Towards closing the gap on ELF and nursing

- an inquiry of nurses' views on ELF communication

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Tutkielmassa tarkastellaan suomalaisten sairaanhoitajien englannin kielen käyttöä potilastyössä puolistrukturoitujen haastattelujen kautta. Tutkimuskysymyksen avulla selvitetään millaiset tekijät vaikuttavat onnistuneisiin ja epäonnistuneisiin tilanteisiin, joissa käytetään englantia lingua francana potilaiden kanssa sairaanhoitajien näkökulmasta. Onnistuneella tilanteella tarkoitetaan tässä tutkimuksessa kommunikaatiota, jossa sairaanhoitaja koki hoidon kannalta tärkeimpien asioiden tulevan ymmärretyksi hänen ja potilaan välillä. Epäonnistuneella tilanteella tarkoitetaan sairaanhoitajan ja potilaan välistä viestintää, jossa tarvittava keskinäinen ymmärrys jäi liian heikoksi sairaanhoitajan näkökulmasta.

Tutkielma pohjautuu soveltavan kielitieteen englanti lingua francana (ELF) –tutkimukseen keskittyen sairaanhoitajien ja potilaiden väliseen kommunikaatioon. Tutkielman taustaosiossa tarkastellaan ELF-tutkimusta ja määrittelyä teoreettisella tasolla sekä kuvataan aiempia hoitotyöhön liittyviä englanti lingua francana tutkimuksia.

Aineistona käytetään kevään 2020 aikana tehtyjä kuuden sairaanhoitajan haastatteluja sekä heidän taustatietojaan, jotka kerättiin kyselylomakkeen avulla. Puolistrukturoidoissa haastatteluissa käytettiin aiempien tutkimusten ja tutkielman kirjoittajan omien sairaanhoitajakokemusten pohjalta kehitettyjä haastattelukysymyksiä. Aineisto analysoitiin temaattisesti sairaanhoitajiin, potilaisiin ja hoidontarjoajiin liittyvien tekijöiden kautta, jotka vaikuttuvat sairaanhoitajien ja potilaiden väliseen kommunikaatioon.

Sairaanhoitajat raportoivat englanninkielisen kommunikaation olevan enimmäkseen onnistunutta ja pyrkivänsä selvittämään sellaiset tilanteet, joissa he huomasivat keskinäisen ymmärtämisen heidän ja potilaan välillä olevan heikkoa. He käyttivät erilaisia sanallisia ja sanattomia keinoja, esimerkiksi lauseen uudelleen muotoilua sekä kehonkieltä, helpottaakseen kommunikaatiota potilaiden kanssa. Tuloksista käy ilmi, että sairaanhoitajan työkokemus ja hyvä englannin kielen taito tukevat englanninkielistä kommunikaatioita potilaiden kanssa johtaen onnistuneisiin kommunikaatiotilanteisiin. Lisätutkimusta tarvitaan selvittämään miten edellä mainitut tekijät vaikuttavat onnistuneeseen ELF kommunikaatioon sairaanhoitajan ja potilaan välillä käytännön tilanteissa.

Avainsanat – Nyckelord – Keywords
sairaanhoitaja, hoitotyö, ELF, kommunikaatio

Säilytyspaikka – Förvaringställe – Where deposited
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1.1 INTRODUCTION

My interest for the topic of English as a *lingua franca* (ELF) in work environment stems from the experiences I encountered and heard of when working as a registered nurse, and later pondering those incidents during a linguistics course in university which was focusing on ELF. Nursing in the capital area of Finland has been linguistically varied for the last two decades due to increased immigration and global mobility. This change in the demography has two main effects on nurses who are native speakers of Finnish: firstly, they encounter non-Finnish speaking patients more often and secondly, they have colleagues and other associates with whom they do not share a native language. My own experience was that although cooperation with colleagues and other health care professionals who were non-Finnish speakers was usually intelligible enough, challenges arose with patients who spoke very little Finnish or English. Later on, while studying English being thus aware of the possible consequences of miscommunication, exploring the issues around nursing and ELF was a natural point of interest and the topic for my BA thesis (Ritala, 2017). My choice of method for studying the phenomenon was a questionnaire for nurses in the capital area hospitals. In the questionnaire I identified, after a literature review of ELF and multicultural nursing studies, the factors and scenarios which are likely to cause breakdowns of communication in the multilingual nurse-patient relationship. The findings of the preliminary questionnaire supported the previous studies and prompted an interest to study the strictly targeted, yet important phenomenon of nursing ELF in Finland. Having formed an overall picture of the experiences nurses face when delivering care in English, I decided to explore the issue further through interviews. There are two major themes in the interviews: the successful and unsuccessful ELF situations in nurse-patient relationship and the factors which influence them. A successful experience in this context means a situation in which the nurse considers the communication to be fluent enough for both participants to understand each other. An unsuccessful experience would be an ELF situation in which the nurse considers the communication to be disfluent enough to impede a satisfactory understanding between her/himself and the patient. By dividing the experiences into these two main categories, some factors which facilitate or impede the nurse-patient communication in English can hopefully be identified, given that there are similar experiences among the participants. Therefore, the research question for this study is

- What kind of factors contribute to successful and unsuccessful nursing ELF situations with patients from the nurses' point of view?

1.2 Background

Globalisation and immigration are the two major reasons why professionals use English in their daily working life, in health care and other fields. The national survey on the English language in Finland looked into the use of the language in Finns' daily lives, both in workplace and free time, and reported that almost half of the respondents used English at work at least every week (Leppänen, et al., 2011, p. 120). Likewise, one in four respondents saw or heard the English language being used in hospitals and other health care facilities frequently in their everyday lives (Ibid. p. 69). These responses indicate that English is a prominent feature in health care professionals' and clients' lives nowadays and national statistics give an indication of how often nurses encounter and communicate with patients in other than the official domestic languages Finnish and Swedish. For example, the national demographics from 2018 show that there were over four-hundred thousand people of foreign origin in Finland (Statisctics Finland, 2019A). The percentage of people who spoke other than non-domestic languages of Finnish, Swedish spoken in Finland and Samí was a little over seven in the same year in the whole country (Statistics Finland, 2019B). In the capital region Uusimaa the percentage of non-domestic languages spoken was over twelve percent (Statistics Finland, 2018). The ten largest groups of non-domestic languages in 2018 were Russian, Estonian, Arabic, Somali, English, Persian/Farsi, Chinese, Albanian, Vietnamese and Thai (Statistics Finland, 2019C). It can be inferred that at least a part of these people who do not speak domestic languages use English as means of communication while visiting a health care provider.

Although there are no statistics available of the number of health care visits made by people of foreign origin or what language they spoke during the visit, the most recent study which gives some indication of the matter is a study made by Statistics Finland in 2014. This study, *The survey on work and well-being among people of foreign origin* is the most extensive Finnish population study which focuses solely on the people of foreign origin (THL, 2014). According to the study, people of foreign origin estimated their health as average or worse than average less frequently than the rest of the population (Ibid., p. 153). The study mentions also that people of foreign origin have an even stronger confidence in the Finnish health care system than the rest of the population (Ibid. p. 172). The self-estimated need for services of a health centre physician was more prevalent in all populations of people from foreign background compared to the total population (Ibid. p 173).

From these figures it can be assumed that especially in Uusimaa region, which has the largest immigrant population, English frequently serves as a contact language between nurses and patients who do not speak the domestic languages. Although interpreter services are used as needed, it requires previous planning to have an interpreter available for a health care visit which may not be possible with sudden manifestations of ill health. Usually, whether in primary care or in special health care units, patients interact most often with nurses. This means that nurses' English skills and using English as a lingua franca are put to the test whenever there is a patient who requires care in English. The goal of this study is to understand the recent phenomenon of delivering care in English in Finland from the nurses' point of view. A broadened view gained partially by this study, will hopefully in the future equip researchers and English language teaching (ELT) professionals to invent effective solutions of enhancing communication in ELF situations between nurses and their patients as much as possible.

In the next section of this thesis relevant previous studies are investigated and literature from the perspectives of general ELF studies, business and nursing ELF. Chapter three of the thesis discusses the implementation of the study and data collection. The fourth chapter lists the findings of the study from three different viewpoints: nurse-related, patient-related and workplace-related factors. This is followed by discussion of the findings and limitations and ethical considerations. The thesis ends with conclusions and recommendations for further studies.

2 PREVIOUS STUDIES AND LITERATURE

2.1 A brief look into the history and definition of English as a lingua franca

Although English as a lingua franca has been an object of intense study for especially the last two decades, research on nursing ELF is in its infancy, somewhat surprisingly, given the importance of communicative accuracy in health care. Therefore, to approach the subject and gain general understanding of the unique phenomenon, one must turn to at least two separate areas of research: applied linguistics concerning English as a lingua franca and multilingual nursing studies. ELF research discusses common features of ELF interactions in different fields and sheds light on the possibly important aspects to be explored in nursing ELF interactions. Recently, some studies concerning nursing ELF have been published which are of great aid tackling this new area of research in the Finnish context.

The study of English as lingua franca has evolved, according to Jennifer Jenkins, in three phases thus far (Jenkins, 2015). The first phase, 'ELF 1' started the empirical research into ELF communication in the late 1980's (Ibid. p. 52). It was during the first phase that the term 'English as a lingua franca' or ELF, became the established way of describing the use of English language in the ever-increasing non-native communication and the use of English as a contact language. Although the term was gradually agreed upon, the precise definition of it was and to some extent, still is an undecided subject. During the second phase, the concept of ELF was discussed and particularly if it involved the native speakers of English as well as the non-native speakers (Ibid. p. 55). The third phase of ELF research, which is ongoing at the time of writing this thesis, views ELF communication as an important part of multicultural communication (Ibid. p. 73). The development of ELF research is tied in part to the development of the definitions of ELF. According to Jenkins, in the most simplified form English as a lingua franca is defined as "*a means of communication between people who come from different first language (L1) backgrounds"* (Jenkins, 2012, p. 486). These people may or may not include people who speak English as their first language, and if they do, the linguistic agenda of ELF interactions is not determined by those for whom English is the L1 (Ibid p. 487). In Jenkins' view, although ELF interactions seem to form specific linguistic regularities, such as linguistic accommodating strategies and promoting plurilingual identity, English as a lingua franca is always heavily context-dependent, and therefore, it cannot be considered as a variety of the English language.

Mauranen defines ELF as a contact language between speakers or speaker groups in which there is at least one person using it as a second language, in addition of understanding it as a non-local vehicular language (p. 8). In her introductory chapter, she investigates ELF from the macro, meso and micro perspectives of social units, that is, from the societal to an individual level of language use (Mauranen, 2017, p. 8). On the macro level she notes that ELF encounters are often short-term and therefore seeing them as part of a speech community is unfitting (Ibid. p. 11). The meso perspective views ELF as the language use in social interactions, and in this thesis the focus is on the communicative interactions between nurses and patients (Ibid. p.12). The meso perspective includes strategies that endeavour to achieve communicative success such as linguistic accommodation and enhancing explicitness in order to create common ground between the speakers of ELF (Ibid. p.13). According to Mauranen, frequent paraphrasing, rephrasing and repetition are ways in which explicitness can be enhanced in practice. On the individual level, viewing ELF from micro perspective, she suggests that "*approximation is the most important cognitive processing phenomenon*"(Ibid p. 18). Approximation refers to the individual's ability to recognise and understand fuzzy language forms which deviate from the standard (Ibid. p. 14). In order to recognise non-standard language forms, antecedent linguistic entrenchment in the chosen language is required. Entrenchment is described as a continuous scale of linguistic units, such as words, in cognitive organisation and every use of a given unit impacts the degree of entrenchment positively (Langacker, 1987, p. 59). Frequent use thus enhances entrenchment of linguistic units and their vary in the strength or weakness of their entrenchment. In an ELF situation, English is at least one speaker's additional language and therefore English is less entrenched in their cognitive processes than a L1 would be to which Mauranen remarks that

> "Since we can assume a certain fuzziness in processing language forms that are less well entrenched, it is a reasonable assumption that ELF interaction leads to the strengthening of approximate forms in production." (Mauranen, 2017, p. 14)

She continues to explain that "*[b]y approximating intended expressions well enough, speakers can achieve communicative success*"(Ibid p. 18). Furthermore, the positive feedback gained from successful communication strengthens the linguistic units of the speaker and they become even more entrenched. However, it is notable that in ELF situations "*widening tolerance for fuzziness*" is required and in successful situations the speakers can adapt to this requirement (Ibid p. 18). Because professional standards and the variety of physical manifestations require nurses to tolerate fuzziness expressed by patients in describing their symptoms while

communicating in their first language, it can be assumed that nurses are prompt to adapt tolerating fuzziness and unclarity as they use English as a lingua franca with patients and thus achieve communicative success. It can be argued that the more frequently a nurse uses ELF with patients, the better different approximations of given linguistic forms are entrenched, and the better she/he becomes at recognizing approximations and achieves communicative success despite patients varying English skills. How close an approximation must be compared to standard form presumably varies on an individual level and it is unclear if the length of the care relationship affects the recognition of approximations as the individuals, the nurse and the patient, familiarise themselves with each other's idiolects.

ELF interactions are usually centred around completing a specific task by a certain people, and therefore it is sometimes useful to consider the interactions from the community of practice framework, although this framework is somewhat probematic. A community of practice (CoP) is a group of people who share a common repertoire to accomplish a common task and who interact regularly, and this term was first coined by anthropologists Lave and Wenger (Wenger, 2015). Seidlhofer started to view ELF interactions through the lens of CoPs after compiling the Vienna-Oxford International Corpus of English, the first general electronic corpus of spoken ELF (Vienna). This view of seeing ELF situations forming communities of practices, was according to Jenkins the starting point for the second phase of ELF research because it viewed ELF through the meaning negotiation process of individuals in ELF interactions (Jenkins, 2015, p. 55). Traditionally, CoP's are seen as somewhat stable groups which interact regularly and share some linguistic and social norms, for example a compilation of scholars from different universities meeting a few times a year in a conference to discuss a shared topic of research in English.

However, as noted earlier by Mauranen, ELF interactions are oftentimes more fleeting engagements than those which can be labelled as communities of practice working together and developing shared norms over a period of time. Mortensen has studied this phenomenon among multilingual encounters and calls these short-lived interactions between at least two participants as transient communities. Transient communities have three defining properties: they are emergent, heterogenous and involve work on some form of shared activity (Mortensen, 2017, pp. 273-4). In the transient communities according to Mortensen norms are developed on the spot as the participants are using their linguistic resources and sociocultural experiences in a specific context of interaction under some form of institution and wider cultural perspective, and this view is similar to Seidlhofer's view of ELF communities of practice (Ibid. p 273).

Mortensen marks that communities can be organised on the scales of transience and semiotic sedimentation. The scale of transience refers to the continuation of a transient community which ranges from one-off encounters to more stable and long-term communities. The scale of semiotic sedimentation focuses on the degree to which the participants '*share semiotic resources, including linguistic ones'* (ibid. p. 275). Depending on the interaction, encounters can range from onetime instances in which the participants share very little semiotic resources to regular meetings between participants who share a variety of cultural norms together. In health care settings, transient communities of nurses and patients range from the one-off instances to long-term care relationships. As Mortensen notes, in multilingual transient settings, there is an ongoing negotiation between the participants about the norms for appropriate conduct, because a pre-established shared framework is often not available (Ibid. p. 283). However, nurse-patient encounters are based on a set framework formed by health care legislation of a given country and the ethical code of nurses, which are known by nurses but not necessarily by the patients. As the norms regarding the appropriate professional behaviour of nurses are fixed as are the rights of patients, nurse-patient encounters might be understood as hybrid communities of practice, in which there is a norm centre, and a transient community in which encounters might be brief and fleeting with at least two participants, the nurse and the patient.

According to Jenkins and the three phases of ELF research, in the third phase ELF is seen as a part of multicultural communication rather than seeing multilingualism as a part of ELF (Jenkins, 2015, p. 73). This means that English is known to everyone present in a multilingual situation and is always "*potentially 'in the mix'* "despite the extend it is used, if at all (Ibid. p. 74). Jenkins urges that "*English as a multilingual franca*" research should, in the future, produce an alternative to CoPs which could better describe the often transient, ad hoc and fleeting ELF groupings and situations (Ibid. p. 76). This alternative, whatever it may be called, could grasp the nature of nurse-patient relationships better than the traditional understanding of CoPs as relatively stable communities. In summary, ELF in nursing can be seen as comprising of transient cooperation in nurse-patient relationship to complete specific tasks in a strictly regulated environment and their communicative success is dependent on the individuals' ability to recognise approximate forms of linguistics units. In this equation the nurses are required by legislation to make a greater effort to understand patients' approximations and presumable their ability to understand approximations improves over time because they interact repeatedly in similar situations with different patients.

2.1.2 Mis- and non-understanding in ELF

Mis- and non-understandings were a focus for Pietikäinen who studied established ELF couples by having them record naturally occurring speech for a period of time (Pietikäinen, 2018). According to Cogo and Pitzl, a non-understanding is a communication situation in which one or more participants realises a gap in understanding (Cogo & Pitzl, 2016, p. 340). A misunderstanding is defined by them as a lack of awareness by the participants at the moment it occurs and is noticed retrospectively by one or more of the participants, if noticed at all. A non-understanding can be therefore addressed and rectified immediately, but a misunderstanding cannot because the participants are not aware that an understanding problem has taken place during the incident (Cogo & Pitzl, 2016, p. 340).

The most notable result of Pietikäinen's study was that there were fewer misunderstandings than expected between the couples. They were resourceful in their corrective communication strategies whenever they noticed that there had been a misunderstanding, which were usually a result of speaking vaguely or confusingly about a reference point in the first turn of conversation (Pietikäinen, 2018, p. 208). The reason for being too an 'economical' speaker was thought be that the couples were settled and expected the partner to understand them with less conversational cues. But whenever they were aware of a misunderstanding, the couples used all available strategies to avoid miscommunication, for example extralinguistic means such as deixis, drawing and acting, probably due to their closeness and not being afraid losing one's face (Ibid. p. 208). Pietikäinen points out that this would not be expected in academic of business ELF situations, which require a certain professional image. However, in this respect nurse-patient relationships are more similar to the ELF couples' communication than to an academic or business discourse as they necessarily involve the patients sharing a great deal of very personal information with the nurse. Naturally, the sharing is not mutual but the degree of 'professional closeness' is much higher in nurse-patient relationships than in, say, academic or business settings. The ELF couples also demonstrated a high level of respect towards their partners, even in challenging situations for example when arguing, and avoided imposing on each other's, used self-repair and confirmation checks (ibid. p. 209). In this instance, too, the nurse-patient relationships resemble the ELF couple's relationships, because a high degree of respect for the patient is a core part of ethical code of nurses. Whether or not nurses are as resourceful as the ELF couples, who through shared experiences, have learned to expect and

undercut communication difficulties, presumably depend on the longevity of the nurse-patient relationship and the nurses' exposure to ELF encounters in general.

2.1.3 Disagreement and conflict in ELF

It can be presumed that not all communication in health care is harmonious because the issues discussed between nurses and patients are serious and the parties may have different aims and visions about the best course of action. Therefore, it is important to study what kind of experiences nurses have of situations in which one or both of the involved parties are disagreeing over a health issue.

In her study, Bjørge, studied conflict talk between international master's level business students who were participating in negotiation scenarios in which unmitigated expressions of disagreement were used (Bjørge, 2016, p. 117). In the field of international business, the ability to handle conflict talk and at the same time maintaining rapport is a part of professional competence (Ibid. p. 116). The students used for example counterarguments and interruptions as disagreement acts during the negotiations (p. 124, 127). These tactics were used to promote clarity and directness between business ELF speakers, and interestingly the results showed no demonstrable link between the use of unmitigated disagreement and negotiation breakdown (p. 128). While rapport management is seen as an important part of the therapeutic relationship in nursing as well, it is fascinating to find out if the nurses think disagreement in ELF nurse-patient interactions contributes to a communication breakdown. Usually, nurse-patient communication aims to mutual agreement and rapport because the delivery of proper and effective care depends partly on the patient's medical compliance, i.e. the patient's willingness to adhere to the recommended medical treatment plan. As discussed before, nursing ELF differs from business ELF in that often the patient is not a health care professional themselves which challenges the communication in a varying degree. One of the legislated duties of nurses is, naturally, to educate the patient about their condition so that they are able to make an informed decision, but depending on the condition, understanding what would be the best predicted course of action can be very challenging in even one's first language, let alone in a foreign one. If a disagreement over the medical treatment plan complicates an already challenging situation, it may be expected to lead to communication breakdown in the worst case.

Jenks' study of *Uncooperative lingua franca encounters* (Jenks, 2017, p. 279) explores how ELF interactants behave in a mutually unsupportive way and do not seek to build consensus in non-institutional settings. They used laughter, joking or ridicule to highlight other speakers' disfluency in English (Ibid. p. 285). In other words, the more fluent speaker of English, whether native or non-native, took advantage of the linguistic disbalance of other interactants. This study, although conducted in *non-institutional* settings, prompt a question of whether nurses have been in situations in which linguistic disfluency has been used as a device towards not reaching a consensus over a health issue with a patient. Of course, nurses are bound by the law and ethical code to speak politely and respectfully to their patients, but patients are not similarly required to try to reach a consensus nor to speak in a civilised manner to the health care professionals. Oftentimes the unwillingness to cooperate on the part of the patient is due to a highly stressing medical situation, but nevertheless and for whatever reason, behaving in a mutually unsupportive way could be a reason for a communication breakdown.

Kaur found in her study that misunderstandings in ELF situations could not be attributed to cultural differences between the participants (Kaur, 2016, p. 140). She studied 15 hours of naturally occurring speech between 22 participants, but similarly with Bjørge's study, Kaur's participants were graduate students of a higher education institution discussing together. There is again a somewhat shared knowledge base between the participants which cannot be expected from patients. Therefore, cultural differences may well play a part in misunderstandings of nursing ELF situations, for example in the form of differing health and illness beliefs which are usually culturally bound. However, Kaur identified four main sources of misunderstanding in ELF interactions which are in fact a part of any communication despite the language used. The first source of misunderstanding was ambiguity or the lack of explicitness on the part of the speaker which required the listener to infer meaning with misinformed consequences (p. 141). The second group of misunderstandings were performance-related, e.g. mishearing and slips of the tongue, which were often clarified by a repetition. Language-related misunderstandings were the third source and these included ungrammaticalities and disfluencies, such as using a wrong word 'make' instead of 'do'. The fourth source of misunderstandings was gaps in world knowledge in which one of the participants lacked knowledge of something that the other one wanted to discuss. Presumably these sorts of misunderstandings are common in nursing ELF because of the great variation in the patients' world knowledge, particularly health-related knowledge which is also affected by the health and illness beliefs of the patient as mentioned

above. At least it is important to explore if the nurses have noticed what factors they have identified as sources of misunderstandings in ELF situations.

2.2 Nursing ELF

2.2.1 Findings from the BA thesis

While writing my bachelor's thesis, I read through several of Finnish multicultural nursing studies which were surveys and interviews for BA and MA thesis' of nursing students (Bergroth, 2007; Hujala, 2009; Kallio, 2013; Kiiski, 2013; Lahtinen & Pekansaari, 2013; Siili & Mäntyharju, 2010; Rissanen, 2013; Välimäki & Tihumäki, 2014; Tynkkynen, 2012). These studies described, among other things, situations in which communication difficulties occurred when nurses interacted with patients from foreign backgrounds. A questionnaire was developed from these reported scenarios of communication difficulties between nurses and patients which was the basis of my BA thesis (Ritala, 2017). However, it is noteworthy that my BA thesis focused on ELF communication from an applied linguistics point of view whereas the multicultural nursing studies explored the phenomenon from a nursing perspective, and to date, similar studies conducted in Finland to which compare the results with have not been conducted. And as English is not a common L1 in Finland, the situations in which nurses speak English with patients in Finland can be assumed to be mostly ELF situations which may or may not include native speakers of English. Guided by the beforementioned multicultural nursing studies and their findings, the questions in my BA thesis questionnaire were categorised under five different themes: general views towards ELF, self-assessed English skills, methods to facilitate ELF communication, cultural influences, and educational needs. Although the BA thesis' questionnaire had only 51 respondents, it describes the unique situation of capital area nurses in Finland to an extent in addition of having similar results with the previous multicultural nursing studies regarding linguistic matters. The results of my BA thesis were, according to the first theme, general views towards communicating in English with patients, that majority of the nurses liked to speak English with their patients and considered it easy, but also thought it more demanding and time consuming than communicating in their first language. Surprisingly, over one third reported that the atmosphere in their workplace or their colleagues were not positive about communicating in English. In the second theme, self-assessed English

skills, three quarters reported their general vocabulary, pronunciation and grammar as good enough to communicate in English fluently. Up to ninety-four percent used lay terms of illnesses and conditions with patients, but two out of five disagreed that they knew how to use official medical terminology when communicating in English. In the third theme, accommodation strategies, nurses generally simplified their language and over half used repetition more often in ELF situations. Only one third used more writing or written aids more, but majority of the nurses reported contemplating afterwards if they understood each other correctly while using English with patients. The influence of cultural differences, the fourth theme, leans more to the nursing studies, but it was important to know what the nurses thought the reasons for possible miscommunication might be, and as expected, almost all of the respondents thought that it is easier to speak English with patients if oneself is culture-conscious and that over seventy percent agreed that it is challenging to communicate in English with patients who do not share the Western health and illness beliefs. In the final theme the nurses were asked about their educational needs and most of them disagreed that they had received enough English teaching during their nursing studies to manage ELF situations at work. Similarly, they responded not having enough education nor readily available aids from their employers to cope in English with their patients, and two thirds would like to have additional education included in their working hours. To mention some of the free comments, quite a few nurses reported that they were mostly self-taught in their English and/or lacked the correct terminology which made it more demanding for them to speak English. Also, patients' limited English skills as a source of disfluent communication were mentioned more than one time (Ritala, 2017). The results of this small-scale study points clearly towards a need of further investigation of the subject of nursing in ELF in the Finnish context. The chosen course of action for further research in this thesis was to interview nurses who are already in the workforce, i.e. not nursing students, and interact with English-speaking patients somewhat regularly. A deeper understanding of the factors affecting the nurse-patient ELF communication will hopefully provide insights towards developing tools to facilitate and ease the communication at least from the nurses' perspective. Next subchapter explores other nursing ELF studies which have been published lately and discovered after completing the BA thesis.

2.2.2 Nursing ELF studies

In the recent years, the use of English as a lingua franca in the context of nursing and health care has arisen as an interest in ELF studies and English for Specific Purposes (ESP) research. The growing number of nursing ELF studies builds the body of knowledge needed by the ESP research to invent ways in which education could solve the challenges identified by the nurses in midst of their professional lives. These studies also guided me on formulating the interview questions and on what matters to cover during the interviews. As stated by Bosher, nursing has not long been considered as a specialty of its own in the field of English for specific purposes and its learning materials are usually developed for international nurses seeking to be employed in English speaking countries (Bosher, 2013, p. 4), but the fundamentals of nursing ESP are relevant to this thesis for two reasons. Firstly, the educational needs of nurses for communicating in English with patients reveal some challenges they face in their everyday work. Secondly, finding out if the nurses interviewed for this thesis have used the techniques listed in the nursing ESP studies, knowingly or unknowingly, might reveal universally practical ways of facilitating communication in a nursing ELF situation.

Tweedie and Johnson, who focus on nursing ELF and ESP, accentuate listening above all of the four macro skills of second language acquisition (SLA), others being speaking, writing and reading as proposed by Flowerdew and Miller (Tweedie & Johnson, 2018, p. 65). Tweedie and Johnson studied nursing students in a simulated end-of-shift situation in which English was used as a lingua franca between the speakers and found that although the students self-assessed their listening skills in the situation positively, the nursing instructors present detected some instances where significant patient information was missed by the listener. Because of the possible health risks related to such instances, Tweedie and Johnson argue that a curriculum incorporating active and interactional listening techniques would be useful for nurses preparing for real-life situations (Ibid. p. 71). They suggest that nurses should be given formative feedback on their communicative accuracy, for example using effective clarification methods, and that nurses would benefit from profession-specific corpora used during the practice scenarios in order to achieve appropriate lexis. They also emphasise the importance of exposing nurses to and teaching them to listen to non-standard English accents because of prevalence of these in ELF situations (Ibid. p. 74).

Similarly, Bosher notes that English as a second language (ESL) nursing students are required to master a complex set communication skills in English to deliver high-quality care to their

patients, including for example interviewing skills for the purpose of gathering information and therapeutic communication skills along with certain proficiency to write the gathered information down accurately in English (Bosher, 2013, p. 3). In another study by Bosher and Stocker, in-service nurses reported using English with patients and foreign caregivers most often to ask for information and to give instructions (Bosher & Stocker, 2015, p. 113). In the same study, nurses considered that writing and reading skills in English were needed to keep oneself up to date with relevant professional research findings and new treatments (Ibid p. 113). Spoken communication was rated as the most important part of English skills in the nursing profession also by nursing students in Badrov's study (2017, p. 269). Understanding a patient who speaks English and being able to communicate in a clear manner were viewed as the essential parts of the spoken communication, although understanding professional information and being able to evaluate if written instructions were comprehensible to patients were considered significant as well (Ibid p. 269). Furthermore, speaking exercises, such as answering questions and role-plays, were estimated as important by both students and in-service nurses in Chien's study which explored the learning needs of Taiwanese nurses regarding to delivering care for English-speaking patients (Chien, 2019, p. 6). Thus, it can be inferred that listening and speaking skills in English would be paramount also for Finnish nurses because nurses tend to interact with patients mostly through speech, whether face-to-face or over a phone, and that nurses recognise the importance of these skills in their daily work. Reading and writing skills in English seem to be important at least for the purposes of following latest research in nursing and medicine in one's field and to understand patient instructions written in English, but the importance of these skills might vary according to the field in a given nurse is working in. For example, in emergency wards the need for written patient guidance material is different than in specialised outpatient clinics which treat people who have chronic illnesses.

As to what kind of exercises an ESP course for nurses should include to promote successful communication with patients, Hämäläinen recommends paraphrasing and asking questions as exercises to help nurses communicate effectively and precisely with their patients (Hämäläinen, 2017, pp. 98-99). Franceshi also promotes paraphrasing and asking for clarification as vocabulary building exercises and emphasises the need for nurses to be familiarised with listening different ELF accents as a part of ELF syllabus for nurses (Franceshi, 2015, pp. 53,58). Other recommended activities for increasing nurses' linguistic awareness were identifying instances of miscommunication and inventing solutions to prevent or solve misunderstanding, such as using repetition or asking for clarification during a dialogue (Franceshi p. 59). Another

aspect of developing nurses' English skills is to use the language as often as possible in different situations, as was found in a study of nursing students who studied in an English-instructed nursing program in Finland (Mejías, 2019, p. 51).

It is noteworthy to mention that Tweedie and Johnson call for further studies to explore the general level of communicative accuracy in healthcare ELF given its importance in patient safety (Tweedie & Johnson, 2019, pp. 6,7). For example, although variation in pronunciation is tolerated in ELF research in academic settings and business, it is unknown if pronunciation differences lead to misunderstandings and risks to patient safety in healthcare settings (Amery, et al., 2019, p. 1). To illustrate the need for further research and innovating effective nursing ESP materials a study by Lu highlights possible stumbling blocks for nurses using ELF with patients (Lu, 2018). In the study Taiwanese in-service nurses were observed and reported having difficulties in finding lay English terms for medical ones while communicating with patients, and they had challenges understanding foreign patients' or healthcare aides' unfamiliar accents of English as well as pronouncing medical terms in a standard way (Ibid p. 122-3). Avoiding communication with foreign patients due to lack in English skills was the most alarming finding as the nurses were unable to ask patients the reason for seeking medical assistance and discover a cause for patient's injuries because these can lead to serious consequences on the patients wellbeing (Ibid. p. 123, 127). Also, inability to establish rapport through small talk and empathetic listening when not using one's L1 was a hindrance to building nurse-patient relationship according to the nurses (Ibid. p. 124). The extent to which Finnish nurses have similar challenges in providing high-quality care to English-speaking patients and use the abovementioned techniques to overcome these are reflected in the interviews of this thesis. The interview questions achieve to cover the aforementioned aspects of nursing ELF in Finland, but due to the semi-structured nature of the interviews, some questions became more highlighted than others according to the kind of experiences the nurses had had regarding speaking English with patients. In the next part of this thesis, the data collection and findings of the interviews are covered in detail.

3 IMPLEMENTATION AND DATA COLLECTION

Interviews were chosen as the method of data collection because nursing ELF in Finnish contexts is a relatively unknown and novel subject of research, and therefore interviews could provide deeper understanding of the experiences of nurses in their own descriptions. The method provided also ample opportunities to discover what their insights were concerning the relevant factors of nursing ELF with patients through singular experiences and individual encounters. Richards defines good interviews as 'rich in details' (Richards, 2003, p. 53) and this aim was certainly fulfilled through the nurses own, direct communication. The purposefully broad research question for the novel subject of study, what kind of factors contribute to successful and unsuccessful nursing ELF situations with patients from the nurses' point of view, demanded a method that allowed the nurses to freely contemplate and speculate these factors according to their experiences which interviewing corresponded to excellently. To prompt and aid discussion, several possible interview questions[1] were prepared beforehand, but as Richards points out that the interviewer and interviewee can differ on what are the important questions (Richards, 2003, p. 69), the interviewees were encouraged to determine on which questions they wanted to elaborate on because not all were relevant to their individual experiences.

The interviewees were six in-service nurses who worked in the Southern parts of Finland and interacted with patients in English somewhat regularly. They were recruited through the researcher's previous connections to the field of nursing and contact information section in the previous BA thesis questionnaire. Five of the sessions were held as individual and one as pair interview according to the interviewees' preferences. The interviews were held in February 2020 as in-person and online meetings, and the recording times were approximately 30 minutes long. Finnish was used in all interviews by the interviewer and interviewees, and the possibility to conduct the interview in English was presented in the beginning of the interview. The interviews were fully transcribed and translated by the interviewer, and the findings were categorised according to three themes: nurse-related, patient-related and workplace-related factors of ELF communication in nursing.

[1] See the appendix for the list of possible interview questions.

3.1 Background information of the interviewees

A link to an online background information survey was sent to the six interviewees before or immediately after the interviews. The online survey was developed according to the background information questions of the bachelor's thesis questionnaire with altogether eleven questions. There were four respondents in the age group of 40 to 49, one in 30 to 39 and one in 20 to 29. Five were registered nurses and one was a public health nurse. Four nurses had 16 to 20 years of work experience, one had 10 to 15 and one 6 to 9 years. Five had the Finnish citizenship and one had a Swedish citizenship, but all of them spoke Finnish as their L1 (native language). Likewise, three respondents reported speaking three languages fluently in addition to their L1, one spoke two languages and one reported speaking one additional language. Further, all of the respondents had stayed or lived abroad, ranging from three months to eighteen years and including countries in which English is a native language. Three had studied English over ten years, one 8 to 10 and two had studied 5 to 7 years. On their free time the respondents used English most to communicate with international or English-speaking acquaintances, friends and family members and to watch English-speaking series' and movies. Three used English at work regularly with other health care professionals. The distribution of frequency of using English with patients was interesting: two used English daily, one used weekly, one monthly and two less frequently than monthly. The participants were given pseudonyms Maria, Sanna, Laura, Tiina, Milla and Helena and their specific background details are not disclosed to ensure anonymity. The interviewees came from different specialisation backgrounds and workplaces such as child health care clinic, occupational health clinic, reproductive medicine clinic, casualty and cardiological clinic which in turn had an influence on the care and patient contact, for example on the length of the care process and frequency of appointments. When necessary, the field is mentioned to clarify how the field of nursing affects the care process. For reasons of clarity, the term 'patient' is used for all those receiving care, although some places preferred to use the term 'client', and in some cases 'patient' refers to a couple or the parents and a child receiving medical care.

3.2 Limitations and ethical considerations

The anonymity of the interviewees was ensured by using pseudonyms and not enclosing any unnecessary information about them. Their workplaces included both public and private sector

health care providers which will not be disclosed to ensure the healthcare providers' anonymity. The interviewees were given a notice of consent prior to the interview and the university's General Data Protection Regulation form informing the interviewees about the recording of their voice and background information. Participating in the interviews was based on voluntariness of which the interviewees were informed when asking their willingness to participate. The sample size of the study is naturally a limitation and the results may not be generalisable in a large scale. The researcher recognises her background as a nurse which may influence on the interpretation of the findings. The researcher also acknowledges that her inexperience as an interviewer may have directed the course and influenced the questions of the interviews more than what was necessary.

4 FINDINGS

The findings were categorised with thematic analysis into three themes: nurse, patient and workplace related factors of ELF communication in nursing. Thematic analysis was chosen to arrange the collected data in coherence with the successful and unsuccessful factors which influence nursing ELF. Thematic analysis identifies and reports patterns within data, while it organises it and describes it in rich detail (Braun & Clarke, 2006, p. 79). The three major themes emerged from the research and interview questions and were confirmed during the interviews since at least these three factors must be present to study English as a lingua franca spoken with patients from the in-service nurses' point of view. Each theme is further divided into subsections which emerged as minor themes during the transcription phase of the research, although the themes are intertwined because they describe the same phenomenon from different perspectives.

4.1 Nurse-related factors

4.1.1 Work experience and mastery of core nursing skills

A major theme emerged from the nurse-related factors which influence the successfulness of nurse-patient interaction: gaining in work experience and increasing the mastery of core nursing skills specific to the field the nurses were working in. All of the interviewees described ELF situations becoming easier and more effortless as they gain more work experience. Building the professional knowledge and practical skills of one's field of nursing over the years enables the nurses to feel confident that they can manage whichever communication situation they face, whether in Finnish or English. Those with less than 15 years of work experience detailed the process of gaining professional confidence through the work so that in the beginning of their career there was a number of details they were not quite sure and giving patient guidance even in their L1 was challenging. Tiina describes her professional development in the following manner

> But if I think back when I had just graduated – well, I didn't really know what I was talking about – that am I right or wrong or is this the right treatment and what. People

asking and I don't know really know how to answer even in Finnish. So, as I have gained more working years, I think that alone affects the quality of care. Then it doesn't matter that the English language addition there – it doesn't stress me. Because I know I can handle this thing.[2] (1)

With a number of working years under their belts, the nurses were able to direct the nursing process towards the goals the situation required. Depending on the health care institutions, the goals of nurse-patient interactions are varyingly predetermined by the nature of the visit, for example in child health care clinic the appointments are arranged accordingly to children's age-determined development and each visit has its specific examinations which the nurse is expected to carry out. Maria, who works in such institution, describes that

Interviewer: Do you feel like that work experience has helped communicating in English overall?

Maria: Yes, I've been here for so long that one already knows how to do something and how not to. I strive to hold the reigns because otherwise it all falls apart. And there's that the next one comes so one can say that did you have anything else; we have a moment still and then we'll wrap up. One needs to direct a little bit like this. (2)

In similar vein, Laura reports knowing how to handle different patients due to the work experience she has gained and feels confident in her field. Additionally, Helena and Milla have worked in their field for years and knowing the terms, processes and procedures related to that field well provides them with a confidence in their professional knowledge. Because of this, they generally anticipate that "*explaining things in English is easy enough*" as Laura described. Sanna feels that her professional knowledge about the topic in hand facilitates communication with patients even if their English skills are not optimal. Vice versa, discussing topics with which she is not very familiar with can be challenging situations, and as an example she gave phone conversations with patients asking about rare travellers' vaccinations, which belong to the domain of public health nurses, and not registered nurses such as herself. Work experience and confidence in one's professional knowledge seems to facilitate communication in English across institutional set-ups as the continuance of the nurse-patient relationship did not come up as a major factor during the interviews. The interviewees worked in places which had a great variability in the duration of nurse-patient relationships: from emergency clinic's one-off

[2] All the excerpts were translated from Finnish to English by the author.

encounters to long-term follow-ups in outpatient and childcare clinics. The ability to establish a satisfactory relationship for all parties involved, as much as it is in their power, is a part of the core nursing skills which these nurses seemed to have developed over the years, despite the diverse institutional settings in which they worked.

Adjusting professional knowledge to aid patients optimally is a daily feature the nurse-patient relationships and one example of this is the nurses' commitment to modify their communication with patients according to their needs. This feature is present in all nurse-patient relationships but using a non-native language to convey this prompted the interviewees to give diverging examples of appliance. Tiina often uses the same terms that her patients' use which are mainly so-called lay terms of illnesses and conditions, especially if the patient's English vocabulary is limited. Laura emphasises "*good groundwork from the beginning with all patients*" because in the detail-focused field in which she operates in, the reproductive medicine, the nurse cannot assume the patients to have previous knowledge of how easily the treatments fails if instructions are not understood and followed minutely. The good groundwork refers to thorough patient guidance from the first visit on about the course of the chosen treatment and of the human anatomy and physiology:

> Because it's so multi-layered thing that if you just rush on from the get-go too fast then the understanding is left behind and then they just act without knowing what they're doing. – – – There's so many different phases so the people have understood from the beginning the treatment's different phases and where were heading at. That's essential. – – – Then you notice that with couples with whom we started a bit too flimsily it backfires, and they'll call all the time about this and that. It creates misunderstandings. In the worst case, the whole treatment fails. It can be like this, the details matter. (3)

Another example of how nurses adjust their professional knowledge communicating openly with patients and family members even when there given information is possibly inconvenient. Maria, who works in the childcare clinic, tries always to find out the parents' stance on the proposed action steps of their child's care by asking simply *"What do you think about X?"*. This endeavors to create the sense of being heard and taken into consideration in every situation for the patients. Sanna strives to make sure the client feels understood even if they don't agree about the proposed care plan which is, as she notes, more challenging in English because she doesn't have a similar command of the

vocabulary to convey empathy to the patient during a disagreement as she does in her L1*: "It doesn't quite sound the same because the vocabulary isn't as large so that you could express your empathy but at the same time leave an experience of being heard, that I'm not just trying to wriggle myself out of this situation"*. Milla comments on the same phenomenon from the viewpoint of it being occasionally more challenging to motivate patients as she doesn't have as extensive vocabulary in English as in her L1 to explain matters differently. On the other hand, Helena sees that the sense of being heard and understood depends on the patient's part of their receptivity in general. Both agree that it is easier to create the feeling of mutual understanding with patients who speak English fluently enough to ask clarifying questions, and Helena points out that for this reason, it is usually effortless to create open communication with native speakers of English because they can clearly indicate when they have not understood and ask for further explanation. Milla and Helena also contemplated on the notion that they use more refined and concise language when speaking English, as they need to think somewhat more ahead what they are going to say next, which can aid in creating clear and open communication. However, they believed it might also be a hindrance to creating a solid care relationship because there is less general chattiness from their side with English speaking patients. "*The situation can be become too formal and rigid because of that*", marks Helena. Sanna's experience of this was that with NSs it is easier to have a more relaxed and less "*strictly business*" like care relationship, because they are accustomed to small talk and going along with it is effortless.

Expertise in core and field-specific nursing skills through work experience seems to have a profound impact on the experienced successfulness of ELF nurse-patient encounters. The prevailing impression among the interviewees was that as they have gained work experience, shifting the language between their L1 and English has become less challenging in general. Conveying subtle nuances in a non-native language was at times a challenge to the nurses but encountering and striving to build a good care relationship with people in various life situations was considered as a part of professional growth by the nurses.

4.1.2 Language skills

The nurses' positive view of their English skills was a prominent feature in all of the interviews. They had developed their skills not only by studying the language, but by living and traveling abroad where they had communicated extensively using English. This had, in turn, enriched them with a confidence to speak the language freely without focusing overly on possible grammatical errors and the like. The confidence to speak English seemed to be intertwined with the confidence gained by the increasing work experience. The knowledge of being sufficiently fluent in English and mastering their field well enough produced a positive outlook to encountering English speaking patients. Studying nursing partly abroad and being a seasoned traveller has, in Sanna's opinion, equipped her with adequate language skills and confidence to speak English with patients. Maria, who lived in the U.K. for a while when she was younger, said that she does not worry about speaking English and considered mutual understanding as the vital part of any conversation: *"I'll just say things and see how it goes on from there"*. Milla had studied languages in a university prior to nursing so she did not think that the language of nurse-patient communication was not "*a decisive point*". She and Helena both participated regularly to their field's international meetings in which they used English as a lingua franca to communicate with their colleagues and thought these specialty related events enriched their already broad vocabulary further. The terms used in their field, cardiology, are most often derived from or directly borrowed from English which made it easier for them to remember and use the terms with patients. Some medical high-tech equipment and its online software which Helena and Milla use in their work, such as cardiac remote monitoring, operate only in English which ensured that they had contact with the language daily even if they did not converse with patients in English that often. Knowing the language and its professional vocabulary well after years of work experience made Tiina feel that she did not mind whether she spoke Finnish or English with patients. The percentage of English-speaking patients in Laura's workplace were such that Finnish and English were considered as the official working languages. She, too, was well-versed in her field's medical terminology and felt that English-speaking patients from different backgrounds gave her "*a cultural education*" as part of her work. Tiina, Helena and Milla were of the mind that having weaker English skills was a source of stress to some nurses. Sanna and Tiina said they liked to help their colleagues in speaking English with patients if they asked for assistance.

The use of prefabricated sentences is more or less common feature in all patient guidance, especially if nurses use information leaflets and other material to structure the guidance session. Some of the interviewed nurses used to ease the communication with English-speaking patients and in some workplaces the practice was part of the care process despite the language used. This was the case in Sanna's workplace which included working as a triage nurse over the phone or online chat and in which a set of questions was used to identify the patient's health issues. In her opinion having a fixed list and using prefabricated sentences ensured that she did not forget to ask important questions. Laura used some prefabricated sentences in face-to-face interactions with patients because each visit was outlined according to the different phase of the chosen plan which directed what was necessary to cover about the treatment, which she also found helpful as it gave the visit a certain structure. Tiina's work included prefabricated sentences in the beginning and end of the care process with English-speaking patients due to the structural proceedings at the private emergency clinic. This included for example using the same phrases over and over for advance payment for foreign patients. Maria's contacts with patients did not contain using prefabricated sentences but she as the visits in the child health care clinic follow an age-determined plan, she knew what were the main topics for each visit beforehand, which she deemed useful as she repeated the same information many times a week. Neither Helena nor Milla recognised using prefabricated sentences because the reasons for patient contact varied and they did not think they encountered English-speaking patients often enough to develop any specific phrases for the occasions.

The nurses used a variety of non-verbal ways of communication to explain and clarify matters to the English-speaking patients. Maria and Laura used drawing and showing pictures especially with patients with limited English skills, for example Maria would search pictures of baby formula for a Russian-speaking parent who did not know what the term 'baby formula' meant in English. Laura found anatomical pictures and physiological charts helpful to explain the different phases of infertility treatments to her patients. Tiina handed out patient leaflets to patients who needed home care instructions and asked her patients to show for example where they had pain, sometimes gesturing also the question if the patient's English skills were very limited: "*Even those don't really speak English can show which part of their body is hurting, and body language goes a long way in those situations*".

The interviews clearly indicated that the combination of being confined in one's professional abilities and language skills equipped the nurses to encounter English-speaking patients. They were also agile in inventing ways to get past the patients poor understanding by using verbal and non-verbal techniques and to establish mutual understanding which seemed to form a basis for successful communication between nurses and patients, regardless of the language used.

4.2 Patient-related factors

Patient-related factors which influence the nurse-patient communication from the nurses' point of view include several aspects such as the patient's English skills, the nature of the illness and presence of family members. Depending on the type of health care institution, these factors have more or less profound impact on the interaction, except for the English skills which naturally always plays a part in the overall successfulness of the interaction.

4.2.1 Various aspects of language

The nurses encountered patients from various backgrounds culturally and linguistically, including native speakers (NSs) and non-native speakers (NNSs) of English. During the interviews the nurses also made a few comments about interpreters which are included in this section. The nurses reported differences about speaking with NSs and NNSs, for example on how demanding they thought speaking with a NSs was, but all of the nurses emphasised that language skills alone did not define the outcome of nurse-patient encounters. Maria, Helena, Milla and Sanna thought that it was usually easy and effortless to speak English with native speakers, especially those who came from the Inner Circle countries[3], because they were familiar with most of their dialects through education and had travelled or lived in these countries. Sanna described her experiences with native speakers as the most positive of all the experiences with English-speaking patients

[3] According to Kachru's model of world Englishes, in the Inner Circle countries 'native-speaker varieties of English' are spoken and these include for example the U.K., U.S.A, Australia and Canada. (Bolton & Kachru, 2006, p. 423).

> The best experiences I have had were with the native English speakers. I remember clearly one American and one Australian patient, both with which were so lovely already with their small talk and so on. And of course, it is cosy for me and in my opinion it's sincere and kind of welcoming, the communication, that it doesn't have only a contextual purpose such as that I just go through an aftercare leaflet or something. Rather, the whole communication is built in entirely different way. (4)

Tiina had mostly non-native speakers of English as patients, particularly during the tourist season in summer, and thought that the mutual will to understand and to be understand was paramount. This was aided by a notion of hers that the foreign patients had "*a lower mental threshold to speak English confidently despite their language skills*". Maria liked to work with non-native speakers as well as with the natives provided that their English skills were adequate so that they could have a conversation about the child's matters.

Laura's English-speaking clientele tended to be divided between highly educated immigrants and refugees for reasons unknown to her. This affected the communication greatly because the "*international academics*" as she described, were fluent in English regardless their linguistic background. She regarded speaking with another NNS sometimes even easier than with a NS because there was "*less pressure to speak correctly*". With the refugee patients she often needed to rely on interpreters who themselves weren't necessarily trained in medical interpreting which at times complicated the flow of information from and to the patient because her field, reproductive medicine, requires minutely focused attention to the different phases of care. She reported that

> … especially those cultures in which these things are not spoken of at all it's difficult for the patients to understand what I'm saying. And then the interpreters interpret the same terms very differently and neither them are allowed to use the proper anatomical terms – well, then they invent words such as flower for womb and everything. (5)

The use of euphemisms instead of the anatomical terms was a source of concern for Laura because she did not know if the interpreters captured the essential information while using figures of speech. Milla had similar experiences with interpreters, namely that she sometimes was not assured that the interpreter knew anatomical terms well enough to mediate the message between her and the patient correctly. Laura also had patients with very limited English skills who would occasionally require urgent guidance over the phone and preferred to have others converse with her, usually their partner or even a friend. She found this often troublesome

because the significant other could not, naturally, explain for example symptoms as accurately as the patient could. In case she could not make out the reason for calling properly, she would ask the patient to come to the clinic for a check-up. Phone conversations were potential challenges for Sanna as well with NNSs who had limited English skills, but she found chat messaging with such patient the most challenging situations as the chat messages "*could be so ungrammatical and contain so peculiar expressions that it's almost impossible to understand them*".

Accent and L1 influences

The nurses were asked whether they thought the patients' accents or language background had an influence on the communication. They were of the opinion that they could understand the patients fairly well in general despite different accents or L1 influences and thought that having an accent was rarely a remarkable aspect in the nurse-patient communication as long as it was not too strong. A too strong accent or L1 influence was, naturally, defined differently by each individual nurse. The nurses reported those accents or L1 influences the most challenging which were either geographically furthest from Finland or culturally unfamiliar to Finns. In other words, areas and language backgrounds which were located far from Finland or had little interaction with the Finnish culture, were challenging because the pronunciation, pace or rhythm of the languages were previously unknown to the Finnish nurses. On the other hand, accents or L1 influences which were familiar to Finns through a cultural contact, were generally thought easy enough to understand. Examples of these include Russian L1 influence on English since Russia is located next to Finland and the interaction between the citizens of the countries is considerate. Another example is Australian accent which is known to Finns because its features are covered in English classes during basic education to an extent and some Australian television shows are broadcasted in Finland. Native Finnish speakers are generally familiar with these accents and L1 influences and their peculiarities beforehand which eases understanding. On the other hand, the accents or L1 influences which were the most challenging for the nurses were of African, Arabic, Asian or Hispanic origins as described by Tiina

> Interviewer: How about accents then – are there some that especially challenging or?
>
> Tiina: Yes (laughter). Well, I mean that I do understand but Indian accents and others, too, which are very strong – that's difficult sometimes, especially on the phone

> because you have to spell some names and letters over and over again to find the patient from the computer. That is something which is difficult to grasp at times. But we always manage in some way or other (laughter). (6)

Milla found Indian accent and L1 influences difficult because the speech tempo was considerable quicker than in Finnish and because they contained speech sounds previously unfamiliar to the nurses

> Interviewer: What about accents? Are there some which are challenging?
>
> Milla: I think there are some. It's highlighted on the phone especially, for example some people from India or thereabouts speak so quickly and there's the accent and pronunciation. And somehow that terribly quick manner of speaking is the thing which makes it [challenging]. And maybe they don't know how to slow it down or say it differently. But these are individual cases but that's what springs to mind. (7)

Tiina, Sanna, Helena and Maria shared Milla's opinion that is was more challenging to understand English which was heavily influenced by L1 or accent previously unknown to them, especially when speaking on the phone with the patient. However, if the nurses interacted with patients who had previously challenging accent or L1 influence repeatedly, they learned to understand the patients better. For example, as Maria had come to understand that the word /ask/ was sometimes pronounced as /aks/ by some of her patients, and that the patients were not referring to 'an axe' which had been a source of confusion to her when she first heard the alternative way of pronunciation. On the whole, the nurses were confident that they had at least a rudimentary understanding with most of the patients.

Lay terms and figures of speech

The nurses were accustomed to the multiple terms used in healthcare to refer to the same illnesses and conditions which made them overall alert to finding an expression that the patients were familiar with if possible. This practice is one of the ways which the nurses accommodate to the patients' needs but depending on the medical field and patients' knowledge of their condition, the nurses employed the strategy in different ways. When asked about using and understanding the patients' figures of speech and terms describing their condition, Tiina reported that she rarely encountered roundabout expressions in the emergency clinic in which

she worked. The patients coming in used straightforward language such as "*I've had flu for five days and need some medicine*" which facilitated finding the right treatment in a timely manner and therefore increased patient satisfaction, Tiina noted. She did use the same lay terms as the patients used because she considered this as a part of the patients' right to understand medical information and be understood although the language of communication was often a foreign one to her and the patient[4]. The only instance in which she herself often encouraged the patients to use figures of speech were in assessing pain type and intensity, such as using a pain severity scale from one to ten or describing it prickly, stabbing, constricting and so on, which are important diagnostic tools of differential diagnosis for physicians.

Maria described that she had learned useful lay terms from her patients which she employs with her other patients as well

> Well, I have learned at least one word! For example, you know, you learn from the clients. So, the intra-uterine device, so one said *coil* and I was like what on earth is that? Because it is a bit slang type of a word but now I use it too because it seems to be something they themselves use often. I pick up some things along the way. (8)

She had not noticed that figures of speech would have caused difficulties in understanding her patients which she contributed to having lived in an English-speaking country for some time as a young adult. Similarly, Sanna had not paid attention to the figures of speech which native speakers of English used, but she had had some challenges to understand ELF speaker metaphors because

> I had chiefly the problem that as English wasn't often the client's mother tongue either, there were at times such odd expressions and grammatically so poor English that as you yourself even knew English better than them, I had sometimes difficulties to understand that halting language or some funny expression or there was a totally wrong choice of word somewhere along the line. (9)

When asked about using figures of speech, Milla and Helena noted to have encountered similar challenges as Sanna with NNSs of English at times because they tended to use the Latin-based terms for conditions in English which is a common practice in their field

[4] Act on the Status and Rights of the Patient (785/1992) contains a section on the patient's right to be informed. For more information, see https://www.finlex.fi/en/laki/kaannokset/1992/en19920785.

> Milla: Well, it's at least – I feel that with patients who are not themselves native speakers of English it can be a problem. And then the problem is maybe that when you translate the Latin-based, I mean one tends to use the Latin-based words more in English. So then, you don't really know how to make it more vernacular which is with these foreigners whose mother tongue is not English – so, you tend to wonder sometimes that did they actually understand. And if you yourself don't know how to explain, how to use a roundabout expression in that situation… Well, it's difficult.
>
> Helena: Yes, same. I agree. (10)

Although the nurses were aware of multiple options of choosing a term, they were not always able to find an alternative instantaneously when interacting with a patient which created an uncertainty to whether there was a mutual understanding between them. If there was a suspicion on Helena's side that a patient did not understand her after a face-to-face interaction, she contacted the patient via phone to make sure that the patient had understood her. In addition, the nurses used the patients' preferred terms and figures of speech as often as possible to enhance a sense of mutual understanding.

4.2.2 Nature of the illness

The nurses were asked whether they thought that the nature of the patient's illness had an effect the nurse-patient communication Specifically they were asked if they though the patient's prognosis or the date of diagnosis were important factors in the care relationship with English-speaking patients. The date of diagnosis refers to how long the patient has been aware of their illness, i.e. if the illness is recently diagnosed or if they have had it for a longer period of time. The diagnoses prevalent in each health care institutions in which the nurses worked varied and in some places the illnesses tended to be chronic and in some short term which also had a possible impact on the nurse-patient relationship. Sanna and Tiina worked in places which the patients had more acute and short-term need for health care services, such as common infectious diseases, health checkups and vaccinations. If the patients were seeking medical attention for a chronic illness, it was because they had suffered a sudden deterioration or they were noticing symptoms for the first time, but these cases were rarer. Helena, Milla and Laura worked in specialised clinics in which the patients had been diagnosed previously elsewhere and were referred for continuation care in the clinics. Maria thought that this question was not applicable

to her because she worked in child health care clinic which followed the predetermined normal development schedule of children and any illnesses would be treated by other health care providers.

Sanna's experience about a recently diagnosed illness' effect on patients was that it varies from person to person and depending on the diagnosis, some patients "*had got completely taken aback by a diagnosis and some were already self-informed as to what illness they might have troubling them*". If the patients were distressed about the information they had received, it made the communication challenging at times because English was often a foreign language to the patient also. Sanna could not recall any acute situations in which she would have had to speak with a patient whose English skills were very limited, but she did remember an emergency case when she was working in a hospital in which "*the patient was luckily already unconscious, so to speak, so there wasn't exactly a need to worry about their very poor language skills*". She and Tiina had witnessed some acute cases in which they needed to take time to calm the patient before trying to have a proper conversation with them, or in a case of bleeding wounds, take care of the malady before trying to establish much communication with the patient. Laura had encountered situations unique to her field in meeting with recently diagnosed patients to which communicating in a non-native language had brought an additional challenge

> For men to admit that, for many who come from other cultures, that they just can't believe that the man could be the infertile one. That it always must be the woman. There could be the entire family pressuring them in the background and all the weight of the cultural baggage and everything. (11)

Addressing these cultural health beliefs was paramount in these situations which often delayed starting the treatment program. Helena's view was that recently diagnosed patients had generally more questions about their illness and Milla noticed that deteriorating phases of chronic illnesses brought up new questions: "*It's always a start of a new disease in a way and patients need time to adjust*". According to her, such instances required her to be as thorough in explaining matters to the patient as if it was the first time they were diagnosed with the illness. A worsening prognosis can add to the patient's psychological burden which requires expertise from the nurse to address the altered situation. For example, Laura has end-of-treatment discussions with patients either when the infertility treatments have been successful or when they have not and there are no further treatment options available. The latter situation is burdensome and speaking English, which is often a non-native language to the couple, might

increase the stressfulness of the situation. However, the infertility treatments often last for a long period of time and the nurse gets to know her patients during that time which Laura sees as an aid to good communication

> So, none of them - most of them - don't speak English as their own language, so it's very good that they have to learn to use a foreign language and go through official events. And also, to discuss emotional issues genuinely because it can be that they don't talk about those things too much in their own language. And then we kind of push them to disclose what kind of feelings this brings up in you – do you have some fears – what are your expectations – is something distressing you? So these are multilevel discussions and it's been great to see how the people genuinely perk up, they wake up to what's actually going on. And they have to face things which they never talk about in their own language. (12)

Sometimes the patient has high expectations of the nurse because of their distressed state and are disappointed when she is not immediately able to respond to them as Sanna describes

> Of course, the more a person is worried or in anguish, it affects the situation so that they don't start logically to explain their condition and I want to say already in the beginning of the call '*Please, calm down and let's begin from the beginning'*. These have happened. Or sometimes, I remember well, that the conversation starts with like '*Hi, it's me calling'*, like it's supposed to be obvious to me who they are and why they're calling, although I can't do anything before I have their name and social security number [for the electronic health record]. (13)

On the other hand, when matters as expected and there are no unusual stressors, communication with patients is usually fluent and genial as Maria stated: "*When things are ok and going well, the visits go well and everybody's happy*". Somewhat similarly Tiina considered the mutual goodwill as one of the key factors in satisfying nurse-patient communication in English and other languages "*People come there to get help and we're there to help, not to quarrel with anybody, so ninety-eight percent are happy with the care they got*".

4.2.3 Educational background, culture and family

During the interviews the nurses were asked how they perceived the patients' educational background influenced the nurse-patient communication. Some of the nurses were more informed about their patients' background than others, depending on why they were seeking health care services. The patients' cultural backgrounds were more significant in the care process and nurse-patient communication to some nurses because of their field. Some ethically challenging situations came up in relation to the Western healthcare system guidelines and the patients' cultural background.

In the emergency clinic in which Tiina worked, the patients' educational background was not necessarily an important piece of information. She thought that on average, her foreign patients had "*a lower threshold to speak English than us Finns do, which gets you far because the courage to speak can cover much, no matter what their educational background is*". Striving for mutual understanding was in her opinion was the most important part of communication. However, she did found that well-educated patients spoke "*clearly more complex English*" but had not otherwise a great significance. Maria had similar observations that it is usually easier for the patient to express themselves if they are well-educated, but she had also noticed that

> Some can be cleaners by profession and be very smart and others can be professors, and still nothing registers with them. So there you go. So it's like… I always say that it's the personality which is important, not only the educational background. (14)

Sanna had experienced in her work that their clientele was marked by fastidiousness and required more information why a certain approach was taken in and not another that they had researched for example on the internet. Laura emphasised "*good groundwork*" with every patient as her field necessitated that the patients understood each phase of the infertility treatments in detail because the correct timing and medicine dosages were vital for successful treatments. Helena and Milla, who worked in cardiology, thought that being well-educated could benefit the patient in other ways aside from having adequate English skills:

> Helena: "Well, to how someone understands their own illness, whether they be English-speaking or whatever language they speak, so the educational background does have an effect."

> Milla: “Yes and understanding that decisions about the care are based on the clinical research findings and those things tend to be easier to understand to those who have more of the basic education. That they are treated according the findings we got from their examinations in the first place. Whereas those who are less educated and maybe have religious beliefs affecting as well, that does influence how they understand on what the treatment is based on.” (15)

Knowledge of the Finnish health care system

The knowledge of how the Finnish health care system operates varies among the patients depending on for example how long they have lived in Finland or how similar the system with their native country’s system. The impact of this knowledge of the lack thereof was asked from the interviewees. Tiina treated mostly English-speaking tourists at the private emergency clinic and she regarded them generally well-informed of how travel insurance operates or at least one of the traveling party did, but if the patient or their companion were not familiar with using travel insurance to receive medical care, it did take time to explain the insurance compensation procedure while taking care of the patient’s condition. Laura remarked that she and her colleagues were often baffled of how well the patients of foreign backgrounds knew prior coming to Finland how to seek infertility treatments in the health care system. These patients were usually from countries which did not provide infertility treatments as part of their public healthcare. They were familiarised with the operation of Finnish health care system in general, but Laura had also patients who had “*lived in Finland for years and still didn’t know how the system works*”. Sanna’s foreign patients at the occupational clinic were mostly in Finland because of work-related immigration, and she did need to spend more time explaining how the system operates to these patients, especially if they had not been in the country long or they had not needed medical care during their stay. Helena commented that

> I got the feeling that the Finns know the healthcare system as equally bad or well as our foreign or English-speaking patients. But maybe it’s more challenging to explain if the person has just arrived in Finland and doesn’t really speak English that well. (16)

From the nurses replies it can be concluded that educating the patients about the Finnish health care system could take more time, but the understanding of how health care systems operate in general was very individual and depended on the general knowledge of the patient.

Cultural background

Cultural background and its differences compared to Finnish culture came up as significant in some interviews. For example, at times Maria needed to spend time justifying to her English-speaking patients why daily outings were considered healthy for children in Finland and in order to accomplish this, children need weather appropriate outerwear. Laura had faced some cultural differences in her work which were even ethically challenging

> Well, the Finnish mentality includes admitting when we don't know something. Or in the Western thought in the first place there's not really a shame in not knowing. So that's sometimes hard with Asian cultures. Losing face and all that. Then the treatment fails because they say they understand when they don't. And in the same vein the heavily patriarchal cultures in which the status of men is markedly strong and the women's clearly weaker. So in then it can be difficult to get the woman's opinion heard. Because sometimes one wonders if these treatments are at all what the woman actually wants. So we have think about these things. They are challenging and at times I feel like are we doing anything right? Is this right? There's always that undertone. Ethically challenging situation. So then we have ethical issues and when there's a bit of that language barrier then it's super hard to tackle the problem through a non-native language. (17)

In some cases, the cultural differences were intertwined with educational background, as Laura recalls that she had seen the cessation of some infertility treatments when the medical team had discovered that the woman was not voicing her opinions and that she was also illiterate because in her original country female education was not endorsed. Because the infertility treatment hormones are possibly fatal if taken incorrectly and useless if taken outside a strict written schedule, it is unethical to provide them to someone illiterate, explained Laura. However, such cases were rare and usually she addressed cultural differences with her patients directly if she thought those could complicate the treatment.

An important positive factor on the nurse-patient communication was mentioned by Tiina who considered that being able to relate to was vital

> I think it's that both parties meet each other as humans. We may not be from the same culture and what not but I'm here as a professional and I can help you. And the patient has come to get help. So, in those situations the communication flows on its own. That's important with everyone, whatever their mother tongue is. (18)

This willingness to relate to people was noticed also by Maria who though that "… *as long as we understand each other on some level, that's the thing*", although she might not share the same cultural background with the patients. Laura had similar view about the willingness to relate to and added that as it was often the case that English was not the patients' native language either, it was "*somehow merciful to go through things together and learning to explain things in many different ways*".

Family members and significant others

Family members and significant others' presence and participation in the care process was common in in three of the six nurses' workplace and had produced different observations about the communication between nurses, patients and their family members. Milla worked in a place in which the next of kins were sometimes present during the visit, but she had not noticed that it would have an effect on the communication in English other than "*there's those relatives in every culture who know how the patient is doing better than the patient themselves does and they don't really let the patient interrupt their flow*" (laughter). Tiina, who worked in an emergency clinic, recalled that most patients had a significant other accompanying them which she considered useful especially if the patient themselves was unable to fully participate in a conversation for example because of pain and if they were non-native speakers of English which most of the patients were. She found it comforting for the patients to have someone they knew with them at the emergency and often they could provide the healthcare staff with additional information as to why they were seeking medical attention. She had also children as patients regularly and parents who communicated on their behalf in English because most of these families were non-native English speakers. Maria, who worked in a child health clinic, naturally had the child and one or both parents present at the visit which she was used to and could not remember that it would have produced any impediment to the communication. However, she

did regard having the whole family, including all other children, cumbersome at times because she or the parents could not focus on the conversation which is demanding for the adults in itself as it is usually not their native language

> So, if there is the parent or parents and the child then everything goes usually pretty well, but it can be that there comes one parent and three or four children. And then you have to be like '*Don't climb over the cabinet*' or '*Don't touch that, there's the toys, play with them'*. So that affects everything. And sometimes it's hard for the parent to discuss about the child's issues when the child is right there, so there's a lot going on. And it's perfectly common in some cultures that '*Oh I had a friend over, so we all came here'*. I've seen all sorts of things (laughter). (19)

In Laura's workplace at the reproductive medicine clinic it was mandatory for some visits for the spouse to attend and usually both spouses did were present at the visits. At times, an aunt, friend or sister would accompany the woman receiving the infertility treatments in place of the husband or partner during non-mandatory visits if reproductive matters were a taboo subject in their culture which did not affect the communication in Laura's opinion. According to her, challenges arose when the woman would not voice her opinions clearly and preferred for the husband or partner to "*handle the talking. But we cannot start the treatments without knowing the woman's opinion because the bulk of the procedures and risks fall on her and her body*". If the reason for preferring not to communicate was having limited English skills, the clinic would have an interpreter present and as mentioned in a previous chapter, the medical team would refuse the treatments if they could not obtain a satisfactory confirmation from the woman that she was willing to participate in the treatment and understood the risks involved.

From the patient-related factors, the willingness to have a mutual understanding surfaced as an important element for successful nurse-patient communication. The patient's fluency in English frequently ensured a thorough communication with the healthcare staff and the ability to ask clarifying questions was considered by the nurses as one of the key features of high-quality nurse-patient conversation. In cases which the patients' medical need was explicit, and they did not need complex aftercare instructions, the nurses could cope even if the patient had very limited English skills. Patient's knowledge of how the Finnish healthcare system operates varied and explaining the process took occasionally more time during patient guidance, but not significantly or consistently. The involvement of significant others or other companions was

not generally seen as a complicating matter and it was occasionally viewed as positive addition if the patient was in a condition which hindered communication.

4.3 Workplace-related factors

The health care provider, type of care provided and working conditions determines certain aspects of the nurse-patient communication. The nurses' views of how the place of work affects interaction with patients was asked during the interviews and these were divided in two main sections, healthcare provider and other staff members which include subsections that will be discussed separately, such as scheduling and use of support material.

4.3.1 Healthcare provider

Scheduling

The healthcare providers which employed the interviewed nurses varied from private to public offering short to long-term care. The two main service types which were asked about were visits and phone calls, while some places offered online services such as nurse-led chats as well. Maria and Tiina had mostly patients visiting the healthcare provider and other interviewees had phone hours included in their work. Sanna's work had the lengthiest phone service duration, so called phone shifts with triage nurse duties, during which an assigned nurse would take in most of the incoming calls and chat messages from the patients. Her view was that over the phone patients required more repetition with instructions than during a face-to-face interaction, especially with NNSs of English. Helena and Milla, who had daily phone hours and cardiac remote monitoring included in their work, had noticed the same phenomenon and added that they often need to ask for a repetition from the patients on the phone, for example to repeat their date of birth and similar. This did not always yield wanted results, as Milla stated

> On the phone things tend to accentuate, for example some people speak very fast and have a certain accent and pronunciation. So, the fast pace of speech on the phone is difficult. And then they don't know how to slow down like a native speaker could, particularly to slow down their own speech or say it in some other way. And then

> those who are not native speakers and are used to speaking in a certain way, well, then they just speak like that and you try to have them say it differently so you could understand what they mean. (20)

Laura's workdays included a two-hour phone service directed mainly to couples who were already going through infertility treatments and she estimated that approximately one third of the calls were from English-speaking patients, most of whom did not speak English as their L1. She regarded that the majority of the calls were unproblematic and that quite often one of the spouses spoke English more fluently and they would act as an interpreter was viewed as an allowable practice for straightforward calls, such as checking appointment times or asking for uncomplicated additional homecare instructions. However, Laura added that

> During the visits, because they come here often during the treatments, we have to make sure that both spouses understand what's happening. For example, if the husband speaks English better as they often do, we have to make sure that the wife understands too, and not charge him with all the information and responsibility. Then we book an interpreter for the appointment. Because these are legal and ethical matters as most of the treatments are directed to the woman. She needs to have a clear understanding. (21)

When she has had suspicions that the caller, whether the patient themselves or a substitute, did not understand her, she have asked them to come for a additional visit especially if the reason for calling was related to the medication used because of the possible serious adverse effects if not taken correctly.

Most of the calls were not scheduled while the visits were, and the nurses were asked if they thought that being able to prepare beforehand speaking English with a patient had an impact on the successfulness of the encounter. Laura and Maria had unscheduled phone calls, but they did not think that lack of preparation for the calls affected their successfulness because they usually knew the callers from previous visits. Helena had more English-speaking patient contacts over the phone and via text messages, because part of her work included remote monitoring of cardiac devices. However, she and Milla had not noticed that scheduled or unscheduled patient contacts in English would have a noticeable impact on the communication, other than the phone calls being unscheduled and sometimes more challenging than face-to-face visits for the lack of seeing another's body

language for example. Sanna had most English-speaking patient contacts over the phone and via chat messages because there were in general more client contacts over those channels than visits to the clinic. She concluded that unscheduled contacts were at times challenging because of the wide range of reasons for contacting an occupational clinic, but work experience and the possibility to direct the patients to a more experienced colleague helped navigating these challenges. In Tiina's workplace at the private emergency clinic all patient visits were practically unscheduled and incoming calls were answered by a call centre, and she thought that the visits went generally well although she had English-speaking patients daily without previous knowledge of their condition: "*Well, anybody can walk in through the doors with anything, but we always manage somehow or other to solve it*".

Scheduling of patient visits and call hours might also influence the nurse-patient communication if the schedule is overly tight and the time allocated for each patient is very limited. The nurses' view on this and if the English-speaking encounters required more time because they needed to speak a foreign language were asked to find out if the time constraints had a major influence on the communication. Milla and Sanna had the experience that English-speaking calls take more time than Finnish-speaking call as those usually required more repetition. During a busy call hour this was at times stressful for Milla because she could see the other callers waiting on the line from the call back system. According to them and the other nurses as well, visits of English-speaking patients do not take longer than Finnish-speaking patients because non-verbal means are also available on a face-to-face encounter which makes the communication more effective. Some of the nurses were in a position to schedule the visits themselves, such as Maria, which gave her flexibility and made her feel that she had enough time reserved for each patient. Laura and Tiina had the same opinion of having enough time for patients, although Tiina added that creating a calm enough atmosphere for coherent communication so that the parties could understand one another properly which, depending the situation, could take some time at the beginning of the visit.

Support material and further training

The availability of support material, such as patient leaflets or guidance material, in the workplace was included in the interview questions to find out if the nurses were satisfied with the support they were given for serving English-speaking patients. Sanna, Milla, Helena and Laura had official English translations of patient leaflets and homecare instructions provided by the employer which they used as appropriate with their patients. All of the nurses used the internet to some extent, for example searching words from an online dictionary or showing pictures of specific matters. Some nurses used information and guidelines from international professional associations web pages during patient guidance sessions. Some nurses, for example Maria, directed patients to specific web pages for additional information because her workplace had replaced paper leaflets with online material. However, none of the nurses relied primarily on support material while communicating with the English-speaking patients as they had enough work experience and good English skills to aid them.

Busy and challenging workdays were not always a result of scheduling but of the patient material and the nurses were asked what they thought of communicating in a foreign language during such days. Maria worked at a bilingual health care station in which the staff spoke at least two languages, Finnish and Swedish, daily with the patients. Therefore, she did not think that "*switching to English instead Finnish or Swedish was not an issue*", i.e. she was familiarised with using different languages during all kinds of workdays. Similarly, Helena had not noticed that busy days would have a major impact on the fluency of her English, except that she "maybe needs to exert herself a bit more than usual while speaking English". Milla had the experience that with patient visits, the language used did not matter, but if the call hour had already been challenging and busy, speaking English with the callers would at times produce extra stress "*Then I would kind of complain to my colleagues that on top of everything, I had to explain things in English*". Tiina also had been used to busy days at the emergency clinic, but she had "*learned to take care of one patient at the time despite the long line waiting in the corridor*" but mentioned that "*naturally it's easier to focus and speak a foreign language with patients if I'm not completely mentally exhausted from some previous case*".

The nurses' self-assessed need for further training provided by the employer was discussed in the course of the interviews and most agreed that they would like to have additional education regarding English used in nursing and medicine. Some nurses innovated during the interviews on what kind of additional education would be most useful, for example Helena and Milla thought that short additional refresher lessons for the whole staff would be beneficial. They mentioned that would like to have liked to have for example English lessons on patient guidance included on their weekly staff meetings every now and then. Sanna's English skills had been tested while she had applied for the position to find out if she needed extra language education which is a novel approach in the hiring process of nurses in Finland, and the rationale given to her by the employer was to ensure that the nurses could reply to the needs of the growing English-speaking clientele. She mentioned that the shifts were allocates according to the nurses' language skills, especially those which focused on the nurse-led phone and chat services, and that the employer was in the process of organising additional language education for those who needed it to respond to the demand. Maria as well had employer-provided language training but according to her those tended to be Finnish and Swedish lessons rather than English, which she would have liked to have more.

4.3.2 Other members of staff

The presence of other staff members impacting the nurse-patient communication was discussed with the interviewees to see how they regarded the presence of other staff members during the visits of English-speaking patients. Most often the other staff members were physicians or other nurses who either needed assistance or whom the nurse in question required assistance from. In Tiina's workplace at the emergency clinic all patients saw a physician and she was present in the appointment room if the physician required assistance, for example in wound care. She viewed this as a positive practice, because then she knew what matters were discussed and the terms the physician had used with the patients, which she used later as she went through homecare instructions with the patients. She also felt that she receives assistance when needed from her colleagues and physicians and likes to help them in turn

> At times – when the patient's English is not great – I have had to help out my colleagues. They would ask me for help, like do you know how say this better or I would like to say this, but I don't know how. Then we think together how to say it. Maybe it's more this way around. That I get to help others. (22)

Sanna was also asked to assist with English-speaking patients often because her colleagues knew she was fluent in it. She did not mind the practice as long as she could delegate some of her own duties to the colleagues while she helped them with the communication. When she required help from others with English-speaking patients, it was because the health topic in question was not her forte, such as vaccinations, although she coped with the language aspect of the interaction. Similarly, Helena and Milla sought help from physicians only when they needed detailed information of illnesses or treatments, because they had extensive work experience in their field and were fluent in English. They saw patients on their own, usually before and/or the physician's appointment, but felt neutral if there was a colleague or a physician in the same space. Helena sometimes asked the other staff members for alternative explanation if they were there and Milla remarked laughingly that "*It doesn't really affect me if someone else is there, I just tend to gabble the same with the patients even if there are people listening*". Laura and Maria mostly saw patients on their own, and their appointments were not always linked to a visit with a physician. However, they did have multidisciplinary team meetings regularly in which they could discuss cases and treatment options. Laura preferred that she and the physicians saw patients separately because she had noticed that there was often overlapping speech and information when there were more than one professional present which confused the patients. Close cooperation with the other professionals involved in the children's care, such as a speech therapist and kindergarten teacher, was an important resource for Maria in challenging cases, although she did rarely required assistance from colleagues otherwise owing to her expertise.

In conclusion, the nurses worked for employers who in general had created functional patient appointment and call systems, although the workdays could be busy because of the medical condition and needs of the patients. The nurses used additional material varyingly depending on where they worked and all of them knew where to search for extra information should they need it. The presence of other staff members was perceived as neutral or slightly negative, but as all of the nurses mostly took care of patients on their own in their current workplaces, their experiences of this were limited.

5 DISCUSSION

The aim of this study was to discover factors which contributed to successful and unsuccessful nursing ELF situations from the nurses' point of view through the six interviews. A successful nursing ELF situation was defined as an experience in which the interviewed nurse considered the communication between her and the patient to be adequately fluent for both participants to understand each other. An unsuccessful nursing ELF situation was one in which the interviewed nurse thought a satisfactory understanding between her and the patient was impeded by a disfluent communication. The interview findings aligned with earlier and larger scale nursing ELF studies, but they also brought forward and emphasised individual aspects of successful English as a lingua franca communication which have not been focused on before. Reasons for this may include my own background in nursing and thus being able to relate easily with the interviewees as well as having first-hand experience of the process of developing professional expertise in one's specific field of nursing.

The results indicated that an individual nurse's growing work experience correlates positively with successful ELF encounters with patients, especially as she or he gains field-specific implicit and explicit knowledge. Closely tied to this was the confidence in one's own adequate proficiency in English and the courage to speak it with patients, trusting that they will eventually understand one another. By adapting Mauranen's (2017) view of linguistic approximation, this phenomenon may be explained by an individual nurse's advancement in approximation as certain terms and concepts specific to the field of nursing become repeated by a variety of speakers over extended period time. As a result, these terms and their approximations become firmly entrenched in an individual nurse's cognitive processing. As the interviewed nurses used English for a number of reasons in diverse contexts, and were thus knowledgeable in the language in general, they probably had had ample opportunities to enhance their ability to recognise fuzzy, non-standard forms of different terms, i.e. the cognitive processes of approximation were familiar to them. This prior familiarity aided them in recognising approximations with patients which in turn fed the positive cycle of entrenching certain terms which were used often in their field of nursing. However, the nurses did not report relying on prefabricated sentences to aid communication in English, except to follow institutionally mandated guidelines, such as information about a private provider's payment procedure or an admittance checklist for on-call nurses, which were used also when communicating in domestic languages. This suggests that using stock phrases is not an integral part of a successful nurse-

patient communication in an additional language. Furthermore, Tweedie and Johnson (2018) warn against overly positive view of one's additional language abilities as healthcare professionals because their study has shown that nursing students missed information during a shift change report which experienced nurse practitioners deemed important. However, the nurses interviewed in this study were not inexperienced and therefore it can be presumed that they recognised when they had not received enough information from a patient in order to make important nursing decisions. For example, Helena would sometimes contact a patient over the phone after their visit if she doubted whether the patient understood her correctly. If Laura did not understand why a patient was calling, she would ask them to come for an extra visit to the clinic to find out. These instances demonstrate that the interviewed nurses recognise when they do not understand the patient and attempt to repair the ambiguity or misunderstanding between them, somewhat similarly to Pietikäinen's study (2018) of the resourcefulness facilitating mutual understanding and recognition of lack of understanding between ELF couples. The nurses also used previously identified[5] verbal and non-verbal pre-emptive measures to ensure mutual understanding , such as paraphrasing, showing pictures and body language, which is not a unique feature of nursing ELF communication, but a part of core nursing skills and responsibilities, i.e. finding a way to communicate with patients in a way which suits them best.

Disagreement and conflict situations were rare, if not non-existent, in the interviewed nurses' experiences of delivering care to an English-speaking patient. Although there were difficulties in establishing similar rapport with patients who had limited English skills compared to patients with same L1 similarly to Lu's (2018) findings, the nurses had solved disagreements often by addressing them openly, which again is skill that develops with work experience. As explicit communication to the patient of their condition and illness is a part of the legal duties of nurses in Finland[6], the nurses had also learned to navigate fulfilling this duty with patients who came from backgrounds in which explicit communication about their bodies was a taboo subject. Accommodating to the patients' by using the terms they preferred, even euphemistic ones and giving anatomically and physiologically accurate information were balanced by using the patient's preferred term whenever the nurses estimated that it precise enough not to cause misunderstandings or that the use of term would not misguide the patients.

[5] See Badrov (2017), Bosher & Stocker (2015), Chien (2019) and Hämäläinen (2017).
[6] For more information, see Act on the Status and Rights of Patients 785/1992, Section 5: Patient's right to be informed. Available at https://www.finlex.fi/en/laki/kaannokset/1992/en19920785_20120690.pdf

In nurse-led online chat services and phone conversations patients' very limited English skills were a source of mis- and nonunderstanding as many of communication aids of face-to-face interactions such as body language were absent. Similarly to Kaur's (2016) study as reasons leading to misunderstanding, ungrammaticalities and misspelling were specifically challenging in chat messages, whereas speech tempo as well as unfamiliar pronunciation were highlighted in phone conversations. Some patients resolved to employ a relative or a friend with better English skills to call on their behalf, but this practice is not uncomplicated although the patient would not mind sharing their health information with significant others. One of the most compelling arguments against using an advocate is that describing another person's symptoms, particularly ambiguous ones, is not an easy task in own L1, let alone in an additional language. Thus, further education for addressing these issues remains a significant challenge for development of nursing ESP courses and materials. Interestingly, managing ethically difficult situations in additional language were not overly challenging for the nurses, probably due to the serious nature of the profession itself and exposure to similar situations previously. The nurses' professionalism through verbal and non-verbal communication, such as being assertive yet empathetic, seemed effective in creating an atmosphere in which difficult matters could be discussed composedly. Contrary to Jenks' (2017) study of uncooperativeness in ELF situations, with the help of their professionalism nurses strive to reach a consensus with patients or at least explain the reasons for a chosen course of treatment to the patients, and do not let the lack of mutually supportive interaction to be a source of communication breakdown. As in Bjørge's (2016) study of international business experts, to whom the ability to handle conflict while maintaining rapport was part of professionalism, negotiating disagreement was part of the interviewed nurses' skillset. Overall, the nurses described conflicts and disagreement in ELF communication as rare occasions, which leads to an unknown factor in the successful navigation of various nursing ELF situations: the outlook of an individual nurse. As opposed to Lu's (2018) findings of in-service nurses who would in occasionally avoid communicating with English-speaking patients due to self-assessed limitations of language skills, nurses in this study did not demonstrate a tendency to avoid ELF communication, on the contrary, they had a positive outlook that any communicative situation can be solved in the end. Once again, the findings suggest that a positive outlook, confidence in using English and growing expertise in nursing equip an individual nurse to be competent in most ELF interactions with patients of various backgrounds and language skills.

6 CONCLUSIONS

If successfulness of ELF interaction between nurses and patients on the nurse's side is dependent their outlook, English skills and work experience as the findings of this study propose, how to address these in nursing ESP materials and courses remains a puzzle and requires further research. An investigation of nurse-patient interactions could reveal the interplay of these and currently unknown factors in practice, thus showing which factors actually contribute to successful ELF communication. Perhaps one solution to encourage and aid in-service nurses in the meanwhile could be to form field-specific international stable or transient online communities of practice in which they could share linguistic resources and effective ways of managing situations in which they encounter patients with limited English-skills, somewhat similarly to what Jenkins (2015) and Mortensen (2017) suggested. To develop useful learning materials for in-service nurses who speak English as a lingua franca with patients there is an urgent need to discover their needs regarding nursing ELF through further research. Perhaps universally effective materials cannot be developed as the needs of individual nurses varies greatly, but an aim to develop content which would encourage nurses to strive towards mutual understanding with patients, such as interviewing techniques and active listening skills, should be taken. Increasing telehealth services provide another area of development for nursing ESP as the findings of this study point out that phone and chat services can be more challenging than face-to-face encounters in which the whole range of human expression can be used. Phone and online chat services are the most popular means of telehealth services at the moment, but other forms such as online nurse consultations are increasing in popularity. Previous nursing ELF studies address the importance of listening and speaking skills, but reading and writing skills ought not to be disregarded as nurse chats and other nurse-led online health services will likely increase in popularity in the future because of their probable cost-effectiveness and convenience, at least in the first stages of seeking medical attention. The solution to equip nurses with nursing ELF savvy telehealth skills should perhaps be elaborated not only by applied linguistics but in collaboration with other fields and their professionals, such as software developers, for creating telehealth software which would have for example built-in autocorrection and translation properties that would help nurses to understand patients with very limited English skills. Whatever the practical solutions may be, as this study among others has shown that successful nursing ELF encounters consist of complex set of factors and individual skills, the development of nursing ESP continues to require multifaceted and innovative approaches to meet the needs of in-service nurses.

REFERENCES

Amery, E., Tweedie, M. G. & Johnson, R. C., 2019. Teaching & Learning Guide for: Research directions in medical English as lingua franca (MELF). *Language and Linguistics Compass,* 13(9), pp. 1-6.

Badrov, T., 2017. Attitudes of nursing students toward the importance of communication skills in the English language. *Journal of Applied Health Sciences,* pp. 265-271.

Bergroth, U.-M., 2007. *Finnish professionals with limited English proficiency: a study of language attitudes and language use,* Jyväskylä: University of Jyväskylä.

Bjørge, A. K., 2016. Conflict Talk and ELF Communities of Practice. In: P. Holmes & F. Dervin, eds. *The Cultural and Intercultural Dimensions of English as a Lingua Franca.* Bristol: Multilingual Matters, pp. 114-133.

Bolton, K. & Kachru, B. B., 2006. *World Englishes: Critical Concepts in Linguistics Volume V.* New York: Routledge.

Bosher, S., 2013. English for Nursing. In: *The Encyclopedia of Applied Linguistics.* Oxford: Wiley-Blackwell, pp. 1961-1966.

Bosher, S. & Stocker, J., 2015. Nurses' narratives on workplace English in Taiwan: Improving patient care and enhancing profesiionalism. *English for Specific Purposes,* Volume 38, pp. 109-120.

Braun, V. & Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative research in psychology,* 3(2), pp. 77-101.

Chien, C.-y., 2019. Identifying Core Learning Needs for English for Nursing Purposes. *English Language Teaching,* 12(7), pp. 1-11.

Cogo, A. & Pitzl, M.-L., 2016. Pre-empting and signalling non-understanding in ELF. *ELT Journal,* 70(3), pp. 339-345.

Franceshi, V., 2015. Nursing students and the ELF-aware syllabus: exposure to non-ENL accents and repair strategies in coursebooks for healthcare professionals. *Iperstoria - Testi Letterature Linguaggi,* pp. 51-61.

Hujala, E., 2009. *English as a Lingua Franca in the workplace: one-size-fits-all? : in search for a deeper understanding of Finnish speakers of ELF,* Jyväskylä: University of Jyväskylä.

Hämäläinen, M., 2017. *Nursing students' professional oral English communication skills in simulated data,* Jyväskylä: University of Jyväskylä .

Jenkins, J., 2012. English as a Lingua Franca from the classroom to classroom. *ELT Journal,* October, 4(66), pp. 486-494.

Jenkins, J., 2015. Repositioning English and multilingualism in English as a Lingua Franca. *Englishes in Practice,* 2(3), pp. 49-85.

Jenks, C., 2017. Uncooperative lingua franca encounters. In: J. Jenkins, W. Baker & M. Devey, eds. *The Routledge Handbook of English as a Lingua Franca.* London: Routledge, pp. 279-292.

Kallio, A., 2013. *Hoitajien kokemukset vuorovaikutuksesta maahanmuuttajien kanssa ja vuorovaikutuksen kehittäminen.* Satakunta University of Applied Sciences. https://www.theseus.fi/handle/10024/54656 (Accessed 16 March 2016).

Kaur, J., 2016. Intercultural Misunderstanding Revisited: Cultural Difference as a (non) Source of Misunderstanding in ELF. In: P. Holmes & F. Dervin, eds. *The Cultural and Intercultural Dimensions of English as a Lingua Franca.* Bristol: Multilingual Matters, pp. 134-156.

Kiiski, M., 2013. *Vieraskielisten potilaiden hoitotyö — haasteet ja niihin vastaaminen kirurgisilla vuodeosastoilla.* Satakunta University of Applied Sciences. https://www.theseus.fi/handle/10024/54529 (Accessed 16 March 2016).

Lahtinen, E. & Pekansaari, A., 2013. *Maahanmuuttajien kokemuksia ohjauksesta ennen ja jälkeen leikkauksen.* Tampere: Tampere University of Applied Sciences. https://www.theseus.fi/handle/10024/68394 (Accessed 16 March 2016)

Langacker, R., 1987. *Foundations of Cognitive Grammar: Theoretical prerequisites, Vol. 1.* Stanford California: Stanford University Press.

Leppänen, S. et al., 2011. *National Survey on the English Language in Finland: Uses, meanings and attitudes,* Jyväskylä: University of Jyväskylä.

Lu, Y.-L., 2018. What do nurses say about their English language needs for patient care and ESP coursework: The case of Taiwanese nurses. *English for Specific Purposes,* Volume 50, pp. 116-129.

Mauranen, A., 2017. Conceptualising ELF. In: *The Routledge Handbook of English as a Lingua Franca.* Routledge, pp. 7-24.

Mejías, E., 2019. *Finnish Students View on the English Language Taught Degree Program in Nursing.* Jyväskylä: University of Jyväskylä.

Mortensen, J., 2017. Transient Multilingual Communities as a Field of Investigation: Challenges and Opportunities. *Journal of Linguistic Anthropology,* 27(3), pp. 271-288.

Nieminen, T., Sutela, H. & Hannula, U., 2015. *Ulkomaista syntyperää olevien työ ja hyvinvointi Suomessa 2014 (UTH),* Helsinki: Tilastokeskus.

Pietikäinen, K. S., 2018. Misunderstandings and Ensuring Understanding in Private ELF Talk. *Applied Linguistics,* 39(2), pp. 188-212.

Richards, K., 2003. Interviewing. In: *Qualitative Inquiry in TESOL.* Basingstoke: Palgrave Macmillan , pp. 47-103.

Rissanen, K., 2013. *Sairaanhoitajien kuvauksia monikulttuuristen potilaiden postoperatiivisesta kivun hoidosta.* University of Eastern Finland. https://epublications.uef.fi/pub/urn_nbn_fi_uef-20130540/ (Accessed 16 March 2016).

Ritala, M., 2017. *ELF in Nursing: Experiences of Finnish Nurses,* Helsinki: Helsingin yliopisto. Unpublished BA thesis.

Siili, T. & Mäntyharju, E., 2010. *Monikulttuurisen asiakkaan kohtaaminen — hoitohenkilöstö- ja asiakasnäkökulma.* Tampere: Tampere University of Applied Sciences. https://www.theseus.fi/handle/10024/15284 (Accessed 16 March 2016).

Statisctics Finland, 2019A. *Ulkomaalaistaustaiset.* [Online]
Available at: https://www.tilastokeskus.fi/tup/maahanmuutto/maahanmuuttajat-vaestossa/ulkomaalaistaustaiset.html
(Accessed 15 February 2020).

Statistics Finland, 2018. *Liitetaulukko 2. Väestö kielen mukaan maakunnittain 1997–2017.* [Online]
Available at: http://www.stat.fi/til/vaerak/2017/vaerak_2017_2018-03-29_tau_002_fi.html
(Accessed 24 January 2020).

Statistics Finland, 2019B. *Statistics Finland.* [Online]
Available at: http://www.stat.fi/til/vaerak/2018/vaerak_2018_2019-03-29_tau_001_fi.html
(Accessed 24 January 2020).

Statistics Finland, 2019C. *Vieraskieliset.* [Online]
Available at: http://www.stat.fi/tup/maahanmuutto/maahanmuuttajat-vaestossa/vieraskieliset.html
(Accessed 24 January 2020).

THL, 2014. *Survey on work and well-being among people of foreign origin (UTH).* [Online]
Available at: https://thl.fi/en/web/thlfi-en/research-and-expertwork/projects-and-programmes/survey-on-work-and-well-being-among-people-of-foreign-origin-uth
(Accessed 24 January 2020).

Tweedie, M. G. & Johnson, R. C., 2018. Listening instruction for ESP: Exploring nursing education where English is a lingua franca. In: *International perspectives on teaching the four skills in ELT: Listening, speaking, reading, writing.* Cham: Palgrave Macmillan, pp. 65-80.

Tweedie, M. G. & Johnson, R. C., 2019. Research directions in medical English as a lingua franca (MELF). *Language and Linguistics Compass,* 13(3), pp. 1-12.

Tynkkynen, T., 2012. *Sairaanhoitajien asenteet maahanmuuttajia kohtaan kulttuurisen kompetenssin näkökulmasta — kyselytutkimus sairaanhoitajille Helsingin ja Uudenmaan sairaanhoitopiirin päivystyspoliklinikoilla.* Laurea University of Applied Sciences.
https://www.theseus.fi/handle/10024/44313 (Accessed 16 March 2016).

VOICE. 2009. The Vienna-Oxford International Corpus of English (version 1.0 online). Director: Barbara Seidlhofer; Researchers: Angelika Breiteneder, Theresa Klimpfinger, Stefan Majewski, Marie-Luise Pitzl. http://voice.univie.ac.at (Accessed 15 June 2019).

Välimäki, H.-M. & Tihumäki, J., 2014. *Hoitajan ja ulkomaalaisen potilaan vuorovaikutus.* Satakunta University of Applied Sciences. https://www.theseus.fi/handle/10024/83354 (Accessed 16 March 2016).

Wenger, E., 2015. *Introduction to communities of practice.*
Available at: https://wenger-trayner.com/introduction-to-communities-of-practice/
(Accessed 23 February 2020).

APPENDIX: A list of possible interview questions

If you think about situation in which speaking English with patients has been successful, i.e. you have both understood each other satisfactorily, what kind of situations have these been? For example:

- Were these situations scheduled or unscheduled?
    - If scheduled, how did you approach the upcoming event, for example nervously, excitedly or neutrally?
    - Did you prepare yourself beforehand for example by researching the topic in English or checking certain words?
- Did you meet the patients face-to-face or was it a phone conversation?
- Did the patient understand the figures of speech which you used? Did you understand the patient's?
- Did you use prefabricated language or stock sentences which are generally used in patient guidance to facilitate the patient's understanding?
- Was it easy for you to come up with new ways of saying things in that situation? For example, to use the same terms which the patient used?
- Did you have support material available? For example, patient guides in English?
- What other methods did you use? For example, writing, drawing, gesturing?
- How was the patient?
    - For example, was the illness recent, acute, chronic? In which part of the care process did you met the patient: in the beginning, during a hospital stay or in the middle of treatments, on a follow-up visit?
    - Was the patient familiar with the operation of the Finnish healthcare system?
    - Do you think the patient's educational background mattered in the situation? How about their English skills?
    - Do you think the patient's accent influenced the fluency of the communication?
    - Do you think there was enough time reserved for the encounter? Does the scheduling influence the communication in your opinion?
- Were there other professionals for example colleagues or physicians present?
- Were there the patient's relatives or other companions present?

- How did you feel about your language skills at the time?
- How much time had elapsed since you last used English with patients? Do you often use English with patients?
- Had you used English in your free time before this?
- What factors influence communication in English with patients the most in your opinion?

If you look back on the situations which were challenging with English-speaking patients, what do you think influenced them?

- When did you notice that the communication is not going well? For example, from the beginning, during the conversation, when disagreeing about the care plan?
- How did you notice that the patient did not understand?
- How was the patient? Anxious or nervous?
- Was the patient willing to cooperate despite the language barriers?
- Was there enough time? Did the situation require swift solutions because of the illness for example?
- Did you get help from other professionals? How did your work community feel about speaking English during the situation?
- Did you find support material helpful, for example word lists? Did you use non-verbal methods, for example body language?
- How did you feel about your language skills at the moment?
- Did you know the subject matter beforehand, for example the patient's illness? Had you been in a similar situation before?
- What do you think had the most profound effect on the communication?
    - Lack of language skills: yours or the patient's?
    - Unfamiliar accent or native language influence on English?
    - Did the patient use unfamiliar words, expressions or figures of speech?
    - Illness-related reasons? Some conditions, for example aphasia or dyslexia?
    - Lack of previous knowledge about the condition or treatment options on your or the patient's side?
    - The presence of other people, for example other professionals or the patient's relatives?

    - The patient's mood? Your mood? Stress, fatigue etc.?
- Did you learn something about these situations? Do these situations become easier over time?
- Have these challenging situations helped you to cope in other similar situations?
- Have these challenging situations caused you worry about speaking English with patients in general?

What else would you like say about using English with patients?

Some general questions about language skills

- How do you feel about your language skills in general?

- How do you develop or maintain your language skills?

    - During free time, self-study, connecting with friends etc.?
    - Or professionally, for example participating in language courses at your workplace or following the development of your field in English?