Parents and nurses during the immunization of children—where is the power? A conversation analysis

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Background. Best practice for health care practitioners is considered patient-centred approaches which empower patients. Immunization of young children requires maintaining this approach while retaining professional management.

Objective. The objectives were to assess situations within the immunization event with discordance between health provider and caregiver and evaluate strategies used to empowering parents while obtaining the desired clinical outcome.

Methods. This was a qualitative study nested within a larger study of immunization rates in 124 randomly selected primary care practices. Interactions between immunizing practice nurses, caregivers and children were videotaped and transcribed and underwent conversation analysis. Six purposively sampled primary care practices in Auckland, New Zealand, served as the setting. The participants were eight practice nurses immunizing 10 children and their parents. Normative pattern of interactions and ‘deviant cases’ involving discordance between nurse and parent.

Results. A total of 168 minutes of video-recorded conversation from 10 immunization sessions provided strong ‘typical’ pattern and equally striking ‘deviant cases’. Parents mostly treated nurses as ‘experts’ and accepted asymmetry of knowledge over medical matters. Nurses demonstrated skilful strategies in delineating their area of medical expertise from areas in which patients are expert—their knowledge of themselves and their children.

Conclusion. While patient centredness and empowering patients are contemporary goals of primary health care delivery, these attributes are not precisely defined. Patients may wish to be informed, but many trust their health professionals to direct their decision making. Although health professionals may impart as much knowledge as they can, asymmetry of knowledge remains. However, patients hold expertise beyond their clinical situation in the social and economic world in which they live.

Keywords. Caregivers, immunization, power, primary health care, qualitative research.

Introduction

In New Zealand (NZ) immunization has eliminated polio and controlled tetanus and diphtheria.\textsuperscript{1} However, due to inadequate coverage, immunization gains are not as high as they should be. Disease persists, as seen with recurrent epidemics of measles and pertussis.\textsuperscript{2,3} The burden from vaccine-preventable disease affects Maori and Pacific children disproportionately.\textsuperscript{4} General practice nurses give most childhood vaccinations,\textsuperscript{5} and their key role in immunization delivery appears to be succeeding, with rates for immunized Pacific children rising from 53% in 1992 to 89% in 2000.\textsuperscript{6}

The general practitioners may have the key role in initially convincing caregivers of their need to vaccinate their children, and caregivers who flatly refuse will not present at the clinic with their children for immunization, except opportunistically. However, this small group tends to be of European ethnicity and higher socio-economic status, whereas the main gains in improving immunization uptake has been targeting the socially deprived and ethnic minorities. Although

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there has been recognition of the importance of nurses in primary care and some exploration of their views on barriers to immunization,7 no studies have looked at the specific methods and processes nurses use to achieve this success within the targeted group.

The interaction between nurse and caregiver at immunization delivery is crucial. Should parents find offence, they may not complete a course of immunizations and may influence others not to immunize. Nurses are inescapably in a position of ‘interactional delicacy’ when they deal with parents.7,8 They must allay parental anxiety, deliver a potentially painful injection and involve parents appropriately in the process, while maintaining professional control and educating or even correcting parental knowledge where necessary. They must achieve a balance between professionalism and expertise on the one hand and friendliness and egalitarian demeanour on the other. This dilemma has been recognized in many institutional settings, particularly when parents and experts are involved in decision making involving a child.9 Mothers have been shown to be sensitive and vigilant to criticism of their mothercraft in their interactions with health professionals.10,11 Interactions between parents and health professionals have been described as ‘encounters . . . drenched with implicit moral judgements, claims and obligations’.12

In maintaining good client relations, veterinarians have been shown to sometimes use talk directed at or on behalf of pets (in the animal’s ‘voice’).9 The literature has demonstrated similarities of this communication when people engage in ‘baby talk’ where the addressee (animal or baby) has limited comprehension and the communication is expressing friendliness and affection.7

The aim of this study was to assess situations of concordance and discordance within the immunization event between health provider and caregiver and evaluate strategies in which primary health care nurses successfully resolve any arising discordance to obtain the desired clinical outcome of immunization.

Methods

The study was nested within a larger study of immunization rates in 124 randomly selected primary care practices in northern NZ. Six practices were purposively recruited to study the interaction between nurses and caregivers of the child receiving an immunization, as well as interactions between the adults and the child. These included one Maori health provider and one practice with a high number of Pacific patients. Eight practice nurses consented to video recording of their administration of vaccinations. Caregivers were approached prior to their child’s immunization procedure to give consent for participation in the study. Ethics approval was obtained from the Auckland Regional Ethics Committee.

Immunization sessions between consenting immunization providers and caregivers were video recorded in 2005.

Conversation analysis (CA) was conducted on all videotaped data. A simplified version of standard CA transcription was used as a practical compromise between precision and readability.13 In this context punctuation is not grammatical but expresses intonation and pauses:

[ ] overlapping talk
() words in round brackets are indistinct, or altered, e.g. (Name)
(() transcriber’s descriptions
:: lengthened vowel
() pause
___ underscoring indicates stress.

CA differs from thematic analysis in that it has a different rationale for building a corpus of evidence and a different object and mode of analysis. In CA the aim is to examine both the organization of talk and the social actions it achieves. The ‘sampling strategy’ is first to accumulate a typical or normative pattern of interactions in a corpus and then to examine when, how and to what end ‘deviant cases’ take place.14 The distribution of either of the ‘typical’ pattern or the deviant case is of little relevance to CA because all the ‘environments of possible relevant occurrence’ cannot be known.15 A primary tool of CA is concentration on single cases and small numbers of deviant cases.16 As the discipline has grown, more analyses are based on large databases17 and interventions based on CA results are proving robust when analysed statistically.18

In the context of this paper, the typical or dominant pattern was of concordance between parent and nurse. The deviant cases constituted the focus of the analysis: when, how and why do parents contradict or rebuke nurses? CA was carried out with particular attention to instances of interactions where some ‘competence struggle’11 could be observed in which a parent was seen to contest or in some sense reject the right of the nurse to ‘know’ or exercise power over the baby or child.

Instances were collected of what we have termed ‘tamariki-talk’ (to distinguish from ‘baby talk’ or ‘motherese’ as used in the literature19,20). Tamariki is the Māori word for children heard commonly in both educational settings and public life. Tamariki-talk was talk addressed to children by either the provider or caregiver. The tamariki-talk enunciated to the baby or infant was collected in context.21

Results

The data consisted of 168 minutes of video-recorded conversation from 10 immunization sessions between
immunization providers and caregivers. These conversation data provided a very strong typical pattern and equally striking deviant cases.

All the immunization providers were female practice nurses. Two fathers (one accompanied by a grandmother) presented with a baby and all other children were presented by mothers.

In conversation, parents treated the nurses as ‘experts’ most of the time and accepted an asymmetry of knowledge between them over medical matters. They commonly asked questions and deferred to the knowledgeable answers provided.

However, this deference to the power of the nurse as an expert was curtailed at the point it presumed knowledge about their child. Parents were to differing degrees vigilant about their own ‘power’ in this regard. Disagreements were always, and only ever, when the parent rebuffed the nurse’s behaviour as ‘presuming’ the role of mother.

An example of this dichotomous power allocation can be observed in an interaction between a first-time mother and a nurse. The mother began the session by launching immediately into a request for information, an explicit deferral to the nurse’s expertise:

N: So, how are you?
M: She’s good. She’s good. I do have a question for you though. The um meningococcal, is that does that have to be done at certain times?...

But someone was saying at coffee group, I was worried that the time had run out, because they were talking at coffee group about it, some of them won’t have them injected at all...

But they were talking about it they had a lady there and they were saying that it had to be done like 28 days, 28 days, 28 days, and I said ‘Oh my God’.

N: No, no, there’s a timeframe, um, between the first and second—four to eight weeks, between the second and the third—six to 12 weeks.
M: That’s right.
N: And, and even if that elapses, we can still [carry on and do it].
M: [Yeah, because it’s like, its like] the Hepatitis isn’t it, in that you have to have them within [but it’s not].
N: [Yes, it’s just] sort of the approved timeframe. The best timeframe I guess you could say.

After further discussion, with the nurse asking a few more clarifying questions, nurse and mother aligned over how ‘scary’ meningitis is:

N: The thing with meningitis is that it is such a, um, a short illness in a way.
M: Hmm.
N: You know, she might be quite well one day and she could be dead the next [and that’s the scary thing].
M: [Or devastating react] like, you know, losing her limbs and stuff like that, that make you think [o:::h].
N: [And that’s] the scary thing about it, that, there isn’t a timeframe, to think is this or is this not, and then, you know?
M: Oh, yes, yes.

While this mother was willing to defer to the ‘power’ of the nurse as knowledgeable in this sphere, she allowed the nurse no expertise in regard to her baby, its antics or development:

1. B: (blert).
2. M: This is, this is the new sound.
5. N: This is the play.
6. M: Yes [this is her].
7. N: [this is the] play time.
10. M: Bubbles, we blow bubbles all the time now cos we think that’s.
11. re::ally cool.
12. N: That’s—it is cool, except that when you’re got a mouthful of food.
13. M: Oh, ynn she doesn’t do it when she’s got a mouthful of food, but, but she
14. does it all the rest of the time so she’ll be soaking, she’ll be soaking.
15. [right down to here].
17. M: No, she’s not. No, no, [no].
18. N: [no].
19. M: it’s just blowing bubbles. Literally she thinks it’s the co::olest noise out.
20. N: Good for her. (.) Now I just need you to get...
In the first nine lines the nurse merely received the mother’s comment with ‘okay’ (Line 3), posed a question to the mother ‘this is play?’ (Line 5), confirmed the mother’s statement in overlapping talk (Line 7) and smilingly greeted the baby with an endearment. All this provoked no resistance from the mother. However, when the nurse proffered a comment which presumed to know the baby’s feeding habits (Line 12), she was immediately rebuffed. Again when she presumed knowledge of the baby’s development in starting teething (Line 15), she was contradicted by the mother (Line 16). The nurse then aligned with the mother by joining in her reiteration of ‘no’, endorsing the mother’s next statement and returning to her own domain of medical expertise: ‘good for her (.) now I just need you to get….’

In this instance the ‘struggle’ was resolved relatively easily; minor repair work was required from the nurse. But other situations called for more skill.

In a second case the mother brought a both baby and a very restless pre-schooler for immunization. This child’s behaviour gradually became more intrusive until finally he began to shoot water from a tap. The mother rebuked the child and the nurse joined in:

(noise of water playing into sink behind M)

M: Sit [down].
N: [You’re tutuu] (Māori meaning ‘naughty boy’).
M: (Name) down now. (.) (You’re) laughing at him.

That’s just provoking [him].
N: [Okay.] So in the other ones I would bring this in cos um, I forget. . . .

This is a severe response from a parent about the tamariki-talk of the nurse: cutting off the nurse’s talk and delivering an outright rebuke. The nurse displays great sensitivity to this. As soon as the mother’s criticism is evident, the nurse initiates return of the talk to matters undeniably her domain: medical information. This nurse never made another comment pertaining to the demeanour or control of the child, except in relation to control of medical equipment when she acted peremptorily and without contradiction from the mother. In this instance she moved unilaterally to remove injection equipment from his range with ‘OK you just leave those. Those are for your sister. We will put your one over here. I would hate you to hurt yourself on it?’

While she spoke without hesitation and without reference to the mother who made no objection to this display of authority, the nurse nevertheless diluted its peremptory force by attaching a conciliatory explanation with a rising end intonation.

When the issue of the child’s obedience to instruction arose again, the nurse was exquisitely careful to ensure her suggestions were taken up and ‘owned’ by the mother. The issue was how best to position the child to receive immunization injections. The nurse initially addressed her suggestions boldly to the mother only to have them rejected peremptorily. When it was obvious that the child would not follow the mother’s instructions, the nurse subtly positioned the mother to accept what the nurse believed would work. The mother had just asserted that the child will sit on a seat next to her and the nurse, who was standing, bent towards the mother to make a sotto voce suggestion (Line 1) and then turned away mid-sentence to plump up cushions on the floor (Line 2):

1. N: I actually prefer it myself if if um, if your child is sitting on (.) on
2. your [knee::?].
4. N: yeah (turns away to plump up cushion on floor).
5. M: It was okay, because it was (X) that did the last one. Hahahaha.
6. N: Yeah. And she heh has heheh got f- far more heh experience
7. than w- what I have [hahah].

The nurse thus made her own preference known, but allowed the mother to over-talk the conclusion of ‘your knee’. This allowed the mother’s continuing ‘yeah’ (Line 3) to be taken as the first part of a pair of utterances, with which the nurse could now agree (Line 4). The nurse then stood up and turned round to face the mother and rejoin the conversation. She not only accepted but upgraded the mother’s face-saving explanation, making of it a joke against herself, in which she joined.

A potential struggle was thus avoided and transformed into a successful event of shared laughter, albeit at the price of some self-criticism and ‘confession’ of limited expertise by the nurse.

Discussion

Over the past decade ‘patient-centred’ consulting skills increasingly are seen as crucial for the delivery of effective primary care. A number of observational studies have reported relationships between doctor behaviour defined as ‘patient centred’ and a variety of patient health outcomes. For example, a positive association was reported between use of a patient-centred
approach by general practitioners with improved patient enablement and satisfaction and reduced symptom burden and referral rate.\textsuperscript{22} However, what constitutes ‘patient centeredness’ is not precisely defined.\textsuperscript{22}

According to the Royal Council of Nurses, empowering patients is a central element of nursing care.\textsuperscript{24} In reality this is not straightforward. Empowerment brings with it responsibility. For true power equality in health care, the issue of an individual taking over responsibility for his or her own health and how these decisions affect others needs to be addressed. The power of health providers is also constricted by financial and political aspects such as rationing of health care services. As with patient centeredness there is lack of clarity and consensus about interpreting patient empowerment, which renders measuring and evaluating an empowering service problematic.\textsuperscript{25} Elliott identifies dilemmas for the empowering nurse as ‘How does the nurse identify what degree of power the patient wishes to wield?’ and ‘How does the nurse reconcile expressions of patient power which may conflict with her duty of care and role as a carer?’\textsuperscript{25}

Power is an inescapable aspect of all social relationships, inherently neither good nor evil. Health providers need power to fulfil their professional obligations to multiple constituencies including patients, the community and themselves. Patients need power to formulate their values, articulate and achieve health needs and fulfill their responsibilities.\textsuperscript{26} The ethical effectiveness of a health system is maximized by empowering providers and patients to develop ‘adult–adult’ rather than ‘adult–child’ relationships that respect and enable autonomy, accountability, fidelity and humanity. However, even in adult–adult relationships, conflicts and complexities arise. Lack of concordance between provider and patient can encourage paternalism but may be best resolved through negotiated care. A further area of conflict involves the double responsibility of providers to both patients and the community.

Similarly, the objective of the UK Department of Health initiative on the ‘expert patient’ is to encourage patients to become actively involved in decisions concerning their treatment.\textsuperscript{27} However, it is arguable to what extent patients can be considered truly experts. While health professionals may impart as much knowledge as they can, most patients will not possess ‘the physiological and pharmacological knowledge to fully appreciate the biological nature of their illness nor the basis, risks or limitations of therapeutic measures.’\textsuperscript{27} Asymmetry of knowledge will remain. Currently available accounts of patients’ perspectives suggest that patients do not generally embrace empowerment.\textsuperscript{25,28} Patient/health provider collaboration can lead to shared knowledge.\textsuperscript{30} However, while they may wish to be informed, many patients want to trust their health professionals to direct their decision making.\textsuperscript{29}

Where patients can be considered expert is in the sense that they are the ones who experience their illness. Furthermore, beyond their clinical situation is the social and economic world in which they live, of which they undoubtedly hold the expertise.\textsuperscript{31}

The dilemma facing nurses around patient empowerment is particularly pronounced in the area of immunization of young children.

A strength of this study is the use of CA (the study of talk in interaction) of a large and rich videotaped data set of 10 immunization events. While the results cannot be generalized, they do demonstrate skilful strategies developed by nurses to delineate their area of medical expertise from areas in which patients are expert—their knowledge and control of themselves and their children. Such findings are likely to be transferable to other circumstances where a fine balance is required by health care providers between empowering their patients and directing the consultation towards the outcome that they consider clinically desirable.

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Declaration

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References


