1990-12-01

Nursing Care through the Eyes of the Patient

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NURSING CARE THROUGH THE EYES OF THE PATIENT

by

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A dissertation presented to the

FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING

UNIVERSITY OF SAN DIEGO

In partial fulfillment of the

requirements for the degree

DOCTOR OF NURSING SCIENCE

December 1990

Abstract

Ethnographic methods were used to examine the nurse-patient interaction for the purpose of developing descriptive and explanatory theory of patient satisfaction based on patients' perceptions regarding their nurses' interpersonal skills. A private acute care hospital was the setting for 40 patients and 12 nurses who were study participants.

Four processes provided the framework for the themes that emerged: "translating," "getting to know you," "establishing trust," and "going the extra mile." I labeled the action of nurses informing, explaining, instructing, and teaching patients the translation process. Informing and explaining were described by both patients and nurses as very important to the patient's well being.

In the process of "getting to know you," personal sharing and kidding were techniques nurses engaged in almost continuously. Both patients and nurses perceived personal sharing as central in the development of the nurse-patient relationship. Many patients verbalized their appreciation for kidding. Being friendly, and understanding were other nurse characteristics that helped patients feel comfortable in the nurse-patient relationship.

Patients described three elements that helped establish trust: First, the nurse "in charge" was defined by patients as a nurse who "knew what she was doing." Second, patients felt confident when the nurse was prompt, followed through,

and kept them informed. Third, the nurse who enjoyed her job was perceived by patients as, "Her concern is for me."

During interviews, patients identified a characteristic they labeled "going the extra mile." Three themes emerged: "clicking," an immediate rapport between patient and nurse, developing friendship, and "doing the extra." Both patients and nurses mentioned the clicking that happens in the nurse-patient relationship, whereas only patients described the nurse who acted as a friend. One patient's description of a nurse who did the extra was, "She's being over nice, beyond the point of no return."

A conceptualization of patient satisfaction with nursing care, grounded in the data, may be considered as a beginning for others wanting to explore this phenomenon. The conceptualization may be useful in quality of care issues for nursing managers and clinical staff.

DEDICATION

This dissertation is dedicated to the nursing staff of 5 North who welcomed me to their unit with open arms, a warm heart, and whose excited enthusiasm for this research continued until the findings were presented some nine months later.

ACKNOWLEDGEMENTS

I would like to begin this acknowledgement by thanking first the patients who allowed me to conduct this research. Their willingness to share their space and feelings with me was beyond the "call of duty." To them I indeed owe a big debt of gratitude. To the nurses who participated in the research I am also deeply indebted. They not only cheerfully took a "tag-a-long," but their sincere interest in what I was doing never ceased to amaze me.

To the physicians who graciously consented to patient access I thank you. A special thank you to Dr. Clifford Colwell. His intensive questioning of my research methods helped prepare me for the proposal defense. During the study he always expressed an interest in what I was doing. Each time I saw him on the nursing unit, he would inquire: "How're you doing? Are you getting enough patients? Now, what are your hypotheses?" To those special orthopaedic nurse clinicians, and nurses in Pre-Admission Testing, I salute you. This study commenced because of you.

Now to my committee. Research is not accomplished without the help of many people, and the guidance provided by my dissertation committee was invaluable. Dr. Mary Ann Hautman, committee chair, was always available and supportive. I'm not quite sure how it happened or why, but with her at the helm, I always knew I would complete the dissertation in my scheduled time frame. To Dr. June

Lowenberg I extend my sincere gratitude. Her expertise in ethnography guided me, and her constant reassurance that I knew the method too, allowed me the freedom to pursue the work in my own way. Dr. Kathy Heinrich, the third member of my committee had the fortitude to read all my beginning field notes. Her guidance for the interviews was very helpful, and her enthusiasm for my work as I progressed always came at the moments when I most needed cheering up.

Next, to my colleagues and friends, I must offer a very sincere thank you. Willa Fields, Judi Dempster, and Mary Sarnecky were always there for me. Somehow at our weekly luncheons, they always knew when I needed to talk. I do not have the words to express a tribute to my classmate, Susan Harris, but I do understand that she knows how very much she helped me.

Finally to my family, I want to issue a very special thank you. They encouraged me and were always supportive. I am deeply indebted to them, especially to my husband, Bob. Once I began the dissertation, he willingly took on unaccustomed household duties. My children John, Sharon and David, and son-in-law Nicki, who were used to fancy Sunday dinners, graciously accepted the fact they needed to help with a Sunday dinner that wasn't so fancy anymore. A thank you also to my mother. I appreciated very much her weekly letters that never failed to inquire about my progress "in school."

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CHAPTER 1

INTRODUCTION

The nurse-patient interaction has always been valued as an important component in providing care to patients (Diers & Leonard, 1966; Peterson, 1989; Salyer & Stuart, 1985). In the last decade, consumerism and competition among health care providers has highlighted the significance of that relationship (Kasch & Knutson, 1985; Stanton, 1988; Taylor, Pickens, & Geden, 1989).

Consumerism and growing public awareness of health care issues have caused health care professionals to become increasingly interested in evaluating patients' satisfaction with the care they receive (Doering, 1983; O'Sullivan, 1983; Speedling and Rosenberg, 1986; Stamps and Lapriore, 1987). Vuori (1987) postulates consumers have the right to decide what they want. He states, "they can best make judgments on matters related to them, including the quality of services purchased" (p.107). Vuori elaborates further by explaining three distinct areas of care that may influence patient satisfaction: (a) the technical aspects of care, (b) the interpersonal aspects of care, and (c) the amenities of care. The intensifying competition among health care providers has underscored the amenities, such as gourmet

meals and fancy furniture, as an aspect of quality care (Vuori, 1987). A danger is that providers may aim at making their amenities more attractive while ignoring other qualitative aspects of care (MacStravic, 1988).

Many studies indicate the patient's perception of quality care is related to interpersonal relationships, rather than technical care (Bartlett, Grayson, Barker, Levine, Golden, and Libber, 1984; DiMatteo, Hayes, & Prince, 1987; Heffring, Neilsen, Szklarz, & Dobson, 1986; Waitzkin, 1984). In response to these issues, a proliferation of hospital guest relation programs has emerged (Benedict, Gemmell, & Anderson, 1988). Consultants and "canned" programs are being purchased to teach hospital employees to respond in a caring manner to patients (Melum, & Sinioris, 1989).

Decreased reimbursement to hospitals has created a level of competition for patients unheard of in years past. Not only are hospitals advertising for patients (Dunbar, 1987), they are touting their guest relation and customer service programs within those advertisements ("Cardiovascular Treatments," 1989; "Healthy Beginnings," 1989). Five years ago, management retreats focused on cost containment; now they center on patient quality service programs.

Nurse executives are very concerned with the impact nurses have on patient satisfaction. In the past, nurse

administrators concentrated on assuring technical staff competence. Today, while technical competence continues to be relevant, staff interpersonal competence is also important. Because of their place in the corporate structure of hospitals, nurse administrators understand and support the recent focus on consumerism (Benedict et al., 1988).

Problem Statement

Do nurses know what patients want from nursing care? What happens in the nurse-patient interaction for the patient to feel satisfied? Eck, Meehan, Zigmund, & Pierro (1988) express that, while patient studies in the last 10 years have become more sophisticated and specialized, the majority of the research and literature on patient satisfaction relates only to general health care services.

In nursing some recent empirical studies have focused on patient satisfaction, but it is difficult to determine exactly what is being measured. In addition, differences between patient perceptions and provider perceptions of quality care have been noted (Allanach & Golden, 1988). Moreover, scant attention has been given to the development of theory regarding patient satisfaction. Dunbar (1987), in the President's address to the American Association of Critical Care Nurses states, "we must first examine what it is that the consumer demands and values. And ultimately,

regardless of definition, it is the consumer who decides whether something has quality" (p. 27A).

Donabedian (1988) suggests we need to understand the nature of the interpersonal exchange between patient and practitioner, so we can identify and quantify its attributes and determine how these contribute to the patient's health. He delineates two elements in the performance of practitioners, technical and interpersonal, and describes interpersonal as key because it is the vehicle by which technical care is implemented, and on which its success depends. Donabedian questions, "if the management of the interpersonal process is so important, why is it so often ignored in assessments of the quality of care?" (p. 1744) In addition, he declares, "our information about the process and outcome of care needs to be more complete and more accurate" (p. 1748). He concludes that we need to seek out the preferences of patients to meet individual needs.

O'Sullivan (1983) and Pope (1978) recommend studies that examine and compare the processes of specific aspects of care with patients' perceptions of that care. Doering (1983) implies the utility of patient satisfaction data may depend on identifying and understanding those factors in the health care process that influence satisfaction.

This exploratory study of nurse-patient interaction was developed from the perspective of the patients, grounding nursing theory in the experience of the patients. After

eliciting patient perceptions, the investigator describes what satisfies the patient with nursing care.

Purpose

The purpose of this study was to examine nurse-patient interaction to develop descriptive and explanatory theory based on the perceptions, beliefs, values, and feelings of patients regarding the nurse's interpersonal relationship skills. It was anticipated that specific findings from this study, would contribute to understanding patient satisfaction with nursing care by describing the qualities of the nurse in the nurse-patient interaction the patient perceived as necessary for her/him to be satisfied.

Research Questions

What happens during a nurse-patient interaction that results in the patient feeling satisfied? What interpersonal skills does the nurse use to make the patient feel comfortable, or what does the nurse do to make the patient feel comfortable? How does the nurses' nonverbal or verbal communication affect patients' satisfaction, their feelings about themselves, and/or their desire to get well? What interpersonal qualities of the nurse facilitate patients' understanding or learning process? These questions served only to chart an initial direction and set up a boundary for inquiry. As Sandelowski, Davis, & Harris

(1989) state, qualitative research "mandates a design that is emergent rather than fixed prior to initiating the study" (p. 77).

Understanding what happens in the nurse-patient interaction from the perspective of patients is essential to the development of nursing theory about this phenomenon. Nursing is a practice profession and its empirically based scientific theories must be grounded in related experience (Chenitz & Swanson, 1986).

Assumptions

A major assumption underlying this analysis is that the nurse is aware of the social contract existing between nursing and society (Nursing: A Social Policy Statement, 1980). Nursing has a responsibility to meet society's needs by alleviating suffering, promoting and restoring health, and preventing illness. It is also this author's assumption that most patients are in the hospital undergoing treatment because they are seeking care. Most patients want to feel better. The last assumption underlying this study is that hospitalized patients are entitled to an interaction that meets their needs. The methodological assumptions will be discussed in the methodology section.

Significance of the Study

Extensive efforts have been devoted to a description of

technical competence, what the nurse defines as quality nursing care, but determination of the patient's perception of quality nursing care has gone undefined. Koska (1989) reports a hospital's nursing staff is the most significant contributor to the quality of care a hospital provides. In a survey of 663 hospital chief executive officers, 97.3% ranked nursing care as the top factor in quality patient care. The survey identified two components of nursing care, technical and interpersonal, and stated both are important.

Insufficient attention has been devoted to a description of the nurse's everyday interpersonal relationship skills, even though Cleary, Keroy, Karapanos, & McMullen's (1989) findings submit that nurses traditionally have been responsible for many of the interpersonal aspects of care. Peterson (1989) comments, "personal interactions between caregivers and patients have been shown to be the most important influence on patient satisfaction" (p. 168).

Because interactions between the nurse and the patient are more frequent and often of greater duration than patient-physician interactions (Ben-Sira, 1983; Cleary et al., 1989; Doering, 1983), the nurse-patient interaction is key to satisfaction of the hospitalized patient. How do we determine what is quality care to the patient? Similar to some of Lowenberg's findings (1989), Spitzer (1988) postulates that the patients' definition of "quality of care" (p. 32) comes from whether their physical and

psychological needs are met.

Studies are needed that describe the nurse's interpersonal relationship skills which the patient views as important to her/his satisfaction. An understanding of the nurse-patient interaction and the skills and competencies that are important to patient satisfaction will expand nursing's knowledge base and provide guidelines for the education and practice of nurses.

Overview of the Dissertation

This dissertation has been divided into eight chapters. Chapter 2, separated into two sections, reviews theoretical and empirical literature. Section one, the analysis of literature on interpersonal competence, includes definitions, frameworks, and elements of interpersonal competence. Section two examines the literature on patient satisfaction and includes, nurse-patient satisfaction, physician-patient satisfaction, and tools to measure patient satisfaction with nursing care.

Chapter 3 details the methodology used to conduct the research. The setting, entree, and sample are discussed along with ethical considerations. Data gathering techniques and the use of The Ethnograph, a computer program that assists researchers with mechanical analytic tasks, are outlined. The chapter finishes with strategies for guarding the trustworthiness of the study.

Chapters 4, 5, and 6 present the research data, and the themes that emerged during data analysis. Chapter 7 includes a summary of the findings, and a conceptualization of patient satisfaction with nursing care constructed from the synthesis of the research findings. The final chapter concludes with study limitations, implications for nursing practice, and recommendations for future study.

CHAPTER 2

REVIEW OF THE LITERATURE

The literature review is divided into two sections. Section one, the analysis of literature on interpersonal competence, includes definitions, frameworks, and elements of interpersonal competence. Section two examines the literature on patient satisfaction and includes nurse-patient satisfaction, physician-patient satisfaction, and tools to measure patient satisfaction with nursing care.

Interpersonal Competence

Strong consensus exists among theorists as to what constitutes interpersonal competence. White (1973) offered the most general statement; interpersonal competence means the ability to have some desired effect on people. Earlier, Foote and Cottrell (1955) defined interpersonal competence as the ability to meet and deal with a changing world, to formulate ends and implement them, to utilize past experience and future aspiration in an effective organization of present effort, and to integrate one's goals with those of others. Because nursing is a practice discipline and patient care is complex, individualized, and goal oriented, these definitions have relevance to the

purpose of nursing.

Benner (1982) defines competency as the ability to perform a task with desirable outcomes under the varied circumstances of the real world. When skills are performed in real situations, the characteristics of the situations have as much influence on successful performance as the knowledge of procedural steps for performing the tasks. Therefore, interpersonal skills used to identify specifics within a situation are often critical to the desired outcome.

Kasch (1986) explains that one criteria for judging interpersonal action of the nurse is the extent of her/his repertoire of strategies for pursuing nursing objectives. Competent nursing action depends not only on the breadth of the nurse's strategic repertoire, but on the ability to adapt those strategies to the patient's unique needs.

Theoretical Frameworks

Frameworks for evaluation of interpersonal competence present a philosophical approach. However, in the literature only Rogers' (1973) description of a helping relationship provides such a framework for subsequent studies. Rogers sets forth the helping relationship in terms of a therapeutic triad: empathy, unconditional positive regard, and congruence. He defines a helping relationship as when one person intends to improve the functioning of the other such as in a physician-patient, or

nurse-patient relationship. This placement of the patient in a passive role may not be congruent with today's health care environment.

Weinstein (1969) based his conceptual framework for interpersonal competence on the belief that if social structure is to be stable individuals must be successful in achieving personal purposes. He defined an individual's capacity to utilize a large and varied repertoire of potential action as a necessary attribute for interpersonal competence.

In 1973, Bennis, Berlew, Schein, and Steele developed a framework for evaluation of interpersonal relationships based upon the assumption that the social environment and the personal competencies of the involved people determine the success of the interpersonal relationship. Bennis et al. propose that to have effective interpersonal relationships, an individual needs to: evoke the expression of feelings; demonstrate a capacity to receive, process and send information and feelings reliably; implement a course of action; and have the capacity to learn in each of the above areas.

Bochner and Kelly (1974) formulated a training framework to develop interpersonally competent individuals and proposed it as a model for organizing teaching and research in interpersonal communication. They noted considerable agreement among teachers of speech

communication, and stated that undergraduate students should learn about, experience, and modify their interpersonal communication skills, but the specific nature of these interpersonal skills was not delineated. They proposed their conceptual framework as a means to define these interpersonal skills.

Two assumptions form the base for Bochner & Kelly's (1974) framework: (a) human beings are motivated to effectively interact with the environment, and (b) social effectiveness is learned throughout life. They state, "Interpersonal competence is a description of a person's ability to interact affectively with other people. It is a learned characteristic" (p. 288). Bochner & Kelly propose that interpersonal competence can be judged by the ability to define and achieve objectives, collaborate effectively with others, and adapt appropriately to a variety of situations. They outlined five observable skills as a potential focal point for interpersonal communication instruction: (a) empathetic communication, (b) ability to process feedback, (c) owning one's feelings and thoughts, (d) self-disclosure, and (e) behavioral flexibility. They suggest developing methods for observing and measuring interpersonal skills through self, peer, and observational ratings.

Kasch (1984a) states, "interpersonal competence depends on the social, cognitive, behavioral, and cultural resources

of communication that underlie the individual's capacity to anticipate, control and flexibly adapt to the demands of the social environment" (p. 77). This perspective recognizes the way in which caregivers and patients organize and structure their interactions to adapt to the environment. He suggests that studies could examine how the social, cognitive, and communicative abilities of nurses interrelate with the cultural context in health care to influence selected health care outcomes. Because communication is the means by which both caregivers and patients interact with and adapt to the demands of the environment, Kasch (1984a) proposes that a potentially fruitful explanatory framework for linking communication and nursing lies in the area of interpersonal competence. He states, "A theory of interpersonal competence helps to elaborate how communication works to accomplish the goals of nursing" (p. 77).

The following elements of interpersonal competence were most salient in the literature: communication, mutual respect, problem solving, and empathy. Self-disclosure and owning one's feelings and thoughts are mentioned, but are not as extensively researched.

Communication

Communication serves to establish and maintain an essential linking function for the nurse and her environment (Kasch, 1984b). Communication effectiveness, evidenced by

expressing ideas, listening skills, and accurately determining patient needs is addressed by the performance evaluations of Lunde and Lafferty (1986), Stalker, Kornblith, Lewis, & Parker (1986), Schwirian (1978), and Levit, Stern, Becker, Zaiken, Hangasky, & Wilcox (1985). Levit et al. adds the elements of style and level of presentation appropriate for audience, plus the development of an environment conducive for learning. Kasch (1986) agrees and adds that competent nursing action depends upon the self-presentation skills of the individual nurse.

Trust, a component of interpersonal communication was examined by Northouse (1979) in an effort to contribute to theory development on communication in health care. He defined interpersonal trust as "the expectancy held by an individual that the communication behaviors of another individual...can be relied on" (p. 366). Although he expressed interest in how trust functions in nurse-nurse interactions, he focused his study on the relationship between trust and empathy because of previous inconclusive and contradictory findings. His study explored the nature of the relationship between interpersonal trust and empathy in nurse-nurse interaction. Analysis of questionnaire data collected from a sample of 36 diploma school nursing instructors indicated slight correlations between specific trust and general trust and between general trust and empathy, but a strong negative correlation was found between

specific trust and empathy. He suggests that one who does not trust spends more time focusing on the communication behaviors of the other. Thus, in an effort to enhance a sense of security, one should increase empathy. This study adds support to other investigations of dyadic relationships, father-son, husband-wife and employee-employer. Further studies would determine whether a similar phenomenon occurs in other health care dyads such as a nurse-patient interaction.

Mutual Respect

The performance evaluations of Schwirian (1978), Davis, Greig, Burkholder, & Keating (1984) and Behrend, Finch, Emerick, & Scoble (1986) focus on mutual respect. The Behrend et al. subcategory of mutual respect emphasizes (a) the acceptance of self to create a climate for the acceptance of others, and (b) the ability to see problems, issues, and feelings from another person's point of view. The subcategory of interactive, trusting relations describes the unconditional acceptance of patients as special, worthwhile, and important individuals and identifies the unique perspective from which each patient views his world.

Rempusheski, Chamberlain, Picard, Ruzanski, & Collier's (1988) grounded theory study of 63 patient and family letters identify unconditional acceptance as an important element of care to hospitalized patients. Rogers (1973), and Athos and Gabarro (1978) view unconditional positive

regard for another person as a necessary condition for interpersonal competence. Wiemann and Backlund (1980) list display of respect as one of their seven dimensions of communication competence.

Problem Solving

When Argyris (1968) was asked to discuss the objectives and nature of laboratory education or group work, he focused on the theory of competence acquisition. His definition of interpersonal competence, the ability to cope effectively with interpersonal relationships, is based on the objective of competence acquisition which provides the participants with opportunities to diagnose and increase their interpersonal competence. Argyris defines this ability to cope effectively with interpersonal relationships as when the individual: (a) perceives the interpersonal situation accurately and identifies the relevant variables and their interrelationships; (b) solves problems so they remain solved; and (c) achieves solutions that allow the persons involved to continue working together effectively.

Demonstration of skill in problem solving at routine and complex levels is a behavioral criteria defined by Behrend et al. (1986) in their performance evaluations of nursing staff. Other criterion include using a multidisciplinary approach to problem solving.

Empathy

The question Rogers (1973) poses is, "Can I let myself

enter fully into the world of his feelings and personal meanings as he does" (p.234)? He comments that in a helping relationship, even a minimal amount of empathic understanding, is beneficial.

Bochner and Kelly's (1974) training framework to develop interpersonally competent individuals focuses on empathetic communication. They propose empathetic communication as a behavioral skill that can be learned, enhanced, altered, changed, or modified. "Empathetic communication is not a fixed attribute or an inherited personality trait" (p. 289).

Empathy is one of the three variables that Weinstein (1969) defined as pivotal to interpersonal competency. An empathetic individual is able to take the role of the other accurately. He must correctly predict the impact of various courses of action on others' perception of the situation. Stetler (1977) investigated the linkages between empathy as perceived by a person receiving help, and the communication of a person giving help during a simulated therapeutic encounter. He utilized an exploratory, descriptive analysis of verbal and vocal communicative behaviors of 32 female registered nurse therapists and their patients. However, no significant relationships were found.

In contrast to Stetler's finding, Harding and Halaris (1983) demonstrated that nonverbal behaviors may be linked to empathy. The Harding and Halaris study explored

nonverbal communication of nurses and patients in interaction. Their specific purpose was to observe the engaging and defensive nonverbal behaviors of patients and nurses, and compare nurses who were rated as highly or not empathic by the patients. A word of caution is necessary when discussing these findings because of the small number (n=10) of nurses and patients in the study.

Empathy in nurse-client interaction was the focus in an exploratory correlation design research study (Forsyth, 1979) of 70 nurses and 70 patients in two midwestern cities. Rogers (1973) helping relationship theory, in which empathy is the most critical component of the therapeutic interaction, provided the framework for the study. Although older nurses (50 to 59 years of age) scored lowest on empathy and 30 to 39 year olds scored highest, the variation by age was not statistically significant. An interesting result found head nurses more empathetic than staff nurses. The author suggests that, because reward systems are better for head nurses, they have better ego satisfaction and thus more ability for empathetic responses.

Baccalaureate nurses achieved significantly higher levels of empathic ability than diploma nurses. The more recent the graduate the higher the empathic ability. Although there were not significant differences between the length-of-practice and empathy scores, there was a negative correlation between these variables. Ninety-eight percent

of the patients in the study rated their nurses as highly empathic while nurses' scores showed only 50% of them having high empathic ability. Thus either patients perceive nurses as something they are not; client perception of reality is somewhat distorted, or nurses are not aware of the impressions they make on others. Another option might be that empathy scales are not measuring what they purport to measure.

Brunt (1985) suggests that nursing care is based on providing a therapeutic relationship with empathy, the ability to focus and concentrate on the patient's experience, as the primary ingredient. The theoretical framework for the study was again Rogers' (1973) helping relationship theory. The study questioned, "what relationship if any, is there between technology and empathy?" (p. 71) Four intensive care units in an 800-bed medical center serving as a major referral hospital in the East were the focus for this factor-relating descriptive study. Contrary to the prediction that there would be a significant negative correlation between empathy and technology, no such relationship was found. Maybe stresses in the intensive care unit have been overly dramatized as greater than those in non-intensive care settings. Could having a greater patient load, four or five patients, on a medical/surgical unit, be as stressful as taking care of one or two patients in the intensive care unit?

The only variable in the study that related to empathy was the number of years nurses worked on the unit. This indicated that nurses who had worked longer on a given unit were less empathic. Interestingly, this result contradicts that by Forsyth (1979), who found no significant relationship between empathy and the number of years a nurse had been practicing nursing. This contradiction suggests that maybe the number of years or age is the independent variable in any causal link. Further testing is needed.

Other Variables. Bochner and Kelly (1974) define two other attributes of interpersonal competence in their framework: (a) self-disclosure, and (b) owning one's feelings and thoughts. Communication that transmits to another what one is feeling, thinking, or wishing is called self-disclosure. Appropriate self-disclosure helps to create a trusting climate for learning. The person who owns his feelings or ideas makes it clear that he takes full responsibility for them. Owning requires the ability to identify and communicate attitudes or feelings. Owning shows a willingness to accept responsibility and commit to others. Both openness and owning were identified in Argyris's (1965) theory of interpersonal competence.

Patient satisfaction

The context within which patient satisfaction must be assessed is patient expectation of hospitals and health

professionals (Oberst, 1984). Doering (1983) defines patient satisfaction as "the degree to which health care providers have been successful in meeting patient-defined needs and expectations" (p. 291).

Four professors in community medicine, Speedling, Morrison, Rehr, and Rosenberg (1983), decided to revise a patient satisfaction survey at Mount Sinai Hospital, a 1,200-bed acute care teaching hospital in New York City. Revision was needed because, although general information was helpful in identifying patient reactions to a service or unit, the ratings offered no clues to what was being criticized or praised. Therefore, the management was unable to identify and solve problems. Their study findings stressed the importance of talking face to-face with patients for increased knowledge about patient perceptions. This feedback greatly enhanced the clarity and specificity of revised questions. Hearing patients describe, in their own words, the impact of a particular service on their hospital stay was a valuable experience for hospital managers. "Exposure to a patient's point of view can sensitize those who plan and supervise delivery of services to the impact of their activities," Speedling et al. conclude (1983, p. 226).

Nurse-patient satisfaction

This review of patient satisfaction with nursing care will include both strengths and weaknesses. The major

strength of the studies demonstrate that nursing care is the most important variable in determining overall satisfaction with hospital care (Stamps & Lapriore, 1987). The major weaknesses are the dearth of studies, the deficiency of patient involvement in questionnaire formulation, and the lack of common definitions and descriptors.

Abramowitz, Cote, & Berry (1987) are among those who propose that nursing staff is key to patient satisfaction. They state, "nurses are the hospital's goodwill ambassadors and frontline representatives. To the extent that nurses cannot fulfill this role, patient satisfaction is severely compromised" (p.128). Abramowitz et al. postulate the nurse's role in satisfying patients is complicated by the fact that patients channel their discontent with nurse aides and the environment through nurses. The results of this study suggest patients perceive nurses in charge of the unit's operation, rather than solely as a deliverer of health care, and thus responsible for all it's activities. Although this study sought to understand consumer behavior by identifying the most important factors in patient satisfaction, the questions were very general, such as, "Overall, how satisfied were you with the nursing care," or "Did you notice any change in the quality of nursing care from one shift to the next?" (p. 124)

A study performed by Richards (1987) sought to determine if the nursing process had an effect on patient

satisfaction with nursing care. A 28 item questionnaire was distributed in one psychiatric unit to 40 patients, 19 in the control group and 21 in the nursing process group. In this unit the nurse-patient relationship was seen as crucial to the effectiveness of the therapy. The 19 patients in the control group received traditional care while 21 patients received care using a nursing process approach. Both groups were nursed using traditional therapeutic community techniques.

Findings indicated that the introduction of the nursing process had no significant impact on patient's perception of nursing care. However, patients' ratings of the nurse-patient relationship demonstrated that patients rated nurses' interpersonal skills high. Patients disagreed with the statement, "When nurses are talking to patients they are not really working" (95%). Patients agreed with the statements, "Just talking to nurses about your problems helps" (82.5%), and "Nurses are easy to talk to" (80%) (p. 561). A limitation of this study is the descriptors of interpersonal skills which focused only on talking to the nurse.

Bader's (1988) research determined the degree of satisfaction with nursing care behaviors as perceived by hospitalized medical/surgical patients and predicted which nursing care behaviors were highly associated with patient satisfaction. Of 14 predictor variables, 10 related to the

affective dimension, whereas 4 related to technical activities. Bader utilized Risser's (1975) conceptual framework for patient satisfaction, and based her study on the premise that evaluation of nursing care from the patient's perspective is needed to obtain a complete picture.

A convenience sample of 50 hospitalized medical/surgical patients provided the subjects for Bader's (1988) research. She utilized Hinshaw & Atwood's Patient Satisfaction Instrument, which addresses the nurses's knowledge of nursing and physical care, the social aspects of nursing care, and nurses' sensitivity to people. The criteria to measure patient satisfaction with nursing care included many of the components of interpersonal skills discussed in other studies such as "The nurse is friendly, the nurse is attentive" (p. 14). Findings determine that, although the concept of patient satisfaction is significant in evaluation of the provider-client interaction, the patient and the care giver may have different ideas about what quality care is, and if it is present.

Eriksen (1987) examined the relationship between quality of the nursing care process and patient satisfaction with nursing care in a descriptive correlational research study that included 136 subjects randomly selected from eight inpatient care units of a large medical center. Her research findings do not support the presence of positive or

significant relationships between the quality of nursing care and patient satisfaction with nursing care. Only unit procedures for the protection of patients yielded a moderately inverse relationship. The limitation of the sample size, and the lack of reliability and validity for the Patient Satisfaction with Nursing Care Check List could account for the absence of significant relationships between quality of nursing care and patient satisfaction. It is also difficult to extract meaning from general statements like, "The need for psychological well-being is attended" (p. 33).

Physician-patient satisfaction

Of the numerous studies concerning physician-patient satisfaction, many indicate that interpersonal relationship skills correlate with a satisfied patient (Dimatteo et al., 1986; Doyle & Ware, 1977; Korsch, Gozzi, & Francis, 1968). It is the nature of professional practice that the client is not in a position to judge the technical competence of the individual practitioner. However, studies by Norman (1985) and Ben-Sira (1976) validate that the one area in which the patient is informed and is the best judge of competence is the interpersonal skills of the doctor.

Dimatteo et al.'s (1986) research findings present physicians' technical skill as only one facet of competence. Eliciting patient satisfaction and cooperation with treatment also requires interpersonal skill. They reported

that effective communication is a major component of a physician's interpersonal skill repertoire, and the behavioral enactment of interpersonal skill is the most significant determinant of general satisfaction with medical care. DiMatteo et al.'s research utilized 57 house staff and 329 ambulatory patients as they investigated the link between physicians' nonverbal communication skills (sensitivity and expressiveness) and patient satisfaction. In addition, they explored the relationship between physicians' nonverbal communication ability and patient appointment noncompliance. DiMatteo et al. concluded there was a significant relationship between nonverbal communication skills, and patient satisfaction and compliance. However, the results of this study should be interpreted with caution because of the dearth of information about what goes on between physicians and patients on a nonverbal level.

Doyle and Ware (1977) tested the importance of consumer perceptions of various characteristics of physicians and medical care services in relation to general satisfaction with medical care in a correlational study of 432 subjects. The most important factor they found in relation to general satisfaction with medical care was physician conduct that included patient perceptions of both the art and technical aspects of such care. The study advocated intervention for the purpose of raising satisfaction levels of consumer

perceptions of physicians. One might question this recommendation because knowledge of how to measure the art and technical aspects of care is vague. Another concern is the author's statement, "Insight into the nature of such changes can be gained from a review of the variables that have been used in previous research to define physician conduct" (p. 800).

A research study on doctor-patient interaction was undertaken by Korsch et al. (1968) because of the "widespread disenchantment with the medical care being offered to the community at present" (p. 866). Korsch et al.'s quantitative analysis demonstrated a significant relationship between the patient's perception of whether the physician was friendly and understood the patient's concerns such as need for information and explanation of his/her child's disease, and satisfaction with the visit. Content analysis of the qualitative information that determined whether an expectation was handled by the physician in word and/or in deed illustrated the importance of meeting patient expectations. This research proposed that the process of communication took on added importance because it affected patient satisfaction, compliance, and physiologic responses to treatment. A possible limitation of this large study of 800 patients is the inadequate explanation of what variables were included in the verbal and nonverbal interaction of the patient and physician.

Bartlett et al. (1984) examined 63 patients and five medical residents at a teaching hospital in Baltimore for the effects of physician interpersonal skills and teaching on patient satisfaction, recall, and adherence to the regimen. The physician's interpersonal skills were assessed using a 14-item rating form that measured interpersonal skills in four conceptual areas: (a) sensitivity to patient's feelings demonstrated by eye contact, interest, warmth, and expression of feelings; (b) interchange of information through open-ended questions explaining what would occur next, and follow up on non-verbal cues; (c) organization and structure of the interview; and (d) environmental factors.

Findings indicated that the quality of interpersonal skills influenced patient outcomes more than quantity of teaching. Since several studies have suggested that lack of patient teaching is a cause of dissatisfaction, this finding was unexpected. Secondary analysis indicated all effects of physician communication skills on patient adherence are mediated by patient satisfaction and recall. These results imply that enhancing patient satisfaction may be pivotal to the care of patients with chronic disease. The strengths of this study relate to the specific identification of interpersonal skills, such as, "uses appropriate open-ended questions", and "conveys understanding and allows expression of feelings" (p. 759). A limitation might be the study did

not assess quality, but rather quantity of teaching.

Nursing Tools to measure patient satisfaction

The development of instruments to measure patient satisfaction with nursing care has spanned four decades. In the fall of 1953, the Division of Nursing Resources of the United States Public Health Service decided to develop an instrument to measure satisfaction of patients and personnel with hospital nursing care. During the previous ten year period, hours of nursing care per day had risen from "3.3 to 4.8" (Abdellah & Levine, 1957, p. 100), but patients and personnel continued to complain. In addition, the same number of complaints were noted whether the hours of nursing care per patient day were high, 4.8, or low, 3.3. Sixty hospitals were utilized during the two year development and testing of the tool. Both nurses and patients assisted in tool development through discussion at open forums and listing of nursing care events.

A multiple regression model was used to measure satisfaction of nursing care by patients and personnel on the 50 item checklist, as the dependent variable. The independent variables were total hours of nursing care available, hours of professional nursing care available, size of hospital, and ownership of hospital. This first research to measure patient satisfaction with nursing care reported that the amount of total nursing hours per patient day does not affect patient satisfaction. In direct

contrast, the amount of professional nursing care provided does have a strong positive influence on satisfaction. The findings of this study could be important today as the ratio of registered nurses to other care providers is being decreased in hospitals.

Two decades passed before Risser (1975) developed a scale to measure nursing care with outpatients. Risser's scale was developed by conceptualizing patient satisfaction as the "degree of congruency between a patient's expectations of ideal nursing care and the patient's perception of the real nursing care received" (p. 673). Risser identified three dimensions of nursing performance: (a) technical-professional behavior of the nurse, nursing knowledge, (b) the social aspects of nursing care and information exchange, and (c) interpersonal-trusting, sensitivity to people. Eck, Meehan, Zigmund, & Pierro (1986) state that the 25 item tool developed by Risser has been the major device used by nurses to measure patient satisfaction.

Risser's (1975) tool has several limitations: (a) It is often used for hospital patients even though the variables being measured are "patients' attitudes toward nurses and nursing care in a primary health care setting" (p. 673). (b) Risser's conceptual framework does not define patient satisfaction as process or outcome oriented. (c) The scale consistently yields high scores under all conditions and

care modalities because the wording of the items makes them difficult to disagree with. (d) The subscales "have correlations with each other ranging from 0.598 to 0.806" (p. 674), indicating the content measured by the three scales may be similar.

The Patient Satisfaction Instrument by Hinshaw and Atwood (1982) was developed over a series of five clinical and administrative studies during a period of eight years with a total of 600 medical/surgical inpatients and outpatients. It was adapted from Risser's (1975) outpatient instrument for use with inpatients . The Patient Satisfaction Instrument is a Likert-type summated rating scale with three dimensions, technical/professional, trust, and patient education. Although the tool demonstrates validity and reliability, a word of caution in the use of this instrument for hospitalized patients is necessary. The inpatient instrument is almost identical to the outpatient tool leading one to surmise that patient expectations of nursing care is the same in both settings. In addition, correlation subscale data posits that samples with homogeneity in reference to medical diagnoses are only one dimensional in scale, while samples with heterogeneity in reference to medical conditions consistently estimate three subscales. Also, many patients today vary in their expectations of their health care encounter (Roter, Hall, & Katz, 1988). The instrument does not measure satisfaction

regarding patient participation in decision making.

LaMonica, Oberst, Madea, & Wolf (1986) carried out three studies to develop and test an instrument to measure hospitalized patients' satisfaction with nursing care. For the purpose of the investigation, satisfaction with care was defined as "the degree of congruence between patients' expectations of nursing care and their perceptions of care actually received" (p. 44). This definition is consistent with that originally advanced by Risser (1975). The major goal in developing the LaMonica Oberst Patient Satisfaction Scale was to produce a more valid, reliable, and sensitive measure of patient satisfaction than other instruments, but in a comparison with the Risser Patient Satisfaction Scale, the goal of greater sensitivity is not achieved. The findings from the factor analysis do not support the construct validity of the three dimensions of nurse performance initially conceptualized for this study as contributing to patient satisfaction.

Two other issues of concern involve the scoring procedure and the operationalized definition of satisfaction. The customary summative scoring approach includes the underlying assumption that all nurse behaviors contribute equally to satisfaction or dissatisfaction. Based on the validity data obtained from patients, this did not occur. The data could have been used to weight the items for scoring, but to do so would have been inconsistent

with the operationalized definition of satisfaction. The authors suggest solving this particular problem by developing instruments that concurrently measure both patients' perceptions of caregiver behaviors and patients' current framework of expectations. An interesting finding from the study is the emergence of a distinct dissatisfaction factor, leading to the supposition that satisfaction and dissatisfaction may not be opposite ends of the same continuum, but are separate continua (LaMonica et al, 1986).

Eriksen's Nursing Care Questionnaire (1988) is a self-administered questionnaire that measures patient satisfaction with nursing care in a hospital setting. The patient-identified satisfying and unsatisfying events described by Abdellah and Levine (1957) form the base for the instrument, which was tested on two general medical/surgical units. The instrument's 35 items, grouped into six dimensions, (a) art of care, (b) technical quality of care, (c) physical environment, (d) availability, and (e) continuity of care, uses a norm-referenced measurement framework.

The results indicate statistically significant differences between the units, corroborating the predictions of the nursing director and the nursing supervisors. Construct validity was examined using factor analytic approaches to substantiate the existence of the six

subscales. The variables loaded on two factors, one concerned with the art and technique of care and the other related to the patient's environment. Because the exploratory factor analysis using the initial sampling of 90 patients did not substantiate the subscale structure of the instrument, the planned coefficient theta was not calculated to test for reliability.

The authors recommend instrument revision and additional reliability and validity research. A limitation of this instrument could be the item construction, which is based on patient input nearly four decades old. In addition, the questions place the patient in an almost totally passive role. Only two items deal with teaching the patient to care for himself, and no items address patient participation in decision making.

Summary

Review of the literature on interpersonal competence presents consensus on the definition of interpersonal competence, and reveals some common elements. Although these elements describe interpersonal skills and competencies, and seem to relate to interpersonal competence, researchers use different definitions for similar elements. Therefore it is difficult to ascertain just what is being measured. In addition, research is scant on the element of self disclosure, and this researcher

questions whether all elements are defined.

The theoretical frameworks vary greatly, probably due to a lack of understanding about this complex phenomenon. The study designs have flaws and limitations, and too little information establishes how they were developed. Only Rogers' (1973) framework of a helping relationship has been utilized in subsequent studies.

Nursing and medical care do impact patient satisfaction, and, although technical care and the amenities of care play a role, interpersonal relationship skills seem to be the major component. These conclusions must be treated cautiously, however, because the research based on different methods, populations, and questionnaire content is methodologically flawed. Information about the interpersonal process is not easily available and criteria and standards that permit measurement of interpersonal relationship skill are not well developed. Only one study was found that delineated interpersonal skills (Bartlett et al, 1984).

The literature review on patient satisfaction denotes its considerable concern to professionals (LaMonica et al., 1986). In spite of the growing popularity of instruments to measure patient satisfaction, they have not achieved a level of technical proficiency (Speedling et al., 1983). Many tools are of a very general nature, and often beset by a variety of theoretical and measurement problems including

relative insensitivity and questionable validity (Oberst, 1984). Questions of instrument validity most frequently arise from failure to adequately define the concept of satisfaction from either the professional or patient point of view (LaMonica et al., 1986). Historically, the most common approach to measuring satisfaction with nursing care has been the use of one or several global questions such as, how satisfied were you? Such measures are clearly inadequate when measuring the multidimensional phenomenon of quality care (Oberst, 1984).

Only recently has nursing research examined patient satisfaction with more than a cursory look. Of immediate concern is the development of questions regarding patient satisfaction with nursing care without patient input. If patients today are not questioned regarding their perception of a satisfactory nurse-patient interaction, how do we know the right questions are being asked on the patient satisfaction instrument? Oberst (1984) states, "the validity of any measure of patient satisfaction is suspect if patients have not been involved in the validation process" (p.2366).

Investigation of nurse-patient interaction is, therefore, indicated through an ethnographic, participant observation study. This research represents an initial effort to address the numerous gaps in understanding the perceptions of the patients for a satisfactory nurse-patient

interaction.

CHAPTER 3

METHODOLOGY

The purpose of this chapter is to present and discuss the epistemological assumptions and specific research strategies used in this study. The research questions focus on describing the qualities in the nurse that patients perceived as necessary to feel satisfied following the nurse-patient interaction. Therefore, this study may be classified as both a factor-isolating and factor-relating study (Diers, 1979). Its purpose is the development of descriptive and explanatory theory. Qualitative research methodologies are appropriate for this type of descriptive study (Munhall & Oiler, 1986). In the broadest sense, qualitative research produces descriptive data from observable behavior and spoken word (Taylor & Bogdan, 1984).

Epistemological Assumptions

Ethnography, one qualitative approach to research, was chosen for this study because ethnography involves learning from people (Spradley, 1979). Ethnography is a carefully planned, flexible, inductive process that has its roots in anthropology and sociology (Rosenthal, 1989). Ethnographic studies can "describe a full range of actions and often

provide an explanation for these actions" (Rosenthal, p. 116).

Leininger (1985) describes ethnography as the "systematic process of observing, detailing, describing, documenting, and analyzing the patterns of a subculture to grasp the patterns of people in their familiar environment" (p. 35). Ethnographic methods allow researchers to view others' worlds from their perspective. This emic perspective described by Leininger (1985) focuses on "people centered data" (p. 44). Living with other people's thoughts, feelings, and actions increases understanding.

The approach of ethnography offered me an opportunity to view nursing care through the eyes of the patient. With ethnography, the nurse can begin to understand the meanings of nursing actions and events to patients (Spradley, 1979). Since the discipline of nursing is in the process of discovering its unique and distinctive domains, ethnographic research studies will help nurses understand complex phenomena as they occur in their natural setting. Descriptive data will provide information to understand the human behavior of practicing nurses. This ethnography can direct attention to the patient's view. The ethnographic methodology thus allows a nurse researcher to integrate the science and art of nursing to benefit patient care (Aamodt, 1982).

Aamodt (1982) focuses on four assumptions that address

questions often asked by clinical nurse researchers as they generate concepts for their research. The first assumption of ethnographic research is, "Human behavior is derived, in part, from a cultural system" (p. 211). Cultural rules provide guidelines for nurses to behave in a particular way when they introduce themselves to patients, measure a medication, instruct a patient, or bathe a patient. The job of the ethnographer is describing these invisible cultural rules and the meanings underlying them. "Direct, face-to-face contact" and immersion in a specific location facilitates the collection of the "richest possible data" (Lofland & Lofland, 1984, p. 11). Cultural data can also be gathered during very brief nurse-patient encounters. Watching and listening enables the researcher to "derive meaning from behaviors initiated by others" (Germain, 1986, p. 148). In this study, patients were observed and interviewed for a description of the behavior of the nurse in the nurse-patient interaction. They constructed their view of reality by explaining what the situation meant to them. Nurses were also observed and interviewed for their perception of the same nurse-patient interaction.

Aamodt's (1982, p. 212) second assumption, "Cultural data derive from abstractions of behavior about what people do (behavior patterns), and what they say they do (ideas, beliefs, knowledge)." This view allows researchers to focus on the events in the setting, such as how the nurse and

patient are behaving during the nurse-patient interaction (Aamodt, 1982). As patients describe the qualities of the nurse in the nurse-patient interaction, they are "describing experience as it is lived" (Oiler, 1983, p. 178). A phenomenological approach, concerned with lived experience, helps researchers understand in their own mind "the feelings, motives, and thoughts behind the actions of others" (Bogdan & Taylor, 1975, p.14). The use of ethnography in this study as a qualitative research method provided rich descriptive data from patients to organize into patterns that can form a base for descriptive theory.

A third assumption states, "ethnographers are active participants in both data collection and data analysis" (Aamodt, 1982, p. 213). Participant observation is research that involves social interaction between the researcher and the participant so the researcher can systematically collect data in the participant's environment (Taylor & Bogdan, 1984). Intensive interviewing, "a guided conversation whose goal is to elicit from the interview rich, detailed materials that can be used in qualitative analysis", is the companion to participant observation (Lofland & Lofland, 1984, p. 12).

In this study, my role was that of observer-as-participant, although on occasion it slipped into participant-as-observer because some "activities were subordinate to activities as a participant" (Munhall &

Oiler, 1986, p. 154). The research was public knowledge which provided me with easy access to known information, and opened doors to inside information (Munhall & Oiler). I spent the major portion of time in the patient rooms where my activities focused on the nurse-patient interaction or in interviewing the patient.

In the role of participant-as-observer I was immersed in the setting for long hours and consecutive days. My presence was not seen as a threat and normal happenings were not disturbed because of my ability to assist with patient care when needed, be out of the way when needed, and to put people at ease. For example, one study nurse responded to my question, "So, how do you feel about my being in the room with you?" with these comments:

> Well at first when I was starting out the shift, it made me kinda nervous. I wasn't quite sure what I should do. Should I come up to you and say, now I'm going to do this or that? Or should I just ignore you which seemed impolite?....So as the shift went on, I kinda just started doing my own thing and not worrying about it anymore. In the beginning it sounded like a fun thing to be involved in. But then, when I realized you were going to be there all the time, I thought, what am I getting myself into? Maybe this isn't going to be fun. But as I got into my shift, and into my patients, back into my regular routine, and just being me, it didn't bother me really. You're really very non-threatening.

Another nurse responded, "Actually, I've enjoyed it. It's been nice to have, I like to have someone else's shoulder so it's been nice to have another person there. You've been helpful and willing to jump in and do things for me when I've been swamped." A third nurse's response

demonstrates how taken-for-granted an observer becomes, "I didn't even know you were there. The first day I did. Now I don't even pay any attention."

The nurse from the step down unit stated, "It was great. I'm used to people watching me, I kinda enjoyed it actually. You were a good helper." When I asked her, "Do you think it made any difference because I was in the room?" she responded:

> No, you know what, you're really good, you have a gift for being very there, but then very unobtrusive, you know. You just say the right things at the right time. You know when to be there and when not, it's great. You've got a nice gift for that. Maybe that's reading the situation I guess.

This ability to enter their world smoothed the way in establishing trust and intimate familiarity.

The fourth assumption states, "The analytical processes in doing ethnography focus on generating categories...and discovering relationships between these categories" (Aamodt, 1982, p. 213). Describing particulars of the interpersonal relationship in detailed field notes provided the vehicle for analysis. Analysis occurred throughout data collection, recording, and coding. Analysis and the resulting theory grew out of, and was directly relevant to activities which occurred in the situation studied (Emerson, 1983). Emerson (1983, p. 95) writes, "The researcher moves back and forth between the data and the theoretical framework modifying original theoretical statements to fit observations" until the best theoretical fit is achieved. Field notes from

ethnography "provide systematic, baseline detail grounded in the culture concept for the continuing generation of hypotheses and theory" (Aamodt, 1982, p. 214).

In this study of nurse-patient interaction, field notes were developed based on participant observation and intensive interviews. These field notes were extensively analyzed to identify categories and relationships which emerged from the data. As Schatzman & Strauss (1982) suggest, analysis of the data involved thinking that was purposeful, systematic, and organized. To increase my understanding of the experiences, I would occasionally adjust observation and interview strategies to protect emerging ideas by "simultaneously checking or testing the ideas" (Schatzman & Strauss, 1982, p. 110).

These assumptions of ethnography offer a base for a "methodology concerned with developing concepts for understanding human behavior" (Aamodt, 1982, p. 214). The data analysis for this study occurred throughout the data collection process as well as after completion of the observations and interviews.

Specific Research Strategies

This ethnographic study took place from November, 1989 to August, 1990. Forty patients, 20 orthopaedic, 15 cardiology and 5 chest medicine were study participants. The 20 orthopaedic patients were housed on the Surgical

Unit. Eleven cardiology and the five chest medicine patients were on the Telemetry Unit, and four cardiology patients were in the Step Down Unit. Twelve nurses were participants in the research study: seven surgical nurses, four telemetry nurses, and one step-down nurse.

Ethical Considerations

Spradley (1979) states that decisions such the use of a tape recorder not only need the informant's agreement, but also the ethnographer's attention to their concerns and interests. Privacy and dignity of participants should always be maintained. In this study, specific research strategies were utilized to protect study participants.

Protection of Human Subjects. The proposed study was reviewed by the Committee on the Protection of Human Subjects at the University of San Diego prior to the initiation of the study (Appendix A). The study was also reviewed by physicians at Division meetings of the Orthopaedic, Cardiology, and Chest Medicine Divisions, and approval for access to patients was received. The study was then reviewed by the Human Subjects Committee of the institution (Appendix B), and conducted under the rigorous guidelines established by that body.

Informed Consent. Spradley (1979) discusses the need to explain the ethnographer's aims to the study participants, and suggests this be accomplished through informed consent at the beginning of the study, and continue

as the study unfolds. Patient study participants received a consent form that described the purpose of and procedure for the research and included required human subjects information such as risks/discomforts/benefits, and assurances (Appendix C). Patients were also given an Experimental Subject's Bill of Rights (Appendix D) as required by the institution. Nurses received a consent form similar to that described for patients (Appendix E). All participants who agreed to participate in the research study signed a consent form.

Orthopaedic study patients were asked by a nurse clinician working with the physician if they would like to discuss the study with me. I approached the cardiology, and chest medicine patients for permission to discuss the study with them. Upon agreement, I presented a brief explanation of the study, and asked the patients to read the consent form and the Experimental Subjects's Bill of Rights. Patients were encouraged to ask additional questions before signing the consent form.

Each patient was assured that the study was not required by the hospital or their physician and that they could withdraw at any time. They were told that the interview would cease if they were too tired to talk. Patients were informed their privacy would be protected by coding descriptions so personal identification was nonexistent, and that study findings would be published in

such a way that individual participants could not be identified.

Out of 79 interviews, only one patient stopped an interview stating, "I don't want to talk any more; it's too much like work." I ended eight interviews when I noticed patients looked tired or sleepy. Two patients who signed consent forms withdrew from the study, one before any observations took place, and one following an observation. It was apparent that one patient's family did not want him to participate (they were not present during the explanation), and the other patient told the nurse, he felt it would be like spying even though he acknowledged I had told him it wasn't.[1]

With these exceptions, all other observations and interviews were warm and friendly. Many patients expressed pleasure about the opportunity to talk about what they perceived as important in the nurse-patient interaction. A few patients were excited about the research, and the potential impact it could have on patient care (these patients had had more than the current hospital experience). One patient asked if she could read the study when it was completed.

The registered nurses were recruited at the beginning

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[1] It is interesting to note that following the explanation of the study to this man, just as he was signing the consent form, he said, "I am in charge of 100 salesman and only ten of them are any good, and that is true of people everywhere".

of the study during staff meetings on the Telemetry and Surgical Units. One Surgical, four Telemetry, and one Step Down nurse were recruited individually. Each nurse was given the opportunity to discuss the study, and was assured the study was not required by the nursing department or their nurse manager. Nurses were assured they could withdraw from the study at any time, and were informed their privacy would be protected by coding descriptions so personal identification was nonexistent. They were told study findings would be published in such a way that individual participants could not be identified. The individual nurse's signature on the consent form indicated her willingness to participate in the study.

One surgical nurse became a part of the study when she announced one morning after report that she had taken two study patients as her patients. She said, "I talked to Myrna (Head Nurse) about it yesterday." She then told me she had signed the original sign up sheet following my first unit meeting, but the Head Nurse had forgotten to inform me.[2] Two other nurses working in the Surgical and Step Down Units expressed a desire to participate in the study, but were not included.

Setting and Entree

The ideal setting is one in which the observer obtains

[2] I had already spent five days in the research setting and wondered if her very friendly attitude toward me was because she was hoping to be entered in the study.

easy access, establishes immediate rapport with informants, and gathers data directly related to the research interests (Taylor & Bogdan, 1984). The goal in choosing a setting is to collect the richest possible data through the establishment of "intimate familiarity" in a naturalistic setting (Lofland & Lofland, 1984, p. 11). The setting for this research was a private teaching hospital of moderate size located in a large western city.

The investigator's entree was facilitated at this institution by previous personal and professional contacts with the nursing and physician staff. Formal negotiations for entree began with the Director of Nursing and specific physicians who were Division Heads. Following those discussions, the research proposal was reviewed with nurse managers, clinical nurse specialists, orthopaedic outpatient nurse clinicians, and finally at staff meetings on the nursing units. Preceding these meetings, I had prepared a document that included the purpose of the study, rationale for the study, a brief summary of the methodology, and a list of potential questions for patient and nurse interviews. This document was utilized in all presentations. In addition, individual physicians who had not had the benefit of explanation regarding the research proposal at Division Head Meetings were approached for

patient access.[3] Following discussion of the study, all 12 individual physicians granted approval for patient access.

There were two goals for these preliminary sessions. The first was to gain support for the project, including patient and nurse access, and formalize the particulars for the entree process. The second was to clarify the role of the researcher as a learner not an evaluator, and to begin to establish boundaries in relation to various aspects of confidentiality.

I began this research as an insider because I am a nurse, and I had previously held a management position in this institution. I was also an outsider because although I worked in this institution for several years, I had been gone for almost four years, and it had been 14 years since I was a staff nurse at the bedside. Two of the three nursing units involved in the research study had managers unknown to me. Of 12 nurses who volunteered to be in the study, six were familiar. One had worked closely with me 18 years previously, but we had not maintained a close relationship in the ensuing years. My concerns about my insider status quickly dissipated as I became familiar with the study nurses who did not know me, and could judge that the

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[3] The Division Heads stated they would discuss the research proposal at their monthly meetings. Following those meetings, I was informed patient access was granted by all division physicians. Upon checking with individual physicians this process did not always occur. Therefore, I approached individual physicians, explained the study, and received consent for patient access.

behavior of all study nurses towards me was not a reflection of having previously known me.

As an insider, I had a problem with just one incident. In my participant-as-observer role I accepted a nursing function that had liability implications. I was asked to witness a narcotic wastage, and promptly complied with the request. Following discussion with the Head Nurse, I informed the study nurses that I would only function in a nurse aide capacity.

When nurse researchers study the behavior of members of their own profession, they avoid the "culture shock experienced by a non-nurse under similar circumstances" (Byerly, 1969, p. 231). In addition, they are sensitive to subtle aspects of nursing behavior that a non-nurse may not notice or fully comprehend. On the other hand, the nurse may overlook a particular item, a part of her own orientation as a nurse, that might be instantly self-evident to someone who is not a nurse (Byerly, 1969). Keeping these thoughts in mind reduced the threat of observer bias.

Sample

Participants for the sample were recruited through the private physicians and the surgical and non-surgical nursing units of a private hospital in Southern California. Purposeful sampling, in contrast to random sampling, means "participants are chosen because of the researcher's belief they will facilitate or expand data collection" (Rosenthal,

1989, p. 117). This hospital was chosen because of previous knowledge of a patient population from a relatively high socioeconomic level. I hoped a literate population would find it easier to describe the elusiveness of interpersonal qualities.

Since this was an exploratory study utilizing participant observation and intensive interviews, the sample size was not determined apriori. It was anticipated that at least 8 nurses (4 non-surgical and 4 surgical) would be utilized when in fact, 12 nurses were study participants. Seven surgical nurses were used to increase coverage of study patients on the surgical unit where patient length of stay was 6-7 days. I wanted to observe patients for at least 3 consecutive days to assure the degree of desired familiarity. Employing only 4 study nurses would not have facilitated this three day pattern. Because of the 12 hour shift staffing, nurses frequently worked only 2 consecutive days, and sometimes worked single days with 2 days off in between. Due to the patient length of stay on the telemetry unit of 2-3 days, and the 1-2 day length of stay in the Step Down Unit, most non-surgical patients were not followed for 3 consecutive days. Thus, 5 study nurses were appropriate.

It was anticipated that 20 surgical and 20 non-surgical patients would be observed and interviewed. Saturation of identified categories was achieved before completing 20 non-surgical patients, but since 20 surgical patients had been

study participants, I decided to complete the observation and interviews with 20 non-surgical patients. This purposive sample was not representative of the patient population in the large Western city where the study took place, but it was representative of the specific hospital, and the immediate surrounding area.

Criteria for Sample Selection. Participants were selected for the study who met the following criteria: (a) Patients admitted to the Orthopaedic, Chest Medicine, or Cardiology Divisions, were between the ages of 18-80, and without neurological deficits, and (b) Registered nurses with at least one year of experience on either the step down, telemetry, or surgical inpatient nursing unit. One patient was dropped from the study when her behavior demonstrated neurological deficits, and one patient was not interviewed the first two days post surgery because of neurological deficits. All nurses who participated in the study met the above criteria. Demographic data were collected on the total sample of 20 surgical patients (Appendix F.1), 20 non-surgical patients (Appendix F.2), and 12 nurses (Appendix F.3).

Data Gathering

The major processes through which ethnographic research unfolds are participant observation and ethnographic interview (Parse, Coyne, & Smith, 1985). The participant-observer role is described by sociologists (Schatzman &

Strauss, 1973) and nurses (Aamodt, 1983; Byerly, 1969). Spradley (1979) defines the ethnographic interview. This phase began with general observations and questions that were recorded as the beginning ethnographic record. Detailed, accurate, and complete field notes are a necessary component of participant observation (Taylor & Bogdan, 1984).

Observations. Spradley (1979, p. 32) states, "Ethnographers often use participant observation as a strategy for both listening to people and watching them in natural settings." This was accomplished informally by spending time with the nurses and patients in the patient rooms. I dressed in street clothes and wore a white lab coat, the standard dress for nurses who were not providing hands-on patient care. I was in close visual and voice range of the nurse-patient interaction, usually sitting on a chair. On occasion, especially when the interaction was brief, I stood. I was normally positioned a few feet away from the participants, but occasionally was in close proximity while I assisted with turning a patient or making a bed.

Most of the time, I was a quiet observer, but sometimes I was drawn into the conversation, or a casual remark was directed at me by the patient or the nurse. During the first few hours with a study nurse, I was usually not asked to assist with patient care, but as the comfort level

increased I offered, or was asked to participate. Some study nurses used me frequently to assist with moving a patient, making a bed or fetching supplies, while others used me rarely.

Intense observations on the Surgical Unit of 20 orthopaedic patients took place during January and February 1990. Observations of nurse-patient interactions transpired every day of the week between 7:00 AM, and 6:00 PM. Three surgical patients were observed till 9:30 PM. I secured permission from 14 orthopaedic patients while they were in the Pre-Admission Testing area preceding surgery. Some patients agreed to participate three weeks before surgery, whereas others were seen the day prior to surgery. Six patients provided consent following admission to the nursing unit, four preceding surgery and two after surgery. I completed a total of 146 observations of surgical patients. Observations included an average of 7 nurse-patient interactions, the range being 2 to 21. Very often the observations lasted 5-15 minutes, but occasionally were over in 1-3 minutes, or extended to 20-25 minutes. Three of the orthopaedic patients were observed with 3 study nurses, and 5 other patients were viewed with 2 study nurses.

Eleven cardiology and 5 chest medicine patients were approached for consent following admission to the Telemetry Unit, and 4 cardiology patients were solicited for consent subsequent to admission to the Step-Down Unit. These

patients were observed and interviewed during March and April, 1990. I concluded a total of 99 observations with non-surgical patients. Observations included an average of 5 nurse-patient interactions, the range 1-16.[4] Very often the observation was over in 5-15 minutes, although some lasted for 25-30 minutes. During observations in the Step-Down Unit where a very delicate procedure was performed by the nurse, one observation was not completed for 90 minutes. Only one of the non-surgical patients was watched with two study nurses.

Observation notes were written during and immediately following the interaction, on a 9 1/2 by 6 inch notebook. Observation notes are statements about events experienced through listening and watching those events. They contain as little interpretation as possible, quoting instead from the situation that was observed (Schatzman & Strauss, 1973). Spradley (1979) stresses the importance of creating a record with the exact words people say. He states, if you summarize a conversation, important clues to the culture are lost and the ability to generate ethnographic questions is decreased. Observation notes with patient and nurse dialogue will be presented in the data chapters that follow.

I transcribed the field notes the evening after the observation, or the day after the observation. Personal

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[4] I observed only one nurse-patient interaction with one patient. He wanted to be interviewed about this nurse because he had received care from her the previous day.

notes regarding the context of the study, my feelings and reactions to specific happenings during the study, and other circumstances important to the study were also transcribed from the notebook and added to the typed transcripts. These observational transcripts along with the interview transcripts served as the primary source of data for the study.

Interviews. Marshall and Rossman (1989) assert the purpose of the interview is to have participants reflect on recent behavior. Three types of interviews were employed in this study: open-ended, semi-structured, and closed (Leininger, 1985). The open-ended interview encouraged patients to talk about the situation, clarify issues, and give examples. I initiated the interview with an unstructured question such as: "How have things been going between your nurse and you this morning?", or "So, how do you feel about what went on this morning with your care?", or "Remember when the nurse came in the room this morning and took your blood pressure? Tell me about that." The open-ended questions gave patients complete freedom to express their thoughts and feelings about the nurse-patient interaction.

The semi-structured interview is designed to elicit both definitive and unexpected kinds of information from the interviewee. Sequential to the initial open-ended questions, questions became more focused, and answers more

illustrative as patients described the qualities of the nurse in the nurse-patient interaction that were important for their comfort. As Rosenthal (1989) suggests, interview questions were generated from the patient's own words and actions. These questions led me into the territory I wished to explore. A sample of both types of interview probes are listed in Appendix G. The closed interview was used to elicit demographic information.

Spradley (1979) states the three most important elements of an ethnographic interview are its "explicit purpose, ethnographic explanations, and ethnographic questions" (p. 59). The three types of questions identified by Spradley as helpful in interviewing strategies, descriptive, structural, and contrast, were all used to expand the explanations of participants.

Patient interviews occurred every day of the week from January through April, 1990, usually between the hours of 9:00 AM and 5:00 PM. Three surgical patients were interviewed as late as 8:30 PM. Initially interviews with patients alone at the bedside followed a nurse-patient interaction, and were conducted more than once during the day. By the fourth research day, patient interviews usually occurred once, at the end of the day of observation. All surgical patients were interviewed at least twice for a total of 61 interviews, and an average of 3 per patient. Patient interviews ranged from 2-6 because of the initial

strategy, and patients were followed for three days. Occasionally an interview ceased after 2-3 minutes, but most interviews took approximately 20 minutes. Some interviews were considerably longer because some patients were very verbose, and I provided a listening ear for matters other than patient's description of interactions with a nurse.[5]

A total of 24 interviews took place with non-surgical patients. Four patients were interviewed twice. On a rare occasion the interview was short, 3-4 minutes. Generally the interviews were 20 minutes in length, and infrequently continued for 30-45 minutes.

It is interesting that even though some conversations began with a specific nurse in mind, the patients frequently generalized to "they" as the conversation ensued. Almost always when I began the conversation, I would ask the patient an open-ended question specific to the nurse who was taking care of them that day. Occasionally I would frame the question, "So how have your interactions been with the nurses?" Regardless of whether the question was singular or plural, patients would usually tell me about one specific nurse and then continue with comments about other nurses.

Most patient interviews took place in patient rooms. Over half of the patients were in private rooms. Privacy and quiet were facilitated in semi-private rooms through the use of curtains, interviewing when the other bed was empty,

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[5] This happened with both surgical and non-surgical patients.

or quietly interviewing one patient while another was sleeping.

Interviews with nurses occurred on the nursing unit in the nurses' lounge, the report room, the nurses' eating area, or a quiet, private corner in the hallway. This served to economize the time and energy of the nurses, as suggested by Swanson (1986). With the exception of the first two research days, nurses were interviewed once each day about the nurse-patient interactions with their assigned study patients. Three times, it was not possible to conduct daily interviews due to the nurse's work load. These interviews were generally 10-20 minutes in length. The purpose of the interview was to elicit from the nurses their perception of the nurse-patient interaction as well as their view of the patient's perception of the interaction. Often the nurse would describe her philosophy of care when it was pertinent to a happening in the nurse-patient interaction.

All interviews, with the exception of one verbal interview, were tape recorded. Brief notes were also recorded in a notebook to remind me of specific context. The tapes were transcribed into a type-script either by myself or a research assistant, who transcribed some taped interviews. Most tapes were transcribed the night after recording; all were transcribed within three days of recording. I independently reviewed the tapes transcribed by the research assistant. Very few sentences were lost to

background noise. Two interview records were cut short by approximately 10 minutes because I forgot to turn the tape over.

In summary, observation and interview sessions with the 20 orthopaedic patients ranged from 7-9 hours with an average of 26 hours per week for 7 weeks. During this 7 week period approximately 185 hours were spent in observation and interviews. Observation and interview sessions with 11 cardiology and 5 chest medicine patients on the Telemetry Unit ranged from 7-9 hours with an average of 17 hours per week for 5 weeks. Observation and interview sessions with 4 cardiology patients in the Step-Down Unit ranged from 7-10 hours with an average of 16 hours per week for 2 weeks. During this 7 week period with non-surgical patients approximately 120 hours were expended in observation and interviews.

Data Coding, Analysis, and Analytic Scheme

Data collection and analysis occurred simultaneously, as Lofland & Lofland (1984) suggest, by utilizing the constant comparative method. The constant comparative method of data analysis is a systematic inductive method of theory building based on data gathered in the field (Glaser & Strauss, 1967; Glaser, 1978).

Developing the Analytic Scheme. Preliminary analytical notes were added daily to the field notes for the first 12 research days. These notes arose as the data from the field

notes were coded and sorted by important observation or interview topics. Early in the study important topics emerging from the data included: nurses translating for patients, personal sharing, reassurance, "in charge", just there to do the job, doing more than their job, smiling, friendly, patient as decision maker, rapport, chemistry, and humor. After the initial open-ended questions, and questions pertinent for the patient to expand on their initial answers, patients were asked questions evolving from the data to expand and verify the earlier codes. (Parse et al, 1985).

Coding and Analysis. In the data analysis phase, the first process is coding; data are examined line by line and each event is coded. The Ethnograph, a computer program designed to facilitate the processing of qualitatively gathered data, was utilized to manage some of the mechanical tasks of coding and analysis (Seidel & Clark, 1984). The use of The Ethnograph frees the researcher to concentrate on the analytic or thinking parts of the research, such as "generating interpretations and propositions more easily and efficiently", and "facilitating the creation of analytical categories and propositions from the data" (Seidel & Clark, p. 112). The Ethnograph "encourages the analyst to develop theoretical specifications while working with the data" (p. 113).

I generated approximately 850 pages of single spaced

transcripts of observations and interviews regarding nurse-patient interactions. Over 170 coding categories emerged in the course of the analysis. These codes were used to define segments of the transcripts. The Ethnograph was used to mark the transcripts with these codes and then extract these segments in an orderly, cross-referenced manner. Numbering the files facilitated identifying segments of the data. These numbered data files form the base for analysis. A printed hard copy of the numbered file allowed me to begin coding and analysis by marking meaningful segments and naming them in pencil. Seidel & Clark (1984) named this paper and pencil work "code mapping" (p. 116). The data label is written in the margin.

I coded some segments of text with one code word, but others were coded with as many as 8 code words. Stern (1980) labels these codes substantive codes, because "they codify the substance of the data and often use the very words used by the actors themselves" (p. 21). On occasion, 4 levels of segments were nested. In The Ethnograph 12 code words can be used to define a single segment, and up to a maximum of 7 overlapping or nested levels are permitted (Seidel, Kjolseth, & Seymour, 1988). Following the paper and pencil mapping, I entered the code words into the data files located in The Ethnograph program. The computer program "asks for the boundaries of segments by line numbers, and their code words, and the analyst responds

according to the way the coding scheme has been mapped" (Seidel & Clark, 1984, p. 117).

The last component I used in The Ethnograph program was an extraction of segments by code word in preparation of collecting specific code words and assigning them to categories. When the code words and data are printed in hard copy, the coded segment is identified by the data file from which it was extracted, a speaker/section identifier, a 38-character file note, and the code word. I utilized the 38-character file note to date the nurse-patient interaction, and to identify the participants with their demographic information.

Using The Ethnograph did not replace any of the thinking aspects of ethnographic research, but it did make the mechanical part of "cutting-and-pasting" a less cumbersome task. In the concept development phase, reduction occurred as category to category was compared to see how they clustered or connected. These connectives are called linkages (Schatzman & Strauss, 1973). As linkages emerged, categories collapsed and formed more general categories (Stern, 1980). The reduction process identified the major processes, called core variables, which explained what was happening. I began to achieve two requirements of theory "parsimony of variables and formulation, and scope in the applicability of the theory to a wide range of situations" (Glaser & Strauss, 1967, p. 111). The ability

to disassemble and reassemble segments of data as schemes emerged and developed during analysis facilitated development of a final analytical scheme.

During data coding and the analytic process methodological notes and theoretical notes provided direction for the study. As Schatzman and Strauss (1973) write, "The methodological notes reflect an operational act completed or planned, an instruction to oneself, a reminder, a critique of one's tactics" (p. 101). Methodological notes helped me to stay on target, even while being emerged in an overwhelming mass of collected data. Theoretical notes, a "self-conscious, controlled attempt to derive meaning from any one or several observational notes" were also helpful as I mulled over the collected data and noted my inferences and interpretations (Schatzman and Strauss, 1973, p. 101).

Trustworthiness

Qualitative methods of inquiry are now acceptable as "pertinent to and congruent with the goals and perspectives of nursing" (Sandelowski, 1986, p.27). Guba and Lincoln (1987) developed four major criteria of rigor to apply in naturalistic inquiry. They contend these criteria are as relevant as those used with respect to scientific inquiry. The four aspects of rigor are truth value, applicability, consistency, and neutrality. Guba & Lincoln suggest "credibility instead of internal validity for truth value,

fittingness instead of external validity/generalizability for applicability, auditability instead of reliability for consistency, and confirmability instead of objectivity for neutrality" (p. 104).

Credibility

A qualitative study is credible when it presents descriptions of a human experience that people having that experience would recognize as their own (Guba & Lincoln, 1987). One method as suggested by Guba & Lincoln for improving the credibility of findings is a prolonged engagement at the site, repeated and continuous observations, and developing a level of rapport without going native. I began the shift with the study nurse and stayed at her side during almost all nurse-patient interactions for 7-9 hours each day to meet the above criteria. I also followed most study patients during their hospital stay for a minimum of 2 days; some patients were followed 3 and 4 days. Rapport was established with study nurses by observing them through a minimum of 3 patients. A maximum patient load of 6 reduced the possibility of "going native" with a specific study nurse.

Another method of improving credibility of findings is continual scrutiny and coding of data. "Member checks" described by Guba & Lincoln (1987) and Sandelowski (1986) as necessary in satisfying the truth value criterion were used to assist in developing a working analytic scheme. As

themes began to emerge from the data, checking was done in the form of "hypothetical situations to which members were asked to respond" (Guba & Lincoln, 1987, p. 112).

Field notes and initial themes were reviewed and concurrence occurred from dissertation committee members. Following the development of the final analytic scheme, the field notes and scheme were provided to one peer for review and verification. That individual developed a comparable analytical scheme.

Six study nurses and one study patient reviewed the drafts of the data chapters. Feedback from these individuals suggested that this analysis of the data captured the reality of the nurse-patient interaction.

Fittingness

Guba & Lincoln (1987) postulate that the questions of whether one's findings might be applicable in another setting is often meaningless, but there are some instances when a researcher using naturalistic methodology might want to generalize information for application from one hospital to another with similar nurse and patient populations. In that instance, Guba & Lincoln (1987) counsel, fittingness should be the criterion against which the applicability or generalizability of qualitative research is evaluated, because if the degree of fittingness between two contexts is good, working hypotheses may well hold for both.

However, "whether or not certain information is

generalizable is a function not only of the degree to which the locale of the study is in fact a slice of life, but also of whether that particular slice of life is representative of other slices of life" (Guba & Lincoln, 1987, p. 116). Therefore each audience must determine for itself the information's applicability. The presentation of these data conveys not only the actual words of the participants but also "thick description," so other evaluators can make their own judgement.

Sandelowski (1986) suggests that when the findings of a study apply to others in their experiences and are meaningful to them, the study meets the criterion of fittingness. One patient, who had undergone major orthopaedic surgery during the study but was not a participant, reviewed drafts of the data chapters. Feedback from this source indicated that these experiences had meaning for her.

Auditability

Guba & Lincoln (1987) postulate that reliability or consistency is not an issue, because reliability follows validity, demonstrating internal validity brings reliability. According to Guba & Lincoln, a study and its findings are auditable, or consistent when another researcher can follow the decision trail used by the researcher in the study, and arrive at the same conclusions given the researcher's data, perspective, and situation

(Sandelowski, 1986). Review of field notes and analytic scheme by another individual with experience in this method meets this criterion. Further verification by nurse and patient readers as part of member checks support auditability.

Confirmability

Confirmability is accomplished when consistency, applicability, and truth value are established (Sandelowski, 1986). Guba & Lincoln (1987) suggest that confirmability be the criterion of neutrality in qualitative research, although neutrality, commonly called objectivity, is a "thorny issue" (p. 124). Even though biases about respondents are often built into test items, and values of the researcher can just as likely creep into procedural decisions before rather than during the inquiry, there are still some who say researchers guarantee their objectivity with quantitative research. Guba & Lincoln deny this by asserting, "naturalistic methods are no worse than scientific in achieving neutrality and may at times be better" (p. 127). This descriptive ethnography of nurse characteristics that satisfy patients values subjective reality and the meanings participants gave to the nurse-patient interaction. Involvement rather than detachment was sought in the interests of truth (Sandelowski, 1986).

Summary

Ethnographic qualitative methodology was used to elicit patient perceptions and interpretations of the nurse-patient interaction. Informed consent was accomplished according to procedures of Human Subjects Review Boards. Data were obtained through observations and interviews of patients and nurses according to established qualitative criteria. Data collection and analysis occurred simultaneously utilizing the constant comparative method. Coding, analysis, and development of the analytic scheme was facilitated by The Ethnograph, a computer program that assists researchers with mechanical tasks. Strategies for meeting Guba and Lincoln's (1987) criteria regarding the trustworthiness of qualitative research were incorporated into this study.

CHAPTER 4

THE TRANSLATING PROCESS

When I began observing nurse-patient interactions, I saw what I expected. Nurses constantly assessed patients, and provided technical and comfort care. What has traditionally been viewed as nursing practice was indeed occurring. However, my attention was immediately drawn to another process that was happening simultaneously in the nurse-patient interaction, nurse initiated communication. This communication was constant, focused, often deliberate, and the center of the interaction, rather than the technical or comforting task. A thorough and thoughtful analysis of observation notes and interview transcripts from the patient's bedside over an extended period of time allowed me to label this very important verbal exchange, this nursing function, the translation[6] process.

The purpose of this chapter is to present and discuss the data derived from observations and interviews regarding the translating process in nurse-patient interactions. The components of translating, as observed during nurse-patient

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[6] Translating is defined by Webster (1988) as "to transmit; to put into different words, rephrase or paraphrase in explanation; to change into another medium or form; to translate ideas into action."

interactions were informing, explaining, instructing, and teaching. Informing, explaining, instructing, and teaching occurred during a variety of nursing functions including: physical assessment, technical tasks, comfort measures, and discharge planning. Often the translating process was accompanied by kidding, smiling, sharing, and reassurance. Patients reported that being informed and having things explained to them were very important aspects of their care.

Informing

Informing[7] happens almost continuously in the nurse-patient interaction. Observations revealed that nurses answered patient questions, ("lunch is at 12:15") and provided information ("your surgery is scheduled for 2:00 PM," "your blood pressure is 128/86") throughout the nursing process. Information about all aspects of patient care was often given very rapidly in two or three sentences. The communication included the patient responding to the nurse's questions. For example, this conversation occurred between JoAnne[8] (Nu) and George (Pt):

Nu: Here's one bucket of ice cold water, and in the next couple of hours the doctor wants you to force a lot of fluids. We have all these juices (she

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[7] Informing as defined by Webster (1988) is "to tell; acquaint with a fact; to give information."

[8] All names are fictional to protect the privacy of the participants. First names reflect the usage in the setting.

names six). Your head needs to come up 30 degrees.

Pt: Where are we now?

Nu: Flat (JoAnne read a list of general rules about what patients needed to do after having a Percutaneous Transluminal Coronary Angioplasty. She explained what symptoms to look for). If you have change of any kind you need to alert a nurse. Do you know what Nitropaste is?

Pt: I'm wearing it. (The nurse began to tell the patient about all the drugs he would receive, how much heparin had to be infused and how it might be adjusted.) Is that the thinner?

Nu: Yes, (she continued to tell the patient what to expect). You've been through this one time before?

Pt: Yeah. When's all the removal of the sheath?[9]

Nu: Tomorrow. Let's look at these [sic] feet. The nurse that brought you up says you have excellent pulses. Let me take your blood pressure and then I'll get your juices.

Pt: I'm dreaming about hamburgers. (They are smiling at each other.)

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[9] The sheath is a pliable plastic tube a little smaller than a pencil. It can be any length, but is usually about five inches long for this procedure. It is inserted like an intravenous tubing in the femoral artery and used to expand the coronary artery.

Nu: Yeah, lots of onion, cheese.

Pt: I can't have those anymore. My wife is strict.

Nu: Well, that's good to have someone on your side. (She explained how to use the TV and call button. The patient nodded affirmatively.)

The patient and nurse had good eye contact during this very fast conversation. Their talk was an exchange of information, but also contained some explanation. Frequently these processes occurred together. The following exchange of information between Debbie (Nu) and Charlotte (Pt) included kidding, smiling and reassurance:

Nu: Good morning sleepy. How are you? (The nurse is smiling at the patient.)

Pt: I have the same pain in my knee that I came in to get rid of.

Nu: Besides the pain?

Pt: I'm a pain in the neck! (They started laughing.)

Nu: How do you feel about pain medication?

Pt: Sure.

Nu: You have PT in 15 minutes.

Pt: I want something to drink.

Nu: The water is right here, you can reach it. You're a skinny little thing. You're tiny aren't you? Pain makes you smaller. (This is said in a teasing voice. They are both smiling.)

Pt: I'm bonier. As Debbie finished taking the

patient's blood pressure she stated:

Nu: It's fine.

Many patients commented specifically on the importance of receiving information. Steve's (Pt) feelings about the importance of being informed are evident in the following comments:

> All of the women here were very good about keeping me informed about what was going on. Yesterday for instance, for awhile I was getting a little upset because the doctor didn't show up. I was here at 7:30 in the morning, and I really didn't get to see the doctor until probably noon or 1:00 o'clock. She was very good about...calling his office...reminding him of the fact that I was here...and that was very helpful. They sorta went out of their way a little bit to explain what was going on...and I think that's what makes your stay in a hospital, which is sorta a serious thing in the first place, a lot more palatable.

When I asked George (Pt) how he felt about the way JoAnne (Nu) was taking care of him, his immediate response was:

> She is efficient, she ran through all the stuff she was going to do. She had a check list. It's not a bad idea to tell you all that stuff. One of the things that makes you feel good, to know what's comin'. So it isn't a surprise when they come in here at 2:00 and take your blood.

Occasionally information given to patients was confusing. For example, Lucy (Pt) states:

> The little part that was confusing was when they told me yesterday that I'd be up the first day, and then when the woman came last night and told me, oh, no! We never get fusion patients up the first day. One person told me yes, and the one person told me no.

When I asked Lucy, "Did you ask the nurse who is taking care of you right now?", she stated:

> She wasn't, she didn't seem to be [sic]. She said depending on how the surgery goes, the doctor might, and depending on how much pain I have, they might attempt to get me up. Maybe there's no set rule...also they told me I'd be here six days. Dr. Brown said six days, everybody said six days, and came in to admissions this morning and she said, "You'll be here eight days". You know little things like that can be so confusing.

The following observation of Wanda (Nu) giving discharge instructions illustrated how warmth and reassurance were used while giving information:

> OK, you can take that [bandage] off tomorrow. Oh, you're going to put lipstick on! Here's the prescription. I know Dr. Jones went over this activity tolerance for you, but let me go over it too. These medicines are (she lists them). I gave you all of these this morning.

As Wanda began to tell the patient about the diet, she informed her that she could not drink any alcohol. The patient said, "Not even a glass of wine"? The patient had a very pained look on her face, and was clearly distressed. Wanda, who was sitting right next to the patient immediately reached over, put her arm around the patient, and gave her a hug. They quickly began to laugh together, and the tenseness of the situation abated. Wanda explained in detail why alcohol could not be taken, and told her to ask the doctor about it in about two weeks, after she adjusted to the new medications.

Often, informing was accompanied by explaining, especially if it had to do with activity level or medications. For example:

Nu: Blood pressure is 126/86. Want to log roll? Sit

on the edge? What do you want to do, wait for the pain pill to take effect? (Patient began the log roll in preparation for getting up.) You do that so well!.

Pt: Except for yesterday.

Nu: There's one Percoset. I'll get your water. The third day is usually the worst because the swelling sets in (Barbara explains the dynamics of this to the patient). Stand up if it's more comfortable, but I'd like to get that needle out of your hand.

When I asked Bill (Pt), "Do you like them telling you everything that goes on?", he answered enthusiastically:

> Yeah! yeah! They're real good about that too. I like it...I like to have 'em tell me what it is. A lot of hospitals won't. They won't tell ya what your blood pressure is, or your temperature or anything. I never could see any reason for 'em to hide it, but they do.

Another patient supported Bill's comments by stating:

> They make me confident that I'm being cared for well. She comes in and she takes my blood pressure, and I say, "How am I doing this morning?" and she says, "Well, today you're 118/80," and I'll say, "That's pretty good," and...that makes me feel good. Then when they come in and bring me my pills, and I ask a question about "What is it?" And then we look at it, and then she says, "Well this is your Coumadin, this is your potassium pill," and stuff like that. It just makes me feel comfortable.

When I asked Brian (Pt), "How have your interactions gone with the nurse?" he replied:

> She is very informative. When I wanta know something,

> I ask her. I get an answer that I can understand, which is not the case with all the nurses. It's just a matter of ah, the way they present things. Some are more curt, some are less curt, some are knowledgeable, some are not knowledgeable. She knows pretty well what's in my chart and she knows...if I ask her, "Did I have my Mevacor this morning?" she can go right to the record and say, yeah that they gave it to you at 7:00 o'clock or no, you're gonna get it at 11:00, or your medicines are five times today. That kinda stuff. Just generally informative.

Explaining

The second theme in the translation process is explaining.[10] Observational notes described nurses explaining nursing functions and the functions of other hospital departments. In addition, nurses frequently helped the patient understand information another health care worker had previously given. For example, while Barbara (Nu) was doing her morning assessment of Larry (Pt) she gave him a thorough explanation of what would happen in physical therapy, such as touch-down weight bearing, and a walker for stability. She further explained the importance of taking pain medication before the therapy:

Pt: How long before?

Nu: About one hour.

Pt: When will I be able to get up and brush my teeth and all that jazz?

Nu: Well, getting up, you mean going to the bathroom?

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[10] Explaining is defined by Webster (1988) as "to make clear, plain, or understandable; to give the meaning or interpretation."

Probably I would say realistically not today, maybe not tomorrow, but the next day.

Pt: Oh, that's alright. The first neck surgery I was up the next morning, and I took a shower.

Nu: I know. That is a little bit different surgery isn't it? It doesn't affect your walking parts.

Pt: Did they bring me eggs? (The breakfast tray had just arrived.)

Nu: Yes, what you asked for, toast and eggs. You fill out the menu here because this will be...

Pt: Can I have a regular menu?

Nu: Thursday. This is for tomorrow, but a dietician will come and see you after breakfast sometime, and give you a menu to fill out for lunch today, so you get your choice today.

In the course of this 10 minute interaction, they discussed Barbara's upcoming marriage, and Larry's trips into Mexico. They were engaged in eye contact, often smiling and laughing together. About an hour later when Barbara was checking Larry's intravenous site, she explained again why this surgery (total hip) was different from his previous one (neck fusion). She also explained his intravenous tube would be removed when he was taking enough fluids by mouth.

During my interview with Barbara, I asked her if she thought Larry was comfortable and had his needs met. She

replied, "I felt they were all being met. I felt the explanations that I gave satisfied him and that he didn't have to ask me anymore. I try to second guess what they might ask me or what they might be thinking about."

When I questioned Jan (Pt), "How do you feel about the explanations Debbie (Nu) gave you?" she responded, "Oh, I appreciate it because I kind of know what they're doing, not that it means a lot, but I don't have to lay here and wonder because I don't have anything else to do". Daniel (Pt) responded to the probe, "What was the one most important thing that a nurse did for you?" with, "I think the most important thing that happened to me was, you know, when I got here, the fact that the nurse went out of her way I think, to explain to me the general procedure, what was going on."

Most of the explanations about nursing functions centered on diet and fluids, activity, treatments, wound healing, bowel control, and pain management. Following surgery, many patients were hesitant about getting up the first time. Susan's (Nu) reaction to the patient comment, "I don't know about getting up," indicates the importance of advanced explanation in delivering care:

> Let's do a bedpan this time, but you have to get up, have to get up and move. Remember it hurts, hurts, but you need to grin and bear it. (Susan's voice is warm and soothing, but also firm. The patient begins to complain about other problems she's had about waiting in the night when she put her light on and it wasn't answered right away.) I can't speak to others. Let's try for that not to happen today. Your blood pressure

is good! Now I want you to lie on your back with your head up to eat your breakfast.

Often the nurse listened closely to the patient to determine what information and explanations were necessary. For example, while Susan was doing her morning assessment of Bertha (Pt), they moved rapidly through a question and answer dialogue all the while interspersing their conversation with comments about children and hair color. As Susan began to remove the intravenous tube, Bertha mentioned the blood she gave before surgery. Susan left the room to check on Bertha's hematocrit and hemoglobin. When she returned Susan explained that she was going to discontinue the intravenous fluids, and convert the line to a heparin lock so Bertha could get her blood if she needed it. She informed Bertha that her blood level was down and questioned her about being dizzy. They discussed pain medication once more. The examination continued, and light conversation was again interspersed with laughter.

Sometimes explanation and instruction overlapped. While Susan (Nu) was changing Judy's (Pt) dressing she explained what needed to be done in preparation for Judy's discharge:

Nu: My suggestion is not to shower, it exhausts you. Mary (nurse clinician) doesn't like you to shower for 24 hours. I'll let you eat your breakfast. Do you need anything for pain?

Pt: My pills are packed in suit case. I don't know if

I can get them.

Nu: I can get you some. I'll tell you what I think we should do. Give you something before you leave.

Pt: How long do you think it will take me?

Nu: Where are you going in Los Angeles?

They smiled at each other for a few minutes while they discussed the trip to Los Angeles. Then as we were leaving the room, Susan said, "Alright, alright, eat your breakfast." When we reentered the room about 10 minutes later, Mary and the patient were discussing medications. Susan joined in the conversation:

Nu: Metamucil this AM. Do you want a stick of dynamite?

Pt: No, I take Correctal at home (Both Mary and Susan explain to Judy why she should not take Correctal).

Nu: Colace, do you want that? It's a stool softener.

Pt: Yes.

They proceeded to discuss bowel control and Susan explained more about Colace. She ended by telling Judy, "I ate bran when I was pregnant."

When I asked Judy what she thought about Susan's instructions, she replied: "Very, very clear! She explained them, and that was very nice." Judy continued by telling me it was good the nurses talked to her about how to take her medicines at home. "I have done them wrong in the past. I

am glad I know the right way now. That is important."

Sometimes very detailed explanations were given to patients during a procedure such as removing sheaths from a Percutaneous Transluminal Coronary Angioplasty. Observation notes record the use of kidding and reassurance as part of this very delicate technical task.

Nu: I'm going to give you a little Demerol because this may make you a little uncomfortable. Alrighty now, the first thing we're going to do is put this board under you.

Pt: Just what I need! Maybe I should have had that last night.

Nu: Yeah, boy. Now the next thing is...(she continues with the explanation).

Pt: Such a cinch.

Nu: Such a cinch. (They are smiling at one another and frequently in eye contact.) I've been taking out sheaths on people for about 1-1/2 years. So, little did you know an old veteran like myself would be with an old veteran like you. You have a lot of men looking up to you for a lot of supervision I bet. OK, doing the dance around the bed here. (She then explains the pain associated with the procedure and how to breathe with the pain). OK, now I'm going to take the little sutures out. This is a real art here.

Pt: Technical, technical art.

Nu: Yup, real art. Are you OK? What a good patient you are, better than good! What a snap (she says this as she pulls two of the sheaths out, and begins to explain the next step in the procedure). How did that Demerol work? Can you feel it now? Blood pressure is 150/80. Not bad at all! A couple of more minutes and then I'll ease up on the pressure here.

Later when I asked Keith (Pt), "How did you feel about the way she explained things to you?", he replied:

> She explained it step by step. You knew what was comin' on. It makes you feel good. You know what it is? It isn't a surprise...you expect it...it helps just knowing that you're going to have pain or not. Then you know it's going to be there, instead of not knowing.

JoAnne (Nu) confirmed the patient's feelings when she said:

> If you teach somebody, then you have less complications. The more they know the better off you are and...it's better for them too. They know what's going on. They feel like they are participating, they have control. It's always worked out.

I questioned another patient who received the same detailed explanation during the removal of a sheath: "So, how are you feeling about what went on this morning?" He replied, "Great, a competent gal...I had one of those before and she [the current nurse] did it better, explained it better, and made me feel more confident of her than the other gal did."

Instructing

The third component of the translation process is instruction.[11] Instruction often focused on activity, or positioning in bed. For example, Diane's (Nu) instruction to Chuck (Pt): "When your PT gets here, she'll talk you through it. What they'll do is stand you. For you, what you can do to help is take deep breaths, keep your eyes open, concentrate on what she's saying." Susan (Nu) told Bertha (Pt) the proper way to get out of bed: "Just remember, be methodical, do things methodical, squared off, don't cut corners. Bend that leg, that a girl, use this overhead."

Frequently praise was given along with instruction. The patient was reluctant to get out of bed, but the nurse had just gained permission when this instruction began: "OK, let's do that now. We'll swing your legs over to the side. I wanted Dr. Smith to see you up, you look so good! Pace yourself, do a little and stop...you're coming along so nicely." Other comments from nurses: "That looks real good...you wash what you can without straining at all, and I'll wash the rest. I don't want you to bend over to try to get your feet. I'll do that...you'll only be up for the bath. We will gradually increase your activity." "I'm sorry but I need you to stand straight. Use your arms,

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[11] Instruction is defined for this study as to communicate knowledge; to order or direct; to educate (Webster, 1988).

don't try and use your legs. You need to be in the middle of your walker, move to the right, keep going, you're doing super! Each time it will get easier."

Lucy (Pt) was feeling "down"[12] as Susan (Nu) began to instruct her to change her position in bed:

> Look at how well you did compared to yesterday. It's not worth comparing with other people. You should only compare with yourself. How did you do yesterday? How did you do today? Be prepared for us nurses and physical therapy to be pushy. We expect the best. Take each day. One day, you may not feel as good, but remember you're moving forward. Everyone deals with pain, illness differently, and we tend to forget that. You've done so well this morning, you can't but get better, right? Now, I want you to lift a little, push with your legs. OK, you did it! Leave legs up if they're more comfortable.

Often kidding accompanied instruction. The nurse and the patient were already smiling and laughing together when this instruction began:

> You look really stiff this morning, like you're holding yourself back. What about taking your Zantec? It's only ordered on a PRN (as needed) level, two times a day, you'll only get it if you ask for it. Now remember you can bring your bowl to you (the patient is lying flat in bed eating). If you slobber on yourself, it's OK. We don't take points off.

Another dialogue:

Nu: Use the walker, turn around, sit in the chair.

One hand back to the chair.

Pt: That's a piece of cake.

Nu: Chocolate?

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[12] Some visitors had just told her that they thought she'd be doing better than she was. They were telling her of other people who had had this same surgery.

Pt: Absolutely!

Sometimes empathy was very much a part of instructing. As Barbara (Nu) was medicating Lucy (Pt) she stated:

> Just let them know what your priorities are. I know if I was your therapist, I would believe you. What you are saying about how you use too much energy sitting up, getting to the standing position, you don't have energy to. Tell her that. (An hour later) I don't know if there is anything worse than all that gas pain. If you would like the suppository earlier, I can give it to you. Let's see how you do after a little rest.

Many instructions focused on pain, preparation for surgery, and what to do at home. For example as Karen (Nu) asked Sandy (Pt), "you got chest pain? I'd go easy with eating today, don't eat a lot, maybe half of your tray. Why don't you lay quietly, let shot take affect." Another example is a conversation between Doris (Nu), and Joe (Pt):

Nu: But you had some discomfort in the night, some chest pain? (The patient is watching the nurse very closely as she changes the piggy-back on the intravenous drip.) I wanted to ask you a couple more questions. When you had your chest pains last night, did it wake you up?

Pt: No.

The patient explained how he woke up with chills before the chest pain. Doris probed gently with questions instructing the patient when to inform her, and what she would do if he experienced chest pain again. They were smiling at each other. Their voices were very soft.

Diane's (Nu) instruction when preparing this patient

for surgery was typical. "I want you to exercise your feet and legs like I showed you, we'll remind you." Another nurse stated, "Your temp is still up, that means you have to breathe on that thing, move around a lot."

Nurses recognized the significance of instructing patients. The following example of Susan's (Nu) nonverbal behavior demonstrated the importance of instruction. Susan knelt by the bed, rested her arm with the clipboard containing the instruction sheet on the bed, and looked directly into the eyes of the patient as she began to instruct her regarding discharge. The instructions included what home activities to do and not do. She ended by saying "You won't feel bad till you've hurt yourself. Just remember! Susan said, don't do it." Smiles, humor, and laughter were exchanged frequently during this discussion.

Doris (Nu) was very clear when she began to instruct John (Pt), "This is how to take care of the site at home." She spent about ten minutes telling him exactly how to take his pressure dressing off in the shower, how to medicate and redress it, and other important things to do and to watch for. As she began to instruct him about exercises, they started laughing.

Kim (Nu) instructed Geraldine (Pt): "When you get home, take a shower and put Betadine on it, and a Bandaid." Kim spent a few more minutes instructing Geraldine about how to get in and out of chairs, the reason for Betadine

ointment, "to keep the germs out," and ended by saying: "it looks fine, plop a little Betadine goo in the center, use a Bandaid. We'll send you home with lots of Bandaids."

JoAnne (Nu) was giving Gary, (Pt) another coronary angiogram patient, discharge instructions when he said:

Pt: Are you going to take the bandage off?

Nu: No, it's easier to take it off when you're in the shower.

Pt: Here?

Nu: No, at home. I'm going to give you a print-out sheet that tells you when, and how to do it.

JoAnne continued the discharge instructions. Later when I interviewed Gary, he stated, "She's excellent giving instructions. I felt really good about that."

It is easy to understand why nurses would interchange the words teaching and instructing. Webster (1988) defines instruction as "any teaching lesson," and teaching as "to give instruction". Yet when one explores the meanings further, there is a distinction. Instructing can be a command or order, while teaching is to show or help a person learn how to do something (Webster, 1988). Utilizing the study definitions, instruction was used much more frequently than teaching in the nurse patient interaction, but they did at times occur together.

Teaching

Teaching is the last major theme in the translating process. Observation notes recorded only a few teaching[13] episodes and most occurred when the nurse taught the post surgical patients how to breathe deeply. For example: Karen (Nu) hummed[14] as she entered Sandy's (Pt) room with a pain shot. She instructed Sandy in log rolling as she asked her to turn so she could administer the pain medication. Karen continued her assessment of Sandy and then began to teach her to breathe deeply. Following the instruction, Karen and Sandy practiced the technique together. Later in the day when Karen was in the room examining Sandy's chest, she told her to take deep breaths as she again demonstrated the technique. While she continued to examine and talk to the patient she interspersed comments, "Great!", "OK," "Alrighty," and "Good!" when appropriate.

One teaching episode occurred that did not involve deep breathing. Debbie (Nu) had previously instructed Ann (Pt) in the proper technique for putting her leg into a knee brace. (Ann had received an artificial knee.) She continued:

Nu: Are you ready?

Pt: No. (The voice was calm and matter of fact, but I

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[13] For this study, teaching was defined as, "to show or help a person learn how to do something" (Webster, 1988).

[14] Three of the twelve study nurses frequently hummed when providing nursing care activities.

felt the patient did not want to get up.)

Nu: Where are you going to pull your leg to? You tell me how to do it. (The patient sits up in bed, puts her leg in the proper position, and they begin to put the knee brace on.)

When I asked Jan (Pt), a patient with a hip replacement, "How do you feel about the way Jane (Nu) has been teaching you, or has she taught you anything?", she expressed these feelings:

> Yes, I mean like just to go in there to the bathroom. See, I wouldn't have gone. I wouldn't have had the guts...had confidence in her. I worried about her being strong enough because I am so much heavier than she is, but I figured that wouldn't bother her. If I could just get up off from it [toilet]...or getting down she said. I think it will make it easier to go home. Just for instance, that stack toilet. I think that will be much easier for me to have, at least for a week or two. I don't want anybody hanging on to me. I like to be independent.

Summary

My field notes established that, during almost all nursing functions, a translating process occurred simultaneously with other functions being performed by the nurse. Although there was a difference in informing and explaining, they frequently happened together. Observation recordings suggest that informing and explaining consumed over 70% of the translation time. Patients perceive both of these processes as very important to their well being.

Instructing comes next in frequency and provides the

patient with what nurses determine to be important to nursing functions and care. According to the study definition, teaching consumes a relatively small component of the translating process. The translating themes are often intertwined and occur simultaneously in the nurse-patient interaction observed.

CHAPTER 5

DEVELOPING THE NURSE-PATIENT RELATIONSHIP

When I asked patients to tell me about what had just happened with the nurse in the room, they almost exclusively characterized the nurse's interactive style, not what task she was doing. I received responses that described the patients' perceptions of the nurse-patient interaction, or the feelings the patients had about the nurse, the interpersonal aspects of the nurse-patient relationship. Patients informed me if the nurse acted "this" way, they felt "that" way.

The purpose of this chapter is to present and discuss the data derived from observations and interviews regarding the establishment of the nurse-patient relationship. The information will be presented primarily from the patient's point of view supplemented by data illustrating the nurse's perception. The first part of the chapter will focus on the nurse-patient interaction during the initial stages of development. The second part will describe the nurse-patient interaction as the relationship grows and trust begins to emerge.

"Getting To Know You"

Both patients and nurses perceived personal sharing as a central component in the development of the nurse-patient relationship. Patients described "kidding," friendliness, and understanding as other important qualities of the nurse that made them feel comfortable in the nurse-patient relationship.

Personal Sharing

According to the patients, the nurses, and my observations, 11 of 12 study nurses engaged in personal sharing with patients.[15] With some it was an integral part of their care, but 11 actually used sharing as a technique. Three nurses who frequently utilized the technique expressed these thoughts:

> Doris: First of all, it breaks the ice, and if they're like anxious about something, it helps them to relax and focus on something other than their illness. You know, and put things in proper perspective. Plus, it develops a type of rapport. I feel (pause) if you just come in and you're straight faced, and all business and very impersonal, the patients don't really like that. I find that they like the personal touch. Either, you know, you say something nice about them, or you share something in common or something, not real personal about yourself but something about yourself on a light angle. I think they lighten up for you and they kinda appreciate that.
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> Willa: They'll open up more if I mention that I have three kids. Then they start talking about their family, and you know sometimes by bringing in my own life, then they share their life with me. I do that a lot. I'll ask them while I'm washing them if they have

[15] Personal sharing is defined for this study as a sharing of self with another; disclosing to another things that are important to you.

> children....I think we all like to share a little bit of who we are with everybody. I find a lot of times it can build a rapport, definitely.
>
> Laurie: I like to do that because I think it kinda puts you on the same level, and you can get really a nice rapport with them. It's almost like a friendship and sharing of information....It's nice, I think, to be able to have a friendly chat with a patient where you can still pass along information to them and kinda give them things that they may not have thought about.

When I asked Susan, another nurse, why she shared personal experiences with patients sometimes and other times she didn't she responded:

> I don't know, I like to just relate personal things, sometimes it makes it easier for a patient to deal with whatever it is they have, or sometimes it's lots of things. I don't know. (pause) I can't even remember how it came up (she had been talking to the patient about her mother having cancer). Sometimes I'm real good at discussing whatever comes up, and at times I know it's really not the right place for me to be discussing my own personal things going on in my life.
>
> When I asked, "When is the proper time?," Susan continued. It depends on how involved the patient is with themselves. If all they're worried about is themselves, me, me, me, then it's not a good thing to really discuss, I can't really explain it...that's when I keep quiet. But dealing with your own personal things with patients sometimes helps them, I think. Put their own thing in perspective, and then it brings out other things when they talk about their friends or family that have had surgeries or illnesses in the past, and how they've dealt with it. And then they can kinda look back on themselves, and it helps them, I think, to get better.

Personal sharing and kidding give patients the feeling that nurses care. A specific question to Mary (Pt) and Lucy (Pt) asking them if they got the feeling that Susan (Nu) cared evoked these responses:

> Oh, heavens sake, yes!....First of all what she said about her mother, and then also she told me a bit about

her little boy. You know, when you talk about your mother and your child, that's kind of firstly important, and, ah, she kids a lot which usually means that's just a way of establishing a relationship.

She told me she's been through this herself...she had a laminectomy, so I'm sure she understands the pain. I feel that she's, she's more involved in my well being because she's been through a back operation.

Observation notes record that Debbie (Nu) freely shared her personal self with patients when she first entered their rooms. As she introduced herself to Ann, a 71 year old patient, she commented that her last name had just changed. With minimal encouragement from Ann, Debbie talked for a couple of minutes about her recent marriage and the redoing of the "bachelor pad."

Pt: How did you redo the bathroom? I'm building a house, I'm laying here thinking what color I want in my bathroom. (As she began to take Ann's blood pressure, Debbie gradually refocused the conversation on the patient.)

Nu: How are you feeling today?...(they are smiling at each other) let me check your (she is examining the surgical site)...is that where they pulled the drain out? Oh, it looks good doesn't it?

Pt: Yes, Oh, do you really think it does? You think I can win a Miss America contest with that?

They continued their conversation as Debbie examined the intravenous site. They were discussing the patient's pain when the breakfast tray arrived. While Debbie got the

patient and food ready to eat, she told Ann to call her if she needed pain medication. As she left the room, she told the patient her name again.

When I asked Ann, how she felt about the interaction when Debbie first came in the room, she replied:

> Oh, she was really nice. She introduced herself nicely and I enjoyed that; most of them are that way. Uh, I mean, the only thing I had was the other night, maybe it was my reaction. I needed a bedpan and this young man came in and "what do you want"? I said, "I need a nurse, I need a bedpan," and he pulled his card out, like you see I am a nurse, or a nurses aid or whatever he is and he shoved that pan under there. I didn't like it!

When I asked Judy (Pt), "Do you like nurses sharing with you?", her comments reflected those of others: "Well it's nice to know if they have a family, you don't, ah, you're married, you know, stuff like that. It's nice, it's nice to know a lot about a person...I am always interested, I am always curious, you know". When I commented that the sharing seems to make "life a little more fun," she responded, "it does, it does, than [if] they [should] just be so, what do you call it, cold?"

Personal sharing also seemed to put the patient at ease. As one patient commented: "I really feel that they're a person, not that you're just a number. You become personal to them, they show some identification with you as a patient, that they can feel what it's like to be a patient." "It puts you at ease, you feel like you belong." "I think it relaxes you a little bit, and it makes you feel

easier....and if they have a smile on their face, I feel good."

Many patient's stated they liked to share personal information with nurses. Sam (Pt) reflected, "It's comforting...a listening ear is very nice...they have a job to do. Debbie (Nu) doesn't just come in, blow through here and blow out, she, she gives quality time." I responded with, "OK, and quality time to you is sharing?" He replied, "is sharing, and being thoughtful. Holding my hand, giving me a hug....Debbie is very cheery, very, very upbeat, and for me that's good...it helps give me a brighter outlook, a more positive attitude. It helps me get better."

Personal sharing can also bring patients a feeling of hope. Juanita, a 39 year old hispanic asthmatic patient, related her appreciation of a discussion. She had been a severe asthmatic since early childhood and continued to be frequently hospitalized for acute episodes as an adult. Her comment related to sharing religious beliefs. "I like to talk to people and then when they talk to you, it's just like ah, there is something in there besides, besides you're sick or you need this." On another occasion, the respiratory therapist confided in Juanita that she too had asthma. Juanita described how this affected her:

> She was saying that ah, when she was little, she was suffering so much and skipping school a lot. And then I remember when I was a kid...hard time to dress myself...like bring memories like that...my God...but that's good that she change...she change her, what town she had to live in, and she looks better. Like it

gives you hope, that's probably what you need too, yeah!

"Kidding"

Eight of the 12 study nurses utilized some form of humor or kidding[16] in almost all nurse-patient interactions. Three nurses utilized kidding in some of their patient interactions, and one nurse was not observed kidding with patients. When I asked those nurses who laughed a lot with their patients why they did so, they responded several ways:

> Laurie: Sometimes I think it's just nervous laughter, other times I just, basically I'm a happy person. I always try to smile, but I don't have to work at it. When I come to work....I am happy in my job and you know, I like to talk to my patients. I think it's good for them to kinda keep things on a light [level]. I don't want to be in there and, "you need to do this, and you need to do that"! Sometimes I do get serious, but that is when I am worried about a patient. I try to watch that, and catch myself so I don't get a frowny look on my face when a patient is not doing so hot.

> Another nurse, Wanda, explained it this way: I feel, it's, I can get my point across with them and I can take care of them and not be that serious with them, and I think they respond better. I feel more comfortable with it that way, and it just seems to work. When I asked Wanda, "does it work with all patients?" she responded. Everyone!,[17] I think every single patient that I have ever taken care of, they all have some sense of humor, some of them you have to fish around. It's interesting to find out what they, you know, it's some wave length that you both think is kinda funny and you get on that one. And that's the good way I like to communicate with people.

Observation notes record that neither the kidding nor

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[16] In this study kidding is defined as teasing, playfully ridiculing, or engaging in joking, Webster, 1988.

[17] Wanda has nursed for 25 years.

the personal sharing interfered with, or slowed down the nurse's performance of her technical tasks. Often the kidding and personal sharing by both the patient and the nurse would begin immediately upon entry into the room. For example:

Nu: How are you, having much pain?

Pt: No

Nu: Up to eating? (Barbara is smiling at the patient although she sounds serious).

Pt: Ya, a porterhouse, just kidding, soft foods.

As Jane (Nu) entered a patient's room to assist the patient out of bed, she commented, "Oh, I see I'm a day late and a dollar short." The physical therapist was already helping the patient out of the bed. When Debbie (Nu) entered Judy's (Pt) room to check on her, they talked about exercise and getting her pain pills. Judy, a lumbar laminectomy patient, told Debbie how much she had been exercising. As we left the room, Debbie stated in an encouraging voice, "you're an ace." Upon reentering with the pain pills, Debbie found Judy trying to sit up in bed. "Are you twisting? You can't do that. We give traffic violations for that!"

Although none of these nurses mentioned kidding or laughing in their interviews, the observation notes testify to kidding and laughter during the nurse-patient interactions. It was easy to see the patient's anxiety

level decrease during a kidding interchange, which supports the findings in a recent study of nurse administrators. Everson-Bates (1990) cited humor as the most pervasive coping strategy utilized by nurse managers to release tension and encourage problem solving.

Many patients verbalized their appreciation for kidding. For example, Bob (Pt) described his feelings about the bath interaction: "No problem, she's a good nurse. I like her, she's fun. She can take my jokes too...it's, I don't know, it kinda eases it up a little bit. They're always so serious, sometimes, kinda stuffy, you know". Jan (Pt) when comparing two nurses said, "I think Debbie is more joking. She makes life a little more fun". Larry (Pt) responded to the question, "Do you get the feeling your nurse cares?" by stating, "It is Barbara's (Nu) attitude. They give me the impression that they care whether I get well or not, if I am comfortable. They are looking after my well being very well. Sometimes if I feel in the mood to kid, they will kid right back. It is just a general attitude." When I stated to Denise (Pt) that I had noticed quite a bit of laughing during the nurse patient interaction she stated, "Oh, I love it, I think the more people laugh, the better it is...laughter kinda brings you together a little bit." John (Pt) stated, "Bad enough being in one of these places, but if somebody can make you laugh, that takes a lot of the sting out of it."

Kidding is an integral part of the nurse-patient interaction, but because of the colloquial expressions they use, nurses may not even be aware it is happening. For example, all of the following expressions were used by nurses in the study: "Should we stir up this secret potion", "Where is the spittoon bucket", "We'll sniff it out and see if it's good," "Tell me when I get the hide," "Time to go home, fly the coop," "You're the bed pan lady," "Do you want to walk down, or do you want to ride in the limo."

Frequently kidding was initiated by the patients. As one nurse waited for a patient to finish on the commode the patient said, "They also serve who sit and wait." As Barbara (Nu) was fluffing the pillow for Larry (Pt), she stated, "How does that feel"? He responded, "Marvelous, I'll take you two girls home with me." As Jane (Nu) helped Beth (Pt) to the commode, Beth said, "Where there's smoke, there's fire." When Diane (Nu) asked Sharon (Pt) if she wanted some prune juice, she answered, "I'm not a pruny person." Mary, a 72 year old patient with a total knee replacement, was two days post operative when she used the dinner plate cover as a bed pan (She said she couldn't wait any longer for the nurse.) Laurie stated as she removed it:

Nu: That was an amazing feat!

Pt: Don't tell anyone.

Nu: I'm very impressed.

Pt: Well, you know, any little port in the storm, you

can use a little...to clean it.

Nu: Well, not to worry, it's not a problem. We'll rinse it out, and it'll go through the sterilizer.

Often kidding was used to support patient comments. For example, "I'm dreaming about hamburgers," "yeah, lots of onions, cheese." Sometimes kidding is used to avoid making a patient feel bad when something negative happens such as when a glass of water is spilled, "At least it got the floor clean." When I specifically asked a few patients if they liked it when nurses joked with them, their comments included: "It lightens things up a little bit," "It's better to be more light, then you don't think about your problems," "Kidding helps relieve anxiety and I wouldn't want to have a stroke."

Kidding and laughter often occur even when a patient is experiencing pain. As Karen (Nu) approached Charlotte (Pt) she put her hand on Charlotte and said:

Nu: I'm going to give you something for pain. You're pretty miserable today.

Pt: I feel like I am frozen to this spot.

Nu: What I want you to do...reach hand over bed side rails, turn a tiny bit more (gave shot). Now you take a couple of deep breaths for me (she breathed with the patient).

Pt: I'm such a mess.

Nu: You're such a mess. (This was said in a teasing

voice, and with vivid facial expression.) We'll get you fixed up today.

Karen began her examination, questioned Charlotte about fluid intake, left the room to get her some fluids and jello, and then began the examination again. During the subsequent assessment, hanging an intravenous fluid bag, and discussion of taking in oral fluids, they laughed over trying to get the jello cubes in the patient's mouth with a spoon. When I asked Charlotte if she liked talking to the nurses about personal things, she responded:

> Oh, sure! Especially when you can say something that makes funny, or I ah, something that makes a laugh....I love to laugh. I don't know what's happened to this generation, you know, coming up. They seem to be so humorless. They're taking themselves so seriously. And that's not the way to live your life, my goodness. (It was almost like Charlotte was shaking her finger at the younger generation.)

Because the nurse taking care of Charlotte was only 27, I asked Charlotte how she felt about her. "Does she enjoy laughing with you?" Charlotte replied, "Oh yeah. She's got laughing eyes....I noticed her eyes...they look happy, you know, and she looks <u>at</u> you."

<u>Friendliness</u>

Smiling, being friendly,[18] warm, having a cheerful personality, and talking on their level were aspects patients described as important in helping them feel comfortable and accepted as a person. For example, "I think

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[18] For this study friendly means to be supporting, helping, kindly, not hostile, Webster, 1988.

they make you feel so much better when they can smile. It makes you feel better." "She's a bubbly type person...it makes me feel real good." When I asked Millie (Pt) how she felt about the nurse's smile, she said, "Well it makes you feel like you are not afraid to ask for something when you need it, when I need it."

Beth (Pt) stated, "She looked into my eyes...she listened with her face and her ears." Sam (Pt) commented, "She talks to me, holding my hand when you guys move me, just real gently." Sally (Pt) described Debbie's (Nu) mannerisms that made her feel comfortable. "She is very friendly...she seemed to look me in the eye...she seemed to really...she was really listening...she just acts like she is here to help me...she has a smile and everything and that really helps...she was very friendly, warmth coming over."

After I asked patients a general question, "How do you feel about her as a nurse taking care of you?" they would often respond with, "She's warm, she makes me feel comfortable." An example from Charlotte (Pt), "She's very warm. And if I had something I had to tell her I wouldn't hesitate to tell her. With some of 'em I wouldn't tell 'em anything. They know too much already, or they think they do." Charlotte spoke of Karen (Nu): "she was warm, friendly. 'What can I do for you, if you need anything be sure to let me know'...she just couldn't have been nicer."

When I asked Millie (Pt) if there was anything in

particular that the nurse did to make her feel comfortable, she replied, "I don't know of anything in particular, except that she just seems like she does one on one, she talks to me one on one, not like she's talking down to me because I'm the patient and she's the nurse."

When I asked Lucy (Pt), "So, how about your interactions with the nurse that's been taking care of you?" she answered:

> I think she's great. She's terrific, I just feel real comfortable with her. She makes you feel real at ease and comfortable. She's, you know, she's interested in her patients. The other gal...but, I like this gal very much.

When I queried Lucy further as to why she felt the nurse was interested she stated, "I think she just seems sincere and ah, she just seems like she cares....well, very down to earth, she's sincere. I like people that are sincere, she makes me feel comfortable."

Understanding

Many patients described feeling comfortable when a nurse was understanding.[19] Lucy (Pt) was recounting an experience with Barbara (Nu) when she stated: "I mean she's thinking, she seems to be ahead of me...she knows what I'm thinking...I feel that way in some instances anyway. I feel she's very understanding." Steve (Pt) was not talking about a specific nurse when he said: "The more you can try

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[19] Understanding is defined for this study as a means to perceive the meaning of the situation, and have a sympathetic rapport with another person, Webster, 1988.

to...put people in that position where they try to understand the people they're caring for, then the more likely it is that they'll be more, you know, responsive even though they may not really feel like it."

Mary (Pt) was speaking of Laurie (Nu) when she related this episode: "That first night was such a nightmare...I was sorta clinging to anybody that would make me feel better, and I think she...understood that. Maybe she understands when patients are having a hard time. I just felt awful and I think she realized that."

Tom (Pt), who had bilateral knee joint replacement, described how Jane (Nu) understood both him, and the pain he was in:

> She seems to have your interest at heart, where some of the other nurses, I couldn't even tell you names, but some of the others, that ah, don't seem to really care about who you are, or what you are, if you were President, they'd just as soon let you drop as anything, so....

When I asked Tom to explain the difference between Jane and those other nurses, he said:

> Well, the personality factor. Even though maybe deep down in her heart, maybe she's not really that interested in me, she gives that opinion to anybody I think she works with. Her personality is such that she gives proper attention...she makes you feel like you're asking for something that you're not stupid to ask about and, um (pause). Some of them that have been in here, they'll just let my leg drop. They'll wop it over to one side and she knows for some reason or other, she knows when the leg hurts.

Janice (Pt), a 28 year old patient recently hospitalized in another city because of an automobile

accident, talked about the nurses who helped her feel comfortable:

> The way they act and the way they say that they understand, if they were hurt that way too. They don't blame me for complaining; they don't make me feel uncomfortable here. I feel comfortable here...when the nurses treat me like part of their family they are a lot more understanding and caring. I like it when they treat me like their daughter...some of them can be...some nurses can be cold, in fact I've had some like that, but I haven't had that here yet.
> Then Janice spoke specifically about Karen (Nu):
> She's just nice and friendly...she treats me with respect, thank God, I shouldn't say this, but the therapy guy...he kinda doesn't understand why I can't get right out of bed. And I'm doing the best I can, it hurts! She treats me like I'm a person, not just a thing.

When I asked Bob (Pt), "Did you feel any different after Susan (Nu) had been in your room?" he replied:

> I felt a little bit more at ease and ah, it could have been because she did present to me the empathetic point of view. 'I know what you're here for, it will be OK, let me see what the problem is.' And so then I, I felt a little bit more relaxed.

Beth (Pt) contrasted nurse behavior by first stating what behavior was not helpful to her, and then, what would have made her feel comfortable:

> I felt like she, she was listening to my problems, but trying to find excuses other than the reality, maybe I took too much drugs, maybe I didn't take enough drugs, did I have a bowel movement? And that probably didn't matter. I still felt not good. I would have liked her to say, what do you need me to do right now to make it comfortable for you now? But instead of her telling me, instead of her telling me eat, and then we'll worry about it. I wanted her to tell me! (This was said with annoyance in her voice.) Is there something we can do right this second to make you feel a little bit more comfortable so you can have, eat your breakfast?

Establishing Trust

When analyzing the areas that patients in the study felt were most helpful in establishing trust, three components surfaced as most important. First, seeing the nurse as being "in charge" increased their confidence. Second, they described what the nurse did that helped them feel confident. And, third, the nurse who acted like she enjoyed her job gave patients the feeling she was concerned about them, and would help them.

In Charge

The term "in charge" for this study was defined by the patients. The "in charge" nurse knew what she was doing; she had planned ahead to anticipate the patient's needs. Frequently patients would begin their description by talking about the nurses' personality. For example, Jan (Pt) described Jane's (Nu) personality:

> Wonderful, she seems to be in charge[20] of herself. Not all of 'em have it that together, at least in my estimation. She walks in here with a sense of having everything together and she has all these ideas in mind. Like she has given it all a little thought.

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[20] When I asked Jane, "were you aware that patients referred to you as in charge, she answered, "I have had that comment from other people in Rave Reviews. They say that they feel confident, comfortable with me because I am confident in what I am doing. They feel safe with me. I am not hesitating, I am not trying to remember things or having to go ask other people. I do my job in a safe and appropriate way, but I am also light as far as humor and talking about other things. But it doesn't distract me from what I am doing." When I asked Karen, another nurse, "do you think Charlotte (Pt) liked what you were doing for her?", she replied: "She was pleased with what I was doing because I know I came across as knowing what I was doing. A couple of times she said she was very pleased with her care. She was aware she was in good hands."

When I questioned Mike (Pt) about his interaction with JoAnne (Nu), he said, "She's great! she's awfully nice, she does good work...she knows her business, she's proficient. I can tell by her actions, by the way she handles herself, and ah, she knows what to do when something happens...she doesn't become flustered. She knows what's gonna happen."

The characteristic of being "in charge" does not necessarily come with experience. For example, Lucy (Pt) contrasted the behavior of two nurses, Barbara and Lisa:

> Barbara really seems to be on top of everything....I mean she's thinking. She seems to be ahead of me, rather than, you know, she knows what I'm thinking or what I'm going to say next. I feel that way in some instances anyway. I feel she's very, very understanding, um (pause). I don't know how the difference...or what their own personal experiences have been, but I think that must have something to do with it. I don't know about this Lisa, I guess she's a really new nurse, she's cute, and she's sweet...and she said, "all you have to do is just," she's sorta like you're in a gym, she said, "just hoist yourself up" (the patient had an overbed trapeze), and I thought "Come on lady, I couldn't do that before I had this operation." That's I think the difference, the understanding and the feeling...and a, maybe it's just through experience. In another few years she'll probably have experienced more.[21]

In a discussion I had with Daniel (Pt), he spoke of Willa's (Nu) actions: "It's her actions, mostly her actions, and then I think you generate an eye contact with them that say, hey this girl is, she knows what she's doing....It's ah, her personality." Joe (Pt) characterized Doris (Nu) by saying, "She seems very efficient, very good,

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[21] Both nurses are 27. Barbara has 7 years experience. Lisa has 6 years experience.

yeah, very good, friendly...she makes me feel relaxed and at ease." Upon further questioning, "I wonder what she does?" he answered, "Just her, just her outward attitude."

Tom (Pt) portrayed Jane (Nu) by stating, "I know she knows what's going on in my mind and she's able to play with that ahead of time, you know, she's there to help you if you need help." Sally (Pt) recounted an experience with Debbie (Nu): "She really acts like she knew what she was doing...she just went about it without any hesitation what she had to do. It wasn't like she was trying to muddle through something." Lucy (Pt) commented about Barbara (Nu): "what little I saw of her, I'm impressed. She seems to have it together."

When Bertha (Pt) told me that some "girls"[22] were better than others, she was referring to Susan (Nu):

> It's just their personalities, don't you think. I mean, ah, yes, the way they care for you. Some, some know more about how to. For instance last night when I was in bed, when I was on my side. Oh, it was so much more comfortable than the previous time I had been put on my side. So, obviously this, this gal knows exactly how to do it. You know, you can't move. I mean there's no way that you can move, once you're there, you're there! So of course that, that kind of knowledge to know how to do it properly.

Patients use many superlatives when they describe nursing care. Bertha (Pt) specifically stated:

> I think the nurses do a good job, especially Susan, she's very good, excellent, she's awfully good. Um, I support [sic]; there's some that could be improved on

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[22] Some men patients referred to nurses as the girls; on occasion, female patients also referred to nurses as the girls.

> but on the whole, I think the girls are quite good. Susan seems to have, oh, I think maybe a little more feeling for people. I'm not sure about that, but it seems to me that she really cares...it's just an attitude that she has....She seems to know what she's doing. She's very, very efficient...certain people give you that feeling that she really knows what she's doing....It's her whole manner, she's, she's very positive, know that you are going to have these pills and "I want you to take them right away" and you know, there's no, no question in your mind."

When Jeffrey (Pt) described Jane's (Nu) ability to do a job, he also described her ability to anticipate:

> She has done a fantastic job...she's good! And, she's not a bit lazy. She looks for things to do to make you comfortable and easier for you and doesn't seem to forget anything, and ah, you know, has everything right handy at the bedside for you. If you've got a job, don't be lazy about it! People say, any job worth doing is worth doing right....It's like a waitress in a restaurant, some of them just bring the food out bing, bam, boom, and others are checking to see if your water glass is empty, and if you need anything.

Charlotte (Pt) was excited when she spoke about her interaction with Karen (Nu). She recited:

> It's like a 10! She was just that good...she knew what she was doing. She went right to it and, and, there wasn't any hesitation on her part. She just went to it, and when I mentioned something, she just went right out and got it and finished it, and there was no ah. (pause) At one time she was busy with the other patient and she excused herself, but told me to call her whenever if I needed her...and so I felt warm to her, that I could depend on her...trust her.

Confident

Patients who described feeling confident[23] reported these characteristics in the nurse: promptness, doing what they say they're going to do, checking on them, keeping them

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[23] Confident is defined for this study as trust, reliance; the fact of being, or feeling assurance, Webster, 1988.

informed, and having a warm, cheerful personality. Sometimes an introduction set the stage for the patient to perceive confidence in the nurse. For example, when Barbara (Nu) entered Chuck's (Pt) room she began:

Nu: Good morning, look at you! (The patient is sitting in a chair, Barbara is smiling at him. He smiles back.) How're you feeling?

Pt: OK, good.

Nu: My name is Barbara. I'll be taking care of you all day today. OK, your therapy is at 8:45.

Pt: She's been here.

Nu: How'd you do without your pain pills? Oh, you had them at 5:00. (She was looking at the medication sheet.)

Pt: I did OK, I guess (he laughs).

Nu: Wonderful! wonderful. Well, listen, call me when you want to go back to bed.

Pt: Do I need to? I could do it.

Nu: Have you done it before?

Pt: I think last night.

Nu: Why don't you call me so I can see how you do. Then I'll feel comfortable the rest of the day. (Her voice tone was firm, yet warm.) I'll be right at the other end of the call bell.

The patient's light went on about two minutes later, and Barbara answered it promptly. During the interview two

hours later Chuck commented:

> The nurses, they've all been really good. I can't complain about any of 'em. They give you a certain amount of security...they don't waste any time getting to you...and they explain everything to ya. They don't come in and just go to work on you, they say, they tell you who they are.

Another example occurred when Willa (Nu) entered Daniel's (Pt) room: "I just wanted to introduce myself, I'm Willa and I'm the nurse on the floor today. I have some medicines to give to another patient down the hall, but I'll be back and give you yours after breakfast. Do you need anything?" Willa returned to that patient about 40 minutes later. When I questioned Daniel, "What is the one most important thing that a nurse does for you?", he replied. "They relax you with their confidence that they show you." Daniel continued, "Not like the girl I had last night, she was very quiet...the friendliness didn't come through, and a believing in her didn't come through as much as it does with Willa."

Patty (Pt) portrayed Willa as both the nurse who knew what she was doing and the nurse you could rely on. Patty stated, "Just her air of competence, when she was going around doing, asking, watching, being there, and coming right back, promptness." Patty went on to contrast that behavior with that of another nurse:

> I think...I've just ah, feel that something that would be helpful would be when they can't come back when they say they're gonna come back, it's at least call you, and let you know that they didn't forget. Rather than just not come back, and then come in later you know,

> and say why they didn't come back. (The patient is trying to smile as she says this, but it's not coming through) That's kinda a little anxiety provoking, when you feel they didn't come back Did they forget? And then I guess that's what you worry about.

Beth (Pt) concurred stating, "[The] hospital is nice, but I had to wait 45 minutes for the nurse after surgery. If you are going to be gone for a long time, you at least need to check in with the patient and give an explanation."

When I asked George (Pt) why he said JoAnne (Nu) was great!, a competent gal, he answered, "You saw what she did! (he almost sounded exasperated with me for asking the question) I had one of those before,[24] and she did it better, explained it better, and made me feel more confident of her, than the other gal did."

Having a cheerful personality seems to convey to some patients a sense of confidence. Denise, a 40 year old patient described Laurie (Nu): "She just seems to be up, she just seems to be encouraging when she walks in the door. When I asked her how she perceived that she stated:

> Well, I don't know, you can kinda tell when somebody is a happy person and a, I have confidence in her. To me she gives off an air of confidence, which one of them didn't do...her actions are smooth and fluid and she knows what she's doing. And the other one was real slow...not to say she may not be a good nurse.

During my interview with Laurie, she confirmed that she was a happy person. Another patient, Hazel commented, "She's wonderful, it's just her effervescent personality and

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[24] He had a sheath removed following a Percutaneous Transluminal Coronary Angioplasty.

her happiness about her...that's very excellent for sick people. She's so helpful when I need to ask her...instant service!" Mark (Pt) referred to Wanda (Nu) as being warm when he described his feeling about gaining confidence: "Well, some are just gonna do the minimum amount and then others are gonna be real warm, and, ah, I think that comes from experience, and certainly you gain a greater confidence when ya feel the person taking care of you knows what it's all about."

Many patients described either feeling secure or anxious according to whether the nurse was checking on them, and keeping them informed. Other patients felt secure when a nurse gave praise for a task completed. For instance, Sally (Pt) described how she felt when Debbie (Nu) gave her verbal reassurance:

> She made me feel like I had confidence too, you know. It was better than maybe yesterday when I was going through physical therapy...everything that she [physical therapist] was telling me, I had already, it was like a clock to me. I started to do on my own and, you know, she says "don't do that!", so...do I dare move? So when I have done something like, Debbie saying "well you did better", you're moving good". Then I felt like I was doing it right, and I wasn't having to be criticized because I went ahead.

Two patients undergoing cardiac monitoring perceived their needs to be similar. Patty (Pt) described it this way:

> I think the most reassuring thing is ah, sticking your head in the door and seeing that you're OK. I've been here, and I don't really need any care, but I can go for hours and nobody sticks their head in the door and I sorta wonder, if anything happened to me would they

know.

Steve's (Pt) view:

> Well, I think the main thing as I say is just, you know, sticking your head in every now and then and just keeping you advised of what's going on. Rarely do doctors give you that kind of information that says, I want you to just sit around for the next eight hours. And it's helpful even if just someone comes in and says, hey! we need to monitor your heartbeat for the next eight hours and there's really not much else that's gonna go on, so, you know, relax and enjoy it. Rather than...what's gonna happen now? Am I doing what I'm supposed to be doing?

Karen's (Nu) checking in behaviors were described by Sandy (Pt) as:

> Well she just comes back and checks on you a little bit more often than...and she's concerned. You could tell with Bea (patient in next bed); Bea was in pain, so she stopped. And some other nurses would just finish up what they were doing, and then go tend to your pain once they're finished. I know if I'm needing something it'll get the appropriate attention.

When I asked whether they felt the patients' needs had been met, only one nurse said that developing a rapport meant developing confidence. When I asked, "How do you develop trust with patients," she responded:

> I think making sure I think that they, their questions are answered correctly. Not giving them false hope, being honest, ah, you know like if I say I'm going to be back in ten minutes, I'll be back in ten minutes, or I'll call them and say I'm tied up. Um, (pause) what else? Answering questions for them, trust, what else can I think of it? (long pause) I haven't really thought about it. There are so many things go into it, and most of my patient trust me. You know if they don't trust you, they're unsure of what you're saying. They don't believe what you've just done.

<u>Enjoying the Job</u>

One descriptive phrase was often used by patients to

illustrate their perception of the good nurse. "They are enjoying what they are doing." Enjoying one's job was perceived by patients as, "The nurse's concern is for me." Sally (Pt) provided specific comments about Debbie (Nu):

> She talks with her eyes and everything, I mean she just seems to, you know, she seems to enjoy what she is doing and she just really seems to um, express herself that way, you know. It makes me feel better, you know. (The patient's voice is firm and cheerful.) It makes me feel like her concern is a lot more for me. Like when she's enjoying what she is doing, and she does seem to enjoy what she is doing, and if she isn't she is acting (laughter), but she does seem very pleasant.

Sally further described her feelings as she discussed nurses in the past who didn't enjoy their job. "I haven't so much, I mean I haven't here. I just (pause), yes I have! and I have felt it too! Like I said, you don't want to ask for any more than you have to."

Bertha (Pt) reported that she knew that Susan (Nu) was concerned about her because she was always cautioning her, "I want you to be careful, be very careful," and she was very up: "Some people seem to be more outgoing...they like their job...it's just not like something they have to do...it's not, let's get it over with." Larry (Pt) spoke about Barbara (Nu): "She acts like she really cares. It is not just another job." Following Mike's (Pt) comment that JoAnne (Nu) liked her job, I asked, "How can you tell when someone likes their job?" Mike responded: "Oh, I think, if they're impersonal and ah, they just get the job done, and that's it, why, that person probably shouldn't be in the job

because you have to do a little bit extra."

Following my question as to whether there was anything different in her interaction with Diane (Nu), Sharon (Pt) replied, "Um, just that she's cheery, positive. Positive I guess would be about the biggest word. They are doing great things, you know, to help you. You can see that they are enjoying what they are doing." When I asked her how she could see they enjoyed what they were doing she said, "By their smiles and how helpful they are. They ask you what you need; they don't just come in and turn around and go back out."

One Example

The following example is presented because it represents many elements patients described happening during the nurse-patient interaction to develop their relationship. As Debbie (Nu) entered the room for the purpose of Charlotte's (Pt) bath, she said:

Nu: You're awake, good! Let me tell you what to do. Did you disconnect these, you little devil? (Her voice was teasing and she was smiling. She was referring to the pulsating stockings.)

Pt: You don't think I could have done that, do you? I don't have arms that long. (Her voice was on the same light teasing note as Debbie's. Charlotte was also smiling. Debbie was getting Charlotte

ready for her bath.)

Nu: I want you to do just about everything.

Pt: Oh, no! (Her voice was almost whiny.)

Debbie put the cosmetic case in front of Charlotte so she could retrieve her personal things. She helped her get started and then went to take care of the patient in the next bed, (which appeared to be deliberate so that Charlotte would proceed on her own). After about two minutes she returned to Charlotte's side and handed her the washcloth. Conversation began again as Charlotte started to wash:

Nu: See, you thought you couldn't do it. You're doing an excellent job! Go ahead and dry. How old are you?

Pt: Seventy-seven.

Nu: Same as my grandmother.

As Debbie began to brush Charlotte's hair, the discussion moved from the weather to family. Debbie started to clean up after the bath and said, "Now I want you to drink this whole thing by the time I come back." (While Debbie was out of the room, the patient drank about 1/4 of the glass.) When Debbie returned she picked up the glass and said, "Did you do it? Close, not bad."

Pt: I can't drink all that.

Nu: You thought you couldn't do it. You did a great job! Now, how do you feel?

They discussed a variety of topics including

Charlotte's pain. Charlotte was doing most of the talking. Debbie listened as she cleaned up from the bath. They often laughed together, they looked like they were enjoying one another. As Debbie completed the last task she said, "OK, what can I do for you now?" Charlotte looked at me and replied, "She's interviewing me for unglamor magazine." We all began to laugh, and then Debbie refocused on Charlotte. She leaned over the bedside table and got very close to her. They were smiling, eyes locked together when Charlotte said:

Pt: You have beautiful eyes.

Nu: Oh, thank you (they talked about husbands for a few minutes). You have till 12:00 to drink this (she lifts up an almost full glass of water). I have this whip.

Pt: Meannie, mean and pretty. (This was said in a teasing voice, and with a wide smile.)

Charlotte described this interaction to me about an hour later:

> I think she's really lovely. She pushes, but very softly...cause you get a stinker like me. I'm not use to drinking, and I just, well, I mean, it gets in throat and I think I can't get anymore, but somehow, you know, she handles me very well...she gets a little rough at times. Like, I, we have it all done by noon, but even if I won't, she won't kill me. When I asked Charlotte how she knew that she replied: Oh, I don't know. I just take it for granted, I could be wrong, because I haven't done so well up to now in certain things. But the minute I do something good, she's all over me with praise. Yes, so that makes me feel good.

Summary

Both patients and nurses described how personal sharing and kidding laid the groundwork for establishing a relationship. Friendliness and understanding helped the patient feel comfortable, and set the stage for trust to develop in the nurse-patient relationship.

Patient accounts of the nurse in charge and how they began to feel confident described the importance of those components to the establishment of trust in the nurse-patient relationship. Two nurses corroborated the patients' perceptions, as they described how patients accepted that nurses knew what they were doing. Patients reported that the nurse who enjoyed her job made them feel better; they knew the nurse was concerned about them.

CHAPTER 6

"GOING THE EXTRA MILE"

During interviews patients identified a characteristic in some nurses that they labeled "going the extra mile." The purpose of this chapter is to describe and discuss data derived from interviews and observations regarding patients' descriptions of nurses who "go the extra mile." Patients described three component processes that occur when a nurse goes the extra mile: "clicking", developing a friendship, and "doing the extra". Both patients and nurses frequently mentioned the "clicking" that occurs with the nurse-patient relationship, whereas only patients described the nurse who acted as a friend. Patients described the nurse who "does the extra," while nurses described the same process in terms of the need to sometimes "bend over backwards" in the nurse-patient relationship.

"Clicking"

Observation notes and interview transcripts consistently confirmed the importance of the "clicking" process. The first time I witnessed "clicking" in the nurse-patient interaction was during an observation period when Debbie (Nu) admitted Judy (Pt) to the surgical unit.

Three hours before Judy was scheduled for surgery, Debbie was taking her history and performing a physical assessment. They immediately began to intersperse talk about family with the question and answer interchange of the history and assessment. The conversation moved quickly back and forth between intimate sharing, health issues, and processes needed to prepare Judy for surgery. There was a copious amount of expressive exchange; the words flowed quickly, sometimes soft, and sometimes high. Interspersed with the examination, and comments like "take a deep breath," or "150/70, how high does it go?, you have high blood pressure and irregular pulse," was a lot of laughter and jovial exclamations. At one point I heard Debbie say, "My, oh my!, oh!, my." They were clearly enjoying one another.

Judy's comments during our interview afterwards described the immediate rapport that I observed between them:

> So we got acquainted and we got going real ah, you know, sweet about it. I mean she was telling me things about Italians she had known in Italy and I had cousins in Italy too. We're both Italians...I asked her if she was going to be my nurse because I liked her.

Two days later, when I followed Debbie into Judy's room, Judy had a huge smile on her face. Debbie leaned over the bed, hugged and kissed her. There was a look of joy on Judy's face. I was so stunned by the display of affection that I forgot to record what was said next. When I resumed

recording a few minutes later, they were discussing Judy's status:

Nu: Did you pee yet?

Pt: About a cup. (They discussed the patient flushing the toilet, the nurse needing to know how much the patient had voided.)

Nu: That looks good. (The nurse is examining the patient's abdomen.) How's the pain?

Pt: I'll take some pills.

Nu: How about the gas, expelling a lot? (The nurse's hand, on top of the bedspread, is patting the patient on the buttocks.) This way? Do you remember the night we put the catheter in, the five of us? That's why I was so happy when you told me you just peed!

While the nurse continued her assessment, informing the patient of her findings, the two of them talked about the patient's family. The tenor of the interaction was very warm. There was vivid expression on both their faces. They were enjoying each other very much, oblivious to everything else.

Nu: You were so funny the other night, a stitch (small laugh). Heart nice and regular today (the voice tone becomes less emotional).

While they talked about the patient's constipation and what to do about it (there was confusion about the

physician's order), Debbie was holding Judy's hand:

> Nu: When we get it figured out, we'll give it to you. (She is examining the abdomen). Better than expected. (Debbie turned to me and said), she put this surgery off once before.

As they began to talk about their families again, they laughed frequently. Judy looked at me and smiled (I think she was trying to tell me how happy she was talking to Debbie.) A few minutes later, Debbie told Judy she was leaving for now, but would be back later. When I asked Judy to tell me about the interaction that occurred when Debbie entered her room that morning, she said:

> She kissed me. She was so sweet...see, she was gone for two days...and we took to one another. Well, all the nurses are nice, really everyone of them, I can't complain...but being that we were both Italians, you know, we had a lot in common and so we were talking about that. Well I mean...it's funny, sometimes we really take to someone. Like with Dr. Jones now, the first time I saw him I didn't like his appearance, or his bedside manner or whatever you want to call it, and that's what kind of stopped me from going for [surgery] the first time.

When I later asked Debbie, "Do you hug all your patients?" she stated "No,(pause) I have to have some chemistry...some people are family feeling and some people aren't family feeling...I think it's cultural." She explained what she meant by "chemistry" in more detail when we discussed another patient:

> I don't think I connected very well with her. Some patients I just click with. Personalities. I don't think there is any negativity or anything like that, but certain people I can just tune right into, you

> know. And with her, she's very reserved....I tell myself that I'm not going to be joking around as much...whereas with Judy in the next bed, I joked around her all the time she has been here.

Two days later I was interviewing Judy about another nurse, and she began to talk about Debbie again, and what had happened between them during an interaction I hadn't witnessed the previous day:

> I got another hug...she was so sweet, she took my name and she said, "Oh yes, she says, my husband likes to gamble."[25] We clicked you know...in fact she showed me her wedding pictures...and told me about her husband and her father and I told her about my family. We were getting a big kick out...then when she saw the cookies. "Ohhh!, she says, I haven't had these in so long!" Italian cookies...I told her to take them home.

Another patient, Daniel (Pt), talked about the patient-nurse relationship and said, "There is something there that clicks." His wife joined in:

Wife: Oh, some have charisma.

Pt: Something about a person when they walk in.

Wife: You relate to them easy.

Pt: Yeah, it's just there...it's with Willa, yes, very much so, she's very fine.

Wife: Don't you think some are more warm, outgoing and they give you that feeling of warmth and caring?

Pt: That's the question isn't it?

Wife: Don't you think it's like....they seem generally concerned. I think it's concern

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[25] Debbie is referring to visiting the patient in Las Vegas.

they show outward.

During the interview with Willa, she said she felt about Daniel the same way he felt about her. We discussed the "clicking process," and how often that happened to her. When I asked her if she felt that way about most of her patients, she said:

> Maybe two out of ten...or, (pause) that may be a little low. I don't know, maybe it is realistic, but I think right off when you just warm up to somebody right...you wonder how much, even subconsciously what plays in here because of the child (long pause). There's certain people that remind you of certain people or your mannerisms, your culture, all kinds of things play into factors with personalities...he (pause) kinda reminded me of my Dad.

Willa continued this discussion as she described a female patient:

> She seemed ready to receive me as a nurse. I guess I just, the conversations go a lot easier. It is easier to converse and get to know her as a person, and I feel more comfortable sharing who I am too, a little more with her through the working day.

Some patients didn't use the word "click", but they described the same process: "Well, I guess I just like her. She just seems to be a neat person and I don't even hardly know her, but she just stands out! I have the feeling that she'd take the time and answer things I wanted to know." "Let's see. I think the personality, the manner...some people you obviously just can relate to more than others."

Nurse as Friend

Some patients described a nurse with whom they wanted

to maintain a friendship. Ann (Pt) said she gave Debbie (Nu) her card so she could visit her, and "Debbie said she'd come see me."[26] Ann was smiling and her voice was very cheerful as she continued to say they could be friends. She stated, "you know, Debbie was so refreshing!" When I asked her to explain this, she raised her hand off the bed and said: "Like up, she lifts you, you know, she was so like up. She also spoke right at me, at all times. I have a hearing problem, she didn't know that. Some don't do that. It is very important that they speak to you."

Ann continued her discussion contrasting Debbie with other nurses: "But this lady, I, I, this one here. If I am looking for a personal friend, I think that [Debbie] would be the one that I am looking for." When I questioned her further she stated:

> The first time I saw her...I like her appearance...her openness...and her directness. That's what I like in people...and I have a feeling about this lady. She is somebody you can depend on...I don't know how I got that feeling, something clicked. I don't remember the others' names....Now her name I remember, Debbie.

Another patient, Lucy, described the nurse she would like to have as a friend. Lucy characterized Barbara (Nu) by stating:

> She seems to take a special interest...you're not just another patient. She makes me feel like she cares about me!...I feel a kinship with her much faster than I did with Susan (Nu). With Susan, it was really towards the end of the first day, whereas with this one I felt it a lot sooner....You can tell when somebody

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[26] Ann lived in Mexico.

> cares about you, and isn't just saying, "how're you feeling?, or how are you?" and they could care less. A friend waits to listen, waits to hear the answer when they ask you. And that's the difference I think."

It is interesting to note that this nurse-patient interaction was not initially positive.[27] Lucy had expected Susan to take care of her again that day, and when Barbara first entered the room, Lucy said, "Where's Susan, I thought she'd be here today?" (Lucy's tone of voice clearly displayed displeasure.) When I interviewed Barbara and asked how she felt about the initial interaction she stated:

> Not very good. I wanted to say, no, Susan isn't going to be your nurse! You're going to have to settle <u>for me</u>, and I felt like she didn't get her purpose and I felt, (pause) just felt real annoyed by that, so we kinda got off on a bad start, I feel like. But as the day has gone on, I feel a little bit better about communicating...I now know how to communicate with her a little bit better. I know that I need to listen until she's finished. With some people you can pop in a suggestion and they'll say, "oh yah," and think about it and keep on with their thought. But she's not like that, she has to finish before she can take your suggestion into consideration. Now I feel like if I just listen to her, and let her have her moment, then when she's ready to listen...she'll listen, and I know that's when I can talk. So it's just a matter of getting to know how she's thinking.[28]

When I asked Barbara if she thought Judy felt OK about her now, she laughed and said:

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[27] Sometimes the patients felt much better about the nurse-patient interaction than the nurse did. In this instance, Lucy immediately forgot the first encounter and viewed their relationship as very positive right from the beginning, whereas Barbara remembered the first interaction.

[28] Another interesting note in that specific case is that Barbara figured out what it was that Lucy wanted very early in the interaction.

> Now I do, but not this morning! See, probably what happened was that Susan had told her she would be back today, and she counted on it. It doesn't happen very often, but when it does, it throws you. Now, I think she has accepted me as her nurse in a positive way.

Charlotte, a 70 year old patient, described why she would want Karen (Nu) as a friend:

> She just couldn't have been nicer, marvelous from the first moment I met her. She was warm, friendly...she was close to me. She put her arm around the bed trying to make me more comfortable...she noticed right away that I was uncomfortable...she must have felt that I wasn't. She said, "are you cold?" and when I said yes, she came with blankets, and she brought me an extra pillow. She did everything like a mother, like a motherly comfort. (long pause) I would like to be her friend because she was so nice...and I'm particular about my friends....I have to feel that I trust them. I will never get real close (pause). I was hurt once, I think I was ten years old, by a girlfriend who betrayed me, and from then on, I...picky about allowing myself to be ever betrayed again.

Daniel's (Pt) wife offered this comment about Willa (Nu) when Daniel was explaining to me how he and Willa "clicked." "Don't you think it's like a friend on the outside. They're genuine, they seem very genuinely concerned. I think it's concern they show outward."

"The Extra"

Patients used the following expressions to describe the nurse who went further than the actual job requirements: "She's being over nice, beyond the point of no return." "Susan was great, absolutely great!, very caring. She tried to make it easy for me, she was very nice about this business of giving it all you have. The other nurse was

hard working, but I think she wanted to go by the book." "She comes in sometimes without the light to say 'how are ya?' not long, you know, cause she's very busy." "It's the competent, friendly, you know, approach to the business. This is their job. We're here to fix you and that's what we're going to do!"

One patient discussed Wanda as the nurse who did "the extra." Wanda has the ability to give you that little extra minute or two, that little extra pat, or, "How do you feel, are you warm enough, can I get you any more water?" Those kinds of things that just make you feel comfortable, in other words, mothering.

Steve (Pt) was not talking about a specific study nurse when he made these comments about nurses having a special attitude:

> Where the nurse takes the time to try to find out a little bit about who you are and what makes you tick, and what your concerns are. You know, obviously there, you must assume they're doing that in an honest effort to be able to totally resolve some of those things. In other cases I think you can feel where somebody is basically just going by the book. Ah, you know, getting you checked in and bedded down and on to the next patient...it's always helpful if the nurse can appreciate what the patient is going through, you know, trying to view the thing from the patient's point of view.

Dorothy (Pt) used the phrase "bends over backwards" to describe the "extra" in the nurse:

> Oh, the fact that they can be pleasant about something even though it's maybe not just the most pleasant thing for them. But when somebody's a little bit irritated...there was one nurse. I couldn't hardly talk to her, she was just so...so I thought, well,

> leave it, leave it well enough alone. She's not the friendly type, and there are those, and then there's the "bend over backwards"...like when you need something. When I had this under my arm...it was burning and smarting so bad...and I thought well now, I wonder how long I'm gonna have to wait before I get this? So when I told her about it, I said, "I hope it won't be too long." And Wanda went right out...got it, and also put it on....I thought that was pretty nice. The fact that she wouldn't say, well, we'll get you some later, next time I go by.

Both JoAnne (Nu), and Jane (Nu) used the phrase "bend over backwards" as they described their philosophy of care. For instance, JoAnne commented:

> I always try to be really nice to people. They seem to respond much better to kindness and caring and nurturing, and niceness, much better than someone who is really straight, efficient, ah, lets get this show on the road kinda thing. So I just "bent over backwards" trying to be really nice to this woman who I felt probably had a terrible problem.

Jane described it this way:

> When I hear in report that someone is a challenge, then I start thinking about what I am going to do to fix it. Like if it's someone who's been real grumpy during the night, maybe they had a pool[29] nurse and they weren't very happy...I make up my mind before I go in the room that I am going to turn it around for this patient as best I can. I will bend over. I will give him the "TLC", I will "bend over backwards." I will do whatever I need to do within reason to turn this patient's day around....I want them to have a positive experience when they are here. I want them to like me. You know, we all want people to like us, although not everybody will like me, but I am like that. I like my patients. I like patient care, the contact. I miss it when I am not doing it.[30]

Doris (Nu) related an experience during the interview

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[29] A temporary nurse.

[30] This nurse if often the charge nurse on the unit. The charge nurse does not take a patient assignment.

that indicated the "extra mile:" "So I said to Hazel (Pt), 'that's quite a pain and agony,'[31] and she closed her eyes and said, 'please don't leave me,'...so I knew I couldn't go to lunch.[32] You cannot walk out when a patient says that you know."

One patient, Sharon, described how she helped a nurse to "do the extra." We had been discussing the nurse who knew what she was doing when Sharon changed the subject and said:

> As far as their basic duties, I think they all know what they're doing. I think as far as friendliness, some are more friendly than others. Maybe it's easier for me because I'm an outspoken person...it doesn't matter to me. Just cause they're quiet doesn't mean I'm going to be. The night nurse that I had last night. She's real quiet, she just does her job, she's very polite, she asks if I need anything, but she's not outgoing in conversation so I keep starting up conversations with her. It seems to be helping her. Every time she walks in now she smiles at me, and so we've kinda made a little bit of a rapport there.

Patients described nurses who "did extra" as those who related in a more personal way. For example, "When the nurse takes the time to try to find out a little bit about who you are and what makes you tick, and what your concerns are, to be able to resolve some of those things. You can feel where somebody is basically just going by the book." Denise (Pt) described it this way. "Some just seem to get

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[31] The patient had just recovered from an acute attack of pulmonary edema. She was terminal with lung cancer.

[32] The nurse had planned to go to lunch with me, so I could interview her. She gave up both her lunch and break that day to spend extra time with this patient.

in and mesh well and do above and beyond the call of duty...she seemed more personal, and then others do just what's expected of them, and they're good nurses too."

When Joe (Pt) told me he was "impressed with the way she handled it," he was referring to the way Doris (Nu) observed his privacy during the bath.[33] He continued with:

> She's a zealous person, wants to exceed [sic] in whatever she does. She takes a little bit more interest...more conscious of you and your attitude...she's concerned with the whole atmosphere...she's johnny-on-the-spot. She don't hesitate a second to oblige me.

Patient Beth described "the extra" as a nurse who used a personal touch. To her, "the extra" seemed to be almost the opposite of "going by the book." She reflected:

> One was a gem last night. She got emotional with me...she held my hand and said, "oh, honey!" Going by the books is good, that is the way I run my business, but a gem does more...she took a moment away from being a nurse, thinking about medicine, she was compassionate. She said to me, "if you doze off, don't worry, I'll be here." (Beth's voice conveyed a warm feeling.) That made me feel good. There is the little extra smile. You need a human touch. The really good nurses do more than just be "formal."[34]

Millie (Pt) expressed her feelings about Willa (Pt):

> She's so sweet...what she does, she does it with such feeling...not because she's a nurse, but that she has feeling for people. Maybe because I work with people myself, and you get the feeling when you're talking to someone that really cares...it seems like she goes that

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[33] Joe was a young man in his 20s who had never been in a hospital before.

[34] Beth did not want to speak poorly about the study nurse, but I think she was referring to Jane (Nu) as formal and going by the book, because she referred to all others as gems.

> second step, that she doesn't, would not really have to do. She doesn't have to be asked.

Denise and Mary (Pts) had Laurie (Nu) taking care of them one day, and Karen (Nu) caring for them the next day. When I began to interview Mary, she wanted to talk about Laurie, the nurse she had had the previous day. When I asked, "Why do you think Laurie is a sweetheart?" she responded, "She's cheerful and she's ready to help me. I'm glad I have her." When I said, "That's good. What about Karen, the nurse that's taking care of you this morning?" she responded, "She was alright, she is alright." Mary's voice clearly conveyed a drop in tone. She then quickly added, "When you say alright, you always think that maybe isn't quite as positive a statement as it might be, but I don't want to sound that way because she was fine." Denise described Karen and Laurie by stating:

> I like them both the same and get along well with both of them, but Laurie seemed a little more on a personal level. Karen is kinda a real professional who comes and attends to your needs and then leaves, you know, as a person she is very, very nice, but she is just a little different. (Denise's voice clearly lifted when she was talking about Laurie.)

Sometimes study patients wanted to talk about an experience they had had with another nurse who "went the extra mile." Two different study patients referred to a specific nurse on the surgical unit who was not in the study. One couple, both the husband and Sharon (Pt), his wife, wanted to tell me about this "special nurse." As they began to speak their voices conveyed a respectful and loving

tone:

Husband: I would like to comment on one of the nurses she had yesterday, Maureen. She was great with us. She took the time....She made sure we understood cause sometimes we're too proud to say we don't understand....I think she detected it in our faces. We would agree with something and kinda look at each other and then she would kind of catch it and go back over it a little and then she could see that we understood it a little better...and then she'd press on. You could tell that she cared about us as people.

Pt: She was very helpful.

Husband: She wanted to make sure that we understood everything that was happening....She didn't want any misperceptions.

Pt: She had a fresh face. She was real positive.

Husband: I'm not saying anything different about the lady that she just had, OK? But there was a different attitude. She was more laid back, she wasn't in a hurry, she kinda took the time to joke around with Sharon and get her in good spirits and kinda related our family with hers. It was really neat, she kind of made it down to home.

Pt: Personal!

Husband: Personal type basis...and so it's like, we're kinda in a limbo situation...are we really here? We didn't want this to begin with. She helped settle that down cause we were real scared...her acting like a more down to earth person. It's not that she spent more time than usual, it's just that she, how do I, how do I explain it, Sharon?

Pt: She used the time that she was in here to make herself known and to make us comfortable, and it wasn't like she was in here a lot longer than anybody else would be, but instead of walking around quiet, she would walk around jokingly and...on "I see you like elephants," or whatever, and kept the conversation going.

Most of the time when patients talked about the nurse "going the extra mile," the comments addressed the nurse's interpersonal skills. Charlotte (Pt) talked about Debbie's (Nu) response to her inadequate food intake. (She was three days post-operation, without nausea or vomiting, and yet was not eating.) When Debbie entered the room she questioned Charlotte about her difficulty eating. She asked about swallowing, teeth problems, and eating habits at home. The following discussion occurred while Debbie was taking

Charlotte's blood pressure and checking the intravenous drip.

Nu: I'm going to have the dietician see you regarding a mechanical diet. Need to take the intravenous out today so the mission today: get you hydrated! You're kinda shaky. Are you shaky at home? Do you want to sit for breakfast?

Pt: Sure, might as well. (The conversation continues to revolve around the diet, and eating habits.)

Nu: How's the pain?

Pt: Right now, sorta alright, lots of pain in the night.

Nu: You have physical therapy at 8:15, do you want pain medication?

Pt: I don't know.

Nu: Let's sit you up and see. Oh! wait a minute, let's take out the intravenous to make it easier. Hang on a second (she left the room for a minute to get supplies to discontinue the intravenous tube). Good sign, getting intravenous out. Progress! (They both have smiles on their faces.)

Pt: Thank goodness for that! Am I going to get up now?

Nu: Don't lean on my, hurt my back. Oh, you did that all by yourself. This is progress! Today is the day of progress, that's good. Now every liquid on

this tray, I want to be drunk, drank!

Debbie left the room to get Charlotte's pain medication. While out in the hallway she discussed the patient's eating difficulty with the doctor. The doctor did not make any suggestions regarding the problem. Upon returning to the room, she gave Charlotte the pain pills. They discussed personal sleep habits, and information about both husbands. Their talk was very warm and comfortable; they often laughed together.

Nu: You going to need help when you get home?

Pt: Yes.

Nu: I'll help you with that. I'll call the social worker to talk to you (she is giving the patient water to drink while she is talking). Now, I'm going to do those two things for you. Were you not eating at home because...? (She listed a variety of reasons for Charlotte to choose from, and then they discussed them.)

Pt: I'm queer.

Nu: You're a fuss bucket! (This is said in a teasing tone with a smiling face.)

This conversation about Charlotte's eating difficulties occurred very rapidly. Laughter was scattered throughout the discussion and Charlotte received positive reinforcement for her responsiveness to Debbie's suggestions to improve her eating habits. Charlotte later commented to me about

Debbie:

> She's very sweet. She didn't control you know. She's not gonna let ya get away with anything, but she's so nice about it that you're more than willing to do what she wants. She's gonna try to help you...like this drinking business...and also with eating...no one else has even mentioned that. Can I have a softer diet?...maybe I would be able to get that down better...the fact that she came up with it. She's not a dietician...you would think a dietician might come up with it, it's her job. No, that's why I thought it was so great. She kept questioning me this morning. Why?, about my eating. She really wanted to get at the bottom of it.

Summary

From the observation and interview data presented, it is apparent that "clicking", developing a friendly relationship and doing "the extra" all describe the nurse "going the extra mile." The "clicking" that happens between patient and nurse in the nurse-patient interaction suggests that process may lead the patient to perceive the nurse as a friend.

Sometimes the patients' comments in relation to all three components seemed connected. Often descriptor words such as caring, nurturing, and mothering were interspersed with other words used by patients to describe the nurse "going the extra mile." Many mentions of mothering and caring cut across the categories of "friendship" and "doing the extra." When Charlotte (Pt) described Karen (Nu) as a friend, she used the word friend and mothering in the same breath.

Of the 40 patients who were interviewed, 15 made a statement about a nurse who did "the extra." Three nurses spoke about doing "the extra," and one patient described how she helped a nurse with "the extra." These comments demonstrate the importance of nurses "going the extra mile", to help the hospitalized patient.

CHAPTER 7

SUMMARY AND THEORETICAL DEVELOPMENT

The purpose of this chapter is to summarize and discuss the major findings of the study, and draw conclusions where possible.

Summary of Findings

Given the descriptive nature of the research, the findings will focus on the description of the phenomenon of patient satisfaction with nurse-patient interactions. Four processes provide the framework for the themes that emerged, "translating," "getting to know you," "establishing trust," and "going the extra mile."

Translating

Nurses were constantly engaged in informing and explaining to patients, activities reported as important by other researchers (Korsch et al., 1968; Matthews, Sledge, & Lieberman, 1987, and Stiles, Putnam, Wolf, & James, 1979). Nurses not only provided explanations for nursing functions, they frequently explained what was going to happen in other departments. Instructing and teaching occurred less frequently, but all took place while the nurse was performing other functions. Patients, families, and nurses

were very vocal when stressing the importance of informing and explaining. Three comments, one from a nurse, one from a patient's husband, and one from a patient typify the participants' views of this. Barbara (Nu) had just completed caring for a patient when I asked, "Did you feel that any of the time his needs were not being met"? She answered:

> No, I felt that they were all being met. I felt that the explanations that I gave satisfied him, and that he didn't have to ask me anymore. I try to second guess what they might ask me or what they might be thinking about and how their day is going to go, and that is generally how I address the morning.

Following an interview with Denise (Pt), her husband stated, "The nurses are good here. They tell us what my wife's blood pressure is. It really helps the family to relax when I know things are in the normal range."

George's (Pt) answer to my question, "Are you having quite a bit of pain?", demonstrates the value of a nurses' explanation. "She wants to give me a shot at 9:30. She wants to prepare me for physical therapy so I will be sure not to have any pain."

Nurses in the academic and clinical setting emphasize the importance of teaching patients, and yet I found informing, explaining, and instructing as the predominant focus of nurse-patient communication. Their definition of patient teaching probably includes instruction, but it is possible that the traditional description of patient teaching needs to be more broadly defined to include the

more informal aspects of informing and explaining.

Getting To Know You

Even though personal sharing and "kidding" occurred during most nurse-patient interactions and seemed to be an integral part of nursing care, they are not talked about in the general nursing literature. Both self-disclosure and humor are discussed in the psychosocial literature.

Personal Sharing. Nearly all study nurses were able to self-disclose with patients, an attribute of interpersonal competence described by Bochner and Kelly (1974). When I asked JoAnne (Nu), "How did you feel about George (Pt) asking you those personal questions," she stated:

> Oh, I liked it. I am very comfortable with that. When I was in nursing school. Well, first I was in a three year program, but I switched to a BSN program. I don't go along with the rule that you don't have any interpersonal sharing. I've always been open to, I do what seems comfortable. I know there are boundaries, and you don't overstep them, but it's a friendly place here. I'm glad to share myself. Once you open up sometimes you get a lot more information out of the patient, which is also beneficial in trying to um, pick the right thing to do with them sometimes.

JoAnne's comments suggest the reciprocity effect described by Warner (1984). When you self-disclose, the other person in the interaction is more inclined to self-disclose. Warner (1984) supports Kasch (1984a) by stating, "client disclosures make important contributions to the therapeutic process" (p. 17). Because patients and nurses in this study perceived personal sharing as very important in the nurse-patient relationship I would postulate that

self-disclosure is both appropriate and normative on a general medical/surgical unit. Fellows, (1983) a 74 year old patient, won first prize in a writing contest for Geriatric Nursing with his portrayal of what he wanted in a nurse-patient interaction. His statement, "I want my nurse to know me" offers support for this research finding.

"Kidding." Both patients and nurses frequently engaged in kidding and humorous banter, and both verbalized their appreciation for the art of kidding in the nurse-patient interaction. Patients and nurses in this study used humor to lessen the effects of tension supporting the work of Pasquali (1990), and Warner (1984) who suggest the use of humor for therapeutic intervention. Warner questions, "Is humor a subset of self-disclosure?", because self-disclosure also relieves tension and humor acts on reciprocity (p. 18). In a recent study by Everson-Bates (1990), the use of humor to cope with daily stress was common among nurse managers.

Sumners (1990) conducted a study of 204 nurses and their attitudes towards humor. She concluded that nurses view humor as positive, and posited nurses' use of such behavior in the practice setting. My research findings provide a beginning answer to one of Sumners suggestions for future research. "What is the patients' perception of humor when it is initiated by the nurse?" (p. 200)

Friendliness. Friendliness and understanding were described by patients as qualities in the nurse that made

them feel better. Smiling, being friendly, warm, having a cheerful personality, and talking on their level were aspects patients described as significant in the development of a relationship to help them feel comfortable and accepted as a person. This study supports Bader's (1988) research that being friendly and talking with, not down to, the patient are predictors of patient satisfaction. These research findings offer descriptive phrases for patient satisfaction questionnaires. Patients did not explicitly use the word respect, but it was often intimated when they spoke of the nurse being friendly, not talking down to them, and being on their level.

Understanding. Many patients described feeling comfortable when a nurse was understanding. Their definition of understanding is similar to Bochner & Kelly's (1974) description of the empathetic person, as one who correctly perceives and accepts another's feelings. My study findings give support to Rogers'(1973) work on the helping relationship when he postulates that the attitude of wanting to understand is a characteristic of a helping relationship. Beth's description of the nurse's nonverbal communication that contradicted verbal communication lends support to Hardin and Halaris's (1983) research findings.

Establishing Trust

Patients described three elements that helped them establish trust: First, seeing the nurse as being "in

charge" increased their confidence. Second, they described what the nurse did that helped them feel confident. And, third, the nurse who acted like she enjoyed her job gave patients the feeling she was concerned about them, and would help them. "In charge" was defined by patients as the nurse who knew what she was doing. Nurses also spoke on this same topic. When I asked Karen (Nu), "How do you think she [patient] responded to you?", she answered:

Nu: She was pleased with what I was doing to her because, I'm gonna tell you that I know I came across as knowing what I was doing.

Me: Why, why did you just say that? What did you do to her to make you feel like she knew you knew what you were doing?

Nu: Well, I didn't have any admitting orders on her at all, but I did everything up until the point where I had to have that order to scrub her.

Me: OK, and you think she was perceptive enough to know that?

Nu: Ummmmm. She wasn't as aware of that as I was. She was just aware she was in good hands. Because I knew what I was doing.

Patients also described "in charge" by explaining the nurse had anticipated their needs suggesting support for Kasch (1984a), who implied that a nurse is able to anticipate when she/he recognizes the existence of patients' personal needs.

Patients who said they felt confident about their nurses reported these characteristics in the nurse: promptness, checking on them, keeping them informed, explaining things, and doing what they say they're going to do. Bader's (1988) research also indicated the significance of informing patients. George, a patient with a Percutaneous Transluminal Coronary Angioplasty who had just had the sheath removed, described the consequence if the nurse did not follow through.

> Contact the patient regular. Even if I don't need anything, you feel abandoned if no one comes around. Also if you say you're going to come back in one hour, come back in one hour. A nurse is competent if she does what she says she is going to do. If JoAnne doesn't take the sand bag off in one hour like she told me, then she will come down a notch on competence.

This comment supports the work of Larson, (1987), who documented through a descriptive comparative study of 57 cancer patients that they perceived the nurse being accessible, monitoring, and following through as the most caring.

A descriptive phrase patients frequently used about the "good" nurses was, "They are enjoying what they are doing." Patients also felt they could trust the nurse if she was happy in her job.

"Going the Extra Mile"

Three predominant themes emerged when the patient described the nurse who did more and went the extra mile: "clicking", developing a friendship, and "doing the extra".

"Clicking." Both patients and nurses often mentioned the clicking that happens in the nurse-patient relationship. Most of the time field notes confirmed clicking. An exception occurred when Ann stated she felt close to Debbie. She used the words "we clicked" during an interview. Debbie stated she joked more with patients when she clicked with them, but she did not joke as much with Ann.

Developing a Friendship. Nurses did not talk about the patient as a friend, but patients did use that term about nurses. While describing the nurse "who could be their friend," patients told me they had invited the nurse to visit them. Jane (Nu) developed an immediate rapport with Jan, a very independent 70 year old female, who was in the hospital for a total hip replacement. Jan's husband had previously been Jane's patient and following his discharge she visited them in their home. In accord was Charlotte's (Pt) portrayal of Karen (Nu), "I would like to be her friend because she was so nice, and I am particular about my friends."

Doing the Extra. The following two comments are representative examples of patient descriptions of the nurse "who did extra": "She's being over nice, beyond the point of no return." "Susan was great, absolutely great! She tried to make it easy for me, she was very nice about this business of giving it all you have." One patient described Wanda by saying, "She has the ability to give you that

little extra minute or two, that little extra pat or 'how do you feel?', 'are you warm enough?', 'can I get you any more water?' Those kinds of things that just make you feel comfortable."

Conceptualization

Because the purpose of this research study was to develop descriptive and explanatory theory of patient satisfaction with the nurse-patient interaction, it is appropriate that a conceptualization of patient satisfaction with nursing care emerge from the research findings:

> Patients feel satisfied with the nurse-patient interaction when nurses share their experiences, their likes and dislikes, their feelings with them. Forms of sharing range from "how many children I have" to "I like roses in my garden too," or "It hurts, doesn't it?" The ability to poke fun at the situation or to joke about something extraneous to the current situation helps the patient relax. When the nurse enters the room with a smile and acts happy, patients feel the nurse cares about them. The nurse who maintains eye contact with the patient while letting them finish their sentence or complete their story promotes the idea the nurse is on their level, and respects them. For most patients, the nurse who has planned ahead and knows what the patient needs helps

the patient to feel confident. For others, it is the prompt return of the nurse to the patients' room, the nurse's follow through on things the patient has asked for or about that brings confidence. Always informing the patient about what is going to happen to them, and explaining what the nurse and other team members are going to do helps patients feel safe and secure in the hospital setting.

Because this conceptualization is grounded in the data from the study, rather than extracted from the literature, a discussion follows.

Discussion

Even though I reviewed the literature in preparation for this study, the research findings were unexpected. I anticipated that many patient comments would focus on the importance of the nurses' interpersonal skills, but I did not foresee the paucity of comments from patients regarding any aspect of the nurse's technical skills. This may have occurred because of my strong orientation to qualitative research which encourages the researcher to enter the field without preconceived ideas, or my expertise as a clinician who values technical skills. This discrepancy also highlights how divergent the values, perceptions, and world views of nurses and patients can be.

Schatzman & Strauss (1973) identify "four related

components of sensitivity," a researcher's most valued tool for discovery (p. 53). Their discussion of the third component, the researcher's sensitivity "to his own interpreted experience" (p. 53) perhaps accounts for my surprise at the amount of personal sharing and kidding that was an integral part of the nurse-patient interaction. I do not remember engaging frequently in either of these actions while nursing at the bedside. Following observations and interviews, which described how important personal sharing and kidding was to patients, my response for active inquiry in this phenomenon sharpened and I questioned, had I been a "good" nurse?

Six study nurses functioned as readers to give me feedback regarding the credibility of the findings. All stated that the descriptions of the nurse-patient interaction were accurate. Three were not surprised at the research findings. JoAnne's statement is reflective of the others when she said, "It is real and very important to the nursing profession." She also noted, "Clicking is important and nice to read in print. I knew it, but I hadn't put a word to it."

The other three nurses each made interesting comments regarding the research. Barbara wondered if my questions had been focused to only bring out the interpersonal response of the patient. She stated:

> Interesting, very well done. It is real in the sense it's an accurate picture, but were they telling you the

> truth? As a charge nurse, when I am called to see a patient, and they tell me they don't want to have that nurse taking care of them any more, they tell me something like, 'She doesn't know how to turn me.' I've really been thinking since I read that. I didn't think that's how patients reacted. It's changed my thoughts.

During our subsequent discussion when I asked Barbara, "Do you think the patient could tell you she didn't want that nurse anymore because the nurse didn't smile at her or was unfriendly?", Barbara answered, "No, probably not." Maybe we don't always receive accurate information from patients because we aren't asking the right questions. Another interpretation is that patients want to be seen as "good" patients and do not want to share negative comments.

Another nurse expressed disappointment in the research findings. Debbie commented:

> It's so good! I'm impressed with what you've done, but I have to tell you I'm disappointed. I might just as well have a bachelor degree of arts as a bachelor of science in nursing. It's just how I get along with people. They don't see my clinical skills.

When I questioned Karen on the phone, she had just completed her shift at the hospital. She stated, "The data chapters are true, that's the way it is, but not today. I had a bad day. I didn't feel good, and I didn't have eye contact with my patients."

I utilized one patient reader whose comments testify in favor of Guba & Lincoln's (1987) criteria that a qualitative study is credible when it presents descriptions of a human experience that people having that experience would

recognize as their own. Denise attached this to the returned manuscript:

> My opinion of your paper based upon what I experienced and discerned of nurse/patient relationships during my hospital stay is that it's right on! In fact, I wasn't able to determine exactly who I was in the paper because so many of the interviews could have fit in with what was going on with me.

In the cover letter, I stated to Denise that she could probably identify herself. I also thought the nurses would see themselves, but in actuality, two study nurses did not identify themselves.

Summary

These comments from the study nurses lend support for my reactions, and perhaps account for the elusiveness of defining interpersonal competence in nursing. Individually, from interpersonal actions of a single nurse in the nurse-patient interaction, a picture can be painted of interpersonal competence. Yet, collectively, within the nursing profession, this has not been accomplished.

It is not surprising to note, in an ethnographic study of first-line managers, Everson-Bates (1990) also described the critical importance of interpersonal skills. When managers hire staff nurses, the concern for technical competence is secondary. They search for staff who are interpersonally competent. Those managers believed technical skills could be taught, but interpersonal skills were different. A quote from a veteran manager:

> If they cannot communicate or if they're abrupt or there's an attitude problem, I wouldn't consider them at all...because at some point they won't be able to get along with patients...attitude is almost impossible to change...I won't hire no matter how technically competent they are because I don't feel that there's much I can do to make up that interpersonal deficit (p. 185).

These comments demonstrate a perception that interpersonal skills cannot be taught. Maybe that perception occurs because the components of interpersonal competence are elusive to most managers. I propose that, once interpersonal skills important to patients are defined, they can be taught. This is supported by Argyris's (1968) theory of competence acquisition outlined in Chapter 2. He believes that, if participants have opportunities to diagnose their interpersonal competence, they can increase their interpersonal competence.

CHAPTER 8

LIMITATIONS, IMPLICATIONS AND RECOMMENDATIONS

In this chapter I will acknowledge the study's limitations, discuss implications for nursing, and recommend areas appropriate for future research.

Limitations

The study limitations encompass those specific to qualitative research, and those specific to this research project. Ethnography is "fieldwork committed to describing the social and cultural worlds of a particular group" (Emerson, 1983, p. 19). This description is sensitive to interpretation, and allows a researcher interested in interpersonal skills to ask a patient what was meant when the patient said the nurse was "good" (Rosenthal, 1989). The researcher increases understanding by asking for examples of what is "good." Thus, what is included or excluded, is not determined randomly, but selected and recorded as reflected by the working themes or concepts employed by the researcher, and derived from the data. Therefore, findings may not be generalizable because, "descriptions of the same social scene will vary depending on the constructs that observers bring to, and use in their

witnessing and representations" (Emerson, 1983, p 21).

In qualitative research the researcher can influence the situation that occurs, and this happened at least twice. Being with the nurse and patient for a significant length of time should minimize that bias, and this came to pass on the surgical unit with Diane (Nu). However, on the telemetry unit, two patients informed me the nurse was different with me in the room. Both patients were very ill and needed a lot of attention. Gayle, a 70 year old patient dying of congestive heart failure stated, "She's nicer talking and everything today." When I probed further she continued, "Yesterday she was a bit snappy, or she wouldn't come at all. I hate telling you this about people."

It seemed difficult for patients to share negative comments about nurses, and they often made excuses for the nurses. For example, Beth stated, "She makes negative eye contact, negative eye twirling, or tightening of the forehead. Maybe she is tired. Verbally they are kind, visually they are not, so they contradict each other." When I asked her to describe the nurse's non-verbal expressions, she stated, "it's not fair to these people." When I reassured her I would protect the participant's anonymity, she stated, "I noticed she was less personable when you were not around. When you were around, she was more personable." The minimal number of negative comments I received, might also be a reflection of the study taking place in a private

hospital where nurses are hired with the expectation they will cater to patient wishes.

One study nurse commented the study might be biased because:

> The patients here are pretty nice and may actually change your survey a little in that we do have nice people. The nurses are happy in their job. We're not harassed every day and therefore the way we interject [sic] with our patients can be calmer, more pleasant.

Implications for Nursing

The phenomena of patient satisfaction with nursing care as seen through the eyes of the patient has implications for both practice and education. In practice, this research has relevance for quality of care and system issues. Quality of care as defined by nurses, and quality of care as defined by patients are very different. Nurses practice within a system and that system can either facilitate or hinder nurses providing care to patients.

Practice

Nurses have standards of practice. For example, we set goals with, and for patients, and if nurses do not motivate patients to comply with the plan of care often those goals are not attained. Nurse Debbie utilized her interpersonal skills to get patient Charlotte involved in two short term goals, increase in activity and increase in fluid intake. Charlotte was very clear in acknowledging that result.

Nurses' standards of practice for teaching patients are

often measured by quality assurance monitoring of documentation. If nursing practice in meeting standards is deficient, is it because the activity has not occurred, or just has not been charted? How often have we heard a nurse say, "I don't have time to teach"? This study demonstrated that informing, explaining, instruction, and teaching occurred simultaneously, and was interspersed with all other nursing functions. Maybe nurses are sometimes deficient in quality assurance activities because instructions are not acknowledged as teaching. As the results of this study demonstrate, a large percentage of nurse-patient communication involves informing and explaining, the informal arm of teaching, thus suggesting that the broader issue is whether we acknowledge and document the other components of the translation process. These findings propose, if nurses documented all translating activities, compliance with teaching standards would increase. More importantly, the process of quality assurance in patient teaching standards would also focus on patient defined quality of care.

This research could have implications for two system issues, patient assignments and employee orientation. Should we make patient and nurse room assignments on general medical and surgical units according to age, culture, or sex? Precedence has already been established for those of pediatric age. In this study, nurse Susan's comment lends

support for the idea of assigning older patients to nurses who like to care for them. When I asked Susan how she felt when she was admitting Mary, she said, "I liked her, but then I like little old ladies to begin with." If patients and nurses have specific likes, we could assign accordingly. Nurses feel comfortable with separation according to preference for technical skills. Nurses may feel comfortable with segregation according to different interpersonal skills.

Managers want to know if new staff are technically competent, so preceptors for employee orientation are appointed because of their technical skills. If managers intend to increase patient satisfaction, it would be appropriate to have preceptors who effectively role model and teach interpersonal skills. This research defines those interpersonal skills of importance to patients. Most hospitals evaluate staff following orientation, and nursing units have check lists to determine staff technical competence. I would suggest adding a component to the evaluation describing the interpersonal skills important for patient satisfaction.

Education

I asked one recent graduate and two senior students, "What in your education prepared you to interact interpersonally with patients?" They replied communication techniques such as actively listening and empathy were

taught in their communication class. They stated role playing regarding patient-nurse communication occurred in both the communication and fundamentals class. They did not note other specific classroom instances.

They explained that their teacher of fundamentals modeled how to relax a patient prior to giving an injection. One student said the pediatric clinical instructor modeled how to communicate, and "get along" with parents. All three informed me that communication was taught in their psychology class. They were taught to not self disclose, and that being "professional" meant not having a friend to friend relationship with a patient.

The recent graduate of a step-up program stated she was taught some basic communication techniques such as open-ended questions and reflecting, as opposed to being yourself and being intimate with another human being during the bridge course. She was taught that touching demonstrated empathy to patients.

Exactly what interpersonal skills are nursing students being taught? Are interpersonal skills deemed important by faculty? One student commented, "I learned how to interact interpersonally when I was growing up." Maybe faculty believe interpersonal skills are already learned and do not need further refining, or, so much time is needed to teach technical skills, there is no time to teach interpersonal skills. This research advocates the importance of

interpersonal skills, thus implying moving students toward interpersonal competence is as critical as moving them toward technical competence. The following interview with a patient demonstrates the significance of interpersonal competence:

Me: Some patients have expressed to me that some nurses make them feel more confident than others. Has that happened to you?

Gayle: Yes, the one that put the IV in a while ago. She was very good. She never snapped or anything. She gave me all the confidence in the world.

Me: What else did she do to give you that feeling? Did you know before she actually got the needle in the vein that she was going to get it in?

Gayle: No, and she didn't, but she tried. And she talked softly and carefully.

This nurse was unable to actually start the intravenous drip, and yet the patient still thought the nurse was "good" [competent] because she "talked softly and carefully."

All patients expressed a desire to have the nurse smile at them, and yet is something this simple explained in the classroom, in the academic setting, or during orientation in the hospital? If all nurses could keep in mind Laurie's (Nu) thoughts on "not having a frowny face," patient

satisfaction might increase.

According to this research, patients want information and explanation. Nurses provide that as well as instruction. As students, nurses learn the necessity of teaching patients. These study findings stress that these students must also be taught the influential role of informing and explaining in nursing practice. It was noted during data collection that communication in the form of informing, explaining, instructing, and teaching occurred simultaneously with all technical nursing functions. Do educators recognize this in the educational process, in the orientation process?

It is interesting that two nurse readers wanted to receive validation from patients that they were technically competent. As professionals, I would advocate we should receive those strokes from our peers and within ourselves. We say nursing practice is different from medicine, because we concentrate on the "wholeness" of the patient. We present ourselves as holistic practitioners. If that is true, patients should define the quality of our work from the social interpersonal perspective. Consequently, if we wish to exert a positive influence on the patient's health, we need to be socially acceptable to them. To function at our professional peak, we must be as competant interpersonally as technically.

Directions for Future Research

First, further analysis of the data for gender, age, education of patient and nurse, medical catagory of patient will all be important. Is having a nurse check in often as important to surgical patients as it is to other patients? How much personal and social talk is part of the nurse-patient interaction? All my observations were during the normal waking hours of patients. If I had observed nurse-patient interactions during the normal sleep hours, would the patients describe other qualities they wanted in the nurse? Do nurses who go "the extra mile" have the same qualities the patients described as most satisfying? Is there a difference in the amount or type of sharing that occurred between female patients and nurses and male patients and female nurses? This study was limited to female nurses. Do male nurses value sharing with patients and would male and female patients want to share with male nurses?

Second, this research needs to be extended to other patient populations. Would other similar patients in similar hospitals or different patient populations in different hospitals describe or value the same qualities in the nurse? Will patients from other cultures want the nurse to kid with them? Would they value being informed? In this study, personal sharing set the stage for trusting to occur. Is that important in other cultures?

Third, what exactly are the circumstances that cause "clicking?" In this study, the common bond was culture once. Often it was similar backgrounds, similar interests; one time the patient reminded the nurse of her Dad. Future researchers might want to focus on, what facilitates such a bond? That rapport is established quickly, and can occur immediately, is a very important concept not only for short stay patients, but because nurses work 12 hour shifts, and often only one or two days at a time. These additional studies would increase our understanding of the nurse-patient interaction and its relationship to patient satisfaction.

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APPENDIX C

CONSENT FORM
STUDY OF NURSE-PATIENT INTERACTION

BACKGROUND

Donna Fosbinder is a nurse and doctoral candidate at the University of San Diego who is studying interactions between nurses and hospitalized patients. To do the study, she needs to observe interactions between nurses and patients and interview nurses and patients on a medical/surgical unit.

PROCEDURE

If I agree to participate in this study, I understand I will be observed during one or more nurse-patient visits. I may be observed one or several times during my hospital stay. I will also be interviewed following an observation. I will be interviewed at least once, but not more than five times. The interviews may be as short as five minutes or extend to 30 minutes. The researcher will keep brief written notes of the observations and tape record the interviews when possible. My identity will not be revealed in any connection with this study, in public or in print, without my permission, although there is a possibility that the Food and Drug Administration and/or the Department of Health and Human Services may inspect the records associated with this study.

RISKS/DISCOMFORTS/BENEFITS

Participation in this study should not involve any risk or discomfort to me except for possible minor fatigue or mild anxiety. If this occurs the interview will stop and nurses or other appropriate professionals will respond to my needs. I may ask that the interview be stopped at any time if I am uncomfortable. While most people like the opportunity to talk about their experiences, and information from this study will be useful to nurses and others working with patients, I will receive no direct benefit.

ASSURANCES

I am free to withdraw from the experiment at any time without prejudice to my future care.

I may contact Donna Fosbinder at telephone number 488-2446 at any time to ask questions about this study, about my rights, or in the event of a research-related injury.

I am under no obligation to enter into this experiment, and if I do, I in no way waive any legal rights, nor do I prejudice my future care at this institution.

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I understand that in the event I develop physical injury resulting from and arising during the time of my direct participation as a subject in the research procedures, Scripps Clinic and Research Foundation will provide me with emergency treatment for those injuries without charge. I understand further that in the event of such injury financial compensation will not be available from Scripps Clinic and Research Foundation.

AUTHORIZATION

I have read the explanation above and understand it. The study has also been explained to me by Donna Fosbinder and I have had an opportunity to ask questions. I consent to take part in this experiment without coercion or obligation. I have received a copy of this form and the "Experimental Subject's Bill of Rights".

_____ _____
Signature of Subject Date

_____ _____
Signature of Investigator Date

_____ _____
Signature of Witness Date

This document approved by the Human Subjects Committee on 12/14/89

_____
Chairman
Human Subjects Committee

APPENDIX D

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

The staff of which includes the professional staff of the Research Institute of and of the Medical Group, Inc., wish you to know:

Any person who is requested to consent to participate as a subject in a research study involving a medical experiment, or who is requested to consent on the behalf of another, has the right to:

1. Be informed of the nature and purpose of the experiment.

2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be used.

3. Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment, if applicable.

4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.

5. Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to the subject, and their relative risks and benefits.

6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.

7. Be given an opportunity to ask any questions concerning the experiment or the procedures involved.

8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time, and the subject may discontinue participation in the medical experiment without prejudice.

9. Be given a copy of a signed and dated written consent form when one is required.

10. Be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion or undue influence on the subject's decision.

If you have questions regarding a research study, the researcher or his/her assistant will be glad to answer them. You may seek information from the Human Subjects Committee, established for the protection of volunteers in research projects, by calling from 9 a.m. to 5 p.m. weekdays, or by writing to the Committee at the above address.

C:HSC-ES

APPENDIX E

Nurse Consent Form Study of Nurse-Patient Interaction

BACKGROUND
Donna Fosbinder is a nurse and doctoral candidate at the University of San Diego who is studying interactions between nurses and hospitalized patients. To do the study, she needs to observe interactions between nurses and patients and interview nurses and patients on a medical/surgical unit.

PROCEDURE
If I agree to participate in this study, I understand I will be observed during the nurse-patient visits. I will also be interviewed following the observation. The researcher will keep brief written notes of the observations and tape record the interviews when possible.

RISKS/DISCOMFORTS/BENEFITS
Participation in this study should not involve any risk or discomfort to me except for possible minor fatigue or mild anxiety. If this occurs the interview will stop. While most people like the opportunity to talk about their experiences, and information from this study will be useful to nurses and others working with patients, I will receive no direct benefit.

ASSURANCES
I understand my research record will be kept completely confidential. My identify will not be disclosed without consent required by law. I further understand that to preserve my anonymity data will be coded so personal identification is nonexistent.

I have had the opportunity to discuss this study with Donna Fosbinder and ask questions prior to signing this consent. I know that her name and telephone number (619-488-2446) will be posted in the nursing station throughout this study should I wish to ask further questions.

I am aware that my participation is voluntary and that I may withdraw my consent at any time without any jeopardy to my employment. My consent on this form does not indicate any other agreement, verbal or written, beyond that expressed in this form.

AUTHORIZATION
I, the undersigned, understand the above explanations and, on that basis, I give consent to participate in this research.

_____ _____
Signature of Subject Date

_____ _____
Signature of Researcher Date

_____ _____
Signature of Witness Date

APPENDIX F.1

DEMOGRAPHIC PROFILE

Surgical Patient

Sex:

13 Female
7 Male

Marital Status:

_____ Single
16 Married
1 Divorced
3 Widowed

Age:

1 18-29
5 30-39
3 40-49
2 50-59
1 60-69
8 70-80

Hospital Admission:

14 First
3 Second
2 Third
1 Four or More

Education:

3 High School
10 Graduate High School
3 AA Degree
3 BS Degree
_____ Masters Degree
1 Doctorate Degree

Ethnic Background:

_____ Black/Afro-American
_____ Chinese
_____ Filipino
_____ Hispanic
_____ Japanese
_____ Native American
19 White
1 Other Persian

APPENDIX F.2

DEMOGRAPHIC PROFILE

Non-surgical Patient

Sex:

__8__ Female
__12__ Male

Marital Status:

_____ Single
__16__ Married
__2__ Divorced
__2__ Widowed

Age:

_____ 18-29
__1__ 30-39
__2__ 40-49
__1__ 50-59
__10__ 60-69
__6__ 70-80

Hospital Admission:

__8__ First
__7__ Second
__2__ Third
__3__ Four or More

Division:

__15__ Cardiology
__5__ Chest Medicine

Education:

__4__ High School *
__6__ Graduate High School
__2__ AA Degree
__4__ BS Degree
__3__ Masters Degree
_____ Doctorate Degree

Ethnic Background:

_____ Black/Afro-American
_____ Chinese
_____ Filipino
__2__ Hispanic
_____ Japanese
_____ Native American
__18__ White
_____ Other

* One patient did not attend high school.

APPENDIX F.3

DEMOGRAPHIC PROFILE

Nurse

Sex:

12 Female
_____ Male

Age:

1 18-29
7 30-39
3 40-49
1 50-59
_____ 60-69
_____ 70-80

Work Status:

6 Full time
6 Part time

Nursing Unit:

4 Telemetry
7 Surgical
1 Step Down

Education:

3 AA or AD
3 Diploma
2 BSN Student
4 BSN
_____ BS Other
_____ MSN Student
_____ MSN
_____ MS Other

Marital Status:

3 Single
7 Married
2 Divorced

11 Day Shift
1 PM Shift

Years of Experience:

1 1-2 years
1 3-4 years
1 5-6 years
9 7 or more years

Ethnic Background:

_____ Black/Afro-American
_____ Chinese
_____ Filipino
_____ Hispanic
_____ Japanese
_____ Native American
12 White
_____ Other
_____

APPENDIX G

SAMPLE INTERVIEW PROBES

* Tell me what happened when the nurse first came in the room.

* Remember when the nurse came in the room this morning and took your BP? Tell me about that.

* So, how do you feel about what went on this morning with your care?

* So, you had a new nurse today. How's that working out?

* Was there anything different in your interacting with that nurse?

* Think for a moment about all the things a nurse does for you. Now let me ask you, what is most important? You can tell me about more than one.

* Was there anything the nurse did that made you feel good or helped you?

* How would you describe a nurse who knew what she was doing.

* How do you feel about sharing personal things?

* I notice there seems to be quite a bit of smiling back and forth between the two of you. How does that make you feel?

* How do you feel when staff jokes or laughs with you?