Continuing the debate on language for nursing, Paul Crawford and Brian Brown argue that merely having a common sense understanding of language is inadequate.

**The importance of linguistics**

Dr Clarke’s (1999) misnaming of the title of our book – it is *Communicating Care* and not *Communication Care* – is only a minor symptom of an incautious reading and response to the serious concerns about language made in our various publications. We would like to refocus the debate on a number of key points that have vanished below his gaze.

While Dr Clarke states that we have added considerable weight to his critique of June Clark, he proceeds to make some rather self-revealing and sweeping comments about our critical readings of nursing language. First, his disdain for applying linguistic science to nursing language is puzzling. The detailed and methodical enquiry at the heart of linguistics has provided valuable insights into the power and effect of language worldwide, and lately in nursing itself. Is Dr Clarke unaware of the inroads that linguistics has made in understanding language interactions in healthcare settings (for example, Brown et al 1996, Crawford et al 1995, 1998, 1999, Northouse 1998, Richards et al 1995, Silverman 1997, Skelton and Hobbs 1999a and b)?

For that matter, is he unaware that linguistics has contributed substantially to securing social justice? For example, it has provided telling evidence in cases of the falsification of police documents (Coulthard 1994, 1996), the self-justification of child abusers (Hyden and McCarthy 1994) and the meaning of sexual harassment (Thomas and Kitzinger 1997) to name but three areas. If nursing ignores all this growing scholarship on how language reflects and promotes inequality, it will be an impoverished discipline indeed. Moreover, as we have argued elsewhere (Crawford et al 1998), an awareness of these issues is important if nurses are to become ethically sensitive practitioners, able to reflect on their contribution to wellbeing.

In suggesting that we evaluate nursing language according to everyday social and moral rules, Dr Clarke advocates that we should be no more aware of the use of language than we already are. This uncritical approach means that linguistic injustices will pass unnoticed. The very social and moral rules themselves are historical phenomena that deserve scrutiny. Their origin can be traced to the courtly behaviour of aristocrats in the courts of Renaissance Europe (Burkitt 1991). From their inception, manners and ‘civilité’ served to manipulate and deceive others, rather than safeguard their interests.

In the present day, politeness and civility may just as easily be a velvet glove around a much more coercive iron fist. The care and dedication exhibited by staff caring for older clients, for example, may be accompanied by the use of ‘secondary baby talk’ with exaggerated intonation, high pitch and restricted vocabulary. This effectively sets the older person in a role which implies impairment and disability (Edwards and Noller 1993).

As well as evidence of the negative effects of language on the recipients of health care, scholars with a linguistic bent have been active in identifying opportunities for language to be tailored to improve clinical outcomes. For example, the likelihood that various aspects and genres of nursing language, such as ‘comfort talk’ (Proctor et al 1996), may benefit patients who have been brought into an emergency room. Or, to take another example, how healthcare workers reha-

**key words**

- Nursing profession
- Communication

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regimes and therapeutic practices. Dr Clarke himself seems to be more concerned to disregard the implications of nursing language by questioning how language has anything to do with what he portrays as the mechanical environment of a surgical ward. However, even when we are dealing with the most pre-eminently physical problems, there are substantial insights possible from the study of language. As Berg has demonstrated, the work of oncology is made possible through written and spoken language (Berg 1996, Berg and Bowker 1997). Fox (1993) has shown how the apparent success of operations is negotiated by the surgical team in post-operative ward rounds. The surgeon can present the operation as ‘successful’, even though the patient may feel much worse.

**Further linguistic research**

Presenting health care as if it were a biomedical or mechanical process is itself a rhetorical device which was popularised in the 19th century. This gathered pace as medicine re-oriented itself towards being a scientific discipline. The engine-room of scientific medicine was increasingly seen as the newly-developing sciences of bacteriology, neurology and biochemistry, rather than the consulting room or the surgeon’s craft.

We can now see this biomedical hegemony being challenged by changes in the organisation of health care (Samson 1995), as well as by an upsurge of interest in psychosocial issues in fields such as immunology and cardiovascular functioning (Uchino and Garvey 1997). In other words, there is a growing interest in the importance of social setting, interaction, communication and – most importantly – language in a variety of healthcare fields, even those which have been dominated by biomedical approaches.

Dr Clarke accuses us of not knowing what we want. Let us summarise for him what we have already stated elsewhere. We want more research into how language operates in all fields of health care, particularly nursing. Beyond promoting greater ‘reflectiveness’ about nursing language, there needs to be more linguistic research on nursing communication through, for example, discourse analysis and conversation analysis. Let us re-affirm our emphasis that nurses need to be alert to how language is used to construct truths or portray the world of health care in a favourable light. It is only by being aware in this way that nurses can safeguard patients’ interests and those of their profession.

The standardisation of nursing language promoted by Professor Clark (Clark 1999) does not resolve the problem, as it allows unexamined assumption and tacit theories about what exists, what happens and what matters in nursing to pass unnoticed. Indeed, there has been much discussion, by ourselves and others about the implicit values in these classification schemes, and whether they represent the patient’s best interest.

A final example of what may happen if this reflective, self critical awareness of language is not pursued comes from Dr Clarke’s recent paper itself. What is particularly striking is that Dr Clarke appears quite at ease with using labels such as ‘devious’ and ‘manipulative’ to describe patients, and settles for the everyday use and abuse of language in nursing practices, rather than critically evaluating the way nurses communicate. The anger of patients who are exposed to these typifications of their distress, and the difficulties faced by the nurses who try to work with them after they have been so labelled, have been well documented (Burstow 1992, Emerick 1996). Thus, it is disturbing to see a distinguished author and educator condoning their use.

Dr Clarke’s pugilistic style of criticism perhaps owes more to the bar-stool than the ‘armchair’ he accuses us of pontificating from. While we may not agree with Professor Clark in terms of standardising nursing language, we would welcome more sensitivity and concern with how language shapes the experience and recovery of people in distress that offered by Dr Clarke.

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