ANALYSING ADDRESS FORMS IN OPENINGS AND CLOSINGS IN NURSE-PATIENT COMMUNICATION

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ABSTRACT

It is important to have good and effective communication between nurses and patients. There are many ways to start and end a conversation. It is said that openings in the form of greetings and a proper closing is needed in a conversation to maintain a cordial relationship between speakers. Therefore the objectives of this study are to identify the forms of addresses used by nurses when communicating with their patients and the relationships between the forms of addresses used and the language choice in the nurse-patient communication. It is important to know the terms of address used because this use determines solidarity among the speakers. The literature review reveals aspects of nurse-patient conversation such as communication, information, collaboration, forms of addresses in openings and closings of a conversation and language accommodation in using the address forms. The data for this study has been taken from surveys and observations. Observations and surveys were conducted among randomly selected nurses from East Tower of University Malaya Medical Centre (UMMC). The quantitative analysis of the data revealed many types of address forms used by the nurses when communicating with their patients. The findings of quantitative analysis also showed the choice of languages the nurses used when communicating with patients from different ethnic groups. The discourse analysis revealed the intention of using address forms in communication and how the language accommodates communication when conversation across cultures took place. A summary of the entire research is presented in Chapter five. The study is significance for programmes or trainings developed for nurses where the nurses can be well-trained to communicate effectively instead of just being a skilled-nurse.

ABSTRAK

Komunikasi yang efektif dan berkesan adalah penting diantara jururawat dan pesakit. Sehubungan dengan itu, terdapat pelbagai cara untuk memulakan dan menamatkan satu perbualan. Dalam satu perbualan, ucapan salam sebagai pembukaan dan penutupan yang sesuai diperlukan untuk mengekalkan keakraban di antara orang yang berbual. Lantarannya, penyelidikan ini menyiasat bentuk panggilan sapaan yang digunakan dalam pembukaan dan penutupan perbualan dan juga pilihan bahasa yang digunakan dalam komunikasi diantara jururawat dan pesakit. Sepanjang komunikasi, ia juga adalah penting untuk mengetahui panggilan sapaan yang digunakan terhadap seseorang kerana ia menentukan keeratan di antara pembual. Bab 2 menerangkan aspek-aspek yang terlibat dalam komunikasi seperti, maklumat, kerjasama, kata sapaan yang digunakan dalam pembukaan dan penutupan sesuatu perbualan serta pilihan bahasa yang suka digunakan dalam perbualan diantara jururawat dan pesakit. Dalam penyelidikan ini, borang soal-selidik dan kaedah pemerhatian digunakan untuk memerolehi maklumat. Kaedah pemerhatian dan peninjauan dilakukan terhadap jururawat-jururawat yang bertugas dalam wad dan di HUKL secara rawak. Kaedah analisis kuantitatif yang digunakan telah mendedahkan pelbagai jenis kata sapaan yang digunakan dalam perbualan diantara jururawat dan pesakit. Kaedah ini juga telah mendedahkan pilihan bahasa yang disukai oleh jururawat untuk berkomunikasi dengan pesakit, yang juga bergantung kepada etnik pesakit. Analisis kaedah kualitatif yang dilakukan melalui analisis wacana menunjukkan secara terperinci bagaimana jururawat menggunakan kata sapaan yang betul dan juga cara mengambil kesempatan dengan bertoleransi untuk berbual dengan pesakit. Kaedah analisis wacana jugamenunjukkan sebab dan kepentingan menggunakan kata sapaan serta bagaimana penggunaan bahasa dalam sebuah masyarakat yang berbilang kaum dan bangsa. Analisis penyelidikan ini

dibincangkan dalam Bab 5. Penyelidikan ini penting dan juga berguna untuk program-program dan latihan kursus untuk jururawat supaya mereka dilatih dengan betul untuk berkomunikasi dengan betul selain dari hanya mempunyai pendidikan dan kemahiran dalam bidang kejururawatan.

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CHAPTER 1

INTRODUCTION

1.1 Introduction

The forms of address used in the openings and closings of a conversation are an important part of language studies for a number of reasons. Research on these forms of addresses may lead to explanation about how individuals in various communities address their conversation partners. Such conversations could be between any addressors and addressees such as family members, teachers and students, members of the royal family or employers and employees. Slobin, Miller & Porter (1968) revealed the communication patterns between employees and their superiors. The variables observed by him were the address forms the employees used with their superior, fellow workers and subordinates. He found out that first names were used between equals and subordinates while title and last name were used with superiors; also, the different forms of address used were important to establish relationships between strata within organizations.

The present study analyzes communication between nurses and patients to add to the contributions made by previous research. Such a study is especially useful in multiethnic societies like Malaysia. A study on forms of addresses in openings and closings of conversation between nurses and patients in multicultural, multiethnic Malaysia may provide information on the sensitivity to language related issues in such societies. The forms of address used by nurses with patients depend on a number of factors including the language used by the interlocutors. In addition language choice or preference of an interlocutor influences the term of address used. This issue was discussed in a study entitled “The study of address terms and their translation from

Persian to English" by Keshavarz (1988). She found that when translating from Persian to English, selecting appropriate and equivalents forms of address is one of the problematic areas. Keshavarz clarified the complexity of the terms of address used in Persian and English and used the translation strategies proposed by Newmark (1981) for translating cultural words. It should be noted that culture is one of the most important factors involved in the use of address terms and the choice of appropriate and equivalent terms must be done carefully when translating from one language to another.

1.2 Background to the study

This study is based on the importance of effective communication between nurses and patients. Nurses are individuals who communicate with patients more frequently compared to other hospital staff. It is vital for the patients to receive correct information in an appropriate manner from the nurses. It is the duty of a nurse to know how to speak and converse effectively. The forms of address used by nurses in the openings and closings of a conversation play a major role in producing effective rapport and hopefully will result in effective communication. Dellasega (2009) has stated that nurses tend to have intimidating and disruptive communication behavior. Thus, a study on forms of address used in the nurse-patient communication could fill the current gap which exists in the research about communication between nurses and patients.

1.3 Statement of the problem

The studies on the quality and service of Malaysian nurses provided in the literature show that the Malaysian nurses are skilled, trained well and capable of multitasking and handling emergency situations. Despite that, it was found that most nurses lack communication skills. Very little research has been conducted on forms of address used in openings and closings in nurse-patient communication. It is hoped that this study

focusing on address forms used by nurses will help to fill the gap which exists and lead to suggestions that can contribute to effective nurse-patient communication.

1.4 Objective

The first aim of this study was to determine the forms of address used in nurse-patient communication, specifically in the openings and closings, in a multilingual setting.

The second aim of the research is to study the relationships between the forms of addresses used and language choice in nurse-patient communication.

1.5 Research Questions

1. What are the forms of addresses used in openings and closings of a conversation between nurses and patients in a multilingual hospital setting?

2. What is the language choice in nurse-patient communication and how does it affect the forms of address used in opening and closing of conversations?

1.6 Limitation of the Study

The main scope of this study is to determine the forms of address used by nurses in the openings and closings of a conversation which takes place with their patients. Through the findings, this research intends to establish the forms of address and the language of the communication used. However the research sample was limited to one particular hospital, University Malaya Medical Centre (UMMC). Therefore the sample will not be able to represent the entire nursing community of the country. In addition the languages used in this setting do not represent all the languages of Malaysia.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

In this chapter, the researcher will explore the literature related to verbal nurse-patient communication and will analyze studies on why communication between nurses and patients is important for successful nursing care, before describing various studies which focus on the use of appropriate forms of addressing patients.

According to Macleod-Clarke (1984), communication is a fundamental foundation of all nursing care and yet it is often been taken for granted or underestimated in the nursing area. Research conducted on communication in health professions provides a negative rather than positive point of view of such communication. It is challenging to conduct studies on communication in health profession as communication is difficult to measure or quantify, and despite its importance it is clearly not the only factor contributing to positive health outcomes. Most of the research on communication in nursing and related professions mentions the source of failures and possible solutions (Simpson, et al., 1991; Dickson, 1995; Heaven & McGuire, 1996; Alexander, 2001).

This study examines the appropriate forms used in addressing others, especially patients. Such appreciative enquiry aims to identify and build on positive aspects of what is being studied which, in this case, is effective communication using proper forms of address.

2.2 Communication in workplace

The use of language is important in a workplace and effective communication is crucial in professional relationships such as nurse-patient, nurse-doctor and more (Tullin, 1997).There have not been many studies on the role of language resulting in effective communication and the important ways in starting or closing a conversation in the nursing field. Effective communication between nurses and patients is vital as it enables the nurse to understand how a patient feels. Effective conversation using appropriate address forms is important as what is considered lacking in effective language might negatively impact on the welfare of patients.

2.3 The importance of communication in nursing

Producing effective communication especially in the nursing field is important not only because it can help provide accurate diagnosis and treatment, but also because communication is a significant factor in patient satisfaction surveys. For patients, it is important to feel respected and valued and this, or indeed the opposite feelings of being disrespected and undervalued can be determined by the way a nurse starts a conversation with them, and how the nurse closes the conversation.

It is not only about talking, but talking to give and take important medical information. In a selective review of the literature on the nurse's role in nurse-patient communication, Jarrett and Payne (1995) identify several factors which are important in communication. They are:

- Having good interviewing skills to understand and identify the problem
- Attending to the patient as an individual rather than a collection
- Sharing information between nurses and patients reduces stress

According to Jarrett and Payne (1995) patient satisfaction surveys show that poor communication and lack of information are significant areas of complaint. Kasch, 1986; Gunther & Alligood, (2002) explain that high quality nursing care (reflected in positive clinical outcomes) is characterized by effective communication. Communication in itself actually constitutes the care or nursing action in some instances (Mishler, 1984; Kasch, 1986; Parker & Gardner, 1991; Candlin, 2000; Fenwick, Barclay & Schmied, 2001).

2.3.1 Complaints and Patient satisfaction

According to the complaints received by health professionals from patients, lack of effective communication is the most common cause of complaints (Fosbinder 1994; Jarrett & Payne, 1995; Macleod-Clarke, 1984; Simpson et al., 1991). The complaints were not always about insufficient information but also sometimes too much, rather than too little, information was provided. At times the style and method of communication was inappropriate. Most nurses prefer using phone calls rather than providing information face-to-face. When the patients were asked about their perceptions of nursing care, “patients almost exclusively described the nurses’ as interactive style but don’t know what task she was doing” (Fosbinder, 1994, p.1087). A similar comment was made in relation to doctor-patient interactions, “Most complaints by the public about physicians deal not with clinical competency problems, but with communication problems” (Simpson et al., 1991, p.1385). Even today, in the health profession, communication problems seem to feature in the complaints received from the patients.

In some professions, communication may not be considered as an essential tool in building a friendly working environment. But in the health profession,

communication is fundamental and is the only way a patient can inform a nurse or a doctor on their health issues.

2.3.2 Beneficial effects of giving information

There is a strong trend towards sharing information between health professionals and patients' even though there is the danger of too much rather than too little information occurring. Hinckley, Craig and Anderson (1990) state, "advocates for patient consumerism have encouraged more active participation by patients and activities focused on encouraging question-asking have developed" (p.524). In meeting the demands and needs of a patient, the medical profession is making much effort, but some physicians still underestimate the patients' decision making capabilities and their desire for more information on the medical processes they are to undergo. This finding is reinforced by Simpson et al. (1991), who found that "Patient anxiety and dissatisfaction is related to uncertainty and lack of information, explanation, and feedback from the doctor" (p.1385). This shows that even when nurses respond to patients' desire to be involved in the decision making process, they still do not provide sufficient information for the patients to make their own choices on treatment. In many circumstances, giving information is not only beneficial but also essential. Discussing options for medical treatment in such a way that the patient is fully informed but not unduly alarmed or burdened is a skill in itself and the only way to properly inform a patient about their health is through this high-quality, effective communication.

2.3.3 Interviewing skills to identify patient concerns

When using appropriate address forms, it is likely to become easier to communicate with the patient. As mentioned above, diagnosis and treatment can be most efficiently done with effective communication and there are various techniques of communication. The most common style, the question-answer method, can be used to

get the immediate facts needed. For this method, closed questions are often considered effective. For example, asking a patient “Are you experiencing pain in this area” will require the patient to answer yes or no. Thus by using this method of questioning, the nurse will immediately get the answer she needs. But in the health profession, a more exploratory and less direct approach is often much more useful.

According to Mishler (1984), nurses are supposed to listen carefully to the stories related to their patient’s life. This can be useful in understanding their previous experiences and apprehensions. The nurses are then better able to contribute to diagnosis and treatment for the patients based on the stories told. This was agreed by Simpson et al., (1991), who said nurses should encourage and provoke patients to talk out what is captured in their inner selves to smooth the consultation process.

A conversational style of interview is also advocated for nurses by Brown (1995), who explains the potential for such an approach to produce an accurate and good understanding of the client’s health. An advantage of this approach, she explains, is a more client-focused and less controlling environment than the traditional question-answer format of many medical interviews. In many cases in the health profession, patients feel that nurses dominate the entire conversation and do not give them space to voice their concerns. Patients are the most important entity in the health profession and the nurses should let them speak since this is likely to influence and ease the entire treatment process.

Appropriate and suitable forms of address are essential in starting a conversation as it forms the foundation of the talk. Using proper forms of address will make a patient feel more comfortable and may also encourage them to “come out” and express their hidden feelings, hopes and fears. Addressing patients with full respect, mentioning their titles properly when opening conversations and thanking them sincerely in closing

conversations will lead to a better relationship and consequently more effective communication. This seemingly small step will likely in turn produce a potentially large positive impact on the health services being provided and result in considerable benefit for patients, health professional's clinics and hospitals alike. According to Macleod-Clark (1984), patients with unrecognized psychosocial needs will take longer to recover. Because psychosocial needs should be identified and attended to largely through conversation, nurse-patient communication therefore becomes an essential part of these needs being identified and met.

2.3.4 Collaboration in the nurse-patient relationship

A nurse-patient relationship is the fundamental aspect in developing quality nursing care (Christensen, 1990; Johnson, 1993; Fenwick, Barclay & Schmied, 2001; Gunther & Alligood, 2002). Such a relationship can only be built on effective communication which basically starts from a suitable and appropriate opening. In a study conducted by Kasch (1986), quality nursing care is created through the role of communication and helps to maintain a positive relationship with a patient. He mentioned that "talk can be a great starting point to establish, maintain repair and even to terminate relationships". Both the nurses and patients have professed that the quality of care increases when the nurse informs the patient the details of the treatment. Related to the activity of collaboration but not explored in depth is the notion of co-constructed meaning. Coupland (2000) explains, through talk there is a co-construction of meaning, a concordance or therapeutic alliance so that both parties (nurse and patient) can work together for an optimal outcome.

2.3.5 Communication in itself can be remedial

There are number of researchers who have agreed that communication is not only beneficial to the perception of care, but also the verbal interaction can contribute to

nursing care in some cases. According to Mishler (1984), communication is not only considered as mere talk, but an essential and critical component in clinical practice. Kasch (1986), too stated that nurse-patient interaction is important and runs parallel with nursing objectives.

Based on research done by Parker and Gardner (1992), nurses talk in their everyday work whilst performing ongoing supportive, maintenance and restorative activities such as delivering both technical and comforting care. Mishler (1984) was of the view that “talk is work” for the nursing profession and Parker and Gardner (1991) echo that with the sentiment that “work is talk”. Eventually both hold the same meaning that talking is important and very meaningful in the nursing profession. To facilitate such opportunities for “therapeutic talk” however, it is important to use appropriate address forms in the opening of the conversation.

2.4 Nurse-patient relationship and communication

According to Aguilera (1967), the nurse-patient relationship is arbitrated by verbal and nonverbal communication. Despite the use of somewhat exclusive professional terminologies, relationships and communication do not differ much in any profession and so it is in nursing. According to Anderson (1979), just like communications, relationships are unique situations and are mutually constructed within a responsive and inter-subjective nurse-patient relationship. This was agreed by Aranda and Street (1999) in their studies on nurse-patient relationship. Relationships or communications can be said to place human beings in strategic situations aimed at overcoming their inner obstacles or problems. For example, in this study the only way for a patient to seek treatment is through communication and conversation regarding their health condition. For a nurse, only through effective communication is she able to

gather information which is essential to the diagnostic process and treatment for her patients.

A nursing career and nursing care can be portrayed as two different entities. A career can be a fully professional pursuit, a striving for the highest standards of academic knowledge whilst good nursing care, despite a dependency on up-to-date knowledge, can be categorized as more humanitarian and directly interactive. Thus interpersonal relationship can differentiate nursing and caring (Tuckett, 2005). In the nurse-patient relationship, benefit is gained by both the parties. Thus patients gain more benefits, in the sense that they will get proper treatment for their illnesses and as previously stated, those benefits can only be obtained with a proper communication and sharing of information. The only way of sharing or gaining accurate and adequate information is through good communication based on a strong relationship between nurses and patients. Aspects like empathy, intimacy and esthetical distance, are important concepts within communication and interaction and can occur in the discourse of nurse-patient relationships. This was based on Larsson and Starrin (1990) research. Most of the studies conducted on nurse-patient communication and relationship are intertwined and strong concepts can be derived from the research. The most common empirical findings based on these studies were “being authentic” and “being a chameleon”.

According to Aranda and Street (1999), these two concepts were important in the nurse-patient relationship which carries the necessity of two different behavioural styles of interaction. Nurses, who adopt the career model mentioned above which may involve a more formal and less patient-focussed approach, need to be authentic and adaptive to the patient and the situation as well.

Understanding type of patients will enable nurses to deal with proper communication and use appropriate forms of address. For example, if a nurse does not

build good relationship with her patients and addresses the patient incorrectly, misunderstandings and a less than ideal relationship may result. For this reason, as previously stated the opening to a conversation carries considerable importance and needs to be thoroughly understood by nurses and other health professionals. This is defined in the study done by Breeze and Repper (1998) who indicates that the professional relationship is an important aspect of nursing profession and medical interventions. How this is done may lead to positive or negative effects on the experience of patients related to nurses and this can in turn have an effect on a nurse's working career. Bearing that in mind, this researcher is enthusiastic about studying the basic principles in a relationship between nurses and patients and the effect that forms of address have on subsequent developments within those relationships.

Anderson (1979), in his research, states that the nurse-patient relationship has the power to create major impacts on those who come in seeking care and treatment. In this case, the patients are the second entity in the relationship and guiding them properly can only be done through effective communication. When patients are treated well and respectfully by medical staff, they often cherish and value the relationship that results. On the other hand, if a patient feels he or she has been treated disrespectfully the opposite can occur. The therapeutic relationship is constructed based on cultural values that often reflect the majority culture such as rugged individualism, autonomy, competition, progress and future orientation and rigid timetables. Among the principal factors in the development of any relationship but especially in the nurse-patient relationship are the different perceptions of the parties to that relationship. A nurse who uses names such as "kakak" for Malay females, "Achiee" for Indian old ladies or "po-po" for old Chinese ladies may well mean no harm and have entirely positive intentions however patients may see this form of address as disrespectful. These differences in perception can therefore result in serious problem within the development of an

effective therapeutic relationship which could possibly be avoided in the first place by the simple mechanism of using proper address forms such as “Sir” or “Madam” or those preferred by the patients themselves, illustrating that major constraints or problems occurring in the developing nurse-patient relationship are sometimes avoidable with courtesy. Nurses mostly are not aware of the effect of using appropriate addressing terms to patients, in directly it also affects the relationship which at the end can be a downfall for the health profession.

In a nurse-patient relationship, the very first step upon which the entire relationship may be based is the initial communication which should be positive and respectful. Considering this from the psychological standpoint, it can be expected that a patient, who experiences this positive and respectful communication from a nurse and comes to consider the nurse as a professional and well-intentioned helper is probably more able to communicate his or her inner feelings without any constraints. This would seem to be a prerequisite for a good therapeutic relationship. According to Spiers (2002), irrespective of the specialist field of nursing, it becomes more important for nurses to have the necessary skills in developing effective relationships in order to cope effectively with ever increasing number of patients.

2.5 Theoretical Framework for data analysis

According to Paltridge (2000), discourse analysis is a process that can assist the understanding of what was said, what was meant and what was understood, especially in a particular context. Discourse analysis has been used in this study as a useful means for data analysis in chapter four. Many approaches can be used to analyze a discourse but there are two basic categories of discourse analysis, namely written and spoken, which are used in varies studies in the literature including those related to nursing communication

In analyzing the forms of address used in nurse-patient communication spoken discourse analysis was chosen as the medium in which the data was collected through naturalistic observation and noting down the nurse-patient communication. Spoken discourse analysis has been implemented in various qualitative studies. According to Brown and Yule (1983), spoken discourse analysis can be interpreted as a process in construing the collected text as records instead of raw data. In this case study, the spoken discourse analysis was considered appropriate as the researcher can immediately observe and understand the different forms of address used in the openings and closings of nurse-patient conversations.

According to Halliday (1989), a number of characteristics can be generated and assumed in the spoken discourse analysis, for example spoken analysis should generally be captured fast and the sound variable also has to be considered.

The researcher intended to apply spoken discourse analysis in her study as it permits more gestures and "non-verbal communication" to be taken into account in the process of data collection. Factors such as intonation, rhythm, pause duration and phrasing also can be observed and recorded, thereby contributing in no small way to the analysis of the data. For example, referring to patient with improper forms of address like "hey" can create different facial impressions in the addressee, directly indicating a patient's level of discomfort with the form of address. For this reason and because the entire thrust of this study is communication and conversation, the spoken discourse analysis appears to offer the best options for data analysis.

Variations of approach as a conversation is terminated also impact the outcome of an interview or nurse-patient interaction. This study will assess this aspect of communication and its impact on the patient relationship. As an example, if a patient is dismissed with the convenient but possibly disrespectful term "Aunty", the entire

"flavour" of the interview or communication may be considered by the patient as negative, however well the actual discussion may have been conducted. This is what will be analyzed in this study.

Spoken discourse analysis (SDA) takes the transcribed conversations and analyzes those texts to understand particular language choices made in each interaction. Discourse analysis assists the researcher to explain the relationship between what is said and what is meant in naturally occurring conversations between nurses and patients. One of the ways of approaching discourse analysis is to examine the "text flows" from one speaker to another speaker and from one topic to another. Factors like ethnic issues, politeness, being respectful and the need for the usage of forms of address with significant impact on the patients were analyzed. The content of the text and the way the relationship between nurses and patients was expressed in the text were studied and analyzed. The three features mentioned above textual, ideational and interpersonal are used by Mishler (1984). His research was conducted in a study of discourse used in nurse-patient interactions and has influenced the writer to utilise these features in her own study. An analysis of the data based on this framework will be presented in chapter four.

2.6 Forms of Address

In a conversation, it is very important to take note of the form used when addressing the other party. According to Baron (2007), addressing people with proper names or starting a conversation may well vary according to the age of the participants. The young may prefer to be called by their first names, whereas older people might not prefer to be called by their first name. Use of appropriate or suitable address forms helps in establishing and maintaining good relationships. Use of appropriate address forms is important both when starting and closing a conversation.

The use of appropriate address forms also varies according to cultures. For example in Malaysia, one may, in some circumstances, address a person as "sister" or "brother", but it is not common in European countries. According to Gaudart (2008) problems therefore occur between Malaysian English speakers and native English speakers from other parts of the world. She suggests that Americans, British and Australians sometimes felt uncomfortable when addressed as 'Uncle' or 'Aunty'. They preferred to be addressed by their first name, for instance, *Carlos* instead of Carlos Paul. Gaudart (2008) also explained that there are some consistencies of words like *Mr, Mrs, Miss and Ms*, in the form of address used in the English-speaking world. She found that Americans wished to be identified by their given name rather than using, for example, the more formal "*Miss…"* with their subordinates. However, Malaysians prefer the use of titles.

Young people and children are trained to address elders as '*Uncle*' and '*Aunty*' at an early age despite the fact that they may not be related to the person. This, in Malaysia, is considered a form of respectful address to be used when conversing with people older than the speaker.

In addition, problems often occur between Malaysians and non-Malaysians with Chinese names. For instance, "Thong Kok Loon" may be addressed as "Mr. Loon" instead of "Mr. Thong" or "Mr. Kok Loon". Gaudart explained that Malaysians address people by using the honorific followed by the first name. For example, Lisa Lindly would be addressed as Miss Lisa.

The function of the address form is to maintain the distance, closeness and intimacy between the speakers. A word used with the intention of expressing respect or esteem towards a person is defined as honorific. Sometimes, the term of address being used does not exactly refer to the honorary title of the speaker because the use may

depend on the social status and age of the speaker. For example, *Miss, Mr, and Mrs* are honorifics mainly used in the second and third persons.

The politeness theory initiated by Brown and Levinson (1978) is related to the address forms which function to sustain rapport between speakers. Forms of address are essential aspects of polite conversation. Wood and Kroger (1991) stated that "the way in which one person addresses another and in turn is addressed constitutes a pattern of great regularity" (p. 37). Hence, effective communication and the relationships which result which occur in institutional interactions may depend heavily on the use of correct forms of address and the maintenance of these patterns. Classification of forms of address varies according to countries. In India address terms were classified into nine categories, whereby in Columbia there are deemed to be five categories (Wood and Kroger, 1991). Listed below are types of forms of address and the way these have been customized in Malaysian usage.

2.6.1 Honorific or Terms of Formality

For most languages, the use of the honorific becomes a common feature. It is employed when the speaker wants to show respect to the addressees. In Bahasa Malaysia, like other oriental languages such as Tamil, Austronesia or Hindi, there are a number of ways to express feelings, which inclusive of honouring or used in order to dignify the addressed person. Honorific terms may include religious, cultural, occupational, and ideological meanings and even pet name (Aliakbari and Toni, 2008). Such terms as described above can also be used in number of ways; before, after or even with or without the name of the addressee. In making the speech appear more formal, Malaysian speakers often use terms of address such as sir, madam, gentleman, lady etc. Although the honorifics can be used as a term of address by themselves, they may also be used in conjunction with other forms of address such as "Dato Seri Najib" in which

the honorific and family name are used. As in the previous example the honorific in language can even be used as evidence of socio-political status or function or the loss thereof. For example, in post-revolutionary Iran, certain types of honorific terms have fallen into disuse. Terms relating to former royal families like prince or princess, his majesty, her majesty and your majesty are very rarely used in Iran today. (Aliakbari and Toni, 2008).

2.6.2 Kinship or Family/Relative Terms

A good number of Malaysian address terms indicate strong bonds in a family relationship among individuals (Afful, 2006) and the list of terms can be extensive in multi-lingual Malaysia. People of Indian, Chinese, Malay and other backgrounds use different terms of address with family members or other addressees. An interesting characteristic of some Malaysian speakers is the use "reverse addressing" in which a speaker uses his own title when addressing another. An example of this might be a man calling to his son, "daddy, open the door". In this example, the dad is using his own title in addressing his son and asking him to open the door. Another interesting and special addressing strategy is the use of family or relative terms for non relative addressees, as if they are calling a family member or a relative (Aliakbari and Toni, 2008). For example, terms of address may include appa/(father), enmagan/(my son), pakcik/(uncle), makcik/(aunt, however, among these "uncle" and "aunty"are common terms used by speakers addressing older people, irrespective of any actual familial relationship (Gaudart, 2008).

2.6.3 Title terms

In order to indicate social rank or gender in different situations, titles, represented by initials are used by most individuals (Brown, Roger and Gilman,

(1960)). Some examples of gender-specific titles which Malaysian male and female speakers may use in their conversation are as follow.

Male addressees may be referred to by:

- General Title (GT), such as Mr.boy,
- GT plus first names like Mr. Ahmad,
- GT plus last names like Mr Zain
- Or a combination of all of these, e.g Mr Ahmad Zain.

Malaysian females are addressed in a similar way, using different title terms, general titles, being Mrs or Miss, Miss girl. So, for an example, a combination of general title and first names could be expressed as “Mrs Maryam” or a general title and last name becomes “Mrs Ahmad” with combined general title, first name and last names becoming “Mrs Maryam Ahmad”. But in Indian culture, husband names will be introduced into females’ names after marriage (Brown, Roger and Ford, 1964). As seen from these examples, although Malaysian people from different cultural backgrounds may use various combinations of title, first and family names, different terms and practices, based on cultural factors, may still be apparent in communication.

2.6.4 Personal Names

In Malaysia, addressing an individual by personal name may also occur in some situations with the possibilities such as:

1. By first name, for example “Ahmad”
2. By last name, for example “Zain”
3. By full formal name, including both first and last name, “Ahmad Zain”

Malaysian names may vary according to the cultural or ethnic background. For example, Chinese and Malays mostly have middle names whilst this is not generally a part of the tradition for Indians. Furthermore, after marriage, many Indian females prefer to use the husband's family name rather than their own family name. In Western culture, it is often appropriate and normal to be called by one's family name rather than a given name, although this is also highly contextual and not always appropriate, depending on rank and social position.

It is common place for younger people to address each other by their given names and so this practice is not generally considered disrespectful. Thus, inserting honorific terms when addressing others may vary considerably according to a number of variables such as culture, ethnicity, age and more and it becomes necessary in most situations, including professional nursing interactions to be aware of these factors to avoid damaging a newly formed relationship upon which a good clinical outcome may depend.

2.6.5 In Openings

A nurse-patient interaction is constructed of three stages, the opening, the conversation and closing. The opening generally consists of greetings or "polite enquiries". Greetings like "Good day to you Sir", "Lovely morning Madam" and so on can be considered as a good opening strategy because they are positive and respectful. According to Parker& Gardner (1991), an opening of a conversation is generally briefer compared to the usual closings used in a conversation. According to Schegloff (1986) there are several elements in openings which are "summons/answer; identification/recognition; greeting tokens; and initial inquiries ("how are you") and answers (Hopper et al. 1991: 370)".

When discussing interpersonal relationships, a speaker can choose to make use of all the conversation strategies known at the beginning of a conversation as explained by Gumperz, (1982) and Schegloff (1986). Schegloff (1986) explains that the summons-answer opening sequence is used in telephone conversations and also in face to face interactions. The summon-answer telephone opening is used during conversations when the phone rings and *hello* is uttered by the party who answers the phone. The identification-recognition sequence explains the response of the second speaker and enables the parties to identify each other. When the identification/recognition sequence is being used, the speakers are able to identify and recognise an interlocutor. For instance, speaker A: Michael? : speaker B : *yes!* is mainly used in telephone conversations.

The third sequence which is the exchange of greeting tokens explains that a greeting is given and is responded to by the listener. This sequence is also used in daily conversations as it is connected to adjacency pairs and the turn taking process. For example, speaker A greets*: Hello,* speaker B replies: *Hi*. Finally the initial inquiries (*how are you* sequence) is where the first speaker asks or inquires about the second speaker. For example, *how are you / I'm okay. How are you?* The reply shows the action of a turn-taking process for an adjacency pair. This is used in daily conversations where changes to another topic occur soon after the greetings and signals the end of an opening. Soon after the actual conversation ends, the closing commonly occurs and this process represents the normal sequence in most conversations.

2.6.6 In Closings

Closings are important in a conversation. Simply saying "Good bye" is not the only way, or even the best way, to end a conversation. Labov and Fanshel (1977) said that closing a conversation is harder compared to starting a conversation. Schegloff and

Sacks (1973) added that a particular conversation does not simply end but is brought to a close. Levinson (1983) states that it is technically and socially delicate to close a conversation whilst Button (1987) and Schegloff and Sacks (1973) have shown that effective closings have principles. Levinson (1983) supported the theory and formulae introduced by Laver (1981) and Coulmas (1981) so that whatever the nature of the conversation, the convention does not force one party to just leave while they still have something to say. Strenstorm (1994) said that speakers tend to initiate closings when they feel like ending the conversation. This implies that the initiation of a closing can start at anytime during a conversation, even, for example, before the intended conversation has taken place. For that reason, a mechanism is needed to identify the closings.

Giving a "closing signal" to the other party is one of the strategies used in closing a conversation. Goffman (1976) said that it is very important for a speaker to know and recognise the signal which is sent by the addressee using this strategy to close the conversation. Without this awareness and recognition of signals, the conversation may falter with negative consequences for the therapeutic relationship as one party attempts to continue whilst the other is desirous of an ending.

It becomes easier and more socially acceptable when both parties agree to end the conversation at the same time. To close the conversation, a topic closing is needed, followed by a pre-closing and then a closing so that a respectful termination of conversation can occur. A finishing and finalizing is defined as "topic closing" by Levinson (1983) whereas Strenstrom (1994) explained that topic closing is "the closure of any topic or closing of the whole conversation".

The pre-closing is defined as a willingness to close the conversation which is done by putting some effort to bring it to an end as explained by Schegloff and Sacks

(1973). Strenstrom (1994) explains that closings happen after pre-closing and take place when the party says goodbye. He added that 'it functions as a post message talk ending the conversation'. Termination marks the end of a conversation and is the point at which words are no longer required.

Schegloff and Sacks (1979) explain that pre-closings are considered as identifying markers in American English and are signs that one party is prepared to terminate the talk but is offering the opponent an opportunity to start another topic of conversation. They explained that certain words such as "okay then" and "well…" should be taken into account to indicate that a topic or conversation is coming to an end. Schegloff and Sacks (1979) introduced several types of closings. Besides pre-closings, they identified the introduction of new topic which indicates the possibility of opening of a new topic as a means by which the current topic could be terminated. They also postulated the concept of a 'summarising theory' which is a brief summary of the subject or issue being discussed and arrangements that are made as a pre-closing strategy.

Finally they hypothesised the 'final-closing, the actual ending of a conversation which takes place according to the context of the conversation. For example, *good bye* or *thank you* in formal context and *see you later* in the informal context. Closing strategies can be related to 'politeness strategies' because, in order to end a conversation successfully, it is important pay due respect to the other party. Brown and Levinson (1978) "we assume that being regarded as polite is achieved in part by maintaining, and, in case of threat, saving desired or conventionally valued aspects of others' face" (p.1). This theory relates to avoiding offending the other party by simply leaving the conversation without proper, respectful closure.

Since these strategies and conventions obviously apply to everyday conversations, it becomes highly likely that in, nurse-patient interactions, they would be even more important in developing the professional relationships upon which the accurate information necessary to successful treatment is provided by both parties.

Brown and Levinson (1978) also explained that politeness strategies encompass both the "positive face" and "negative face". They defined *negative face* as 'the basic claim to territories, personal preserves, rights to non-distraction' and *positive face* as'the positive consistent self-image or 'personality' claimed during interaction'. They explained that positive politeness basically maintains a speaker's self-image whereas negative politeness respects another speaker's speaking rights and freedom to finish their conversation. Weinreich (1986) mentioned that "verbal interaction which comprises of openings and closings is easy to be accepted as being important for an interpersonal relationship, as it evolves, develops, and provides the face work", supporting the contention that it is important to use correct and appropriate linguistic forms (openings or closings) during an interaction. Cameron (2001) explains that a speaker should take note of endings which involve inherent face threats.

Conversation strategies are created to save a speaker's "face". Ending a conversation without a proper closing can damage the possibility of a positive relationship, (critical in a healthcare environment), but can also reflect negatively on the reputation and professionalism of the person involved. Goffman (1967) explained that it is important to give the freedom to a specific speaker to end a particular conversation or continue speaking on the subject being discussed and interrupting a conversation avoids the 'negative politeness'.

Coppock (2005) discusses several kinds of strategies in closings. The first one is 'the positive comment' which can be described as the most common closing strategy. It

is a direct indication to indicate that the other interlocutor is not annoying or boring. For example, "*I had a great time with you*."

Another is the 'excuse strategy' which explains "where the conversation gets to the root of the face-threatening chain of implications" (p.3-4). For example, *"I'd better continue my work*." It takes away the insinuation that one desires to end the conversation by giving an alternative motivation, an alternative explanation for one's potentially face-threatening behaviour.

Lastly is the 'imperative to end strategy' where it shows that a conversation must come to an end. Therefore, the interlocutors may use phrases such as '*It's time to leave*' or '*It looks like times up*!'

Pomerantz (1984) explained that dispreference markers are usually combined with many politeness strategies particularly "non-preferred responses", for example, the opposing of or disagreement with statements in a peaceful discussion. For example, the use of words like "*well…"* or "*so…"*, followed by silence. Schegloff and Sacks (1973) disagree with Pomerantz suggesting that words such as '*well*' may function like "pass" in the ending of turn-taking conversations. They further added that "its use as a marker as to that which is not preferable also contributes to its function in conversation endings". Though Schegloff and Sacks (1973) disagree with Pomerantz, word like '*well*' functions in the same way as the excuse and imperative to end strategies in the strategies of closing a conversation.

The combination of positive and negative strategy is one important strategy to be examined. On the other hand the *blame* which is a form of excuse explains that the need to leave by blaming and attributing the need to the other party (Schegloff and Sacks, 1973). For example, a statement such as "*I think you're not free now, I'll get back to you"* makes a speaker appear polite by saving their own 'positive' face.

When a conversation is coming to an end, it suggests that the *goal* of the conversation has been reached and that it need not be continued. Schegloff and Sacks (1973) explained that when a conversation need not be continued, 'this construes ending as desirable outcome for the other, and is therefore a negative politeness strategy'. Next, may appear the *summary* which prepares for the up-coming end of the conversation. The *summary* indicates that the conversation took place, that it ended successfully and that the other party is now free to leave if he or she wishes to. As a sign that the conversation is about to end, clearly this strategy also offers, for example, an opportunity for a patient to contribute further information to a nurse if necessary, which again may prove crucial in diagnosis and treatment.

In addition, Schegloff and Sacks (1973) introduced the topic-bounding which proposes up-coming pre-closings such as "*well"*. This explains that a topic may possibly close when a speaker proposes to one party and the latter concurs, allowing the topic to be brought to a close. This is a form of negative politeness which gives the interlocutors their freedom from the norms of usual conversation.

Another closing strategy in conversation is the "solidarity closing" (Schegloff and Sacks, 1973). Solidarity closing strategy is used to maintain the relationship between both speakers. Therefore, norms of politeness reflect the solidarity between the speakers. Schegloff and Sacks (1973) explained that when making arrangements to meet: for instance, '*see you on Saturday'*, *'talk to you in a short while'* indicates that a speaker has made an arrangement for further discussion. This will maintain the solidarity between the speakers. Button (1991), cited in Coppock (2005), indicated that the general wish is aimed at fixing the solidarity threat posed by ending a conversation. Expressing their good and positive wishes, like '*have a fruitful day' or 'have fun*!' displays solidarity between the speakers. Brown and Levinson's (1978) explanation on the second definition of positive face is related to Button's (1991) 'general wish' theory

which explains that solidarity is shown when one shows good wishes towards the other interlocutor.

2.7 Language in multi cultural society

Communication worldwide is a common effective way of sharing information and knowledge (Smith, 2011). Every religion in the world encourages their devotees to promote values of harmony, duty, respect, honor and allegiance to family through conversation or any other practices. Within societies of various ethnic and cultural backgrounds, one of the issues that often arise in a country such as Malaysia where over a hundred languages and dialects are spoken daily by the people is the choice of language (David, 2006).

When having conversation with someone, it is appropriate to know their cultural background, how to respect them, using polite terms and most important addressing people with forms, first names or last names. A good communication practice is responsive and sensitive to the addressee and this needs timely action or proper follow up after an intervention. Such manners show consideration of the individual's wishes and preferences and family or care bond. Good communication respects the customs, beliefs, emotions and values of an individual. The following criteria highlights good communication practices in caring patients in a hospital setting according to Multicultural Communities Cultural, (2005).

- Learn and use key words in the person's own language to improve communication during routine care and doing some other medical practices.
- Use proper gestures and physical prompts
- Use proper language during assessment or consultation and seek the assistance of language interpreters when necessary. The person chosen for this task needs to understand the specific health situation of the patient,(for

example whether the person is critically or dangerously ill), and understand the general wellbeing of the patient.

- If all information in delivering the service care can be implemented in the patient's own language and the need to use respectful sentences is understood the communication is likely to be of a much higher quality.

As a way to achieve cultural competence, health care providers should have a sense of compassion and respect for patients with different backgrounds and cultures. When a nurse has an inherent caring, respect and appreciation for a patient, that patient may display warmth, empathy and openness in return, thereby improving the therapeutic relationship. According to Asmah (1982) "the social environment in Malaysia is a situation where various languages are used in daily communication". This means that in a multicultural country different languages are used in daily conversations and it is therefore highly desirable for successful nurse-patient relationships for nurses to have at least some proficiency in the basics of major languages and cultural customs.

Using polite language is one of the ways of showing respect towards addressee. For example, the speaker may have high respect for the addressee, but if they use language that may not seem polite, it will affect the whole communication process. A common feature among Malaysians from the same linguistic background is to have their conversation with much linguistic interference as well as code-switching. Communication among Malaysians, where inter and intra group encounters are common, is seldom a straightforward use of one language, be it Malay, Chinese, Tamil or any of the vernacular languages (Jariah Mohd. Jan, 2003).

According to Baskaran (2005), the Malaysian array of English, which is widely used in informal settings in the country today, has endured massive "nativization". In a study of a car assembly plant in Malaysia, Morais (1998) found that Bazaar Malay is

generally used by members of all ethnic groups to varying degrees in day to day informal communication. The Bazaar Malay frequently used by older members of the Chinese and Indian communities differs in terms of pronunciation and intonation due to L1 interference. Morais furthermore pointed that the manifestation of occasional code-mixed varieties where lexical items of the minority languages and even English are inserted in the dominant Malay.

2.8 Accommodation in Communication

The linguistic form to build rapport and create effective communication will be discussed in this section. This includes the CAT theory otherwise known as Communication Accommodation Theory which was developed by Howard Giles, psychologist and linguist. The theory was the result of his studies in 1973, in which he sought to explain the process of creating communication bonds between speakers. Giles also suggested that the CAT encompasses the changes in communication style, vocal patterns, speech and gestures that occur to influence listeners. According to CAT theory, speakers in a communication carry their experience and backgrounds into the conversation, suggesting that speech and behavioural resemblance occur in all communication processes (Giles, 1979). Similarly, the theory suggests that accommodation is influenced by the way that people differentiate and gauge what takes place throughout a conversation, how people interpret and judge the messages. Furthermore, in the communication accommodation method there is a “tuning” of the speaker’s style of presentation to that of the listener in order to improve the listener’s comprehension and adoption of the message being conveyed, a clearly vital objective in any medical therapeutic interaction but especially so in the case of the “front-line” interactions of nurse and patient. Accommodation Theory involves understanding the patient’s ethnic, cultural and language style, enabling nurses to tune their own communication method and adjust the way they talk to maximise the effectiveness the

gathering and imparting of information critical to the diagnosis and treatment of the patient.

According to Street (1991), accommodation is a combination of strategy and theory of communication which is also known as 'Communication Accommodation Theory' created by Giles. The theory of accommodation suggests that when people wish to establish rapport, win approval, associate, identify socially or communicate effectively, they become willing to adjust their conversation or, in other words, to use strategy to achieve their aims. According to Bourhis, Roth and MacQueen (1989), convergent accommodation is reflected in many ways such as changes in speech velocity, vocal strength, language changes and pronunciation switches. According to Street (1991), complementarity occurs when speakers mutually attempt to maintain their social differences communicatively. Accommodation divergence occurs when a speaker intentionally does not change the communicative style based on the person they are talking to. So, when an effective nurse communicator speaks to an Indian patient, the addressing style will be different to that used in the case of a Malay patient. In another example, if the nurse herself is Malay, then it would be appropriate for her to greet the Malay patient with a religious greeting whilst this may not be appropriate for other ethnic backgrounds. Accommodation is noted in the data of this study and will be referred to in the analysis in the Chapter 4.

2.9 Summary and conclusion

Address form is an important aspect in almost all communication as it is a major influence in the creation of a good relationship, rapport and the demonstration of respect. This applies in all careers and in almost all social settings, including the nursing field however address forms alone are not sufficient as they should be supplemented by 'effective communication'. Starting a conversation with a proper opening and closing

appropriately will enhance the entire communication process. In the health profession, nurse-patient communication is important as it is one of the most important ways vital information is exchanged and the patient's comfort enhanced. As stated by Gaudart (2008) (See 2.6), young Malaysians are trained from their early years to use the term 'Uncle' and 'Aunty' to respectfully address older people however nurses, in order to be considered effective and professional, should be encouraged to broaden their communication to enhance the nurse-patient relationship with patients from other ethnic, cultural and language backgrounds. Accommodation theory can be considered an important and effective educational tool for this process.

CHAPTER 3

METHODOLOGY

3.0 Introduction

In this chapter the methodological framework used to collect the data and the way the data is analyzed is discussed.

3.1 Selection of Method

A mixed method was used to conduct this study. The data from this study has been obtained from observations and questionnaires. Williams (1993) has mentioned that "qualitative observations are believed to generate more valid information because it allows researcher to empathize with his or her respondents and view their situations from their own points of view".

The sampling method chosen in this study was purposive sampling which is mostly adopted in qualitative research. Honigmann (1987) mentioned that "this method is logical as long as the field worker expects mainly to use his data not to answer questions like "how much" or "how often" but to solve qualitative problems, such as discovering what occurs, the implications of what occurs, and the relationships linking occurrences" (p.84).

For the quantitative phase of the study, a set of questionnaires was given to participants. Participants were chosen based on a flexible set of criteria. Participants who could deliver valuable data to answer research objectives of this study were selected. Selected participants were then asked to name another possible participant (Merriam, 1998).

The data was collected by observing the conversations which took place between the nurse and the patient. Only the utterances related to the objectives of this study were recorded. This observation was considered to be ‘naturalistic observation’ under the unstructured observation. An observation carried out in a real-world setting is considered as naturalistic observation. ‘It is an attempt to observe things 'as they are', without any intervention or manipulation of the situation itself by the researcher. This has been described as a 'pure' or 'direct' observation’ (Punch, 2009, p.154). After observing the conversation, the researcher took a few minutes to complete the notes, which had been written by adding the necessary actions observed. After completing the conversation, the researcher confirmed any doubts with the other party to get more clarification. This procedure was conducted in accordance with Mack (2011) stating that “in community settings, researchers usually make careful, objective notes about what they see, recording all accounts and observations as field notes in a field notebook” (p.13).

Connelly and Clandinin (1990) state that in all cases, qualitative observational research involves preparing a caring, kind and well-understood relationship and rapport between the researcher and participants. In order to understand more about the address forms used in openings and closings, observation was found to be an appropriate methodology. Observation plays a very important role in understanding the physical, social, cultural, economics which studies a participant’s life, the relationships among and between people, ideas, norms, characteristics, behaviors and activities. For instance, what are the activities which are being done, how frequently or often is it being done etc.

Besides using the non-participant observation method in the qualitative research, the quantitative research was also used in this study. Quantitative research statistically determines the research participant’s behavior, performance and attitudes and will

normally give in data that develops to a bigger population using a sequence of tests and techniques. Quantitative research can efficiently decode and interpret data into easy quantifiable charts and graphs because it totally originates in numbers and statistics. A questionnaire was used to conduct the quantitative phase of the study. The questionnaires were then analyzed according to the frequency counts on the use of a particular address form used.

3.2 Instruments

The non-participant observation was used in the qualitative phase of the research whereas questionnaires were used to conduct the quantitative phase of the research. All conversations, which were observed, were written down unobtrusively and questionnaires related to the objective of this study were given to nurses to be answered. This questionnaire contains two parts. Nurses are supposed to answer all the questions in this questionnaire.

3.3 Setting

This research was done in University Malaya Medical Center (UMMC). The observations took place at 7U, the surgical ward. This research was conducted for 3 days at various times of the day. In the ward, there were 3 other patients who were admitted. The conversations of these four patients with the four nurses in charge in this ward were also noted. On the other hand, the questionnaires were also given out to nurses in University Malaya Medical Center (UMMC). All the nurses who participated in this questionnaire were from various wards in University Malaya Medical Center (UMMC).

3.4 Participants

To conduct the qualitative phase of this research the non-participant observation method was used. Eight conversations were observed involving four female nurses, (three Malays and one Indian) one male Chinese patient, an Indian male and two female Malay patients. In contrast, the quantitative research using questionnaires involves only 30 nurses. As this is just a small study, 30 nurses were considered sufficient to conduct this quantitative research.

Each participant was observed on different times of the day, when the nurses on duty came to check the patient's pressure, temperature and drip. Each conversation was short as the nurses had to move on to the next patient so that they could complete their duty before the doctors came to examine the patients.

3.5 Pilot study

Before the actual study was conducted, the researcher did some pilot testing by collecting data from few sample nurses and interviewing them. This was to ensure that the interview questions chosen and the survey questions would be understandable. See Table 1 and 2 below for the characteristics of the involved nurses and patients in the pilot study.

Table 1: Characteristics of patients involved in the participant observation

Patient Id	Gender	Race	Age (years)
Patient A	Male	Indian	55-59
Patient B	Male	Chinese	35-39
Patient C	Female	Malay	50-55
Patient D	Female	Malay	45-49

Table 2: Characteristics of nurses involved in the participant observation

Nurses Id	Gender	Race	Age (years)
Nurse A	Female	Indian	25-30
Nurse B	Female	Malay	25-30
Nurse C	Female	Malay	25-30
Nurse D	Female	Malay	30-35

Each patient was observed and checked by different nurses at various time of the day. There were total of eight conversations which were observed. These are shown in Table 3.

Table 3: Conversations and patients involved at various dates

Conversation	Date	Patient involved	Nurse Involved
1	23rd November 2011	A	A
2	23rd November 2011	B	C
3	24th November 2011	A	D
4	24th November 2011	C	B
5	25th November 2011	A	C
6	25th November 2011	A	A
7	26th November 2011	D	D
8	26th November 2011	A	A

The questionnaires were distributed to 30 nurses for the pilot study. There were 19 Malay nurses, 7 Indian nurses and 4 Chinese nurses involved in this questionnaire (See Table 4).

Table 4: Characteristics of nurses involved in the questionnaire

Age group *(years)*	Race			Gender	
	Malay	Chinese	Indian	Male	Female
20 – 25	2				
26 – 30	5		2		
31 – 35	2	1	1	1	
36 – 40	3	1	2	1	
41 -45	4	1			
46– 50	2	1	1		
51- 55	1				
None			1		

The table above shows the age groups, race, and gender of the nurses who were involved in the quantitative phase of the research. The table above shows that there were 30 nurses involved. One participant did not specify age. This, therefore; was categorized under the age group of *'none'*.

Although all the tables (Table 1-4) above illustrate the differences in age groups, race and gender, as mentioned earlier in limitations (See 1.5), this study focuses only on the objectives of this study regardless of the mentioned variables. The characteristics shown in the tables above (Table 1-4) are only to give an idea about the participants who are involved in this study.

3.6 Data collection

Many factors needed to be considered in the qualitative phase of the study. One of these important factors was to obtain genuine data and naturally occurring conversations during observation. The researcher's role here was to neutrally and objectively record the interactions using the qualitative investigation tools. All the observations were noted. The conversations were not recorded. This is not a disadvantage because this research mainly focused on the address forms used in the

openings and closings of conversations. Saville-Troike (1982) mentioned that if the observer is absent, the observer would not be able to observe [hear] what would have been taking place (p.113). The writing of notes was conducted unobtrusively during the routine check up between nurse and patients, which took place more than three times a day. Throughout the interview process, the researcher wrote down the statements made by the interviewees.

Delamont (2002) in Fieldwork in Educational Setting explains that recording what was said throughout the observation should be done as discreetly as possible, if possible not word for word but some key words or phrases would be helpful to jog the memory later.

In conducting the quantitative research, many important elements and aspects were considered. A questionnaire (See Appendix) is merely a 'tool' to bring together and accumulate information about a specific aspect of interest. It contains a list of questions. This composed questionnaire contains two parts, Part 1 has four questions regarding general personal particulars whereas Part 2 is divided into 2 sections, *Section A* and *Section B*. There are three questions which require short answers in Section A. Section B contains 4 parts. *Part a* discusses address forms in the openings and closings, *Part b* asks about the languages used to communicate with patients, *Part c* is about the openings and *Part d* is about the closings. All the questions in Part B are answered using likert scale *(5-always/ 4-often/ 3- sometimes/ 2-seldom/ 1-never)*. Three statements in *Part a* require explanation whereas three statements in *Part b* are multiple choice questions. The nurses were supposed to answer all the questions.

A questionnaire needs to have clear and understandable instructions, therefore; the instructions for this questionnaire were written clearly in order for better understanding of the participants. Questionnaires must always have an exact reason

which is related to the objectives of the research. Thus, the objectives of this study were written on the front page and the title of *Section A* and *Section B* explained what were the objectives of the questions and

A pilot study was first conducted to check people's understanding and ability to answer the questions, highlight areas of confusion and look for any routing errors, as well as providing an estimate of the average time each questionnaire will take to complete. Therefore, the first pilot study using this questionnaire showed that the instructions were not precise and clear. The participants did not know how to answer the questions as there were many redundant questions. This was then amended to remove the redundancy and repeated questions in different forms. After amending it, a second pilot study was done. This showed improvement as there were no questions asked which caused any doubts. The second pilot study was considered to be successful. The participants involved were then given the final erosion of the questionnaire. They were informed about the aim of the questionnaire in order to understand the questions.

It is important to analyze and interpret the collected data carefully. The collected data were interpreted objectively. The forms of address used in the openings and closings, and languages used in the openings and closings in nurse-patient communication will be analyzed in the following Chapter. All the collected data will be analyzed and interpreted focusing on the aim of this research.

CHAPTER 4

DATA ANALYSIS

4.1 Introduction

In this chapter, findings obtained through observations and questionnaires will be discussed. The quantitative analysis of the data is done using the survey results from 30 nurses working in various wards of East Tower (Menara Timur) of University Malaya Medical Centre (UMMC). After highlighting the relativity of the survey questions and expected research findings together with the research objectives and research questions (See 1.4 and 1.5), the findings of the survey were tabulated in tables and graphs to represent the findings. The findings of the survey then were discussed based on the research questions (See 1.5) and answer them based on Paltridge (2000) discourse analysis frame work. The overall research findings and data analysis were summarized at the end of this chapter.

4.2 Analysis of the Results based on Research Objectives

The main objective of this research was to determine the forms of address used in openings and closings of conversations between nurses and patients. The gaps that exist along the way of the nurses' communication can be recognized by identifying the forms of addresses used by them when communicating with the patients. The other objective of this research was to study the relationship between the forms of address used and the language choice in the communication between nurses and patients. In identifying this element, the relationship between language and ethnicity which involves the accommodation theory could be identified. The findings of this study can lead to future researches on language and ethnicity or how language and ethnicity in a multicultural society accommodates in communication across different cultures.

4.3 FINDINGS OF THE SURVEY

4.3.1 Quantitative Phase (Part 1 of the questionnaire)

The purpose of analyzing part 1 is to identify the age distribution of the respondents, which ethnicity the respondent belonged to, their gender and the languages they master. Since one of the aims of the research was to study the relationship between the forms of address and the language choice used in the communication between nurses and patients, it was important to identify the language spoken by the respondents and the ethnicity they belong to. Table 4.1 shows the age distribution of the respondents that took part in this survey.

Table 4.1: Age distribution of the respondents

Age range	Frequency
25 -29	8
30-34	6
35-39	5
40-44	5
45-49	5
50-54	1

Figure 4.1 shows the same distribution in the form of pie chart.

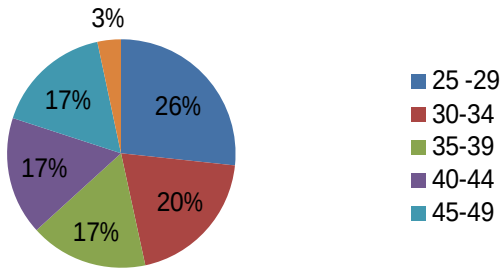

Figure 4.1: Age distribution (%) of the respondents

Figure 4.2 shows the distribution of ethnicity among the respondents who took part in this research. The majority of the respondents were Malays with the total number of 19. Indians and Chinese make up 7 and 4 respectively.

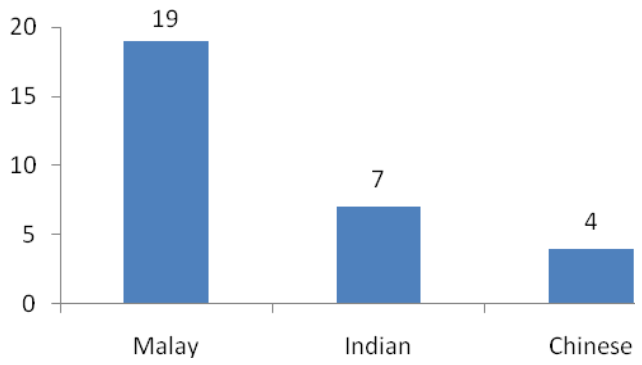

Figure 4.2: Distribution of ethnicity among the respondents

The respondents were both males and females. But there were very few male respondents compared to the females. Out of the 30 respondents, there were only 2 males. The rest of the respondents were females. Figure 4.3 illustrates this distribution.

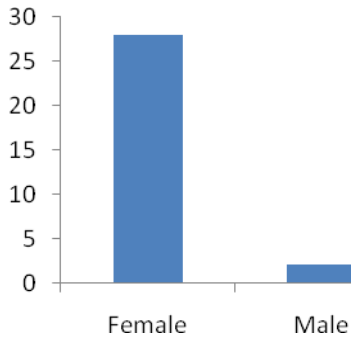

Figure 4.3: Gender distribution among the respondents

The last question of Part 1 investigated the language spoken by the respondents. The data shows that all of the respondents spoke two or three languages. Table 4.2 shows the distribution of languages spoken among the respondents. Majority of the respondents spoke Malay and English while nine of the respondents spoke Malay, English and Mandarin. The remaining seven respondents spoke Malay, English and Tamil. Thus 14 of them spoke two languages while 16 of them spoke three languages. This is related to ethnicity since Chinese and Indians in Malaysia have to learn Malay as

the countries national language, and their ethnicity requires them to speak either Mandarin or Tamil.

Table 4.2: Language spoken among the respondents

Languages spoken	Frequency
Malay/English	14
Malay/English/Mandarin	9
Malay/English/Tamil	7

4.3.2 Quantitative Phase (Part2 of the questionnaire)

Part 2 of the questionnaire contained two sections. The findings of these two sections are reported separately in this subtopic.

Section A

Section A reported on how the nurses address their patients according to their age group. The relation is many to many types, where more than one nurse, uses more than one forms of addresses to address the patients. The patients are divided into age groups namely: children, younger patients and older patients.

Table 4.3 shows how the respondents generally addresses children and the frequency of each forms of addresses used.

Table 4.3: Frequency of the terms used by the respondents to address children

Terms	Frequency
Names	21
Adik	18
Lengloi	1
Lengchai	1
Thambi	1
Dik	4
Dei	1
Sayang	1
Hi	1
Boy	1
Hey	1

The table shows various languages used by the respondents when addressing children in the ward. The most commonly used term would be the children's names. The frequency of using names is 21 times; which is the highest. Then the respondents tend to address children as *Adik*. This was shown by 18 responses. Another term with the same meaning as *Adik* which is *Dik* was the next commonly used term with a frequency of four. Some other terms found in this survey which are not so commonly used are *Lengloi*, *Lengchai*, *Thambi*, *Dei*, *Sayang*, *Hi, Boy* and *Hey*. These groups of patients were much younger than the respondents causing the respondents to be more jovial.

Table 4.4: Frequency of the terms used by the respondents to address younger patients

Terms	Frequency
Names	20
Adik	20
Dik	3
Hello	1
Hi	1

Table 4.4 shows the forms of addresses used by the nurses to address younger patients. It was observed that most of the terms used to address the children are not used when addressing the younger patients. Those terms are *Lengloi*, *Lengchai*, *Thambi*, *Dei*, *Sayang*, Boy and Hey. This showed that the respondents practice more formality when approaching the older patients. The age compatibility could be the reason since most of the respondents were in the group of 25 to 29 years old. In this scenario, the patients' names are still the most preferred way of addressing the patients. The frequency of using names to address was equivalent to the frequency of using *Adik* (20 times). The less formal forms were used for this age group where a more formal word *Adik* was used more often. At the same time the form of address *Dik* was still used with a frequency of four. As mentioned earlier, both the words *Adik* and *Dik* are from the same language and carry the same meaning. It is just a norm or by preference that some respondents used one word instead of another (See 2.6.2, 2.7 and 2.8). Very seldom the respondents address the younger patients with Hello and Hi which are classified under greetings. The frequency is only one for each of these address forms.

Next in the list are the forms of address used by the respondents to address older patients. The terms used and the frequencies at which those are used are summarized in Table 4.5. The formality practiced in approaching the younger patients seemed diminishing and more when the respondents approach older patients.

Table 4.5: Frequency of the terms used by the respondents to address older patients

Terms	Frequency
Uncle	26
Aunty	26
Abang	5
Kakak	2
Pakcik	7
Makcik	7
Kak	8
Brother	2
Sister	3
Miss	1
Akka	3
Anne	2
Names	3
Bang	4
Hi	1
Hello	1

It can be observed that the form Uncle and Aunty are most commonly used; 26 times each. The word *Abang* was used more often compared to *Kak*. These two terms were the most commonly used words after the terms Uncle and Aunty with a frequency of five and eight each. *Bang* has exactly the same meaning as *Abang* but it is the individual's preference to omit the first letter when addressing older people. The frequency for the form *Bang* was four. The forms *Pakcik* and *Makcik* carry the same meaning as Uncle and Aunty respectively *(*See 2.6, 2.7 and 2.8*)*. These two are next commonly used with a frequency of seven each. It is just the individual's preference and ethnicity variance that makes the respondents to choose either Uncle or *Pakcik* or Aunty or *Makcik*. The forms Brother and Sister are the translation of *Abang* and *Kak* from Malay to English. Few respondents stated that they address older patients by using the forms Brother and Sister. The frequency of this form of address is two and three respectively. At the same

time, the term *Kak is* pronounced as *Akka* and *Abang* pronounced as *Anne* once translated to the Tamil language. These two forms were used at a frequency of three and two respectively.

The frequencies of using names were very few for this age category (three). Again, the age is the factor that contributes to such result. The majority of the nurses working in the ward were younger compared to the patients being handled. As such it is less likely for them to use the patients' names to address them. The frequency reported for the forms of using Miss, Hi and Hello is only one for each. This quantitative study shows that nurses prefer using 'kinship' terms to address their patients compared to honorifics. This can be related to the nurses' desire to maintain the relationship between themselves and their patients.

Section B

This section consisted of four questions a, b, c and d. The responses for each of these questions were analyzed.

Question a

Question a required the respondents to select a scale for three different statements and provide a reason as a supporting answer. The scale is a 5 level Likert scale, with 5 = always, 4 = often, 3 = sometimes, 2 = seldom and 1 = never. Table 4.6 and figure 4.4 show the summary of the responses on the likert scale while table 4.7 shows the reasons for all the three statement according to the scale they chose. The respondents that gave the same reasons, were compiled as a single entry in table 4.7.

Table 4.6: Summary of using address forms at different stages of conversation

Using address forms	Often	Sometimes	Seldom
Beginning of the conversation	19	6	5
End of the conversation	18	6	6
Throughout the conversation	13	4	13

Based on the analysis, the majority of the respondents often used a kind of address form when communicating with patients at all stages of the conversation. But it is apparent that a lower number of respondents use the forms of addresses throughout the conversation even though they admit that they often use the address forms. There are 19 out of 30 respondents who often use the forms of addresses in the beginning of the conversation, 18 uses at the end of the conversation and 13 who used them throughout the conversation.

The overall distribution of using the address forms only sometimes at all three different stages of conversation is obviously lower compared to the often usage. It is observed that only six respondents stated that they use address forms at the beginning of the conversation and at the end of the conversation and four respondents responded that they use address forms throughout the conversation. Only five and six out of the 30 respondents stated that they seldom use address forms in the beginning of a conversation and end of a conversation while 13 of the respondents stated that they seldom use address forms throughout a conversation.

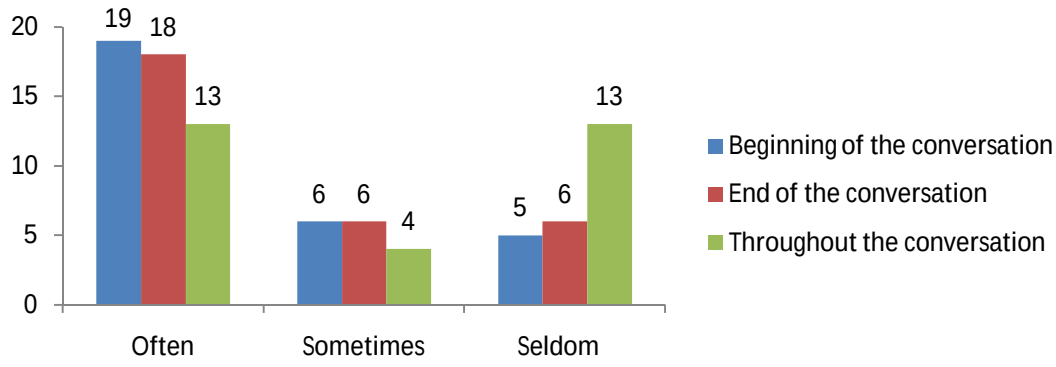

Figure 4.4: Distribution of address forms usage frequencies at three different stages of conversation

Table 4.7: Summary for using address forms with different frequencies

Frequent	Reasons
Often	To provide comfort for the patients To allow patients feel like they are at home To maintain closeness with patients To show patients that we care
Sometimes	Do not know how patients perceive the addressing The patients emotions appears confusing
Seldom	Prefer conversation short and accurate Do not prefer to establish closeness with patients

Question b

Question b required the respondents to select a scale for three different questions regarding the language usage in forms of addresses. The scales were from 5 to 1, with 5 = always, 4 = often, 3 = sometimes, 2 = seldom and 1 = never. This question explored if the respondents used English/ Malay/ Mandarin or Tamil when communicating with patients from different ethnicities. Table 4.8 summarizes the frequencies at which the respondents used each language when communicating with patients from different ethnicities.

Table 4.8: Frequency of using each language with patients from different ethnicities

Frequent	English to Malay patients	Malay to Malay patients	English or Malay to Indian patients	Tamil to Indian patients	English or Malay to Chinese patients	Mandarin to Chinese patients
Often	10	20	25	5	22	8
Sometimes	15	10	10	20	15	15
Seldom	5	10	15	15	9	21

The analysis shows that majority of the nurses often use Malay language to communicate with Malay patients (See 2.8). 20 of the respondents stated often, 10 stated sometime and another 10 stated seldom to use Malay. But only 10 respondents stated that they use English with the Malay patients. Comparing this to the language used towards Indian patients, most of the nurses reported that they often use English or Malay with Indian patients. 25 of them confirmed this while only five of them stated using Tamil language with Indian patients. About 10 nurses stated that they sometimes use English or Malay while 15 nurses seldom use English or Malay when communicating with the Indian patients. For the case of the Chinese patients, 22 respondents stated that they often use English or Malay, 15 responded that they sometimes use English or Malay and nine respondents stated that they seldom use English or Malay when communicating with Chinese patients. With regard to communication with Chinese in Mandarin, eight of the respondents stated that they often use this language, 15 responded that they sometimes use this language while 21 stated that they seldom converse in Mandarin with Chinese patients. Overall screening the data showed that there are more respondents who use Malay language with Malay patients compared to respondents who use the mother tongue of Chinese or Indian with patients from those ethnicities. The majority of the nurses (19 out of 30) who took part

in this survey were Malay. Thus it is very less likely that they will have the ability to converse in Tamil or Mandarin. The nurses that worked in that ward were all Malaysians from different ethnicities (Malay, Chinese and Indians) and they mingled among themselves,. As it is reported in table 4.8 the nurses use English to address patients from all three different ethnicities only sometimes.

Question c

This question required the respondents to state how they start their conversation with the patients on daily basis; by greeting, inquiring about patients' health or by asking non-medical questions to the patients. The respondents were allowed to choose the scale that most represented their way of starting the conversation. Table 4.9 shows the summary of the responses. In the category of starting conversation with greeting, 20 respondents stated that they often use greetings in their openings.

Table 4.9: The frequent of methods of starting conversation with patients

Method of starting conversation	Often	Sometimes	Seldom
Greeting	20	6	4
Inquiring about health	15	9	6
Asking non-medical questions	12	12	6

It can be observed that most of the respondents started their conversation with some kind of introduction. Even if they don't have any subject to start conversation, they used greeting to begin their conversation. The most common methods of starting a conversation were greeting and inquiring about health which 20 and 15 respondents stated they use them often as their choice. Very low number of respondents stated that they either sometimes or seldom start the conversation using any one of the three methods shown above. This conclusion is based on the results in which six respondents

sometimes and four respondents seldom started the conversation through greeting. For the method of inquiring about health, nine respondents stated that they sometimes use this method and six respondents stated that they seldom use this method to start their conversation with the patients. Comparing among the methods of starting conversation, most respondents use greeting rather than inquiring about health or asking a non-medical question. The next preference was inquiring about health. Asking non-medical questions was their last option of starting a conversation (See 2.6.5).

Question d

This question required the respondent to state how the nurses end their conversation with the patients on daily basis. It could be by saying '*see you later*', '*I'll come later*', by just saying 'bye', 'rest' or without a proper ending *(e.g : just walk away)*. The respondents were allowed to choose the scale that most represented their way of starting the conversation. Table 4.10 shows the summary of the responses.

Table 4.10: The frequent of methods of ending conversation with patients

Phrases used to end conversation	Often	Sometimes	Seldom
'*see you later*'/ '*I'll come later*'	22	4	4
'bye'/ 'rest'	18	9	3
No proper ending	2	24	4

It can be observed that most respondents used certain kind of phrases upon leaving their patients. There were 22 respondents who stated that they often say '*see you later*'/ '*I'll come later*', four would sometimes use this word and another 4 seldom used it. In terms of the phrases 'bye'/ 'rest', 18 of the respondents said that they often used these terms; nine respondents stated that they sometimes use these phrases while three of the respondents stated that they seldom use them. Almost none of the nurses would walk away without a proper ending in their conversation with the patients. Only two out of the 30 respondents stated that they often walk away from patients without properly

ending the conversation. Around 24 respondents stated that they sometimes only do this while four of the respondents stated that they seldom walk away without properly ending conversation with their patients (See 2.6.6).

4.4 FINDINGS OF THE SURVEY- Qualitative

Qualitative Phase

The qualitative data was analyzed based on Paltridge's discourse analysis. Paltridge discourse analysis was applied to the responses provided by the nurses to analyze their statements to understand their actions, perceptions, and attitudes.

4.4.1 Forms of addresses

Example 1 Form of Address used in the Openings: *Extracted from Conversation 1 (Source Language-SL)*

1	N	Hello, **uncle**.
2	M	Vaa Maha. Saptiya? *(Come, Maha. Have you eaten?)*
3	N	Yesss, aunty Naa inniki samichitu vanteney! *(Yes **aunty**. Today, I cooked and brought to work.)*
4	M	Yessahh. Enna samichigey? *(Yes ah? What did you cook?)*
5	N	Naaa vanthu mutton, sambar and ah somemore what… ah…salad eduthutu vanthen. *(I brought mutton, dhal curry and ah somemore what ah….. Salad.)*
6	M	Wah, very good lah you. You cook everyday ah? *(Wah, very good lah you. You cook everyday ah?)*
7	N	Nolaa aunty. Aunty, Appadinu uille, we all ladies aunty. It's not that I'm talking proud… my hobby is cooking la aunty. I love to cook. *(Nolah**aunty**. Not like that, aunty, we are all ladies **aunty**. It's not that I'm talking proud… my hobby is cooking la **aunty**. I love to cook.)*

Example 2 Form of Address used in the Closings: *Extracted from Conversation 4 (Source Language-SL)*

8	S2	Hmm! Ambillah*(Hmm! Ok.)*
9	S1	Angkat tangan ***makcik***. Sakit tak? *(Put up your hands. Is it painful?)*
10	S2	Sejuk. Tak sakit*(Cold. Not painful.)*
11	S1	klah, ***makcik*** rehatlah lepas nie..Ikah datang lepas pukul 2 lah. *(Ok, have some rest after this. I'll come after 2 lah.)*

The data above shows that the nurse, who is the first speaker, addressed the second speaker by using the forms "*uncle*" and "*aunty*" in the opening of the conversation. This term of addressing elderly people occurs in all the conversations (C1-C8). It also applies to other races in Malaysia, for instance, the use of '*makcik*' (aunt) and *'pakcik'* (uncle) when using the Malay language. This shows that the nurse accommodate the language with the patients based on the ethnicity of the patients. This supports the theory mentioned by Giles (1973) and Street (1991) (See 2.8). For instance, in *example 2* above, the nurse has addressed the patient using the address form '*makcik*' in T9 and T11. In T11, the nurse was already leaving the conversation. Therefore, it is shown that the nurse has used the term '*makcik'* as the address form in the closings of her conversation.

4.4.1.1 Politeness and form of address

Correct forms of addresses in a communication are essential to avoid social embarrassment. In this study the nurses may have addressed the older patients in a correct way so that both the nurse and the patients feel comfortable during the communication. When encountering an older patient, instead of calling them by their first or last name, the nurses used the forms of address such as 'uncle' or 'aunty'. Since forms of address matters whether the listener is young or old, the forms are associated with politeness. In a communication, politeness is one of the factors considered when

correct forms of addresses used. This statement can be explained by Brown & Levinson's (1987) theory of politeness. The way an individual is addressed and the manner in which the same person is referred are not always the same. The use of direct address is influenced by a relationship between the speaker and the hearer. As such when choosing a form of address, the speaker needs to also decide how to present the address in a situationally appropriate way. So the direct address and the way of referencing should be looked at from a pragmatic and sociolinguistic point of view. Thus politeness is an integral factor which influences the choice of the nurses in this survey to use the address forms. In this analysis, the differences and similarities between the forms of addresses used by the nurses and reference from socio-pragmatic viewpoint are determined.

Example 3 Politeness and Form of Address: *Extracted from Conversation 1 (Source Language-SL)*

Turns	Speakers	Utterances
1	S1	Hello, **uncle** .
2	S3	Vaa Maha. Saptiya? *(Come, Maha. Have you eaten?)*
3	S1	Yesss, **aunty.** Naa inniki samichitu vanteney !*(Yes aunty. Today, I cooked and brought to work.)*
4	S3	Yess ahh*. Enna samichigey ?(Yes ah? What did you cook?)*
5	S1	Naaa vanthu mutton, sambar and ah somemore what… ah…salad eduthutu vanthen. *(I brought mutton, dhal curry and ah somemore what ah….. salad.)*
6	S3	Wah, very good lah you. You cook everyday ah? *(Wah, very good lah you. You cook everyday ah?)*
7	S1	Nolaa **aunty**. **Aunty**, *Appadinuu ille,* we all ladies **aunty**. It's not that I'm talking proud… my hobby is cooking la aunty. I love to cook. *(Nolah aunty. Not like that, aunty, we are all ladies aunty. It's not that I'm talking proud… my hobby is cooking la aunty. I love to cook.)*

Example 4 Politeness and Form of Address: *Extracted from Conversation 4 (Source Language-SL)*

7	S1	Ah, tengok, suhu **makcik** turun banding semalam. Kalau turun lagi… tak demam, takde infection, nanti boleh balik cepat. Tulah, **makcik** rehat dulu, Ikah check pressure. *(Ah, look, your temperature has gone down compare to yesterday. If it reduces more…no fever, no infection, you are free to go back. That's why, you should take rest, I will check your pressure.)*
8	S2	Hmm! *Ambillah .(Hmm! Ok.)*
9	S1	*Angkat tangan **makcik**. Sakit tak?(Carry your hands. Is it painful?)*

In the examples above, the "*aunty*" as a form of address was used several times from the beginning until the closings of the conversation. Example 3 shows that S1 greeted S2 using "*uncle*" and S3 with "*aunty*". This is also seen in Example 4 where the word "*makcik*" meaning "*aunty*" and "*pakcik*" meaning "*uncle*" are also used. Gaudart (2008), states that a common form of address which indicates politeness among Malaysians is the use of "*aunty*" and "*uncle*" for anyone older than the speaker (See 2.6).

4.4.1.2 Respect and form of address

Using forms of address has strong connectivity with respect. The multicultural background in Malaysia emphasizes address forms for each title to instill respect for those titles. In this survey, the nurses address older patients by uncle or "*pakcik*" when these patients are not related to them. The same applies when the nurses address a slightly older female than them by sister or "*kakak*".

4.4.2 Language in a Multicultural Society

As mentioned by Asmah (1982), it is common to use more than one language in a multi cultural society. This non-participant observation analysis showed that all the nurses

have used Malay and English to communicate with their patients. It can be concluded that Malaysians are mostly bilinguals or trilinguals and code-switching is normal as in other multicultural and multilingual societies. David's (1997) study has shown that code-switching is a usual phenomenon in a multilingual society. The example below shows that the nurses, who are Malaysians, use more than one language when they communicate and also code-switch to maintain the solidarity and identity with the patients.

Example 6 Language in Multicultural Society: *Extracted from Conversation 2 (Source Language-SL)*

1	S1	Halo uncle. Hari ini baikkah? *(Hello, uncle. Are you fine today?)*
2	S2	Sakit belakanglah. Selalu tido saja, rasa boringlah. *(Having some back painlah. Every time sleeping only, I feel very boredlah.)*
3	S1	Sikijapahh uncle; takdesakitpunya. Sayamahu check pressure uncle saja. *(Hold on, uncle; it won't be painful. I just want to check your pressure.)*
4	S2	Ahh…Ahh (While Nodding the head)
5	S1	So, mana isteri you uncle? Hari ini tak datang? *(So, where's your wife uncle? Is she coming today?)*
6	S2	Nanti datanglah dia. Macam mana o.k ?*(She'll come laterlah. How's it? O.K ah?)*
7	S1	Pressure uncle kuranglah. Pressure okay tapi heart beat low. Nanti biar doktor mari check. Uncle tidur dululah. *(Your pressure is low uncle. Pressure still OK but heart beat low. Let the doctor come and check you.)*

In example six above, S1 is a Malaysian bilingual Muslim. She uses two languages to communicate with S2, Malay and English. She code-mixes some English words while speaking in Malay to her patient. In *Example 7* (See 4.3) below, where the speaker is a trilingual Malaysian who uses Tamil and English in her conversation to

maintain her rapport and relationship with the hearer as they belong to the same ethnic group.

Analysing the non-participant observation data above showed that nurses use more than one language to communicate with a patient. As mentioned in chapter 2, ethnicity influences the languages which are used in a particular group. Code-switching and code-mixing which often occur in conversation are used to show closeness, understanding, intimacy, an attentiveness of being a part of an ethnic group and to avoid face-threatening acts. In analyzing the data, it is clearly seen that nurses use their mother tongue to communicate with the patients who belong to the same ethnic group as the nurse. This therefore shows that nurses accommodate with their patients based on the background of the patients. Besides that, most of the nurses use English and also the Malay language in communicating with their patients. “The languages considered primary in Malaysia and which are used both for intra-group and inter-group communication are Malay, the national language, and English, an international language” (Asmah, 1987). Therefore, being a bilingual or trilingual Malaysian leads to the use of a variety of languages in a conversation. Romaine (1989) and Gumperz (1982) point out that code-changing often follows a change of addressee. Therefore, a code changing following the addressee here shows that the speaker is accommodating to suit the environment.

4.4.3 Accommodating in use of languages

As the nurses have to communicate with patients from different cultures, it is clear that they apply the theory of accommodation in order to indicate politeness. The aim of this study was to find out the use of address forms in openings and closings in conversations between nurses and patients. in accordance to this research question, the analysis of the data shows that in some conversations, speakers (nurses) accommodate

by doing some adjustment to the conversation, both verbally and non- verbally. This research has shown that the nurses accommodate with the patients depending on their race. As mentioned in the literature, people tend to make changes when they communicate with others to apply the CAT theory which is related to the 'language', 'context' and 'identity'. The example below shows the application of the CAT theory in these conversations.

Example 7 Theory of Accommodation: *Extracted from Conversation 1 (Source Language-SL)*

1	S1	Hello, uncle .
2	S3	Vaa Maha. Saptiya? *(Come, Maha. Have you eaten?)*
3	S1	Yesss, aunty Naa inniki samichitu vanteney !*(Yes aunty. Today, I cooked and brought to work.)*
4	S3	Yess ahh. Enna samichigey ?*(Yes ah? What did you cook?)*
5	S1	Naaa vanthu mutton, sambar and ah somemore what… ah…salad eduthutuvanthen. *(I brought mutton, dhal curry and ah somemore what ah….. salad.)*
6	S3	Wah, very good lah you. You cook everyday ah?
7	S1	Nolaa aunty. Aunty, Appadinu uille, we all ladies aunty. It's not that I'm talking proud… my hobby is cooking la aunty. I love to cook. (Nolah aunty. *Not like that*, aunty, we are all ladies aunty. It's not that I'm talking proud… my hobby is cooking la aunty. I love to cook.)

S1 started the conversation in English by greeting and using an appropriate address form. However, when the patient S3 used the Tamil language to respond to S1, S1 used the Tamil language to accommodate the language choice of the patient. In this situation, the speaker has accommodated in terms of language bearing in mind they are both Indians. This means that S1 had strived to maintain a positive social identity where she feels more comfortable.

Accommodation occurs again in T6 where S3 uses English and S1 uses English after using Tamil in the previous turns. S1 was being polite to S3 by switching from English to Tamil. This shows that S1 is polite by maintaining the negative face of the hearer and accommodated by shifting the code used.

While analyzing the non-participant data and the languages used in the quantitative research, it can clearly be seen that nurses accommodate in using their preferred language. The Theory of Accommodation by Giles (1979) proposes that "interlocutors switch to the preferred language of their speech partners if they intend to create rapport". By switching their language to towards their speech partner's language, the speaker shows his or her will to accommodate to create a bond and closeness. Giles CAT explains that the language choices actually influences the social distance between the two interlocutors. In analysing the non-participant data it can clearly be seen that the nurse had attempted to accommodate with her patients. The data obtained from the questionnaire showed that the Chinese and Indian nurses mostly use the Malay and English to communicate with Malay patients. This shows that the nurses are accommodating with the patients as Malay is considered the national language in Malaysia and English is the international language.

The nurses in this study accommodated according to the situations and patients. Nurses speak in Tamil to Indian patients and in Malay to Malay patients because this is a multicultural society and it is also known as accommodating in terms of in group social identity where the nurses actually feels that they belong to that particular identity. As a result, they use a language that makes both the parties feel comfortable just to maintain the rapport between them.

4.4.4 Openings

Besides looking at address forms, the objective of this research was to look at the use of openings. The non-participant observation data revealed that participants start their conversation with greetings. Sacks (2006:183) mentioned that "greetings" are the universal openings in conversation. The example below shows that the First Pair Part (FPP), the nurse started the conversation by greeting the Second Pair Part (SPP), the patient.

Example 8 Openings and greetings: *Extracted from Conversation 2*

1	N	Halo uncle. Hari ini baikkah? *(Hello, uncle. Are you fine today?)*
2	U	Sakit belakanglah. Selalu tido saja, rasa boringlah. *(Having some back painlah. Every time sleeping only, I feel very boredlah.)*

In the example above, the nurse, who is the FPP used the greeting "*halo*" to start the conversation. Then the nurse continues to ask the condition of the patient with "A*re you fine today*?" This can be categorized under the summon-answers types of opening because when the nurse (FPP) greeted the patient (SPP), the latter responded to the nurse's question. Although the second speaker did not respond to the first speaker's greeting, the first speaker i.e. the nurse used the greetings and address form to start the conversation. Schegloff (2009:49) mentioned that summon answers are the most commonly used terms in the openings of structured common talk in interactions and explained that "a generic pre-sequence order is not directed to any sequence type in particular, but rather is aimed at a feature generically relevant to the efficacy of talk-in-interaction".

Example 9 Openings and greetings: *Extracted from Conversation 3*

1	N	Helo pakcik. Apa khabar hari ini? Badan baik? *(Hello, uncle. How are you today? Are you well?)*
2	D	(Nods) Ya, tapi demam saja belum turun. Why the fever has not gone down? *(Yes, but the fever has not gone down. Why has the fever not gone down?)*

As the example above shows, one nurse greeted the patient with '*halo pakcik*' which is a greeting followed by the address form. In this example, the address form *pakcik* is being used as this is a Chinese male patient. The nurse started the conversation with greetings and also questions related to the patient's health. Openings are often related to other parts of discourse analysis. According to the study by Schegloff, openings are connected to the topic talked about, and this is where many other topics can be raised and discussed (See 2.6.5). For instance, when the first pair part (FPP) initiates a topic, it may be greetings, and this is connected to other topics which are discussed as the conversation moves on. Some of the data shows that the openings have connections to other parts of conversation analysis. For example in Example 8 above, the FPP initiates the topic with greetings and continues with other questions.

The example above shows that the FPP initiated the topic as mentioned in Schegloff's theory. The nurse, FPP, greeted the patient by enquiring about his health. Therefore, here in the first turn (T1), the FPP started with a greeting and asked other questions which made the SPP first respond to the question then move on to another question to keep the conversation going. Through the analysis it can be said that the openings are related to other parts of the conversation analysis.

4.4.5 Closings

Closings are another aspect which this research aimed to look at. Analyzing the conversations made it clear that there were closings used in all the conversations. While

analyzing the non-participant data it was revealed that that the pre-closing and pre-sequences closing were used. Pre-closings were used to end a conversation. In general, as discussed by Button (1987), pre-closings consist of two unit turns such as 'okay' and 'alright' whereas the pre-sequence type of closing explains if the speaker makes an arrangement to meet up again, to summarize the purpose of calling, to express good wishes, for example *take care* or *have a good rest* and many others. The extracts below provide examples of pre-closing and pre-sequences.

Example 10: ***Example of pre-closing*** *extracted from Conversation 1*

18	M	Fever? Temperature?
19	N	If fever goes up, we'll give antibiotics.
20	M	Ok *ma (Ok ma.)*
21	N	Ok aunty.

Example 11: ***Example of pre-sequence closing*** *extracted from Conversation 7*

5	N	Makcik, semalam misi ada bagi ubat tak? Kencing makcik kuning lagi eh? Biar Sue lap makcik. Pas tu, makcik rehatlah ye. *(Aunty, did the nurse give you medicines yesterday? Your urine looks yellow right? Let me clean you up. Then, you can have some rest.)*
6	M/L	Ah ah. Lepas Sue selesai, makcik rehat. Nanti Sue datanglah, makcik kenalkan anak makcik. Arrr… *(Ahah.I'll rest after you're done. You drop by laterlah, so I can introduce my children to you. Arrr…)*
7	N	Kalau ada masa, Sue datang, kena bagi ubat lagi. Nanti bila ubat habis, Sue datang tukar. Makcik rehatlah. Lama lagi anak makcik datang. *(If I have time, I'll come. Moreover I need to give medicines. When it finishes, I'll come and change it. You have some rest. It will take some time for your children to come.)*

Example 10, shows an example of pre-closing. Sacks and Schegloff (1973) say a pre-closing consists of two-turns and words like '*OK*' or '*all right*'. Usually the pre-closing with such words ends with a falling tone and this is the indication of the closing.

On the other hand, in *Example 11*, the nurse in T7, has mentioned to the speaker that she would come to visit the patient later to give her some medicine. When the patient invited the nurse to meet the children, the nurse was not sure about the meeting. But to close the conversation politely, she said "*Moreover I need to give medicines. When it finishes, I'll come and change it*". This indicated that the nurse used the pre-sequence type of closing to leave the conversation politely by making an arrangement to meet later. This is a polite way to leave without hurting the other party and also to maintain the face of the listener.

4.4.5.1 Types of Closing

Closing on the other hand is very simple as the speaker just ends the conversation by just *good bye* or *bye* if the second speaker is willing to end the conversation and there is no initiation of a new topic. Example 12, 13 and 14 below show each category of closings, which has been found in the data.

Example 12 Pre-Closing: *Extracted from Conversation 1 (Source Language-SL)*

18	S3	Fever? Temperature?
19	S1	If fever goes up, we'll give antibiotics.
20	S3	Ok ma.*(Ok ma)*
21	S1	Ok aunty.

Example 13 Pre-Sequence: *Extracted from Conversation 4 (Source Language-SL)*

8	S2	Hmm! Ok.
9	S1	Put up your hands. Is it painful?
10	S2	Cold. Not painful.
11	S1	Ok, have some rest after this. I'll come after 2 lah.

Example 14 Pre-Sequence :*Extracted from Conversation 8 (Source Language-SL)*

11	S3	Okay.. (Showing eye signal) not to say it's cancerous.
12	S2	Critical. But nothing right?
13	S1	Uncle, you stop stressing yourself and go and have some rest. Doctor is going to come for rounds. Take care uncle.
14	S2	Hmmm. Ask the doctor later about the report and what does the scan shows?
15	S3	Listen. Don't worry and just rest

T20 and T21 show that *pre-closing* is being used. The speakers used 'okay' to end the conversation. Example 13 explains that the speaker has used *pre-sequence* type of closing where she makes an arrangement to meet the patient after two, whereas in Example 14, the speaker also uses the pre-sequence type of closing in order to express positive wishes like *take care* and *don't worry and just rest*. Only 2 types of closings are commonly used is this study because this is a talk in interaction (See 2.6.6). Closings usually occur in telephone conversation where speaker says *good bye* or *bye*, if there is no new topic initiated. Hence, closings as mentioned by Button (1987:102) in *Discourse Analysis* "may be extended by repetition of pre-closing and closing items". For example, *see you later/ see you, love you/ love you too, have a nice day/you too* and many more.

4.5 Summary

As stated earlier the objective of this study is to investigate the address forms used only in the beginning and closing of a conversation. Both quantitative and qualitative analysis showed that most nurses use address forms to start, end and throughout the conversation. This study supports Gaudart (2008) stating that Malaysians are trained to use the term 'uncle' and 'aunty' to address older people since they are

very young. The frequency tables showed that nurses use terms like ‘mak cik’ and ‘pak cik’ which also means ‘aunty’ and ‘uncle’. This is where the accommodation theory comes in where nurses accommodate with their patients depends on the ethnicity and background of the patient. This was supported by Giles (1973) where he mentioned that accommodation is based on identity, context and situation (See Literature Review).

Chapter 5

CONCLUSION

5.1 Introduction

The aim of the study was to identify the forms of addresses used by nurses when interacting with patients. And by doing so, many aspects of a two way communication were revealed; these include language accommodation, cultural factor in choice of words and age factor in choosing the appropriate forms of address. By analyzing the survey and the conversations between the nurses and patients in UMMC, a pattern was identified. The researcher is able to summarize specific components of effective nurse-patient communication within these conversations such as the forms of address in openings and closings of a conversation. These findings are beneficial for future research or programmes that might need information about how nurses should communicate with patients.

This research started with identifying objectives and building research questions based on these objectives. In order to conduct this research effectively, the researcher having read relevant literature to adopt a suitable research methodology. Questionnaires and observations were the methods used in collecting the data. The collected data were then analyzed and some important factors of the study such as the different forms of addresses used by the nurses when communicating with patients of different age groups and different ethnicity were determined.

Some findings of the study showed that most of the nurses who took part in this study use address forms to address their patients. For example, when the nurses responded that they do not use forms of address, either in the beginning or at the ending of a conversation with the patients, the patients can perceive this differently as an “unfriendly nurse” or “rude nurse’ thus diminishing the confidence and esteem in the

patient, and nurses could be perceived as patronizing. This will not happen when the nurses do not use proper address forms when closing the conversation with their patients. Such instances are not many yet one of the questions which can be generated from this study is what are the forms of addresses used by the nurses in UMMC, how many nurses emphasize the importance of using appropriate address forms. There is a big difference when the nurses ask “are you able to eat or drink anything?” and “Uncle/ Hello/ Hi/ the patients names, are you able to eat or drink anything?” The nurse practitioners should be aware of what they are saying and whether these instances have detrimental effects on their patients. The researcher believes that nurses in general would not be able to reflect on their communication and its effect when there is no research conducted on their conversations with the patients. The methodology used in this study offers a solution to this limitation.

There is a need for nurses to develop self-awareness in the area of verbal skill and in the potential to receive different interpretations of what one understands as openings and closings and the use of address forms in the openings, and closing of a conversation. Such knowledge could contribute to growth and development even in the most experienced practitioners.

As language is living and constantly changing and the data in this study was analyzed and interpreted in relation to a specific time and context, readers must be mindful of the possible limits this imposes on future applications of the findings.

A potential weakness in this study was the assumption that all nurses will be excellent communicators. As discussed in chapter 3 the nurse participants were randomly selected from a group of nurses who worked in the surgical ward of East Tower, UMMC. There was no preliminary screening of the participants to determine if their communicational skills were excellent.

The researcher used random sampling to identify the participants of the survey. Since language and ethnicity is one of the aspects of this study, the sampling technique can be perceived as another weakness. A more suitable sampling technique would be stratified sampling. Stratified sampling is when a certain number of respondents are randomly selected from the three groups i.e. Malays, Indians and Chinese.

5.2 Recommendation

The outcome of the research provides lessons for nurse practitioners, whether they are novice or expert, nurse educators, nurse managers and researchers. The data in this study shows that expert nurses, despite enormous variation in the nature of their verbal interactions, nevertheless follow a pattern in their talk with patients. The pattern takes the form of: negotiating the agenda, eliciting information, doing a physical examination and planning care. Identifying this pattern is useful as a guide for novice nurses who are learning how to approach a domiciliary visit. For expert nurses the pattern acts as a standard against which practice can be measured. And the process of reviewing and reflecting on a recorded interaction is a valuable means of affirming effective practice and identifying areas to be improved. These features of effective nurse-patient communication can be identified and learned. The use of effective language is not only a skill which nurses can add to their repertoire but it can also be used as a measure of nursing expertise. In their professional development nurses benefit from opportunities to review and reflect on their practice. This work suggests that hearing a recorded interaction could be incorporated as part of the process of achieving this.

This report exposes the potential therapeutic effect of the ‘everyday’ conversations between nurses and patients. In particular it draws attention to the way in

which small talk and commentary can enhance the purpose of nursing. Even the best nurse communicators need support in order to be effective.

5.3 Significance of the study

There is potential for this study to contribute to a much more substantial work on nurse-patient communication. It would be useful to repeat the study using a larger group of participants, including novice nurses, and a different setting for example a hospital ward. A priority would be to seek the patients' agreement in collecting the data.

5.4 Summary

This study was born of a belief that the communication skills of nurses affect the clinical outcomes for their patients. As a first approach to this hypothesis, I have examined the literature on the characteristics of effective communication, have devised a field investigation of actual nurse-patient communication and have analyzed the data for significant features.

A review of the literature indicated that effective communication is important for patients, nurses and the positive outcomes of health care. In some circumstances, communication actually constitutes nursing care. However much of that literature about nurse-patient and doctor-patient communication focuses on the failures or shortcomings of this activity and what might or should be done to remedy the situation. The literature is sporadic with little evidence of dialogue, development or comparisons between studies. There is a gap in our knowledge of the actual features of expert nurse-patient communication.

In this research, I have attempted to determine and examine these features. I have recorded the interactions of the selected nurses with patients as they occurred in everyday practice. Few conversations involving more than five nurses and 10 patients

were transcribed and analyzed using a combination of ethnography and discourse analysis.

The analysis showed that all conversations had a number of common features. Interesting and unexpected findings were the use of humour and, more importantly, the distribution of talk between the participants. Communicative strategies were identified and found to be common to all conversations. These were: the use of humour, small talk, accommodation and multifunctional questions. As described by Johnson (1993) every conversation follows a pattern in terms of its structure and content. This included: negotiating the agenda, eliciting information, doing a physical examination and planning future care.

In addition, I found another feature which seemed to be an essential ingredient in the accomplishment of nursing goals: relational practice. Relational practice is the communication work that goes in to build the relationship between careers and patients that supports their mutual activities and endeavors' and goes largely unnoticed. Relational practice encompassed both the transactional and social elements of the conversations. Nurses used relational skills to build rapport, avoid or repair misunderstandings and enhance the patient's own ability to manage their health. The findings indicate that while the conversations may appear to be predominantly light, superficial and inconsequential, the nurse is working in a complex and effective way to achieve a communicative environment.

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APPENDIX A

Date : 23rd November 2010 : After a several times of meeting

S1 : Nurse A

S2 : Patient A

S3 : Patient's wife

Conversation 1 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	Hello, uncle .
2	S3	Vaa Maha. Saptiya?
3	S1	Yesss, aunty Naa inniki samichitu vanteney !
4	S3	Yess ahh. Enna samichigey ?
5	S1	Naaa vanthu mutton, sambar and ah somemore what… ah…salad eduthutu vanthen.
6	S3	Wah, very good lah you. You cook everyday ah?
7	S1	Nolaa aunty. Aunty, Appadi nuu ille, we all ladies aunty. It's not that I'm talking proud… my hobby is cooking la aunty. I love to cook.
8	S3	Very goodlah. Soo, Deepavaliku vittuku polle?
9	S1	Sure aunty. Got two days holiday. Going back to JB lah.
10	S2	Where are you staying maa?
11	S1	I'm staying here only uncle, opposite the hospital, the apartment.
12	S2	Oh, how much is the rental there?
13	S1	RM1000 uncle. Three of us are living there. We share uncle.
14	S3	So, how BP all okay ah?
15	S1	Ok aunty
16	S3	Not low ahh?
17	S1	No aunty, it's okay.
18	S3	Fever? Temperature?
19	S1	If fever goes up, we'll give antibiotics.
20	S3	Ok ma.

21	S1	Ok aunty.

Date : 23rd November 2010 : After a several times of meeting

S1 : Nurse C

S2 : Patient B

Conversation 2 : Wad 7U (55)

Turns	Speakers	Utterances
1	S1	Halo uncle. Hari ini baikkah?
2	S2	Sakit belakanglah. Selalu tido saja, rasa boringlah.
3	S1	Sikijap ahh uncle; takde sakit punya. Saya mahu check pressure uncle saja.
4	S2	Ahh…Ahh (While Nodding the head)
5	S1	So, mana isteri you uncle? Hari ini tak datang??
6	S2	Nanti datanglah dia. Macam mana o.k ?
7	S1	Pressure uncle kurang lah. Pressure okay tapi heart beat low. Nanti biar doktor mari check. Uncle tidur dulu lah.
8	S2	Boleh turun bawah tak. Nak pergi jalan sekejap sampai luar?
9	S1	Uncle, rehatlah ye. Nanti I yang kena marah. Nie, jaga ayah, ye?

Date : 24th November 2010 : After a several times of meeting

S1 : Nurse D

S2 : Patient A

Conversation 3 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	Helo pak cik. Apa khabar hari ini? Badan baik?
2	S2	(Nod the head) Ya, tapi demam saja belum turun. Why the fever has not gone down?
3	S1	Demam pak cik belum turun lagi? Semalam apa doktor cakap?
4	S2	Doctor cakap mahu bagi antibiotic, tapi belum…
5	S1	Nantilah, tanya doktor. Doktor datang pukul 9.30.

6	S1	(look at the time)
7	S2	Pak cik rehat dulu sampai doctor datang. Saya check pressure pakciklah.
8	S1	(Nod the head) hmmmm

Date : 24th November 2010 : After a several times of meeting

S1 : Nurse B

S2 : Patient C

Conversation 4 : Wad 7U (58)

Turns	Speakers	Utterances
1	S1	Hello mak cik, dah makan??
2	S2	Baru makan sarapan tadi…pagi…
3	S1	Makan apa…?
4	S2	Makan roti ngan planta. Ade lelaki yang gemuk datang gi..pagi tadi
5	S1	(Laughs) Oh, yang itu, orang yang ambil order. Mereka kerja untuk tukang masak kot.
6	S2	Eh, penat dan lesu lah, kat rumah bole tengok cucu…main, sini macam tiada apa yang nak buat
7	S1	Ah, tengok, suhu makcik turun banding semalam. Kalau turun lagi… tak demam, takde infection, nanti boleh balik cepat. Tulah, mak cik rehat dulu, Ikah check pressure.
8	S2	Hmm! Ambillah
9	S1	Angkat tangan mak cik. Sakit tak?
10	S2	Sejuk. Tak sakit
11	S2	klah, mak cik rehatlah lepas nie..Ikah datang lepas pukul 2 lah.

Date : 25th November 2010 : After a several times of meeting

S1 : Nurse C

S2 : Patient A

Conversation 5 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	Khabar baik uncle? Sudah makan? Hari ini ade demam? Urine ok?
2	S2	Hmm (Nodding the head) o.k
3	S1	Hari ini makan apa, uncle?
4	S2	Buah- buahan saja.
5	S1	Uncle, semalam you demam, ada bagi antibiotik tak?
6	S2	Antibiotik dan susu (Nodding)
7	S1	Eiii…kenapa demam lagi? Nanti biar doctor datang check lah. Ok yeh uncle.
8	S2	Arrr

Date : 25th November 2010 : After a several times of meeting

S1 : Nurse A

S2 : Patient A

S3 : Patient's wife

Conversation 6 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	How are you uncle?
2	S2	A bit better, I think the fever has gone down now.
3	S1	Nurse enna sonnangey?
4	S2	Morning, the nurse…arrr….arrr, the nurse
5	S3	The nurse told if he's fever has gone down totally, the doctor will prepare to put the stand in. They have done the scan but we are waiting for the report.
6	S1	Avanggey unnum ethuvume sollaley thane? Appe…nenggey kavallai padathingey, chumma uncle ahh motivate panugey aunty.

7	S3	Uncle ah!! Very difficult lah he. Always negative thinking. Always think nonsense and disturb his mind. He should rest. Tell him oso no point. Vai thaan vallikithu.
8	S1	Appadi thaan aunty. (laughs) poga poga he'll be ok. Don't worry lah. Naan appadiye rounds ku poittu vanturen. Serrriya (Smiles)?

Date : 26th November 2010 : After a several times of meeting

S1 : Nurse D

S2 : Patient D

Conversation 7 : Wad 7U (56)

Turns	Speakers	Utterances
1	S1	Mak cik dah makan?
2	S2	belum. Tunggu anak datang
3	S1	Ohh, anak aunty bawa bekal ke?
4	S2	Ah..Ah.. nie kan hari ahad, nanti, anak mak cik masak dan bawa ke hospital.
5	S1	Oh, Aunty ada berapa orang anak?
4	S2	Makcik ada 6 orang anak. 4 lelaki dan 2 pumpuan.
5	S1	Mak cik, semalam misi ada bagi ubat tak? Kencing mak cik kuning lagi eh? Biar Sue lap mak cik. Pas tu, mak cik rehat lah ye.
6	S2	Ah ah. Lepas Sue selesai, makcik rehat. Nanti Sue datanglah, mak cik kenalkan anak makcik. Arrr…
7	S1	Kalau ada masa, Sue datang, kena bagi ubat lagi. Nanti bila ubat habis, Sue datang tukar. Mak cik rehatlah. Lama lagi anak mak cik datang.

Date : 26th November 2010 : After a several times of meeting

S1 : Nurse A (Indian)

S2 : Patient A (Indian)

S3 : Patient's wife

Conversation 8 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	Hello uncle how are you today? Taken your dinner?
2	S2	Oh, you are working night shift ah today
3	S1	Ammah uncle, every two days once night shift.
4	S2	So, what did my reports shows?
5	S1	Your report is still not out uncle. We are waiting for the professor to look into your case.
6	S3	Why? How long already still not out
7	S1	See, aunty, we are just the nurse. Nambe yethuvom sole mudiyathu. Terinja kode solla mudiyathu… because if the patient gets to know before the doctor confirm, we will be in problem
8	S2	(Confused faced) Yes, the doctor said it's a list and not sure it's cancerous or not. Is it cancerous?
9	S3	You stop talking about cancer, cancer! Think positively
10	S1	(Smiled) we are not sure uncle. When the doctor comes for round, you can ask. Yenna, uncle ode nellamai critical ah irukey aunty.
11	S3	Seri.. (show xxxxx sign) not to say its cancerous
12	S2	Critical. But nothing right?
13	S1	uncle, neengey stress panamel poi rest edungey. Doctor is going to come for rounds. Take care uncle.
14	S2	Hmmm. Ask the doctor later about the report and what does the scan shows?
15	S3	Don't worry and just rest

APPENDIX B

TRANSLATION OF THE SOURCE LANGUAGE

Conversation 1(a)

S1 : Nurse A

S2 : Patient A

S3 : Patient's wife

Conversation 1 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	Hello, uncle.
2	S3	Come, Maha. Have you eaten?
3	S1	Yes aunty. Today, I cooked and brought to work.
4	S3	Yes ah? What did you cook?
5	S1	I brought mutton, dhal curry and ah somemore what ah….. salad.
6	S3	Wah, very good lah you. You cook everyday ah?
7	S1	Nolah aunty. Not like that, aunty, we are all ladies aunty. It's not that I'm talking proud… my hobby is cooking la aunty. I love to cook.
8	S3	Very goodlah. Soo, are you going back for Deepavali?
9	S1	Sure aunty. Got two days holiday. Going back to JB lah.
10	S2	Where are you staying maa?
11	S1	I'm staying here only uncle, opposite the hospital, the apartment.
12	S2	Oh, how much is the rental there?
13	S1	RM1000 uncle. Three of us are living there. We share uncle.
14	S3	So, how BP all okay ah?
15	S1	Ok aunty
16	S3	Not low ahh?
17	S1	No aunty, it's ok.
18	S3	Fever? Temperature?
19	S1	If fever goes up, we'll give antibiotics.

20	S3	Ok ma.
21	S1	Ok aunty.

Conversation 2(a)

S1 : Nurse C

S2 : Patient B

Conversation 2 : Wad 7U (55)

Turns	Speakers	Utterances
1	S1	Hello, uncle. Are you fine today?
2	S2	Having some back painlah. Every time sleeping only, I feel very boredlah.
3	S1	Hold on, uncle; it won't be painful. I just want to check your pressure.
4	S2	Ahh ahh
5	S1	So, where's your wife uncle? Is she coming today?
6	S2	She'll come laterlah. How's it? O.K ah?
7	S1	Your pressure is low uncle. Pressure still OK but heart beat low. Let the doctor come and check you.
8	S2	Can I go down? I just want to go for walking till outside.
9	S1	Uncle, you just rest ok. Then I will get scolding. You, take care of dad, ya!

Conversation 3(a)

S1 : Nurse D

S2 : Patient A

Conversation 3 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	Hello, uncle. How are you today? Is your body feeling good?
2	S2	(Nod the head) Yes, but the fever has not gone down. Why the fever has not gone down?
3	S1	Your fever hasn't gone down? What did the doctor say yesterday?

4	S2	The doctor said that he wants to give antibiotics but not yet…
5	S1	Later, you ask the doctorlah uncle. Doctor will come at 9.30
6	S2	(look at the time)
7	S1	You just take rest till the doctor comes. I'll check your body temperature and pressurelah.
8	S2	(Nod the head) hmmmm

Conversation 4(a)

S1 : Nurse B

S2 : Patient C

Conversation 4 : Wad 7U (58)

Turns	Speakers	Utterances
1	S1	Hello aunty, have you eaten??
2	S2	Just ate my breakfast… morning…
3	S1	What did you have?
4	S2	I had bread with planta. A fat man gave me…this morning.
5	S1	(Laughs) Oh, that's the guy who takes order. Ithink he works for the chef.
6	S2	Eh, I'm tired lah. At home, I can look after grandchildren… playing, here there's nothing to do.
7	S1	Ah, look, your temperature has gone down compare to yesterday. If it reduces more…no fever, no infection, you are free to go back. That's why, you should take rest, I will check your pressure.
8	S2	Hmm! Ok.
9	S1	Put up your hands. Is it painful?
10	S2	Cold. Not painful.
11	S1	Ok, have some rest after this. I'll come after 2 lah.

Conversation 5(a)

S1 : Nurse C

S2 : Patient A

Conversation 5 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	Are you Ok uncle? Had your meal? Today got fever or not? Urine ok?
2	S2	Hmm (Nodding the head) O.K
3	S1	What did you have today, uncle?
4	S2	Just fruits.
5	S1	Uncle, did they give you antibiotics for your fever yesterday?
6	S2	Antibiotics and milk. (Nodding)
7	S1	Eiii…why are you still having fever? Let the doctor come and check you later uncle. Ok ya uncle.
8	S2	Arrr

Conversation 6(a)

S1 : Nurse A

S2 : Patient A

S3 : Patient's wife

Conversation 6 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	How are you uncle?
2	S2	A bit better, I think the fever has gone down now.
3	S1	What did the nurse say?
4	S2	Morning, the nurse…arrr….arrr, the nurse
5	S3	The nurse told if he's fever has gone down totally, the doctor will prepare to put the stand in. They have done the scan but we are waiting for the report.
6	S1	They did not inform anything right? Then…you don't worry, just keep on motivating unclelah, aunty.
7	S3	Uncle ah!! Very difficult lah he. Always negative thinking. Always think nonsense and disturb his mind. He should rest.

		Tell him oso no point. My mouth only painful..
8	S1	It's like that aunty (laughs). He'll be ok as time goes. Don't worry lah. I'll just go for rounds and come. Ok (smiles)?

Conversation 7(a)

S1 : Nurse D

S2 : Patient D

Conversation 7 : Wad 7U (56)

Turns	Speakers	Utterances
1	S1	Have you eaten, aunty?
2	S2	Not yet. Waiting for my children to come.
3	S1	Ohh, are your childrens bringing food?
4	S2	Ah..Ah.. since it's Sunday, my children will cook and bring for me.
5	S1	Oh, how many children do you have?
4	S2	I have 6 children. 4 boys and two girls.
5	S1	Aunty, did the nurse gave you medicines yesterday? Your urine looks yellow rite? Let me clean you up. Then, you can have some rest .
6	S2	Ah ah.I'll rest after you're done. You drop by laterlah, so I can introduce my chidren to you. Arrr…
7	S1	If I have time, I'll come. Moreover I need to give medicines. When it finishes, I'll come and change it. You have some rest. It will take some time for your children to come.

Conversation 8(a)

S1 : Nurse A (Indian)

S2 : Patient A (Indian)

S3 : Patient's wife

Conversation 8 : Wad 7U (57)

Turns	Speakers	Utterances
1	S1	Hello uncle, how are you today? Taken your dinner?
2	S2	Oh, you are working night shift ah today?

3	S1	Yes uncle, every two days once night shift.
4	S2	So, what did my reports shows?
5	S1	Your report is still not out uncle. We are waiting for the professor to look into your case.
6	S3	Why? How long already still not out
7	S1	See, aunty, we are just the nurse. Even if we know, we can't say anything… because if the patient gets to know before the doctor confirm, we will be in problem
8	S2	(Confused faced) Yes, the doctor said it's a list and not sure it's cancerous or not. Is it cancerous?
9	S3	You stop talking about cancer, cancer! Think positively
10	S1	(Smiled) we are not sure uncle. When the doctor comes for round, you can ask. It's just that uncle's situation is a bit critical.
11	S3	Okay.. (show eye sign) not to say its cancerous.
12	S2	Critical. But nothing right?
13	S1	Uncle, you stop stressing yourself and go and have some rest. Doctor is going to come for rounds. Take care uncle.
14	S2	Hmmm. Ask the doctor later about the report and what does the scan shows?
15	S3	Listen. Don't worry and just rest

QUESTIONNAIRE

Thank you for participating in my research. The objective of this questionnaire is to find out what are the forms of address used by nurses to address patients when starting and ending a conversation. This questionnaire will also find out the languages that you use with your patients and how you start and end a conversation. If you have any questions regarding this questionnaire, please contact Thinusha a/p Selvaraj at 016-6105157. All the information in this questionnaire is confidential and only for research purpose.

Instructions:

Mark only one choice per question for the required information. Put a tick or a cross for the suitable response below. Write short answers for the required questions.

Part 1 : General Personal Particulars. Tick more than one if it's applicable.

1. I am _____ years old.
2. I am a/an : Malay ( ) Chinese ( ) Indian ( ) Others ( )
3. I am a : Male ( ) Female ( )
4. I can speak _____ languages.

   Malay ( ) Chinese ( ) Tamil ( ) English ( ) More than 3 ( )

Part 2: This section investigates how you address patients. It also examines how you start and end a conversation.

A. Write short answers to support your answers. This section examines how you address patients.

1. I address children by calling them

   _____

2. I address patients who are younger than me by calling them

_____

3. I address patients who are older than me by calling them

_____

B. Fill in the brackets using the likert scale given below. This section contains 4 parts *(a,b,c,d)*. Answer all the 4 parts. Some statements may require short answers.

5	**Always**
4	**Often**
3	**Sometimes**
2	**Seldom**
1	**Never**

a. Statement regarding Address Forms

i. I use address forms with patients when I start my conversation. ( )

Why: _____

ii. I use address forms with patients when I end my conversation. ( )

Why: _____

iii. I use address forms from the beginning until the end of my conversations. ( )

Why : _____

b. Statement regarding Language

I sometimes use other languages to start and end conversations while communicating with my patients to maintain the closeness. ( )

From question i to iii, underline the languages that you use with your patients.

i. I use Malay/ Chinese/ Tamil/ English with Malay patients.

ii. I use Malay/ Chinese/ Tamil/ English with Chinese patients.

iii. I use Malay/ Chinese/ Tamil/ English with Indian patients.

c. Statement regarding Openings

I start my conversation

i. with greetings. *(e.g: Hello, Hi, how are you)* ( )

ii. by inquiring about my patient's health . ( )

iii. by talking unrelated things. *(not related to health and medical field)* ( )

d. Statement regarding Closings

I end my conversations

i. by saying '*see you later*', '*I'll come later*'. ( )

ii. by just saying 'bye', 'rest' . ( )

iii. without a proper ending. *(e.g : just walk away)* ( )

Thank you for participating in my research.

Your contribution is much appreciated.

APPENDIX D

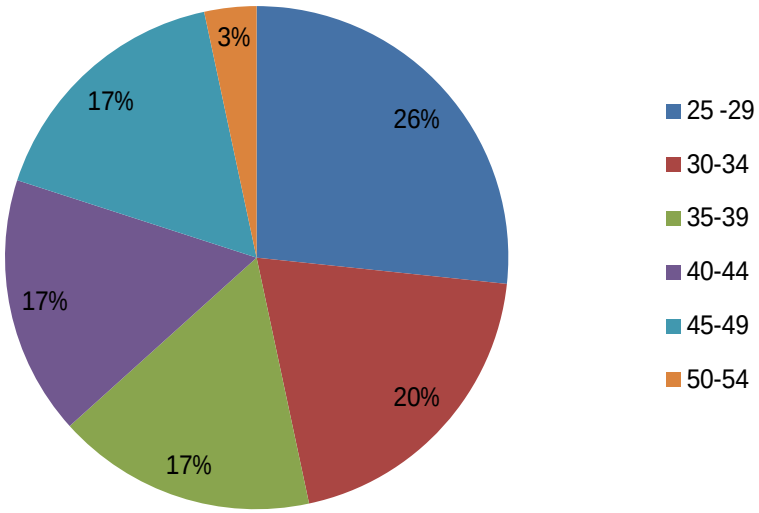

Figure 4.1: Age distribution (%) of the respondents

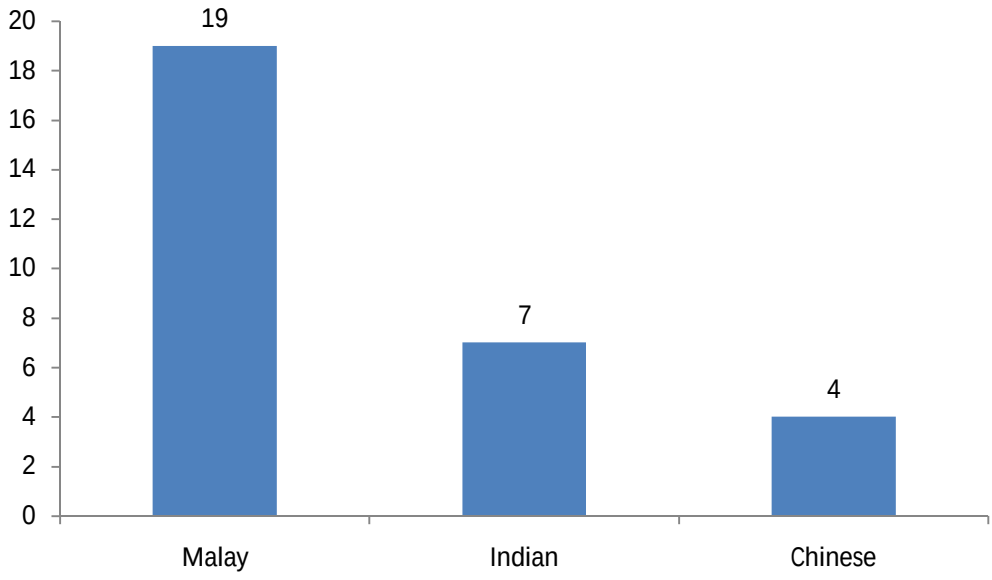

Figure 4.2: Distribution of ethnicity among the respondents

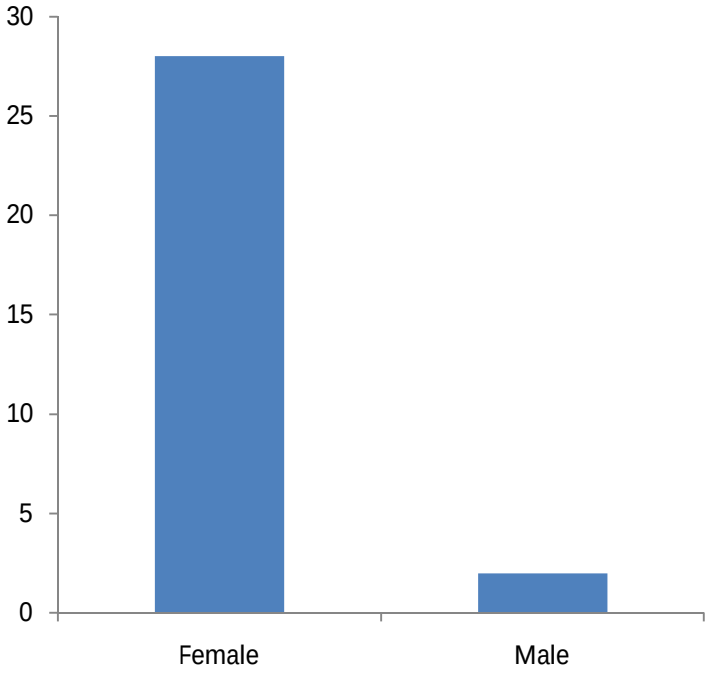

Figure 4.3: Gender distribution among the respondents

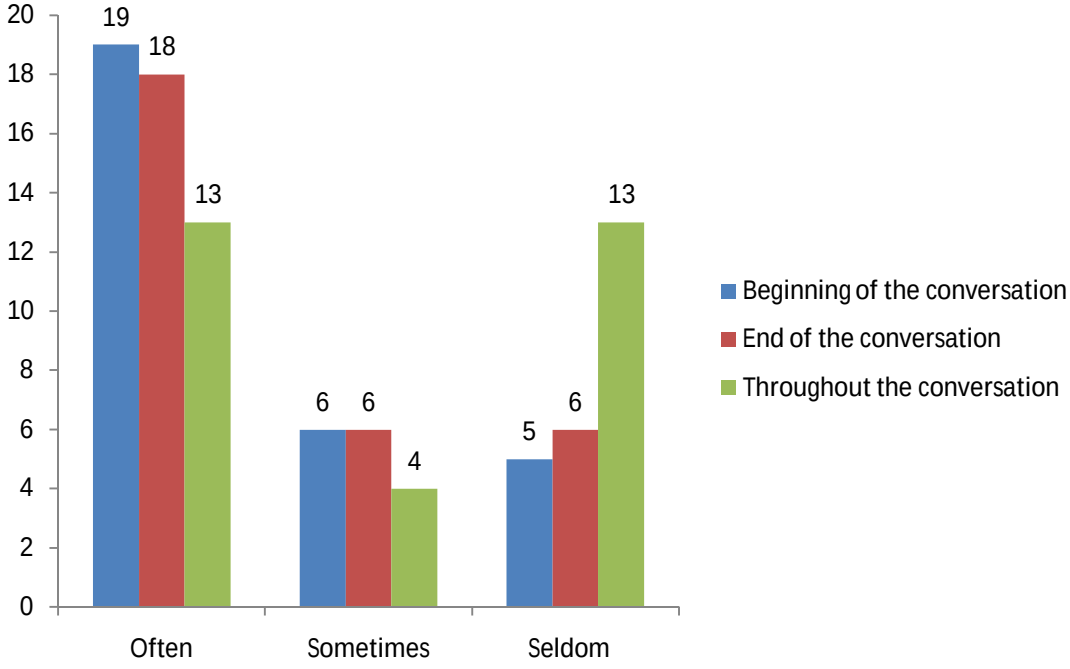

Figure 4.4: Distribution of address forms usage frequencies at three different stages of conversation