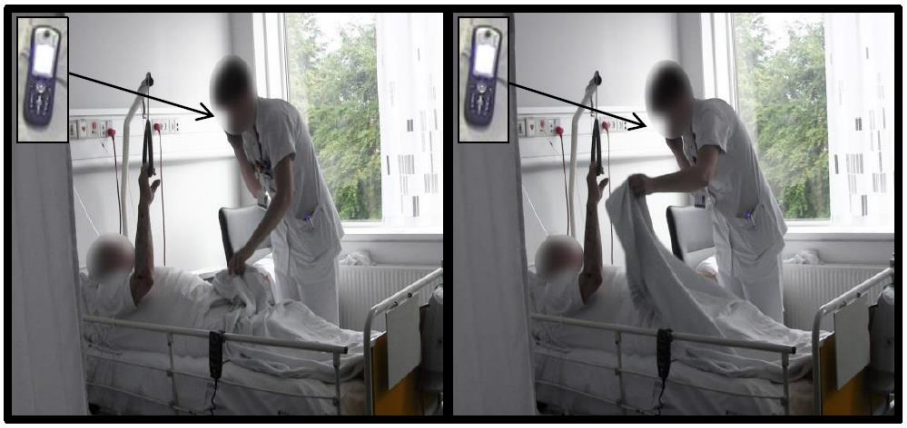

Figure 50: Covering patient with blanket during phone conversation

Having finished the phone conversation, the nurse turns off the task-relevant object (the phone) (Modaff, 2003) and replaces it in her pocket. At this point, the patient repositions his upper body by the force of his right arm and hand (line 523). He lifts his upper body from the madras, moves it a bit to the left, and then lowers it again. In doing so, the patient treats this as a transition-relevant moment in which he can move his body without disturbing the nurse's activities. With the phone now in her pocket, the nurse steps towards the patient's head and produces the utterance, "can you lift your head a bit" (line 528) while she reaches for his pillow. As the patient complies with her request for action, she adjusts his pillow and continues the activity of making him comfortable for a nap.

12.2. CASE FIVE: “THE ARTERIAL BLOOD GAS”

In case five, “The arterial blood gas”, the nurse is sitting on a chair next to the patient’s bed. The patient’s left arm and hand are lying stretched towards the nurse, who is about to perform an arterial puncture in the patient’s wrist (Figure 51).

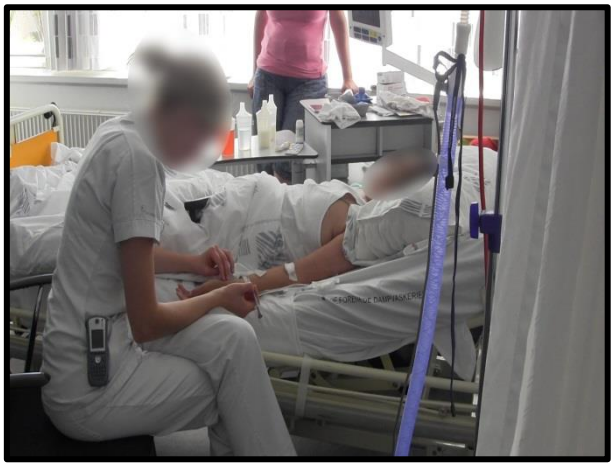

Figure 51: The arterial blood gas – intro

The body of the nurse is directed towards the patient, and she is holding a syringe in her right hand. With the index and middle fingers of her left hand she is palpating the patient’s wrist. The nurse and the patient constitute a close embodied participation framework (C. Goodwin, 2000), with their bodies directed and oriented towards each other, and with the nurse repeatedly touching the patient’s skin in order to establish a precise position for the puncture (excerpt 12). Through her embodied conduct the nurse is thus enacting the discourse of patient-centred care.

Excerpt 12:

```
533  N    ((palpates P´s wrist with tip of left hand index and middle
534       finger))
535
536  T    [-----------][-------------------------------------------
537  N    [((stops palpating, rests fingers on patient’s skin]))
538                    [((moves right hand towards wrapping, aborts
539                      movement, moves right hand to left hand))
540
541  T    [-----------------------------][-------------------------
542  N    [((shifts syringe from right to left hand, holds syringe
543       between thumb and index finger, tip of index and middle
544       finger rests on patient´s skin))]
```

```
545  N                                      [((moves right hand to pocket
546                                         gaze patient, grabs phone,
547                                         twists phone, pushes button))
548
549  N    ((moves phone to right ear, bends head, gaze hands))
550
551  N    de:t susie
552       susie speaking
553
554  N    hej
555       hi
556
557  N    ja jeg sidder lige og er ved at tage en a gas jeg kommer
558       lige ud til dem lige om snart
559       yes i am just sitting here doing an a gas i will come out to
560       them in just soon
561       ((nods head))
562
563  N    de:t godt he:j
564       okay bye
565
566  N    ((replaces phone in pocket, gaze pocket, moves right hand to
567       left hand, gaze hands, [shifts syringe to right hand))
568  P                           [((turns head towards nurse))
569
570  N    det var godt jeg ikke havde stukket nålen i dig endnu
571       good that I did not have the needle stuck into you yet
572       ((gaze p, smiles))
573
574  P    j(h)a
575       y(h)es
576       ((smiles, turns head forward, closes eyes))
577
578  N    ((bends head, gaze hands, places right hand on P's hand,
579       lifts left hand fingers from P's skin, palpates skin with
580       left hand fingers))
```

When the phone rings, the nurse postpones her response to the summons and thus also postpones putting the discourse of being efficient into practice (Figure 52). She moves her right hand holding the syringe towards the wrapping lying on the sheet, but aborts the movement and instead moves the syringe to her left hand still resting on the patient's wrist (line 538). The nurse shifts the syringe with the needle to her left hand to ensure that the needle does not become contaminated by touching anything during the phone conversation. Holding the syringe between her left hand thumb and index fingers, the nurse maintains the position of her index and middle fingers against the patient's skin. Resting her fingers against the patient's skin is not a way of marking a spot for the needle to be inserted. Any nurse experienced with respiratory care experience knows that this is not possible when performing an artery puncture. Furthermore, in this case the nurse employing this tactile resource is not exhibited as marking a spot in any way, as is demonstrated in the data below. By sustaining the tactile sensation, the nurse is thus displaying the activity of the artery puncture as not finished but only temporarily suspended.

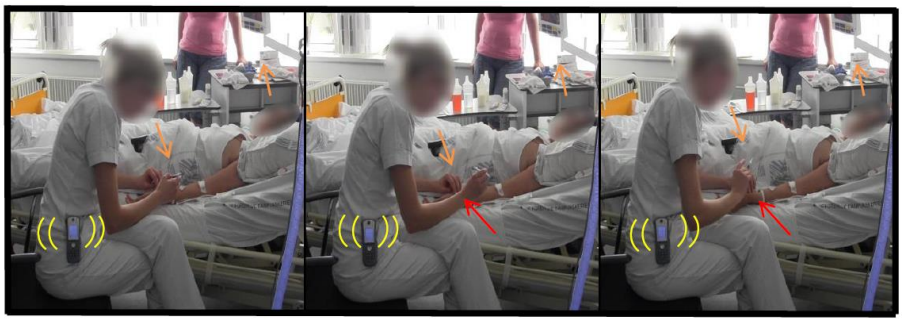

Figure 52: Sustained orientation towards ongoing activity as phone rings

The nurse then distributes orientations towards the summons of the phone; she straightens her upper body slightly and moves her right hand to grab the phone in her pocket (line 545). Simultaneously, the nurse shifts her gaze to the patient's face but does not verbally mark the phone call as a side sequence (Jefferson, 1972) or inserted sequence (Schegloff, 2007). The summons makes salient a moral obligation for the nurse to attend to the remote caller (Licoppe & Tuncer, 2014); thus, she does not produce an account for answering the phone but rather treats the sound of the summons as an account in itself. The nurse uses the fingers of her right hand to twist the phone inside her hand, making it rest inside her palm with the display facing her (line 547). By not having to look at the phone, the nurse exhibits the mobile work phone as internalized in her practice. Gazing at the patient, maintaining her fingers resting against the patient's skin, and sustaining her body in a position tuned towards the patient all indicate that the nurse is displaying the patient as the main activity (Sutinen, 2014) and is enacting the discourse of patient-centred care.

The nurse pushes a button with her thumb and moves the phone to her right ear (line 547). In answering the phone, the nurse is putting the discourse of being efficient into practice. While talking on the phone, the nurse lowers her head and fixes her gaze on the patient's hand to display herself as unavailable to the patient. However, she maintains her body oriented and tuned towards the patient, and continues to rest the fingers of her left hand against the patient's skin (Figure 53). In this way the nurse continues to display the patient as her main activity and demonstrates to the patient' that their mutual activity is merely suspended to be resumed after the phone conversation has ended. By her continued distribution of orientations the nurse is thus enacting the discourse of patient-centred care while simultaneously putting the discourse of being efficient into practice by speaking on the phone.

Figure 53: Sustaining tactile contact during phone conversation

After an identification turn and a greeting turn (Schegloff, 1986) the nurse in her third turn proposes sequence closure to the caller on the phone by uttering, "yes I am just sitting here doing an a-gas; I will come out to them in just soon" (line 559). Doing so, the nurse works to keep the duration of the inserted activity (Sutinen, 2014) short and return to the main activity with the patient; in this way she is seen to prioritise the discourse of patient-centred care.

After a closing turn (line 564) the nurse replaces the phone in her pocket and shifts the syringe back to her right hand. She lifts her head and directs her gaze towards the patient's face as she utters, "good thing that I did not put the needle into you yet" and smiles (line 571). The utterance is exhibited as humorous; the patient responds with a "yes" produced with a smile and an inserted laughing particle (line 575). The meaning of this utterance cannot be ascribed on the basis of the data. The nurse might be referring to the fact that it would have been difficult for her to answer the phone if she simultaneously had to support a syringe with an attached needle inserted into the patient. She could also be referring to the fact that she would have been unable to answer the phone if the needle had been inserted into the patient as it rang. Regardless, the nurse uses the humorous utterance to resume the suspended activity with the patient in an unpretentious way.

The nurse then bends her head and directs her gaze towards the patient's wrist. She positions her right hand, which is holding the syringe, on the heel of the patient's hand (line 578). Having established tactile contact with her right hand, the nurse lifts her left-hand fingers from the patient's skin, thereby breaching the tactile contact which has been upheld since the phone started ringing (Figure 54). The nurse's resting her fingers on the patient's skin for the duration of the inserted activity is

thus not exhibited as a way of marking a spot for the needle to be inserted. Rather as the nurse resumes the activity of performing the artery puncture she palpates the patient's skin for approximately 50 seconds before determining where to insert the needle.

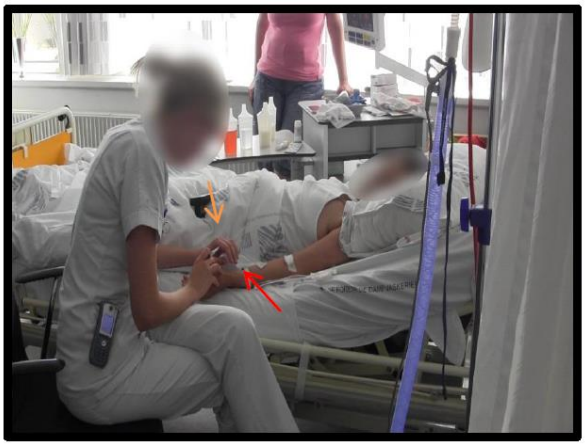

Figure 54: Releasing fingers from patient's skin

With her body oriented towards the patient and sustaining her fingers resting against the patient's skin, the nurse is exhibiting the activity of performing the artery puncture as the main activity, which is only temporarily suspended for the duration of the phone call. In these ways, the nurse enacts the discourse of patient-centred care while she simultaneously puts the discourse of being efficient into practice by managing the phone call.

12.3. CASE SIX: "REMOVING A CATHETER"

In case six, "Removing a catheter", the nurse has just removed a catheter from the inside of a patient's elbow, and is now attaching a dressing to the site (Figure 55).

Figure 55: Removing a catheter – intro

The patient is lying flat in bed and the nurse is standing with her upper body bent over her. She is holding the removed catheter in her left hand and attaching the dressing with her right hand. As the nurse retracts her right hand from the dressing and moves it to grab the patient's wrist, the mobile work phone starts ringing (excerpt 13).

Excerpt 13:

```
581  N    ((adjusts plaster with right hand, holds catheter in left
582       hand))
583
584  N    ((removes left hand, moves right hand to patient´s wrist))
585
586  N    [((grabs wrist, bends patient´s arm, gaze patient))
587  T    [-------------------------------------[------------------]
588  N                                          [så lig sådan der bare
589       lige et par minutter]
590                                             [then lie like that
591       for just a couple of minutes]
592                                             ((folds dressing,
593                                               gaze dressing))
594
595  T    [----------------][----------------------------------------]
596  N    [så er det fint
597       then it is fine
598       [((folds dressing, gaze dressing, gaze P))]
```

```
599  P                      [ja
600                         [yes
601                         ((nods head))
602
603  N                      [((gaze bandage, grabs bandage, gaze P,
604                          smiles, turns head left, gaze foot of
605                          bed, grabs wrapping))]
606
607  T    [-------------------------------------------------------]
608       [((gathers utensils in left hand, gaze midair, straightens
609       upper body, gaze P, moves right hand to pocket, grabs phone,
610       gaze phone))]
611
612  T    [----------------]
613       [((holds phone in right hand, gaze phone, presses button))]
614
615  N    ((straightens body, moves phone to right ear))
616
617  N    de:t anna
618       anna speaking
619       ((gaze down mid-air))
620
621  N    hej
622       hi
623       ((turns))
624
625  N    nej ikke endnu
626       no not yet
627       ((walks, gaze forward))
628
629  N    jeg er lige inde på stue 9
630       i am just in room 9
631       ((drops utensils in bin, gaze bin, moves shoulders))
632
633  N    ((turns around, stops with feet gathered, left arm down,
634       gaze midair))
635
636  N    okay (0.3)fint fint
637       okay (0.3)fine fine
638       ((head nod))
639
640  N    godt hej
641       okay bye
642       ((walks, gaze forward))
643
644  N    ((removes phone from ear, gaze phone, presses button,
645       replaces phone in pocket, walks to patient))
646
647  N    ((bends upper body, squats next to patient´s bed, gaze
648       patient))
649
650  N    øh vi kiggede lige på det der vi har fået hjemmefra, for
651       lige at skrive [at vi lige skriver] til dem nu når du
652       kommer hjem
653       er we were just looking on this that we got from home to
654       just write that we just write to them now that you go home
655                      [((gesture with left arm))]
```

When the phone rings, the nurse does not orient towards it but sustains her gaze on the patient's arm and grabs the patient's wrist. With a shepherding movement (Cekaite, 2010), she then bends the patient's arm (Figure 56) to prevent bleeding from the catheter site. Her gaze follows the movement of the arm and shortly shifts to the patient's face once the arm is fully bent (line 586).

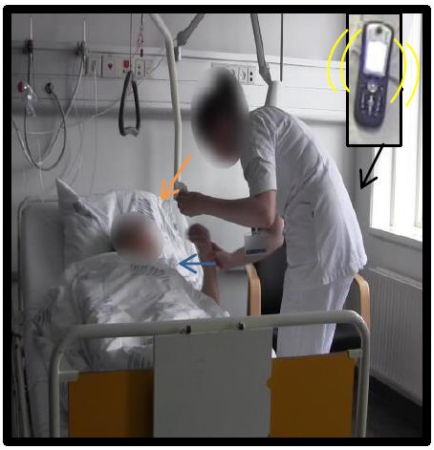

Figure 56: Bending patient's arm while phone rings

Ordinarily, the summons from a phone makes answering it the priority next thing for the addressee to do (Schegloff, 2002). However, the nurse recognizably postpones her response to the summons by saying, " then lie like that for just a couple of minutes; then it is okay", overlapping with the ring tone produced by the phone (line 590, 591, 597). Gazing at the patient's face, the nurse is addressing the utterance (Lerner, 2003; Rossano, 2013) to her. Her utterance is designed as an instruction for the patient to keep her arm bent, but she does not provide any explicit account as to why the patient has to do so. By prefacing her utterance with the word "then", the nurse is making reference to something previous to this account – the removal of the catheter – and exhibiting it as the reason for her instruction. However, by omitting an explanation, the nurse is exhibited as possessing epistemic access (Heritage, 2012) and right to this domain of knowledge. By telling the patient what to do rather than making a request for action, the nurse encodes her utterance with an epistemic stance (Heritage, 2012), displaying a steep gradient between her knowledgeable epistemic status and the less knowledgeable patient.

Upon initiating the utterance, the nurse shifts her gaze to her hands and folds the old dressing around the removed catheter (line 592). The nurse is thus employing several embodied resources to perform more than one action at a time pursuing the trajectory of actions that constitute the activity of removing the catheter (Figure 57).

As she finishes the utterance, her gaze briefly returns to the patient's face (line 598). Here, the nurse is displaying that she has reached the end of her utterance and addresses the patient as the next speaker (Kendon, 1967). The patient produces a "yes" (line 600) along with a head nod, thus displaying her alignment with the nurse's instructive turn and the epistemic stance encoded in it.

Figure 57: Giving patient instruction while phone rings

The nurse then immediately shifts her gaze back to her hands. After folding the dressing a few more times, the nurse directs her gaze towards the elastic bandage positioned next to the patient's shoulder and reaches for it (line 603). As she does so, her gaze briefly shifts to the patient's face, and they achieve mutual eye contact. The nurse smiles as she turns her head away and directs her gaze towards the foot of the bed. By her smile the nurse marks their establishment of eye contact, even as she turns her head and withdraws her gaze. The direction of gaze is an indicator of accessibility; mutual gaze can be used as a display of willingness to initiate an encounter (Goffman, 1969). By withdrawing from mutual eye contact the nurse is displaying herself as unavailable and unwilling to open a new sequence with the patient, but with her smile she employs another modality to display an affiliated stance towards the patient. Her smile as she turns her head away demonstrates to the patient that her unwillingness to uphold mutual eye contact is not a breach of a cooperative stance (C. Goodwin, 2007) but a response to her being summoned by the phone. Here, the nurse demonstrates herself as attentive and sensitive to the patient, thus enacting the discourse of patient-centred care.

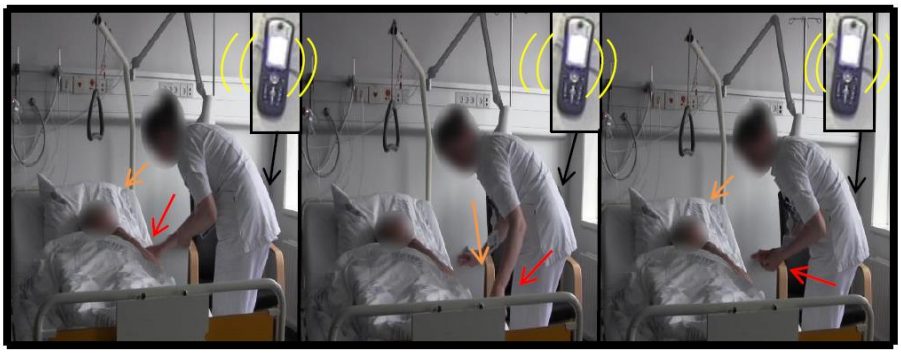

Figure 58: Pursuing trajectory of actions while phone rings

With her left hand, the nurse then takes the wrapping from the gauze dressing lying on the foot of the bed and gathers the utensils in her left hand (Figure 58). By keeping her body bent over the patient, by maintaining all orientations distributed towards the patient, and by observably postponing her response to the summons of the phone, the nurse is enacting the discourse of patient-centered care. Meanwhile, by postponing her response to the phone the nurse also postpones putting the discourse of being efficient into practice, thus assigning it lower priority.

That the nurse assigns lower priority to the discourse of being efficient is further underlined by her not increasing her pace, rather, she maintains an unaltered tempo in her verbal and bodily conduct. The historical body of the nurse has embodied knowledge of the duration of the activity she is performing and of the general timespan that the phone will ring before it is disconnected. She is observably exploiting that timespan to pursue the planned trajectory of actions constituting the activity of removing the catheter. The embodied resources required for the activity of removing the catheter and the activity of answering the phone are not mutually exclusive, as each can be performed by the use of one hand. However, in her organization of the activities, the nurse employs both hands as embodied resources to perform the activity of removing the catheter. The nurse thus orders the activities as consecutive rather than simultaneous and does not allocate embodied resources for the activity of answering the phone. Exploiting the length of the ringing to pursue the planned trajectory of actions, the nurse is displaying the activity with the patient as the main activity (Sutinen, 2014) from which she does not cease even though she is being summoned by others, continuing to enact the discourse of patient-centred care.

Once the nurse has assembled the utensils in her left hand, she observably attends to the summons as she straightens her upper body with her gaze in mid-air, and simultaneously moves her right hand to a pocket and grabs the phone (line 609). At this point the nurse deploys her embodied resources to produce involvement in more

than one course of action at a time, performing multiactivity (Haddington et al., 2014). Still holding the utensils from the activity of removing the catheter in her left hand, she releases her right hand from that activity, and allocates it to the activity of answering the phone. That the nurse does not have to look where to move her hand to grab the phone exhibits the phone as internalized in her practices. She shifts her gaze to the phone as she moves her hand in front of her stomach, pressing a button with her thumb (line 613). The nurse does not verbally mark the activity of answering the phone as a side sequence (Jefferson, 1972) or an inserted sequence (Schegloff, 2007). The summons from the phone is the first pair part of an adjacency pair (Schegloff, 1968) imposing a normative obligation on the nurse to provide an answer to the summons at first possible opportunity. Thus she does not produce an account for answering the phone; she treats the sound of the summons as an account in itself. The nurse straightens her upper body and moves the phone to her right ear (line 615). Facing the patient, the nurse is displaying a continued orientation towards her during the first part of the phone conversation, thus continuing to enact the discourse of patient-centred care. By gazing downwards, she simultaneously demonstrates herself as unavailable to the patient while exhibiting her dual involvements (Figure 59)

Figure 59: Basic orientation towards patient as phone is answered

The nurse initiates the phone conversation with a self-identification sequence and a greeting sequence (lines 618 & 622). As she produces the greeting sequence the nurse turns and walks to the bin. She drops the utensils which she gathered in her left hand into the bin, and then turns around to face the patient. In answering the phone, the nurse puts the discourse of being efficient into practice. She further enacts the discourse of being efficient by performing multiactivity, as she walks to the bin to dispose of the utensils while speaking on the phone. Here, the nurse exploits the duration of the phone call to finish the activity of removing the catheter, which means that she will be able to resume interaction with the patient as soon as the phone conversation ends. After dropping the utensils in the bin, the nurse turns around and orients herself towards the patient. She pauses and stands still next to the bin (Figure 60). Opening a new conversational sequence with the patient would require the nurse´s vocal modality which is also required for the phone conversation. She thus awaits the closure of the phone call before approaching the patient again. However, the nurse with her display of embodied orientation towards the patient is observably demonstrating the patient to be her relevant next, and is in this way putting the discourse of patient-centered care into practice.

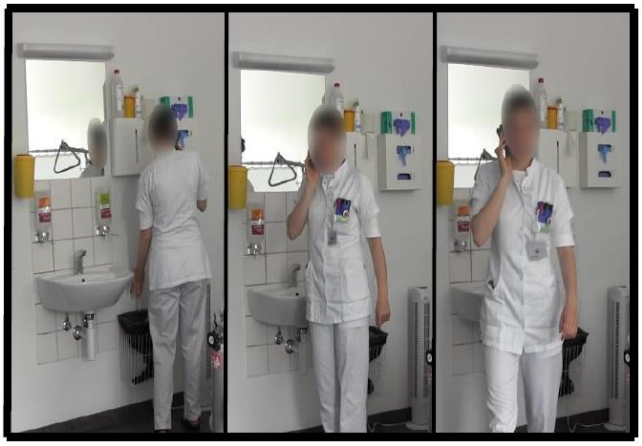

Figure 60: Finishing activity and re-orienting towards patient

As the nurse launches her penultimate turn (line 637), she observably projects the closure of the phone conversation as she steps towards the patient. While she is approaching the patient, the nurse produces her last turn (line 641) and repositions the phone in her pocket. She then assumes a squatting position in front of the patient and opens a new verbal interactional sequence with the patient (line 653). Doing so,

the nurse foregrounds the discourse of patient-centered care and works to accomplish a close embodied participation framework with the patient (Figure 61).

Figure 61: Opening new verbal sequence

CHAPTER 13. SUMMARY OF ANALYSIS: CASES ONE TO SIX

The analyses performed on cases one to six demonstrate how nurses working in the nexus of practice have developed strategies to enact both the discourse of being efficient and the discourse of patient-centred care in interactions with patients when mobile work phones ring. In their moment-to-moment actions nurses are seen to enact both discourses by the subtle use of multiple embodied resources. At some points managing the two discourses conflict; nurses are then seen to foreground one discourse and background the other, depending on the circumstances at hand and the progression of activities.

13.1. POSTPONING THE ENACTMENT OF THE DISCOURSE OF BEING EFFICIENT AS THE PHONE RINGS

In all six cases nurses are seen to foreground the discourse of patient-centred care and postpone the enactment of the discourse of being efficient as the mobile work phone rings. This is most evidently exhibited in case two, in which the nurse postpones her distribution of orientations towards the summons of the phone for an extended period of time. It is also exhibited in case one, when the nurse sustains her orientation towards the patient for the duration of the first pulse of the ring tone and maintains her gaze on the patient's face while she grabs the phone. In case three, the nurse continues to display adequate attention towards the patient as the next speaker, and only when it is clear that the patient refrains from taking the floor does she attend to the phone. In case four, the nurse continues the activity of inspecting the tube and covers the patient's intimate areas before orienting herself to the phone. In case five, the nurse secures the needle, while in case six the nurse exploits the length of the phone's ringing to instruct the patient, give her a smile, and to gather the utensils used for the activity of removing the catheter. Foregrounding the discourse of patient-centred care in favour of the discourse of being efficient as the mobile work phone rings, nurses in cases one to six are exhibited to prioritise the discourse of patient-centred care. In this way care is demonstrated to influence the way nurses use mobile work phones in interactions with patients, which answers one of the questions put forward at the beginning of this thesis.

As nurses postpone their response to the phones, they exploit the duration of the postponement to accomplish a respectful transition to the activity of answering the phone. This is done by continuing to display adequate attention towards the patient as next speaker (cases one and three), or by ensuring the well-being of the patients

as observed in cases two, four, five and six. The nurses not only enact the discourse of patient-centred care as detailed above, but also accomplish transitions which are intelligible to patients. This is exhibited in all six cases, as patients are observably doing waiting during the phone conversations. Patients display themselves as waiting by turning their heads, by upholding a middle distance gaze, by not pursuing the progression of talk, or by not taking activities forwards or engaging in other activities. In these ways patients demonstrates themselves as available to resume activity with the nurse once she has finished the phone call. They thus display that they understand that their activity with the nurse is her main activity, which is only temporarily suspended for the duration of the inserted activity of the phone conversation. In case one, the nurse does not ascribes the patient to display this understanding initially and employs tactile resources to demonstrate this to her, which makes the patient recognisably display waiting.

13.2. CONTINUING THE ENACTMENT OF THE DISCOURSE OF PATIENT-CENTRED CARE DURING PHONE CALLS

Although nurses in cases one to six postpone answering the phone for longer or shorter periods of time, they all do answer it and thus put the discourse of being efficient into practice. However, in all cases nurse continue to enact the discourse of patient-centred care during the phone conversations, which demonstrates them to be capable of combining a new semiotic field with the on-going contextual configurations.

In cases one to six, nurses enact the discourse of patient-centred care during phone conversations by maintaining orientations towards the patient and displaying that the patients remain their primary activity. In case one, the nurse's body is oriented towards the patient while she holds her hand. In case two, the nurse displays a strong orientation towards the patient while she adjusts and smooths her shirt. In case three, the nurse maintains her squatting position, her close proximity, and her strong basic orientation towards the patient. In case four, the nurse stands with her upper body bent over the patient while inspecting the tube. In case five, the nurse keeps her body leaning towards the patient while resting her fingers on the patient's wrist, and in case six, the nurse displays the patient as her relevant next by orienting towards her after having disposed of the utensils.

In four of these cases nurses use tactile resources in various ways to enact the discourse of patient-centred care while they speak on the phone. In case one, the nurse holds the patient's hand, squeezes and strokes it. In case two, the nurse uses the palm of her hand to stroke the patient's back and smooth her shirt. In case four, the nurse continues to inspect the tube with one hand, and in case five, the nurse rests her hand against the patient's wrist for the duration of the phone call. The

analysis thus demonstrates the use of tactile resources as a strategy for enacting the discourse of patient-centred care during phone conversations.

Answering a mobile work phone requires at least the use of verbal resources and one hand, which means that these resources are unavailable for simultaneously enacting the discourse of patient-centred care. Mobile work phones thus constrict the multimodal repertoire that nurses can employ to enact this discourse during phone conversations. However, the analyses demonstrate that this does not preclude nurses from enacting the discourse of patient-centred care during phone conversations, as they are able to compensate by using other embodied resources to accomplish this goal. This finding answers another question put forward in the beginning of this thesis, which asked whether the mobile work phones precluded the delivery of features constituting care in nurse-patient interactions. The way nurses realise the discourse of patient-centred care during phone conversations varies, as the concrete actions performed are influenced by the circumstances of the concrete situation. The divergence demonstrates how the enactment of the discourse of patient-centred care during mobile phone conversations does not consist of standardised actions, but is shaped in every interaction by the historical bodies participating, the order of the interactions unfolding, and the semiotic cycles circulating in the situation.

CHAPTER 14. ANALYSIS OF CASE SEVEN: “THE NEWCOMER”

The analytical findings of case seven, “The newcomer”, diverge from the analytical findings of cases one to six. Transparency into the analytical process is thus considered necessary, so the analysis of case seven is presented in full. Case seven features a nurse who has only been working in the ward for four months. She had been working in another medical department, but was transferred to the present ward due to the organisational restructurings noted above. The nurse is assisting a patient in getting out of bed. She passes the patient on her way out of the patient room after having attended to another patient. The nurse notices the patient sitting on the bedside and changes direction towards the patient (Figure 62).

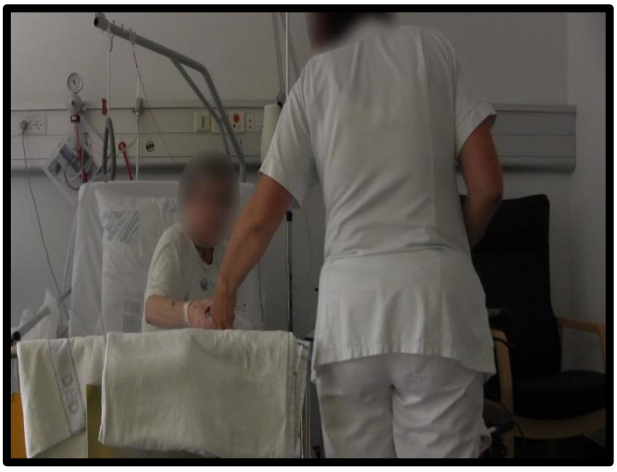

Figure 62: The newcomer – intro

14.1. INTERACTIONAL ANALYSIS OF CASE SEVEN, “THE NEWCOMER”

The patient is sitting in the middle of the bed with her legs over the side. Passing the patient’s bed on the way out, the nurse notices the patient and changes the direction of her walk. She approaches the patient and initiates an interactional sequence (excerpt 14).

Excerpt 14:

```
656  N    jeg skal nok lige hjælpe dig
657       i will help you
658       ((walks to P, gaze P))
659
660  P    ja
661       yes
662       ((streches right hand holding tissue towards foot of bed,
663       gaze tissue))
664
665  N    ja
666       yes
667       ((takes tissue with left hand))
668
669  N    ((places tissue in bed))
670
671  P    jeg skal også lige have mine sko
672       i need my shoes as well
673       ((places both hands on bed table))
674
675  N    yjar
676       yes
677       ((gaze P))
678
679       ((pushes walker away, steps towards bed table, gaze table))
680
681  N    urgh der er langt derned
682       urgh it is far down
683       ((bends over, grabs shoes, gaze shoe shelf))
684
685  P    ja og når jeg kommer ned det er ikke med at komme ned men
686       det er med at komme op igen
687       yes and once i get down it is not getting down but it is
688       getting back up
689
690  N    ((straightens up, turns body towards P))
691
692  N    skal du have hjælp til at få dem på eller hvordan er det
693       do you need help putting them on or how is it
694       ((bends, places shoes in front of P’s feet with right hand,
695          places left hand on walker handle))
696  P    ((moves hands to bed, gaze shoes))))
697
698  P    nej jeg kan bare lige stik i her
699       no i can just slip in here
```

```
700         ((moves forward, places left foot in shoe, gaze shoes))
701
702   N     ((straightens up, pushes shoes with right foot, places right
703         foot in front of P’s shoe, gaze shoes))
```

Approaching the patient, the nurse produces the utterance, “I will help you” (line 657). In her recipient design (Sacks et al., 1974) the nurse demonstrates her understanding of the patient as being in need of assistance to be able to leave the bed. Designing her utterance as an ascertainment rather than an offer, the nurse maximises the chance of her obtaining the preferred affirming response from the patient. The patient accepts the proposition of assistance with a “yes” (line 661) while stretching her right hand, which is holding a tissue, towards the foot of the bed. The nurse confirms with her own “yes” as a freestanding receipt marker (Beach, 1995), grabs the tissue with her left hand, and places it in the bed. The patient then produces the utterance, “I need my shoes as well” (line 672). By her utterance the patient points out that she has bare feet to have the nurse share attention to this fact. By inserting the words “as well” in her utterance, the patient makes reference to the nurse’s previous turn of offering assistance. The patient displays that she needs the nurse to help her get her shoes, and the nurse accepts the patient’s request with an “yjar”, which is a distorted version of “yes” (line 676). The nurse pushes the walker aside, steps towards the bed table, and bends over to grab the patient’s shoes from the shoe shelf (Figure 63).

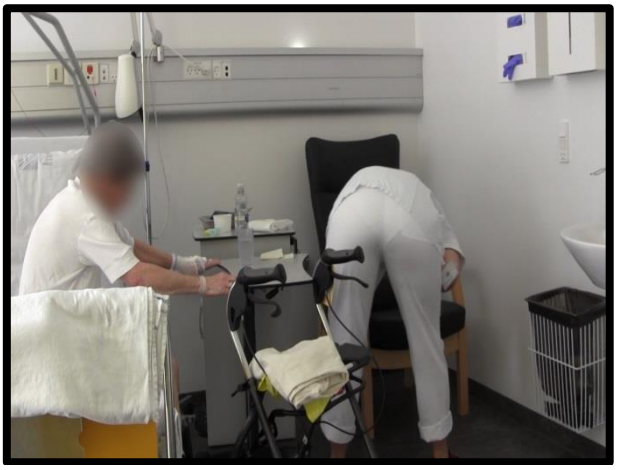

Figure 63: Grabbing patient’s shoes

During this action, the nurse produces the utterance, “urgh it is far down”, which is designed to expresses the effort she is making (line 682). The patient acknowledges the effort it takes to grab the shoes by her utterance, “yes when I get down, it is not

getting down but it is getting up again" (line 687). By her utterance the patient displays that grabbing the shoes herself would be difficult. The nurse straightens her body, turns towards the patient, and places the shoes on the floor in front of the patient's feet. As she places the shoes the nurse produces the utterance, "do you need help putting them on or how is it" (line 693) with her gaze on the shoes. Simultaneously, the nurse places her left hand on the handle of the patient's walker. By her utterance the nurse is displaying her understanding that the patient might not be capable of putting on the shoes herself and offers her assistance. As the nurse places the shoes the patient moves her hands from the table to the bed and pushes her backside forward. Stretching her legs and feet towards the shoes the patient produces the utterance, "no I can just slip in here" (line 699). By this utterance, the patient declines the nurse's offer of assistance. The nurse maintains her gaze on the shoes and pushes them towards the patient's feet with her right foot. She then places her own foot in front of the shoes. Her movement is designed to prevent the shoes from sliding forward as the patient puts her feet into them. In this way the nurse subtly assists the patient, even though her offer to do so was declined. The patient slips both feet into the shoes and produces the utterance, "then I might as well sit out there and see if I can" with her gaze on the shoes (excerpt 15).

Excerpt 15:

```
704  P    så kan jeg lige så godt sidde derude og se om jeg kan
705       then i might as well sit out there and see if i can
706       ((gaze shoes, places right foot in shoe))
707
708  P    ((turns head right, gaze bed side, turns head forward, lifts
709       head))
710
711  N    ((gaze P))
712
713  P    jeg tror nok jeg fik lidt feber for [forvrængelse her i
714       i think i had a bit of fever de delirium here in
715       ((lifts head, gaze at N, moves left hand to bed table,
716  N                                        [ja
717                                           [yes
718
719  P    ((moves right hand to bedside, stands up))
720
721  N    ja
722       yes
723       ((pulls walker towards patient, lifts head, gaze at oxygen
724       device))
725
726  P    ((shifts right hand to handle))
727
728  N    nu skal du se nu=
729       now you shall see now
730       ((turns, walks towards foot end of bed))
731
732  T    =-------------------[----------------------
733  N                       [tager vi lige den her
734                          [we just answer this
```

```
735                              ((bends head, gaze phone, grabs phone,
736                               shifts direction of walk, pushes button
737
738 ((moves phone to ear))
```

The patient aborts her turn, "then I might as well sit out there and see if I can" (line 705), turns her head to the right, and gazes towards the bed-side. The incomplete syntax of the patient's turn projects continuation of her turn, given the general preference for progressivity in interaction (Schegloff, 1979). The patient turns her head forward again and gazes at the shoes. The nurse shifts her gaze from the shoes to the patient, thus addressing the patient as speaker (Lerner, 2003; Rossano, 2013) and marking the previous turn produced by the patient as incomplete (Figure 64).

Figure 64: Addressing patient as speaker

The patient lifts her head and gazes in mid-air. The nurse smiles at her, and the patient produces the utterance, "I think I had a bit of fever de- delirium here in" (line 714). In producing the word "delirium" the patient repeats the first syllable, which causes the nurse to produce an overlapping "yes" (line 717). As the patient finishes her utterance the nurse produces another "yes" as a freestanding receipt marker (Beach, 1995). While producing her utterance, the patient lifts her head, gazes at the nurse, and moves her left hand to the bed table. The patient aborts her turn and leaves the utterance incomplete as she places her right hand on the bed and stands up (line 722). Producing two incomplete turns exhibits the patient to be having difficulties in employing verbal resources while she simultaneously has to use other embodied resources to leave the bed. The nurse sustains her gaze on the patient, displaying adequate attention towards her as the continued speaker. As the patient stands up, the nurse pulls the walker towards the patient (line 723). The patient shifts her right hand to the right handle of the walker and the nurse lifts her head and gazes towards the oxygen device on the wall (Figure 65).

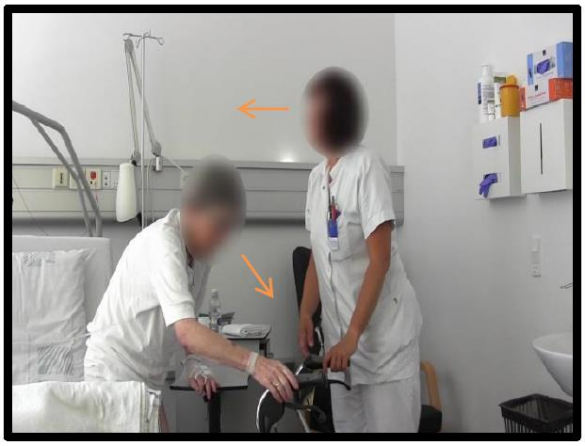

Figure 65: Gaze towards oxygen device

By her distribution of orientation towards the oxygen device, the nurse is displaying that she projects the next relevant action to concern this. The nurse walks around the walker and towards the foot of the bed while she produces the utterance, “now you shall see now” (line 729). This utterance is designed to draw the patient’s attention towards something, presumably the next relevant action. At this point the nurse’s phone starts ringing. She aborts the planned construction of the turn and instead produces the utterance, “we just answer this” (line 735) as a natural continuation of the turn she was producing when the phone started ringing. This displays that the summons of the phone makes answering the phone the next relevant action. The nurse simultaneously moves her left hand towards the phone, bends her head, gazes at the phone, and takes it out of her pocket. Meanwhile, she turns her head and changes the direction of her walk (Figure 66).

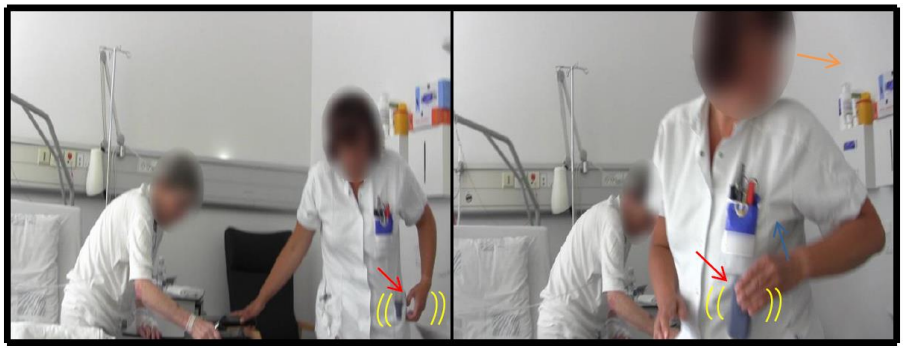

Figure 66: Grabbing phone

While the nurse is moving the phone to her ear she walks to a portable table with a computer and some used tableware (Figure 67). The patient at this point shifts her left hand from the bed table to the left handle of the walker. Standing at the table the nurse positions herself with her back towards the patient, no longer distributing any orientations towards the patient. She thus closes the embodied participation framework (C. Goodwin, 2000) with the patient and displays the activity with the patient to be discontinued.

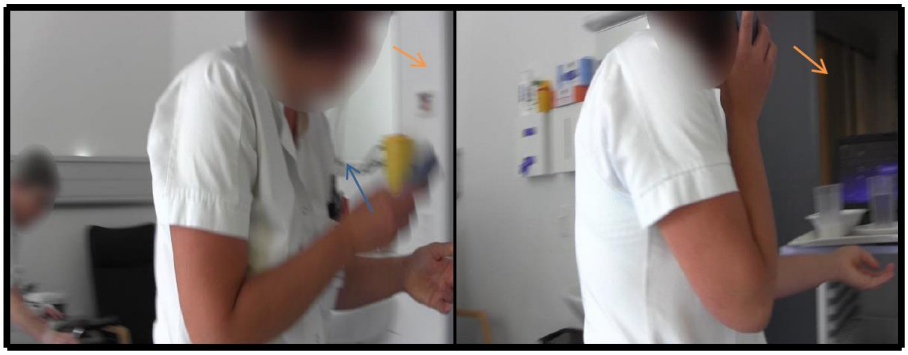

Figure 67: Answering phone

The nurse answers the phone by producing a “jargh” which is a distorted version of “yes” (excerpt 16).

Excerpt 16:

```
739  N    jargh
740       yes
741       ((turns towards table))
742
743  P    ((walks))
744
745  N    jeg er stadigvæk nede på stue otte
746       i am still down in room eight
747       ((fiddles with table with left hand, gaze table))
748
749  N    ja
750       yes
751
752  N    ((turns head, gaze P))
753
754  N    ja
755       yes
756       ((turns around, walks rapidly towards oxygen device, gaze
757       oxygen device))
758
759  N    >godt hej<
760       >okay bye<
761       ((moves phone from ear, gaze catheter))
762
```

```
763  N    ((pulls catheter with left hand and right hand holding
764       phone, moves right hand towards bed, aborts movement,
765       repositions phone in pocket, gaze pocket))
766
767  N    hov jeg skal lige have det her
768       oops i just need to have this
769       ((pulls catheter with both hands, gaze catheter))
770
771  P    ja
772       yes
773       ((stops walking, turns head, gaze N))
774
775  N    sån
776       there
777
778  N    ((turns around, walks to door with cathter in left hand))
779
780  P    ((walks towards nurse/door))
781
782  N    ((turns head, gaze P))
```

Rather than interactionally accomplishing an anchor position (Schegloff, 1986) through a series of canonical sequences, such as a self-identification sequence or a greeting sequence, the nurse designs her first turn as a request for information, prompting the caller to launch the reason for the call. The nurse in this way pre-emptively refrains from claiming speakership and urges the caller to initiate the first topic before an anchor position is accomplished, which can be a display of urgency (Schegloff, 1986). Meanwhile, the patient starts walking away from the bed (line 743). Standing with her upper body slightly doubled up towards the table and with her gaze on the table (Figure 68), the nurse then produces the utterance, “I am still down in room eight” (line 746).

Figure 68: No orientation towards patient

By her utterance, the nurse is not simply giving information about her location; the activity she is performing and with whom can also to some extent be projected from this information. While producing this utterance, the nurse is fiddling with the table. After producing her next turn, “yes” (line 750), the nurse turns her head and gazes towards the patient (Figure 69), who is continuing to walk towards the door.

Figure 69: Gaze towards patient

As the patient moves further from the bed, increasing strain is placed on the catheter, which is still attached to the oxygen device. As the nurse produces another “yes” (line 755), she turns around and rapidly walks round the bed to the oxygen device on the wall (Figure 70).

Figure 70: Rushing towards oxygen device

The sudden increase in the tempo of the nurse’s walk displays that there is a degree of urgency in reaching another physical location. Walking towards the oxygen device, the nurse removes the phone from her ear while still producing the closing utterance ”okay bye” (line 760), which is delivered more rapidly than the preceding talk. In this way the nurse is further exhibited to be in a hurry. Arriving at the oxygen device, the nurse grasps the catheter with both hands, still holding the phone in her right hand (Figure 71).

Figure 71: Working to release catheter with phone in hand

The nurse pulls the catheter using both hands and then releases the catheter with her right hand, which still holds the phone. The nurse moves her right hand towards the bed but aborts the movement. She releases the catheter with her left hand and uses both hands to reposition the phone in her pocket (line 765). These body movements are performed at a higher speed than the surrounding embodied conduct performed by the nurse, and with her gaze fixed on the catheter. The increased tempo and the direction of her gaze demonstrate an urgency concerning the catheter. The nurse then produces the utterance, “oops I just need to have this” (line 768). She again takes hold of the catheter with both hands and pulls it (Figure 72).

Figure 72: Working to release catheter

By producing the preface "oops", the nurse uses a response-cry expression (Goffman, 1981) to formulate the event as a failure; she does not remove her gaze from the catheter or distribute any embodied orientations to address the patient. The patient, however, stops walking, turns her head to the right, and gazes towards the nurse (Figure 73). Simultaneously, she produces the utterance "yes" (line 772) as a freestanding receipt marker. The patient thus treats the utterance as being addressed to her, and ascribes it to be a request for her to stop walking.

Figure 73: Patient waits for nurse

The catheter releases from the oxygen device and the nurse produces the utterance, "there" (line 776). Her utterance can both display the activity itself as finished or that the purpose of that activity has been accomplished. The nurse then turns around and walks to the patient, carrying the catheter in her left hand. As she passes the patient and proceeds towards the door, the patient resumes her walk and follows the nurse out the door (Figure 74).

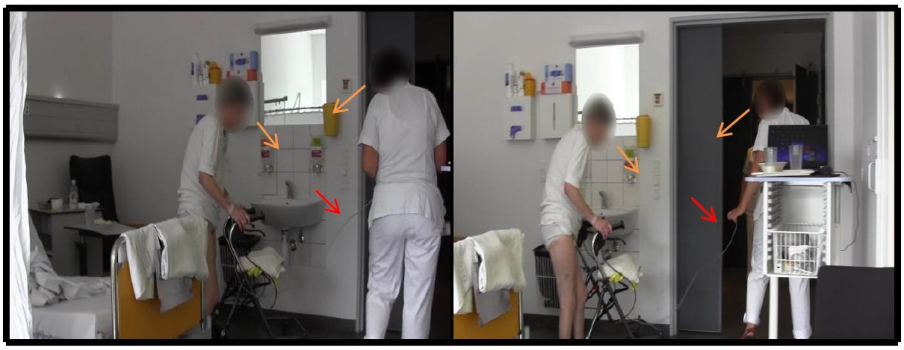

Figure 74: Patient follows nurse within reach of catheter

Walking out the door the nurse turns her head and gazes towards the patient, making sure she follows within the reach of the catheter (Figure 74).

14.2. STRATEGIES USED IN CASE SEVEN, “THE NEWCOMER”

As she is leaving the two-patient room after attending to one patient, the nurse notices that the other patient is sitting with her legs over the side of the bed. Even though that patient has not made a request for assistance, the nurse approaches her and offers assistance. The nurse is observably being attentive towards the needs of the patient even though she has other tasks. Sensing that the patient is leaving her bed, the nurse aborts the planned trajectory of actions to assist her, displaying that this patient is more important than the awaiting tasks. The actions of the nurse thus demonstrate a focus on the patient and exhibit that patient to be central. In this moment of action the nurse is thus seen to enact the discourse of patient-centred care. In doing so and thus postponing the awaiting tasks, the nurse assigns a lower priority to the discourse of being efficient.

The nurse continues to enact the discourse of patient-centred care as she grabs the patient’s shoes and discreetly assists her in putting them on. She also puts the discourse of patient-centred care into practice as she continues to display adequate attention towards the patient as next speaker, even though the patient repeatedly produces incomplete utterances. As the patient stands up, the nurse orients towards the oxygen device on the wall, projecting that the next relevant action is to detach the catheter. However, as she walks – presumably to perform this action – her mobile work phone rings. The nurse immediately answers the phone and thereby puts the discourse of being efficient into practice. She assigns it higher priority and suspends her enactment of the discourse of patient-centred care by not working to accomplish interactionally a suspension of the activity with the patient beforehand.

As a consequence, the patient continues that activity while the nurse engages in the phone conversation.

In answering the phone, the nurse positions herself in front of a table with a computer, turning her back towards the patient. Standing with her upper body doubled up and with her gaze directed at the table, the nurse no longer distributes any orientations towards the patient. In this moment of action the nurse is thus not enacting the discourse of patient-centred care; rather the nurse has shifted from a contextual configuration (C. Goodwin, 2000) with the patient in the centre to a contextual configuration with the phone as the centre. She therefore does not notice that the patient takes their mutual activity forward and walks away from the bed, which places critical tension on the catheter. By speaking on the phone, the nurse enacts the discourse of being efficient as she skips what Schegloff has termed "a full opening" (1986) and pre-emptively moves directly to an anchor position, without wasting time on interactionally accomplishing this position through a series of sequences.

As the nurse produces her third turn, she turns her head and directs her gaze towards the patient. Noticing that the patient is walking away from the bed and that severe strain is being placed on the catheter, the nurse rushes to the oxygen device to release the catheter. Her rush is exhibited by the increased tempo in her actions and by her removing the phone from her ear before she has finished the production of her closing utterance. Detaching the catheter requires the use of both hands. Realising that she is unable to release the catheter with the phone still in her right hand, the nurse disposes of the phone and again grabs hold of the catheter. In this moment of action the nurse is exhibited as rushing and working hard to release the catheter and thus enacting the discourse of being efficient. She does not orient towards the patient; however, by working to release the catheter before the strain placed on it can harm the patient, she may also be considered to enact the discourse of patient-centred care.

At this point the nurse employs verbal resources and produces an utterance which makes the patient discontinue her walk. The catheter is released and the nurse walks to the patient, carrying the catheter. In resuming the planned trajectory of actions, the nurse again enacts the discourse of patient-centred care by orienting to the patient and making sure she follows within the reach of the catheter.

CHAPTER 15. CONNECTIONS TO OTHER TIMES AND PLACES

When the mobile work phones were introduced into the nexus of practice by others, nurses had to find ways of solving the practical problems of their ringing while they were interacting with patients. The solution was not something they were taught or thought out beforehand; rather, as nurses performed their practices, strategies were developed over time. As demonstrated in the analysis of cases one to six, nurses in the nexus of practice succeeded in developing strategies which allow them to enact both the discourse of patient-centred care and the discourse of being efficient when answering these phones in their interactions with patients. The analysis of case seven demonstrates that these strategies do not occur naturally, but are a skill to be acquired. In this chapter, the analysis thus zooms out further to study the interconnectedness and evolution of the practices of nurses using mobile work phones by analysing connections to other places and other points in time.

15.1. DEVELOPING STRATEGIES IN THE NEXUS OF PRACTICE

The strategies revealed in this analysis represent a glimpse into the practices of nurses as they unfolded in the nexus of practice at the time of my engagement. Their practices are constituted by a multitude of individual actions reproducing the practices and forming patterns in an on-going collective accomplishment. By their embodied conduct during interactions with patients and mobile work phones, nurses working in the nexus of practice participate in the constitution of practices that simultaneously enact both the discourse of patient-centred care and the discourse of being efficient. In every dynamic interaction with a patient and a mobile work phone, the historical bodies of nurses evolve and their practices of managing the dual involvements develop. The practices of enacting both discourses simultaneously are thus not only collective accomplishments but also a process that develops over time. The practices revealed in this thesis may thus have changed and developed since the video recordings were made. This can be explored by re-engaging the nexus of practice, which is elaborated upon in Chapter 16.

The fact that nurses' practices of managing mobile work phones develops over time is illustrated by their utterances. On the day I went to the hospital department for the first time as an examiner, the nurse told me that "when we first got the phones we were all wound up about them", as described in the opening narrative. It is also reflected in an utterance produced by a nurse in the minor ethnographic study, which was conducted in the same nexus of practice 18 months prior to the present study. Talking about her experience of using mobile work phones, the nurse said, "in the

beginning I found it really difficult to carry it [the phone] with me (…) it almost broke my neck initially" (Paasch, 2014, p. 26),[76] which means that working with mobile work phones almost defeated the nurse at first. In the nexus of practice, the strategies used by nurses that allow them to enact both the discourse of patient-centred care and the discourse of being efficient when they answer mobile work phones while interacting with patients, are not put into words. Possibly, nurses working in the department are not even aware of the strategies. Newcomers who enter the nexus of practice do not know about the strategies and may experience difficulties in solving the practical problem of mobile work phones ringing during their interactions with patients. The difficulties of being a novice are demonstrated in the case, "The newcomer", which feature a nurse who has only been working in the ward for four months. The nurse had been working in another medical department, but was transferred to her present department due to the organisational restructurings noted above. The case illustrates that mastering strategies that allow nurses to enact both discourses when they answer mobile work phones during interactions with patients does not occur naturally, but is a skill that must be acquired.

In case seven, "The newcomer", the nurse is enacting the discourse of patient-centred care before the phone rings. She responds immediately to the summons and aborts her planned trajectory of actions. The nurse thus does not foreground the discourse of patient-centred care when the phone rings and does not postpone her enactment of the discourse of being efficient, as nurses are observed to do in cases one to six. Rather, when the discourse of being efficient materialises in the ringing phone, the nurse instantly stops enacting the discourse of patient-centred care and immediately foregrounds the discourse of being efficient. As a consequence the nurse does not interactionally accomplish a suspension of the activity with the patient, and the patient therefore continues their activity while the nurse answers the phone. During the first part of the phone conversation the nurse does not enact the discourse of patient-centred care at all; she turns her back towards the patient and does not distribute any orientations towards the patient. The nurse in case seven in this moment of action only puts the discourse of being efficient into practice, which diverges from the strategies used by nurses in case one to six; in various ways, they continue to enact the discourse of patient-centred care when they answer the phone. Not orienting herself towards the patient means that the nurse does not observe that the patient is taking their mutual activity forward, with the catheter still attached to the oxygen device.

The strategies used by the nurse in case seven allow for an inexpedient course of actions to occur. This demonstrates that developing expedient strategies for managing interactions with patients and mobile work phones has a real bearing on patient safety. It also demonstrates the significance of the practices displayed in

[76] "I starten synes jeg, det var rigtig svært at have den [telefonen] med (…) jeg var ved at knække halsen på det i starten".

cases one to six, where experienced nurse who have been working in the department for at least two years foreground the discourse of patient-centred care as mobile work phones ring, and continue to enact this discourse during phone conversations.

15.2. STRATEGIES DEVELOPED IN OTHER HOSPITAL DEPARTMENTS

Following connections from the nexus of practice to hospital departments at the university hospital revealed that nurses working there have developed other strategies to solve the practical problem of ringing mobile work phones during interactions with patients. The various strategies developed in different hospital departments demonstrate that there is not just one solution this practical problem; instead, different nurses working in a range of circumstances continuously constitute and develop practices in an on-going collective accomplishment.

The various strategies employed do share a view that constitutes the patient as central. The analysis reveals how nurses working in the nexus of practice use strategies to maintain a patient-centred focus while at the same time managing phone calls. In one of the departments at the university hospital, nurses simply refuse to use the phones. Their strategy to enact the discourse of patient-centred care in interactions with patients is to exclude mobile work phones entirely from such interactions. This does not prevent the discourse of being efficient from circulating through the interactions, as nurses are still aware of other patients and tasks that are queuing up. With this strategy, however, the discourse of being efficient does not materialise in a ringing phone during the interaction, so nurses may find it easier to background this discourse while enacting the discourse of patient-centred care.

In another department at the university hospital, nurses have developed yet another strategy to enact the discourse of patient-centred care in interactions with patients and mobile work phones. Nurses in this department do not answer their mobile work phones when they are with patients. The utterance produced by a nurse in the department – “if I am with a patient I can’t” (nurse u3, 17.12.14) – may display a normative stance that it is inappropriate to answer the phone during interaction with patients. It may also reflect that the nurse simply finds it difficult to enact both the discourse of being efficient and the discourse of patient-centred care simultaneously. Regardless, the aim of the strategy is to maintain focus on the patient. However, this strategy still allows the discourse of being efficient to materialise in an interaction when the mobile work phone rings. As interactions in this department were not videotaped but merely observed, it is not clear whether nurses accomplish this aim by using this strategy. It thus remains unexplored whether the strategy of not answering the phones during patient interactions makes nurses capable of enacting the discourse of patient-centred care or whether, for instance, they cut interactions

short once the discourse of being efficient materialises in a ringing phone left unanswered.

15.3. SUMMARY OF ANALYSIS

On the basis of the analyses performed on seven selected interactions between a nurse, a patient, and a mobile work phone, this thesis has revealed key insights about this complex phenomenon. In the six cases featuring experienced nurses the analyses unveiled how they foreground the discourse of patient-centred care and postpone their enactments of the discourse of being efficient when their mobile work phones ring. Experienced nurses are in this way exhibited to attach greater importance to the discourse of patient-centred care than to the discourse of being efficient. This prioritisation may to some extent originate in the nursing curriculum, which makes the patient, the relationship with the patient, and care for the patient the pivotal goal.

Nurses in all the cases analysed answer their mobile work phone, thereby putting the discourse of being efficient into practice. Experienced nurses, however, continue to enact the discourse of patient-centred care during their phone conversations. They do so by employing tactile resources and embodied orientations to demonstrate that the patient is central. Experienced nurses are thus in cases one to six exhibited as caring not only in the transition to the activity of answering the phone but also while they are engaged in phone conversations. Mobile work phones are thus seen not to preclude experienced nurses from enacting care in interactions with patients.

One of the cases selected for analysis features a nurse who has only been working in the department for four months. Before the phone rings the nurse's actions exhibits her as caring. When the mobile work phone rings, however, the nurse immediately suspends her enactment of the discourse of patient-centred care and foreground the discourse of being efficient. This may indicate that the nurse prioritises the discourse of being efficient over the discourse of patient-centred care, which would be incongruent with the nursing curriculum. It may also exhibit that this nurse is not yet able to combine the new semiotic field of the phone with the on-going contextual configurations. The nurse thus shifts from a contextual configuration with the patient at the centre to a contextual configuration with the phone at the centre, and continues not enacting the discourse of patient-centred care for the first part of the phone conversation.

By immediately suspending the discourse of patient-centred care when the phone rings, the nurse in case seven does not suspend the activity with the patient in a way that is intelligible to the patient. This is demonstrated as the patient, unlike those in the other six cases, does not "do waiting" but moves the activity forward. The nurse has backgrounded the discourse of patient-centred care so much that she does not notice this development; she does not continue enacting the discourse of patient-centred care even partially during the phone call, which means that none of her

embodied orientations are distributed towards the patient. This allows for an inexpedient course of action to occur, as critical tension is placed on the catheter.

The analysis of case seven suggests that strategies used by nurses in the other six cases analysed do not occur naturally but are something learned over time as newcomers participate in the community of practices. The analysis of case seven also suggests that developing strategies for managing interactions with patients and mobile work phones may have a bearing not only on the enactment of care but also on patient safety.

The aim of this thesis was to explore if and how nurses are able to enact care in interactions with patients and mobile work phones. The analysis of the seven videotaped interactions has demonstrated that nurses working in the nexus of practice have developed strategies which enable them to enact care in interactions with patients. Precisely how nurses enact care varies with the historical bodies of the nurse and the contextual configurations of each unique situation, but the use of tactile resources and embodied orientations are salient features which appear indispensable. In other hospital departments, nurses have developed other strategies for solving the practical problem of mobile work phones that ring during interactions with patients. These strategies, however, have not been videotaped or otherwise analysed in close detail. It is thus beyond the scope of this thesis to list all the concrete ways that nurses deal with ringing mobile phones when they are with patients. However, the analysis has unquestionably shown that enacting care while taking a phone call requires a general mastery of multiactivity, specifically in providing enough attention both to the patient and to the phone. This skill requires smooth handling, both in the concrete and metaphorical meaning of the word, and is dependent on the complex features of the on-going situation.

CHAPTER 16. CHANGING THE NEXUS OF PRACTICE

The aim of this thesis was to explore if and how nurses are able to enact care in interactions with patients and mobile work phones, not to provide directions for practices or to change the way that nurses use mobile work phones. However, Scollon and Scollon report that conducting a nexus analysis will inevitably alter the trajectories of the nexus of practice and thus in itself bring about change. As I participated in the nexus of practice my research activities became part of the activities of the hospital department and therefore part of a process of constructing the social world within it. Even though changing the nexus of practice was not an aim, it is thus a basic condition of conducting any nexus analysis. The changes brought about are unpredictable, uncontrollable, and "remain to be seen" (R. Scollon & S. W. Scollon, 2004, p. 178) over the time of the nexus analysis. In this chapter I thus reflect on my role as a researcher and on the changes taking place in the nexus of practice during the course of research. Although it was not the aim of this research process to bring about change, the analytical findings have prompted reflections on the potential for change. This chapter thus also present reflections on possibilities for change, which could be pursued intentionally.

16.1. CHANGE BASED ON PARTICIPATION

By participating in the nexus of practice as a researcher, I inevitably also participated in the constitution of the practices of nurses working there. As described in Section 3.1, this thesis takes the perspective from practice theories that human interaction is mutually accomplished, and that during interaction we continuously analyse the actions of others. This means that my actions and inquiries in the nexus of practice influenced the actions of participants. It also means that by being present in the videotaped situations I may have influenced the way nurses took action, as by making them aware of and wanting to do "the right thing". However, as outlined in Section 4.8, this does not make the recorded interactions inauthentic; rather, they are a constitutive part of situations inhabited by both participants and by me as a researcher. However, if my presence in a situation with a video camera motivates a nurse to do "the right thing" or simply prompts her to reflect on what "the right thing" is, this may serve as an example of the way my participation in the nexus of practice could alter trajectories and influence the actions of nurses working there.

A concrete example of such an altered trajectory was revealed during my engagement with the Nexus of Practice in conducting the present study. Sitting in

the staff room eating my lunch, I spoke to a nurse who had participated in the minor ethnographic study I conducted in the same department 18 months years earlier. The nurse told me how her participation in that study had made her think about the way she used her mobile work phone and made her change the way she took action with it. In a similar way, my research activities during the present nexus analysis may have prompted reflections and altered trajectories of nurses working in the department, not only in regard to mobile work phones but also in regard to their practices in general. The ways in which my activities during this nexus analysis may have influenced trajectories in and beyond the nexus of practice remain to be seen and explored in a phase of re-engagement. In returning to the department it would not be possible to determine causal relations, as any changes taking place would be mediated by numerous actors. As demonstrated in the mapping performed in Chapter 6, countless semiotic circles contribute to the constitution of the nexus of practice. Conducting a new nexus analysis, however, would make it possible to trace connections and follow trajectories over time. For this reason, it is my ambition to return to the nexus of practice upon the completion of this thesis.

16.2. CHANGE BASED ON DIALOGUE

Another reason for re-engaging the nexus of practice is to bring the findings and analysis of this thesis back to the nurses working there. This will accomplished by using the video recordings as the basis for a dialogue with the nurses, as suggested by Carroll et al. (Carroll, Iedema, & Kerridge, 2008). The nurses working in the nexus of practice possesses expert knowledge about their own practices and about institutional possibilities and constraints. Bringing their expert knowledge together with the knowledge generated in this thesis may lead to reflections on the way practices are performed and point to possibilities for change. Active collaboration with members of the nexus of practice is essential when analysing possibilities for change, as I may suggest changes that are not relevant or feasible to its members. Instead, I offer the multiple trajectories and the connections between them that are made visible in this analysis for members of the nexus of practice to consider. Engaging in dialogue with nurses working in the department could also provide me as a researcher with the opportunity to receive feedback on my analysis of the video recordings. This could nuance and qualify that analysis and point to additional analytical foci.

Bringing the analytical findings of this thesis back into nursing practices can also be achieved by disseminating them in articles, at conferences, on project days, directly to other hospital departments. This may similarly realise a potential for dialogue by bringing the expert knowledge of nurses into interplay with the knowledge generated in this thesis. In this way this research process may initiate reflections and influence trajectories in other nexuses of practices. As an example, I presented some

of the findings of this thesis at a project day for nurses at a hospital in another region. The hospital did not at that point in time use mobile work phones, but has subsequently implemented them. At the project day my presentation led to a spirited discussion on the values and practices of nurses in regards to mobile work phones. This discussion undoubtedly prompted reflections and had at least some bearing on trajectories influencing the subsequent process of implementing mobile work phones.

16.3. CHANGES IN RESEARCH AND EDUCATION

Employing theories and methods rarely used in nursing research to explore interactions between nurses, patients, and mobile work phones, has triggered reflections on potentials for change in this regard. As described in Chapter 2, phenomenological and hermeneutic perspectives are prevalent in nursing science, with common methods being ethnographic observations and interviews. Ethnographic observations do not capture in detail the embodied choreography used by nurses, which precludes analysis of the way that interactions are collectively accomplished, which has been used in this thesis to reveal the strategies used by nurses to manage phone calls during interactions with patients. As the strategies nurses use to enact both the discourse of patient-centred care and the discourse of being efficient when they answer mobile work phones are probably not, or at least not always, conscious to them, they also would not likely arise in interviews. Video ethnography is demonstrated in this thesis to hold great potential for the generation of knowledge about nurse-patient interactions. The thesis also demonstrates that the analysis of nurse-patient interactions can profit from ethnomethodological and nexus analysis perspectives. It is my ambition to propagate its potential benefits in the hope that other nurse researchers draw inspiration from this effort and that theoretical and methodological multiplicity within nursing research is encouraged.

The findings of this thesis have also triggered reflections on potentials for change in the nursing curriculum. The analysis of the seven situations in which nurses were engaged in close interaction with a patient when the mobile work phone rings revealed a striking variation between experienced nurses and a nurse who recently joined the department. Experienced nurses were able to employ tactile resources to enact the discourse of patient-centred care during phone conversations, whereas the newly employed nurse did not display this skill. This analytical observation prompts reflections concerning the nursing curriculum, in which the use of technologies in nursing practices is only briefly addressed. In the North Denmark Region where the present study is situated, three lessons on information technologies are scheduled. These lessons centre on technologies as a concept and on the various computer software systems used in hospitals (University College Nordjylland, 2015). The findings of this thesis may profitably also be included in the teaching of nurse

students. One way of doing this could be to employ the conversation analytic role-play method developed by Elizabeth Stokoe (2014). This approach to training communication skills uses video recordings of actual encounters as a way to examine communicative practices in detail. Traditional methods for teaching communication skills in the nursing curriculum like role play or simulation differ systematically from actual events (Stokoe, 2013), whereas the conversation analytic role-play method generates evidence about the effectiveness or lack thereof of different communicative practices on an empirical basis. The strategies developed by nurses in the nexus of practice can in this way serve as examples of practices that lead to nurses successfully or unsuccessfully enacting the discourse of being efficient and the discourse of patient-centred care simultaneously during their interactions with patients and mobile work phones. Using this as a frame for discussion and evaluation may provide nurse students an unique unparalleled opportunity to examine communicative practices and to understand what works.

CHAPTER 17. DISCUSSION

As outlined in Chapter 3, this thesis constructs a combination of theories and methods in order to straddle the heterogeneous and subtle aspects involved in the complex, multi-actor, technology-mediated practices of nurses using mobile work phones. For zooming in on the situated accomplishment of interactions between nurses, patients, and mobile work phones the analysis has drawn on the insights and toolkit of ethnomethodology (Garfinkel, 1967) and interaction analysis (Jordan & Henderson, 1995; Streeck et al., 2011). To transcend the boundaries of the incidental and look at the influences shaping the interaction, nexus analysis (R. Scollon & S. W. Scollon, 2004) was used to connect the situated social action with the elsewhere-and-then. This chapter offers reflections on the construction and utilisation of this research framework and on the specific contributions of this thesis.

17.1. DISCUSSION OF THE RESEARCH FRAMEWORK

The main reasons why Nicolini proposes a package of tools and methods to be applied to the study of practices is to "provide a richer and more nuanced understanding of the world, and not to offer simplified answers to complex questions" (Nicolini, 2012, p. 215). In this thesis, nexus analysis as the overall research framework has been supplemented and refined with interaction analysis as a way of favouring complexity and nuance in the analysis of interactions between nurses, patients, and mobile work phones. Used separately, nexus analysis and interaction analysis would have been able to shed light on this phenomenon from their own perspectives. An analysis based on ethnomethodology and interaction analysis would have focused on the embodied accomplishment of interactions between nurses, patients, and mobile work phones in the material world. However, this type of analysis would not have taken institutional matters and power relations into consideration, unless they were visibly manifested in the actual actions under analysis. Using only interaction analysis this thesis would thus have been able to provide detailed descriptions of the bodily choreography of interactions between nurses, patients, and mobile work phones, but without appreciating how those interactions are affected by cultural, historical, and discursive currents.

Using only nexus analysis, without the refinements drawn from interaction analysis, this thesis would have been able to investigate the motives and discourses circulating among the interactions between nurses, patients, and mobile work phones and to connect them to other times and places. This analysis, however, would have had to rely on a less sophisticated toolkit for the in-depth investigation of the way those interactions are accomplished and perform an analysis on a broader level;

focussing on accounts and formulations in passages of talk, and addressing the wider interpersonal and social functions.

Switching between theoretical sensitivities and exploiting the strengths of various theories has allowed this thesis to analyse the many dimensions and complex interrelationships of interactions between nurses, patients, and mobile work phones. Investigating how discourses are put into practice by nurses in interactions with patients and mobile work phones, the analysis is sensitive to the basic building blocks of social interaction and the multiple modalities of communication that constitute interaction. At the same time, the analysis transcends the boundaries of the here and now and appreciates not only embodied and material dimensions but also the cultural, historical, and discursive dimensions of the interactions. Supplementing nexus analysis with interaction analysis has thus offered a repertoire of resources, which has made it possible to produce thicker descriptions and achieve more nuanced understandings of interactions between nurses, patients, and mobile work phones from a multi-layered perspective. It further responds to criticism that interaction analysis is too rigorously empirical and fails to address core sociological issues, and to criticism that discourse analysis often fails to warrant its analytical claims empirically (Wooffitt, 2005).

17.1.1. THE CHALLENGE OF COMPLEXITY

By incorporating different angles of interpretation, this thesis allows both the detailed features of practices and their associations to come to the fore. During the process of analysis, it proved impossible, given the sheer scale involved, to embrace the full complexity of interactions between nurses, patients, and mobile work phones. The close analyses of interactions rely on seven videotaped situations, which constricts the dimensions analysed. Ideally, all recorded interactions between nurses, patients, and mobile work phones should be included in an analysis, as each has the potential to contribute unique observations and understandings, but the resources required do not accord with the production of a thesis. Likewise, mapping the countless number of semiotic cycles circulating in the interactions proved to be unachievable. Although Scollon urges preserving the complexity of social situations (R. Scollon, 2001a), Scollon and Scollon, in their nexus analysis field guide, acknowledge the impracticality of mapping all semiotic cycles: “In thinking of these cycles do not try to map all the semiotic cycles of every person, discourse, or object that occurs within the place where the action is occurring” (R. Scollon & S. W. Scollon, 2004, p. 160). Relinquishing the aspiration of preserving the full complexity does not imply the inadequacy of nexus analysis; rather, it reflects the immense complexity of human interaction. This complexity is the reason for Nicolini’s proposal of a toolkit approach, which acknowledges that no single theory or method is capable of producing nuanced understandings of human practices

(Nicolini, 2009). From this, it follows that it is impossible to encompass the full complexity of interactions between nurses, patients, and mobile work phone in a Ph.D. thesis. Supplementing nexus analysis with interaction analysis has enabled this thesis to generate insights into an important segment of the complexity of such interactions for later studies to supplement and refine. Thus, although the dimensions included in the analysis have been limited to some degree, the research framework constructed for this thesis helps compensate by suggesting a way to handle the complexity of analysing social interactions.

The repertoire of resources made available by interaction analysis and nexus analysis for the investigation of interactions between nurses, patients, and mobile work phones did not entail ready-made conceptions of this phenomenon. Neither did the package of theories and methods dictate how inquiries of it should unfold. Rather, the investigation of interactions between nurses, patients, and mobile work phones took as its point of departure the actions of nurses and what those actions displayed as relevant. Every phase of the research process was guided by the participants' perspectives. Inquiries followed the lead of participants and pursued connections to other actors, places, and times, gathering as much data as possible on the way. For instance, it was the utterances and actions of nurses in concrete interactions that caused me to contact other key actors such as Ascom, to visit other places such as departments at the university hospital, and to pursue links to other points in time by reaching out to the regional construction department. By mapping the nexus of practice, the discourse of patient-centered care and the discourse of being efficient were not only manifested in texts of governing authorities, but also in the utterances and actions of nurses working in the department. The participants' perspectives thus delimited the complexity and focused the analysis. Performing the analysis of interactions between nurses, patients, and mobile work phones was based on the perspectives of ethnomethodology and interaction analysis. Their analytical perspectives centre on participants' display of how they understand the situation and how their actions are meant to be understood. Hence, in every phase of the research process, from engaging the nexus of practice and gathering data to mapping the nexus of practice and focusing the inquiry and finally to conducting the actual analysis, the participants' perspective has been pursued. This has prompted this research process to develop in directions that were not predicted, and has focused my inquiries on what the participants themselves have demonstrated to be relevant. The complexity of analysing interactions between nurses, patients, and mobile work phones has thus been approached in two ways; by complementing nexus analysis with interaction analysis to take advantage of the analytical sensitivities of both and by letting the perspectives of participants guide and focus the inquiries.

17.2. DISCUSSION OF RESULTS IN RELATION TO RESEARCH ON MOBILE PHONES

As outlined in Section 2.4.2, social studies report that people talking on a mobile phone turn away from those in front of them and treat others as disembodied (Turkle, 2008), distance themselves from others present and turn their bodies away (Ling, 2004), and move their heads and bodies away from others present (Murtagh, 2002). Furthermore, studies report how the attention, mind, and senses of people speaking on mobile phones are drawn to the mediated conversation on the phone (Fortunati, 2002), and how, by excluding others, they define those authors as secondary and possibly not significant (Gergen, 2002).

In the analysis of case seven, "The newcomer", the nurse is seen to act in ways that corroborate these perspectives by distancing herself from the patient and by turning her back towards the patient. During the first part of the phone conversation the nurse excludes the patient and defines her as secondary in these ways, and the attention of the nurse is drawn to the phone conversation. The actions of this nurse, who has only been working in the department for four months, are thus in agreement with the conclusions of the research listed above.

The ways in which experienced nurses take action stand in contrast with this relative newcomer. In cases one to six, the analysis demonstrates how nurses maintain close proximity to patients and display sophisticated perceptual awareness towards patients. Rather than acting in ways which make the patient lose significance, experienced nurses act in ways which exhibit the patient as central when they respond to a ringing mobile work phone, a key finding made abundantly clear in the close analyses of cases one through six. Experienced nurses achieve this by employing tactile resources and embodied orientations, though the precise ways in which they organise courses of actions varies with the different contextual configurations. The findings of this thesis thus also contribute to the understanding that the ways people use mobile phones are influenced by numerous situated conditions (Arminen & Weilenmann, 2009; Katz & Aakhus, 2002; S. Raudaskoski, 2009).

The analysis in this thesis demonstrates that mobile work phones do not preclude experienced nurses from enacting the discourse of patient-centred care when they answer the phones. Although the activity of answering the phones may confine the multimodal repertoire available to nurses for enacting the discourse, experienced nurses are able to compensate by using the embodied resources available. However, the statements of nurses in studies on mobile work phones presented in Chapter 2 do not seem to reflect this outcome. As outlined in Section 2.4.3.2, nurses report that the phone "takes out the communication" between them and the patient, or makes them feel "out of it" (Klemets et al., 2013, p. 331). They explain how the phones can cause them to "lose the moment" in interactions with patients (McGillis Hall et al.,

2010, p. 173) and that the phones have "nothing to do inside a patient room" (Kristiansen, 2011, p. 4). Similar perceptions were articulated in the nexus of practice 18 months prior to the present study. In the minor ethnographic study conducted in 2012, nurses articulated how the phones make "conversation stop" and how they think "oh no – not now" when a phone rings during interaction with patients (Paasch, 2014). Section 15.2 further described how nurses working in departments at the university hospital articulated that mobile work phones "cause disturbances inside patients' rooms" and how if they are with a patient they cannot answer the phone.

This apparent incongruence between the conceptions of nurses and the findings of this thesis led me to revisit transcripts of interviews conducted for the minor ethnographic study carried out in this nexus of practice 18 months earlier (Paasch, 2014). Two of the nurses participating in the video recordings of the present study had also participated in interviews in the earlier study, which enables me to link utterances of specific nurses with their concrete actions in videotaped situations. In the interview 18 months earlier the nurse in case one, "The work of a thumb", said that a phone ringing during an interaction with a patient "does something both to me and to the patient" and how it makes her "feel a little out of it myself, too" (nurse 12, 23.11.12).[77] The nurse in case two, "Anything important", in an interview conducted for the minor ethnographic study said that when a phone is answered during interaction with a patient, "one breaches their trust" and acts "as if I don't care" (nurse 1, 30.11.12).[78]

Incongruence between the utterances and actions of participants has been addressed by researchers who have proposed that video ethnography has the capacity to bridge the gap (e.g., Iedema, 2007; Jordan & Henderson, 1995). However, the video data for the present study was recorded two and a half years after the interviews for the minor ethnographic study was conducted. The historical perceptions expressed by the two nurses in the interviews may have changed in the interim, as their historical bodies evolve and new practices of using the mobile phones are developed. The dissimilarity between the perceptions expressed by the two nurses historically and their embodied conduct in the videotaped cases may well reflect a development of their practices over time. It may also indicate that these two nurses are not even aware of the expertise they have developed in enacting the discourse of patient-centred care by using the embodied resources not required to manage the phone call. It is, however, also important to consider the interactions taking place in the interviews conducted with the two nurses in the earlier study. The utterances were articulated in interactions with me, a nurse teacher who had an agenda, and involved their expressing something about themselves in the situation. In the interactions, matters of identity were thus at play, such as being a "good" nurse. What the two nurses said in these interactions is thus not necessarily directly transferable to the

[77] "det gør jo et eller andet både ved mig selv og ved patienten", "kommer også selv sån lidt ud af det".
[78] "bryder deres tillid", " som om jeg er ligeglad".

way they took or take action in other situations. Instead, the utterances produced by the two nurses long before the video recordings were conducted may be considered to articulate what they understood to be essential in nursing. In this light the preoccupations and concerns expressed by the two nurses may reflect what motivated them to develop ways of enacting patient-centred care while answering mobile work phones.

17.3. DISCUSSION OF RESULTS IN RELATION TO RESEARCH ON EMBODIED CONDUCT

The analysis in this thesis demonstrated how experienced nurses are able to enact both the discourse of being efficient and the discourse of patient-centred care when they answer mobile work phones during interactions with patients. The analysis highlights the embodied conduct of nurses and displays it to be crucial to the understanding of the practices of nurses. However, as laid out in Section 2.2.2, the embodied conduct of nurses in interactions with patients remains largely unexplored. Nursing literature often cites touch and holding the patient's hand as ways to conduct care (Benner et al., 1996; Eriksson, 1998; Martinsen, 2010; Scheel, 2005). Interview studies have explored how nurses and patients experience the use of touch (e.g., Borch & Hillervik, 2005; Estabrooks & Morse, 1992; O'Lynn & Krautscheid, 2011), and observational studies have explored when and why touch is used (e.g., Routasalo & Isola 1998; Van Dongen & Elema 2001). However, little empirical knowledge exists about the concrete ways in which care is enacted through embodied conduct. In a fieldwork study Bundgaard, Sørensen, and Nielsen investigated the use of physical touch in an outpatient clinic (2011). They found that physical touch was applied to serve relational aspects and build a nurse-patient relationship. They also ascertained that the use of physical touch can be a way of conforming with caring aspects of nursing, but that it is a highly complex matter.

This thesis contributes with key insights into the embodied conduct of nurses in several ways. It demonstrates how nurses maintain their bodies, including their gazes, so as to be oriented and directed to patients during phone conversations so as to sustain a close embodied participation framework. It demonstrates concrete ways in which care is enacted through the use of tactile resources, when nurses smooth or tidy patients' clothes during phone conversations. Furthermore, it demonstrates how holding a patient's hand is not simply *holding* the hand but also squeezing it and stroking it. This often cited and apparently simple action of holding a patient's hand is revealed in the close analysis to consist of a series of subtle and carefully timed micro actions that are used as a sophisticated resource to achieve intersubjectivity.

In these ways this thesis contributes insights about the embodied conduct of nurses, about the ways nurses use tactile resources in concrete situated actions to enact care, and about the ways a nurse-patient relationship is achieved. Subscribing to a growing body of embodied interaction studies, this thesis thus demonstrates the potential for interactions analysis in nursing research and highlights the significance of applying this perspective to explore the practices of nurses.

CHAPTER 18. CONCLUDING REMARKS

The aim of this thesis was to explore if and how nurses are able to enact care in interactions with patients and mobile work phones. To investigate this, several strands of practice theories were mobilised. Nexus analysis served as the overall research framework with the aim of connecting the concrete actions of nurses with the social, cultural, and historical currents that influence them. To explore the situated accomplishment of interactions between nurses, patients, and mobile work phones in detail, the nexus analysis was supplemented with insights and methods from ethnomethodology and interaction analysis.

To answer the research question, 144 hours of video recordings of a Danish hospital department were obtained. A multitude of additional empirical data was collected by participating in the nexus of practice and following trajectories to other times and places. The empirical investigations generated a data corpus consisting of participatory ethnographic observations, video recordings, interviews, photos, documents, and webpages. Logging the 144 hours of video data was carried out by identifying events and registering the actors participating in them and the actions that took place. In this process, 47 events in which only one nurse, one patient and one mobile work phone participated were identified. Seven of those events in which the mobile phone participated by producing a ring and in which the nurse was simultaneously performing actions in close proximity to the patient, including actually touching the patient, were selected for further examination. In mapping the numerous semiotic cycles circulating in the videotaped interactions between nurses, patients, and mobile work phones, the discourses of being efficient and of patient-centered care were exhibited as ubiquitous. On this basis a close interactional analysis was performed on each of the seven situations to investigate how nurses distribute orientations and how they organise activities. Subsequently, the analytical implications of the close interactional analyses were connected with the ubiquitous discourses circulating in the nexus of practice, and connections to other times and places were analysed.

The analysis of this thesis has revealed how experienced nurses in six of the seven analysed cases foreground the discourse of patient-centred care and postpone their enactment of the discourse of being efficient when their mobile work phone rings during interaction with a patient. Nurses in the six cases are shown suspending, rather than abruptly terminating, the activity with the patient in a way that was intelligible to the patient before answering the phone. As the nurses subsequently put the discourse of being efficient into practice by answering the phone, they are demonstrated to enact simultaneously the discourse of patient-centred care through the use of tactile resources and embodied orientations. In contrast, the analysis of a case featuring a nurse who had been in the department for four months demonstrates

how the nurse immediately foregrounds the discourse of being efficient as the mobile work phone rings and discontinues her enactment of the discourse of patient-centred care. In using these strategies, this nurse does not accomplish intersubjectivity and leaves the patient exposed to inexpedient trajectories of actions.

The analyses of the seven cases show that for nurses to enact care while answering a mobile phone during interaction with a patient requires them to master multiactivity by providing attention to both the patient and the phone. This requires nurses to compensate for the embodied resources required to handle the phone conversation by employing their remaining embodied resources; their specific solutions depend on the complex features of each on-going situation.

This thesis is not able to offer a comprehensive list of the concrete ways in which nurses deal with ringing mobile phones during interactions with patients. Connecting the analyses performed on the seven videotaped cases with other environments has revealed that nurses in other hospitals have developed different strategies for managing the practical problem of mobile work phones ringing during interactions with patients. These practices are however not investigated in detail and it therefore remains unexplored if and how nurses are able to accomplish patient centred-care by employing other strategies.

Connecting the analyses of the seven cases with other points in time has suggested that the strategies used by experienced nurses to foreground the discourse of patient-centred care and for postponing their enactment of the discourse of being efficient, and for putting both into practice simultaneously are developed over time, at least in the specific hospital department investigated. This means that the strategies revealed in this thesis will continue to evolve. This thesis offers only a glimpse – if a revealing glimpse – into some of the multiple dimensions circulating in a small but strategic selection of recorded interactions between nurses, patients, and mobile work phones, at a certain point in time. Hence, further research is clearly warranted; some possibilities for future research are suggested below.

18.1. FURTHER RESEARCH

The package of theories and methods constructed for this thesis has enabled it to explore the concrete practices of nurses as they unfold. It has thus bridged phenomenological philosophies of care with the way that care is put into practice in the concrete actions of nurses. It has also demonstrated the potential that interactional and discursive perspectives and video ethnography have for nursing research. This opens up a wide range of future possibilities of research.

First of all, this thesis leaves multiple dimensions of interactions between nurses, patients, and mobile work phones unexplored. Close interactional analyses have only been performed on a selection of seven situations in which the mobile phone participated by producing a ring and in which the nurse was simultaneously performing actions in close proximity to the patient. This leaves the majority of the 144 hours of video data recorded for this thesis unexplored. By analysing other constellations of actors performing other types of actions, more dimensions can be revealed. Likewise, the analysis of this thesis has focused on the discourse of patient-centred care and the discourse of being efficient which were exhibited as ubiquitous in the nexus of practice. This still leaves available for further research the enactment of numerous other discourses circulating in the nexus of practice. The analysis performed in this thesis has focused on the ways that nurses enact care. Although patients may play a less active part in the enactment of care, they nevertheless cooperate in its achievement. An analysis focusing on the ways that patients make their contributions could reveal additional dimensions of nurse-patient interactions.

This thesis also leaves the practices of using mobile work phones in other hospital departments unexplored. Investigating the strategies used by nurses to manage phone calls during interactions with patients in other hospitals could reveal what is accomplished when different strategies are employed and might make it possible to point to strategies that are more expedient for accomplishing patient centred-care than others. Another fruitful line of research that I would like to explore is the development of nurses' practices over time. Because of recent organisational restructurings and a high staff turnover in medical wards, several nurses in the nexus of practice were novices in regard to using mobile work phones. The analytical findings of this thesis suggest that the skill of enacting both the discourse of patient centred-care and the discourse of being efficient in interactions with patients and mobile work phones are developed by nurses over time. Likewise, other practices of using the mobile work phones, such as shielding patient rooms, were not enacted by newcomers. In future research I would thus like to scrutinise how the practices of nurses develop over time and how their methods for embodied interaction evolve.

In line with the considerations put forward in Section 17.3, another valuable area of further research is the way that nurses use tactile resources in their embodied conduct. As outlined in Section 2.2.2, this area of research has been more or less neglected, with little knowledge existing about the way, for instance, touch is used in situated actions. The present analysis has revealed the sophisticated way in which tactile resources can be used when verbal resources are occupied by a phone conversation. Future research concentrating on embodied aspects of nurses' practices is likely to reveal more dimensions of touch as a meaning-making resource.

The contributions to knowledge generated by the areas of research above would not only be significant for nurse students and recently qualified nurses who are still learning the embodied practices of nurses but also for nurses throughout their careers. From mapping the nexus of practice it is evident that the practices of nurses are influenced by the many actors and authorities that place expectations on them. Knowledge about the ways that nurses navigate such expectations in concrete interactions with patients is crucial for on-going efforts to improve communication and patient experience and to achieve strategies of improved quality and efficiency.

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APPENDICES

Appendix A.

AALBORG UNIVERSITET

Kære bruger af Sygehus Vendsyssel.

Jeg er sygeplejerske, og er lige nu i gang med et forskningsprojekt på Aalborg Universitet, hvor jeg undersøger sygeplejerskers arbejde. Sygeplejerskers arbejdsdag er meget kompleks, fordi de hele tiden skal tage sig af mange opgaver samtidig, og ofte må ændre planer. Samtidig forventes de at tage sig godt af patienterne - men er det muligt? For at undersøge det, har jeg fået lov til at følge sygeplejersker i denne afdeling med et videokamera. Formålet er at undersøge, hvordan sygeplejersker håndterer de mange forskelligartede krav i deres arbejde.

Jeg vil gerne optage sygeplejerskerne i alle arbejdssituationer, og derfor vil jeg bede om lov til også at videofilme dig, hvis den sygeplejerske jeg følger er sammen med dig. Det er helt frivilligt om du vil være med i forskningsprojektet, og det får ingen betydning for din nuværende eller fremtidige behandling på sygehuset, hvis du ikke har lyst til at deltage. Hvis du siger ja, kan du til enhver tid fortryde dit tilsagn og udgå af projektet. Du kan kontakte mig via nedenstående oplysninger, så vil jeg straks slette alle videooptagelser hvor du medvirker.

Hvis du siger ja til at deltage i projektet, vil du blive filmet på video hvis den sygeplejerske som jeg følger, kommer til dig. Videooptagelserne vil være strengt fortrolige. De bliver forsvarligt opbevaret på Aalborg universitet, hvor andre ikke kan få adgang til dem. Ansigterne på videooptagelserne sløres, og navne m.m. slettes, så det ikke er muligt at identificere personerne på dem. Det er kun mig som ser videooptagelserne, med mindre du giver tilladelse til andet. Du har også mulighed for at bestemme om filmen må bruges når resultaterne af projektet skal fremlægges eller ej. Dette gøres ved afkrydsning på næste side.

Hvis du på noget tidspunkt har spørgsmål, kan du altid kontakte mig på telefon:72 69 12 40 eller mail: bpaasch@hum.aau.dk

Med venlig hilsen

Bettina Sletten Paasch
Ph.d.-studerende, lektor og sygeplejerske
Aalborg Universitet og University College Nordjylland

1

Tilsagn om deltagelse i forskningsprojekt om sygeplejerskers arbejde

Jeg bekræfter at have modtaget skriftlig og mundtlig information om projektet, der ved hjælp af videooptagelser undersøger sygeplejerskers arbejde. Jeg ved at det er frivilligt at deltage, og at jeg til enhver tid kan fortryde mit tilsagn om deltagelse. Jeg har læst ovenstående, og giver hermed tilladelse til brug af optagelserne i det angivne omfang:

Optagelserne må benyttes til analyse af forskningsprojektets formål.
Ja ☒ Nej ☐

Optagelserne må analyseres sammen med forskerkollegaer.
Ja ☒ Nej ☐

Optagelserne må bruges i videnskabelige publikationer (anonymiseret).
Ja ☒ Nej ☐

Optagelserne må benyttes til konferencer og møder for forskere (anonymiseret).
Ja ☒ Nej ☐

Optagelserne må benyttes i forbindelse med undervisning (anonymiseret).
Ja ☒ Nej ☐

Optagelserne må benyttes til foredrag (anonymiseret).
Ja ☐ Nej ☒

Optagelserne må benyttes til analyse i senere forskningsprojekter.
Ja ☐ Nej ☒

Dato: 13/6-14 Navn: [redacted]

Evt. mail/tlf: [redacted] Underskrift: [redacted]

2

SUMMARY

In this thesis, Bettina Sletten Paasch conducts research on the use of mobile work phones in the practices of nurses. On-going demands for efficiency have triggered the implementation of multiple technologies in Danish hospitals. One such technology is mobile phones. With care being a key value in nursing, a potential tension arises when nurses have to attend simultaneously to both a patient and a ringing mobile work phone. Using discursive and interactional approaches, this thesis explores if and how nurses are able to enact care during interactions with patients when mobile work phones intervene in those encounters.

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