RECALLING THE DOCTOR TO ACTION – TWO REQUESTING FORMATS EMPLOYED BY A NURSE FOR MAKING RELEVANT THE DOCTOR'S INTERVENTION

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Abstract: At the hospital, nurses' telephone calls to doctors mostly revolve around obtaining doctors' intervention in a medical case. To achieve this, nurses need to make the doctor's intervention relevant, by explicitly requesting it or, more indirectly, by reporting a medical problem. Two recorded telephone conversations have been selected for analysis that show a young and newly employed nurse dealing with a medically and inter-professionally difficult situation: reminding a doctor that he has delayed too much his coming to see a patient. By deploying a conversation analytic approach, the article assesses two different practices or resources the nurse uses for negotiating and obtaining the doctor's intervention – an explicit request and a report of a medical problem[1].

Keywords: conversation analysis, hospital, telephone, requests, reports

Özet: Bir hastanede, hemşirelerin doktorlarla yaptıkları telefon görüşmeleri çoğunlukla bir tıbbi bir vakaya yönelik doktorların müdahalede bulunmalarını istemek üzerine gerçekleşir. Bunu başarmak için hemşirelerin açık bir şekilde doktor müdahalesini talep ederek ya da tıbbi bir problemi dolaylı bir şekilde rapor ederek bu müdahaleyi gerekli kılmaları gerekmektedir. Analiz için genç ve yeni atanan bir hemşirenin tıbbi ve kurum içerisinde zor olan bir durumla nasıl başa çıktığını gösteren iki telefon görüşmesi seçilmiştir: bir doktora bir hastaya bakmak için gelmesini geciktirdiğini hatırlatmak. Konuşma çözümlemesi yöntemini kullanarak bu çalışma, hemşirenin doktor müdahalesini görüşmek ve istemek için kullandığı iki farklı uygulama ya da kaynağı incelemektedir- açıkça talep etmek ve tıbbi bir problemi rapor etmek.

Anahtar sözcükler: konuşma çözümlemesi, hastane, telefon, istekler, raporlar

1. Introduction

The nursing profession is experiencing constant change with regards to professionals' roles and practices, which translates into the acquisition of new medical responsibilities and the modification of inter-professional relations (Allen, 2001; Nadot, 2012). Combined with the ever-developing technological environment, this flux requires that nurses must display competencies not only in the medical domain but also in terms of managing good work relations with their peers and other hospital staff (Ly et al., 2013; Munoz et al., 2013; Tjora, 2000; Wu et al., 2011).

Nurses' and doctors' collaboration as a medical team within the hospital has an important impact on patients' outcomes and on the general clinical performance of the institution (Manojlovich & DeCicco, 2007; Schmutz & Manser, 2013; Randamaa et al., 2014). Routine yet unscheduled oral communication is the basis of their day-to-day interaction as several occasions bring these two professionals together (Hill, 2003; Flicek, 2012; Lanza et al., 2004). With doctors and nurses receiving separate education on intra-professional communication (Dixon et al., 2006), young professionals experience a marked gap between the "prescribed work" and the "real effective work" that is involved in dealing with

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unforeseen incidents, cases and circumstances that require planning and negotiation through oral communication (Seferdjeli & Terraneo, 2015).

This study seeks to contribute to research on nurse-doctor interaction by looking at an activity that is specific to nurses' effective tasks in a hospital surgery unit: coordinating activities with doctors over the telephone, and negotiating and obtaining their intervention in medical cases. The article provides an in-depth investigation of an instance of interaction that sheds light on the characteristics of the nurse-doctor relationship and their mutual communication at the hospital. It also offers an insight into how the inter-relational and medical challenges the two professionals are faced with are handled.

2. Project and data
This article uses the data collected for the project "New on the job"[2], which aims to achieve an understanding of the interactional competencies of newly employed nurses as displayed during telephone conversations with members of the hospital personnel. Within this framework, a corpus of 374 audio-recorded telephone calls was collected over six months, between three young nurses in their first year of employment in a hospital surgical unit, and 59 different telephone numbers corresponding to other hospital professionals. The data were supplemented by ethnographic observations carried out in the units recorded.

Several publications on the conversations collected (González-Martínez et al., 2015; Petitjean et al., 2015) have shown the advantage of using telephone recordings, as naturally occurring interactions in medical settings, to study nurses' task coordination with other professionals, and to determine how particular business is dealt with when they call specific interlocutors. This article focuses on how nurses deal with medical problems when they call one of their most frequent interlocutors: doctors.

By adopting a conversational analytic (CA) approach (Sacks et al., 1974), the article focuses on the most recurrent activity encountered in the conversations between these two professionals: the nurse makes relevant and requests for a doctor intervention. Doctors may intervene by engaging in a future activity (for example, the doctor comes to see the patient or sign the release forms) or by giving a verbal order through which the nurse is required to take some action (for example, the doctor orders the nurse to administer medicine to the patient). The distinction is an important one, as the nurse's request may be immediately accomplished over the phone (through verbal orders) or accomplished in the future (with the doctor agreeing, promising etc. to do something). In order to achieve this, the nurse may mobilize different kinds of resources, such as explicitly referring to the intervention or reporting a medical problem.

The event selected in order to describe how nurses make relevant and request doctors' intervention consists of a nurse dealing with a particularly problematic medical situation: a doctor who first agrees to come to the unit to check a patient's bandage (Call 1) fails to make an appearance, and the nurse must call him back and remind him of his engagement (Call 2). Though both conversations follow from the same "reason" for the call (Schegloff & Sacks, 1973: 301), the resources used for making the reason relevant vary, as in the second call the nurse has to not only request something from the doctor, but also make a reference to something that was already requested, and granted (i.e. the doctor agreed to engage in the intervention), before.

The exchange was selected because it makes observable how the day-to-day challenges with which a nurse is faced are not only of a medical nature, but of an interactional one as well. The nurse making the two calls is managing both medical and inter-professional contingencies in a very short lapse of time. The article will investigate the way the doctor's intervention is made relevant in the first and then the second conversation, as a subsequent (already discussed) issue, and how the nurse displays her orientation to the second call as a professionally and medically delicate issue through the use of a change in requesting formats and other resources.

3. Review of literature

The focus of the article intertwines several perspectives, all of which are the interests of CA: How are subsequent calls structured and negotiated in institutional interactions? How is intra-institutional interaction, especially that between nurses and doctors, organized? How can requesting an intervention in medical settings be accomplished through different formats?

Though not inquiring into the activity of reminding someone of previous engagements *per se*, CA studies on institutional interaction have taken an interest in the study of subsequent calls in which a same issue is discussed and oriented to (Beach & Lockwood, 2003; Ekström & Lundström, 2014; Raymond & Zimmerman, 2007; Shaw & Kitzinger, 2007; Whalen et al., 1988). In such situations, interlocutors deal with and orient to the telephone call in ways that display it as not an ordinary but a "same event call" (Raymond & Zimmerman, 2007). Changes can be traced through the initial and subsequent interactions. They are made manifest by, for example, the speaker announcing the engagement in a repetitive activity (Ekström & Lundström, 2014; Shaw & Kitzinger, 2007), accounting for it (Whalen et al., 1988), as well as by making subsequent modifications in the format of their reason for the call (Beach & Lockwood, 2003).

Another perspective engaged by the present article is that of professional interaction among health practitioners within the hospital, i.e. the intra-institutional dimension – the "third major stream of research in medical CA" (Gill & Roberts 2013:580). In this line of research, several studies have taken interest in the accomplishment of coordinated activities and actions during hospital training (Pomerantz, 2003, Pomerantz et al., 1995, Hindmarsh, 2010) and during the organization of teamwork (most especially, surgeries Koschmann et al., 2007, 2011; Hindmarsh and Pilnick, 2002, 2007; Mondada, 2011, 2014), showing how coordination is achieved through various conversational actions such as instructions, requests, directives, and orders. Telephone interaction and nurse-doctor telephone interaction have however remained fields still largely understudied.

Several authors have observed that a speaker may employ reports or explicit requests when requesting that an interlocutor engage in a current or future activity (such as assistance to a problem, providing help or for joint projects), in mundane situations as in institutional ones (Drew, 1984; Curl, 2006; Kendrick & Drew, 2014). Requests make explicitly available to the recipient an action that is to be accomplished (Kendrick & Drew, 2014). Different linguistic and interactional resources used to accomplish this activity index the speaker's orientation to and perception of their entitlement to make the request and the contingencies related to it being granted (Wootton, 1981; Lindström, 2005; Vinkhuyzen & Szymanski, 2005; Heinemann, 2006; Curl & Drew, 2008 - among the most salient).

Extensive conversation analytic literature on the use of reports as initial actions during institutional phone calls has pointed to the fact that they accomplish requests for assistance.

Three domains have received particular attention: citizens' calls to emergency services (Zimmerman, 1984; Whalen & Zimmerman, 1987; Whalen et al., 1988; Whalen & Zimmerman, 1990; Zimmerman, 1992; Wakin & Zimmerman, 1999; Raymond & Zimmerman, 2007), clients' calls to helplines (Baker et al., 2001; Houtkoop et al., 2005; Kraan, 2005; Danby et al., 2005) and patients' calls to medical professionals (Leppänen, 2005; Drew, 2006; Shaw & Kitzinger, 2007). While varying in content according to their institutional purpose and recipient, reports project a next relevant action by the call taker (Whalen & Zimmerman, 1987) and present the recipient with an opportunity for offering assistance to the speaker.

Until recently, conversation analytic literature on clinical telephone calls focused mainly on interactions between care providers (doctors or nurses) and patients (Sacks, 1966; Greatbatch et al., 2005; Drew, 2006). The data analyzed in this article offers an interesting practice for conversational analytic purposes as it allows a better understanding not only of intra-institutional interaction (between nurses and doctors) but also of how one nurse uses a request and a report to make relevant the doctor's intervention, and how her orientation to a subsequent request is made observable. With respect to the specific conversational phenomena dealt with, this study draws from and contributes to the rapidly expanding field of research on requesting in talk-in-interaction (Drew & Couper-Kuhlen, 2014).

4. Case study: Recalling the doctor to his previous commitment
The event described and analyzed here consists of a nurse dealing with a doctor who hasn't shown up to fulfill a previous engagement. It shows the set of interactional skills and resources deployed by the nurse in order to obtain and manage the doctor's intervention in the unit, even when occasional setbacks arise.

The two calls are made by the same nurse (referred to as Amaryse in the conversation, May in the transcript) to the same resident doctor (Ben in the transcript), and take place 23 minutes apart on a weekday morning. Calls are very short in intra-hospital telephone interaction (Edwards et al., 2009): the first conversation (Call 1) takes place at 10:10 am and lasts 15.7 seconds; the second conversation (Call 2) takes place at 10:35 am and lasts 12.2 seconds[3].

Both conversations are a discontinuous exchange concerning the same patient and procedure: the nurse is calling about a patient, Mr. Morin, who is to have his dressing checked by the resident doctor. Five other conversations in the corpus of calls between nurses and doctors involve requests for a patient's dressing to be redone by the doctor, with assistance from the nurse. This is a recurrent activity in a surgery unit: as most patients are recovering from surgery, their wounds need to be checked and the dressing changed, an activity performed by the nurse in charge of the patient and the surgeon who operated[4]. The activity is usually scheduled during the morning rounds but, as not all surgeons manage to make their rounds, the nurse sometimes calls the surgeon, or is called to plan and coordinate the dressing change. The days for dressing changes are scheduled in advance and written down on the patient's chart; both the doctor and the nurse have access to this.

Below are the complete transcripts of the two conversations and brief comments on how the interaction develops; a closer analysis will be presented afterwards.

Call 1
```
1          ((1.0 ringback tone))
2          (2.9)
3  Ben:    (oui) allô?
```

```
             yes    hello
 4           (0.3)
 5  May:   ·h ↑oui salut c'est Amaryse en unité quatre
               yes hi    it's  Amaryse in unit four
 6  Ben:   oui: (ci[ao)]
           yes    ciao
 7  May:        [euh]:: j't'app↑elle ( ) si tu veux v'nir voir
                  uh  I'm calling you ( ) whether you want to come see
 8         le pansement de m'sieur: Morin. h
           the dressing of mister Morin
 9         (0.4)
10  Ben:   oui: écoute tu le laisses ouvert euh: cinq minutes
           yes listen  you leave it  open    uh   five minutes
11         et pis je: je viens le voir [(.) (après)        ]
           and then I I come    see it      afterwards
12  May:                               [↑ouais pas d'souci] ça marche
                                         yeah no problem    that's fine
13         merci ciao
           thanks ciao
14  Ben:   merci >ciao<
           thanks ciao
15         ((1.0 phone being hanged up))
```

In Call 1 the nurse uses a straightforward request to inquire whether the doctor "wants to see" (line 9) Mr. Morin's dressing (i.e. the intervention). The requested activity (coming to see the patient) is presented as something within the doctor's volition via the format "want to"). This type of format is frequently used in the other conversations of the corpus as a display of the nurse's knowledge and entitlement to request the doctor to make the intervention. The doctor asks the nurse to leave the dressing open for five minutes (line 10), and subsequently informs her that he will come by to see the patient (line 11). This obliges the nurse to undo the dressing, disinfect the wound and leave it exposed (routine tasks), and wait for the doctor's arrival at the patient's side. The second conversation (Call 2) is a result of the doctor not showing up after twenty minutes of waiting.

Call 2
```
 1          ((1.0 ringback tone))
 2          (4.0)
 3  Ben:   a↑llô?
           hello
 4  May:   ·h <oui: excuse(h)-moi c'est encore Amaryse en U quatre ·h=
           yes excuse me it's Amaryse again in U four
 5  Ben:   =[(ouais)]
           yeah
 6  May:   =[£j'ai  ]installé le ↑patient£ mais du cou(h)p i(h)l commence à avoir
           I've installed the patient but  as a result he is starting to have
 7         un peu mal à la ↑jam:be alors [euh  ]
           a bit of pain in the leg so uh
 8  Ben:                                 [ouais] >eh je viens ↓je viens<
           yeah eh I'm coming I'm coming
 9  May:   £d'acc↓ord ça marche£ merci
           all right  that's fine thanks
10  Ben:   °ciao°
           bye
11         ((1.0 phone being hung up))
```

In Call 2, we discover that the patient has been ready for a while[5] for his dressing check (line 6) and is starting to experience pain in his leg (line 7) - likely, the place where the dressing is placed. The nurse makes this available through a report of a medically problematic and unexpected situation, which makes no explicit reference to the doctor's commitment to engage in a future intervention. The situation reported is one in which the nurse has reached the limit of her professional knowledge and which depends on the doctor's medical expertise. In

response to this report of unexpected medical trouble, the doctor restates his commitment to "coming" (line 8).

Call 1 and Call 2 exhibit an identical sequential three-part structure: opening (Call 1 lines 1-6; Call 2 lines 1-5), body (Call 1 lines 7-12; Call 2 lines 6-9) and closing (Call 1 lines 13-14; Call 2 line 10). The intrinsic changes from Call 1 to Call 2 show the nurse and the doctor displaying an orientation to this being an issue that was already discussed and for which a decision has already been made.

Using the telephone to coordinate with other professionals in the hospital for the purpose of accomplishing collaborative activities (such as the dressing change) is a complex task that requires a certain organization (Vaucher & González-Martínez, 2015). The situation here is particularly delicate as the nurse only has a small window of opportunity for calling the doctor: a dressing cannot be left open for too long because of the risk of infection. Overall, these two conversations also make relevant a consideration of the attribution of rights and responsibilities between the doctor and the nurse. While the doctor has the authority to evaluate the state of the wound and to assess whether additional intervention is needed before the dressing is redone, the nurse has the right to request the doctor's intervention, to schedule it, or to bring to the doctor's awareness any events that have occurred in his absence (a different repartition of deontic rights, Stevanovic, 2011). The roles of these two professionals are thus intertwined in achieving the same goal - the patient's well-being.

The situation is even more interesting as the nurse is faced with a situation that presents interactional difficulties in a private or institutional context: reminding someone of something they forgot to do. The successful way in which the nurse handles this problematic situation shows her aim towards maintaining a delicate equilibrium between accomplishing her nursing tasks in the unit (i.e. getting the doctor to come redo the bandage) and preserving harmonious work relations (i.e. not explicitly presenting the doctor's delay as failing to accomplish his duties).

In the following section, a line-by-line analysis will offer a better understanding of how the doctor's intervention can be obtained in the hospital and what resources are employed by the nurse to address such a sensitive issue as the doctor not showing up.

5. The first conversation: initiating a request
The first conversation shows a three-part structure (opening, central part and closing). This structure, as well as the format of the request, corresponds to how nurses usually accomplish an explicit request for the doctor's coming to see a dressing.

5.1. Opening
In the opening of the call the interlocutors establish mutual recognition, showing closeness through the use of a first-name basis, before launching the reason for the call:

Call 1: Excerpt 1.1.
```
 1          ((1.0 ringback tone))
 2          (2.9)
 3  Ben:    (oui) allô?
            yes   hello
 4          (0.3)
 5  May:    ·h ↑oui salut c'est Amaryse en unité quatre
               yes hi     it's  Amaryse in unit four
 6  Ben:    oui: (ci[ao)]
            yes   ciao
```

The opening is similar to that described in English in institutional settings, in which practices encountered in ordinary calls are reduced and specialized (Heritage & Clayman, 2010; Zimmerman, 1992; Whalen & Zimmerman, 1987): doctor's answer to summons (line 3), nurse's interlocking turn containing the confirmation of reaching the right number, a greeting and the institutional identification (line 5), and doctor's recognition of and reciprocation to the greeting, which also serves as a go-ahead for developing the reason for the call (line 6).

5.2. Launching a request

After the establishment of identities, it is the caller who provides the first and only topic of the conversation (Schegloff, 1968) - a request for the doctor's intervention accomplished through a reference to his wanting (i.e. desire) to come:

Call 1: Excerpt 1.2.
```
 7  May:        [euh]:: j't'app↑elle ( ) si tu veux v'nir voir
                 uh  I'm calling you ( ) whether you want to come see
 8           le pansement de m'sieur: Morin. h
             the dressing of mister Morin
```

The nurse begins her turn by marking audible preparation to speak ("uh") and using the anchor position to overtly introduce ("I'm calling you") the reason for the call (Schegloff, 1986; Couper-Kuhlen, 2001). The call experiences a technical problem and the rest of the utterance is not available (a 0.06-second glitch that seemingly erased the sound); the nurse continues her turn by requesting the doctor's intervention: coming to see the dressing. The use of the conditional "whether" in this first pair-part (Sacks et al., 1974) shows the nurse testing her inference about what the doctor wants to do instead of explicitly requesting him to do it; her use of a conditional mitigates the request. The activity is thus apparently left to the doctor's assessment, as he is the only one entitled to know his own desires (epistemic authority, Heritage, 2012).

In addition, through the use of a locally initial reference (Schegloff, 1996) in a turn-final position to designate the patient, "mister Morin", the nurse displays an orientation to the activity seeing the dressing as being the main one, contrary to seeing the patient (which generally in this corpus start off with the patient's name). This reflects the fact that, indeed, dressing checks are a routine activity for both the nurse and the doctor.

5.3. The doctor's answer

In an adjacent turn and second pair-part (Sacks et al., 1974) in the request sequence, the doctor agrees to comply with the nurse's request, and provides a specific time frame for his intervention:

Call 1: Excerpt 1.3.
```
10  Ben:   oui: écoute tu le laisses ouvert euh: cinq minutes
           yes listen  you leave it  open   uh   five minutes
11         et pis je: je viens le voir [(.) (après)       ]
           and then I I come   see it      afterwards
12  May:                              [↑ouais pas d'souci] ça marche
                                        yeah no problem   that's fine
13         merci ciao
           thanks ciao
14  Ben:   merci >ciao<
           thanks ciao
```

The doctor's reply starts with a stressed and lengthened acknowledgement token ("yes", 10) that shows an understanding of the activity requested as being recognizable (what coming to *see* a dressing entails) and expected (routine and scheduled). This is enhanced by the use of "listen", a turn-initial element that indexes a departure from the topic's progressivity and projects that the answer to the request will be delayed (Heritage, 2013). The doctor summons the nurse's attention as he first issues a verbal order (or instruction) to "leave it open " (line 10). In other words, the nurse is supposed to leave the wound exposed for five minutes. Through the use of a locally subsequent reference ("leave it", Schegloff, 1996) the doctor orients back to only one of the potential items in the nurse's previous talk (the dressing vs. the patient), thus aligning with the nurse's own orientation to the dressing as being the main item on the agenda. This also makes the intervention more abstract (a doctor dealing with generic dressings) and puts emphasis on the organization of dressing checking as a routine activity for himself and for the nurse.

The doctor continues with a conjunction ("and then", line 11), that points to a relation of posterity in time, thus displaying the previous instruction to the nurse as concerning something that has to be done beforehand. He repeats the same intervention that the nurse requested ("come see"); this repetition is a resource particularly useful as the doctor's response first dealt with other than providing an answer to the request (but instead gave a verbal order). By linking his coming to see the dressing to the nurse's activity, the doctor is thus using the time frame of "five minutes" (the amount of time that the nurse would leave the dressing open) to imply that it also represents the period of time that will elapse before his arrival in the unit. The doctor therefore not only agrees but also commits to coming to see the patient by offering a restrictive time frame after which he will show up.

5.4. Closing
After the doctor's answer, the nurse orients towards closing the business of the call while displaying a full understanding of how and when her future activities and the doctor's intervention will unfold:

Call 1: Excerpt 1.4.
```
10   Ben:    oui: écoute tu le laisses ouvert euh: cinq minutes
             yes listen  you leave it  open    uh   five minutes
11           et pis je: je viens le voir [(.) (après)        ]
             and then I I come    see it      afterwards
12   May:                              [↑ouais pas d'souci] ça marche
                                         yeah no problem    that's fine
13           merci ciao
             thanks ciao
14   Ben:    merci >ciao<
             thanks ciao
```

The first turn after the doctor's response (lines 12–13) is a composite sequence-closing third (Schegloff, 2007) that displays the nurse dealing with the multiple activities that were negotiated and coordinated in the previous sequence. In overlap with the doctor's increment ("afterwards", line 11), the nurse introduces an acknowledgement ("yeah"), displaying herself as "registering and accepting" (Schegloff, 2007) the doctor's answer, that is, acknowledging both the doctor's request and his agreement to come and see the dressing. By saying "no problem," the nurse orients to her involvement in the activity of opening up the dressing in the absence of the doctor and waiting for five minutes as being non-problematic (in regards to her knowledge and her other activities). Subsequent to this, the nurse assesses the general result of the request sequence, saying "that's fine" (using a French colloquialism) to express that the way the situation is planned to unfold is satisfactory.

As the sequence-closing third treats the business under discussion as ready to be concluded (Schegloff, 2007), it allows the nurse to engage in sequence termination by initiating an exchange of appreciation tokens, to which the doctor responds identically ("thanks"-"thanks"). This identical exchange and the speedy movement toward closing ("ciao") positions the nurse and the doctor as coworkers in an intra-institutional setting of shared constraints: the nurse orients to the fact that the doctor is complying with her request, and the doctor orients to the nurse keeping him up to date with business in the unit that requires his attention.

At the end of this call, the nurse has received ample reason to expect the doctor to come see the patient within a specific time frame. According to my ethnographic observations, at this point the nurse goes towards the patient and engages in the activity of opening up the dressing, informing the patient that the doctor is on his way and waiting for the doctor's arrival by the patient's side. As Call 2 is made 23 minutes after, it becomes clear that the nurse has accomplished her tasks but that the doctor has failed to show up. Though the reason for the delay is never discussed, the nurse will need to find the resources to remind the doctor that he has failed to show up and recall him back to action.

6. The second conversation - reminding the doctor of his intervention

The second call has a sequential structure identical to the first, while paying tribute to the fact that it is a subsequent conversation about an issue discussed before. Its subsequent nature permeates through the opening to the closing of the call, and will generate resources through which the nurse will treat the situation as in urgent need of the doctor's attention and intervention.

6.1. Opening

Right from the opening, the nurse makes explicit that she is calling the same doctor again:

Call 2: Excerpt 2.1.
```
 3  Ben:    a↑llô?
             hello
 4  May:    ·h <oui: excuse(h)-moi c'est encore Amaryse en U quatre ·h=
                 yes   excuse me    it's Amaryse again   in U four
 5  Ben:    =[(ouais)]
             yeah
```

Though the conversation starts in a similar way to the first (doctor's answer to summons, nurse's initial confirmation), a first noteworthy difference is the absence of greetings, through which the nurse is establishing a sense of immediacy to some previous conversation (Arminen & Leinonen, 2006) and more specifically displaying the current call as not being her first contact of the day with the doctor.

The nurse proceeds by displaying the call to be a possible future offense, and initiates a request to be excused ("excuse me", line 4), generally differentiated from explicit apologies (such as "sorry": Robinson, 2004; Heritage & Raymond, 2015). This "offense-remedial-related action" (Robinson, 2004) projects a future offense to come rather than orienting to a past one. By continuing with her self-identification, the nurse treats the offense as being related to the fact that she is calling again and that this is a subsequent call. On the first hand, the projected offense may be the call itself: though a new request is needed because the doctor hasn't yet come to see the patient, the nurse orients to this recall and reminder as being a potential interruption or disruption for the doctor. At the same time, another type of offense

may be caused by the professional asymmetry between the two participants: nursing staff vs. medical staff. The apology is uttered with breathy laugh particles (Jefferson, 1985; Potter & Hepburn, 2010), a phenomenon often encountered in situations of troubles-talk in which the speaker is exhibiting "troubles resistance" (Jefferson, 1984), and associated with the reporting of misdeeds (Jefferson et al., 1987; Haakana, 2010; Heritage, 2009). In this case, as the laugh particles accompany the uttering of the request to be excused, they mark this exact activity as being a transgression (instead of the whole turn or action). As the laughter is mid-turn, the recipient isn't offered the interactional space to join and reciprocate. These two resources (the breathy laugh particles and the apology) help her move forward in the call to the next action (reporting) while orienting to the next action as possibly dispreferred.

The work on making the conversation receivable continues as the nurse inserts, in the middle of her self-identification, a reference to this being a subsequent conversation ("again"). The adverb is used here within its iterative significance, announcing an event that would not be expected under reasonable circumstances (Mosegaard, 2002). Explicitly orienting to *calling again* before issuing a reason for the call may show that the speaker is faced with a dilemma of needing to tell someone something they already know (Raymond & Zimmerman, 2007:42) but it may also be a resource for accomplishing potential indirect criticism of the recipient (Ekström & Lundström, 2014). In this case, the moral and professional dilemma that the nurse seems to face is how to tell someone something they were told before, but that they have seemingly not (yet) taken into consideration. Through these three resources (breathy laughter, apology and orienting to this being a subsequent request), the nurse displays herself as aware of being about to engage in a possibly transgressive but necessary activity. As these resources are inserted before the actual reason for the call is issued, the nurse pre-empts any possible criticism and shows herself as claiming entitlement to performing such an activity (much in the way as one wouldn't disturb someone unless something important happened). By making this explicitly a *calling again* and orienting to her next action as dispreferred, the nurse is also indexing what the upcoming action will be (requesting his presence for the dressing check). This could be a first opportunity for the doctor to come in with some sort of offer of promise for action, before the nurse is forced to make a request.

6.2. Making the doctor's intervention relevant
In the central part of the call, the nurse makes a report on the state of affairs relating to the patient. The report makes relevant, without explicitly requesting, the doctor's intervention, both because of the new situation (the patient is in pain), and because his intervention has been expected since the last conversation:

Call 2: Excerpt 2.2.
```
 5  Ben:    =[(ouais)]
             yeah
 6  May:    =[£j'ai  ]installé le ↑patient£ mais du cou(h)p i(h)l commence à avoir
              I've  installed the patient  but  as a result he is starting to have
 7          un peu mal à la ↑jam:be alors [euh  ]
            a bit of pain in the leg so    uh
```

The report is issued directly after the nurse's identification and consists of two references: something that the nurse did ("I've prepared the patient", line 6) and the situation ("he is starting to have a bit of pain in the leg", lines 6-7). The first reference is to a nursing activity and concerns the fact that she has removed the dressing (as the doctor previously requested in Call 1 - excerpt 1.2.) and has prepared the patient so that the doctor can inspect and assess the results of the surgery (infection, swelling, suture points). By displaying herself as having complied with the doctor's request, the nurse is making an implicit reference to the activity

that is the subject of the call - seeing a dressing - which requires both interlocutors to take action. The nurse thus shows herself as having completed her part of the activity and thus makes more obvious that the doctor is lagging behind. This is uttered with a smile voice (Glen & Holt, 2013), projecting the problematic character of what is about to be said (Petitjean & González-Martínez, 2015). The nurse chooses a recognitional description in order to refer to the patient ("the patient", line 6), instead of his name (Schegloff, 1996). Indeed, the patient was mentioned earlier and is in conversational "close proximity" (Schegloff, 1996) for the doctor to achieve recognition. By using this anaphora, the nurse is engaging the doctor in the reminding of a previous conversation - of the patient, the request and therefore the intervention that was to be accomplished.

The second part of the nurse's turn ("but as a result...", lines 6-7) is a report of a problematic activity encountered in the unit: the patient is experiencing pain. It is latched onto the previous TCU with two syntactic connectors. The first one ("but", line 6) marks what follows as being in contrast with the previous activity and as inadequate (Deppermann, 2005): pain is an unwelcomed result in any medical activity. The second connector, "as a result", is a French colloquial expression employed to introduce a new element as a direct consequence of a previous one.[6] Overall, the patient being in pain is an undesirable situation having arisen from the nurse's activities as dictated by the doctor's orders, and, though not articulated, from his not being there right away to take over from the nurse. It is produced with breathy laughter particles, a display of the nurse's uneasiness with the inference of this direct and indirect causality. The nurse may also hint at the delicate situation in which the doctor puts her, which is of having to manage a patient in pain. Put together, these two connectors establish the second part of the report as being in contrast and at the same time a consequence (yet unattended) of the first part. The fact that the patient is experiencing pain is displayed as a direct consequence of the nurse's activity (a dispreferred result marked by the use of suppressed laughter at the beginning of the turn), as well as an indirect consequence of the doctor's previous orders and of his not showing up to complete the task.

The patient is described as "starting to have" (line 6), which describes a situation that has just begun but is also ongoing. On the one hand, the nurse describes herself as in the midst of an activity and as in an interaction with the patient, turning to the doctor just when things start to go bad. On the other hand, the nurse is also indicating that a problematic situation is about to get worse - "starting to have" pain projects a shift into soon having even more pain. This is enhanced by the use of the adjective "a bit of pain" which treats the current situation as being minimal, compared to a projected one that would involve increased pain. Talking about pain means localizing the problem entirely within the patient's realm and sensory field, and reporting something reported by the patient, unlike something noticeable and reportable by the nurse alone, such as a swelling. The nurse introduces the patient as being the prime character of the problematic event and thus distances herself from complaining about something that is problematic for herself. However this also serves the purpose of mitigating the implicit accusation of the doctor having caused this symptom through his absence.

The nurse also mentions the exact location of the pain and, through inference, the region where the dressing is - the leg (line 7). In doing so, she transforms the request from a routine one, about examining a dressing (in Call 1), to a problem-oriented and pain-related one (in Call 2), thus avoiding doing the same thing twice. By naming a part of the body (instead of, for example, mentioning general pain), the nurse makes her report more specific and the trouble more tangible and concrete. The word "leg" is pronounced with a jocular inflection, tying it to the preceding instances of words pronounced with laugh particles. This resource is

used by the nurse to refer to the situation (the patient being in pain as a consequence of the doctor's non-compliance; the nurse having to deal with a complaining patient) as being a delicate one (Jefferson, 1984; Jefferson et al., 1987; Haakana, 2010; Heritage, 2009).

A new syntactic connector, "so", is used as the report is completed ("so uh", line 9), indicating the start of a new TCU in which the nurse prepares to draw conclusions, which will ultimately be abandoned. This provides an opportunity for the doctor to intervene and show understanding of what the issue is, which would avoid the nurse accomplishing a highly dispreferred action (drawing conclusions).

In her short turn, the nurse uses several resources to report a problematic situation to the doctor (a format often used by nurses in order to obtain the doctor's intervention), all the more worrying since the doctor himself has caused it. Her reminding of the doctor is made with implicit reference to the fact that the dressing check has been initiated (the nurse has opened it) but not finalized, and that this is endangering the patient's well-being.

6.3. The doctor's answer

Though the nurse abandons the conclusions she was preparing to draw from her report (line 7), the doctor recognizes her syntactically incomplete turn as interactionally complete (Chevalier & Clift, 2008). He is able to retrieve what else needs to be done without the nurse making it explicit. He replies (line 8) to the nurse's report by committing to a self-selected intervention that was not explicitly mentioned by the nurse during this conversation, thereby recognizing that the situation needs to be addressed but also that he was supposed to do as much before:

Call 2: Excerpt 2.3.

```
6  May:   =[£j'ai  ]installé le ↑patient£ mais du cou(h)p i(h)l commence à avoir
              I've  installed the patient  but  as a result he is starting to have
7          un peu mal à la ↑jam:be alors [euh  ]
           a bit of pain in the leg so     uh
8  Ben:                                   [ouais] >eh je viens ↓je viens<
           yeah eh I'm coming I'm coming
```

The doctor responds "I'm coming" (line 8), displaying an understanding of the report as being an unarticulated request for his intervention, and evaluating its implications as qualifying for an intervention on his part. The rapid repetition of his projected intervention "I'm coming I'm coming" is an instance of multiple and identical sayings accomplished with one intonational contour (Stivers, 2004), a resource used by speakers to address the action embodied in the previous turn and to show a stance against the interlocutor continuing. By delivering this repetitive answer in a single prosodic unit, the doctor is not merely acknowledging what is expected of him but also displaying himself as engaged in doing it and signaling to the nurse that no further talk (and especially talk of causality and consequences) is needed. He is also repeating the intervention that was asked of him in the previous call, thus engaging in the process of remembering what he was supposed to do. This works in overlap with the nurse's turn and her abandoning her turn at talk, to show the doctor as not in need of being reminded, not having forgotten, but rather having been busy elsewhere and now physically engaged in coming to see the wound.

6.4. Closing

The doctor's answer is acknowledged and accepted during a sequence-closing third by the nurse (line 9):

Call 2: Excerpt 2.4.

```
 8  Ben:                                   [ouais] >eh je viens ↓je viens<
            yeah eh I'm coming I'm coming
 9  May:    £d'acc↓ord ça marche£ merci
            all right  that's fine thanks
10  Ben:    °ciao°
            bye
```

The nurse issues a minimal post-expansion (Schegloff, 2007): "all right" and "that's fine"; the first one indexes the nurse's acceptance and acknowledgement of the doctor's answer to her report, while the second one addresses the whole process of the patient's wound still needing to be looked at, and soon, by the doctor. The nurse utters these assessments with a smiling voice, which shows that a delicate situation is successfully being dealt with. As in the previous call, it is again the nurse who initiates the appreciation token ("thanks" line 9); this however doesn't receive a reply from the doctor, and it portrays the nurse as benefitting (Heritage & Clayman, 2010) from the doctor's commitment. Her appreciation is answered by his initiating a soft-spoken, though definite, closing ("ciao" line 10). The doctor is thus displaying his understanding that the conversation is over, that the nurse does not have other business to address in this call, and that he is in a hurry (hopefully, to come see the patient).

7. Discussion
As the ethnographic observations within this unit have shown, one of the realities of hospital work is that most practitioners are often on the move and the nurses need to track them down. This is particularly true for surgeons - especially residents, who when called are often between surgeries, dealing with patients of several units and their families, or at seminars. The nurse has to keep track of the doctor's activities, while displaying an understanding that delays are possible and do not inherently convey a careless or forgetful attitude from the doctor. This activity would be very difficult in the absence of the telephone as a technical communication device.

The study of Call 2, contrasted to that of Call 1, allows reflecting on the fact that though the medical aspects of a nurse's tasks may be the most salient of her activities, they are often the result of collaborative work (with other nurses, with doctors or other health professionals), which requires employing various interactional resources. Communicating about regular business, such as in Call 1, even when expected and not problematic, unfolds according to interactional contingencies such as establishing identities, choosing a particular format for a request, identifying what needs to be done. These contingencies are also present when dealing with trouble, as in Call 2, though supplemented by additional work that addresses a particular practice: that of reminding or recalling someone back to a previous engagement that was not upheld.

Both calls illustrate two instances in which the nurse manages to make relevant, over the telephone, the doctor's intervention in quite different medical and interactional contexts, though related to an identical reason for calling.

Call 1 exemplifies how a nurse may successfully request a doctor's intervention in what can be considered a routine context. It also shows that even though requests are granted by doctors, this does not automatically lead to their accomplishment (a specificity of long-distance communication). The nurse is as much engaged in making the request as in the monitoring of how and when the doctor's intervention will take place. Call 2 was chosen because, although different from the majority of the calls in the corpus, it is an example of a kind of interactional trouble that intra-institutional callers face, and of the resources employed

in order to successfully deal with this situation. Such cases are unforeseen but are often encountered in any professional environment, and pose two difficulties to the newly employed nurse, notably her medical responsibility toward the patient (and the need to prevent risk of infection and pain) and the need to maintain good inter-professional relations with the doctor (by not engaging in assigning blame or complaining).

The nurse employs several strategies to manage and negotiate these two responsibilities. A first set of resources is directly targeting the character of the second call. By inserting suppressed laughter and breathy laugh particles in her talk, and by starting the call with an apology and situating it as a *calling again*, the nurse shows that while the call may be of a transgressive nature, it is warranted by special circumstances that grant her the entitlement to engage in this activity. A second resource used is allowing the doctor to engage in a process of remembering and self-selection in order to perform an activity he had already committed to. This is achieved by avoiding openly articulating any direct reference to the past request, and instead orienting the doctor to associate the reference used in the second conversation with the first. The nurse avoids formulating any mention of blame, her report being loaded with mitigation of a worsening situation. And ultimately a third resource resides in the choice of format through which the doctor's intervention is made relevant: while in Call 1 the nurse uses an explicit request that allows her to deal with routine and expected/scheduled business, in Call 2 she makes a report of a medical problem and a reference to pain, which are sufficient to highlight the urgency of the situation and to trigger the doctor's intervention. As such, by reporting untoward circumstances and indirectly displaying them as caused by the doctor's non-attendance, the nurse positions these possibly complainable elements as in need of urgent assistance. The doctor's presence is not explicitly requested but made relevant by virtue of the institution's rules: dressings should not be kept open for too long because of a risk of infection, and patients should not be kept in pain (not to mention that nurses should not be kept waiting). In this way, the nurse emphasizes how the activity is and should be routinely accomplished, and not the fact that the doctor hasn't accomplished it yet.

Reminding an interlocutor to whom a request has been made that its application is still pending is a delicate business. It is made even more so by the difference in institutional roles combined with the different and delicate balance of epistemic position (Heritage, 2013) and deontic authority (Stevanovic, 2011) between nurses and doctors, as well as the fact that the nurse is a recent hire, perhaps not yet acclimated to the usual practices in the unit. By mobilizing specific resources, the nurse reaches a balance between her duty as a nurse (to the patient's well being) and as a co-professional (not assigning blame), which allow her to competently overpass this delicate moment with no friction and pursue her tasks.

Such incidents are of interest not only from a CA perspective but also from an applied one. Understanding how the nurse requests, negotiates and manages the doctor's intervention during telephone calls is of particular interest for better understanding nurse-doctor communication and can be relevant for the development of training programs for both nurses and doctors.

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Transcript symbols[7]

`=`	no discernable break or gap/latching conversation
`[`	point of overlap onset
`]`	point of overlap end
`(3.4)`	elapsed time by tenths of seconds
`(.)`	micro pause (less than 1/10 of a second)
`:`	prolongation or stretching of the sound
`–`	cut-off or self-interruption
`.`	falling intonation
`,`	continuing intonation
`?`	rising intonation
`h`	hearable aspiration
`·h`	hearable inhalation
`£ciao£`	smile voice
`e(h)xcuse`	laugh particle within speach
`bien`	syllable is 'punched up'
`↑alors que`	high pitch
`↓d'accord`	low pitch
`°c'est ça°`	sounds are softer than the surrounding talk
`<parce que`	hurried start
`>alors<`	bracketed material is speeded up
`<parce que>`	bracketed material is slowed down
`((il lit))`	transcriber's descriptions

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[1] The subject of this article was discussed during a presentation given at the UCLA Discourse Lab on April 22th, 2015. I am indebted to all my reviewers and their comments.

[2] "New on the job. Relevance-making and assessment practices of interactional competencies in young nurses' hospital telephone calls" a research developed in the framework of the Sinergia IC-You project (Swiss National Science Foundation grant). The research is led by Prof. Esther González-Martínez (University of Fribourg) and is conducted in partnership with the *Hôpital Neuchâtelois*, with the collaboration of the *Haute école Arc santé*.

[3] Times measured without the telephone rings and the waiting time for the call to be answered.

[4] The exact distribution and duration of tasks differ depending on the surgeon and the case. According to my ethnographic observations, most dressing changes involve the nurse removing the dressing and cleaning the wound, the doctor performing a visual check and palpation, and, if everything is deemed normal, the nurse disinfecting the wound and placing a new dressing and bandage on it. As such, the doctor's role in this activity is one of observation and assessment while the nurse is involved in the actual dressing change.

[5] When the nurse refers to the patient as being "installed" (l. 6), she refers to his physical positioning, for example in an armchair, with the leg supported by a disposal.

[6] "du coup", *Larousse*, Retrieved May 27, 2015, from http://www.larousse.fr/dictionnaires/francais/coup/19796/locution

[7] Adapted from the Jefferson (2004) transcription system.