Global Qualitative Nursing Research
Volume 3: 1–9

DOI: 10.1177/2333393616643201
gqn.sagepub.com
SAGE

Expertise in Everyday Nurse–Patient Conversations: The Importance of Small Talk

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Abstract

A great deal of nursing activity is embedded in what is considered to be everyday conversation. These conversations are important to health professionals because communication can affect health outcomes, and they are important to patients who want to know they are being heard and cared for. How do nurses talk with patients and what are the features of effective communication in practice? In this exploratory study, two expert nurses recorded conversations with patients during domiciliary visits. Linguistic discourse analysis, informed by contextual knowledge of domiciliary nursing shows the nurses skillfully used small talk to support their clinical work. In their conversations, nurses elicit specific information, normalize unpleasant procedures, manage the flow of the interaction, and strengthen the therapeutic relationship. Small talk can be big talk in achieving nursing goals. Critically reflecting on recorded clinical interactions can be a useful method of professional development and a way of demonstrating nursing expertise.

Keywords

communication, discourse analysis, education, professional, health care, nursing, relationships, patient-provider

Received July 20, 2015; revised February 29, 2016; accepted March 9, 2016

The starting point for this study was sparked by an overheard conversation. Two student nurses were discussing their time out in the community with experienced domiciliary nurses. One told the other that her nurse had "done nothing much just talked to people." This almost throw-away comment led to my interest in exposing and explaining the unrecognized but powerful nature of conversations between nurse and patient, which lie at the heart of nursing practice. The student had not recognized the talk for what it was, and the experienced nurse had not articulated the purpose and value of the talk. Do we recognize the value of these conversations?

In my work as a district nurse for 12 years, there was regular opportunity for collegial discussion, both formal and informal, of day-to-day activity. However, the role and importance of conversations with patients were not broached even among experienced health professionals except perhaps where communication failed. Little time was spent reflecting on the consequences of diminishing opportunities for unhurried and uninterrupted interaction with patients or on the need to work speedily while attending to the norms of visiting in a domiciliary setting.

With increasing use of personal medical technology and the potential for a corresponding reduction in actual contact time between nurses and patients, an understanding of the significance of everyday nursing talk is of even more importance.

Clinicians usually recognize interactions with patients that go particularly well, and they can also recognize (and have a sense of unease) when they are unable to communicate optimally with patients. At the same time, clinicians may not realize when they have not elicited a full or accurate story from a patient, nor do they necessarily know when a patient has not fully understood something. Both of these possibilities can affect actual health outcomes and patient satisfaction. The question that arises is as follows: What makes the good interactions good? If we record and examine the communication between expert nurses and patients, where much of the nursing work is accomplished via talk, what will we find and what can we learn?

Learning how to have more of the "good" conversations was the impetus for the study.

In this article, I make explicit the details of what is actually being communicated and done during seemingly everyday conversation between nurse and patient and discuss the

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value of observing expert talk as a professional development tool. Taking an appreciative approach (Cooperrider, Whitney, & Stavros, 2008; Preskill & Coghlan, 2003; Reed, 2007), identifying what was good and building on it seemed a natural starting point.

Context of Conversation During a Domiciliary Visit

Nurses who make domiciliary visits have an explicit purpose: to attend to the health and well-being of patients, in their own home setting. Attending to any immediate health issues is the explicit or "transactional" purpose (Cheepen, 2000; McCarthy, 2000). The domiciliary setting gives rise to a second, implicit, purpose: It exerts strong contextual weight on the commitment made by domiciliary nurses to work in partnership with patients (Christensen, 1990; Jones, Ingham, Cram, Dean, & Davies, 2013) in what may be a relatively long-term intermittent health care relationship. Such a partnership deliberately seeks to enhance collaboration and reduce any perceived power differences between the nurse and patient. This may involve teaching and guiding patients toward managing their changing health circumstances. Sometimes, it means managing a lifelong illness or coming to terms with the certainty of a poor prognosis.

This second implicit purpose of these conversations can be easily overlooked. An experienced nurse understands the added function of these interactions, to establish, maintain, and build on a therapeutic relationship. This includes sharing the patient's emotional burden of illness, and strengthening the patient's position either through affirmation of the patient's own actions or through facilitating access to other help or information.

The nurse–patient conversations take place within the confines of limited time, and with the prospect of having to achieve many tasks during the domiciliary visit. The nurse does not have the luxury of time for much social chat, but at the same time does not want to risk appearing rude and uncaring by focusing only on the business of health without attending to the norms of everyday social interaction in a domiciliary setting. Context is important. The domiciliary setting places a nurse in the potentially conflicting role of guest and professional offering expert advice (Ceci & Purkis, 2009; Purkis & Bjornsdottir, 2006; Spiers, 2002). The location of nursing care—in the patient's home rather than in a hospital—creates a different dynamic between patient and nurse (Holmberg, Valmari, & Lundgren, 2012; McGarry, 2004). This dynamic is managed and navigated largely through conversation.

Studies of Language Use in Health Settings

Early studies of nurses' language use in health settings often focused on negative outcomes of communication, such as alienating patients with the use of jargon and technical terms (Wodak, 1996) or maintaining power differences (J. Coupland, Coupland, & Robinson, 1992; N. Coupland, Wiemann, & Giles, 1991; van Dijk, 1998). Later studies turned their attention to how to communicate in certain situations, for example, breaking bad news (Maynard, 2006; McGuigan, 2009), managing challenging behavior (Farrell, Shafiei, & Salmon, 2010), or talking with patients toward the end-of-life (Ekdahl, Andersson, & Friedrichsen, 2010; Fine, Reid, Shengelia, & Adelman, 2010; Gawande, 2014; Marcusen, 2010). There is also is a large body of literature that reports on the varying methods and degrees of success in teaching communication skills to the range of health professionals including nurses. However, despite the attention on communication and improving "communication skills," there is in fact relatively little on what actually happens (rather than what is recalled or reported to happen) in everyday interactions. There are few cases where conversations have been recorded so we know the detail of what is spoken in everyday interactions between patients and nurses, particularly expert nurse clinicians and, relevant to this study, in domiciliary settings. The work reported by Spiers (2006), based on 31 videotaped home visits is an exception. Her study explores the notion of stoicism through "the subtle communicative expertise of nurses . . . in patterns of expressing and responding to suffering" (p. 293).

Communication and Quality Nursing Care

There is increasing recognition that quality nursing care depends on establishing a collaborative nurse/patient relationship (Christensen, 1990; Fenwick, Barclay, & Schmied, 2001; Gunther & Alligood, 2002; Irurita, 1999; Johnson, 1993; Street, Makoul, Arora, & Epstein, 2009; Weiss, Goldlust, & Vaucher, 2010). For example, a study of communication in a neonatal unit (Fenwick et al., 2001) revealed that "chatting" between nurses and mothers was both the context for and the method by which a collaborative relationship was established and nursing care was delivered. The question, "How does communication heal?" is explored very usefully in a study linking clinician–patient communication to health outcomes (Street et al., 2009). They argue that although talk can be therapeutic in itself, the talk more often affects health outcomes more indirectly by, for example, building trust and increasing adherence. A similar notion is described in earlier work by others (Morse, Havens, & Wilson, 1997).

In the context of palliative care, the powerful nature of ordinary conversations between patients and health professionals is described very accessibly in a recent book (Gawande, 2014). In the book, Gawande tells how his early years in medicine were spent "learning how to properly diagnose and treat" (p. 3) and how to become familiar with what

he describes as the vast trove of discoveries and technologies amassed against illness; only to find how unprepared he was for the realities of inevitable decline and mortality faced by many patients. Later, he makes domiciliary visits with a palliative care nurse whose powerful yet deceptively simple conversations with patients reinforce how important it is to ask patients about their understanding of their situation, and their hopes and fears. He describes how such conversations can dramatically redirect clinical effort in a more helpful way for patients.

There remains a gap in our knowledge, however, of how this is achieved in ordinary conversations and particularly in exactly how expert nurses talk with patients. This article goes some way to addressing this gap by exploring the function of small talk as it occurs in clinical practice.

Definitions of Small Talk

In popular perception, small talk is seen as formulaic, peripheral, trivial, minor, or unimportant. However, sociolinguists explain that small talk is not as unimportant as first thought—and might be better described as off-topic chat, not concerned with the explicit purpose for which the speakers are together (Coupland, 2000a). The edited collection of papers titled "Small Talk," by Justine Coupland (2000b), provides a considered and comprehensive account and analysis of various aspects of small talk. The view of small talk as unimportant has been further challenged by others who demonstrate that small talk can serve a pivotal role in the workplace by furthering interpersonal and sometimes transactional goals (Holmes, 2000; Holmes & Stubbe, 2015). Some functions of small talk seem ambiguous or contradictory. For example, small talk can enable speakers either to approach or to avoid discussion of more serious topics. Small talk can put people at ease but can also cause annoyance and irritation. It fills or avoids silence and therefore defuses a situation where silence might be perceived as awkward or unfriendly (McCarthy, 2000). I was particularly interested in Tracy and Naughton's (2000) finding that small talk helps accomplish social goals such as "putting people at ease, building connection, winning approval and predisposing a listener to one's perspective" (p. 63). For the purpose of this research project, I define small talk as off-topic chat.

Method

I deliberately adopted an appreciative inquiry stance both at the outset and throughout the analysis (Hammond, 1996; Preskill & Coghlan, 2003; Reed, 2007; Srivastva, Cooperrider, & Associates, 1990) because this focused my attention on the positive aspects and existing strengths of nurse–patient communication. Potential participants were aware that I was interested in positive aspects of everyday communication, looking for what "worked well."

To investigate the features of effective communication in clinical nursing practice, two expert nurses audio-recorded conversations with a sample of patients during domiciliary visits. These recordings were the primary data for the study. This method draws on the characteristics of naturalistic inquiry (Lincoln & Guba, 1985) to develop a qualitative description (Morse, 2015; Sandelowski, 2010). Naturalistic inquiry occurs in a natural (rather than experimental) setting, with human participants and using tacit knowledge of social processes. Sandelowski (2010) refers to this as "entailing a commitment to studying phenomena in a manner as free of artifice as possible" (p. 79).

Several strategies were used to obtain typical, naturally occurring nurse–patient interactions as will be described below. After the visits, I conducted semi-structured interviews with the nurses, as secondary data, to note the clinical context and purpose of their visits, to help me interpret the content of the recordings, and to ask whether the recording affected the visit in any way. The interviews were guided by questions such as the following:

- Tell me about your recordings today. Who did you see (age, gender, main medical problem)?
- What was the purpose of the visit, what were your concerns about this patient?
- Did the visit go as expected or otherwise?
- Is there anything I need to know to help me understand your conversation?
- Do you think the recording affected the visit at all?

These interviews provided a supplementary component of data in case later analysis of the recording included any otherwise inexplicable references. During and after data collection, participants (both nurses and patients) were free to stop and start the recording, or edit and delete material, if they wished. This gave participants control over data collection and was less intrusive than having me present. In fact, none of the participants chose to edit or delete any material, and every recording was of the entire domiciliary visit. Recordings were transcribed independently by a professional transcriber.

Participants and Setting

Recruitment to the study happened in stages. First, the nurses were recruited and then they recruited patients. Nurses in this study were employed in the domiciliary service attached to a large metropolitan hospital. All eligible (i.e., expert) nurses in the domiciliary service were invited to participate, and I accepted the first two who volunteered. The health service is the major government-funded public (i.e., non–fee paying) health provider of primary, secondary, and tertiary health care in the city. The nurses primarily worked alone, attending to patients at home. They also had a role assisting those patients with transition into and out of hospital and working

in collaboration with many other health professionals to provide ongoing health support. Both nurses in the study had some teaching responsibilities as well as their clinical work, and so they were used to describing the nature and context of their work.

I purposefully recruited two expert nurses to record their conversations with three patients each. All participants (nurses and patients) were given a brief verbal description of the study along with written information, and all gave written consent prior to any recording. On three occasions, a third person (family or friend of the patient) briefly joined the recorded conversation. None of the three "extra" people gave written consent, but all were aware of the recording and all were given the opportunity to have their remarks deleted. There was no attempt to obtain an ethnic or gender balance in either the nurse or patient groups.

The nurse participants in this study were senior nurse clinicians, recognized both by their peers and by their employer as expert practitioners. Both nurses had been in full-time practice for at least 19 years. One had a postgraduate qualification and had been instrumental in establishing and integrating a new field of clinical service. The other had a specialist role and was known and sought after nationally for her expertise in that field. Both nurses were situated within the regular domiciliary nursing service and had everyday contact with a large team of domiciliary nurses. The two nurses chose the sample of patients. Inclusion criteria, determined before the start of the study, were simple, broad, and pragmatic. They were that the patients

- had met the nurse on at least two previous occasions
- were able to give informed consent
- were due to be visited by the nurse in the week chosen for data collection
- were 18 years or older.

Data Collection

Nurse participants nominated a time for data collection that suited them best. The nurses were shown how to use the recording equipment and were then able to operate it themselves. There was no pressure to complete data collection in a certain time. It was left largely to the discretion of the nurse participants. Allowing them to do this was one way of helping ensure the data were as natural as possible. Data consisted of six recorded nurse–patient interactions and six semi-structured interviews with the nurses. The nurse–patient data were collected in the course of domiciliary visits as part of a normal working day. In total, 2 hours and 35 minutes of audio-recorded interaction data were collected and transcribed. I was conscious of the need to allow the nurses time to collect data at a pace that suited their workload. I conducted the semi-structured interviews with each nurse in their office at the end of each data collection day. The interviews were prompted by questions described above.

One of the most obvious challenges to this type of research was to obtain data consisting of genuine naturally occurring conversations while attending to ethical concerns of informed consent, privacy, and confidentiality; and maintaining the existing trust between nurse and patient. To address these issues,

- the nurses nominated a time for data collection that suited them best, when they were not unduly stressed by other commitments
- the nurses selected patients who had met them on at least two previous occasions, so that they already had a rapport that would enable a natural flow of conversation during the recording
- I ensured the patients were allowed sufficient time to consider whether or not to participate (time ranged between 2 days and 2 weeks)
- the nurses used discreet recording equipment, worn or placed unobtrusively
- the nurses did the recording, so no extra outside person was present

Ethical Considerations

The Ethics Committee of the organization the nurses are employed by granted ethical approval for the study (Wellington Ethics Committee Ref. No. 01/02/008). All participants knew the purpose of the study. They agreed to participate voluntarily, on the understanding that they could withdraw at any stage without prejudice to any future care or employment. All participants, nurses and patients, gave written consent prior to any recording. Immediately before any recording, participants were asked whether they were still happy to participate on this occasion, and no pressure was exerted if there was any hesitation.

All raw data (recordings and transcripts) were stored in a separate folder within a password-protected archive of similar data. Access to this folder was restricted to me, the transcriber, and data manager. This database was securely stored on the university's firewalled institutional server. All transcripts were de-identified. I explained these arrangements to all participants both verbally and on the project information sheets.

Rigor

A lively debate has recently been reignited concerning measures of rigor in qualitative research (Greckhamer & Cilesiz, 2014; Morse, 2010, 2015; Sandelowski, 2010).

One of the two most obvious threats to validity in linguistic studies is in the authenticity of the data. This threat is sometimes called the observer's paradox. In other words, the process of gaining consent and the presence of recording equipment means that there is a heightened awareness of "being observed," and this may alter the nature of the

conversation. As described in the "Data Collection" section of this article, several strategies were used to minimize this threat. In fact, the nurse participants said they had "forgotten" about the recorder after the initial minute or so of each visit. The second major threat lies in the analysis where it is very easy to stray from the actual transcript and make assumptions about what is meant rather than giving primacy to the fine-grained examination of what is said, line by line. Clearly linking findings to excerpts of identified text is necessary to add strength to claims of transparency in analysis. Validity in qualitative research has to do with evidence of an auditable process and, in the findings, whether or not the explanation fits the description. "Can the description be recognised by others who have had the experience, or appreciated by those who have not had the experience?" (Morse, 2015, p. 1213).

Data Analysis

Analysis proceeded in stages. The main focus of data analysis was on the recorded conversations between the nurses and patients, complemented by the post-recording interviews with the nurses, which provided additional contextual information.

I reviewed the audio recordings and transcripts many times throughout the analytic process, initially looking for patterns with the aim of developing an in-depth characterization of how nurses and patients accomplish their work through talk. In linguistic discourse analysis, the aim is not to achieve "saturation" as it would be understood, for example, in traditional thematic analyses of interviews, but rather to ground the emerging analysis in the detail of the unfolding interaction. Analysis proceeded in iterative stages, starting with brief and broad descriptions of the content of each conversation, for example, categorizing sections such as "Greetings" or "Discussing Medication." A pattern emerged from the data revealing that the interaction in each domiciliary visit included four distinct elements:

1. negotiating the agenda
2. eliciting concerns
3. a physical examination
4. planning future care

Part of the emerging analysis, and a thread that I chose to follow, involved determining the proportions of social talk and clinical talk. It was not straightforward to distinguish between sequences of clinical and social talk, or to code and quantify these in any meaningful way. Many fragments of the conversations were categorized as both. The most obvious example is, "How are you?" but the blending of social and clinical talk was a strong and recurring feature of the data and prompted me to explore that blending in more depth.

Linguistic analysis examines *what* is said, *how* it is said, and how the talk is structured; as such, it can "help explain the relationship between what we say and what we mean and understand in a particular context" (Paltridge, 2000, p. 3).

The reality of everyday spoken interaction, as evidenced in the recorded conversations, is very different from the clarity and simplicity I had expected to find from expert nurses. As in all conversations, people rarely speak in full sentences (Crystal, 1981; ten Have, 2007; Wardhaugh, 1992), and the nurse–patient interactions are full of hesitations, false starts, repetitions, and utterances that trail off unfinished. What did emerge from this apparent disorder was a consistent pattern in terms of structure and content, and an impressive repertoire of successful communication strategies, one of which is the frequent use of small talk. I chose to examine the sequences of small talk more closely to see what the nurses were doing.

Findings

Expert nurses in this study used small talk as one of their strategies throughout their interactions to skillfully and economically support their clinical work. Small talk elicited and imparted information and built the therapeutic relationship.

Small Talk

Small talk serves many functions. Of particular relevance to my research, small talk helps accomplish social goals such as "putting people at ease, building connection, winning approval and predisposing a listener to one's perspective" (Tracy & Naughton, 2000, p. 63).

The following four extracts illustrate patterns I observed in the analysis. They are typical of what appears in the large data set.

Extract 1—Casual question gives clinically useful information. Extract 1 neatly illustrates the dual functions of the nurse's small talk in smoothing the social aspects of an interaction while doing important clinical work and, in this case, also signaling that the visit is coming to a close. The context of this domiciliary visit was that the nurse was still getting to know the young patient, who had bowel surgery with formation of an ileostomy. The nature of the surgery meant the nurse would expect to be seeing this patient for many months and possibly longer. The nurse wanted to find out how the patient was coping with convalescence during this uncomfortable time. Toward the end of the visit, she asked this general question:

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1  Nurse: Good, so what have you got
2  organised for today?
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The word "good" at the start of the sentence, followed by a small pause, signals the end of one topic and the beginning of the next. In this way, the nurse is indicating that the essential purpose of the visit is over and she is now preparing to finish up and leave the house. Although the question that follows sounded like a casual friendly inquiry, and a prelude to closing the conversation, the nurse in fact used it in a subtle and expert way to build a connection with the patient and to elicit clinical information. The nurse also managed the conversation in terms of timing. The patient replied that her friend has a day off work so they will probably do some errands and see a movie. From this reply, the nurse gained a sense of the patient's energy levels, mood, social network, and confidence to go out. These were all significant markers of the patient's convalescence and recovery.

Extract 2—Minimal small talk adds immediacy and sense of concern. In the next extract, the near absence of small talk where it would normally be expected added immediacy and a sense of the nurse's concern to this exchange. The context for this conversation was that the nurse had just parked her car and was approaching the patient's open front door.

```
1   Nurse: Good morning.
2   Patient: Good morning.
3   Nurse: Is it a smile?
4   Patient: Yes.
5   Nurse: Wonderful.
6   Patient: It's working like a dream.
7   Nurse: How fantastic Louise. Can I
8   remind you I've got the thingy on
9   [the recorder].
10  Patient: Yeah yeah sure.
11  Nurse: That's great, okay, hello
12  cat, okey doke.
13  Patient: You haven't got time for a
14  cuppa or
15  Nurse: No I'm fine for fluids this
16  morning. How about you?
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With virtually no preliminaries the nurse asked, "Is it a smile?" This extremely economical opening remark served many functions. It was a variant of "How are you?" but was more than a greeting. Here, the nurse elicited information from the patient, determining whether things were going well or otherwise. In doing this, she also gauged the effectiveness of her advice given on the previous visit. By convention, conversations have openings and closings, which are often categorized as small talk.

The minimal small talk here gave the impression that the nurse resumed a conversation after a brief break although it was in fact 2 days earlier. It suggests that what we heard was a fragment of a continuing conversation. A continuing conversation in turn implies that the nurse remained with the patient and there had been no break in the continuity of physical care. This was an interesting use of a linguistic convention as a tool. The nurse used the convention to create the illusion of continuity of care. It was particularly apt at this point in the patient's recovery. The transition from hospital into home, which the patient just made, was a stressful time. It involved adjusting from an environment where there was constant help at hand to a situation where the patient was home alone and having to cope. The notion of constant care by the nurse was highly desirable at this point.

Extract 3—Small talk to normalize unpleasant procedure. Small talk can also take the form of a commentary that functions to normalize unpleasant or unfamiliar procedures as in the next example where the nurse and patient are standing in the bathroom. The nurse is changing a colostomy bag.

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1   Nurse: now I'm just going to give
2   this a wee wipe.
3   Patient: Yep.
4   Nurse: Because I think if we don't
5   that we'll have a
6   Patient: Mess [faeces].
7   Nurse: A mess on the toe.
8   Patient: Yeah.
9   Nurse: Yeah that's miles better.
10  Patient: Yeah.
```

Here, the nurse used a repertoire of linguistic strategies simultaneously. The matter-of-fact tone and the nurse's commentary helped to normalize the process and reduce any sense of stigma or embarrassment the patient may have felt. In Line 7, the nurse used the words "on the toe," which minimized the mental image of what may actually occur. In Lines 7 and 9, the nurse echoed the words used by the patient. This linguistic mutual alignment reinforced the fact that they were undertaking a shared task and strengthened the notion of a partnership.

Extract 4—Tactful and diplomatic small talk. Small talk can be used as a strategy by which unpleasant or sensitive topics can be avoided or dealt with in an indirect manner. In the final example, the nurse used small talk as an exceptionally tactful and diplomatic way of eliciting information during a visit to a patient with chronic respiratory disease. The patient uses oxygen at home via a metered machine. While checking the equipment, the nurse noticed that far less than the prescribed amount of oxygen had been used, and that the tubing had been chewed. The nurse suspected the patient was not using the oxygen equipment as intended, but was not sure why.

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1   Nurse: How does your little dog like
2   this tubing?
3   Patient: Oh he hates that.
4   Nurse: Does he, yeah?
5   Patient: Yeah.
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Line 1 may have been intended and heard as a piece of small talk. It may have been simply acknowledging that pets are part of the family, but in fact, the nurse was also indirectly seeking an explanation for why the oxygen was being used far less than the prescribed time and commenting on how the tubing had been chewed up. The nurse wanted to give the patient an opportunity to admit and explain non-use but did not want to do this with a direct challenge that could have been seen as punitive. The nurse did not pursue the topic on this occasion. This was a time when small talk was used to avoid "big talk."

Discussion and Conclusion

Combining the tools of linguistic analysis with deep contextual knowledge enabled me to examine nurse–patient conversations, which lie at the heart of everyday domiciliary nursing practice. The findings reinforce the view that small talk can serve a pivotal role in the workplace by furthering interpersonal and transactional goals (Holmes, 2000; Holmes & Stubbe, 2015). I found that although the nurse–patient conversations appeared on the surface to be light and superficial, in each case, the nurse was working in a complex and effective way to achieve a therapeutic outcome using the conventions of everyday conversation as a powerful interactional and clinical resource.

A limitation of the study was that these interactions were small in number and inevitably localized and context-bound, so the specifics of how these nurses communicated may not in themselves be able to be generalized, although the higher level patterns observed can be. Another aspect to be considered lies in the assumption that the recorded interactions were typical of those that occur in clinical practice. Participants reported that they were entirely typical, and that the visits had proceeded in the usual way. Questions arise concerning whether or not the conversations would be different depending on factors such as age, gender, educational level, and socioeconomic status of the participants. The nurse participants reported that their recorded conversations were typical, and, as a colleague in the same field, they certainly resonated as being typical. Despite the small numbers of participants and interactions in my exploratory study, this article illustrates clinical situations that are readily recognizable and familiar.

If small talk fulfills a particular and important clinical function, as I suggest, it raises the following questions: Is small talk really small talk? Is small talk a skill that can be taught? In their use of small talk, expert nurses were role modeling a highly developed clinical skill. The nurse participants in this study were surprised at the analysis because they were unaware of, and underrated, this way of describing their expertise.

Here is an opportunity for professional development, for expert nurses to understand their skill and student nurses to learn from it. Expert nurses could use guided reflective practice to articulate the skill (and art) of using small talk to elicit important clinical information and manage the therapeutic relationship, and to show others how to emulate this.

The literature reports heavily on shortcomings and possible remedies for weaknesses and challenges in nurse–patient communication; however, there is little on what actually happens in positive interactions between patients and expert nurse clinicians. My findings build on the work of Johnson (1993), who made a valuable contribution in uncovering the voice of nursing in primary care practice. Her study of nurse–practitioner consultations explored how differences in ideology between medicine and nursing play out in clinical discourses. She described how expert nurses, through their conversation, systematically manage the main activities of each consultation, moving easily from one activity to the next while remaining alert to cues from the patient, which may signal other concerns or priorities. The nurses in her study were able to "divert from the strictly medical to the perceived concerns of the patient" (p. 156), to view immediate problems in a broader context, and therefore personalize solutions in a useful way.

My study contributes to our understanding of the function and value of what happens in conversations between nurses and patients. It heightens our awareness of the consequences of an everyday activity. Being able to review and re-examine a recorded clinical interaction as demonstrated in my study is a powerful learning tool.

The examples in this article have shown how small talk can be used to efficiently elicit large amounts of information, normalize unpleasant procedures, broach sensitive topics, and build therapeutic relationships. The success of the methodology also affirms that it is possible, with careful attention to ethical concerns, to record naturally occurring interactions in clinical practice. Analysis of talk-in-interaction using the tools of discourse analysis enables us to explore the detail of talk between nurse and patient as constructed turn by turn. The clinical "work" being done by the talk, which may not be immediately obvious, is revealed in this way. Such recordings can be productively used to critically reflect on practice as a method of learning and professional development. Examining the detail and significance of everyday nurse–patient interaction reveals how small talk has the potential to be big talk when it comes to achieving nursing goals.

Acknowledgment

I thank the nurses and patients who so generously participated in this study and also my colleagues for their unfailing encouragement.

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The

author acknowledges receipt of a grant from the University of Otago in support of publication of this article.

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