UNIVERSITY OF JYVÄSKYLÄ

NURSING STUDENTS' PROFESSIONAL ORAL ENGLISH COMMUNICATION SKILLS IN SIMULATED DATA

A Licentiate Thesis

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ABSTRACT

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Content and language integrated (CLIL) programmes became possible in Finland at the beginning of the 1990's. This study examines the professional oral English communication skills of students who took part in an English-enhanced medical-surgical programme in Lappeenranta Health Care Institute starting in 1994. The study aims to describe how professionally the students communicated with their patients in English in simulated work samples and in addition to consider the role of the students' general English language skills in the communication process. The data for the study was collected through a professional skills test that was constructed in cooperation with a nursing teacher involved in teaching in the programme. The nursing students took care of a wound and exchange students played the part of the patient.

The theoretical framework for describing professional competence in nursing is based on literature on nursing interaction and a theory of health communication. The Roper, Logan and Tierney (1980) model for nursing had been introduced to the students at the beginning of their studies and therefore this model was used as the core guideline in what the nursing students were required to be able to communicate in the wound care situation. A modified Model of Health Communication was defined on the basis of Northouse and Northouse (1985) Developmental Model of Health Communication to set the professional interaction into a theoretical framework of health communication.

The results of this study indicate that the nursing students' oral English language proficiency was sufficient for them to be able to communicate professionally in the simulated work samples. The fact that the students were novices in nursing seemed to influence the wound care situation more than their language skills. The students' general oral language skills had some typical English as a lingua franca (ELF) features but there was nothing that would have caused a real obstacle in negotiating and sharing meaning.

In this study, professional communication provides the context where language is used. Thus, language is part of professional communication. This aspect has been the challenge to CLIL education from the start but with the developing conception of language as dialogue, the gap between content and language may gradually start diminishing. The implications of this study are

based not just on the empirical part of the study but also on the theoretical discussion of research. The study offers some suggestions of how CLIL curricula could be developed in the light of current research.

Keywords: Content and Language Integrated Learning, CLIL, professional communication, health communication, English as a lingua franca, ELF, dialogue

TIIVISTELMÄ

HUMANISTINEN TIEDEKUNTA
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1990-luvun alussa Suomen lainsäädäntö mahdollisti opetuksen vieraalla kielellä (CLIL – Content and Language Integrated Learning). Tässä tutkimuksessa tarkastellaan englanninkielipainotteisessa sisätauti-kirurgisessa koulutusohjelmassa opiskelleiden sairaanhoidon opiskelijoiden ammatillista suullista englannin kielen taitoa. Koulutus aloitettiin vuonna 1994. Tutkimus pyrkii kuvaamaan miten ammatillisesti opiskelijat viestivät potilaiden kanssa simuloiduissa työnäytteissä. Lisäksi tavoitteena on tarkastella, mikä rooli opiskelijoiden yleisellä englannin kielen taidolla oli vietintäprosessissa. Tutkimuksen aineisto kerättiin näyttökokeella, joka laadittiin yhteistyössä koulutusohjelmassa opettaneen sairaanhoidon opettajan kanssa. Kokeessa videoitiin haavahoitotilanne, jossa kukin sairaanhoidon opiskelija hoiti potilaan haavan. Vaihto-opiskelijat esittivät potilasta.

Teoreettinen viitekehys sairaanhoitajan ammatillisen kompetenssin kuvaamiseksi perustui kirjallisuuteen sairaanhoidon vuorovaikutuksesta ja teoriaan terveysviestinnästä. Roper, Logan ja Tierneyn (1980) sairaanhoidon malli oli esitelty opiskelijoille heidän opintojensa alussa, ja siksi tätä mallia käytettiin tutkimuksessa keskeisenä kuvauksena siitä, miten sairaanhoidonopiskelijoiden edellytettiin osaavan viestiä haavahoitotilanteessa. Tutkimuksen modifioitu terveysviestinnän malli perustui Northouse ja Northousen (1985) terveysviestinnän malliin. Tätä modifioitua mallia käytettiin ammatillisen vuorovaikutuksen kuvaamiseen terveysviestinnän teoreettisessa viitekehyksessä.

Tutkimuksen tulokset osoittivat, että sairaanhoidon opiskelijoiden englannin kielen taito oli riittävä ammatillisen viestintään näyttökokeessa. Se, että opiskelijat olivat aloittelijoita omalla alallaan, näytti vaikuttavan enemmän haavahoitotilanteeseen kuin heidän kielitaitonsa. Opiskelijoiden yleiselle suulliselle kielitaidolle olivat ominaisia jotkin englantia lingua francana (ELF) puhuvien tyypilliset kielen piirteet, mutta ne eivät aiheuttaneet ongelmia merkitysten neuvottelemisessa ja jakamisessa.

Tässä tutkimuksessa pyrittiin kuvaamaan kieltä osana ammatillista viestintää. Tämä näkökulma kieleen on ollut CLIL-koulutuksen haaste alusta alkaen, mutta samalla, kun käsitys kielestä dialogina kehittyy, kuilu sisällön ja

kielen välillä voi vähitellen alkaa pienentyä. Tämän tutkimuksen johtopäätökset eivät perustu vain tutkimuksen empiiriseen osaan vaan myös aihepiirin nykyisen tutkimuksen tarkasteluun. Lopuksi tässä lisensiaatintyössä tehdään joitakin ehdotuksia CLIL-opetussuunnitelmien kehittämiseksi nykytutkimuksen valossa.

Avainsanat: Vieraskielinen opetus, CLIL, ammatillinen viestintä, terveysviestintä, suullinen kielitaito, englanti lingua francana, ELF, dialogi

FIGURES

TABLES

CONTENTS

1 INTRODUCTION

1.1 The study

This study examines the oral English language skills as part of professional communication skills of a group of students who were studying medical and surgical nursing through English in southeast Finland in the mid 1990's. This was a time when English enhanced study programmes started flourishing in the country. As the students were studying for a profession in which oral communication with patients and clients is central, the focus in the study is on oral professional communication and only secondarily on the students' general oral English proficiency. The latter is acknowledged as part of the communicative competence that the students need in their profession but professional communication in nursing has its own characteristics and requirements. It follows from this that studying for a profession through a foreign language entails describing professional oral communication. Another important area in this approach is the context of studying through a foreign language. This context, content and language integrated learning (henceforth CLIL) has become an established part of education in Finland as well as elsewhere in Europe (Eurydice 2006). Although the data of this study was collected a long time ago, it has not lost its validity as an example of language use in an international educational and professional context. With globalisation and increased migration, the CLIL approach and professional communication through English as a lingua franca has become an everyday challenge in education and health care in Finland (cf. Lehti, Järvinen and Suomela-Salmi, E. 2006 and Alitolppa-Niitamo, Fågel and Säävälä, M. 2013). Research, such as this study, is needed to develop content and language integrated programmes for nursing: increasing understanding of how content and language integrate for the purposes of professional communication is a key issue.

1.2 Background

The study has its origins in the internationalisation of the Finnish educational system that started at the beginning of the 1990's. The 1991-1996 national development plan of education in Finland made it possible for schools to implement bilingual programmes with the goal of supporting all levels of the educational system to internationalise (Hirvi 1994). Lappeenranta Health Care Institute was one of the first vocational institutes to start teaching in a foreign language. As internationalisation was encouraged and financially supported by the Finnish Board of Education, the institute was quick to take this opportunity to be on the cutting edge of this educational reform; an English language enhanced medical-surgical nursing programme was started in the autumn of 1994. When the first group participating in this programme was starting the second term of their studies, I was asked as an English language teacher to describe briefly to our teachers in an in-service training day what would happen to the students' English language skills during this programme. I had been teaching English as a foreign language for approximately ten years but I had no experience or theoretical knowledge of the effects of teaching professional subjects through a foreign language. I therefore tried to get hold of research on this in Finland and found none done in the vocational sector. This gave me the impetus start this study. The need to know more about professional communication in nursing is growing and since the 1990's the topic has extended to the role of Finnish in the nursing context in Finland. There are several recent studies on Finnish as a second language in nursing (e.g., Virtanen 2015 and Kela and Komppa 2011) but research on the role of English oral skills in the Finnish nursing context is harder to find.

1.3 Terminological considerations

Since the 1960s there has been a growing amount of empirical research directed to describing the characteristics of L2 learner language and how these change as acquisition takes place (Ellis 1994, 1). Although education in a second or foreign language has a long history in the Western world (Takala 1996, 9), teaching content through a foreign language (TCFL) was at the time of the onset of the programme a new phenomenon in Finland. This has been well reflected in the terminology. When the Continuing Education Centre of the University of Jyväskylä first started its national teacher in-service development in this area, it was called a TCE/TCFL Programme (Räsänen and Marsh 1994). TCE/TCFL referred to *teaching content through English/a foreign language*. In the report published by the Finnish National Board of Education in 1996 (Marsh, Oksman-Rinkinen and Takala, eds. 1996), a new term appears, TCFL is now referred to as *mainstream bilingual education*. Lehtonen, Lönnfors and Virkkunen-Fullenwider (1999) and Tella, Räsänen and Vähäpassi (1999) use TTE/TTFL to refer to *teaching*

through English/a foreign language. The term *plurilingual education* is also often used. Towards the end of the 1990's the developments in language education policy brought the term *content and language integrated learning, CLIL,* into use. (Nikula and Marsh, eds. 1997, 7.) For more recent overviews of CLIL policies, see Dalton-Puffer 2014 and Nikula and Mård-Miettinen 2014. According to Rauto and Saarikoski, in tertiary-level education content teaching through a foreign language without any language goals in the programme is referred to as *foreign-language-medium instruction* (Rauto and Saarikoski 2008, preface). This distinction between CLIL and foreign-language-medium instruction (FL-medium instruction) is not always clear. It seems that often the underlying assumption is that any type of FL-medium instruction equals to CLIL. In 2002 Marsh defines CLIL as follows: "CLIL and EMILE refer to any dual-focused educational context in which an additional language, thus not usually the first language of the learners involved, is used as a medium in the teaching and learning of nonlanguage content." (Marsh ed. 2002, 2).

Whether referred to as TCFL, mainstream bilingual education, plurilingual education or CLIL, by the end of 1990's, this type of education had been little researched in Finland. By 1996, as Takala points out, there were several small-scale studies but no comprehensive surveys (Takala 1996, 14). The situation has changed since then and now there is a lot research in CLIL in Finland but the interest has been mostly in CLIL applications in schools (e.g., Nikula 2016, Roiha 2014, Tainio and Harju-Luukkainen 2013), not in professional education in English. In this study, I will follow the European trend of referring to content instruction through a foreign language as CLIL. This is documented in various publications, for instance in the special issue on CLIL in the *Language Learning Journal* 2015 (Dalton-Puffer and Nikula eds. 2015). The choice of terminology clearly points to the dual focus of content and language integrated learning.

The CLIL approach has expanded in many European countries and on all levels of education; for example, Garotti (2007, 131) reports that in Italy, the number of schools experimenting with CLIL has increased more than half during a decade. This is hardly surprising as the CLIL approach is promoted by the European Commission (cf. Comission of the European Communities 2003, 8). What is typical of CLIL in Europe is that there is diversity in the implementation not just from one country to another but from one educational context to another. This has been widely documented in European CLIL conference reports (e.g., van Leeuwen and Wilkinson 2003, Wilkinson, Zegers and van Leeuwen 2006, Marsh and Wolff, 2007) and other publications (Dalton-Puffer and Nikula 2006, Dalton-Puffer, Nikula and Smit 2010).

1.4 CLIL research in higher education

Although the trend of teaching through a foreign language started some twenty years ago in Finland, research on CLIL in the Finnish higher education is still scarce. There are two Finnish surveys on the implementation of teaching and

learning through a foreign language (referred to as TTFL in the report) carried out by the Higher Education Evaluation Council. In the first survey, the external Evaluation Team evaluated 15 Finnish Polytechnic and University level programmes with a special view to language and communication. The team made recommendations which reflect the problems in the implementation of the TTFL approach. Six of these recommendations concern the role of language in TTFL; four have to do with the teachers' language skills and two with the students' language learning and their proficiency at graduation. (Tella et al. 1999, 66-67.) The follow-up evaluation of programmes taught through a foreign language at Finnish institutions of higher education was made in 2005. This evaluation did not have a special view to language and communication as did the one done six years previously. The recommendations from 1999 are brought back to mind, but, as Lahtonen states, no clear change had happened in the evaluated programmes as to the acquisition of multicultural skills or training in them. This is disappointing as all the programmes aim at internationalisation and some express this as a clear aim and emphasis on providing the students skills for international and multicultural contexts. The role of a language specialist is referred to as "teaching of professional/vocational vocabulary, which has not been included as a part of all teaching through a foreign language" (my translation from Lahtonen in Lahtonen and Pyykkö 2005, 44). This seems a very limited view of language in CLIL with no reference to communication skills. This comment on the role of a language specialist seems to follow a very traditional way of thinking of the language teacher's role. CLIL is in fact mostly implemented by content teachers.

A more recent publication from VAMK University of Applied Sciences edited by Rauto and Saarikoski (2008) reports various small-scale studies on FL-medium instruction in tertiary education ranging from models of implementing CLIL in higher education to CLIL experiences in secondary education and language education planning in higher education. In the VAMK report, two articles are partly related to the focus of this study. Johnson and Rauto (2008, 33-47) discuss their research projects on the effect of short-term exposure to English on the students' language learning. They used error analysis and language tests to measure changes in grammar, vocabulary and comprehension. Johnson and Rauto state that there was "a change towards target language norms" in the development of the productive skills (ibid., 37). Their approach then was to consider the students' general language skills, not their professional communication skills. In the same publication, McAnsh, Kannasmaa and Ruddock report on supporting the development of professional competencies through the integration of language and biochemistry studies in university biochemistry studies (McAnsh, Kannasmaa and Ruddock 2008, 49-54). The approach to language learning in this project is closer to the focus of the present study starting from a needs analysis approach by defining what competencies are relevant to the students as they progress from novice to full members of the scientific community. Integrating English with content studies on presentation skills and scientific writing courses resulted in high outcomes in both. In this

experiment, the focus was on professional communication but the context was not that of CLIL; the content courses were taught in Finnish.

At this writing, there are three academic theses on CLIL in higher education in Finland; one licentiate thesis and two doctoral dissertations. The focus in these studies is on the implementation of CLIL in an engineering programme in Hietala 1999, on intercultural competence as part of engineering students' professional qualifications in Korhonen 2002 and on the development of engineering students' interlanguage grammar in Rauto 2003. Thus, none of the three looks at the students' professional oral English communication skills in a CLIL programme.

The situation elsewhere in Europe in CLIL research is not that different from the situation in Finland what comes to CLIL in professional/vocational education. *Vienna English Working Papers, View[z]*, is an online journal published by the English Department of the University of Vienna. The journal has dedicated three special issues on what they call "a hot topic" of content and language integrated learning, CLIL. Of the 29 articles published in the special issues in 2006 and 2010, none deals with CLIL in professional/vocational education. The 2008 special issue focuses on instructed language learning and it includes two articles on CLIL in primary and secondary school settings.

There are several special issues on CLIL that have appeared recently. In addition to the one mentioned in chapter 1.2, the special issue of the *Language Learning Journal*, for example the *International Journal of Bilingual Education and Bilingualism* provided a special issue in 2013 with the title "Content and Language Integrated Learning: Language Policy and Pedagogical Practice". In this issue, Denman, Tanner and de Graaff look at CLIL in junior vocational secondary education in the Netherlands. Their focus was not on professional communication but on such aspects as learner motivation, in and out of class learning and teacher skills (Denman et al. 2013). Neither one of these special issues reports research on professional communication in the CLIL context.

One development to enhance research in CLIL is *the International CLIL Research Journal* supported by the Lifelong Learning programme of the European Union. The first issue of the journal was published in 2008. In the existing four issues, there is only one article that relates to the present study discussing CLIL vocational education. Again, the focus is not on professional communication. Dalton-Puffer, Hüttner, Schindelegger and Smit (2009, 18-25) studied the students' perceptions of using CLIL in content subjects in the training of engineering students in Austria.

It is interesting to note that still in 2008, when the VAMK publication referred to above was published, Rauto and Saarikoski ask the same question as I was asked back in 1995: "Do we know enough about what happens to the learner in the FL-medium instruction (degree programmes, modules and courses) in terms of language attainment and academic success?" (Rauto and Saarikoski 2008, preface). Still in 2017, the obvious answer is: No, we don't. This is expressed as a worry in *Language Use and Language Learning* edited by Dalton-Puffer, Nikula and Smit 2010. Lorenzo and Moore report of "concerns over the fact that CLIL implementation may be outpacing the CLIL theory" (Lorenzo and Moore 2010,

23). Dalton-Puffer, Nikula and Smit (2010, 288) point out a real gap in CLIL research which tends to focus either on language or on content but not their integration. The present study considers the nursing students' use of the English language as part of their professional competence. From the perspective of language education, which is the perspective of this study, the integration of language and content cannot mean that language education would not have a role in supporting the development of the professional competence in a CLIL nursing programme. It is hoped that this study will shed some light on the matter.

1.5 English enhanced programme of the current study

The English language enhanced medical-surgical programme was started in Lappeenranta Health Care Institute in the autumn of 1994. This new programme was consistent with the 1991-1996 national development plan of education in Finland. In Lappeenranta Health Care Institute teaching content through English was started as a part of the institute's internationalisation process. The decision to start was made by the principal and the programme was made possible by a group of enthusiastic teachers. The programme was to start international student exchange and to make it possible for non-Finns living in Finland to participate in the programme. The programme in Lappeenranta was called an English language enhanced programme, rather than an English programme, as instruction in this programme was mainly in English but Finnish was used in practical placements and the services in the institute were provided in Finnish. The curriculum was based on the national curriculum for medical-surgical nurses. The full descriptions of the goals of the nurse's work and professional skills are in the extract from the curriculum for medical-surgical nurse education in Appendix 1. The importance of interpersonal and communication skills is evident in the definition of the goals of the nurse's work described in the shared national curriculum as the nurse is to co-operate not just with the patient but also the wider social context:

> The nurse is a nursing expert who together with the clients/patients, their relatives and other professional groups aims at achieving, maintaining or restoring health, activities, wellbeing and balance to the patient. Side by side individualized nursing the nurse aims at influencing the community and the environment in order to find solutions which will promote the health of both individuals and the whole population. (Appendix 1**)**

No specific goals were set as to the level of language proficiency that the students would achieve in the programme. In the light of the survey by the Higher Education Evaluation Council in 1999, it was quite common not to define clear aims for language learning in CLIL programmes (called TTFL programmes in the report) (Tella et al.1999, 67). At my institute the issue of language was not discussed until the beginning of the second year, that is, in the autumn of 1995. The programme was then defined by the TCE teachers of the institute as follows:

> The general goal of the programme is to train nurses for the Finnish society using the English language as a mode of instruction. The programme further aims at strengthening the acceptance and tolerance of multiculturalism and developing both basic interpersonal communication skills and cognitive academic language proficiency in English.
>
> (Lappeenranta Health Care Institute 1994)

The distinction made between basic interpersonal communication skills (BICS) and cognitive academic language proficiency (CALP) comes from Cummins (1979). This was the teachers' attempt to understand and define what language proficiency could mean in an educational context. Cummins explains the two concepts as follows: "BICS refers to conversational fluency in a language while CALP refers to students' ability to understand and express, in both oral and written modes, concepts and ideas that are relevant to success in school." (Cummins 2008) I, as the English language teacher, brought Cummins' definition to the CLIL teachers of the nursing programme and they accepted it. However, the meaning of the definition within the curriculum was not discussed in any detail. The basic assumption was that the general language proficiency that the students would need academically in reading, writing and speaking (CALP) would be strengthened during the studies as would the basic interpersonal skills (BICS). Following the national curriculum of nurse education, the curriculum included 35 hours of instruction of English. This is how the aim of the English language studies was defined:

> ENGLISH 35 hrs (1 sw)
>
> The aim of the English language courses is to enable the student to understand the significance of language skills at work and in social interaction. The student should also have a positive attitude towards maintaining and developing her/his language skills.
>
> Furthermore, the student should understand the significance of language skills as a tool in acquiring new information. She/he should understand the meaning of language skills as a basic requirement for international co-operation and have a positive attitude towards this co-operation.
>
> (Lappeenranta Health Care Institute 1994)

The language learning aims directed the course contents towards awareness raising and creating positive attitude. On the one hand, this gave the instructor a lot of freedom and flexibility in designing the content; on the other hand, as broad a definition of aims as the above makes assessment very challenging if not impossible. The lack of explicit aims in TTFL (teaching content through a foreign language) in Finnish higher education was clearly stated in the 1999 survey mentioned above. The recommendation that followed was the following:

> The aims set for the FL proficiency of the graduating students should be determined on the basis of the students' future profession, if this is possible, and according to what is expected of the professional in the field in an international context. (Tella et al. 1999, 67.)

The recommendation takes into account that defining the needs of the students' future profession may not be a straightforward task.

No follow-up or assessment of language skills was planned to be carried out in the medical surgical English enhanced programme. It was simply assumed that language learning would take place. Introducing the VAMK report, Rauto and Saarikoski start with the same assumption still in 2008: "It can be presumed that increased foreign-language-medium (FL-medium) instruction would result in advanced language command." (Rauto and Saarikoski 2008, preface). As pointed out in the previous section, they also ask the same question as my colleagues did in 1995 as they wondered what exactly would happen to the students' language proficiency in the nursing training. Dalton-Puffer, Nikula and Smit (2010, 11-12) report that there is research with evidence that CLIL learners perform better in some aspects of language. However, interpreting the implications of these findings is complicated. This is due to the fact that a lot research is based on second language acquisition (SLA) which in turn has resulted in focusing on how well learners master certain aspects of language such as vocabulary, grammar, pronunciation rather than considering the CLIL learner's competence more holistically. In 2010, Dalton-Puffer et al. point out "much of the existing CLIL research has tended to focus on either its language or its content aspects, with much less attention being devoted to their interface, that is, the integration of language and content."(ibid., 288). This focus on language rather than integration of language and content can be seen in the question that Rauto and Saarikoski ask. Applied linguists often seemed to be concerned of language proficiency per se and not of how language and content integrate to serve the purpose that they together should serve in any particular educational context. Recent CLIL research has focused on the integration of language and content. In their book on the roles of language in CLIL, Llinares, Morton and Whittaker (2012) present approaches to the integration of content and language in the CLIL classroom. Llinares et al. (2012) describe CLIL in general education in a context where content teaching through English is done by non-native content teachers. They consider the role of language through Halliday and Mathiessen's (2004) systemic functional linguistics framework (SFL). SFL is a meaning-based theory of language, where form is always part of function. Studies by for example Nikula (2015a, 2015b) have focused on classroom interaction and the integration of language in content classrooms. Classroom interaction with young students is different from the challenges that professional education, such as nursing education, has in a CLIL context.

Next, I will define the research questions. In chapter 2, I will first discuss research on constructing professional competence in nursing with a special focus on communication as part of the professional competence. The chapter will end in a definition of the theoretical framework of professional nursing communication for the analysis of empirical student communication data. The research design will be presented in chapter 3 and chapters 4 and 5 will discuss the results and conclusions. In chapter 6, I will consider the findings in the light of current research and further reflect on the implications of this study.

1.6 Aims of this study

As became obvious in the preceding chapter, the goals of the programme did not explicitly define the role of the English language in the nursing profession. It is assumed here that basic interpersonal communication skills referred to in the goals would include such oral English skills that would be professional when taking care of patients and using the English language as a medium of communication. Defining what kind of communication skills would be professional may not be an easy task, but on the other hand, it is the only meaningful approach to language and communication in the context of care giving: mere linguistic accuracy can surely not be enough. This study will focus on the professional oral English skills of the nursing students in simulated work samples involving a wound care situation. The role of the students' oral English skills will be thus considered as an integrated part of professional nursing communication and therefore within the theoretical framework of nursing communication. The reason why simulation was used as a data collection method was that in that way it was possible to gather systematic data. Real-life situations in English were not likely to happen in the monolingual Finnish surroundings of this nursing programme. The data, although collected in 1996, is still valid today because it is unlikely that nurse-patient communication in a wound care situation would be essentially different today.

The aims of the study are to find answers to the following research questions:

1. How does the students' way of communicating with their patients in English in simulated work samples show professionalism?
   - The focus in this research question is on the definition of professional communication, as described in the nursing literature, and how it ideally, according to nursing interaction models, is carried out and becomes verbalised in nurse-patient communication contexts. To what extent can the students' communication be explained using the definition of ideal professional nursing communication?

2. What is the role of the general oral English language skills of nursing students in simulated work samples?
   - As non-native English speakers, the students' oral language use is likely to have features of the oral language use of foreign language learners in general. How is this reflected in the data and does this influence how professionally successful the communication is?

Defining professional communication is a prerequisite for answering any of the questions above. The first question relates to professional communication directly. As for the second research question, the link is not so clear. The underlying question is whether general oral English skills have a role in

professional communication. The students' professional oral skills will be considered from the point of view of nurse-patient communication. In other words language is considered as part of nurses' professional competence. Communication as a theoretical construct has hundreds of definitions, but here the focus will be on what is relevant in professional nursing context, that is, on professional health communication. The concepts will be explained in the theory section. The approach taken here is in accordance with Candlin and Candlin's (2003, 134) plea for applied linguists to "look outside their own professional literature for studies that direct themselves at health communication, especially where this involves issues of intercultural communication." Answering the two research questions hopefully helps examine the connections between content and language in the context of professional communication in nursing.

2 CONSTRUCTING PROFESSIONAL COMPETENCE IN NURSING

2.1 Defining professional competence

Considering language as part of professional communication for any educational or research purposes, inherently presupposes an understanding and a definition of professional competence; in this study, professional competence in nursing. The following discussion will be based mostly on literature that was linked to the nursing program. The students had been exposed to a theory of nursing practice and that theory then defines professional competence which should have an effect on the way the students would communicate with their clients or patients. Health communication has been studied in applied linguistics and this research will also be taken into account. However, as studies of applied linguistics are descriptive rather than prescriptive, they do not provide systematic tools for assessing how professionally the students communicate in the work samples. The reasoning is that in education content and assessment should be aligned (cf. Biggs 1996). To assess how professionally the students communicate in the work samples is not possible without a definition of professional competence and professional communication. The work samples that constitute the data of this study represent performance data. The relationship between competence and performance needs to be looked at before discussing what a competent nurse is expected to be able to do. In order to clarify the definitions of what is competence and what is performance, I will first consider these definitions in the context of assessing professionals and then discuss definitions of a nurse's competence.

2.1.1 Competence and performance in assessing professionals

Rethans, Norcini, Barón-Maldonado, Blackmore, Jolly, LaDuca, Lew, Page and Southgate (2002) discuss the relationship between competence and performance in the context of assessing doctors in practice for the purposes of medical education. They describe Miller's (1990) Triangle assessment model that has four levels in it: 'knows', 'knows how', 'shows how' and 'does'. The 'does' level designates performance and the others are part of competence. Rethans et al. infer that Miller's model is suitable as a basis for curricula in education for example for medical students. They disagree with Miller in assuming that competence would predict performance as straightforwardly as they think Miller's model seems to imply. Their modification of Miller's model, the Cambridge Model for delineating performance and competence in Figure 1, takes into account various factors that can influence performance.

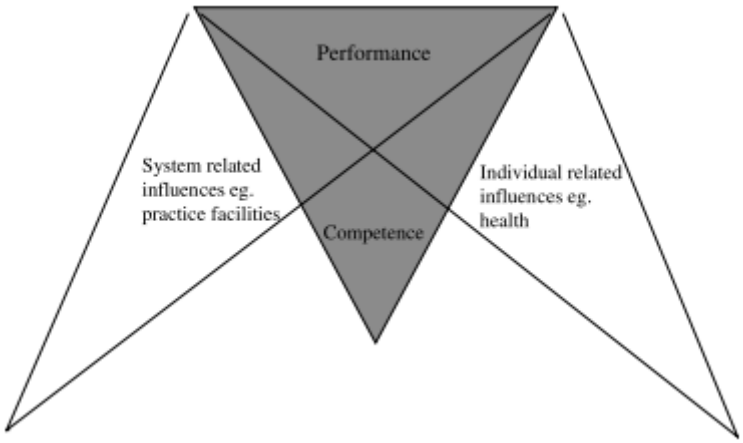

Figure 1. The Cambridge Model for delineating performance and competence (Rethans et al. 2002, 907)

Rethans et al. also think that the "shows how" level should already be called "competence" because the testing should be competency-based testing, not performance-based testing. The definitions of competence and performance in Rethans et al.'s differ from how they are usually defined. The simple distinction between what they call competency-based assessment and performance-based assessment is that the first one measures what "doctors can do in controlled representations of controlled professional practice" and the latter what they actually do in professional practice (Rethans et al., 2002, 902).

The Cambridge Model has two triangles or shafts of life that affect a doctor's performance in tests: the system-related and individual-related factors. Systems-related factors include such aspects as government programmes, patient expectations and guidelines. Individual-related factors, on the other hand, include relationships with others and their physical and mental health. (Ibid., 907.) This model clearly attempts to link performance to the context as it takes system-related factors into account. In both Miller's and Rethans et al's models, competence and performance are depicted very clearly as underlying knowledge and skills in practice respectively. The simulation data in the present study is, following Rethans et al., competence-based as the simulations are "controlled representations of professional practice" and not "actual performance practice". Following the model also means that the factors influencing the students' performance in the work samples need to be taken into account.

2.1.2 Defining a nurse's competence

Definitions of what a competent nurse should be like keep changing over the years. This reflects the developments and changes in the world view at all levels of the surrounding society. In adult education, before the 1960's, there was a change from the 'classical curriculum' to the 'romantic curriculum'. The 'classical

curriculum' focused on subject-centred skills, knowledge and content whereas the 'romantic curriculum' encouraged creativity, discovery, processes, involvement and cooperation (Jarvis 1990, 223-224). In the same vein, Butterworth (1998, 3) describes the philosophical changes in nursing to have been from the biomedical to the interpersonal; from assisting doctors to giving person-centred, individualised care. He stresses the importance of the introduction of the nursing process as a new way of organising nursing care.

The curriculum of the first group of medical-surgical nurse students at the Health Care Institute of Lappeenranta seems to reflect the 'romantic curriculum'. In accordance with these developments in nursing care, the students were introduced to the Roper, Logan and Tierney (1980) model for nursing at the beginning of their studies. This model provides a framework for nurses to plan individualised nursing, in other words, it describes the nursing process (cf. Butterworth 1998 above). This model was not only used in educating nursing students; it was the prevailing one in the regional hospitals at the time (Raminen Pirjo, nursing teacher at Lappeenranta Health Care Institute 1984-2008, personal communication 2008). Roper, Logan and Tierney (1980) model for nursing will be described and discussed in the following so as to get some idea of how the students were taught to practice nursing. The model will form a basis for defining how the students should communicate professionally with patients.

The model starts with the concept of 'living' and connects it with 'nursing'. Tierney (1998, 79) discusses the relevance of the Roper, Logan and Tierney model for nursing and points out that the rationale behind this linkage was that it had become evident that health is linked with lifestyle. Living is conceptualised by means of the Activities of Living (henceforth ALs). The other concepts in the model are the lifespan, the dependence / independence continuum, the factors influencing the ALs and individualising nursing. The model views nursing as helping patients to prevent, alleviate or solve, or cope with problems related to the ALs. The 12 ALs which are considered to constitute the main component of the model for nursing can be seen in the figure below.

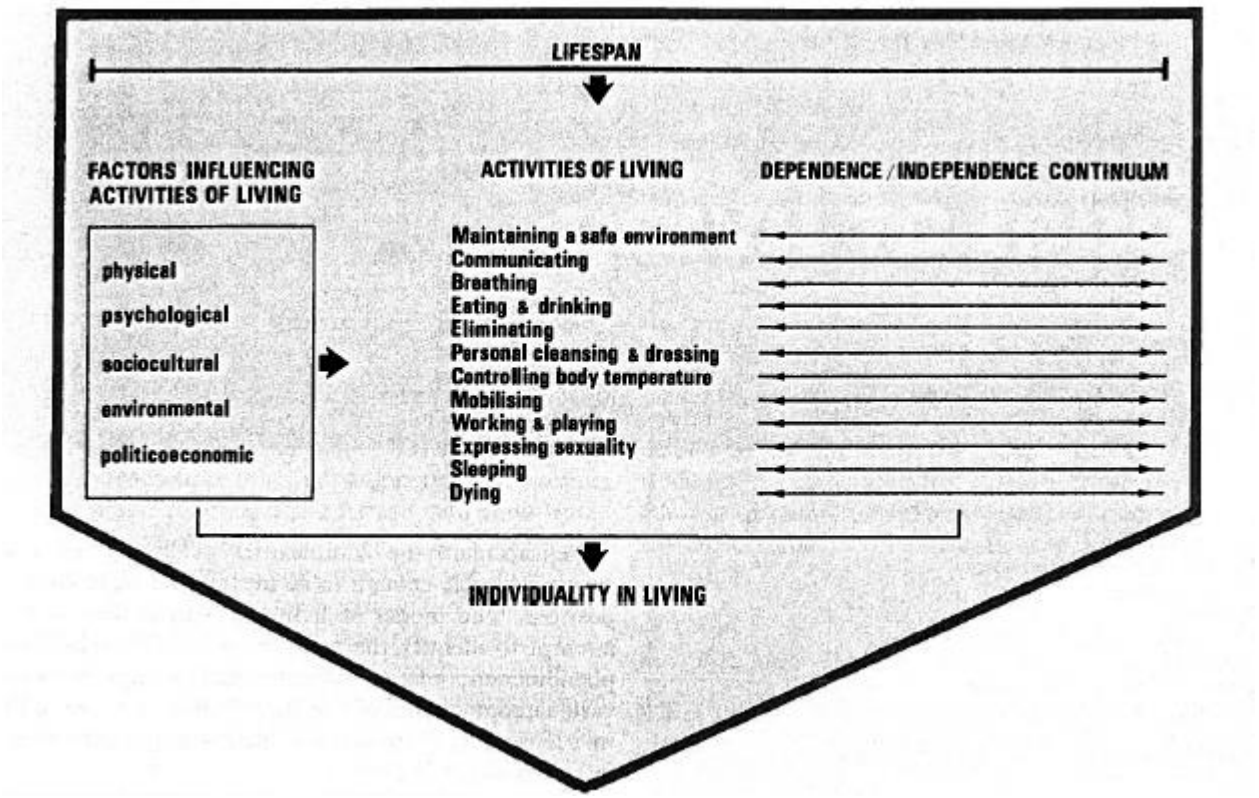

Figure 2. Diagram of the model of living (reprinted from Roper et al. 1980, 22).

Roper et al. emphasise that although the ALs are described separately, they are very closely related to each other and can, in fact, be separated only for the purpose of description.

The ALs are affected by the other four main components. The stage of the lifespan or, in other words, the patient's age, influences all phases in the process of nursing. Assessing the patient's level of independence in each of the ALs as well as taking into account the physical, psychological, sociocultural, environmental and politicoeconomic factors (cf. Figure 2) influencing the ALs are important aspects of nursing. Again the five factors are linked to each other and also to the ALs, the lifespan, and the dependence/independence continuum. All these components influence the fifth one, that is, individuality in living. (Roper and al.1980, 21-34.)

The model of living described above forms a basis for the Roper, Logan and Tierney model for nursing. According to the model, individualising nursing is accomplished by the process of nursing, which involves four phases; assessing, planning, implementing and evaluating. Although the process is described as comprising four separate phases, in reality they are connected and the process operates with continuous feedback. Assessing the patient includes: collecting information from/about the patient, reviewing the collected information, identifying the patient's problems and identifying priorities among problems. The nurse needs to know about the patient's usual routines and current problems, the patient's ALs. The objective in planning is to prevent the identified potential problems from becoming actual ones, to solve actual problems, where possible

to alleviate those which cannot be solved, and to help the patient cope with those problems which cannot be alleviated or solved. A written plan contains the following information: stated goals for each problem, a date on which the goals are expected to be achieved, and the nursing interventions to achieve the goals. Implementing the nursing plan involves varied nursing interventions. The objective of the fourth phase in the nursing process, evaluating, is to find out whether or not the goals, which were set, have been achieved. (Ibid., 35-63.)

As the model forms the basis for individualising patient care, it should be possible to infer the competences that a nurse needs from the model. It is surprising to me that the model focuses mostly on behavioural aspects of living excluding the cognitive and affective aspects. Maslow's (1954) hierarchy of needs is a much used source in nursing. It seems that Roper et al.'s model makes use of Maslow's first description of the hierarchy in 1954. In the 1970 adapted version, Maslow included Cognitive and Aesthetic needs to the hierarchy in addition to the lower level needs that are similar to the Activities of Living described in the Roper et al. model.

Roper et al.'s model operates on a conceptual level, but it is possible to apply the model when observing and describing professional competence from the point of view of language use and communication. It is obvious that in all phases of the nursing process communication is crucial; oral communication is needed before recording a nursing plan and documenting the nursing interventions. Assessing the patient's problems is seldom done without interaction that involves speaking, the only possible exception being an unconscious patient without, for instance, any significant others available to collect information from and to help identify the patient's problem. Although other health care professionals can be involved in all of the four phases, the conscious patient is also informed of the planning, implementation and evaluation of the process through oral communication. In the description of the nursing process, Roper et al. use the terms 'communication' and 'interaction' without defining the difference between them. This is seems to be typical in nursing literature as Fleischer, Berg, Zimmerman, Wüste and Behrens (2009, 339-353) found out in their systematic literature review on the relationship between the two concepts. They state "the terms are used interchangeably or synonymously, and a clear theoretical definition is avoided or rather implicit" (ibid., 339). Rather than focus on theoretical definitions of the two concepts, I will discuss and define communication in the nursing profession as part of interaction. A more detailed theoretical discussion of the two concepts is beyond the scope of this study.

2.2 Communication in the nursing profession

In this chapter, I will first consider how communicating is dealt with in the Roper et al. 1980 model of nursing described above and also how Roper further discusses the role of communication in her book on 'Principles of Nursing in Process Context' from 1988. These considerations will provide a starting point

for finding a relevant way of defining professional communication in nursing. A framework or a model of professional communication is needed to enable the analysis of the work sample data in view of the two research questions.

2.2.1 On communicating in the Roper, Logan and Tierney 1980 model for nursing

As communicating is one of the 12 Activities of Living (ALs), the Roper et al.1980 model discusses it separately like the rest of the ALs. It is repeatedly pointed out that all the ALs are related to each other and to the other components of the model of nursing. Although the individual is the centre of this model and communicating is seen as 'a highly individual activity', Roper et al. (1980, 104) state that in discussing communicating, it is the interpersonal relationship that is crucial, not the individual. However, the starting point is the model of living and the four components, namely, age, factors influencing the ALs, the ALs themselves and the patient's level of independence that all affect the individuality of living and thus, communicating. It follows from this approach that communicating is discussed as an activity of living that the patient can have problems with. The nurse should be able to assess those problems. The importance of effective nurse-to-patient communication is emphasised but the discussion does not involve any model of health communication in particular that would define what exactly would make communication effective**.** Roper et al. describe what they call a basic model of communicating where a person (sender) has a message which he sends in a particular medium, so that it is received by a recipient who responds to the message by giving feedback to the sender. (Ibid., 102.) Thus, according to this view, messages are transmitted rather than constructed. This sender-receiver model is further developed by adding stages in the chain of communication where an error can occur and adding such dimensions of communicating as attitudes, beliefs, values and prejudices. This means that communicating is seen as cultural behaviour, but on the whole the model seems to reflect the mathematical model of communication by Shannon (1948). In Shannon's model information is transmitted (ibid., 3), not constructed in interaction. The basic communication model does not seem to contribute much to the model of nursing as it is not integrated in it. As communication is considered to be only an activity of living that the patient can have problems with, the focus does not include communication as part of successful professional nursing interaction at all. Thus, the basic model of communication is not suitable for the purposes of this study where defining successful professional communication is a prerequisite for the data analysis.

Roper et al. (1980) discuss nurse/patient relationship rather briefly in the context of patients' problems in communicating and related nursing. The relationship is described as essentially a human one but nurses are not in the individual nurse/patient relationship from choice; they are making a professional contribution. Nurses bring "to the relationship themselves as unique human beings" and they also bring "compassion for people, commitment to nursing, together with nursing knowledge and skills" (ibid.,110). All in all the

Roper et al. 1980 model, in accordance with its main objective, individualising nursing, stresses the importance of acquiring information about the patient and giving information to the patient. References are made to other sources on the nature of the relationship. I will here mention only those aspects of the discussion that are of interest to this study and include the references to research that Roper et al. use in the formulation of their model.

Patients do not seek only treatment; they also seek comfort and giving information to the patient is said to be an important component of comfort. Roper et al. mention some of the skills involved in showing empathy: "the ability to listen, (to the words but also noting volume, pitch, eye movements and related body language); ability to offer free attention to note and accept, not analyse and interpret); to suspend judgement (to refrain from categorising as good/bad, right/wrong); and to control what is said in reply and how it is said, with a facial expression which is genuine, not mechanical" (Roper et al. 1980, 111). It may be possible to analyse at least some of these skills in work sample data as part of professional oral language skills.

The English-enhanced programme of the present study started in the beginning waves of internationalising the Finnish educational system. A conclusion from this then new approach would be that nursing was thought of as an international occupation, which it of course was in the 1990's as always and increasingly so at the beginning of the 21st century. Yet, the nursing model by Roper et al. introduced to the students of the aforementioned programme did not really take the international and intercultural aspect of nursing into account. Roper et al. (1980, 112) point out that "the new patient who probably has the biggest problem with communication is the one who does not speak the national language". However, this is passed by noting that translations and interpreters are available. If not, then nurses can help by "using empathy, ingenuity and miming" (ibid., 113). More attention is paid to the fact that even when the same language is spoken by patient and nurse, communicating can be problematic because of accent or dialect, differences in even ordinary vocabulary, technical terms and embarrassing topics (ibid.).

Roper et al. discuss giving information in the light of various studies. For instance, lack of communication skills instruction for nursing staff seems to explain why studies in the 1970's and early 1980's indicate that patients were more dissatisfied with communication than anything else. The importance of giving information is brought up again as an effective way to reduce stress and produce better results in self-care after operations. Counselling is compared with information-giving as a more patient-centred method of guiding the patient in decisions that concern the care. Roper et al. note that counselling can reduce stress more effectively than mere information-giving.

When discussing the problems in communicating related to change of the patient's dependence/ independence status, problems related to speech such as temporary or permanent loss for words and aphasia are mentioned. Problems related to hearing that are included in the discussion are middle ear infection, tinnitus and deafness. Nurses are encouraged to use non-verbal language,

tolerance and good humour to reduce the problem of communicating with deaf patients. (Ibid., 117-118.) Problems with foreign language are not discussed in this context. Leaving this issue out of the discussion seems strange, especially as health care in the authors' multicultural society has surely had to cope with communication problems that come up in intercultural nursing contexts. Roper gives an explanation for this lack of awareness of intercultural communication in her next book on principles of nursing in process context discussed below.

2.2.2 On communicating in Roper Nancy 1988: Principles of Nursing in Process Context

In her book 'Principles of Nursing in Process Context' from 1988, Roper has changed her view somewhat on the role of communicating in the process of nursing from the one in the Roper et al. 1980 model:

> It is unfortunate that the process of nursing, which has a large communicating component, has come to be mainly associated with documentation. In an over-zealous acceptance of the fact that the main objective in using the process of nursing is to individualise nursing and document it, we may have overlooked the fact that many communicating activities which occur and recur in a ward or wherever a nurse works, do not need to be documented. Nevertheless, they can contribute to individualised nursing. (Roper 1988, 18-19.)

This phrasing seems to give more emphasis on the amount of communication that occurs in taking care of a patient, but it still leaves the quality of communication as nurse-patient interaction undefined. The discussion that follows does not differ much from the one in Roper et al. 1980. A more exhaustive list of conditions which can impede the process of communicating is included in Roper 1988:

aphasia	**foreign language**
blindness	hard of hearing
changed level of consciousness	laryngectomy
cleft palate	mental impairment
deafness	spasticity (cerebral palsy)
dumbness	tracheostomy
dysphasia	
dyspnea	(Roper 1988, 24, emphasis mine)

On the list of problems, Roper simply notes that most items are medical diagnoses. To be more exact, only "foreign language" is not a medical diagnosis and therefore it does not really seem to belong to the list. A medical diagnosis necessitates medical treatment, but a foreign language does not. However, a patient who does not share the nurse's native language changes the professional requirements placed on the nurse. From the point of view of this study, this is a crucial aspect of the definition of professionalism and nurses' competences. Roper also states that nurses should write the information collected of the patient in the patient's language so that they form a large data bank which can be analysed. (Ibid., 24.) This would seem quite a task in a multicultural nursing context. When discussing implementing the nursing plan for a person's problem

with communicating, Roper mentions problems with a foreign language. To help cope with the situation, translations and interpreter services are mentioned again but this time with a warning: "However it has to be remembered that an interpreter can dilute a nurse/patient relationship. Body language, miming and drawing all help to convey the message to the patient." (Ibid., 28). The view that Roper et al. have on communication in nursing is that of a native speaker nurse taking care of non-native speaker patients whose foreign language causes problems in the nursing process. Considering international and intercultural communication this view is very limited as it ignores such nursing situations where neither the nurse nor the patient share the same native language or where the nurse is not a native speaker of the 'national language' but the patient is.

In nursing literature, the role of non-verbal communication is often emphasised. From an applied linguistics point of view, this seems to be done at the cost of undermining the role of language in interaction. Alfaro-LeFevre (1994,17,19) claims that good communication skills are only half of what is required to build sound interpersonal relationships, in other words, relationships are developed as much by how people behave as by how they communicate. Her approach then sees behaviour and communication as two different things. Leppanen Montgomery (1993, 34) states that an estimated 55% to 70% of feeling is communicated through non-verbal channels. Based on such claims as the aforementioned, encouraging the use of body language when nurse and patient do not share a common verbal language is quite reasonable. However, considering the fact that, according to the Roper et al. 1980 model for nursing, nurses should be able to give and gain a lot of factual information during the nursing process, it seems a rather surprising thought that interpreters could be substituted by "body language, miming and drawing" (cf. above).

The relationship between language and communication is crucial for this study as both characteristics of the nursing students' professional communication and oral language skills in English relevant to professional communication are examined. The use of the two concepts *communication* and *language* needs clarification especially in connection with the nursing approaches presented above. As the Roper et al. 1980 model was the framework used in the English enhanced nursing programme where the data derives from, the analysis of the discourse data gathered in simulated work samples should ideally meet with the nursing framework. This means that the use of language is considered in the context of the nursing framework. If the discourse data were analysed solely in terms of language as linguistic form, the analysis would not capture what is relevant in the use of oral language in the nursing profession.

In her book *Approaches to Discourse* Schiffrin (1994) makes an overview of core approaches to discourse and also addresses the problem of how to define discourse as a field of linguistics and in relation to communication. Although there are different approaches to discourse analysis, what they all have in common is that they relate to some model of communication. In fact, Schiffrin makes it quite clear that it is not possible to analyse discourse without a reference to a model of communication whether explicitly or implicitly. (Ibid. 1995, 386-

387.) Her final conclusion is that language is a social interactional phenomenon and it cannot be understood without understanding the world. Linguistic analysis alone is not enough and therefore other disciplines are needed in analysing discourse. (Ibid. 1995, 415-419.) This view is shared in this study as it clearly builds a bridge between language as part of discourse and communication, and nursing as a discipline.

The Roper, Logan and Tierney 1980 model for nursing was a well-established model in Britain (Pearson and Vaughan 1992, 60) and, as I mentioned earlier, also in some parts of Finland. Roper et al. state that their model is sufficiently broad and flexible to be used as a framework for the process of nursing in any area of professional practice. The model does not claim to exhaust every aspect of the subject. (Roper et al.1980, 35-36.) The focus on the individual patient explains the fact that interaction gets little attention in the model. For a professional nurse the model may imply a lot about interaction with patients. For a study on the role of second or foreign language in multicultural nursing situations the model provides a general framework for understanding the nursing process but it does not provide a sufficient framework for analysing the verbal nurse-patient communication in the situations. Therefore, I will next look at some applied research done on health communication, which Northouse and Northouse (1985, 4) define as "a subset of human communication that is concerned with how individuals in a society seek to maintain health and deal with health-related issues." To understand the role of foreign language in the framework of nursing, a framework of communication is needed.

2.3 Health communication

In this chapter, I will take a look at health communication models described in relevant literature and then describe the model used in this study as a framework for analysing the work sample data.

2.3.1 Models of health communication

In 1994, when I started this study, health communication was a relatively young discipline. According to Pettegrew and Logan (1987, 675) it had been dominated by the values and interests of medicine. In nursing literature, health communication was rarely mentioned as an approach to communication in health care. It was common to present the basic model of communication with sender, message, receiver, feedback and, sometimes, context (see e.g., Roper et al. 1980, 102, Sundeen et al. 1981, 96-99, Sundeen 1991, 245-246, Earnest 1993, 25-26). A lack of coherent research in this field was brought up by, e.g., Pettegrew and Logan (1987, 675) and Thompson (1990, 27).

In their review of approaches to health communication, Northouse and Northouse (1985) describe several models of communication starting from the

Shannon and Weaver model. Building on the earlier models, they then proceed to describe their *Developmental Model of Health Communication*.

I will here describe Northouse and Northouse's model of health communication first presented in 1985 to form a basis for defining what features would be the relevant ones to analyse in work sample simulations in a nursing context. Silverman, Kurtz and Draper (2008, 8-21) describe a framework of a communication curriculum for medical students with most of the elements included in Northouse and Northouse's model. However, the framework is about skills that medical practitioners should have and it does not discuss a comprehensive model of communication. The skills correspond to the communication variables in Northouse and Northouse's 1998 model.

Northouse and Northouse's (1985) developmental model of health communication is based on communication and health-related models like the therapeutic model by Rogers 1951, the health belief model by Rosenstock 1974 and the King interaction model by King 1981. They call their model *developmental* as in 1985, when their handbook of health communication was first published; they considered the field of health communication to be taking its initial steps (Northouse and Northouse 1985, 21). As the developmental model takes into account the perspectives provided by the earlier health-related models, it gives a broader view on health communication than any of the preceding ones did.

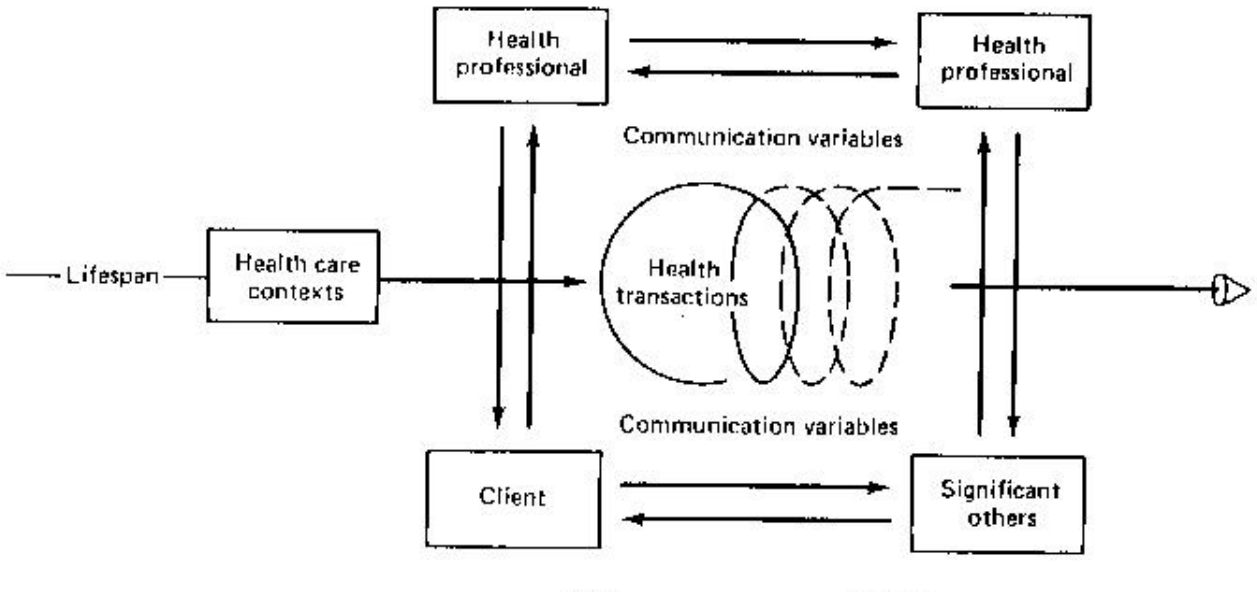

Figure 3. Health Communication Model (reprinted from Northouse and Northouse 1985, 22)

I will here briefly report how Northouse and Nothouse (1985) explain the Health Communication Model (HCM) shown in Figure 3. To begin with, the primary participants in health communication are health professionals, clients, and significant others. Both health professionals and clients bring their specific

characteristics, values and beliefs in the health care setting. The age, sociocultural background and past experiences of both sides affect health communication. Transactions refer to the health-related interactions that occur between participants in the health communication process. These involve any interaction between individuals about health-related information. The model only refers to transactions as an abstraction but in their explanation of the model, Northouse and Northouse note that Health transactions in the HCM include both verbal and non-verbal communication and also both the content and relationship dimensions of messages. These dimensions are not depicted in the model. The relationship dimension of health transactions is established within the various relationships represented by the model and it influences how the health-related content of the messages should be interpreted.

The circle with an unending spiral in the model represents health transactions and their ongoing nature. Health communication is an interactive process that occurs at various points in time during the course of a person's life. Continual feedback allows participants to adjust and readjust their communication. The participants and their messages are influenced by many variables, of which Northouse and Northouse consider five that they think are central to effective health communication. The five central variables considered are empathy, control, self-disclosure, trust and confirmation. The third major element in the model, health care contexts, refers to health care settings, such as hospitals, nursing homes and outpatient clinics and to the number of participants within a particular health care setting. To summarise the Health Communication Model, Northouse and Northouse state that the components of their model, participants, transactions and contexts, provide a systems perspective on communication in health care. They also propose that the many contextual factors and relationships that affect the health transaction be kept in mind when studying health communication. (Northouse and Northouse 1985, 21-26.) This model, similarly to other communication models discussed above, does not mention language in health transactions. However, it is clear that all of the five central variables can and do involve the use of language.

The Roper et al. 1980 model of nursing and Roper's 1988 book on the principles of nursing describe the elements of individualising nursing but fail to provide a comprehensive view on the role of communication within the model of nursing. Northouse and Northouse's model does provide a comprehensive and systemic description of health communication and it has been referred to in health communication literature ever since it appeared. In the following I will look at the present state of health communication research.

In her book on health communication, Berry (2007, 28-30) discusses two communication models: Shannon and Weaver model from 1948 and a model of interpersonal communication (e.g., Hargie and Marshall, 1997). The interpersonal model takes into account many of the factors that influence health communication. In the third edition of *Handbook of Communication*, Hargie has changed the name of the interpersonal model into model of skilled communicative performance (Hargie 2006, 40). This model focuses on describing

communication as a professional skill that professionals in various fields need. In the 2006 edition, the model still has all the same constituents as the one described in the second edition of the handbook from 1997 that Berry referred to.

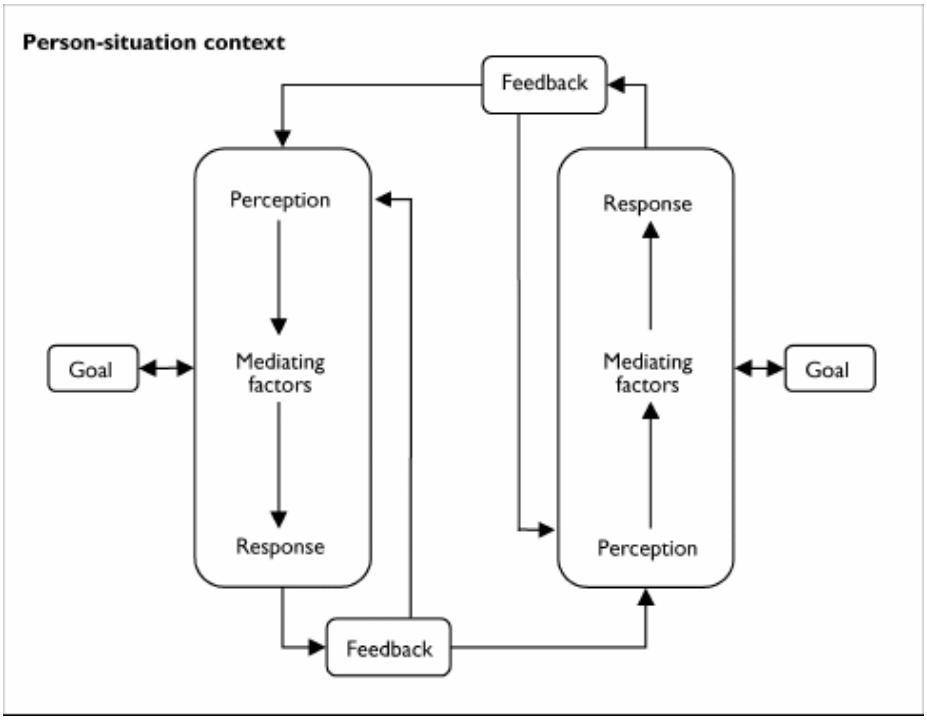

Figure 4. Hargie's model of skilled communicative performance (Hargie 2006)

In Hargie's model, people engaged in communication are both senders and receivers of information at the same time. However, as can be seen from the figure, the model focuses on describing the process of communication, the participants, in other words, the professionals and/or clients are not named in the model. In his discussion of the model, Hargie refers to 'individuals' and 'skilled performers' in social interaction. Skilled interpersonal interaction is described as having six basic elements: the person-situation context, goals, mediating processes, responses, feedback and perceptions. (Hargie 2006, 37-70.) The starting point of Hargie's model is that skilled communication is transactional (ibid., 63). This means that goals affect the perceptions and responses of individuals in person-situation contexts. Mediating factors exist within the individual, in the 'mediated mind'. There are two main mediating factors in this model: cognition and emotion. Hargie also discusses responses, feedback and perception under mediating factors. The person-situation context is described in terms of definitions of personal factors such as personality, gender age and appearance. Goal-structure, roles and culture are discussed as factors related to the situation. Speech is referred to as linguistic behaviour and discussed in connection with responses. Responses are social behaviour and can be either linguistic or non-linguistic and linguistic behaviour again can either be

verbal or paralinguistic. (Ibid., 37-48.) When discussing feedback, Hargie states that "messages are received and transmitted in a continuous return loop" (ibid., 50). Thus, Hargie still looks at communication as transmission of messages rather than as construction of meaning. The model takes a holistic view of communication as social behaviour where linguistic behaviour, speech and verbal messages are embedded in the realm of other social factors. It seems to me that although Hargie considers communication as transaction, his main interest in the model is in the individual and the mediating factors rather than the relationship between individuals.

Shannon and Weaver's transmission model and Hargie's interpersonal model are the two general communication models that Berry reviews in her discussion of theories and models of communication (ibid., 26-38). In addition, she presents Northouse and Northouse's (1998) model of health communication as a model that combines theories of communication and models of health behaviour (ibid., 26) as communication is considered specifically in the context of health and health care settings.

The Northouse and Northouse model of communication (1985 and 1998) seems 'old' in 2017. However, the reality is that the Shannon and Weaver's transmission model from 1948, although a lot older than the Northouse and Northouse model, has been influencing health communication for a long time and may still be the approach in many contexts. In her article from 2007 on medical interpretation, Dysart-Gale writes that the transmission model is, in fact, the predominant model overall in the medical discipline and not just in medical interpreting. She points out that the model has a place in such clinical contexts where accurate information is a requirement. (Dysart-Gale 2007, 240-241.) Dysart-Gale does not directly refer to the Northouse and Northouse model, but she does refer to it in passing when describing how healthcare training has been changing with respect to "cultural competency" (ibid., 238). As an alternative to the transmission model, Dysart-Gale describes what she calls the semiotic model of communication. This model actually reflects the Northouse and Northouse model as it describes communication as a process in which meaning is constructed through negotiation (cf. ibid., 243).

Northouse and Northouse's model has proved to have captured something essential about communication as it is still being cited in health studies. Davies, Krisjanson and Blight (2003, 344) use the Northouse and Northouse's model to reflect on the results of their study of communicating with families of patients in an acute hospital with advanced cancer. They found that the way Northouse and Northouse's model describes the role of interpersonal relationships and the context was in accordance with their findings. In their report on applying a conceptual framework for patient-professional communication to the cancer context, Feldman-Stewart, Brundage, Tishelman, and the SCRN Communication Team (2005, 802) construct their framework with reference to several sources including Shannon and Weaver 1949 and Northouse and Northouse 1998. Their specific reference to Northouse and Northouse's model is again to the process nature of communication. More recent studies referring to the Northouse and

Northouse model are, for instance, Melville-Smiths and Kendall's study on the importance of effective collaboration between health professionals for the facilitation of optimal community diabetes care in 2011 and Lopes, Ruão, Marinho, and Araújo's study on a media pandemic of influenza A in Portuguese newspapers in 2012. They mention Northouse and Northouse as ones contributing to the emergence of the field of Health Communication research within Communication Studies. Still in 2013, when defining communication for the context of health promotion, Corcoran refers to Northouse and Northouse's concept of communication as a transactional process (Corcoran 2013, 5-6).

The field of health communication has expanded over the years and with globalization, the challenges and requirements facing health communication have expanded as well. Among the most recent books on the topic are the *Handbook of Global Health Communication* edited by Obregon and Waisbord in 2012 and Schiavo's book *Health Communication: From Theory to Practice* from 2013. Both books discuss theories and models of health communication. What is typical of both Schiavo's approach to health communication and the approaches in the articles in the *Handbook of Global Health Communication* is that they all emphasise the process and participatory nature of communication. These are part of Northouse and Northouse's model of health communication as well, as was shown in the discussion of their model at the beginning of this chapter.

2.3.2 Model used in this study

The model that I will use in this study will be my modification of Northouse and Northouse's HCM (Health Communication Model) for the purposes of the analysis of the work sample data. The major framework will be the same as in the HCM. The main modifications in the model for this study will be in the definitions of the context and transactions. Thompson (1990, 40) states that the nurse needs to know that, from a systemic view, communication occurs on content, relationship, and identity levels. Northouse and Northouse (1985, 22) point out that their model takes a broader systems view of communication than the communication and health-related models that form the basis for their developmental model. Yet, in the HCM, as Northouse and Northouse (1985, 18) note in their description of their model, health transactions include only content and relationship dimensions of messages. Age, sociocultural background, past experiences, specific characteristics, values and beliefs are mentioned as factors that affect how the participants interact with each other (ibid., 17). Those factors, however, are not described as an interactional dimension in health transactions. The HCM is here modified by adding the identity dimension to it so as to acknowledge the role of individual participant's characteristics in the transactions. Figure 5 shows the modification.

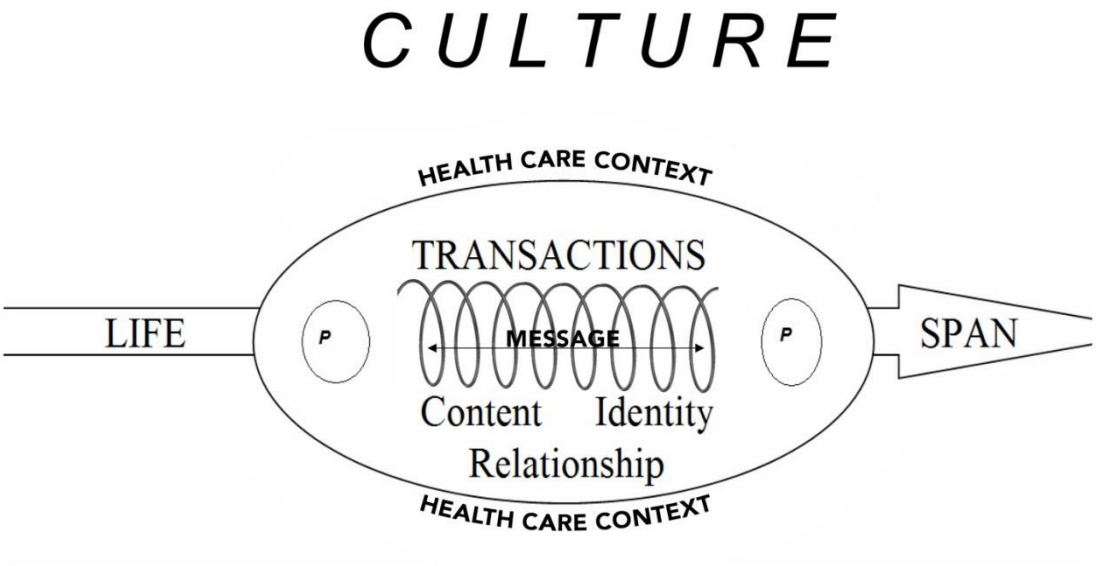

Figure 5. A modified Health Communication Model

The model shows only the relationship between the nurse and the client, as it is the focus of this study, but the relationships with other health professionals as well as clients' significant others could be added when needed. The framework for this model comes from the HCM, but I will describe and define the components of the modified model with references to relevant research.

The modified HCM (henceforth mHCM) describes communication in health care settings from a systemic perspective. In his overview of systems thinking, Aronson (1996, 1) describes the important difference between traditional forms of analysis and systems thinking. The main difference is to see the parts of a system interacting and interrelated with each other rather than breaking the object of study into smaller isolated constituents. Interaction or transaction, as the communicative events in health communication are called in this model, is a complicated, many-layered process. To analyse the parts, for instance the language, without taking the interconnectedness of the system, such as the various components of health communication, into account would not give a relevant picture of language in health communication. Systems thinking has gained ground in all walks of life from social studies to engineering (ibid.). The following definition of a system by Yura and Walsh from 1978, still captures the relevant aspects of a system that the mHCM describes. Following Yura and Walsh, *a system* is here defined as

> an entity composed of interrelated interacting parts or components. A system is comprised of purpose, process, and content. Purpose refers to that which must be accomplished and therefore gives direction to the system, content refers to the parts that make up the system, and the process of the system and its operations are functions of the parts in fulfilling the purpose for which the system was developed. (Yura and Walsh 1978, 43.)

All communication, health communication included, is in the mHCM viewed as interdependent with culture. Communication is always culturally situated and culturally relative. (Cf. Schiffrin 1994, 403.) *Culture* is here defined as the values, norms, and material goods characteristic of a given group (Giddens 1989, 582). Health communication in the mHCM refers to transactions between participants in the health care context, which is always a cultural context. When English is used as a foreign language in the transactions, the health care context becomes an inter- or multicultural context. Kreps and Kunimoto describe the proficiency in multicultural communication "as skills in communicating with members of diverse cultural groups to achieve desired objectives." (Kreps and Kunimoto 1994, 25). This summarises the English language proficiency requirements for the nursing students in this study, as well as the proficiency requirements for any other professional communicator.

The health care *context* includes everything that is involved in the system of taking care of a person's health from training health care personnel to health promotion campaigns and giving individualised care to a patient. As in the HCM, health care contexts in this model also refer to such health care settings as hospitals, nursing homes, and outpatient clinics but not only those; they also refer to any other settings, e.g., homes and schools, where health transactions take place. Health care contexts can also refer to the number of participants within a particular health care setting. The number of participants in health transactions varies from two to many. Health communication takes place in organisations as well as through the mass media. This definition of context follows the HCM and includes aspects that are not relevant for this study (e.g., health promotion campaigns) but they are included here for the sake of explaining a complete model rather than a partial model for the analysis of the present data only.

The primary *participants* in health communication are health professionals, clients, and significant others. The terms *client* and *patient* have been used interchangeably in the previous chapters depending on which term has been used in the source of reference. Both terms refer to individuals who use health services. According to Roper et al. (1980, 5) the word 'client' is used of well people who are helped to maximise their health status whereas 'patients' are traditionally perceived to have an illness status. This distinction is made in the mHCM as well; in the simulated work samples the exchange students played the part of a patient, not a client.

Transactions are here defined following King (1981, 82) as "a process of interaction in which human beings communicate with environment to achieve goals that are valued." In the health care context the valued goals of health transactions are always health-related. However, communication in the transactions may include other than health-related topics. In the mHCM, all communication in health transactions is included in the definition of health communication as long as the ultimate goal of the transaction is health-related. As in the HCM, health transactions in Figure 5 (cf. p. 36) are represented by a circle with an unending spiral illustrating the dynamic nature of health communication, which includes continual feedback. Health transactions are here

viewed as the abstract and dynamic events of participants exchanging verbal and non-verbal messages through a channel. The channel can be written, oral/spoken, electronic, print, audio or face-to-face.

In the mHCM, health transactions include the relationship, content and identity dimensions of messages. The three dimensions are present in every message of a health transaction and each dimension, in combination with the other two, affects the nature of the message. However, as Villard and Whipple (1976, 98) point out, there is usually a loading or primary emphasis on one of the three dimensions. The five variables that Northouse and Northouse (1985, 29) consider central to effective health communication function on the relationship dimension. Empathy, control, trust, self-disclosure, and confirmation all affect the relationship between the caregiver and the patient and therefore the language used in the messages of the transactions.

The *content* of a health transaction is influenced by the goals set for it. In the present study, the overall goal of health transactions is defined according to Roper et al. 1980 model for nursing as individualising nursing. The model was summarised in chapter 2.1.2. as a process of giving person-centred, individualised patient care. *Identity* is probably the most complicated aspect of communication and as Benwell and Stokoe (2006, 17) note it is also "a heavily theorized, academic concept". It is certainly beyond the scope of this study to open up all aspects of identity. The attempt here will be to try to make observations about how the student's professional identity as a nurse/nursing student affects the oral language in the transactions. The assumption then is that there is such a thing as 'professional identity' and that this identity becomes evident in discourse data. Looking at research on identity, it quickly becomes obvious that 'identity' in general can be understood in many various ways. What is relevant in the context of professional education is accepting the idea that 'identity' is something that can be socially constructed rather than something that is "absolute and knowable" (ibid. 24). Benwell and Stokoe observe that identity theories approach the concept from those two theoretical lines; 'constructionist' (socially constructed) and 'essentialist' ("absolute and knowable") ones (ibid.). According to Skinnari (2012, 33) the constructionist line has been prevalent in research on language learner identity especially since the 1990's. In their book *Beginnings of Relational Communication,* Villard and Whipple (1976) give a definition of identity that is suitable for the purposes of this study. Their approach has influenced literature on nursing interaction (see, e.g., Thompson 1990, 40). The definition is clearly based on the constructionist way of approaching identity. Villard and Whipple define human identity as directly drawn from cultural and group values, which are acquired through the process of learning and which are constantly subject to change. Furthermore, identity has observable manifestations and must be supported and maintained through interaction with others. The individual's identity consists of three types of self-perceptions or identities, which are personal, interpersonal and social-role identities. Villard and Whipple define these three types of identities as follows:

> Personal identities refer to those self-perceptions which are based on genetic traits or that are directly derived from inherited characteristics of the individual.
>
> Interpersonal (between people) identities refer to those self-perceptions that reflect our own interpersonal style of communicating - that is, how we see ourselves relating to others in our interpersonal lives.
>
> Social role identities refer to those self-perceptions that have been learned through interaction with others and that carry certain rights and privileges, as well as behavioural duties and obligations, consistent with a particular role location or position in the social system.
>
> (Villard and Whipple 1976, 71-73.)

In the mHCM, the main interest in the identity dimension is in social role identities. Giddens (1989, 79) defines roles as socially defined expectations that a person in a given social position follows. Thus, both the nurse and the client have expectations of his/her own and the other's role in a health transaction. It is not possible to make a clear distinction between the three types of identities; as Villard and Whipple (1976, 75) point out, personal, interpersonal, and role identities are highly interrelated. As this study focuses on the verbal messages of health transactions, the nature of the relationship, content and identity dimensions will be discussed in further detail in the following chapter.

2.4 Dimensions in verbal messages

In order to be able to analyze the verbal messages as to how professionally the nursing students communicate in the simulated work sample data, it is necessary to have an understanding of the content that the nurse needs to be able to convey and deal with in a nurse-patient transaction. The relationship between a nurse and a patient affects the interaction and therefore it is likely to affect the content of the transaction. In the mHCM, the role of the expectations of the nurse's identity needs to be considered as well. Each one of these dimensions will be discussed in the following three subchapters

2.4.1 Content dimension

According to the mHCM for this study the content dimension includes the individuality of nursing accomplished by using the nursing process. This process was briefly described in chapter 2.1.2 as consisting of the phases of assessing, planning, implementing, and evaluating. As these phases will be considered in the analysis of the nurse-patient discourse data of this study, a more detailed description is needed to enable the analysis. Each of the four phases of the process will be considered separately, but it is kept in mind that the phases are connected and the process operates with continuous feedback. Interviews are in a central role especially in assessment but questions in general are crucial in other parts of the nursing process as well. I will first describe the four phases of the nursing

process according to Roper et al. and finish the chapter with considerations of interviews.

Assessing. The form of the word 'assessing' implies the on-going nature of the activity in the nursing process. As was already mentioned in chapter 2.1.2, this phase includes: collecting information from/about the patient, reviewing collected information, identifying the patient's problems and identifying priorities among problems. Although assessing as part of individualising nursing should ideally be carried out as early as possible in the patient's stay, it is often not possible to collect extensive information within a few hours of admission. However, Roper et al. (1980, 53) point out that there are some topics about which information must be collected early. These include among others assessing bleeding or injury immediately. In the nursing simulation of the present study, the patient has a bleeding cut and therefore the nursing students need to collect relevant information from the patient during and after taking care of the wound. Roper et al. define two sorts of information that should be recorded. One is called the patient's 'biographical and health data', and the other is 'Activities of Living data' which are concerned with the individual's usual routines and current problems. Roper et al. discuss the two kinds of data quite thoroughly (Roper et al. 1980, 53-60). Identifying the patient's problems involves collecting information about the ALs. The objective is to discover: previous routines, what the patient can do independently, what the patient cannot do independently, what problems the patient has, both actual and potential. The third part of assessing is identifying priorities among problems. Here Roper et al. distinguish between 'nurse-perceived problems' and 'patient-perceived' problems. They point out that when it comes to identifying *potential* problems, the nurse's greater knowledge makes it possible to collect information which the patient may not volunteer without prompting. Decisions on the relative priority among the problems should be made in collaboration with the patient and maybe with the family. (Ibid., 60.)

Planning. Roper et al. describe the objective of a nursing plan to consist of four goals: to prevent problems, to solve and/or to alleviate them, and to help the patient to cope with problems that may still remain. Their description of making a nursing plan applies to a situation where the patient is hospitalized for a longer-term period as the nursing plan needs to be documented in writing and shared between all nurses taking care of the patient. (Ibid. 60-61.) An emergency situation is not discussed, but obviously this does not mean that no planning would be done when taking care of a patient with a wound, for example, as in the data of this study. The nursing plan cannot be written in an emergency context, but it needs to be discussed with the patient in some way (at least with a conscious patient). This will become clear in the description of the implementation phase.

Implementing. From the viewpoint of this study, it is interesting how Roper et al. emphasise that although nursing has traditionally been 'doing', the awareness of the importance of interaction when taking care of a patient has increased. The 'doing' needs to be explained to the patient so that the patient

understands the thinking and decisions that the 'doing' is based on. This involves verbal as well as non-verbal communication. The communication skills that Roper et al. mention are listening and talking in addition to such skills as observing and helping or not helping. (Ibid., 61-62.) The nursing students would then be expected to describe to their patients what they were going to do and also listen to the patient during the nursing process.

Evaluating. The last phase of the nursing process includes assessing how well the goals have been met and whether there is a need to continue the care if the problem still prevails to some degree (ibid., 62-63). Thus, at the end of the wound care situation, the students should evaluate the process and make plans for any necessary further care.

In the above description of the nursing process, sharing and negotiating the meaning of content has been in the focus. The nurse needs to be able to gain information from the patient, share his/her content expertise and verbally evaluate the need for further care. None of this can be done without questions. One of the most common health transactions that health professionals must have skills to do is conducting an interview which is part of the assessing stage. The simulation task of this study also includes an interview section. Northouse and Northouse divide interviews in health care settings into *information-sharing interviews* and *therapeutic interviews.* In information-sharing interviews the emphasis is on the content rather than on the relationship dimensions of the interaction whereas in therapeutic interviews the primary emphasis is placed on the development of the relationship. However, the authors point out that establishing a good relationship in an information-sharing interview is also important although it is not its distinguishing character. (Northouse and Norhthouse 1985, 175-176.) The relationship between the interviewer and interviewee may influence what kind of information is offered in the interview. This has been shown in various studies on doctor-patient communication (e.g., Gwynn 2002). Thus, the content of the interview is affected by the relationship between the nurse and the patient/client. Another aspect of interviewing that also affects the kind of information gained is the type of questions used. There are two types of questions and they are used for different purposes: closed and open questions such as 'Are you feeling all right today?' in contrast to 'how are you feeling today?' This first leading type of question is used to elicit structured, constricted information whereas the second 'open' question should elicit unstructured detail that should reflect the person's true state more accurately. (cf. Northouse and Northouse 1997, 181-182.) The context where these two types of questions are used can probably affect the kind of information that is gained in the interview or during the whole nursing process.

The information-sharing interview included in the simulation task of this study has very specific and defined goals in terms of the information that the nurse should elicit from the patient. It is hoped that the analysis of the data will bring out whether the nursing students of the study are successful in their task in terms of using the English language to elicit the required content and whether the relationship level as observable in the transcribed linguistic data can be seen

to have an effect on the content of the interviews. It is obvious that the content of the transactions is very much intertwined with the relationship dimension.

2.4.2 Relationship dimension

Roper states that a registered nurse must be capable of establishing, maintaining and ending nurse/patient relationships (Roper 1988, 29). However, the interactive nature of such relationships is discussed only with respect to a few aspects of nurse/patient communication. The emphasis in Roper 1988 is still on communicating as a patient's activity of living (AL), in which the patient may have problems that should be facilitated.

Peplau's 1952 model of the nurse-client (henceforth N-C) relationship seems to be one of the classic models of interpersonal relations as it is frequently referred to in the nursing literature. Peplau defines nursing as a significant, therapeutic, interpersonal relationship and discerns four overlapping phases in a nurse-patient relationship. Each of the four phases defines tasks and roles that are required of the nurse in the situation. The phases are orientation, identification, exploitation and resolution. During orientation, the patient seeks assistance and asks questions to clarify his problem. During this phase and also the other phases, the nurse may function in a role of a resource person, in a counselling relationship, in a role of surrogate for mother, father or sibling, or as a technical expert. During the next phase the patient identifies with the nurse, which means that the patient has a clear idea what he can expect from the nurses in the care relationship and this influences the way the patient reacts to them. Having identified with the nurse he is able to make full use of the services offered to him during the exploitation phase. Finally, the patient is helped to free from the identification of the helping people during resolution. (Peplau 1988, 17-42.) As the names of the four phases imply, Peplau defines them from the patient's angle, although she does discuss the roles of the nurse as well. Sundeen (1991, 383) describes the four phases in the N-C relationship in a slightly different way as consisting of preorientation, orientation, maintenance, and termination.

What I consider very useful in Sundeen's model is the observation that the phases of the N-C relationship can be aligned with the stages in the nursing process:

> Preorientation and orientation are related to assessment. Planning is the bridge between orientation and maintenance phases. Implementation and maintenance occur simultaneously.
>
> Evaluation occurs throughout the relationship, but is particularly prominent during termination.
>
> (Sundeen 1991, 249.)

Preorientation happens before the nurse and the client meet. The orientation phase includes introductions, orienting the client to the relationship, data collection and goal setting. The maintenance phase overlaps with Peplau's phases of identification and exploitation and Sundeen points out that it is

sometimes called the working phase, because it is the time during which the nurse and the client work on accomplishing the identified goals of the relationship. The termination phase is the same as the resolution phase in Peplau's model. Sundeen discusses what she calls interpersonal skills that are helpful when meeting the client's identified health care needs during the maintenance phase of the relationship. These include interviewing skills, nondirective therapeutic communication techniques, nontherapeutic communication techniques, active listening, empathy, and trust. (Ibid., 249-259.) Sundeen's interpersonal skills seem to overlap partly with the five variables that Northouse and Northouse consider to be central to effective health communication. In the HCM the phases of the N-C relationship are discussed only in the context of interviewing. Northouse and Northouse discern four phases in the interview process; preparation, initiation, exploration and termination (Northouse and Northouse 1985, 18). These phases are also reflected in Silverman et al.'s (2008, 17-19) framework of the structure of the medical interview which has the following five phases: initiation including preparation, gathering information, physical examination, explanation and planning and closing the session. Structuring the interview and building the relationship are aligned all through the interview. These frameworks give a clear picture of the phases that the students should be able to accomplish in the simulation task.

Northouse and Northouse (1985, 82-94) discuss the various relationships in health communication separately namely: 1) professional-patient, 2) professional-professional, 3) professional-family, and 4) patient-family. They contend that professional-patient relationship is influenced by the personal and professional characteristics that both the patient and professional bring to the relationship. They also consider four factors that are potential barriers to effective professional-patient communication. These include role uncertainty, responsibility conflicts, power differences, and unshared meanings. (Ibid., 82-94.) To look at these factors from another angle would be to regard roles, responsibility, power, and sharing meaning as factors that influence the relationship dimension of health transactions and thus the language in communication.

For the purposes of the present study, I will simplify the description of the phases in the nurse-patient relationship as consisting of three phases: orientation, working and termination. The orientation phase here refers both to the preparatory work done before meeting the client and the initiation part of the encounter. Orientation happens during the assessment and planning stages of the nursing process. The working phase corresponds to Peplau's phases of identification and exploitation and Sundeen's maintenance phase. As in Sundeen's model, implementation and working occur simultaneously. The termination phase signals the end of the N-C relationship and this is when evaluation is mostly done. The three phases of the nurse-patient relationship will be analysed in the data of this study. For the analysis, this process is presented in Table 1 below. The three phases of the N-C relationship defined above are aligned here with the nursing process and the nursing tasks that need to be accomplished

at each stage of the process. The phases clearly seem to proceed on a timeline and therefore it should be possible to identify them in the performance data.

Phases in the N-C relationship	Stages in the nursing process	Tasks
Orientation	Assessment	Introductions
	Planning	Goals /purpose Gaining information questions: open, closed
Working	Implementation	Nursing interventions / Giving information
Termination	Evaluation	Summarizing

Table 1. Phases in the N-C relationship aligned with stages in the nursing process

Of the five variables (empathy, control, self-disclosure, trust and confirmation) that Northouse and Northouse (1985) consider central to effective health communication, only two will be included here, namely, empathy and confirmation. These two variables will be focused on in the analysis of the relationship dimension of messages as they seem to be the most central ones in health communication. Both variables involve or are directly linked with the other variables: communication techniques that produce, for example, trust overlap with those that produce empathy. An example of this could be 'accepting'. In this study, empathy and confirmation are considered to be interpersonal skills that can be expressed both verbally and nonverbally. The non-verbal expression of the two skills is not within the scope of this study. The two variables are described in more detail below.

Showing empathy is an aspect of nurse-patient relationship that is discussed widely in nursing literature because of its relevance and complexity. Northouse and Northouse quote various definitions of this variable but I will use their definition: "Empathy is an attempt to feel *with* another person, to understand the other's feelings from the *other's* point of view." (Northouse and Northouse 1985, 31.) According to Rogers, empathy involves cognitive, affective, and communication components. (Rogers 1961 as quoted by Northouse and Northouse 1985, 31). Northouse and Northouse state that it has been possible to design specific strategies and techniques to assist professionals in developing and enhancing their emphatic skill. They point out that many of the common therapeutic techniques (such as reflection, restatement, and paraphrasing) are actually communication skills. (Northouse and Northouse 1985, 32.) Thus, looking at the empathy expressed verbally by the nurse in the work samples might mean analysing what kind of communication techniques the nurse uses. It should be possible to identify such techniques as reflection, restatement and paraphrasing in the transcribed discourse data: they are all communicated through language.

Although Northouse and Northouse characterise confirmation as involving dimensions of showing empathy, sharing control, exhibiting trust, and disclosing personal thoughts and feelings to each other they also consider it to be a distinct variable. It refers to communicative responses that are confirming, which means that they acknowledge and validate the other person's perspective. (Northouse and Northouse 1985, 64-74.) In his doctoral dissertation, Sieburg (1969) showed that confirming responses include direct responses, agreement, clarification, supportive responses, and expression of positive feelings; disconfirming responses include imperviousness, interruption, irrelevant responses, tangential responses, and unclear responses. (Sieburg 1969 as quoted by Northouse and Northouse 1985, 71-72.)

The verbal aspects of empathy and confirmation will be approached by analysing the use of certain communication techniques that are frequently mentioned in connection with the two variables. Lists of such variables by Faulkner (1992), Macleod Clark (1988), Earnest (1993), Sundeen (1991), and Northouse and Northouse (1985) are in Applendix 2. Table 2 is a list that includes the ones that will form the basis for the analysis of this dimension in the work samples.

Empathy	Empathy blocks
1. Restatement	1. False reassurance
1.a. Paraphrasing	2. Making stereotyped comments
1.b. Repeating	3. Moralising
2. Reflection	4. Belittling
3. Accepting (backchannelling)	
Confirmation	Disconfirming responses
1. Direct responses	1. Impervious
2. Agreement about content	2. Interruptive
3. Supportive responses	3. Irrelevant
4. Clarification	4. Incoherent

Table 2. Categories of communication techniques involved in showing empathy and confirmation and of communication blocks

The communication techniques listed under empathy have been discussed by various researchers. The techniques listed under confirmation have been adapted from Sieburg 1969 by Northouse and Northouse (1985, 72).

Northouse and Northouse (1985, 32) mention reflection, restatement, and paraphrasing as therapeutic techniques that enhance empathic skill. When discussing *restatement*, Northouse and Northouse state that it is a technique that confirms clients because it directly acknowledges their point of view (ibid., 195). Thus, the distinction between empathic and confirming communication techniques is not a clear one either. As a communication technique, restatement involves paraphrasing the client's statement or part of it to encourage continuation and to validate understanding of the meaning of the communication. Apart from paraphrasing, restating may be repeating all or part

of the clients' message. (ibid., 195, Sundeen 1991, 253, Earnest 1993, 38.) Northouse and Northouse (1985, 195) state that restating the message in slightly different words seems more empathic and less mechanical than restating exactly the same words.

According to Sundeen *reflecting* requires the nurse to identify the main theme of the thoughts or feelings that are being expressed by the client. She further points out that in case the nurse misunderstands the client, reflecting allows for correction while indicating to the client that the nurse wants to understand. She warns interviewers overusing restating and reflecting as the effect of overuse would be like parroting. (Sundeen 1991, 253.) Northouse and Northouse conclude that the effective use of reflection requires health professionals to have a broad vocabulary of feelings (Northouse and Northouse 1985, 197).

Earnest includes *acceptance* in her list of facilitating communication skills. It is here taken for granted that acceptance enhances empathy in the N-C relationship. According to Earnest the nurse can convey acceptance through comments like: ″I hear you″ or ″I follow you″. Such comments indicate that the nurse is following the client's trend of thought and the client can therefore feel safe that the communication is understood. (Earnest 1993, 38.) Backchannel signals are not mentioned by any of the four writers. However, such signals are common in communication, and I would assume that to be true of professional communication as well. Saville-Troike (1996, 148-149) describes backchannel signals in English conversations to include such nonverbal vocalizations as *mm hm* and *uh huh*, verbal *yeah* and *I see*, or nonvocal head nods and postural shifts. I will consider verbal backchannel signals like 'yea', 'I see', 'aha', 'really' as ways of indicating acceptance and understanding. As the focus in this study is language use, nonvocal or nonverbal signals such as described above will not be included in the analysis.

Communicating empathy successfully is blocked by various factors of which four will be considered here. *False reassurance* may help the nurse but not the client. When the nurse says″Don't worry. Everything will be all right,″ she discounts the client's feelings and implies faulty judgement on the part of the client. (Earnest 1993, 40, Northouse 1985, 201, Sundeen 1991, 254.) *Making stereotyped comments* involves exchanging meaningless words and clichés. When referring to stereotyped comments Earnest uses the notion of 'automatic responses ' and points out that although automatic responses are a part of everyday conversation, the nurse would do well to limit them. (Earnest 1993, 40.) With automatic responses Earnest probably refers to stereotyped comments. Northouse and Northouse give an example of *moralising*: ″You acted too hastily; you should have thought through the consequences before you got involved.″ They comment that this does not move interaction forward blaming the client and stagnating interaction. (Northouse and Northouse 1985, 201.) The example might also serve as an example of a value judgement or advice giving. Sundeen describes value judgements as including using phrases such as ″that's good″, or ″that's bad″ (Sundeen 1991, 254). Moralising here includes both value

judgements and giving moral advice. Northouse and Northouse (1985, 201) and Earnest (1993, 41) give examples of *belittling feelings*. When the nurse equates the client's feelings with her own or others', she overlooks their importance for the client. Earnest states that no empathy or understanding is expressed by the nurse, and the impression is conveyed that the feelings are temporary or minor. (Earnest 1993, 41.)

Northouse and Northouse base their discussion of confirmation largely on Sieburg (1969). The items included in confirmation are discussed by others as well although the term confirmation is not used. Sundeen (1991, 258) and Earnest (1993, 37) consider clear and complete answers to questions as a component of building trust. As was stated above, confirmation involves a dimension of trust, among other things. In this study *direct responses* are considered as part of confirmation. *Agreement about content* means reinforcing or supporting what the other person is talking about. *Supportive responses* express understanding, reassurance, or they try to make the other person feel better. (Sieburg 1969 as adapted in Northouse and Northouse 1985, 71). *Clarification* is a communication technique that is discussed by all these four authors. Faulkner (1992, 34) mentions two specific situations when clarification is required: when a patient uses an ambiguous word and when words with both social and professional meaning are used. The other three authors see a need for clarification whenever the client's message is unclear to the nurse (Earnest 1993, 38, Northouse and Northouse 1985, 71 (from Sieburg 1969), Sundeen 1991, 254). Although Earnest has clarificating and validating listed separately in her table of communication skills and blocks (cf. Appendix 2), she uses the two terms as synonyms when giving examples of the skills of communication (Earnest 1993, 38). Sundeen (1993, 254) mentions consensual clarification as a related technique to clarification which refers to assuring mutual understanding of words or phrases. Here clarification is considered asking for further information whenever the client's message is not clear.

Those of the disconfirming responses that are included in the analytic tool of the relationship dimension are presented in Table 3 as they appear in Northouse and Northouse's adaptation from Sieburg (1969) (Northouse and Northouse 1985, 72).

Disconfirming responses deny the other person's existence. These responses are inappropriate or irrelevant to what the other person has communicated. They make the other person value herself or himself less as an individual.

Disconfirming responses may be characterised as follows:

1. *Impervious.* To ignore or disregard the other person's attempt to communicate by making no verbal or non-verbal acknowledgement of what they have communicated.

2. *Interruptive.* To cut the speaker off before she or he has a chance to finish a statement or fully elaborate on a point.

3. *Irrelevant.* To respond in an unrelated way to what another person has communicated. This can be done by introducing a new topic or shifting to a previous topic without warning.

4. *Incoherent.* To respond in incomplete sentence or long, rambling speeches. This response is often difficult to follow because it contains much retracing and rephrasing which adds nothing to the content of the message.

Table 3. Disconfirming responses

It will be interesting to see whether the nursing students use disconfirming responses. Looking at the definitions of impervious, interruptive, irrelevant and incoherent responses, one would be tempted to consider those kinds of responses quite typical of human everyday interaction. Therefore avoiding them in goal-oriented professional communication may not be easy.

2.4.3 Identity dimension

The identity dimension of the mHCM includes roles, norms, values, power and language. Each one these concepts could be and have been discussed at length and from various different theoretical viewpoints (for example Castells, 2010 on identity, Wallace on norms 2008, and Fairclough 2013 on power and language). Here they will be discussed only briefly in the light of research on nursing profession so as to help in analysing how the professional identity of the nursing students becomes apparent in the language of the work samples.

2.4.3.1 Professional role

As was pointed out in chapter 2.3, the mHCM model focuses on the social role identities in the identity dimension. Öhlén and Segesten (1998) made a literature review and an empirical interview study on the professional identity of the nurse. On the basis of their review and study, they conclude that such attributes as compassion, competence, confidence, conscience, commitment, courage and assertiveness are connected with the professional identity of a nurse.

Öhlén and Segesten also bring up the need for cross-cultural studies on this topic. (Öhlén and Segesten 1998, 725-726.)

Ora-Hyytiäinen (2004) studied the development of professional identity of Finnish nursing students during their polytechnic studies, which lasted three and a half years. She defined the nurse's identity as comprising of a nurse's role, an experience of the work and belonging to a group. The group could be any of the groups related to the work: workplace, workers, caregivers and nurses. The development of the nurse's role had five different phases in her data. (Ora-Hyytiäinen 2004, 45). Four of the phases corresponded clearly to the number of academic years in the nursing curriculum. During the first year, and the first phase, the students do not have a professional identity and they feel their role to be a helper. In the second phase, the identity comprises a role of implementing care together. In the third phase, the identity includes a role as a provider of not just primary care but nursing care. In the fourth phase there are two different types of roles; that of an effective nurse and a reflective nurse. (Ibid., 66-68.) The four phases in Ora-Hyytiäinen's are not that different from Benner's (1984) description of five levels of nursing experience, which she bases on the Dreyfus skills acquisition model (Dreyfus and Dreyfus 1980). The five levels are: novice, advanced beginner, competent, proficient and expert. Nicol, Fox-Hiley, Bavin and Sheng have created a Schedule of Skills Development operationalising Benner's (1984) model. In this schedule Nicole et al. describe the clinical and communication skills included in each of Benner's five levels (Nicole et al. 1996, 178). Both Ora-Hyytiäinen and Nicole et al. focus on nursing students' skills development during their studies and both also consider the approach to be different from skills development in nursing in general. Table 4 shows the levels of communication skill development according to Nicol et al. 1996.

Box 2 Levels of communication skill development

E: Skill mastery
- Communication skills are a natural part of every professional interaction
- Cognitive, affective and psychomotor components are highly developed and less subject to interference from other ongoing activities
- Performance, based on increasing knowledge and experience, is confident, efficient and responsive to situational cues
- Reflection is central to practice at this level

D: Safe and accurate performance with indirect supervision in the care setting
- The student is able to use an appropriate blend of communication skills, in a coordinated and effective manner
- The student is aware of his or her limitations and seeks help and advice as appropriate
- The student is able to adapt his or her performance in response to changes in the care situation
- Performance at this level is 'competent'

C: Safe and accurate performance under direct supervision in the care setting
- The student is able to utilize and blend communication skills together
- The communication skills chosen are appropriate to the patient/client and the situation
- The skills are executed smoothly and appear natural

B: Safe and accurate performance in the skills centre
- The student is able to utilize and blend communication skills together
- The communication skills chosen are appropriate to the patient/client and the situation
- The skills are executed smoothly and appear natural

A: Foundation
- The student is able to identify the rationale for use of the skill, although tends to reiterate text book explanations
- The student is able to state when use of the skill is appropriate, and to what degree
- Performance of the skill is awkward and the student may appear self-conscious

Table 4. Levels of communication skill development (reprinted from Nicol et al. 1996, 178)

On the levels of communication development above, the levels between the Foundation and Skill mastery are described as to the safety and accuracy of performance with or without supervision. The levels are characterised further with such features of communication as appropriateness and smoothness. On the Foundation level the student's communication is awkward and reliant on text books. The Skills mastery level is characterised by confidence, reflection and communication skills being a natural part of professional interaction. It is hoped that the analysis of the work sample data will shed some light on the level of the nursing students' communication skills. Such considerations might be of value for curriculum development.

Ora-Hyytiäinen emphasises the importance of the surroundings to the development of the professional identity. By surroundings she means the social and symbolic environment. (Ora-Hyytiäinen 2004, 66-68.) In the mHCM this would correspond to the health care context.

2.4.3.2 Norms, values and power

The effect of *norms* in nursing practice has been studied from the angle of work place ethics (e.g., Verpeet, Meulenbergs and Gastmans 2003) and from the angle of patient care (e.g., Nash, Edwards and Nebauer 1993). Fagermoen (1997, 435) describes the emergence of professional identity as part of self-formation which in turn involves social interaction and self-reflection. *Values* are an important part of this process. Based on her Norwegian study and other similar studies in Canada (Oberle and Davies 1993), the USA (Appleton 1993), and Scotland (May 1991), she contends that it is possible to discern a transcultural common core of

nurses' professional identity. Such values as dignity, personhood, being a fellow human, and reciprocal trust in providing care to patients seem to be transculturally actualised by nurses. (Fagermoen 1997, 439.) This is not surprising as the profession is guided by common principles, which are expressed in codes for nurses (cf. Roper et al. 1990, 47 and Numminen 2010, 17).

Ora-Hyytiäinen's (2004) study of the professional growth of Finnish polytechnic nursing students included the development of professional values. During the 3,5 years of study, the students' values changed from benefiting the organisation to benefiting the patient. (Ibid.,68.) Thus, the nurse's values will become evident in the relationship with the patient.

Power is present in all institutional talk as such talk is, according to Drew and Heritage (1992, 47), typically asymmetrical. In health communication, it seems that power has been studied most in doctor-patient interaction whereas other health professionals are still waiting to be the focus of research, especially in Finland (Kettunen, Poskiparta and Gerlander 2002, 112). Kettunen et al. found in their analysis of 38 counselling sessions in a Finnish hospital that the nurses and patients constructed power together. The patients asked information-seeking questions, clarifying questions, brought their own knowledge and experience into the counselling situation and interrupted the conversation. The nurses held the floor longer, chose the topics and mostly controlled the structure of the conversation. (Ibid., 103-109.) Both nurses and patients in the simulations are students. Their power relations may not be exactly what the power relationships in real nurse-patient situations would be. Still, the aspect of power may come into play in the data in the form of role expectations and conceptions. Therefore, the above-mentioned aspects will be considered in the data analysis.

2.4.3.3 Language

Language is an important part of identity or, as Byram puts it, "language, and language variety – dialect or sociolect – is one of the overt signs of cultural identity which people meet daily in their lives." (Byram, 1989, 40). This approach to language is typical of sociolinguistics (cf. Norton 2010). Language as part of identity and culture has become a common approach in language education (cf. Council of Europe 2001). Professional identity has been researched as part of institutional talk, for example by Drew and Heritage (1992). Drew and Heritage characterise institutional talk as goal-oriented involving constraints and possibly associated with institution-specific procedures (Drew and Heritage 1992, 22). This description fits well with the mHCM used in this study. The way nursing students talk in the institutional situations reflects their professional identity which is influenced by the goals and the tasks that they need to accomplish. The nurse's role is also characterised by certain constraints and expectations. It is not only the nurse who is aware of the constraints but the patients/clients have their expectations of the roles as well (cf. ibid. 23). All the personal factors to do with a person's identity such as age, sociocultural background, past experiences, specific characteristics, values and beliefs, and contextual constraints such as roles, norms, values and power, all come into play in communication. The

dynamic nature of communication affects the participants' professional and personal identities as they construct communication in the institutional context.

2.5 Context: positioning language as part of CLIL and professional competence

To further clarify the role of language in the context where the nursing students of the study performed, this chapter considers first the educational CLIL context with respect to the professional nursing studies that build the nursing students' professional competence. All language education in Europe has been widely influenced by the *Common European Framework of Reference for Languages: Learning, teaching, assessment* (CEFR) (Council of Europe 2001) and as it is based on long-term research on language learning and teaching, it cannot be overlooked in the context of this study. To bridge a potential gap between content and language in the health care context, I will thirdly look at research on language and oral proficiency in health care. The chapter finishes with acknowledging the paradigm shift in language conceptualisations that has been taking place especially in this millennium. When this study started, language conceptualisations were narrower than they are now. To consider language as part of professional competence was very new at the time.

As became evident in the review of previous research in the introduction, studies on the effect of Finnish CLIL programmes in professional/vocational education on learner language in English have focused on the linguistic aspects of the language (cf. Johnson and Rauto 2008 and Rauto 2003). The fact that there is very little or no research on professional communication within CLIL reflects the reality of the challenges that the CLIL approach has been facing ever since it started. The definitions of CLIL have emphasised the dual focus of the aims in any CLIL programme, "the learning of content, and the simultaneous learning of a foreign language". (Marsh 2002). Emphasising the dual focus is important because without focus the aims of the programmes would be vague. Still, this definition seems to work in a way that keeps the two, content and language, in their own categories. In the programme of this study, the roles of the content teachers and language teachers were not made very clear in the mid 1990's. Some content teachers said that they gave feedback on language for instance in written tasks, but whether language was ever explicitly taught or paid attention to in the content classrooms was not discussed in the CLIL teacher group of the programme. The role of language remained fuzzy. This is a topic that is yet to be resolved. In her article published in 2015 on subject-specific language use and learning in the CLIL science classroom, Nikula calls for awareness raising of the relationship between language teachers and CLIL teachers. As content teachers bring the language of their subjects to the students, they are language teachers as well. The CLIL content teacher does not easily take on the role as a language teacher as their professional identity and their orientation to language seems to

be to approach language as a decontextualized formal system. (Nikula 2015 a, 29.) The content teachers in the English enhanced programme of this study may have felt that language is not really part of their professional identity. This can point to a state of affairs where there is a gap between content and language in a context where language is inherently part of professional communicative competence. This gap in CLIL may be due to what is meant by 'language'; whether language means a decontextualized formal system or whether it involves aspects of communication as well.

2.5.1 Recent developments in CLIL

Coyle has developed a model that aims to support CLIL pedagogy. Her model integrates "content (subject matter), communication (language), cognition (thinking/learning) and culture (intercultural understanding including awareness of self and *otherness*)". (Coyle 2007, 550). This approach deals with similar concepts as the mHCM with the main difference that it puts culture in the centre and communication, content and cognition in the sphere.

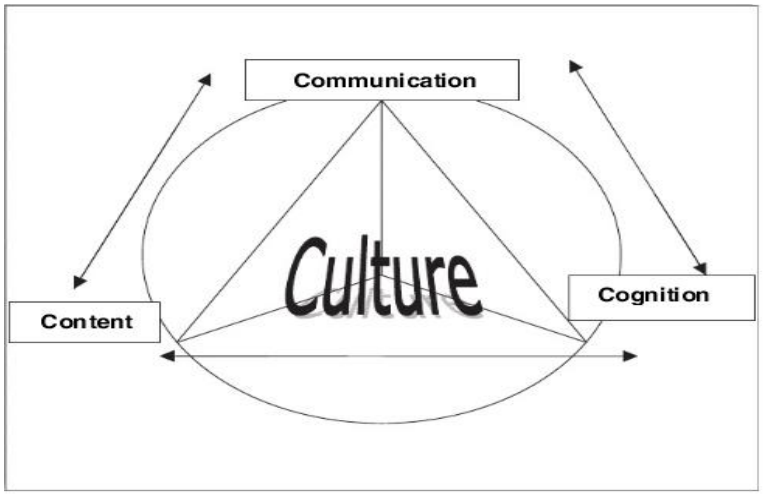

Figure 6. The 4 Cs Framework for CLIL. *Source* Coyle 2006 (in Coyle 2007, 551).

Coyle sees a need to reconsider the role of language in CLIL. She refers to language teaching and learning as progression of grammar. She also thinks that within CLIL this should change and language use should be taken into account as well. Coyle seems to consider language teachers challenged in developing CLIL pedagogy as

> there is now an identified need to explore alternative approaches beyond those embedded in grammatical progression which are commonplace in foreign language classrooms. Such approaches to CLIL have to take into account teaching and learning scenarios led by the content teachers, who may not be familiar with second language acquisition theories and those led by language teachers, who may resort to an overemphasis on linguistic form.
>
> (Ibid., 552.)

The communicative approach to language teaching has been prevalent ever since the 1970's but as the worry that Coyle expresses above reveals, the idea of language teaching as equalling teaching of grammar (and vocabulary) seems to prevail. Changes in education are slow; Coyle expressed her wish of taking language use into account six years after *Common European Framework of Reference for Languages: Learning, teaching, assessment* (CEFR) was published. The CEFR is a framework of reference for European language teachers to be used for curriculum and material design, and assessment of language proficiency. The framework has a functional approach to language education with language use in the focus (Council of Europe 2001, 1).

Mohan, Leung and Slater (2010) are among the first to start developing an integrated assessment of language and content in CLIL and second language educational contexts. They criticise the fact that content and language are continually assessed separately in contexts where there is integration of content and language instruction. Mohan, Leung and Slater refer to the communicative competence models developed for testing in second language research (Bachman 1990, Bachman and Palmer 1996 and Canale and Swain 1980) and then to Widdowson's (2001) observation of the communicative competence approach: the models do not explain how the various competencies function together in communication. Following Widdowson, Mohan et al. recommend using Halliday and Mathiesen's (1999) concept of meaning potential as a basis for integrated assessment of language and content. This means dismissing the idea of competence as a basis for testing and having meaning making in the centre. (Mohan et al. 2010, 217-220.) This again is a clear indication of a need for a paradigm shift: the communicative competence models referred to above have turned out to be problematic in their abstract definitions of competence and performance. Content and language integrated learning has pushed boundaries and it is no longer meaningful to consider language as an object of study, the way Coyle criticised it in 2007, and, as Mohan et al. above propose, nor consider it as part of a separate competence. The CEFR from 2001 is actively in use in Europe and it has influenced approach to language learning, teaching and assessment all over Europe ever since it was published (see, e.g., Figueras 2012, 477-479). The framework is based on competence-performance thinking. The CEFR being such an influential document reflects an approach to language that is widely acknowledged. The next chapter will look at how the CEFR describes language and especially oral language skills.

2.5.2 The CEFR: oral proficiency

In the European educational context, the CEFR cannot be overlooked and as this study focuses on oral language skills, the descriptions of those skills in the CEFR need to be considered. The CEFR does not start from defining or describing language, but sets language in two contexts: that of the learner and the culture (Council of Europe 2001, 1). In other words, language is considered in the framework of learner competence; what the learner needs to be able to do to use

language for communication in a cultural context. The concept of competence in the CEFR includes general and communicative competences. The communicative language competence is considered as consisting of linguistic, sociolinguistic and pragmatic components. Each one of the components consists of knowledge, skills and know-how which are activated when performing language activities including reception, production, interaction or mediation. In other words, students' performances show what they can do with the language and this performance is based on their competences. Language activities are part of four domains: the public domain, the personal domain, the educational domain and the occupational domain. Furthermore, the individual needs strategies in communication, and learning and he or she needs to be able process oral or written texts. (Council of Europe 2001, 9-16.) The concept of domain seems to account for such approaches as CLIL and language as part of professional competence.

In addition to defining competence and performance (language activities), what is of interest in the CEFR to this study is the way oral language proficiency is described in the framework of the language proficiency assessment levels. The descriptions of the six proficiency levels have a horizontal and a vertical dimension. The vertical dimension depicts learner progression in terms of objectives and achievement. The horizontal dimension includes descriptions of communicative activities and communicative competence. The qualitative aspects of spoken language use are described horizontally in five categories in one assessor-oriented table as including range, accuracy, fluency, interaction and coherence. Each one of these is described vertically on a proficiency level. (Council of Europe 2001, 28-29.)

Oral skills are further described under 'speaking' and divided into 'spoken production 'and 'spoken interaction'. The first one looks at speaking in what seems to me to be transmission of messages or text as they are referred to in the CEFR. The descriptor grids of spoken production are about monologue, which is not relevant to this study. (Ibid., 58-60.) Spoken interaction is described in the context of various communicative situations including some occupational/professional ones such as meetings, goal-oriented co-operation and interviewing. In these interactive situations the language user is both the speaker and the listener and this is taken into account in the scales. The descriptions of the spoken interaction start with an overall description where the highest proficiency level, C2, is described in terms of 'command of idiomatic expressions', 'colloquialisms', 'awareness of connotative levels of meaning', 'reasonable accuracy', and 'smooth backtracking and restructuring'. (Ibid., 74). B2 level description includes references to fluency, accuracy, grammatical control and a special focus on interacting with native speakers: "Can interact with a degree of fluency and spontaneity that makes regular interaction, and sustained relationships with native speakers quite possible without imposing strain on either party" (ibid.). The focus on native speakers is further emphasised in the grid presented after the overall description of spoken interaction; the grid is about 'understanding a native speaker interlocutor' (ibid., 75).

The illustrative scales for, e.g., the occupational/professional contexts mentioned above (meetings, goal-oriented co-operation and interviewing) only mention fluency in the context of interviewing. In the other contexts neither fluency, accuracy or understanding native speakers are mentioned, rather the focus is on such cognitive skills as argumentation ("at no disadvantage to native speakers") and speculating about causes or consequences. (Ibid., 78-79.)

What can be concluded from the descriptions of spoken interaction is the fact that the target and the comparison point is native speaker competence. Yet, this does not seem to be in accordance with the Council of Europe language policy which aims to promote plurilingualism: the aim of language education is profoundly modified. It is no longer seen as simply to achieve 'mastery' of one or two, or even three languages, each taken in isolation, with the 'ideal native speaker' as the ultimate model". As is stated in the CEFR, to fulfil this aim calls for a paradigm shift. (Ibid., 5.) The descriptors for spoken interaction will certainly need some modification to take the plurilingual aspect into account. This aspect further concerns plurilingualism in professions/vocations. To describe the requirements and challenges of plurilingual work life is a demanding undertaking worth thinking about though. Vocationally oriented language learning (VOLL) is considered in the CEFR and the fact that the descriptors do not cover all themes in the occupational area is recognised (ibid., 53). The descriptions of the variables in the model used in this study could be used for developing CEFR descriptors for nursing. There is a need to develop such descriptors and the process has already started; for instance, descriptors for nurses with Finnish as a foreign language have already been made (Komppa, Jäppinen, Herva and Hämäläinen 2014). Designing and sharing descriptors for professions/vocations naturally enhances shared understanding of what it is in language use that is important for work life.

As was pointed out at the beginning of this chapter, the CEFR describes three communicative language competences. Functional competence, which is the main interest in this study, is part of pragmatic competences together with discourse and design competences. The CEFR defines functional competence as "the user/learner's knowledge of the principles according to which messages are used to perform communicative functions" (ibid., 128). Linguistic competences include considerations of vocabulary (lexis), grammar (accuracy), meaning (semantics), pronunciation (phonology), and writing (orthography). Sociolinguistic competences are illustrated in terms of a scale of appropriateness. (Ibid., 108-122.)

Spoken discourse is considered in the light of communicating for functional purposes. This would overlap well with the goal-oriented communication in the professional health transactions described in the model of this study. Two generic qualitative factors are described in the CEFR for determining how successful the language user is in the transactions/interactions, namely, fluency and propositional precision. Fluency is defined as "the ability to articulate, to keep going, and to cope when one lands in a dead end" and propositional precision as "the ability to formulate thoughts and propositions so as to make one's meaning

clear" (ibid., 128). Spoken fluency is further described in the illustrative scale with, for example, such words as 'effortless, unhesitating flow', 'spontaneity' and 'ease of expression'. The scale illustrating propositional precision includes such descriptors as 'reasonable accuracy', 'passing detailed information reliably' and 'explaining the main points in an idea'. (Ibid., 128-29.)

The above summary of how the CEFR describes communicative competences and oral proficiency in interaction gives an idea of the way the CEFR breaks down and defines various aspects of communication with language use. The concept of 'language' with all the various competences is wide in the action-oriented approach that the CEFR represents. When the different competencies are described within separate scales, it may be possible to forget the relationship between the competencies. However, as all descriptors are presented on the same six-point scale from A1 to C2, the interpretation might easily be that all competences develop at the same time: the better linguistic competence the language user has, the better, say, her functional competence is. There is research that shows that in working life functional use of language is more important than grammatical accuracy (Sajavaara and Salo 2007, 238, Härmälä 2010, 33). This would mean that functional competence and linguistic competence need not be at the same proficiency level. Thus, the CEFR seems to share the same problem as the models criticised by Mohan et al. 2010 for not explaining how the competencies function together (see p. 46 in this study).

The scales provide useful observations that can be applied to analysing discourse data for the purposes of assessment, but there are questions that arise as well. Referring to native speakers in several scales is understandable from the point of learning and teaching a language, but not so in the context of using a language in global or intercultural professional contexts where the language, very often English, is used between non-native speakers as a common foreign language, a lingua franca. Can this be considered when assessing the functional success of transactions? Are such aspects of language use as 'command of idiomatic expressions', 'colloquialisms', 'awareness of connotative levels of meaning' and 'reasonable accuracy' as important in English as a lingua franca communication as they might be when communicating with native speakers? What is the role of fluency between non-native speakers? What role does accuracy have in propositional precision? The CEFR has been a great development in furthering understanding and discussion about language instruction in Europe. It has its weaknesses as various critics have shown (cf. e.g., Figueras 2012, 482). The CEFR does recognise the fact that vocationally-oriented language learning may need descriptors that are not yet part of the CEFR (Council of Europe 2001, 53). Härmälä (2008) used the CEFR in her doctoral dissertation study on tasks and assessment criteria that are used to assess the language skills required in the Qualification of Business and Administration (QBA) as part of vocational competence. She defines vocational competence in very broad and general terms because the QBA covers over 30 possible job titles. The data in Härmälä's study comprised of a survey of language teachers' language conceptions, analyses of tasks and criteria, and language teacher

interviews about work sample tasks ad assessment. She found the CEFR a useful tool in showing the differences in requirements between different institutions. (Ibid., 255.) In this study, the CEFR is used in describing the nursing students' general English proficiency. The CEFR descriptions of the linguistic competence will be made use of when considering the second research question.

2.5.3 Language and oral proficiency in health care

Studies of health communication and interaction rarely mention language and the same is true of nursing literature discussing interaction. This was also the case with Roper et al.'s model for nursing (1980 and 1988) discussed in chapter 2.2. In their discussion of the interaction phase of symptom management, Haworth and Dluhy (2001, 308) conclude that "establishing shared meaning during symptom disclosure and interpretation represents a task for the client and nurse". They also emphasise that the study of the interaction phase between a nurse and a client involves various fields and theories (ibid., 304). To describe and explain this interaction presupposes a transdisciplinary approach where the focus needs to be on meaning. Unlike many other theorists, Haworth and Dluhy include language as an important factor in the interaction phase. This is well-depicted in the client-nurse interaction phase of symptom management presented in Figure 7.

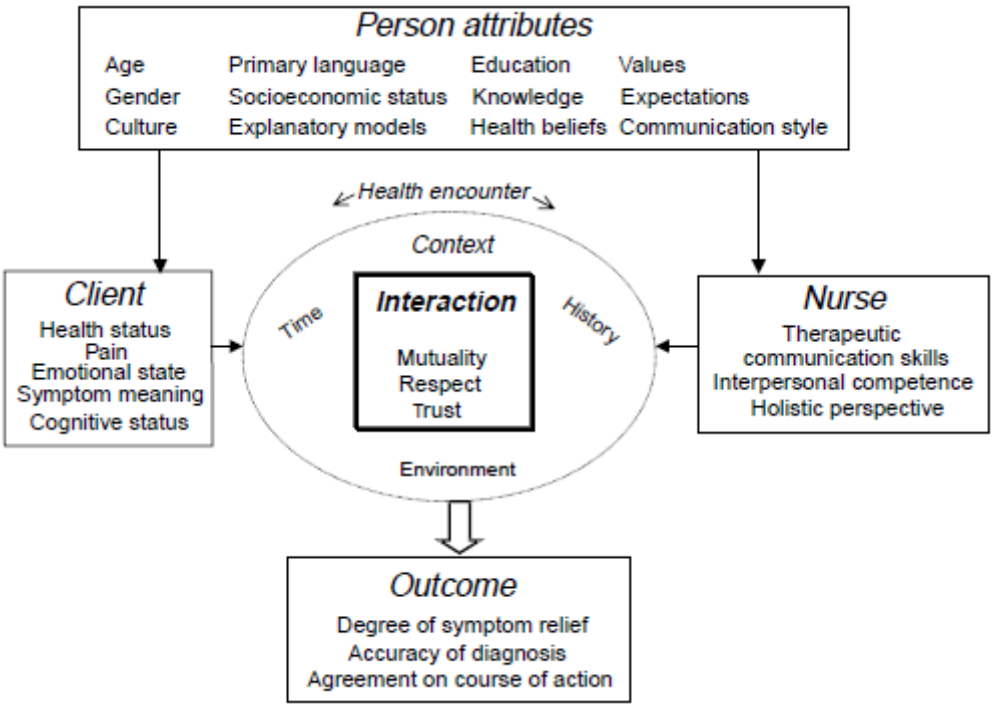

Figure 7. Client-nurse interaction phase of symptom management (Haworth and Dluhy 2001, 304).

Although language is considered important in the model above, it is only 'primary language' that is mentioned as part of 'person attributes' and not

mentioned in any way in the actual interaction. Haworth and Dluhy do not define 'primary language' in their discussion of 'person attributes'. Language is mentioned only in connection with people giving "language to their symptom experience" (ibid. 305). 'Primary language' might refer to a person's native language as that, I assume, is usually considered to be the first language.

Foreign and second language proficiency is a central factor when employing immigrants in nursing. Therefore language skills have been tested as part of recruiting nurses in English-speaking countries. Language testing in professions then also gives a picture of what kind of language skills foreign employees should have as the validity of a test always calls for a clear answer about what is being tested. Although the data in the present study derives from simulations and not from an actual test, there is a theoretical overlap in testing approaches and the one in this study as both need to define what professional language proficiency is. The approach has been for a long time to consider this in terms of competence and performance. Any research done on language testing gives an overview of different definitions of the two terms starting from Chomsky's (1965) introduction of the distinction between competence and performance followed by a discussion of Hymes' (1972) definition of communicative competence and later definitions by Canale and Swain (1980, 1981) and Bachman and Palmer (1996). The latter two have influenced language education and assessment most during the past decades (cf. Bagarić and Djigunović 2007). The CEFR of course is influential in Europe. None of the models seem to be perfect as distinguished language test developers have come to realise in their practical work. In his discussion, McNamara, who has developed a performance test for health professionals in Australia, has come to the conclusion that the model of language ability by Bachman and Palmer (1996) and Bachman (1990) is too abstract for testing purposes (McNamara 1996, 66-76). In 1996 McNamara puts forth that the problem with the models at that time was that they focus too much on the individual. He calls for more attention to performance assessment in interaction and to research on the use of language in interaction. (Ibid., 84-85.) Discourse analysis describes language use in interaction, but assessing interaction is complicated with many variables to control and not easily validated. In her book on assessing speaking, Luoma reviews all the influential models of communicative competence mentioned above. She also looks at Vygotsky's activity theory and sociocultural approaches to learning by Lantolf and Pavlenko (1998) and comes to the conclusion that they are too abstract to be applicable for assessment. Luoma's conclusion is that the theoretical framework that is used depends on the purpose of the test. (Luoma 2004, 96-112.)

The situation in CLIL nursing education in Finland has changed a lot since the nursing programme of this study started in 1996. Language as part of professional competence does not concern only the English language in the CLIL programmes in Finland, but in the 1990's this was not discussed. Degree programmes taught in English as part of the internationalisation of Finnish higher education have brought up questions of the role of the Finnish language

in these programmes. According to Jäppinen (2010, 5-6) research on Finnish as a second language (S2) related to working life has only started during the recent years. She discusses the language proficiency requirements in the work of those with a higher education degree (Jäppinen 2010). The question of proficiency level naturally applies to English language as well. Komppa et al. (2014) provide a professional language proficiency framework for Finnish as a second language in polytechnics. The central work-related tasks were defined on the basis of texts on the work environments and the work as well as by interviewing those working in the fields or studying them. The language needs were then considered with respect to the CEFR (ibid., 9). Komppa, who designed the framework for nurses, set the Finnish as a second language language proficiency requirement level for nurses in Finland at minimum B2 level or higher (ibid., 14). Oral communication for a nurse is described in terms of understanding and oral production as follows: "Understanding: understands spoken language, also dialects and speech of special groups." and "Production: pronounces clearly, understands feedback and is able to give it." (ibid. 29, my translation). These descriptions are quite general and Kela and Komppa point out that the frameworks were based on teacher experience, collegial discussions and other information sources. They emphasise that more research would be needed to confirm the conceptions of what sort of language skills are required in the professions. (Kela and Komppa 2011, 177.)

2.5.4 Paradigm shift: On language conceptualisations

In the preceding discussion three approaches to 'language' appeared: language as a formal linguistic system (as referred to by Coyle (2007), language as competence which is tested and assessed through performance (e.g., Bachman 1990, Bachman and Palmer 1996, Canale and Swain 1980 and Council of Europe 2001) and language as meaning making as described by systemic functional linguistics, SFL (Halliday and Mathiessen 1999). Johnson (2004) reviews three major scientific research traditions in second language acquisition, namely Behaviourist, Cognitivist-Computational and Dialogical. The formalist or structural approach is part of the cognitivist approach to language. It describes language as a monolingual code where structure or grammar is central. This is problematic as the reality is not monological as pointed out by various researchers (cf. e.g., Dufva, Suni, Aro and Salo 2011). Johnson puts forth that the problem with the communicative competence models is that they focus on mental processes and do not take the social context into account. He proposes a new model of second language acquisition where competence and performance are not separate and where language is not considered an abstract set of morpho-syntactic rules but as *speech.* Johnson's model is based on Vygotsky's sociocultural theory and Bakhtin's theory of dialogised heteroglossia. (Johnson 2004, 172-173.) In 2008, Suni points out in her doctoral dissertation on second language learning in interaction that in linguistics, dialogue is not an independent theory or a method, but rather a trend based on the philosophy of Bakhtin's circle. She also reports criticism on Johnson's model as there just is not

enough research to support such a synthesis. (Suni 2008, 20-25.) More research on the dialogical approach in applied linguistics is certainly needed as there clearly is a need to this paradigm shift. 'Dialogue' has become a much-used term in many contexts, in CLIL contexts as well. For example, Llinares et al. (2012, 54) use it for describing dialogic communication in the CLIL classroom in the sense that students are encouraged to talk and interact as opposed to authoritative communication where only the teacher's voice is heard.

Bakhtin's dialogical approach has been gaining ground in applied linguistics. Without going into the details about Bakhtin's theories, suffice it here to say that dialogism is a socio-cognitive theory of language learning (Dufva et al. 2017). Dialogism sees language not as a monolingual system but a dynamic phenomenon, a process of meaningful participation, a multilingual and multimodal practice (Dufva et al. 2014). Salo discusses the paradigm shift from the cognitive approach (or approaches) to dialogism in language education. He notes that the conceptualisation of language in language education is dialogic whereas foreign language teaching can mainly be considered monologic and formalist. In language education, language is seen as a tool for communication and oral communication is emphasised especially in the beginning stages of language learning. The focus then is comprehensibility and linguistic features such as phonetic or syntactic features are paid attention to only as far as they are necessary for getting the message across. (Salo 2009, 92-93.) Dufva et al. touch upon the challenges that the dialogic approach has in its functionalism as opposed to formalism. They ask for instance, how accuracy is guaranteed when the functional approach is primary but formal knowledge still needs to be introduced. When language is a tool for meaning-making, how should students' productions be evaluated? (Dufva et al. 2011, 118-119).

The approach presented through the mHCM in this study is clearly functional. In the mHCM, communication is seen as participating in meaningful goal-oriented communication in a cultural and professional context. Sharing meaning, which involves comprehension between the participants, is primary in the transactions. Formal monolingual aspects of communication, such as problems with pronunciation and grammar, come into focus only when they affect the transactions somehow. The language conception in this study reflects the meaning-based theory of language, in that form is always part of meaning (cf. Llinares et al. 2012, 190). In this study, the formal aspects of language as a system will be considered in the professional context of the work samples. In terms of professional communication context, the description focuses on meaning sharing and understanding: if a form does not hinder mutual understanding, it is not relevant whether the form is 'correct' (i.e. target language like as described in a grammar book) or not as long as it functions in that context. However, there is an additional point in considering form. As was brought up in the introduction of the English enhanced programme of the current study, the students' general language skills were expected to develop during the programme. This is a common expectation and there is research on formal aspects of language that shows that students' formal language skills improve in CLIL education. (Cf.

chapter 1.4 this study). To ignore linguistic skills as defined in the CEFR, including the ones relevant for oral skills: vocabulary (lexis), grammar (accuracy), meaning (semantics), pronunciation (phonology) and fluency, would be ignoring language as a system. It is maybe too early to dismiss language descriptions as monolingual systems. Formal linguistic considerations are part of foreign language learning and teaching. The question is rather the one posed by Dufva et al. above, namely, how to combine form with function. The CLIL approach is a perfect context for developing this thinking. This is still a challenge, but one might think that a student studying nursing would find the context studying nursing through English personally relevant in view of foreign language learning. This kind of dialogic context is where Dufva et al. (2011, 139) think a language learner learns best: a personally relevant environment. The mHCM model seems to me to be in line with the dialogical approach to language, although it is not the same. As I pointed out at the beginning of this chapter (2.5), language conceptions were narrower when I started this study. To start considering oral data from the point of view of professional communication was not a customary approach in applied linguistics and there were even some objections to the approach at the time. The questions that was raised when I presented the mHCM was: where is language in the model? What was meant by language was not explicitly stated but clearly to look at language as communication seemed to be problematic. With the dialogical approach, the problem has not disappeared, but it gains more attention. As described above, in this study, the approach to language is to look at functional, meaning making, communication. The mHCM with the definitions of message dimensions creates a functional framework for analysing professional speech data. This, however, is not enough in terms of defining 'where language is in the model'. There is no language without the individual, who produces and uses it. Thus, language is part of a person and a person's identity. This aspect was already discussed earlier (see chapter 2.4.3.3.).

3 METHODOLOGY

This is a qualitative study on the professional oral English communication skills of nursing students in an English-enhanced medical-surgical programme with some numerical information from the background material and the data. The data for the analysis came from simulated work samples. The subjects, the simulations and the analysis method will be described below.

3.1 Subjects

The subjects of this study were two male and nine female nursing students, who studied in the English enhanced nursing programme between August 1994 and December 1997. At the beginning of the project I was granted permission for the study by the principal of the institute (an oral response to the application of research permit; application in Appendix 3). The students were informed of the broad aims of the study which were described as collecting data for a research on the students' English language proficiency. The exact research questions were not given as they were not defined in the very beginning. On the same occasion the students signed their informed consent to participate in the study and chose their code names that were to be used when reporting the results of the study. However, as most of the code names turned out to consist of the initial letters of the students' names, I decided to use numbers instead when referring to the students to ensure their anonymity. The consent form was part of a self-assessment and background questionnaire that the nursing students filled in in November 1995 (Appendix 4). The self-assessment form of language proficiency was adapted, with permission, from a study by Huhta (1994) on Finnish exchange students self-assessed language proficiency. Collecting background material on situations of language use was considered important although the exact research questions were not defined at that time. As the broad aim was to examine the students' language proficiency, the expectation was that information of the self-assessments and language background could be linked with the analysis of the data of the study.

To get more information on the students' general English language skills, a tailored National Certificates of Language Proficiency test (henceforth NC), levels 5-7, was designed for them in the Language Centre for Finnish Universities (Korkeakoulujen kielikeskus). Levels 5-6 represented an intermediate and level 7 an advanced level of proficiency in the scale. The test was administered in Lappeenranta in September 1995 and it included all the four language skills (reading, writing, listening and speaking) as the focus of the study was unclear at that time. However, the test was tailored to the extent that it did not include the interview section that was part of the NC test battery in levels 5-7. This was simply due to practical limitations of running the test. There was very little

funding available. Table 5 below summarises the background information material collected.

Self-assessment and background questionnaire	May '95
NC tailored test, levels 5-7	
(all sections, but no interview)	Sept '95

Table 5. Background information

The NC test results of the nursing students' oral language proficiency levels will be discussed when considering the role of oral English language skills in the simulated work samples.

3.2 Design and procedure

The simulation design was originally constructed for a study that Annamari Raikkola, a nursing teacher, and I conducted in the spring of 1996 as part of TCE-teachers training programme in the Continuing Education Centre of the University of Jyväskylä (Ikonen and Raikkola 1996). At that time I was a teacher at Lappeenranta Health Care Institute. The starting point then could be seen as teachers researching their own work, in other words, doing action research. In action research, the goal is to develop one's work through a cyclical process of data collection, observation and self-reflection (cf. eg. Kemmis and Wilkinson 1998, 21-22 and Burns 2010, 2). However, this present study is not an action research study; the focus here is on analysing the data of a one-time work sample simulation using a model of health communication as a framework for analysis. This framework defines professional competence and how it ideally, as described in literature, becomes verbalised in nurse-patient contexts (cf. p.10 in this study). When planning the simulation, the focus was on professional behaviour. It was assumed that relevant language and communication would be part of the simulation.

We called the simulation a professional skills test in our study report, but this was not quite accurate as such central considerations in testing as validity and reliability (cf. eg. van der Vleuten and Schuwirth 2005, 309) were not considered in the study. Jeffries (2005, 97) defines simulations as activities that imitate real-life clinical situations and where such techniques as role-play can be used. Role-play has been used for language testing purposes (e.g., Roever, 2011 and McNamara 1996) and for eliciting data for linguistic analysis of (e.g., of syntax as in Cornips and Poletto 2015). In her discussion of simulation designs for teaching, Jeffries (2005, 109) considers five areas that need to be paid attention to: the objectives, fidelity (realism), complexity, cues, and debriefing. Objectives, realism, complexity and debriefing were taken into account in the simulation for collecting the data of this study as described below.

The nursing task for the simulation, taking care of a wound, was planned based on the curriculum by Annamari Raikkola, and Lola Lucke, a practising American nurse in Finland. Both of the aforementioned had been teaching the group. The task was in line with the goals of the curriculum and the content validity was ascertained by the group of nursing teachers teaching in the programme. The task involved both clinical skills and interaction skills as the nurse's task was to take care of the wound and fill in a documentation sheet with the patient's information. Interaction was also necessary as the patient was instructed to ask questions. However, as we pointed out in our study report, when planning the task, the aim was to focus on professional skills and not on language (Ikonen and Raikkola 1996, 1). The simulation reflected a real-life situation: the nursing students had their white coats on, each patient had a simulated wound on the palm of his/her hand which was done with make-up by Lola Lucke. The equipment available was that usually available in a casualty and emergency department. The focus of this study, the oral language data, was thus gathered in a context where verbal interaction was part of professional competence.

In terms of task complexity, the group of nursing teachers considered taking care of a wound a fairly simple task that the students were expected to be able to perform at that stage of their studies. According to Jeffries (2005, 101), nursing studies have defined a task to be complex when the patient has several problems. In this simulation, the patient's only problem was the wound.

The simulation was held in February, 1996, which was the beginning of the students' fourth term of studies. All the performances were video recorded. The students entered the classroom one at a time and they were given the following written instruction:

> *You are working in a casualty and emergency department. You are asked to take care of a patient that has just arrived and is waiting for you in a treatment room. The patient has a cut that does not need any stitches. You can make use of all the things that are available on the table. Fill in the documentation sheet.*

Three exchange students played the part of the patient in turns. Two of the students were boys, Gustavo Gonzaléz (17) from Argentina and Kike Hernández (18) from Costa Rica. Their mother tongue was Spanish. Their English proficiency was not formally assessed but it was not as good as the nursing students'. The third student to play the patient's part was a native English speaker, Amy Roberts (18) from Australia. (The names of the students are given here with permission.) three exchange students were instructed as follows:

> *You have cut the palm of your hand with a very sharp knife at home. You have some pain and the sight of blood makes you slightly hysterical. You cannot keep still and the nurse will have to calm you down. Answer the nurse's possible questions briefly and complain about the pain and look away from the blood. You can either moan or cry at first but calm down after a while. Ask the nurse about the bandaging:*
>
> *Will it hurt? Will it sting?*
> *Can't you make it stop bleeding?*
> *How long do I have to keep it bandaged?*
> *Can it get wet?*

Can I go to the sauna?
When should I change the bandage?

The written instructions were given to both the nursing students and the exchange students on cards (Appendix 5). The teachers arranging the simulation, Annamari Raikkola and myself, were present in the room during the whole time of the video recordings as were the exchange students. The role of the teachers was only to do the video-recording and to observe. As this simulation was not designed for teaching purposes, there was no cueing, i.e., the students did not get any help in the task. There was, however, debriefing as Annamari Raikkola discussed 'the test' with the students the following day and made notes of 'the test's' good and bad sides that the students mentioned in the discussion. Our report on the simulation (or 'the professional skills test') included a summary of the comments. These will be also be discussed when evaluating the methods of this study. The participants and the exact lengths of the samples are listed in the table below.

Nursing student	Exchange student	Length of recording
S1	P1	12'24 "
S2	P2	9'23"
S3	P3	7'53"
S4	P1	4'30"
S5	P2	14'58"
S6	P3	11'23"
S7	P1	13'52"
S8	P2	7'17"
S9	P3	11'57"
S10	P1	10'46"
S11	P3	8'53"

Table 6. Students' code names and recording lengths

As the exchange students took turns in playing the patient's role, they had time to assist with the recording and write their evaluations on the nursing students' performances. They were asked to write down how their 'nurse' managed the situation and comment on his/her English language skills. There was no form for them to fill in; they only wrote free notes. The exchange students' assessment of how the nursing students managed the wound care situation was considered important information as they had the patient's viewpoint. Trout, Magnusson and Hedges (2000, 695) state that patient satisfaction is linked with the quality of care in emergency departments although it does not necessarily link with the technical aspects of care.

Three nursing teachers, the American practicing nurse and one psychology teacher, evaluated the video-recorded performances. This group was involved in teaching the nursing students who participated in the simulation and thus were the subjects of this study. The assessment sheet was based on Earnest's

(1993, 25-43) descriptions on interaction skills and clinical skills. However, the final set of criteria was a result from discussions with the nursing teachers. The different aspects of interaction skills, clinical skills and oral English skills were to be assessed on a three point scale; fair, good and excellent. A rough scale was used because we felt that there were so many aspects of the performance to be evaluated that a more detailed assessment would have been too much to ask from the assessors, who did their work on a voluntary basis. The skills assessment form is in Appendix 6. The nursing students assessed their own performances on video using the same assessment sheet as the nursing teachers. Table 7 summarises the data collected in connection with the simulations. All of this data will be analysed and discussed in the results section.

Wound care, video and audio
Teachers' and exchange students' assessments of students' performances
Students' self-assessments

Table 7. Work sample simulations in February 1996

The video- and audio-recorded material in the work sample simulation was transcribed. The transcription conventions used are explained in Appendix 7. As was mentioned earlier, the students are referred to with numbers in the transcriptions, as are the patients. The letter S before the number stands for Student and the letter P for Patient.

3.3 Method of analysis

The modified Health Communication Model (mHCM) will be used in the analysis of the simulated work sample data. The mHCM captures the features that are most relevant in professional nurse-patient interaction. This approach to data analysis is similar to content analysis, as the model has predefined categories. Content analysis has been widely used in health studies (Hsieh and Shannon 2005, 1277), but it originates from communication studies (Krippendorf 1989, 403). To begin with, content analysis was quantitative (Berelson 1952. 18), but later qualitative content analysis has become frequent, for example, in nursing research and education (Graneheim and Lundman 2001, 105). The aim in content analysis is to analyse the content of communication (Bos and Tarnai 1999, 659). There are different types of qualitative content analysis approaches, but as Graneheim and Lundman (2001, 107) point out, the first step is to create categories for the analysis. This can be done in two main ways: either through conventional analysis starting from the data by clustering emergent categories or through directed content analysis. In directed content analysis, existing research is used to create the key variables. (Hsieh and Shannon 2005, 1279-1281.) In this

study, the approach resembles the latter scenario as the dimensions of the modified model of health communication form the categories for the analysis. The focus in the categorization is, according to the model used, on the stages of the process of nursing in the content and relationship dimension of messages in the simulation data. In addition, the quality of the nursing student's oral communication will be analysed with respect to the goals in each stage of the nursing process. These categories are listed in Table 8 below.

Dimension of message in transaction	Stage of the nursing process	Identity
Content	Assessment Planning and implementing Evaluation	Roles Norms Values Power Language
Relationship	Orientation Working Termination	
Identity		

Table 8. Categories of analysis in the nursing process

The analysis will be based on the categories of the nursing process in each dimension but the theoretical considerations about the communication techniques and other characteristics described in the theory section will be taken into account. Language certainly has a crucial role in the communication techniques. The *identity* level of messages cannot be described in terms of the nursing process in the way content and relationship dimensions can. The identity level of the messages will be analysed using the theoretical categories of *roles, norms, values,* and *power. Language* is part of identity in the model but as it is the focus of this study in the verbal messages of the nursing students' professional communication, it is part of all the dimensions. The power structure in the simulated work samples will be analysed with respect to the distribution of turns in the data. This approach is based on Kettunen et al.'s description that power has to do with who holds the floor and controls the structure of conversation (Kettunen, Poskiparta and Gerlander 2002, 112). The definition of turns is here based broadly on Sacks, Schegloff and Jefferson's (1974, 700-701) 14 facts of conversations. In this study, what will be counted as a turn has the following features: speaker change occurs, a turn can be a verbal sound (as for example 'mmhmm'), a word or several sentences in length and there can be overlap in the turns. In the analysis overlapping turns will be counted as well. The beginning of a turn is marked by P (for Patient) and N (for Nurse) in the transcriptions.

The model used in this study with all the theoretical considerations will be reflected on in the discussion of the findings. Hsieh and Shannon give a word of warning on using theory for the analysis as it may lead the researcher to not to see all aspects of the phenomenon (Hsieh and Shannon 2005, 1283). In this study,

the approach is to compare the nursing students' performance to the 'ideal' performance as described in the literature. McNamara (1996, 95) also mentions literature search as one way of establishing the communicative demands of the target setting, which in this case means the communicative demands a nurse faces in her work.

The simulations consist of goal oriented speech events which aim to get something done; to have the patient's wound taken care of and to have the patient's history taken. In such goal-oriented speech situations, the goals define the characteristics of the situations. Gumperz and Cook-Gumperz (1982, 11) state that it is easy to determine to what extent the communication has been successful by just looking at the content of the goal-oriented speech event. Accepting Hsieh and Shannon's warning, it may well be that the analysis will not capture all there is in the data as the analysis will be based on theories of nursing and communication, but trusting Gumpertz and Cook-Gumpertz' faith in assessing goal-oriented speech, it should be possible to examine aspects of professionalism in the nursing students' communication in the work samples.

4 PROFESSIONAL COMMUNICATION IN THE DATA

This chapter describes how the students' way of communicating with their patients in English in simulated work samples shows professionalism. The modified Health Communication Model (mHCM) is used as the overall framework for describing the transactions in the work samples. The analysis of the data considers the three dimensions depicted in the model: the content, relationship and identity levels. Communicating within the transactions in each of the dimensions is considered regarding the theoretical discussion on constructing professional competence in nursing with language as part of professional competence (cf. chapter 2). In terms of the way the CEFR defines communicative competence, this analysis focuses on the students' functional competence, i.e., communicating for functional purposes (cf. chapter 2.5.2 in this study).

4.1 Content dimension

The contents of the health transactions in the data of this study are considered in the light of the Roper et al. 1980 model of individualising nursing through the nursing process. The four phases of the process, namely, assessing, planning, implementing and evaluating are described as they appear in the data. The nurse's first task was to take care of the wound and after that to interview the patient in order to fill in the documentation sheet given. The actual wound care and the following interview constitute two speech events.

4.1.1 Assessment

According to the nursing model, the first thing to do in the nursing process is assessment. Roper et al. (1980, 53) define assessing as including:

- collecting information from/about the patient
- reviewing the collected information
- identifying the patient's problems
- identifying priorities among problems

In an acute situation such as the wound care situation in the work sample, one would think that collecting any general information about the patient would not be the first task. Roper et al. (ibid.) point out that assessing bleeding or injury would need to be done early in the nursing process. There is a lot of variation in how the student nurses start the conversation with their patients and these fall into six categories described below in Table 9.

The purpose of the first utterance	Number of students
asking what happened/how it happened	4
looking at the patient's hand	2
introducing oneself	2
calming the patient down	2
asking about the patient's pain	1

Table 9. The content of the nursing students' opening utterances in the data

Comparing the opening utterances to Roper et al.'s description of what would be relevant to assess in the beginning, it seems that only two students focus on what would seem to be the most important thing to assess urgently in this context: the wound and the bleeding. S5 and S7 ask to see the patient's wound:

(1) S5: Okay
P2: Oh ah
S5: Let me see. Mm hmm (P: /aih/) hurts doesn't it?
P2: Yeah
S5: First I'm gonna take care of this cut (P: Okay) and then I'm gonna fill out this form
P2: Yeah yeah quick

(2) P1 Please somebody help me
(Teacher: xxx xxx käy istumaan siihen)
S7: Oh okay. Hello, hello. It is okay. Let me see, let me have a look here. (P moans)

The students' most common approach is to start by asking what happened or how it happened. The reason why S1 in example (1) chooses to ask about the pain first is that the patients were instructed to be "slightly hysterical" so that the nurse would need to calm them down. Naturally the three exchange students taking turns playing the part of the patient expressed this in varying degrees. In terms of assessing the patient's problem and Activities of Living data, the two types of questions most frequently asked in the beginning would contribute to identifying the patient's problem. Knowing what happened and/or how it happened can throw some light on how severe the problem is. This is how S6 and three other students approach the wound care situation:

(3) S6: Okay hello!
P2: Hello /sau/(?) Ah it's hurting very much
S6: What kind of situation you have been in now?
P: I was just in just in in my home and making salad with a big knife, I don't know how it just /kut/ part of my hand

On the other hand, asking about the patient's pain rather than ignoring it and also calming the patient down would contribute to building the relationship

between the nurse and the patient. One student asked the patient about the pain in her first utterance but three other students also inquired about this at the very beginning of the situation. As was reported earlier, Northouse and Northouse (1985: 175-176) maintain that the relationship between the nurse and the patient influences what kind of information the patient offers to the nurse, in other words, the relationship affects the content of the transaction. Although in an acute situation such as a bleeding wound, introducing oneself could easily not be the first thing to do, this too would be part of relationship building. Thus, it is not meaningful or even possible to exclude the effect of other dimensions, when analysing one.

As the wound care situation ended in an information-giving interview, the content of the assessing phase of the nursing process would be assessing the wound through observing it and gaining information relevant to the wound assessment. All except one of the students get the information on how the accident happened at the beginning of the situation. S1 focuses on asking about the patient's pain and does not inquire about the accident until in the interview section when she does elicit the information about the patient getting the wound through cutting him/herself while making salad. All the ten students who ask about what had happened use an open question of the following type:

(4) S2: So what has happened to you?
(5) S3: so how did this accident happen?
(6) S4: so where did it happen?
(7) S5: Mm so how it happened?
(8) S7: Okay, so tell me what happened?
(9) S9: What is the problem?

With these open questions the student nurses get the same information, because exchange students followed the instructions for their part and they all had the same background information. With reference to the discussion about open and closed questions in section 2.4.1., using open questions was professional from the student nurses' part.

Assessing the severity of the wound varies somewhat in the data. Some students simply state what the wound looks like; others are more concerned about the pain. The following observations are made about the wound:

(10) S2: Oh you have some blood in your hand
(11) S3: You know it looks okay
(12) S4: It doesn't seem to be so bad

As this is not a real situation and the instructions for the nurse said that the wound did not need stitches, the assessments were naturally influenced by the instructions. This can explain why the students say that the wound "looks okay" or does not seem "so bad". On the other hand, the observations vary quite drastically and can change during the conversation. S7 makes one assessment in the beginning and after four exchanges; she says something different that seems to be the opposite of the first assessment:

(13) S7: This is not a major big cut
[*four exchanges later*:]
S7: Mm you sure have cut your hand

Some students adjust the assessment to the patient's pain:

(14) P2: xx like I cut all my hand
S5: Ye-es, ye-es. Looks big.

(15) P2: It's hurting very much
S9: It looks very bad. I bet it hurts.
P2: I think it's very deep. It's bleeding very much

(16) P2: Do they want ... the blood is stopped do you know stop the blood
S11: Just try to be calm it's it's not so bad that it it just looks that because it's so bloody

In (16), S11 may be more professional in trying to calm the patient down and giving her a professional opinion rather than emphasising the severity of the wound as S5 and S9 do in (14) and (15) respectively. The students who agree with the patient in that the wound is 'bad' probably want to make the patient feel that his or her feelings about the wound are accepted as valid and not belittled by the nurse. Despite that, saying that the wound looks 'big' or 'very bad' does not sound like a professional reaction as the patient might get unnecessarily worried about the situation. In addition, such an unmedical assessment would not fulfil the requirement of giving information in a care situation, which is emphasised in the Roper et al. 1980 model for nursing (cf. chapter 2.2.1). The nursing students' role-play instructions said that no stitches would be needed. This would indicate that the wound was not especially severe.

Assessing the pain that the patient experiences is central in wound care. All the patients were painful, some more than the others. The degree of pain seems to diminish after the first time of playing the role as the exchange students get tired of the acting. In the first role-play situation, the patient is especially painful:

(17) P: My god would somebody help me here. This hurts. Someone come and help me please, no-ow. This is hurting so much, I'm gonna bleed to death.

This is probably the reason why S1 does not ask any questions about the accident at all, all her six questions are about the pain or otherwise the patient's condition, for example:

(18) S1: Is it hurting very much?
P1: Yes it hurts /au au/

(19) S1: You've got a headache?
P1: No just pain, it hurts so much ... /au-u/ it won't stop bleeding.

There are several aspects of pain that should be observed when assessing pain. Roper et al. (1980, 127) list for example the following aspects of pain for the

nurse to assess: its location, pattern intensity, and character. Such information might be relevant to acquire in a wound care situation. All the patients complain about their pain but only four students ask about it. The questions they ask are mostly of the type:

(20) S2: Do you have a lot of pain? in your hand?
P2: Yeah
S2: Do you think that you would need er something pain killing?
P2: Yeah

(21) S5: hurts doesn't it?
P3: Yeah
S5: First I'm gonna take care of this cut (P: Okay) and then I'm gonna fill out this form
P3: Yeah yeah quick

The students, who ask about the pain, mostly do not react to the patient's complaint at all. Those, who ask questions about their patient's pain, do not really give any help; only one offers to give a pain killer to the patient. In (20) S2 is the one who asks the patient whether he needs a pain killer, whereas in (21) S5 goes on to explain what he will be doing next. This rather unemphatic behaviour from the nurses' part can be explained by the role-play situation. In the first two role-play situations the students, S1 and S2, were given a key to a medicine chest, but that turned out to be unpractical considering the video-recording and therefore the key was not given to the rest of the students anymore. They had no other means to relieve the patients' pain than by their actions or their communication. The nurses' reactions to the patients' pain apart from the assessing will be described in more detail when considering the relationship dimension of the communication in the situations. Four patients ask the nurse for pain medication, but only one student nurse gives it to the patient. One says that a doctor will give the medicine afterwards, and two promise to give the medicine later on. Roper et al. point out that information about any sensitivities or allergies to medicines should be collected early (ibid., 53). No medication should probably be given without such information. None of the student nurses ask their patients about any allergies.

Assessing bleeding is a priority when taking care of a wound. Only two of the nursing students assess the bleeding verbally. In nine out of the eleven work samples, the patient complains about the bleeding or blood. The nurse students reactions vary somewhat, but rather than assessing the bleeding, they either ask about the pain (18-21), try to calm the patient down or start some wound caring process.

All in all, the students seem to manage quite professionally in the assessment phase. They identify the patient's problem, calm him/her down, asses the wound and are also concerned about the pain the patient experiences. Using English to accomplish all this does not seem to be a problem at all. The role-play situation influenced the assessment phase to varying degrees. Identifying the patient's problems goes on in the next phase of the nursing process.

4.1.2 Planning and implementing

In the transactions of the data, planning and implementing occur simultaneously in the working phase. The objective of the planning phase of the nursing process is to prevent the identified potential problems from becoming actual ones, to solve actual problems, where possible to alleviate those which cannot be solved, and to help the patient cope with those problems which cannot be alleviated or solved. The former can be either 'nurse-perceived' or 'patient-perceived'. In both cases, the other is not aware of the problem. When identifying potential problems, Roper et al. point out that it is the nurse's greater knowledge of factors to do with ill-health that make it possible to collect information which the patient may not volunteer without prompting. (Roper et al. 1980, 60.) Some of the questions that S6 asks could perhaps be interpreted as questions based on identifying potential problems as for example in the following extract when the patient has just asked whether the wound will be infected:

(22) S6: Do you know if they were er Finnish tomato or or tomatoes from from some other country?
P3: No it was Finnish. I just buy here in the supermarket
S6: Uhhuh. So I think they are quite clean and did you wash them before .. you started to
P3: Yeah I was just I was just washing those and cutting
S6: Uhhuh xx there's not gonna be any problem.

The nursing student's assumption seems to be that Finnish tomatoes are clean but tomatoes from some other country would not be and therefore they would have been a potential problem causing a possible infection.

On the whole, questions on 'Activities of Living data' which are concerned with the individual's usual routines and current problems (cf. p. 33 in this study) are not very frequent in the work samples. Only four other students ask questions that could contribute to identifying potential problems. At the beginning of the implementation phase S3 and S11 ask their patient how he got to the hospital and before departing, they also ask about how he gets home:

(23) S3: Now, you'll be okay. (P: xxx) How did you come to the hospital?
P3: My wife drive into here
S3: Yeah

(24) S3: Mm ... and then okay er how are you going back home? Do you have someone to take you home
P3: Yeah my /wais/ my wife is waiting for me
S3: Oh I so that's important I can't let you go go driving because it just happened so (P: Yeah xx) so we gonna take you home. Is she waiting for you down the block?
P3: She is she is just in the hall
S3: Oh yeah well that's good

The nursing students thus want to make sure that the patient is safe going home and getting there is not a problem.

Two students ask about the patient's work. In example 25, S7 seems to be making small talk rather than identifying potential problems. This is indicated by S7 starting with joking and going on to ask general getting-to-know questions. However, as the dialogue proceeds, the participants agree that a sick leave is needed.

(25) S7: It's okay, just hold on. You tell me whatever you want. You wanna tell stories (laughter) or you want me me to tell you the stories so (laughs) ... So are you housewife or?
P1: No
S7: No you're working yeah?
P1: Yeah
S7: Okay. Where are you working?
P1: I work at the city market in in the centre.
S7: Oh yeah?
P1: Yeah
S7: Have you er er actually no may be having some holidays off
P1: days off xxxx
S7: Yeah yeah ... yeah
P1: Greatest in the holiday (?)
S7: Well you can have now nice few days, taking care of yourself.
P1: Yeah. Now definitely I can't do anything
S7: (laughs) No you can't.

In the following excerpt, S11 clearly tries to find out whether the bandaged hand will be a problem for the patient:

(26) S11: What do you do for for, do you are you mm (*waves her own right hand)* right-handed?
P3: Yeah this is my right hand
S11: Yeah, are you in school or where?
P3: Yeah xx here exchange student programme
S11: Yeah (P: But now xx) So you can't you can't write (P: Yeah) for a moment
P3: How long you think I I have to ... take er
S11: It takes er .. I don't know (*laughs*) about er at least week or two, I guess.

The above instances are the only ones in the data, where the nursing students identify actual and potential problems.

The tasks in the planning and implementation phase include nursing interventions and giving information (cf. Table 1, p. 34). All the students clean the wound, bandage the patient's hand and explain what they are going to do or what they are doing. Roper et al. point out that although nursing has traditionally been associated with 'doing', however, "it is both helpful and necessary for nurses to make explicit the thinking and decision-making which underlie and explain the nursing interventions which they carry out" (ibid., 61-62). In the following extract S2 speaks very slowly and seems to speak to herself rather than

to the patient as if thinking aloud what she is going to do. This is more obvious in the recording than in the transcription:

(27) P2: Can you do something to try to stop it?
S2: Yeah it's okay (P2: Okay) fine. Now I'm gonna take this petadine er liquid and I'm gonna take this kind of a paper and er clean your wound a little bit
P2:Yeah quick quick xxx ----- /aih/

This thinking aloud functions well as explaining the patient how he will be taken care of.

Four students have four to six turns, where they explain what they will be doing. Six students have only approximately two explaining turns. It may be that the students who are more uncertain of what to do keep explaining more what they are going to do. This student expresses her uncertainty through getting focused on what she is doing: "wash my hands […] Where do I have the gloves?" and through expressions such as "I'm try to be calm …". These strategies may reassure the nurse herself as much as the patient.

(28) S8: So you just have to relax and (P: That's right) I know it's painful but (P: Yeah) I try to take care about it. (*clears her throat*) (P:xxx) wash my hands
P2: Okay
S8: Where do I have gloves?

P2: Okay can you stop just blood?
S8: Yeah, just wait a minute. I'm I try to be calm .. Now I will clean it up (P: Okay) a bit.

The information that the students need to give to the patient is how to take care of the wound afterwards. As the patients were instructed to ask questions, most nursing students do not have time to offer any instructions before the patient asks for them. Only in three work samples the nurse starts to give instructions and in all others, the patient initiated that discussion. The instructions that the nurses give vary somewhat. The questions the patients were instructed to ask about bandaging were:

How long do I have to keep it bandaged?
Can it get wet?
Can I go to the sauna?
When should I change the bandage?

All students agree that the bandage should not get wet, but the instructions vary on whether the patient can go to the sauna or not. Four students forbid the patient to go to the sauna altogether. S1 in (29) does not give a definite answer; S3 in (30) just seems to follow the patient's line of thinking as the patient suggests the answer himself, whereas S7 in (31) and S9 in (32) give a strict directive:

(29) P1: Mmhm .. can I still go to sauna or anything? Can I get it wet or anything?
S1: Well it's better not to
P1: Okay

S1: You have to take care of it so that it doesn't er it doesn't get wet (P: Mmhm)

(30) P3: Looks to me I cannot go to sauna
S3: No no you cannot go to sauna so

(31) P1: Can I still go to sauna?
S7: No you don't go to the sauna and you can put this- don't wet your hand now okay?

(32) P3: Okay. But I can. Can I do sauna with these or can I get wet?
S9: Er if you go to- don't do sauna - at all (P: Okay) but if you go to the shower you have to put something which is plastic on it (P: Okay) so it doesn't get wet

Going to the sauna was not discussed in three work samples and four nursing students said that going to the sauna was fine if the patient used a plastic bag. This means that the eight nursing students who gave instructions about going to the sauna had two opposite opinions about it, which seems professionally incoherent.

Instructions about changing the bandage vary a lot as well. The topic is not discussed in three work samples. Two students give very vague instructions. In the data, S1 says first that she will give the patient instructions on how to take care of the wound, but then she merely states that the patient shoudl change the bandage at home without any further specification as to how often. The patient goes on to other questions and seems to accept the vague answer. S4 says that the bandage should be kept until the wound is not bleeding; S3, S5 and S6 ask the patient to come to show the hand in two days, a couple of days or the following week and the bandage would be changed then. Several students clearly hesitate with the instructions:

(33) P2: Okay. Can I can I play soccer?
S2: Well it's up to you. I I don't think that it's .. it it would be good for you

(34) P1: Do I have to do anything at home?
S10: You have to change the bandage
P1: How often?
S10: Er I think like .. every day

S7 in (35) is an example of how the student changes the instructions while giving them. At first she says that the patient needs to come back only if the wound seems infected, but when the patient repeats this to make sure he has understood the instruction correctly, S7 decides otherwise and asks the patient to come back in two days. Again, this does not seem prefessionally coherent in terms of giving information.

(35) S7: No, you have to keep this dry now right? (P: Mmhm) xx
P1: For how long?
S7: Oh er (P1: xx) yeah when it closes when the when the /waund/ is er healed (P1: Mmhm) when it's closed (P1: Mmhm) Now the cut is open but it's not that open that xxxx (P1: Yeah) And er while it's closed nicely and it's clean around

there around the /waund/. Gets nice and clean and you can - you have to check it every day. You get any problems you come back okay? (P1: Okay) If it gets very red and hot and it really hurts and you think it's infected (P: Uhuh) you come back right away, alright?
P1: Okay
S7: And er xxx

S7: (mumbling) Oh sorry .. where is my eyes. Behind my head (laughs) And er do you have anything to ask. Do you wanna know something about this?
P1: E-erm
S7: What you have to do or (P: Er) just keep it- every time you change the /pandage/ you have to disinfect it (P: Uhhuh) Okay you - next time when you take this put it under the sink and rinse it very well okay (P:) dry it and desin- use the disinfection lotion
P1: Uhhuh
S7: And put the new /pandage/ on it, the clean sterile /pandage/ on it
P1: So I need to come back if I think it's infected or something
S7: A-a- ah okay let's make it this way. You come back after two days okay? (P1: Uhhuh) We change it we clean it (P: xx) xx how it is and then yeah okay and er then we see how the situation is

Considering professional quality on the content level in the wound care speech events, the students are able to collect some relevant information and identify patients' problems to some degree. When giving information on wound care, the students show uncertainty and also mark this by phrases such as 'I think', by using the conditional or by leaving the decision to the patient.

In the interview part of the role play, the nursing students' task was to fill in a form with the following information: the patient's name, Social Security number and a description of the patient's problem. Five students checked the spelling of the patient's name and this involved some negotiation as well:

(36) S3: Just some kind of description about what happened. And your name?
P3: Gustavo
S3: Mmhm ... Gustavo
P3: Yeah Gonzalez
S3: Mmhm (laughs)
P3: It's a little bit difficult to write
S3: Is it ...?
P3: It's okay
S3: Like this?
P3: Yeah
S3: Yeah
P3: Right

(37) S8: Oh sorry, of course I do. So what is your name?
P2: Kike
S8: Sorry?
P2: Kike
S8: How do you spell it?
P2:/kei i: kei ei/

S8: E-er
P2: No / kei ai kei ei/
S8: /kei ai kei/
P2: /ei/
S8: /ei/
P2: Yeah sorry, you know
S8: /kei ei kei/
P2: Yeah, it's okay
S8: Okay. How about your last name?
P2: Hernandez
S8: Hernandez
P2: Yeah
S8: Hernandez. Is this the right way?
P2: Yeah

In both (36) and (37) the student shows the form to the patient to make sure the spelling was correct. In (37) the patient spells his name incorrectly and perhaps therefore the student nurse decides to show her writing to him. Asking about the social security turned out to be quite problematic. Visitors to Finland do not have a Finnish Social Security number (a personal identification number) which consists of the date of birth and a verification code. The patients had instructions only about the complaint but they were not given any identity information for their role. The students were clearly not prepared to ask about the Social Security number which is a common question within the health care system. This can be seen in the examples below. Three students decide that the patient's birthday is enough information and they only ask for that. All the others ask for the social security number and sometimes the exchange students playing the patient's part make up the number as in (38) "one two three" or in (40) "Yeah, nine four … nine four five" or often the student nurse having first asked for the social security number decides that the date of birth is enough as in (39) "And what is your er *henkilölitunnus* what is your birthday?".

(38) S1: Okay (P1:Mmhm) that's good. So when are you born?
P1: Nineteenth October (N: Mmhm) seventy-seven
S1: Okay and what's the end of your ...?
P1: One two three

(39) S2: Okay. And what is your er *henkilölitunnus* what is your birthday?
P2: Seven of April
S2: And the year?
P2: Seventy-seven

(40) S9: xxxx (P: Yeah, yes) And your er securit- social security?
P3: Ten (N: Mhm)zero nine (N:Mhm)seventy-eight
S9: Seventy-eight
P3: Mhm
S9: Do you have the last code?
P3: Yeah, nine four .. nine four five, I think it is
S9: Nine four five
P3: Yeah
S9: Er it should be four xx

P3: Yes, maybe two I don't know, I don't remember
S9: You you're not sure, okay, I can check it out later .. Right and you said that er this happened in the kitchen xxx

Explaining the structure of the Social Security number is not easy to the students and that may be why S2 in (39) code switches, i.e., says the word in Finnish. There is no way of knowing why she adds an extra syllable ('*li*') in the word. In four work samples, the exchange students want to help the nursing student by making up the code as in (38) and (40) above.

The last part of the interview to fill in the required information in the form was writing down a description of the patient's situation *('teksti'* in the form, cf. Appendix 8). Six nursing students do not do this at all; either they skip it altogether or they say that they will deal with it later. Three students ask the patient again how it all happened. Two students say aloud what they write in the form:

(41) S6: Eight five seven. Okay and today is twenty-second of February and the year is nine teen ninety- six .. and you correct me if I put something that's (P: Yeah yeah) not true. So the patient was cutting .. cutting /tomei/- tomatoes (P: Yeah) for salad. And .. and he cut ..er slight er
P3: In the palm
S6: Er yeah a cut to in his right hand .. and .. I put it shortly that's okay no stitches needed .. xx bandages .. er on
P3: Mmhm

(42) S11: Seven seven alright. So I just write what has happened. So you have cut with your knife
P3: Yeah
S11: xx right hand arm .. and I cleaned it with this petadine and put xxxx and bandaged it. No need of stitches

The two nursing students in the above extracts give an impression of being professional as they let the patient hear what they document in the form.

The content of the interview part in the work sample has a considerable amount of variation. There is most consistency in collecting basic information from the patient, although the Social Security number causes some problems and most students do not document the description text. The students' weakest areas on the content level are identifying potential problems, gathering AL data and giving information and instructions.

4.1.3 Evaluation

The nurse's task in the evaluation phase is to summarise the information given to the patient during the planning and implementation phase. This serves the purpose of assessing how well the goals of the nursing intervention have been achieved (cf. Roper et al. 1980, 62). Three nursing students make a summary:

(43) P1: I think the knife was was turned the wrong way up

S1: xx It's gonna get much better so don't worry. It's just a little one so you don't need ..any stitches but just keep it clean (P: Mmhm) and don't let it get wet (P: Mmhm) and er it will probably bleed more if it gets gets broken you know the skin (P: Mmhm) It might bleed a bit so (P: Mmhm) don't be scared
P1: So I'd have to come back here (N: xxx) in the next few days, okay.

(44) S6: Er yeah a cut to in his right hand .. and .. I put it shortly that's okay no stitches needed .. xx bandages .. er on
P3: Mmhm
S6: Okay (P: xxx) and so I said that - yeah er just after week so next er next Thursday
P3: Next Thursday I can come here and (N: Yeah) check it out
S6: And check it out. We see how how has it proceed.

(45) S7: And er let me see this timetable I give now the time you come again (P1: Mhm) And you come tomorrow (P1: Mhm) or day after tomorrow which one is better? (P1: Day after tomorrow) Day after tomorrow okay you come at one o'clock (P1: Mhm) Okay we check the /waund/ (P1: Mhm)
And er and and then I give you the xx the new stuff with you xx (P1: Mhm mhm) so this xx for a
few days now (P1: Mhm mhm okay) okay. xxx

In (43) and (45) the nursing students initiated the summary, thus fulfilling their professional task as described by Roper et al. (1980). S1 and S7 summarised the home care instructions, though S7 is not as detailed as S1. In (43) the patient contributes to the summary by checking when she would need to come back for a check-up. In (44) (continued from 41), the summary is part of the interview where S6 speaks as he fills in the form. The patient again is active in making sure he has understood the check-up date right. Summarising in the evaluation part seems to become a joint effort with negotiation and sharing meaning.

In three work samples the patients start asking for instructions and the nursing students (S2, S4 and S10) just answer their questions without giving any comprehensive summary. Two samples end in the nurse asking the patient to follow him/her (S5 and S9) to the doctor or to take a pain killer. S8 finishes the interview after having asked the patient's personal details:

(46) S8: You don't have that (P: Yeah) okay. Well that was that was it, I will see you
P2: Okay two days
S8: Okay .. . two days .. Okay
P2: Thank you
S8: You're welcome

Again the patient makes sure he got the date right and the nursing student confirms it by repetition. In the two samples that have not been mentioned so far, the students S3 and S11 answer the patients' questions about home care and then seem to follow Roper et al.'s (1980) model of individualizing nursing in that they ask how the patients will get home. This would be showing concern for an Activity of Living and identifying a potential problem:

(47) S3: Mm ... and then okay er how are you going back home? Do you have someone to take you home?
P3: Yeah my /wais/ my wife is waiting for me
S3: Oh I so that's important I can't let you go go driving 'cause it just happened so (P: Yeah xx) so we gonna take you home. Is she waiting for you down the block?
P3: She is she is just in the hall
S3: Oh yeah well that's good
P3: Okay
S3: Okay

There is a considerable amount of variation in the content of the evaluation part. It is difficult to know whether more than the three nursing students would have summarised the homecare instructions if the patients had not asked about them. It is not possible to know whether the nursing students follow the model of individualizing nursing intentionally or not. However, negotiating and sharing meaning is necessary when the patients ask the nursing student to repeat and clarify the instructions.

4.2 Relationship dimension

In the theory section, the phases in the N-C relationship were described with reference to Peplau's (1952) model and Sundeen's (1991) description as consisting of orientation, working and termination phases. In the preceding analysis of the content level of the transactions, the focus was on analysing on how the nursing students used English to perform the tasks defined to be done in the nursing process, i.e. assessing, planning, implementing and evaluating. The quality of the relationship may show in how well the tasks in the phases of the relationship are performed. This in turn may result from whether the nurse is able to use such successful communication variables as described by Northouse and Northouse (see chapter 2.4.2 in this study). A conclusion was made in the discussion of the relationship level in the theory section that empathy and confirmation are the two most central aspects in the nurse-patient relationship.

4.2.1 Orientation

From the nurse-patient relationship perspective, the first task in the orientation phase is introductions (Sundeen 1991, 383). As was pointed out in the analysis of the content level (Table 9, p. 61), only two students introduced themselves to the patient. The reason why nine students did not introduce themselves was probably because the patient is in a lot of pain. Looking at the first utterances, it seems that both asking what had happened (gaining information) and looking at the hand (assessing goals) could be interpreted as focusing on the content level of the transaction and the clinical task of wound care whereas introducing oneself calming the patient down and asking about the patient's pain would be focusing

on starting to build the relationship with the patient. These two approaches were quite even in the data: six students started with content questions and five had a more relationship-oriented approach.

The techniques that enhance empathic skill and ones that function as empathy blocks were listed in Table 2 (p.35). Restatement, reflection and accepting (backchanneling) enhance empathy whereas false assurance, making stereotyped comments, moralising and belittling do the opposite. Some of these occur already in the orientation. All the students except for S6 react to the patient's pain somehow. As was pointed out above when analysing the assessment phase on the content level, S1 is most concerned about the patient's condition from the start (extracts 18-19). She does not use any of the techniques mentioned in the list that enhance empathy, but one might think that showing concern for the patient by asking about his well-being would produce empathy as well. Showing this concern could also be a sign of the student's uncertainty of her clinical skills. The techniques of enhancing empathy that appear in the data are not quite straightforward to analyse. As was pointed out in the theory section, making stereotyped comments is seen as blocking empathy. Earnest defines stereotypical comments as "meaningless words and clichés". (Earnest 1993, 40.) Saying that the patient "will be alright" could be categorised as a stereotypical comment although it is quite natural to use the phrase when trying to calm down a person. As the following extracts show, it seems that stereotypical comments of this kind (bolded in the extracts) are quite frequent in the orientation phase and they are very similar to the example of false reassurance given on page 46 ("Don't worry. Everything will be all right.):

(48) P2: Can you do something to try to stop it?
S2: Yeah just **it's okay** (P2: Okay) fine. Now I'm gonna take this petadine er liquid and I'm gonna take this kind of a paper and er clean your wound a little bit
P2: Yeah quick quick xxx ----- /aih/

(49) P1: Okay. Oh quick, it's bleeding so much. O-oh. Hurts.
S7: (Washing her hands) **You'll be fine** xxx

S7: Okay, so tell me what happened?

(50) P1: Oh help me please this hurts so much. I'm bleeding everywhere
S10: Alright, calm down, calm down**, it's alright. It's alright xx don't worry.**
P1: I'm gonna- it's all bleeding everywhere you gotta ..
S10: Alright alright erm you can push it , you can just like that. Right? I I just take the gloves.

The patient in (48) seems to accept the nursing student's comment *(P2: Okay)*. In (49) both the nurse and the patient fall silent for a while. In (50) the patient is not soothed by the comment but goes on asking the nurse to take action, which the nurse then does. All of these reactions could probably happen in real life as well.

The patients always bring their own interpretations of meaning in the transactions.

4.2.2 Working

After the orientation phase, the nurse students start taking care of the wound and the nursing process moves to the working phase of the relationship level. In Peplau's (1952) model (discussed in chapter 2.4.2) the patient identifies with the nurse and makes full use of the nurse's services during this phase after the orientation. The patients in this data were instructed to complain about their pain and ask specific questions. This means that they were ready to 'exploit' (Peplau's term) the nurse as it was so clearly their task to seek help. It is more difficult to find out how the identification phase happens in the work samples. Although patients contribute to the transactions in the nursing process, the focus here is in the nurses' communication and therefore it is more meaningful to look at how the nursing students react to and cope with the patients' needs in the transactions.

As was pointed out earlier (in chapter 2.4.2), in Sundeen's (1991) terms the working phase involves maintenance of the relationship. During this phase, the use of interpersonal skills with communication techniques might become very relevant to maintaining the relationship successfully. Looking at the occurrence of the communication techniques that enhance empathy as described by Northouse and Northouse (1985, 72, cf. Table 2), only restatement is a clearly observable technique used in the data. Six students have one occurrence of paraphrasing or repeating what the patient says. These speech acts concern mostly the patient's complaint:

(51) P3: Oh I can't believe I have a football game tomorrow I cannot go
S3: Yeah not with that hand no (laughs)

(52) P3: Okay it feels better now. It feels better.
S6: It feels better.
P3: Yeah
S6: Okay I think it's yeah
P3: It stopped bleeding
S6: Yeah it stopped

(53) S8: So are you alright now?
P2: Yeah
S8: Just a bit better.
P2: Yeah yeah

All the above extracts are slightly different from each other. In (51) the nursing student agrees with the patient saying "Yeah not with that hand no" and thus confirms his assessment of not being able to play football through repeating the negation. The similarity between empathy and confirmation techniques was pointed out in section 2.4.2. . Extract (52) is an example of repeating: S6 repeats the patient's words twice: "It feels better" and "Yeah it stopped". Extract (53) is an example of paraphrasing and interpretation: the patient simply answers

"Yeah" to the nursing student's question: "So are you alright now?" and the student interprets the answer paraphrasing it: "Just a bit better". Both paraphrasing and interpretation are techniques that enhance empathy. Five nursing students, S2, S4, S5, S9 and S11, do not have any clear occurrences of using reflecting, restatement or interpretation.

Using the communication techniques described in Northouse and Northouse (1985) (cf. Table 2, p. 35) that block empathy are just as infrequent in the data as the ones that enhance empathy. There are a couple of speech acts where the nursing students seem to be moralising. In extracts (54) and (55) the nurse students give advice for next time thus also making a judgement (bolded in text) of what the patient had done this time .

(54) P1: I was er washing the dishes and I cut myself xx
S1: Oh .. oh **next time you have to be more careful.**

(55) S6: So what, uhhuh, so what were you er cutting cucumber or tomato or
P3: It was a tomato
S6: Tomato yeah. **Maybe next time you are little bit more careful**.

There are also some instances that can be interpreted as belittling.

(56) P1: I was washing dishes and I cut my hand while I was washing dishes. It hurts .. bleeding everywhere
S4: It doesn't seem to be so bad

(57) S7: So how was your day? Any way cutting your hand and
P1: xxxx going round the world .. It hurts so much
S7: Yeah I know it hurts and this hurts a little bit more. But (laughs) you just have to be strong now, okay? ... This is not a major big cut

In both extracts above the nursing student seems to belittle the patients complaint about the bad pain they are experiencing. On the other hand, saying that the cut was not so bad could also be interpreted as reassuring and calming the patient down. In (57) the nurse seems to be joking as she is laughing. Being professional in the role-play situation clearly was a challenge to these nursing students.

Apart from the techniques that were listed in Table 2 (p.35) as ones that either enhance or block communication, there are various other techniques that the nursing students used that could be working to the same effect. It was already mentioned in the description of the orientation phase that asking about the pain that the patient was experiencing would be likely to enhance empathy. This did not just occur in the orientation phase but also in the maintenance phase. Especially S1, S3 and S5 keep asking about the pain throughout the maintenance phase. All the nursing students (except for S4) show some consideration of how the patient is feeling. They either ask about the pain, whether the patient feels better, warn the patient that the sterilising liquid is going to sting or hurt a little or ask whether the bandage is too tight.

Another frequently used communication technique that is not mentioned in any of my sources on lists of communication techniques in the health care context (cf. Appendix 2) is small talk:

(58) S9: You don't sound Finnish. Are you from somewhere ..?
P2: No, I I am from Argentina
S9: xxx it's bit cold in here, isn't it?
P2: Mm?
S9: Bit cold in here, isn't it?
P2: Yeah, it is.
S9: Comparing Argentina
P2: I almost xx in here ... yeah it is terrible
S9: Are you in a exchange student or?
P2: Yeah, yeah yeah
S9: Do you like it here?
P2: Yeah, I don't know .. just fine - before this (both laugh) (N: You'll be fine) before this was just fine. I was just helping my mother with cooking, cooking and xx .. I'm not so good for do that those things

(59) S10: Where do you come from?
P1: Australia
S10: Mmhm what are you doing here in Finland?
P1: Er exchange student
S10: Exchange student.
P1: Mmhm

Eight of the eleven students have similar exchanges with their patients. Although small talk is not listed in the professional communication techniques, as was brought up in chapter 2.4.2 on communication techniques and skills in health transactions, social communication in general is mentioned as developing trust in the N-C relationship.

The use of humour is not mentioned in my sources either. There are a couple of clear cases of humour in the data:

(60) P2: xxx ----
What are you gonna do?
S5: Mm?
P2: What are you gonna do?
S5: I was gonna cut these in little pieces. Nothing serious.
P2: Ha
S5: I'm not gonna cut you .. anyway

When the patient asks the nurse what S5 is going to do in (60), S5 says: "Nothing serious" and the patient understands this as a joke. S5 continues explaining that she not going to cut the patient. Both P2 and S5 seem to share the humour in the extract. Above in extract (54) S7 jokes about the pain she is causing to the patient. She makes other similar comments as well:

(61) P1: No, it's just that it hurts.
S7: Sorry about that. Can't help you with that one (laughs)

The reason why the student says this as a joke is that she does not have the means to help the patient by giving her pain medication. S7's joking seems to derive from the role-play situation; she cannot alleviate the patient's pain as there was no medication available. Small talk and humour are not mentioned in nursing literature, but in applied linguistics they have been studied especially in medical contexts. Cicourel (2011, 76) states that in doctor-patient interaction patients consider small talk as proof of the doctor's attentiveness and politeness. This would probably be the case in nurse-patient communication as well.

4.2.3 Termination

In the termination phase of the nurse-patient relationship the nurse's task is according to Peplau (cf. chapter 2.4.2 in this study) to free the patient from the identification with the nurse. Termination occurs simultaneously with the evaluation phase of the nursing process, which was analysed above in the analysis of the content dimension. It turned out that only three students make a summary of their own accord, other summaries are initiated by the patients. Still, the termination phase is very similar in all the samples. Confirming communication techniques are used a lot:

(62) P1: So I'd have to come back here (N: xxx) in the next few days, okay.
S1: Yeah because we'll just make sure it's getting better and there's no danger of infection or anything

(63) P: xxx I have to I have to buy some medicine to this or some?
S2: No you don't have to, do you have any painkillers at home?
P2: Yeah
S2: Okay you can use them if it's gonna hurt a lot.
P2: Okay

(64) P3: Okay. Okay just er okay xxx to take care it xxx get wet. What about sauna? I cannot get to sauna.
S6: Yeah don't go to sauna. P: Okay) Just er just tomorrow. Yeah. I think that er maybe it's better if you if you could call me tomorrow.
P3: Okay, okay. Okay I just call you and say how it's going on.
S6: Yeah
P3: Okay thank you very much
S6: Okay thank you. Bye.
P3: Bye

The above extracts are examples of direct responses (all three), agreement about content (62 and 63) and clarification (64), which all contribute to confirming communication (cf. Table 2, p. 35). The nursing students fulfil the task of freeing the patient from the identification with the nurse through evaluating the wound care and using confirmation to techniques.

4.3 Identity dimension

The discussion of the identity dimension in chapter 2.4.3 included such aspects as the nurse's professional role, norms, values, power and language. As the second research question deals with language more specifically, the first four will be considered here. Using the mHCM as a framework, the analysis will focus on how role, norms, values and power are communicated rather than focussing on what the language as form is like. The more formal aspects of language will be covered when answering the second research question.

The nursing students of this study were in their fourth term of studies when the work sample test was conducted. This means that it was their second year of nursing studies. On the basis of her study of polytechnic nursing students, Ora-Hyytiäinen (2004, 67) describes the identity of a second year student as having a role of implementing care together with the other nurses. The second year student no longer defines the role to be just a helper as the first year student does. In the light of Table 4 (p. 40) which represents the levels of communication skill development, this could be interpreted to mean that the students of this study would have the foundation level, level A, and their communication in the nurse's role would be the kind Nicol et al. (1996, 178) describe on level B of the five levels of nursing students' communication skill development. On level A the students' communication is "awkward and the student may appear self-conscious" (cf. Table 4). Despite the fact that the students in this study were in their second year of nursing studies, they sometimes made it very explicit that they were uncertain and self-conscious. In extract (28) S8 shows her uncertainty by saying that she tries to be calm. In the following extract, S9 makes her status even more explicit:

(65) S9: I'm sorry I'm a bit slow but I'm a student (laughs)

Two students introduced themselves in their first utterance (cf. Table 9, p. 61) but one more student did this in her second utterance. Of the three students who introduced themselves only one introduced herself as a nurse and not a student:

(66) S1: It's alright hello, I'm [name] the nurse and I'm gonna help you so just hold on.

(67) S8: Oh so my name is [name] and I'm nurse student and I'm I will take care of you now.

(68) S9: I'm nurse student [name] and I came to look at you. What is the problem?

As already pointed out (p. 75), all the students were clearly uncertain when giving instructions on wound care. Using the conditional and phrases like "it's better not to" and "I think" are frequent and even S1 "the nurse" hesitates:

(69) P1: Mmhm .. can I still go to sauna or anything? Can I get it wet or anything?

S1: Well it's better not to

On the basis of the work sample communication data, these students seem clearly to be more on level A than B in terms of their communication skills. There is even one occurrence of what resembles 'text book reiteration' (level A in Table 4, p. 40).

(70) P3: What about what about wet, can I get wet this or?
S9: Er no and you should change the bandages, bandages should be changed er .. I think ..

The nursing student's switch to the passive voice in the above extract gives the impression that she is trying to remember what she has read about changing bandages. This interpretation is based on the fact that the passive voice is far more frequent in academic writing than in informal oral communication. In their second year of nursing studies, these students' communication skill level may have been fluctuating between the foundation level, level A, and level B, where safe and accurate performance is typical (cf. Table 4, p. 40). In Benner's terms the students are clearly novices.

To consider how norms and values are reflected in the verbal communication data is not very straightforward. There is one aspect in the data that does bring up nursing ethics (that norms and values are part of) and that is the nursing students' reactions to their patients' pain. Nash et al. (1993, 946) point out that "Regardless of the clinical setting, one of the most important functions of the nurse is to alleviate the suffering of people who are experiencing pain". The students had some problems with this as was exemplified with extracts (56) and (57) (p. 82). As the role-play situation made it impossible for them to give any medication to the students, their reactions were not what they could have been in a real nursing context. However, the fact that only four students asked about the patient's pain seems to indicate that they were not following the code for nurses in this respect.

The role-play situation clearly influenced the power structure in the work samples because the exchange students were given instructions to be "slightly hysterical", to "complain about the pain" and "ask the nurse about the bandaging". The instructions had seven suggestions for questions as well. The nurse's role-play instructions only described the patient's problem in the context of a casualty and emergency department (cf. Appendix 12). Thus, the patients were guided to be active rather than quiet for example. The instructions may have contributed to the fact that the turn taking is quite symmetrical in all the work samples. The number of turns in all work samples is very even between the nurses and patients as can be seen in Table 10.

Sample	1		2		3		4		5		6		7		8		9		10		11	
N/P	1	1	2	2	3	3	4	1	5	2	6	3	7	1	8	2	9	3	1	1	1	3
Turns	4	7	4	6	6	0	8	8	9	2	5	02	5	7	7	6	9	8	3	9	7	5
Questions	7	1		7	6					9		4	9	0	8		6		5		4	

Table 10. Number of nurse (N) and patient (P) turns and questions in the work sample data

The turns are not just even in number but their length is fairly even as well. Although the patients were instructed to ask questions, the nurses still made most them as can be seen in Table 10. The nurses' questions were part of accomplishing the task of taking care of the wound and the interview. The nurses needed to know certain things about the wound and the patient to be able to carry out the tasks properly. These observations seem to be in line with Kettunen et al.'s (2002, 112) study where the nurses and patients constructed power together in interaction (see p. 52 in this study). With the questions the nurse students of this study controlled the structure of the conversations. All this of course is part of using language and communication skills for professional purposes.

It can be deduced from varying number of turns, and as Table 6 (p.56) showed, that the lengths of the samples varied quite considerably. It is not possible to draw any far- reaching conclusions based on the length of the samples. To get a comparison point, we recorded the same wound care situation with Lola Lucke, the professional nurse, and a Finnish student with very good English skills and the situation took 4 minutes 43 seconds. Thus, the wound care situation is one where clinical skills and communication skills form a combination that cannot be assessed based on the length of the time the situation takes.

4.4 Overall assessment of student performance

The preceding analysis of the students' professional performance and thus competence was based on the theoretical framework described in chapter 2.4 on the model used in this study. By way of 'testing' how well the theoretical framework captured the relevant aspects of the nursing situation and helped answer the first research question, a more practice-based educational approach will be reported in here, namely assessment. Assessment is in a very central role both in health care and in education. In the health care context, patient satisfaction is an important factor when evaluating how successful the given care has been. As was mentioned in chapter 3.2 on the design and procedure of this study, according to Trout et al. (2000, 695) patient satisfaction is linked with the quality of care in emergency departments and it does not necessary link with the technical aspects of care. This chapter considers the students' performance in the

light three types of assessments of the nursing students' performance in the work samples: the exchange students assessed them on the spot, while they were not playing a part in the role-play and the teachers and the students themselves assessed the performances on video. The exchange students were asked to write general notes on the nursing students' performance. No specific assessment form was given. Their comments were all very positive. All the exchange students thought that the nursing students spoke good or very good English, handled the situation well and made the patient feel safe. Some were said to have been a little nervous but that was not a problem in the interaction. Table 11 is a summary of the teachers' assessments of the nursing students' skills and the students' self-assessments. The assessment scale was: fair -1, good – 2 and excellent 3.

INTERACTION SKILLS	Teachers	Students
Verbal communication	2.19	1.80
Therapeutic relationship:		
- listening	2.06	1.80
- client feels safe	1.99	1.60
Interpersonal skills:		
- relaxed	2.09	1.90
- friendly behaviour	2.24	2.40
- direct eye contact	2.17	2.30
- attentive posture	1.98	2.00
-use of appropriate words	2.02	1.40
CLINICAL SKILLS		
- attention to aseptic technique	1.22	1.20
- clarity of instructions	1.59	1.60
- ability to answer questions	1.72	1.70
- documentation	1.50	1.10
ORAL ENGLISH SKILLS	2.26	1.95

Table 11. The teachers' (n=5) and the nursing students' (n=11) assessments

The assessments show that the students assessed their performance slightly more critically than the teachers did. The teachers assessed the interaction skills to be good but the clinical skills not so good. The nursing students' self-assessments were similar as to the clinical skills; they felt uncertain of their skills. Both the teachers and the students assessed the oral English skills to be 'good'. The teachers assessments are in line with the analysis above: the students managed quite well in the wound care situation as far as interaction is concerned. However, the students themselves assessed their verbal communication to be a little less than 'good', i.e., a little below 2 (1.80). The fact that they felt that they were not able to make the client feel safe is probably due to their uncertainty of their clinical skills. There is a possibility that their English skills might have a role there as well. Looking at the students self-assessments of their interpersonal skills, the low estimate of their skill to use appropriate words catches the eye. The analysis showed very few clear problems with vocabulary, but perhaps using generic terms instead of specific ones (cf. extract 75) indicated the lack of words that the students experienced.

4.5 Summary

The analysis of the data with the modified Health Communication model as an analytic framework showed that the nursing students were quite able to manage in the wound care situation with respect to the tasks that they needed to do. They all assessed the wound, implemented the care, gave instructions and collected information required to fill out the documentation sheet. There was very little or no problems in sharing meaning with the patients. The uncertainty that the students expressed during the different phases of the wound care situation were more due to the students' being novices still in their practice than their capability to use the English language to fulfill the goals set for the task. Some sort of inconsistency when assessing the wound (as in extract 13) or giving instructions for home care (as in extract 35) probably resulted from the role-play situation. The students were well aware of their lacking skills in wound care and made that apparent also through language by sometimes thinking aloud (27) or by simply stating this as a fact (28). Sharing and negotiating meaning worked best in the interview part of the situation. The patients were active as they had the questions in the instruction for their role. Again the role-play situation influenced the dialogue. The nursing students had problems with how to document the Social Security number which the patients did not have.

Considering negotiating and sharing meaning on the relationship level, it turned out that the nursing students did not use the emphatic communication techniques described in the theory section (Northouse and Northouse 1985, Faulkner 1992, Macleod Clark 1984 and Earnest 1993 and Sundeen 1991). Instead, there were techniques that were not mentioned in the sources cited in the discussion of communication variables. These were small talk and humour. It is not possible to know whether using small talk and humour are variables that would always be beneficial for relationship building. Small talk is often taught in language classes, but probably not in nursing interaction classes. Humour can be a very tricky communication variable. In their study on what lay persons think constitutes good communication, Mazzi, Rimondini, Deveugele, Zimmermann, Moretti, van Vliet, Deledda, Fletcher and Bensing (2015, 1223) report that humour is not always valued positively in medical encounters. It is likely that that the use of humour could create conflicting opinions in nursing as well. The nursing students in this study probably felt safe with their young patients and therefore they felt it natural to use humour. The role-play situation induced some jokes as well. The analysis of the work samples from the perspective of the nursing students' identity dimension showed that the students were clearly novices and also that the role-play situation influenced the way the students communicated with the patients. As both the nursing students and the patients were approximately the same age, the roles seemed to be quite even in terms of power structure.

5 THE ROLE OF GENERAL ORAL ENGLISH LANGUAGE SKILLS

The preceding analysis of the work sample data focused on professional communication without specific attention to the linguistic features of the nursing students' English language use. However, certain aspects relating to formal aspects of language came up already in the analysis of negotiating meaning professionally. The analysis of the data for the first question covered the relevant aspects of the students' professional oral English skills for communicating for the functions defined in the mHCM. The dual focus of CLIL was thus interpreted as integration of form and function (c.f. chapter 2.3.4 in this study on language conceptions).

Ahern (2014) discusses the roots of CLIL that show the route from focus on form in language teaching (e.g. the Audio-lingual method) to focus on meaning (Krashen's 1985 Input Hypothesis). She points out that before CLIL appeared, awareness of language and constructing meaning had already started to spread in education in the United Kingdom and the USA as a way of enhancing learning in various subject areas. Referring to schema theory, she writes: "comprehension of written or spoken texts requires access to knowledge of many kinds, in addition to linguistic knowledge." (Ahern 2014, 21.) This line of thinking is the basis in CLIL and surely an important one. As was pointed out earlier in the discussion of language conceptualisations, the nursing students' general English skills were expected to develop during the programme. In European education, general language competence is described in the CEFR as consisting of linguistic, sociolinguistic and pragmatic components (cf. chapter 2.5.2 in this study). The first research question followed the integrative approach of CLIL in that the focus was on function and not on form within the professional framework provided by mHCM. Although form may not be crucial for carrying out the communicative tasks in the wound care situation, there is a good reason to look at the data from a linguistic point of view as the development of language skills/competence does include the development of the linguistic component as well as the other two components. Linguistic form is considered important also from the point of view of language education; form is always part of meaning (cf. chapter 2.5.4 in this study). This means that the mHCM is still the framework when considering the linguistic aspects of transactions in the data in terms of vocabulary, accuracy, fluency and appropriate use, in other words, the linguistic features will be analysed in the content, relationship and identity levels of messages. In theoretical discussions and analyses, it is always possible to separate factors of a phenomenon for the purposes of description (cf. e.g. Roper et al. 1980 as cited in chapter 2.1.2 in this study). Before looking at the nursing students' use of linguistic forms in the work samples, the general assessment of the students' orals English skills will be reported.

5.1 Students' general oral English proficiency test results

The students' English language proficiencies were assessed through the National Certificate of Language Proficiency (NC) test. This was done right at the beginning of the study as the level of general language proficiency was considered an important aspect in the educational context. When the NC test was administered in 1997, the test had 9 levels that were later changed to 6 to correspond to the six proficiency levels of the Common European Framework of Reference for Languages (the CEFR). The Finnish National Board of Education decree D 18/011/2003 described the correspondences of the test levels between the old NC 9-point scale and the 6-point scale of the CEFR (Opetushallitus 2003). The law was implemented in 2004 (Opetusministeroiö 2004) and it stated that the 9-point proficiency scale was valid until the 1st of January 2002. Table 12 below is my translation of the conversion table in decree D 18/011/2003 with my addition of the CEFR names for the levels in the 6-point scale.

Original proficiency scale levels 1-9	New proficiency scale levels 1-6	The CEFR names of the levels
1	1	A1
2 and 3	2	A2
4	3	B1
5 and 6	4	B2
7	5	C1
8 and 9	6	C2

Table 12. Correspondences between the old proficiency scale before 2002 and the new proficiency scale taken into use in 2002 Opetushallitus 2003)

The NC test used in the assessment of the nursing students' general English language proficiency for this study was placed on levels 5-7 and it had sections on reading comprehension, writing, listening and speaking. The speaking test was recorded in a language studio. The results of the test are in Table 13 with the corresponding CEFR proficiency level for each student. The general descriptions of the CEFR proficiency levels can be seen in the self-assessment grid in Appendix 9.

Nurse student	NC level	The CEFR level
S1	6	B2
S2	5	B2
S3	6	B2
S4	6-	B2-
S5	7-	C1-
S6	6-	B2-
S7	6	B2
S8	5	B2
S9	6	B2
S10	6-	B2-
S11	5	B2

Table 13. NC test results

The NC test assesses interaction in an interview section, but that section was not included in this tailored test, because of lack of funding. Thus, the test assessed only the individual students' language proficiency as a set of skills possessed by an individual rather than in interaction. However, it is safe to say that the students' English language proficiency was level B2 and above; a level of proficiency considered sufficient for nursing in Finnish by Komppa (Komppa et al. 2014, 24). I would assume that the level of proficiency required for nursing would be the same regardless of the language in question.

In the following I will reconsider the students' language use on the content, relationship and identity levels of the transactions. Both form and function will be taken into account and their potential relevance will be discussed in the concluding chapter.

5.2 Content dimension

The analysis of the data in the content dimension of negotiating meaning professionally showed that the students had no functional linguistic problems in the assessment phase. They used open questions professionally to collect the patients' background information. The majority of the students had no problems in forming the open direct questions. There were only a few inaccuracies with the word order as in extract (7) which was given as an example of an open question in the analysis of the professional communication on the content level (cf. p. 72) :

(7) S5: Mm so how it happened?

Some possible problems with vocabulary appear in the data.

(71) S6: Hang on ... here is some blood this is like er ... er how long have this so at what time did this did this happen?
P2: Maybe something like one hour ago
S6: One hour
P2: Yeah
S6: Yeah

The reason why S6 in (71) changes the structure may not be that he wants to self-correct the subject-verb agreement error in "how long have this", but it may be that he does not have the vocabulary for describing clotted blood so he decides to ask when the accident happened as he probably makes the conclusion that it was not very recently because the blood seemed to have dried up already. He seems to get the information he needed from the patient without any misunderstanding. Extract (26) was an example of searching for vocabulary and finding it:

(26) S11: What do you do for for, do you are you mm (*waves her own right hand)* right-handed?
P3: Yeah this is my right hand
S11: Yeah, are you in school or where?
P3: Yeah xx here exchange student programme
S11: Yeah (P: But now xx) So you can't you can't write (P: Yeah) for a moment
P3: How long you think I I have to ... take er
S11: It takes er .. I don't know (*laughs*) about er at least week or two, I guess.

Although in the above extract, S11 found the vocabulary she needed ("right-handed"), it seems to take her some effort to get to the point she wants to make, that is, the patient not being able to write for a while. Using English may have complicated the exchange there.

As was pointed out in summary of the analysis of the students' professional communication in the work samples (cf. chapter 4.5), the students were uncertain when explaining the procedure and giving instructions. The reason for this uncertainty seemed to be due to lack of clinical skills and the new test situation rather than language skills. However, there is an interesting feature that comes up in the planning and implementation phase and also elsewhere in the data: three students seem to resort to language use that seems to have little to do with the situation at hand. Some of this may well be the result from slips of the tongue as the meaning seems to create a discrepancy within the context. Here are some examples:

(72) S1: So you can have a rest
P1: Yeah thank you ... thank you
S1: Well thanks for coming anyway. (Laughter) Do have a rest (P:Yeah) for a while and er get in touch (P: Mmhm) we'll get in touch with you and come for a check.

(73) S3: Yeah after two days (P: Okay) you can come back and we we then we can check out (P: Okay great) if it's infected and we change the bandages unless it starts bleeding
P3: Mmhm

(74) P1: I don't think xx infected *(laughter)*
S7: You what?
P1: I don't think it will get infected
S7: *(laughs)* That's what I make sure *(laughs)* because I couldn't take you to the sink *(laughs*) sorry
P1: Oh that's okay
S7: O-oh yeah I feel fine (*laughs*). And then let me see that size

In (72) the complimentary phrase "Well thanks for coming anyway" is not really appropriate in the wound care context and S1 realises this of course and therefore laughs. In (73) S3 uses the word 'unless' in a way that makes no sense even if it were interpreted in the opposite sense ('if it starts bleeding') because what she mean is simply that they will check any infections and will change the bandage when the patient comes back after two days. In (74) S7 seems to make a funny interpretation of the patient's statement. She probably wants to joke about the test situation; how she was not able to clean the wound with water and that is why she 'makes sure' that the wound will be infected. When S7 says that she feels fine, she must also be referring to the test situation. Whether the students make these utterances that make no sense in the context because of excitement or because of using a foreign language and not knowing what to say is difficult to estimate. Both aspects may be at work. The students playing the patients' role do not react to this discrepancy in any way.

The most obvious problems with vocabulary appear in the interview section. As it was pointed out in the analysis above (p. 75 in this study), negotiation was needed to get the spelling of the patients' names correct. The names of Gustavo Gonzalez and Kike Hernandez caused more problems than Amy Robert's name. The strategies the nursing students used to confirm the spelling were either by showing the patient how they had written it as in extract (36) or by asking the patient to spell the name as in extract (37). The problem that arose in (37) was that Patient 2, i.e., Kike did not know how to spell his name. The nursing students who had to deal with a non-native patient had a different situation from the ones who had Amy, the native speaker, as their patient.

Negotiating was also needed in finding out about the patients' Social Security number. Extract (39) was the only occurrence of code-mixing in the data, which means that the speaker uses L1 to deal with the communication problem (cf. Ellis 1994, 28). Otherwise there are plenty of examples of L1 interference in the nursing students' speech from pronunciation to grammatical accuracy, but L1 use does not appear elsewhere in the data. One typical grammatical problem that the nursing students often have is not marking the future tense. Extracts (41) and (42) are examples of this.

(41) S6: Eight five seven. Okay and today is twenty-second of February and the year is nineteen ninety- six .. and .. you correct me if I put something that's (P: Yeah yeah) not true. So the patient was cutting .. cutting /tomei/- tomatoes (P: Yeah) for salad. And .. and he cut ..er slight er
P3: In the palm
S6: Er yeah a cut to in his right hand .. and .. I put it shortly that's okay no stitches needed .. xx bandages .. er on
P3: Mmhm

(42) S11: Seven seven alright. So I just write what has happened. So you have cut with your knife
P3: Yeah
S11: xx right hand arm .. and I cleaned it with this petadine and put xxxx and bandaged it. No need of stitches

Neither S6 nor S11 mark the future tense when explaining to the patient that they will write down a description of what had happened. As the future tense is not marked in Finnish, this is clearly L1 interference. The transactions do not seem to suffer from this kind of interference at all.

In the evaluation and termination phases, there were no occurrences of negotiation because of language problems. The nurses and patients often summarised the home-care instructions together and they managed it well. The language as to form had similar characteristics as described above. The following extract has examples of typical linguistic features of the nursing students' oral English:

(75) S7: And er let me see this timetable I give now the time you come again (P: Mhm) And you come tomorrow (P: Mhm) or day after tomorrow which one is better? (P: Day after tomorrow) Day after tomorrow okay you come at one o'clock (P: Mhm) Okay we check the /waund/ (P: Mhm) And er and and then I give you the xx the new stuff with you xx (P: Mhm mhm) so this xx for a few days now (P: Mhm mhm okay) okay. xxx
P1: Thank you
S7: You're welcome

The lack of marking the future tense, occasional pronunciation problems (/waund/) and lacking vocabulary all appear throughout the data. The lack of vocabulary is not so obvious here, but it is possible that S7 uses the generic word 'stuff' in need of more specific vocabulary. In the following there is a vocabulary problem that seems to go unnoticed by both transactants:

(76) S11: Right. Then I need this er to fill this blanket.
P3: Okay
S1: Okay. What's your name?

The word 'blanket' stems from interference from the Swedish word for 'a form' which is 'blankett'. This type of interference from L2 to another L2 occurred only once in the data. Interference from L1 is at work in this exchange:

(77) S9: How does it feel, is it too tight? (P: No no no, it's just okay, just okay) xxx (laughs) Okay, I will give you the ..er painkiller if you could follow me. (P: Okay great, yeah because I have, I am having) Oh sorry, I have to take your knowledge
P3: I'm having you know...
S9: First of all can I have your name?

As in extract (74), this interference of using the word 'knowledge' instead of 'history' does not cause any negotiation between the nurse and the patient.

Considering the above extracts in the light of fluency, it can be summarised that some lack of vocabulary and uncertainty when giving instructions result in pausing and hesitations. Those two features are referred to in the CEFR as diminishing fluency. On the whole the transactions in the work samples are smooth without any long disturbing pauses. The exchange of content in the transactions was quite successful.

5.3 Relationship and identity dimensions

In terms of language, the relationship and identity dimensions are difficult to analyse separately as the nursing students' identity is reflected in the language that they use in their relationship with their patients. In the analysis of the content level, it turned out that the nursing students had different approaches to the wound care transaction to start with as approximately half of them focused on the clinical task and the other half on starting to build the relationship. Language did not seem to cause any problems or negotiation in either case. The students' use of stereotypical comments when calming the patients down was frequent. Stereotypical comments were defined earlier following Earnest (1993, 40) as exchanging "meaningless words and clichés". This definition bears resemblance to formulaic speech as a language learning and communication strategy. Formulaic speech has been described in second language acquisition research, e.g., by Hakuta (1974), and Krashen and Scarcella (1978). Language learners often memorise chunks of speech such as greetings and other fixed expressions without analysing them. Such speech does not occur only in second language learner speech but also native speakers can use it. (Ellis 1994, 84.) Defined in this way, it seems that stereotypical comments and formulaic speech are actually the same phenomenon.

The analysis of the working phase of the relationship dimension in terms of professional communication revealed that the nursing students did not use many communication techniques that enhance empathy. There were some occurrences of paraphrasing and repetition. Again these techniques have been described as language learner communication strategies in second language acquisition research (cf. Ellis 1994, 397). There were a couple of occurrences that could be described as moralising and belittling in the nursing students' speech data:

(54) P1: I was er washing the dishes and I cut myself xx
S1: Oh .. oh next time you have to be more careful.

(55) S6: So what, uhhuh, so what were you er cutting cucumber or tomato or
P3: It was a tomato
S6: Tomato yeah. Maybe next time you are little bit more careful.

(56) P1: I was washing dishes and I cut my hand while I was washing dishes. It hurts .. bleeding everywhere
S4: It doesn't seem to be so bad

(57) S7: So how was your day? Any way cutting your hand and
P1: xxxx going round the world .. It hurts so much
S7: Yeah I know it hurts and this hurts a little bit more. But (laughs) you just have to be strong now, okay? ... This is not a major big cut

Looking at the nurses' reactions in all of the above extracts, it would be possible that referring to 'next time' and belittling the patients' pain with phrases like 'it doesn't seem to be so bad' could be formulaic speech again, but this time working unfavorably as empathy blocks. These kinds of reactions with formulaic speech/stereotyped comments are not just learnt phrases but they seem to be combined with learnt ways of reacting. Learnt language, communication and interaction skills all seem to function together in these transactions.

The use of small talk may be part of the general interaction/communication skills that the nursing students have acquired elsewhere in their lives as this is not mentioned as a communication technique in the health care context (cf. Appendix 2). The questions that the students ask are the kind that are very commonly asked from anybody coming from another country, as in extract (59): *Where do you come from?, What are you doing in Finland?* Such questions are often practised in language classrooms.

The nursing students' use of humour as exemplified in extracts (57) and (58) could be connected to the fact that the nursing students and the exchange students who played the role of the patient were of the same age or the exchange students were slightly younger. All in all, the relationship between the nurse and the patient in all of the simulated work samples was very informal. The patient role was defined only in terms of the injury that had happened in the kitchen at home and the students playing the patient role were asked to be slightly hysterical. As they were not given any instructions about personal details concerning for example age, family status or profession, the assumption was that the students would be playing the role as themselves. This was mostly what happened. There were only a few samples where the patient made up another persona. Gustavo Gonzalez created a story where he had a wife who had brought him to the hospital. Still, when he was asked his date of birth he gave his own (18 years) in two samples and only in one he changed it to be older (31 years). In one sample Amy Roberts said that she worked at the super market. These few changes in the role did not affect the communication style of the exchange students in the role play.

One simple example of how the informality of the relationship of the nurse and the patient in the data is the use of 'gonna' instead of the full form 'going to'. There are 37 occurrences of 'gonna' that appear in five nursing students' speech whereas there are only seven occurrences of 'going' to in four nursing student's speech. The patients use 'gonna' as well: there are 16 occurrences in seven patients' speech. The use of 'gonna' is not just evidence of an informal relationship but also of the participants' identity.

5.4 Summary

The analysis of the nursing students' linguistic skills in the work samples using the mHCM as a framework showed that the students sometimes lacked some vocabulary, did not mark the future tense and that there was some L1 interference. None of these created any serious communication problems or meaning negotiation in terms of the professional content level of the interactions. In three samples, students spoke what was described as not appropriate to the context at hand but the patients did not react to that in any way.

The analysis of the language use at the relationship and identity levels showed that such language learning or communication strategies as formulaic speech, paraphrasing, repetition and small talk can have a different role in nursing communication from the role they have in language learner language. Formulaic speech can function as stereotypical commenting. Paraphrasing and repetition can work in a positive way as enhancing empathy. The nursing students used informal language marked with extensive use of the form 'gonna' instead of 'going to'.

The fact that non-target language like forms did not cause any misunderstandings or negotiations bears resemblance to the observations made in English as a lingua franca (ELF) studies. In ELF contexts, English is used as the common language of communication when it is either not the native tongue of any participants or only some of the participants in a communication situation. The context in the work samples of this study was always an ELF context. ELF research started at the turn of the 21st century and it is growing in number. In 2002, in her article on developing pragmatic competence in English as a lingua franca, House cites some results from Meierkord's (1996) study:

- There are surprisingly few misunderstandings
- The few misunderstandings that do occur are not overcome by negotiations, but rather by topic changes.
- ELF interactants use a markedly reduced number of tokens, especially in ritualized phases of ELF talk.
- Interference from L1 interactional norms is almost completely absent.
(House 2002, 248.)

The findings of this study seem to support the above findings. There seemed to be no misunderstandings and very little negotiation of meaning.

6 CONCLUSIONS

6.1 Critical evaluation of the study

The starting point of this study was to approach the oral English language skills of the nursing students from the point of view of the profession by defining the professional competence of a nurse. The Roper, Logan and Tierney (1980) model for nursing was discussed since that was the model introduced to the students in the programme at the beginning of their studies. To get a fuller picture of professional communication in nursing, the Northouse and Northouse (1985) model of health communication was chosen as the basis for the model used in this study for analysing the work sample data in a wound care situation. At the point when I had described my modified Health Communication Model, mHCM, explaining its dimensions with references to literature on nursing interaction and health communication, I run into a dilemma. When presenting the model in conferences, I was asked where was 'language'? The word 'language' is still not in the mHCM as depicted in Figure 5 (p. 26). This is quite typical of communication models; the concept used is 'message' as in the model of this study as well. Positioning language in the model was fairly straightforward as language is seen as part of identity (cf. chapter 2.4.3.3). However, it was not enough to place 'language' in the model; it also had to be defined. Different ways of defining 'language' were discussed in chapter 2.5 on positioning language as part of CLIL in general and as part of professional competence in particular. Based on the theories discussed in this study, it seems that theories of 'language' very often are connected either with language learning/acquisition, language teaching or language assessment/testing, and may not orient to language use as communication and interaction the way communication theories do. There may be a gap this approach to language between applied linguistics and communication studies. Communication models do not seem to consider language and language studies do not seem to consider communication models. The approach in this study is about filling the gap; bringing the mHCM and its background theories together with applied linguistics approaches to language.

Although the theoretical framework, to begin with, originated from health communication and not from a theory of language in applied linguistics, it turned out that the mHCM was a functional model within which it was also possible to take sociocultural aspects of language and communication into account. The studies cited in chapter 2.5.2 about professional language skills in Finnish as a second language (S2) in Finland have mostly had two main approaches to language. Kela and Komppa's (2011) study on nurse's working S2 starts from the perspective of functional language teaching with references to Halliday's systemic functional linguistics and the functional approach in the CEFR. Komppa et al. (2014) base their framework for professional S2 in higher education on the CEFR and so does Jäppinen (2010) in her study on the

sufficiency of S2 skills in work life. Thus, based on the CEFR, the approach is that of a functional language conception. Suni's (2008) doctoral dissertation on second language in interaction applies dialogical views on language and so does Virtanen (2011) in her article on conceptions of the S2 language skills of internationally recruited nurses. In the present study, the analysis of the transactions in the work samples was complemented with the CEFR as the National Certificate on Language Proficiency test that the nursing students took at the beginning of the study corresponded to the CEFR functional approach. The CEFR approach to language was described to some length in chapter 2.5.2 and the categories of linguistic and sociolinguistic descriptions were reflected on in the context of the second research question. Following the CEFR, the functional approach was clearly the primary approach to language in this study. Yet, the mHCM has a lot in common with the dialogue approach referred to in chapter 2.5.4 on language conceptualisations and paradigm shift. It is not within the scope of this study to discuss the concept of dialogue in detail. However, it does seem that the concept needs some clarification, also within applied linguistics as it can be used with different meanings (cf. e.g., Llinares et al. 2012 and Dufva 2014). It also seems that research on 'dialogue' and its definitions might be the step needed for applied linguistics to meet with 'communication' and 'interaction' studies. I would here like to refer to Candlin and Candlin's (2003, 134) plea again for applied linguists to "look outside their own professional literature for studies that direct themselves at health communication, especially where this involves issues of intercultural communication." In the context of this study, health communication is the relevant direction, but for applied linguistics in general, the direction might be 'communication'/'interaction'.

It was mentioned in chapter 3.3 that the method used in this study originates from communication studies and it has been used in health studies as well. It was pointed out in the description of the method of analysis that using the mHCM as a framework for data analysis in this study bears resemblance with content analysis. Content analysis is a method that can be used in many contexts and it is also used in applied linguistics (cf. Dörnyei 2007). The ways in which content analysis is used can vary. In his book on research methods in applied linguistics, Dörnyei defines the difference between quantitative and qualitative content analysis to be that in qualitative content analysis the categories of analysis are not predetermined unlike in quantitative content analysis. In the latter, predefined categories are used; a text can be analysed, for example, through counting words, phrases and grammatical structures. Dörnyei's description of qualitative content analysis in applied linguistics is that the categories are derived from the data. (Ibid., 245.) This was not the case in this study as the categories for the content analysis were based on the theoretical description of the dimensions in the mHCM. As the aim was to consider professional oral English skills of the nursing students in the study, the analysis of the data was made using the theoretical framework with its categories rather than exploring what would inductively emerge from the data. This method could be criticised as possibly missing something in the data. However, keeping in

mind the pedagogical considerations of this study, the theoretical framework seemed to give a very extensive view of the kind of professional communication skills a nurse would need. The Roper, Logan and Tierney (1980) model of nursing was used as the main source for defining a nurse's competence. This was the model that was introduced to the students at the beginning of their studies. Therefore evaluating their skills with respect to the model is pedagogically justified. The model of nursing viewed communication as an activity of living that a patient can have problems with. This approach was not suitable for the purposes of this study and therefore the theory was extended to include considerations of health communication. The mHCM was described with references to relevant research on nursing communication. Constructing the model in this way provided a sound base for the analysis of professional communication. The mHCM was based on the Northouse and Northouse's (1985) developmental Health Communication Model. The mHCM can also be developed and updated with new research. The framework itself may not need to be restructured.

One question that came up when the data was described using the CEFR proficiency levels was that in English as a lingua franca situations such aspects of language use as 'command of idiomatic expressions', 'colloquialisms', and 'awareness of connotative levels of meaning' might not be as important as they might be when communicating with native speakers. This was not a research question, but the lingua franca approach could be something to consider in the educational context of CLIL. The role of such CEFR descriptions of language use as 'command of idiomatic expressions', 'colloquialisms', and 'awareness of connotative levels of meaning' would need to be reconsidered when the communication context concerns communication between non-native speakers. The lingua franca aspect in relation to the CEFR has been discussed by e.g. Hynninen (2014). Her contention is that the CEFR might not accommodate lingua franca at all and a new framework might be needed.

The analysis of the work sample data revealed no considerable shortcomings in the nursing students' oral English language proficiency. The overall conclusion was that as to their English skills the nursing students managed the wound care situation quite professionally. Using the theoretical framework described in this study, the analysis confirmed and supported Komppa's conception of the sufficient requirement level of S2 language proficiency for nurses (Komppa et al., 2014, 9). The nursing students had B2 or above CEFR level of oral English proficiency and that turned out to be a sufficient level for them to manage the wound care situation. It is possible that one reason for no obvious challenges for the students in communicating could be that the simulation task was not too challenging for the nursing students in terms of oral English use. In her article on assessing vocational language skills, Härmälä (2010, 31) points out that when professional and language skills are assessed in one situation in integration, the situation may be too narrow to be used as a basis for conclusions about the testee's professional language communication skills as the focus is on the professional goal and not on language and communication. This

may be true of the wound care situation where the data for this study was drawn from. The main goal in a wound care situation is, of course, taking care of the wound and a lot of that can be done without speech. Yet, language and communication are a very central aspect of any nursing care situation as the relationship with the patient/client is created through communication/interaction.

One obvious criticism of the present study is that the data was collected 20 years ago. The core of the theory, the modified Health Communication Model, was formulated at the beginning of this long research process. The Health Communication Model by Northouse and Northouse (1985) has outlasted the past 30 years well as was shown in chapter 2.3.1 on models of health communication. Another interesting aspect of the long stretch of this study is that the approach to nursing seems to have gone through a change since the 1990's, but that change has not affected the nursing theories presented in this study. In chapter 2.1.2 on defining the nurse's competence, the curriculum of the nursing students' medical-surgical programme was described to reflect the 'romantic curriculum' as opposed to the 'classical curriculum' that had been prevalent before the 1960's. The difference between the two, as described by Jarvis is that the 'classical curriculum' focused on subject-centred skills, knowledge and content whereas the 'romantic curriculum' encouraged creativity, discovery, processes, involvement and cooperation (Jarvis 1990, 223-224). During the time that this study was in process, a notable change must have happened. In an article published in 2015, Rolfe suggests that nursing is a human science with a focus on understanding and relating to individual persons. He sees that this aspect has been lost for a time with an inappropriate scientific paradigm which focuses on research-based and evidence-based practice. (Rolfe 2015, 1.) He refers to Peplau's work as follows: "As Hildegard Peplau (1952) suggested more than 60 years ago, nursing is defined in terms of the relationship between a nurse and her patients" (ibid., 6). Peplau is one of the central sources in the description of the relationship dimension of the model in this study. Her role as a classic is also strengthened, e.g., by McKenna, Pajnkihar, and Murphy in their book on *Fundamentals of Nursing Models, Theories and Practice* published in 2014. In the chapter on interpersonal relationships, McKenna et al. devote a considerable amount of space looking at Peplau's theory of nursing as a therapeutic interpersonal process (ibid., 129-133) and finish the chapter with a recommendation that nurse educators would develop an interpersonal culture of education (ibid., 134). In the following chapter I will relate this to the implications that the present study has for CLIL nursing education.

6.2 Implications

The main overall result of this study was that the nursing students managed the wound care situation using English and their uncertainty was more due to the lack of clinical skills than oral English skills. The B2 level and above seemed to be sufficient in the communication context of the work samples. What then can the implications about this finding be? Looking at the English-enhanced nursing programme from a language education point of view, the viewpoint of this study, several aspects to do with curriculum planning come to mind on the basis of this study. The goals of the English-enhanced nursing programme of this study were:

> The general goal of the programme is to train nurses for the Finnish society using the English language as a mode of instruction. The programme further aims at strengthening the acceptance and tolerance of multiculturalism and developing both basic interpersonal communication skills and cognitive academic language proficiency in English.
>
> (Lappeenranta Health Care Institute 1994)

The time when the goals of the programme were defined was considerably different from the 21st century Finland. As was brought up earlier, the role of the Finnish language was not discussed in the programme. The focus was on English. With S2, Finnish as a second language, research, the CLIL nursing programmes have started to look different. In the present study, the nursing students were all young Finnish adults, who wanted to develop their English skills and they had therefore applied for the English-enhanced programme. The context is different when non-Finnish speaking nursing students are trained for the Finnish work market through English. They will still need to learn Finnish as a second language. The roles and goals of these two languages, English and Finnish, would need to be reconsidered in the CLIL nursing programmes. What connects the two languages in the Finnish context is that they are used in lingua franca nursing situations. There is a need for research on how lingua franca communication affects the nurse-patient relationship. In addition, it may not be that only the role of English and Finnish would need to be considered. The multicultural aspect was stated in the goals of the programme, but it might need some clarification. Would a nurse need a plurilingual communication awareness, in addition to the English/Finnish as a lingua franca awareness? I suggest that this would be something to take into account when planning CLIL nursing programmes. The nursing students of this study were clearly not prepared to come across a situation where they needed to consider the differences in the social systems between different countries (e.g. the problem of dealing with the social security number). In a multicultural CLIL programme, such differences could be easily brought to focus in the language classroom; students could be asked to interview each other on topics related to health care systems and health care in general. Communication strategies could be combined with such exercises as well as awareness of constructive collegial communication in a multicultural

work place. Learning from and supporting each other should be considered a task that all embrace in a work place. This approach would benefit all parties.

In the discussion on CLIL research, the integration of content and language was repeatedly brought up as something that is desired of CLIL: language skills should not be assessed separate from content (e.g., Mohan et al. 2010) and in addition, as language is learnt in the content classroom, the content teachers could be more aware of their role as language teachers (e.g., Nikula 2015b, 25). The CLIL approach has changed the role of the content teacher teaching in English. A lot of research has focused on this matter and whenever the focus shifts, it can be that for a time something is missed. Before the CLIL programmes started, language courses in nursing and other professional/vocational programmes were content-based. With CLIL instruction, there no longer is a need for separate content-based instruction by language and communication specialists. Content can probably be defined in many ways, but in the light of the model of health communication used in this study, content is only one part of professional nursing communication. The other dimensions, relationship and identity, are equally important when taking care of a patient/client. This is where there is a connection to the definition of nursing as a process of interpersonal relationship referred to in the previous chapter. The participants' identities are part of the relationship between them in a communication event. Suni (2010, 56) finishes her article on worker's perspective on her language and communication competence by stressing that the main thing about professional language and communication is not "only language skills" but about a phenomenon that goes to the core of participation and professional identity. Rather than to think that content, relationship and identity can all be in focus in the content classrooms, the role of language in CLIL nursing programmes could be reconsidered from a language education perspective. Content-based language instruction is not needed in the CLIL educational context, but there might be a real need for focusing on the professional relationship and identity aspects with respect to language and communication. So far in CLIL and in language teaching for professional/vocational purposes, the focus has been on more on content and to shift the focus more to relationship and identity aspects seems to me to be an approach that could change the role of foreign language teaching. It may be that the approach to language as mainly conveying content rather than focussing on constructing relationships and identity has affected the analysis of this study. As a language teacher, I would accept the criticism and take on the challenge to renew my thinking of the role of language education. The paradigm shift from the cognitive approach (or approaches) to dialogism in language education (described in chapter 2.5.4) has been taking place while this study has been in process. The shift is still not complete, though.

In the light of the present study, such aspects as how language affects communication in an ELF, English as a lingua franca situation, could also be studied and practiced in the language classroom. Awareness of ELF communication could be raised. Such aspects as, for example, in the nursing context, pointing out the similarities between some communication techniques

that are used in health communication and some second language communication strategies could be useful. Paraphrasing is a much used communication strategy by language learners especially when they lack a word (Ellis 1994, 396). Paraphrasing can also be used as communication technique to show empathy or confirmation (cf. Table 2, p. 35). Another example could be that questions are important in many ways in health communication. The nursing students of this study did not have any great problems in formulating the questions, but still the different functions of questions could be discussed and practiced in a language classroom and focus on form would be possible in that context as well. This would be focusing on professional language and communication as an integrated part of professional competence.

The above are tentative suggestions of how to look at the role of language education in the CLIL context. It is not only the content teachers who need to reconsider their role in the CLIL context, but the language teachers need that as well. Integration of language and content does not mean that language and communication cannot be in the focus other than in the content classroom. The question is rather how the focus needs to shift in the language classroom. The discussion of the need for a paradigm shift is very relevant and needs to continue.

6.3 Concluding thoughts

Thinking of the small number of participants in the empirical part of this study, generalisations on the basis of the data would be quite daring. However, the implications of the study already included some generalisations. The implications and generalisations made here are not based only on the analysis of the work samples, but more on the theoretical part of the study. Constructing the model of health communication was a very eye-opening process to me. Since the turn of the millennium I have not been working in the said institute, but I have still been teaching English for professional purposes in higher education. I have been able to make use of the health communication model extensively; I have just left out the word 'health'. The communication techniques used in nursing can be applied to any human relationship and surely, they are useful for any professionals who encounter people in their work. When describing the methodological approach in chapter 3.2, I pointed out that the study was not action research. Still, this long process has been about a teacher developing her own professional skills. There were years when the project did not advance on paper, but it was always present and influencing my work as a language teacher.

Many streams seem to be coming together at this point of my teacher career because of the contact with the theories reported in this stud. I have here suggested that in CLIL nursing curricula, language education could focus on the relationship and identity dimensions in communication. In the fairly new book reviewing nursing theories referred to in chapter 6.1, McKenna et al. (2014, 127) contend that knowing oneself is a prerequisite for nurses to develop interpersonal relationships to others. Again, I do not see why this would be true

only about nurses. As language is part of identity, it is a natural part of language education to deal with awareness of identity issues. Supporting the development of professional identity can be the task of all teachers in a professional programme. The generalisation would be that supporting the development of identity; knowing about oneself with awareness of language as part of identity and knowing about interpersonal communication in relationships, are all essential parts of language education. Looking at identity construction in ELF contexts, Virkkula and Nikula (2010, 5) point out that there is still not much research on the topic, but they consider the topic an important one.

As CLIL research keeps reminding teachers, content and language teachers need to cooperate. I would add that applied linguists and communication researchers could join their forces as well. The conception of language is changing with the paradigm shift; language is meaning; language is sociocultural involving multiple voices and dialogue. This affects not just the approach to language but the way language teachers approach their task. To be able to develop language education for the purposes of global professions such as nursing and generally for the needs of the global world, language teachers are faced with the challenge of understanding relationships and identities in a much deeper sense than ever before.

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8 APPENDIX 1: AN EXTRACT FROM THE CURRICULUM FOR MEDICAL-SURGICAL NURSE EDUCATION

The goals of the work

In her work a nurse meets people of different ages, coming from different social circumstances and with different kinds of illnesses. The goal of the nurse's work is to promote health to prevent illness, to minimize the harmful effects of disease and to ensure the recovery of the individual, his family and community, or to support him in the face of death. If necessary, the nurse will also act as the patient's advocate. The nurse is a nursing expert who together with the clients/patients, their relatives and other professional groups aims at achieving, maintaining or restoring health, activities, wellbeing and balance to the patient. Side by side individualized nursing the nurse aims at influencing the community and the environment in order to find solutions which will promote the health off both individuals and the whole population.

Professional skills

The holistic care of clients/patients requires of a nurse qualities such as responsibility, an ability and an active interest in for confidential interaction, empathy, a capacity to get on with different individuals regardless of their cultural backgrounds, an ability to take into consideration matters concerning the health and life situation of persons under nursing care, and other social factors. Knowledge and mastery of the nursing process as well as responsibility for the quality of the nursing work form the basis for professional nursing

Working in the profession of a nurse requires interdisciplinary knowledge of nursing and of humans as physical and psychosocial beings, as well as of the environmental factors affecting an individual's life. Knowledge of nursing science, social and behavioural sciences and the natural and medical sciences form the knowledge base and the starting point for professional skills. Great importance is attached to various technical, interactive and supervisory abilities. The coordination of a client/patient's care is a central part of a nurse's work, requiring the ability to cooperate flexibly, to work systematically and to think and make decisions logically. A nurse is required to be committed to her work, to internalise the ethical principles guiding nursing work and to want to develop herself, her professional skill and the profession as a whole. A nurse should possess the knowledge and readiness to work as a health care expert in the fields of social welfare and health care at both national and international levels. In addition to the basic professional nursing skills, a nurse must have trained in one of the following fields of specialization: medical and surgical nursing, surgical and anaesthesiological nursing, paediatric nursing, psychiatric nursing, midwifery or public health.

9 APPENDIX 2: COMMUNICATION TECHNIQUES IN THE HEALTH CARE CONTEXT

Faulkner 1992: *The skills of interviewing*	**Macleod Clark 1988:** *Communication skills*	
Questioning:	Observing and listening to verbal and non-verbal cues	
open	Reinforcing and encouraging patients to communicate	by:
closed		attending
leading		praising
Facilitation:		supporting
empathy		mirroring and reflecting
educated guesses		
cues		open questions
precision	Questioning	closed questions
clarification		exploratory questions
control		
sequencing		to direct questions
closing	Responding	to indirect questions
		to statements and cues
	Giving information	at appropriate time
		at appropriate level
		at appropriate form

Earnest 1993: *Communication skills and blocks*	
Skills	*Blocks*
Accepting	Advising
Using broad opening statement	Agreeing
Clarificating	Belittling feelings
Encouraging formulation of a plan	Challenging
Focusing	Defending
Using general leads	Disapproving
Giving information	Falsely reassuring
Offering self	Giving literal responses
Recognising	Interpreting
Reflecting	Introducing an unrelated topic
Sharing observations	Making stereotyped comments
Using silence	Probing
Summarising	Using denial
Translating feelings into words	Rejecting
Validating	Requesting an explanation

Sundeen 1991: **The maintenance phase of the nurse-patient relationship** *Nondirective therapeutic communication techniques*	*Nontherapeutic communication techniques*
Establishing guidelines: broad openings Restating Reflecting Clarification Consensual validitation Summary *Active listening* Neurolinguistic programming: pacing mirroring *Empathy* Four stages by Ehman 1971: identification incorporation reverberation detachment *Trust* Reliability Honesty Clear and complete answers to questions Giving information promptly Confidentiality	Value judgements Advice giving Reassurance Stereotyped responses

Northouse and Northouse 1985: *Communication techniques in interviews*	*Communication techniques that block effective interviewing*
Questions: open closed Restatement (paraphrasing, repeating) Reflection Clarification Interpretation	Probing Advice-giving False reassurance Moralising Belittling

10 APPENDIX 3: APPLICATION OF RESEARCH PERMIT

Lappeenrannan terveydenhuolto-oppilaitos

TUTKIMUSLUPA-ANOMUS

Rehtori Outi Sarvilahti

Olen aloittamassa lisensiaatintyötä Jyväskylän yliopistoon ja anon tutkimuslupaa englanninkielipainotteisen sisätautikirurgisen sairaanhoitajaryhmän S 15 englannin kielen kehittymisen tutkimiseen. Oheistan Jyväskylän yliopiston humanisistisen tiedekunnan ja professori Kari Sajavaaran hyväksymän alustavan tutkimussuunnitelman.

Tutkimukseeni lisensiaatintyötä varten sisältyy S15 opiskelijoiden kielitaitoon liittyvän materiaalin kerääminen vuosina 1994-1996, mutta mahdollisuuksien mukaan heidän kielitaidon kehittymistä seurattisiin koko koulutuksen ajan. Lisäksi vertailun vuoksi joitakin sairaanhoitajan opintoihin liittyviä kirjallisia tehtäviä teetettäisiin esimerkiksi S16 opiskelijoilla yhteistyössä ammattiaineiden opettajien kanssa.

Tutkimussuunnitelmassani viittaan laajempaan projektiin, jonka osaksi toivon lisensiaatintyöni tulevan. Toive on jo toteutunut. Jyväskylän yliopiston englannin kielen laitos on hakenut Suomen Akatemialta rahoitusta *Kielikoulutuksen vaikuttavuuden tutkimusprojektiin* ja työni on hakemuksessa mukana kuuden muun opinnäytetyön lisäksi. Vaikka rahoitusta ei saataisikaan kaikki tutkijat varmasti jatkavat työtään ja toimivat yhteistyössä. Asia ratkeaa kevään kuluessa.

Lappeenrannassa 17.3.1995

Mirjá Ikonen

11 APPENDIX 4: SELF-ASSESSMENT AND BACKGROUND QUESTIONNAIRE

Lappeenranta Health Care Institute
Date:

S15

SELF-ASSESSMENT AND BACKGROUND QUESTIONNAIRE

This questionnaire is a part of the project that I am doing as a licentiate thesis in the University of Jyväskylä. The aim of the project is to describe the effects of TCE (teaching content through English) on the development of your English language skills during your studies. This means analysing data on your receptive (reading and listening) and productive (speaking and writing) language skills. I will use some of your written work for this purpose and in addition audio and video recordings will be arranged at least once a year. Special language tests may also be arranged at the end of each academic year.

The questionnaire consists of three parts. Parts I and II have been adapted, with permission, from a study by Ari Huhta (1994) on Finnish Exchange Students' Self-Assessed Language Proficiency. Only some minor adjustments have been made in the questions.

By signing this form you give your consent to being an informant in this study. As all the materials and test results will be handled in strict confidence I ask you to write a three-letter code name that I will use when reporting on the results of the study.

Mirja Ikonen

Informant's consent

Name: Code name:

_____ _____

I ASSESSMENT OF LANGUAGE PROFICIENCY

Please, estimate your English language skills. Use the assessment scales below that describe the proficiency in reading, listening, writing and speaking. Circle the number that best fits your skills on all four scales. If you cannot choose between two levels, write between the descriptions of the levels e.g. "I am between these levels". You can specify your choices by writing your comments in the places provided for comments.

READING IN ENGLISH

1. I understand only some of the main points of texts, I read slowly and often need to consult a dictionary.

2. I understand some details of the text in addition to the main points. I sometimes need to use a dictionary.

3. I understand most of the text. I read rather fluently and need to consult a dictionary only occasionally.

4. I understand most of the texts fully or almost fully. I may not understand some words; I rarely need to consult a dictionary. I read English texts almost as fluently as I read Finnish texts.

5. I fully understand the texts I read. I need to consult a dictionary only in cases of rare terms that belong to subjects I do not know. I read English texts as fluently as I read Finnish texts.

Comments:

LISTENING IN ENGLISH

1.I can understand only some main points. I find it difficult to follow somebody speaking at normal speech rate; I can really understand only if a person speaks slowly.

2. I can understand most of the main points, if the speaker does not use an unfamiliar accent. I find it rather difficult to follow somebody speaking normal speech rate, this requires that I really concentrate on listening and it also requires a good reception (that is, there should not be too much background noise etc.).

3. I can understand most of what is said, unless a totally unfamiliar accent is used. I can follow speech delivered at normal tempo, if I concentrate on listening. Background noise can sometimes make comprehension difficult.

4. I can understand almost everything that is said, unless an unfamiliar accent is used. I can follow speech delivered at normal rate, and normal background noise does not usually disturb me.

5. I can understand everything that is said in English regardless of the speech rate, and normal background noise does not disturb me. Only a totally strange accent can cause difficulties.

Comments:

WRITING IN ENGLISH

1. I can write short, intelligible messages, etc. I find it difficult to write and I have to consult a dictionary very often. I usually write simple, short sentences. I make quite a lot of errors of different kinds (vocabulary, grammar, spelling) quite a lot, but I believe that the reader understands what I want to express.

2. I can write intelligible letters, messages, etc. I have to consult a dictionary rather often; writing is rather laborious. I usually know only one or two ways to express a particular matter. I make quite a few errors, but they do not impede comprehension. I can write a text that is reasonably coherent and in which different parts and points are connected with each other.

3. I usually write rather easily and fluently, although I have to consult a dictionary once in a while. I can sometimes express a particular matter in different ways depending on the situation and on the purpose of my text. I make some errors. I can express what I want to say rather well in different kinds of situations. My text forms a coherent whole, in which the parts of the text are connected with each other.

4. I write fluently and have to consult a dictionary only occasionally. I can express a particular matter in different ways and choose the right expression for the situation. I make few errors. My text forms a coherent whole, in which the parts of the text are very well connected with each other.

5. I write fluently and I don't need to consult a dictionary. I can express a particular matter in different ways and choose the right expression for the situation. I do not make errors, except such mistakes that I might make in my mother tongue. My text forms a coherent whole, in which the parts of the text are very well connected with each other.

Comments:

ORAL PROFICIENCY IN ENGLISH

1. My pronunciation is usually intelligible, although it clearly deviates from the ways in which English is pronounced. I make errors of many different kinds (e.g. in vocabulary and grammar), but I can usually sort out the misunderstandings that they may cause during a conversation. I am not very fluent and I have to struggle to find the expressions I need. I can take part in a conversation, but not very actively; usually I answer briefly when I am asked something.

2. My pronunciation is usually intelligible, although it deviates from the ways in which English is pronounced. I make quite a few errors which do not, however, impede comprehension. I have to struggle somewhat to find the expression I need. I can speak roughly in the manner that is appropriate in the particular situation where I am using the language; others can usually understand what I want to say. I can take the initiative in a discussion and I can occasionally speak a little longer if I have to.

3. My pronunciation is intelligible, although it deviates somewhat from the ways in which English is pronounced. I make some errors. I do not usually have to struggle to find the

expressions I need. I can use differen expressions for the same matter and I take an active part in discussions. I can speak in the manner that is appropriate in the particular situation and my intention; others can usually understand what I want to say. My turns can be rather long if necessary.

4. My pronunciation is accurate and intellligible, although it can be noticed that I am not a native speaker. I make few errors. I can say what I want to say without having to struggle. I use language that is appropriate to the situation and the purpose of my communication; others do not have any difficulties in understanding what I want to say. I can maintain conversation and my turns can be long in necessary.

5. My pronunciation is accurate and intelligble, although it can be noticed that I am not a native speaker. I do not make errors, except such unintentional mistakes that I might make in my mother tongue. I can say what I want to say without having to struggle. I use language that is appropriate to the situation and the purpose of my communication; others do not have any difficulties in understanding what I want to say. I can maintain conversation and my turns can be long if necessary.

Comments:

II SITUATIONS OF LANGUAGE USE

Please, estimate how often you have used English in the situations listed below during your studies so far. Have you had any difficulties in these situations on account of your language proficiency? Please, mark your estimates in the boxes by writing the most appropriate number. Use the following assessment scales:

How often have you used English in the situation?	Have you had any difficulties because of your language proficiency?
0 = never	0 = none / never
1 = a couple of times	1 = little / seldom
2 = monthly	2 = somewhat / occasionally
3 = weekly	3 = quite a lot / rather often
4 = daily	4 = very much / very often

SPEAKING AND LISTENING	How often?	Difficulties?
Seminars / Tutorials and lectures: Understanding others Speaking during discussisons Giving a presentation		
Oral examinations		
Social situations: Discussion with others Understanding others in these situations		
Understanding radio and TV programmes		
READING AND WRITING		
Reading books and articles in one's own field		
Reading newspapers and magazines		
Taking notes during lectures, seminars and tutorials		
Writing answers in examinations		
Writing essays		
Filling in forms etc.		
Writing formal, official letters		
OTHER SITUATIONS (please, specify what?)		

III BACKGROUND INFORMATION

1. How many years have you studied English at school?

2. What were your final marks / grades in English?

3. Have you studied English after school? If you have, where, when and how long?

4. Have you stayed in an English-speaking country? If you have, where, when and how long?

5. What other languages have you studied? Where, when and how long?

6. Are you studying or planning to study other languages? What languages?

7. Do you prastise your English in your free time? In what way?

8. How has studying in English affected your language skills?

9. In what way do you expect your English to improve during your studies?

10. What is the role of language (Finnish & English) in your nursing studies in your opinion?

11. Would you need language training during your studies? If you think you would, in what areas of language use?

12. Is there anything that you would like to change in your studies considering the role of language in your nursing studies? (Please, specify)

13. Other comments

12 APPENDIX 5: ROLE-PLAY INSTRUCTIONS

NURSE

You are working in a casualty and emergency department. You are asked to take care of a patient that has just arrived and is waiting for you in a treatment room. The patient has a cut that does not need any stitches. You can make use of all the things that are available on the table. Fill in the documentation sheet.

STUDENT

You have cut the palm of your hand with a very sharp knife at home. You have some pain and the sight of blood makes you slightly hysterical. You cannot keep still and the nurse will have to calm you down. Answer the nurse's possible questions briefly and complain about the pain and look away from the blood. You can either moan or cry at first but calm down after a while. Ask the nurse about the bandaging:

Will it hurt? Will it sting?

Can't you make it stop bleeding?

How long do I have to keep it bandaged?

Can it get wet?

Can I go to the sauna?

When should I change the bandage?

13 APPENDIX 6: SKILLS ASSESSMENT FORM

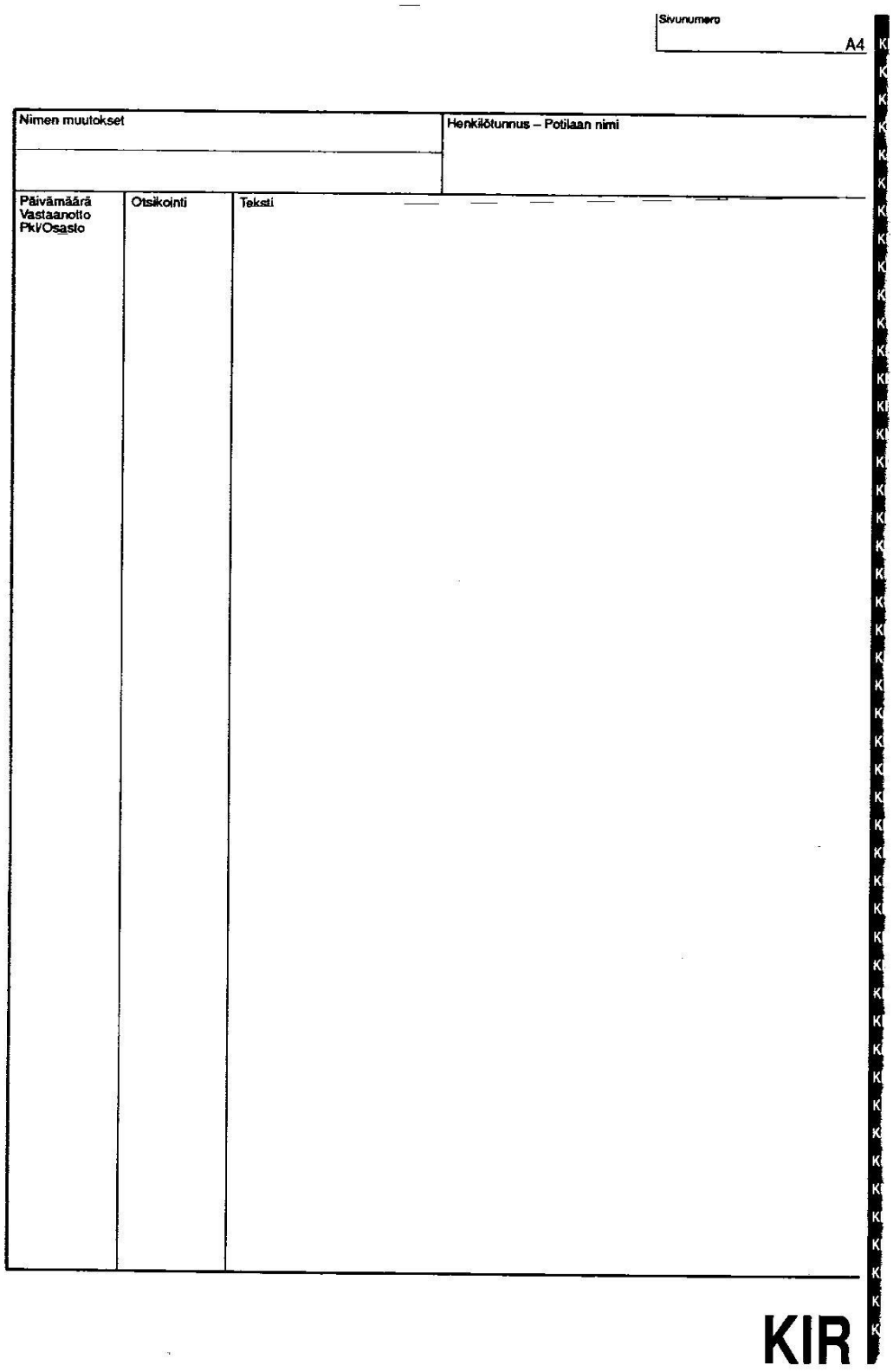
The assessment scale was: fair -1, good – 2 and excellent 3

INTERACTION SKILLS	Teachers	Students
Verbal communication		
Therapeutic relationship:		
- listening		
- client feels safe		
Interpersonal skills:		
- relaxed		
- friendly behaviour		
- direct eye contact		
- attentive posture		
-use of appropriate words		
CLINICAL SKILLS		
- attention to aseptic technique		
- clarity of instructions		
- ability to answer questions		
- documentation		
ORAL ENGLISH SKILLS		

14 APPENDIX 7: TRANSCRIPTION CONVENTIONS

Speakers		
Student		S
Patient		P
Speaker's identity/turn start		:
Speech overlap		( )
Transitional continuity		
Final		.
Continuing		,
Appeal		?
Pause		
Long		… (N)
Medium		…
Short		..
Latching		(0)
Vocal noises		
Explained in italics in parentheses		(*laughs)*
Phonetics		
Phonetic/Phonemic transcription		/ /
Transcriber's perspective		
Uncertain hearing		(xx)
Indecipherable	syllable	x
Specialised notations		
Code switching		(L2L2)

15 APPENDIX 8: BACKGROUND INFORMATION FORM



16 APPENDIX 9: COMMON EUROPEAN FRAMEWORK OF REFERENCE FOR LANGUAGES PROFICIENCY LEVELS