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"Make them your friend" : a phenomenological study of patients' experience soliciting nursing care in the hospital setting

Mona M. Shattel
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To the Graduate Council:

I am submitting herewith a dissertation written by Mona M. Shattel entitled ""Make them your friend" : a phenomenological study of patients' experience soliciting nursing care in the hospital setting." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Sandra P. Thomas, Major Professor

We have read this dissertation and recommend its acceptance:

Howard Pollio, Mitzi Davis, Patricia Droppleman

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

To the Graduate Council:

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"MAKE THEM YOUR FRIEND:"
A PHENOMENOLOGICAL STUDY OF PATIENTS' EXPERIENCE SOLICITING NURSING CARE IN THE HOSPITAL SETTING

A Dissertation
Presented for the
Doctor of Philosophy
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Mona M. Shattell
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ABSTRACT

The purpose of this study was to explore hospitalized patients' experience soliciting nursing care. To discover what patients were aware of when soliciting such care, without directing them to specific aspects pre-judged to be important, a phenomenological interview was used, following procedures outlined by Thomas and Pollio (2002). Eight participants ranging in age from 29 to 65 were interviewed and were included only if they had one or more experiences soliciting nursing care in the hospital, were open and willing to talk about their experience, and were at least 21 years of age. Nondirective, in-depth phenomenological interviews were conducted, transcribed verbatim, and analyzed for themes.

Hermeneutic analysis of the interview texts resulted in the following three themes: "make them your friend," "be an easy patient," and "try to get them to listen." Hospitalized patients solicit nursing care by strategically building relationships. These relationships were formed in order to get nurses to remember them, hoping the nurses would be more responsive to their needs if they "stood out from the crowd." Patients used such strategies such as using nurses' names, being likeable, making them laugh, taking an interest in them, and making them feel liked. Some patients also reported having a sincere desire for establishing a genuine relationship with their nurses. Patients avoided "bothering" or "burdening" nurses in their effort to be an easier patient and often reported making multiple attempts, often unsuccessfully, to get nurses to listen to them. Participants tried to get nurses to listen to them by asking for what they wanted and my asking questions. If these strategies did not result in getting nurses to listen, participants escalated their tactics.

The thematic structure of the experience of soliciting nursing care was contextualized by patients in terms of their experience of the hospital environment (Shattell, 2002). In an environment experienced as dangerous, insecure, and disconnecting, patients actively solicited care in an attempt to increase individual security and interpersonal connection.

Findings from this study have many implications for nursing practice, education, research and theory. Patients have a vested interest in developing relationships with nurses that are based on the model of friendship where social conversation is important. The relationships that patients developed were formed in order to lessen feelings of insecurity and disconnection, and to enhance their chances of receiving quality nursing care. Nurses in practice should be aware of the importance patients place on conversation about topics outside "the world of the hospital." In patients' efforts to be an easy patient, patients are hesitant to "burden" or "bother" nurses and often minimize negative care experiences. They don't want to take nurses away from others with "more serious needs" which leads to many unmet patient needs. Nurses should check in with patients frequently, ask patients directly, and listen actively.

Implications for nursing education include reexamining the "social relationship" versus "therapeutic relationship" dichotomy that exists in baccalaureate education programs. Concepts such as "mutuality" should be reviewed; elements of the patient-nurse power structure should be more clearly articulated in all levels of nursing educational programs.

The phenomenon of soliciting nursing care in the hospital setting has not been described elsewhere. The phenomenological method is advanced in that the context of the current study of soliciting care is the thematic structure from a previous study of the hospital environment (Shattell, 2002). Further research could investigate soliciting nursing care in other settings or with other patient populations such as 1) psychiatric patients' experience soliciting nursing care in the hospital, 2) the experience soliciting nursing care in other institutional settings such as rehabilitation and long term care, and 3) the experience soliciting nursing care in outpatient settings. Serendipitous findings from this study related to the patients' meaning of "nurse" is another fruitful area for further research.

This study also has implications for nursing theory. The nurse-patient relationship as described by Hildegard Peplau's Interpersonal Relations Theory (1952) may not be relevant in today's world. Findings suggest that the nurse-patient relationship as it was known may not exist and that the patient's contribution has been widely underestimated.

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CHAPTER I

INTRODUCTION

Society views nurses favorably, often as benevolent, virtuous, and admirable. Nurses have been positively stereotyped as "ministering angels" or "angels of mercy" (Muff, 1982). Nurses frequently experience this positive view of the profession first hand in clinical practice. How often have you heard statements such as: "they [the nurses] are so nice," "oh, honey, you are so sweet," "you are the best nurse," "the nursing staff is very nice." How often during the holiday season, have nurses' stations been overflowing with candies and treats that have been sent from appreciative patients and/or their families?

Two of the laudatory statements quoted above were taken from interviews with patients who were asked to describe their experiences of the hospital environment (Shattell, 2002). The study was undertaken because little is known about particular aspects of the world of the hospital that may (or may not) matter to patients. The main research question used in that study was the following: "tell me about what you notice or what stands out to you in the hospital environment?" In this study of patients' experience of the hospital environment, each interview transcript was dominated by references to people and such descriptions often included nurses and the nursing staff. One participant's words captured this more general focus on people:

> I see that the environment, if you take away the people it's just empty hallways and empty rooms...I think the environment is not a principal issue...I think the people make up the environment, and I think the process of how you work with others and how you deal with the people up here [on the inpatient unit] is more important than the environment that you're in, because this environment is only a fleeting moment...The environment here is a very minor matter. It could be a shack with newspapers for insulation.

Patients in their descriptions of the hospital environment emphasized nurses. In addition to positive statements about "nice nurses," there also were some strong negative statements about nursing care. One participant who was hospitalized on an oncology unit said of her hospitalization and of the nursing staff collectively:

> It's terrible [the radium implant]. So finally I thought okay, endure this, we'll get through it. And heck with it and I'll get through the next one and of course I didn't want to come back here. I mean this time when I had surgery, I mean I knew I had to come back up here and I thought, *I hate them, and they hate me* [italics added].

In another interview, a participant described his personal reactions to nursing care on an inpatient psychiatric unit,

> I think that it could be much more, more personal, more up front, more seriously delving to find what troubles people and find solutions, rather than just put a pill on it or a tab on it or something, and saying, 'you're going to be okay now. Just hang in there.' I think that we are failing and these type wards that they are failing. And it's very easy to find staff members who will not like you and will

cut you off when you try to speak, just because they don't like you, because they feel intimidated.

These descriptions clearly suggest a paradox; patients' overall experiences of nursing care appear inconsistent with their initial description of the "nice" nurse. While nurses may be seen as "nice," patient participants in the study of the hospital environment longed for more and deeper connections with them. They experienced the hospital environment as disconnecting and actively sought ways to connect with nurses. The patients' dependence on the nursing staff, as well as their perceived powerlessness, created a situation where patients believed they had to actively find ways to solicit needed nursing care. In addition, nurses were viewed as overworked and overwhelmed, leading to even greater patient needs and, hence, to more active strategies to get their own needs met. In another recent study, which examined the effect of decreases in the number of nursing staff on inpatient acute care units in a general hospital, Storr (1996) found that patients were dissatisfied with nursing care and believed that nurses were under a lot of pressure and, therefore, did not have time to care for them.

Hospitals in the United States were directly affected by the economic and political changes in the 1980s and 1990s. Major public policy changes aimed at decreasing rising health care costs had a huge impact on hospital care reimbursement. Since hospital care was the largest category in national health care spending (38% of the total expenditures), hospitals became a major target. Sweeping changes were brought about by, 1) the regulation of Medicare through the implementation of the prospective payment system (PPS) in 1984, and 2) the Omnibus Budget Reconciliation Act of 1990 which aimed at cutting 2 billion dollars in Medicare payment to hospitals (Hull/American Hospital Association, 1994). In addition to increased federal regulation of federal health programs (Medicaid and Medicare), managed care and other managed care products (such as health maintenance organizations and preferred provider organizations) became increasingly prevalent during this period, decreasing hospital care reimbursement for those privately insured. The lower reimbursement caused by the fall in hospital admissions and shorter lengths of hospital stays were financially perilous, leading many hospitals to close, merge, or downsize which led to layoffs of thousands of Registered Nurses. Between 1990 and 1999, the number of community hospital beds declined from 927,000 to 830,000 and between 1980 and 1990 the community hospital occupancy rate declined from 76% to 67% respectively (National Center for Health Care Statistics, 2001).

In addition to major changes in hospital care reimbursement, another relevant issue affecting hospital care and the hospital environment is the current nursing shortage. The nursing shortage is attributed to an aging nursing workforce and a decline in enrollments in basic RN preparation programs. The National Sample Survey of Registered Nurses (Health Resources and Services Administration, 2001) found that the average age of employed registered nurses (RNs) is 43.3; in addition, the percentage of RNs under the age of 30 comprise only 10% of the total employed RN population. To further exacerbate the nursing shortage, the American Association of Colleges of Nursing (2001) reported a decline in student enrollments in baccalaureate programs for the previous consecutive six years.

The majority of nursing care is provided in the hospital setting; specifically, 59.1% of employed RNs work in a hospital (Health Resources and Services Administration, 2001). Amid the current nursing shortage and the financial challenges of hospitals in providing quality care, nurses have become increasingly frustrated and challenged in this environment. The American Nurses Association (2001) found that 76% of the 7300 RNs surveyed reported that an increased patient load for RNs has resulted in decreased quality of patient care; 75% of nurses reported that the quality of care has declined in the past two years due to inadequate staffing (69.4%, n=5067) and that nurses were experiencing decreased satisfaction (60.8%, n=4445). These factors have served to create a hospital environment that is unpleasant for patients and difficult for nurses.

Shattell (2002) found that patients reported trying to get nurses in the hospital to pay attention to them in various ways. Participants mentioned strategies such as using humor, being extremely kind and charismatic, or simply submitting to the demands of nurses and other hospital staff members so that they would be perceived as "good" or "easy" patients. Patients in the hospital setting tried repeatedly to connect with nurses in order to have their nursing care needs met, and communication between patient and nurse was central to this tactic.

Conceptual development of patient communication within the nurse-patient relationship is lacking in the relevant literature. Although most would agree that communication is central to nursing practice, there are few studies that address patients as partners in nurse-patient communication. Morse, Havens, and Wilson (1997) assert that "the patient's behaviors have been relatively ignored when nurses have been examining the nurse-patient relationship. Additional research is urgently needed to examine the patient's contribution" (p. 341).

Most of the research on nurse-patient communication has focused on the actions of the nurse in the encounter or on the outcome or consequence of that encounter. Power dimensions have been found to negatively influence nurse-patient communication within the nurse-patient relationship since the nurse and patient have unequal power bases (Breeze & Repper, 1998; Hewiston, 1995a; Johnson & Webb, 1995; Martin, 1998; Morse, 1991; Roberts, Krouse, & Michaud, 1995; Taylor, Pickens, & Geden, 1989). According to Hewiston (1995a), "nurses do exert power and the language they use is a major factor in its exercise. The fact that this is the 'normal' situation and accepted by both staff and patients constitutes a barrier to nurse-patient communication" (p.81). Johnson & Webb (1995) suggested that nurses gain power in the nurse-patient relationship through humiliation, for example, by scrutinizing patients' private matters such as urination and defecation. This is an example where the goals of care are different for nurse and patient in that excretory matters are typically private, and when made public, embarrassing. When patients are in the hospital, these matters become public (for the patient, not the nurse who has use of "staff only" restrooms). Johnson and Webb (1995) contend, "the aim is to make clear the status difference and power differential between the parties" (p. 86). As Johnson and Webb (1995) noted, a nurse's seemingly simple request for a stool sample to check for fecal occult blood can make this aim apparent.

In a study by Taylor, Pickens, and Geden (1989), nurse practitioners used power in their attempt to influence patient decision-making and were found to use commands or consequence statements more frequently than concordance statements in attempts to influence patients' decisions about health care choices. Nurses have been shown to exert power over patients through language consisting of demands, persuasion, controlling of the agenda, and terms of endearment (Hewiston, 1995a). Studies on nurse-patient communication have shown an inconsistency between nurses' self-perception of communication ability and what is observed (Hewiston, 1995b). The unethical social labeling of patients as "difficult" or "bad" has been shown to have negative effects on nurse-patient relationships and on the outcomes of care (Carveth, 1995; Erlen & Jones, 1999; Finlay, 1997).

Patients are aware that there is a nursing agenda, that they are expected to follow that agenda, and that there are consequences for non-compliance. This awareness is shown in the words of this elderly hospitalized patient, "I have to do as I'm told. I'm 94 next week and I still have to do as I'm told" (Hewiston, 1995a, p. 80). What happens when patients do not "do as they are told?" Patients who disregard the nurses' agenda may be labeled as "difficult" or "bad." Patients may try to manage their care environment in an effort to mitigate negative social labeling. It is understandable why patients try to avoid being labeled "difficult" since this, in part, determines their quality of care.

In a descriptive study of the ways in which patients communicate their need for pain medication after surgery, McDonald, McNulty, Erickson, and Weiskopf (2000) found that some patients avoided or delayed communicating needs because of not wanting to complain. Two more general questions suggested by this finding are: In an effort to manage their desire to be liked, do patients communicate with nurses in patterned ways? Do nurses recognize the more subtle ways in which patients solicit care? Unfortunately, no research was found to address these questions.

Purpose Statement

The purpose of this study was to describe the patient's experience of soliciting nursing care. This purpose was achieved by using phenomenological interviews with persons who have had experiences of soliciting care from a nurse in a hospital setting. Participants were encouraged to describe, in as much detail as possible, what stood out for them in soliciting needed care. Through analysis of the interviews, a thematic structure of the experience was discovered. This structure will be considered in terms of its implications for theory, nursing practice, education, and research.

Research Perspective

Existential phenomenology "can be viewed as that philosophical discipline which seeks to understand the events of human existence" (Valle & Halling, 1989, p. 6). An existential phenomenological research method was utilized in this study to examine the patient's experience of soliciting nursing care through patient-nurse interaction. To this end, patients were asked to describe their experience of soliciting nursing care in a

hospital setting. Interviews were conducted and analyzed according to the method outlined in Pollio, Henley, and Thompson (1997) and Thomas and Pollio (2002). This method will be described more fully in Chapter III.

Delimitations and Limitations

The purpose of this study was to describe the patient's experience of soliciting nursing care. The study was delimited to English speaking individuals over the age of 21 who were willing and able to describe their experiences of soliciting nursing care. Study participants were limited to those who were not cognitively impaired and were restricted to experiences in the hospital setting. The study was further confined to patient experiences with nursing care.

Significance

The purpose of this study was to describe the patient's experience of soliciting nursing care. If language is a way in which social interaction occurs and if nursing care is delivered through nurse-patient interaction in the nurse-patient relationship, and if patients desire nursing care, then it is important to understand the patient's experience of soliciting that care. The knowledge gained in this study will contribute to filling a gap in the literature and should have significance for nursing practice, education, and research. More specifically, knowledge deriving from this study should elucidate how patients' language and behavior are used to seek nursing care. This information will enable nurses to recognize patient help seeking and assist them to respond more appropriately and expeditiously to patient needs.

This study will have implications for nursing education. An understanding of the patient's experience of soliciting nursing care should effect the teaching of interaction processes in nursing education such as therapeutic communication, mutuality, goal-setting, patient autonomy and patient empowerment.

Previous research on nurse-patient interaction and on the nurse-patient relationship has focused mainly on the nurse's role in providing care. The present study will build on this body of knowledge by illuminating the patient's role in soliciting that care. Future research will explore other phenomena that emerge from the study.

CHAPTER II

LITERATURE REVIEW

Since patients solicit care within the context of the nurse-patient relationship through nurse-patient interaction, more specifically in the patient's communication with the nurse, a brief review of this body of literature will be presented. The broad context of nurse-patient relationships will be reviewed from the perspective of Peplau's Theory of Interpersonal Relations. Nurse-patient interaction will be explored in terms of the following four topics: 1) nurse communication within the nurse-patient interaction, 2) nurse-patient communication as a mutually constructed interaction, 3) patient perception of nurse-patient interaction, and 4) patient care-seeking. This review will be delimited to these four topics and will not include literature concerning help seeking, doctor-patient communication, patient satisfaction, autonomy, mutuality, or empowerment.

Nurse-Patient Relationship -- Peplau's Theory of Interpersonal Relations

Hildegard Peplau was the first to speak about interpersonal relationships between nurses and patients and, as such, her theory became a framework for studying this phenomenon. The nurse-patient relationship is central to Peplau's definition of nursing -- "nursing is a human relationship between an individual who is sick, or in need of health services, and a nurse especially educated to recognize and to respond to the need for help" (Peplau, 1991/1952, p. 6). According to Peplau (1991/1952), "the extent to which she [the nurse] can come to understand the situation confronting the patient and the way he [the patient] sees it. Positive, useful nursing actions flow out of understanding of the situation" (p. x). Although Peplau's theory of interpersonal relations and the nurse-patient relationship were first introduced as relevant to mental health nursing (what Peplau called "psychodynamic nursing"), it has become more and more significant for more general descriptions of nursing.

The nurse-patient relationship has four phases as outlined by Peplau's theory: orientation, identification, exploitation, and resolution (Peplau, 1991/1952). The orientation phase is when the nurse and patient first some together due to a patients "felt need" for professional assistance. Identification refers to the phase when the patient identifies with the nurse who can provide needed help with recognized health problems. Exploitation refers to the phase where the patient makes "full use of all the services offered to him [*sic*]" (Peplau, 1991/1952, p. 37). Finally, the resolution phase occurs when the patient no longer needs the assistance of the nurse and therefore implies the "gradual freeing from identification of helping persons and the generation and strengthening of ability to stand more or less alone" (Peplau, 1991/1952, p. 40). Forchuk (1994) studied the orientation phase of the nurse-client relationship in a sample of 124 nurse-client dyads from a long-term program for chronically mentally ill adults. The preconceptions of both nurses and patients were related to the development of the nurse-patient relationship, which remained unchanged over a 6-month period, supporting the presence of the orientation phase in Peplau's theory.

Peplau's Theory of Interpersonal Relations describes the nurse-patient relationship as unique to the individual nurse and patient dyad. As suggested by Forchuk (1995), "the combination of nurse and client factors are more predictive of the quality of the therapeutic relationship than either nurse or client factors alone" (p. 38). Forchuk (1995) studied the uniqueness of the nurse-client relationship by comparing the relationships of two different nurses with the same client and of two different clients with the same nurse. The findings from this study support the conclusion that "although both partners in the relationship contribute to the relationship, the interpersonal combination rather than the separate individuals would seem more important" (p. 38). The phenomena of what happens between nurse and patient are unique to that particular relationship and not directly transferable to other relationships with other nurses or other patients. Another significant finding in this study was that nurse-patient relationships were more important to patients than to nurses.

The nurse-patient relationship is one of the most frequently studied aspects of Peplau's Theory of Interpersonal Relations. The relationship as a whole has been the object of study in addition to the specific phases of the relationship. Long-term care was the setting for two studies that explored the possibility of nurses entering into therapeutic nurse-patient relationships with cognitively impaired patients in the later stages of Alzheimer's disease (Middleton, Stewart, & Richardson, 1999; Williams & Tappen, 1999). Middleton et al. (1999) studied staff perceptions and staff distress related to patients' aggressive behaviors in two different long-term care settings. Middleton et al. (1999) noted that staff on special care units (specializing in dementia care) reported more incidents of patients' aggressive behavior but less personal distress than what was found on traditional care units. Since "caregivers' behaviors always have an impact on the individuals who are receiving care" (p. 18), the authors suggested the use of Peplau's interpersonal relations theory to enhance the therapeutic milieu and therefore improve the quality of life for residents.

In another study of nurse-patient relationships between nurses and elderly patients in long-term care, Williams and Tappen (1999) examined the relationship between four advanced practice nurses and forty-two patients in the later stages of Alzheimer's disease over a 16-week period. Williams and Tappen (1999) found that "despite the participants' severe memory impairment, there was evidence that most (84%) were able to form a relationship with a nurse by weeks 8 and 16" (p. 32). This study supports the occurrence of nurse-patient relationships, even with severely cognitively impaired elders.

Nurse Communication within Nurse-Patient Interaction

Most research on nurse-patient interaction focuses primarily on the nurse's communication in the encounter, thereby assuming the power position in the relationship. "Traditional sociological theory on professions awards power to the professional based on knowledge, acquired through academic training and leavened by a service orientation toward the client" (Haug & Lavin, 1981, p. 212). This context of unequal power has been examined as it relates to patient decision-making. Taylor, Pickens, and Geden (1989), for example, studied patient-provider interactions and found that both nurse practitioners and

physicians attempt to influence patient decision-making by using command or consequence statements.

In their ethnographic study of social judgment and the social processes of care as experienced by nurses and patients in a medical hospital setting, Johnson and Webb (1995) found that nurses exerted power over patients and that interactions between nurses and patients were filled with conflict and struggle, resulting in "acquiescence of patients to the nursing and medical goals of care" (p. 83). A grounded theory approach, involving constant comparative methods, was used to analyze the data and Johnson and Webb (1995) found the following concepts central to the social process of care and to social judgment: assessing, negotiating, struggling, and acquiescing. In a vignette of how one patient negotiated the social judgment of the nursing staff, a patient interrupted a nursing shift report, knowing that this was a violation of social norms. To combat the possibility of being labeled a "bad patient," he acquiesced to having x-rays that he did not want in order to mitigate his failure to follow the rules (interrupting shift report). His social skills, awareness, and previous experience enabled him to successfully manage his social standing in this environment of care. What happens when patients are too ill or have inadequate social skills? Their ability to assess and negotiate the social environment of care is then seemingly limited.

Several studies have focused on nursing students. Communication style and communication behavior was examined in a sample of 150 nursing students (Harrison, Pistolessi, & Stephen, 1989). Harrison et al. (1989) used the Communication Styles Q-Set (CSQS) to measure communication behavior and a demographic questionnaire to assess nursing experience in their study of sophomore, junior, and senior nursing students from a liberal arts college in the northeastern region of the United States. The CSQS is a "forced-choice Q-sorting procedure consisting of a deck of 100 cards, each containing a statement describing an aspect of interpersonal communication behavior" (Harrison, et al. 1989, p. 78). The researchers wanted to know if more experience or education resulted in better nurse communication behaviors. Discriminant analysis was used to determine the difference in communication behaviors based on nursing-related experience. Results indicated a significant difference, in favor of the high experience group, in the following categories: realize when others don't understand them, use facial expressions and meaningful gestures, and are sensitive to others' feelings. The high experience group scored lower (indicating a behavior least characteristic) in deception, gossiping, blaming, and judging. Interestingly, the low-experience group scored lower (meaning behaviors that are least characteristic) in threats to gain compliance or cooperation, disagreeing frequently, and interrupting. In addition, researchers found that "sophomores rated themselves higher on listening and sociability than juniors and seniors, and lower than juniors and seniors in their use of gossiping and critical or sarcastic behavior" (Harrison et al., 1989, p. 87). It appears that as nursing students gain more experience and education, their communication behaviors become less consistent with desirable communication behaviors taught in nursing courses.

In another study of nursing students, Baer and Lowery (1987) examined the effect of patient characteristics and helping situation on nursing students' like or dislike of caring for patients. Baer and Lowery (1987) found that students preferred to care for

persons who were cheerful, communicative, accepting of their illness, and accepting of the nursing care offered. According to Garvin and Kennedy (1990), "the findings from this study [Baer and Lowery, 1987] highlight the fact that patient communication characteristics are important variables to consider when examining the nurse-patient relationship" (p. 27).

Caris-Verhallen, Kerkstra, van der Heijden, and Bensing (1998) used Roter's Interaction Analysis System to analyze nurse-patient communication in home care and institutional long-term care. This study measured the amount and type of nurse communication in the two different settings using video recordings of nurse-patient encounters. Caris-Verhallen et al. (1998) found two clusters of socio-emotional communication—social behavior and affective behavior, and three instrumental clusters—variables that structure the communication, information exchange concerning nursing and medical topics, and information exchange involving lifestyle and emotional topics. Interestingly, Caris-Verhallen et al. (1998) found that communication related to nursing and medical topics occurred with greater frequency in home care than in the institutional long-term care setting and that communication related to relationship building was found more frequently in institutional care than in home care. The authors concluded that this finding was not surprising since nurses in the home are focused on nursing and medical technical tasks and nurses in institutional long-term care settings are focused on lifestyle and emotional topics. Limitations of this study include self-selection (where nurses selectively recruited patients for participation in the study) and performance bias (where the presence of a video recorder could affect the communication of the nurse).

Gibb and O'Brien (1990) studied ten registered nurses' "speech acts" and "speech style" with elderly clients in two different nursing homes. Data were collected by equipping nurses with microphones pinned to their lapels and tape recorders in their pockets. Nurses then audiotaped verbal interactions during routine morning care. It was not stated whether the patient participants gave informed consent to participate in the study or whether they were even aware that they were being audiotaped. Another researcher acted as a participant-observer who recorded "broad aspects of physical care" (Gibb & O'Brien, 1990, p. 1391). The authors found that most of the nurses' communication elicited little verbal elaboration from the patients, often requiring only "yes" or "no" responses. These closed questions enabled nurses to maintain control over patient care procedures by limiting patients' verbal responses. The authors describe the study as ethnography using grounded theory methods to analyze the data. A limitation of this study is that the data analysis technique described was not entirely consistent with ethnography in that only the transcripts of the interactions were analyzed, not the whole of the culture (including the nursing home culture, the culture of care, or the social process of the encounters).

Both Caris-Verhallen et al. (1998) and Gibb and O'Brien (1990) found that speech patterns varied depending on the nursing task performed and that social interaction was present and important. Caris-Verhallen et al. (1998) found that communication during technical nursing tasks involved "more statements that structure the encounter (such as 'turn around please,' 'here is your dress') than communication in

psychosocial care" (p. 104). Caris-Verhallen et al. (1998) were surprised at the amount of socio-emotional communication used to establish the nurse-patient relationship and reported that "about half of the verbal utterances used in this study were directed at the establishment of a relationship between nurse and patient and concerned personal talk, jokes and other affective behaviour" (p. 105).

Mutually Constructed Nurse-Patient Interaction

One of the early studies that viewed nurse-patient interactions as mutually constructed phenomena was a study by Altschul (1971) who studied nurse-patient relationships using participant observation and interview methods on four inpatient psychiatric units. During this time period there was controversy about whether or not nurses should form relationships with patients, some believing that nurse-patient relationships were "dangerous" (to patients and nurses). In an attempt to examine this concern, Altschul observed nurse-patient interactions, interviewed both nurses and patients about their experience of a nurse-patient relationship (if they claimed to be in a nurse-patient relationship), and interviewed patients who described themselves in a nurse-patient relationship as to whether they considered the relationship therapeutic. Also studied was what she called reciprocity – an awareness of the relationship by both nurse and patient. Patients were asked to describe what they thought helped them and nurses were asked which patients they spent the most time with. If both nurse and patient expressed feelings of relationship with each other, they were deemed reciprocal.

Altschul (1971) found that both nurse and patient were aware of being in a nurse-patient relationship; however, nurses often were unaware of the patient's view. This study quantified the number and duration of nurse-patient interactions and found that nurses "were not observed in frequent or prolonged interactions with the patients" (p. 184). This finding, however, did not preclude nurses from forming relationships with patients; in fact, in three out of four examples (on one psychiatric unit) where both nurse and patient claimed that they were in a nurse-patient relationship, the researcher only observed one interaction of a short duration (which, incidentally, was initiated by the patient). Therefore, the nurse-patient relationship was not dependent on many interactions of long duration. In interviews with nurses, the nurses reported believing they spent a lot of time with patients when this was contrary to what was observed.

Altschul (1971) found that *patients* in nurse-patient relationships believed that these relationships were therapeutic, however, *nurses* "frequently expressed doubt about the value of their relationship with the patient" (p. 185). The researcher did not judge the relationships to be therapeutic because they did not seem to be "purposeful or goal-directed" (p. 185). Consistent with the researcher's assessment -- that nurse-patient relationships were not therapeutic -- the nurses interviewed in the study did not support, and in fact ridiculed, colleagues who had therapeutic relationships with patients, although they themselves were all, to some degree, in them. The nurses' views of the nurse-patient relationship in this study were antithetical to those espoused by Peplau's Theory of Interpersonal Relations (Peplau, 1991/1952).

In contrast to Shattell (2002), whose participants usually referred to nurses in the aggregate and seldom used the names of individuals, Altschul (1971) found that some patients, when asked what had helped them while in the hospital, spoke at length about certain nurses. Patients not only knew the nurse's name, but also described each nurse "in vivid terms and it became obvious how much detailed information patients had about each of the nurses on the ward" (Altschul, 1971, p. 183). It is obvious that there are many differences between psychiatric nursing care during Altschul's (1971) study and the more recent one (Shattell, 2002), in addition to the three decades between the investigations: namely, reduced lengths of hospital stay, reduced nursing staff levels and increased nursing workloads. However, differences in nurse visibility in these studies of psychiatric hospitalization are apparent. Findings common to both Altschul (1971) and Shattell (2002) are that patients desire nurses who are genuine, do not seem to be in a hurry, and are available and willing to talk to them.

Patient Perception of Nurse-Patient Interaction

Only three studies were found that explored patient perceptions of nurse-patient interactions. These studies sought to explicate the patient's perspective on the interpersonal competence of nurses (Fosbinder, 1994), the patient's experience of exclusion and confirmation through nurse-patient interaction (Drew, 1986), and the patient's experiences of care when labeled 'difficult' (Breeze & Repper, 1998).

A theory of interpersonal competence, developed by Fosbinder (1994), was developed from her qualitative ethnographic study of patient perceptions of nurse-patient interactions. In this study, participants included 40 patients and 12 nurses from orthopedic and cardiac care units in a private teaching hospital in Southern California. The author used participant observation and interview methods to collect data. Patients were asked what happened when the nurse took care of them and how they felt about their care. Overwhelmingly, patient participants talked about the interpersonal interaction instead of other aspects of nursing care. The theory as it emerged from the data included four themes: translating (informing, explaining, instructing, and teaching), getting to know you (personal sharing, humor/kidding, being friendly, and clicking), establishing trust (being in charge, anticipation of needs, being prompt, following through, and enjoying the job), and going the extra mile (being a friend, and doing the extra) (Fosbinder, 1994). This theory was derived from the patient's perception of nursing care. Fosbinder (1994) admits to the importance of the reciprocal aspect of the patient's role and suggests this as an area for future research; "interpersonal competence is assumed to carry a reciprocal nature, where characteristics in the patient have important influence. Such issues need further study to expand the model proposed here" (p. 1092).

Another study that explored the patient's perspective of nurse-patient interactions was a phenomenological study of the experience of exclusion and confirmation in hospitalized patients (Drew, 1986). Exclusion is defined as "to be excluded, that is, to experience one's feelings' being disregarded by another on whom one depends" (Drew, 1986, p. 40); confirmation is "having one's feelings acknowledged by an important other" (p. 40). Participants were individually interviewed and asked to describe one

positive and one negative experience with a caregiver. Participants also were asked questions such as "what is it about a caregiver that lets you feel like a person? Like a non-person?" Data was collected from thirty-five patients on a surgical unit and an obstetrical/gynecological unit of a community hospital and analyzed using constant comparative methods. Exclusionary experiences of patients (through interactions with caregivers) involved experiences with caregivers who were emotionally cold, hurried, and who avoided eye contact. Experiences with caregivers who were energetic and enthusiastic, made eye contact, were physically relaxed (i.e., moved slowly) and willing to talk about their own lives were characterized as confirmatory.

The use of the term "caregiver," which was never defined, was confusing to the reader. In the beginning section of the research report, Drew (1986) used the terms "health care professional," "nurse," and "caregiver," with minimal differentiation. She never explained why she chose "caregiver" in her schedule of interview questions, other than that the interview tool had "content validity" through its evaluation by "a group of health care professionals (a psychologist, a sociologist and several nurses)" (p. 40). The caregivers that participants included in their descriptions were nurses, physicians, and radiology technicians. Another possible limitation concerns wording of the interview questions. Asking participants to describe one positive and one negative experience assumes that they had these experiences. In introducing the study to potential participants, the researcher explained that they would be asked to describe their feelings about being a patient. The questions asked to the participants were very specific, came from a particular theoretical perspective and were not wholly consistent with phenomenological research methods.

Although Drew's (1986) study has some potential problems, it does illuminate the patient's experiences of a caregiver as exclusionary and confirmatory. It shows that caregiver communication and behavior has an impact on patients in the hospital setting. Patients who were negatively affected by exclusionary experiences reported feeling like "energy was being taken away." Confirmatory experiences were described as "energy-giving." The effect of nurse-patient interaction on the experience of the patient can be helpful or hurtful, confirmatory or exclusionary. Although not all of the findings can be entirely attributed to nurses as caregivers, some participants' descriptions did include nurses.

Drew's (1986) findings are consistent with those of Shattell (2002) and Plaas (2002). Shattell (2002) found that patients experienced the hospital environment as a disconnection from others where their identities were disconfirmed. In a phenomenological study of the patient's experience of outpatient health care environments, Plaas (2002) found that being treated either as an object or person was thematic in participants' descriptions. In many participant descriptions, the outpatient health care environment was experienced as a place where participants were treated as objects. Also thematic in descriptions of outpatient health care settings was that the environment was described as cold and uninviting. These studies of the inpatient hospital environment and the outpatient health care environment yielded findings consistent with those of Drew (1986); namely, what she termed exclusionary and confirmatory experiences are present in both settings.

The negative social labeling process of tagging patients as "difficult" can also affect patient care in the hospital environment. In a phenomenological study of occupational therapists' moral evaluation of patients, nine interviews were analyzed producing the following themes: ambivalent moral evaluations, "good," "bad," and "difficult" (Finlay, 1997). The label "difficult" or "bad" has been associated with patients who are "demanding, uncooperative, and ungrateful...[who] make staff feel ineffective" (Finlay, 1997). Finlay (1997) found that "the process of making social evaluation defies simple formulae and involves complex social processes" (p. 444). This description of "difficult" derived from social constructionism is different from earlier research that used patient characteristics such as medical diagnosis, physical attractiveness, race, gender, and age to define the "difficult" patient. Current research shows that nurses who label patients as "difficult" often avoid or distance themselves from these patients (Breeze & Repper, 1998; Carveth, 1995; Finlay, 1997). Such distance has been shown to result in less supportive nursing care, such as responding less promptly to patient requests for assistance, providing less privacy, informing the patient to a lesser amount, providing fewer comfort measures, and using the patient's name less often (Carveth, 1995).

In an ethnographic study of the mental health patient's experience when labeled "difficult," Breeze and Repper (1998) used focus groups and unstructured interviews to study patient perceptions of care experiences. The researchers used a focus group of nine mental health nurses to examine what they regarded as "difficult." This group yielded the following characteristics: does not respond to intervention, does not conform, primary or secondary diagnosis of personality disorder, long-term mental health problem, multiple and complex needs, demanding (of staff, time or resources), disruptive, and aggressive (Breeze & Repper, 1998). The researchers then interviewed six patients who met the "criteria" of the "difficult" label. Apparently, the researchers initially had a list of 17 patients who met the criteria, although patients who were labeled "difficult" by the nursing staff also were difficult to interview by the researchers. Many of the potential patient participants were unavailable, too ill to consent, or unwilling to participate.

The data obtained from these patient interviews were analyzed using a "stage-by-stage" method adapted from grounded theory. Findings included three major themes – control, patient response, and nurse intervention. Patients described feeling like they had no control over their treatment and were coerced or forced into certain behaviors that the staff thought appropriate. Participants reported responding to this control with anger, which led to a "struggle for control" (p. 1306). Nursing interventions that patients regarded as positive included relationship, empowerment, skilled intervention, and support. Participants also expressed a desire to be respected and valued as a person; this finding is consistent with Plaas (2002). A difficulty in Breeze and Repper's (1998) study is the apparent hodgepodge method. They refer to ethnography, Burnard's stage-by-stage method, and grounded theory although their analysis does not seem consistent with any of the stated methods.

There has been little research on patients as active participants in the nurse-patient interaction. As stated by Russell (1994), "one implicit assumption, among many others, inherent in the focus of most research efforts in this area is that the caregiver has the power to make changes and influence the care giving situation" (p. 308). Subsequently, we know much more about how nurses communicate with patients than how patients communicate with nurses. A search of the literature revealed only four studies that addressed patient communication. The context of these studies was pain management (McDonald et al., 2000; Pettegrew & Turkat, 1986) and care seeking of elders in a continuing care community (Russell, 1994, 1996).

Two empirical studies examined how patients communicated with their providers and how that communication contributed to the patient-provider relationship (Pettegrew & Turkat, 1986). Both studies were performed at a low back pain clinic at a university medical center. In the first study, all clinic patients (n= 96) were mailed three measurement tools – a Patient Communicator Style Measure (PCSM), an Illness Behavior Inventory (IBI), and a questionnaire to measure utilization of medical treatment. A total of 50 patients returned completed questionnaires, yielding a relatively good response rate of 52%. Since no reliability or validity statistics were reported for any of the measures, findings should be viewed with caution.

Using Elementary Linkage Analysis to examine correlations between the PCSM and IBI, Pettegrew and Turkat (1986) found that a cluster of communication styles (open, dramatic, dominant, contentious, animated, and precise) was correlated to measures on social illness behavior. Social illness behavior "constitutes a series of social cues about one's internal and external state – frequently bringing up one's illness in conversation, acting more ill than one really feels, giving off nonverbal cues about one's illness, complaining, and so on" (Pettegrew & Turkat, 1986, p. 382). Multiple discriminant analysis was used to evaluate the association between utilization of medical treatment (split into high, moderate, and low medical utilization groups) and patient communication behaviors. Only two of the utilization of medical treatment variables were statistically significant; the number of physician office visits and the number of days of missed work. Three statistically significant communication typologies were found through cluster analysis: assertive, ideal, and stoic.

In their second study, Pettegrew and Turkat (1986) videotaped seven patient-provider interactions to examine differences between participants' self-reports of communication style and independent raters' reports of communication style. These interactions were videotaped during patients' initial visits to the clinic, in a meeting with a physical therapist. The same physical therapist was used for all seven interactions. There were no significant differences found between patient self-reports and independent rater assessments of communication behavior. The small sample size, however, may have prevented finding any statistically significant differences. The authors inappropriately went further than the data allowed and said, "dominant and social illness behavior approached significance" (p. 389).

Both studies reported by Pettegrew and Turkat (1986) on patient communication about illness were value-laden with clearly articulated judgments about how chronic pain patients utilize medical care and workers compensation claims. For example, in a discussion of the significance and purpose of their study, the authors stated that:

> Some patients manipulate the health-care system and its providers for purposes of secondary gain. They visit the provider frequently so they can avoid work while collecting workman's compensation and other benefits. How patients communicate to providers may inform us about such ulterior motives. (p. 382)

Condemnatory statements such as these make one skeptical of the study design, data analysis, and conclusions. The authors suggest an area for further research into patient communication typologies and their relationship to medical care utilization. In this context, they state, "it may be, for example, that a certain patient typology tends toward overmedication, overutilization, or excessive application for workman's compensation" (p. 391). What are overmedication, overutilization and "excessive" application and who decides this? What is the importance of having the knowledge of a certain patient typology? Despite this tendency toward moralism, Pettegrew and Turkat (1986) do make the useful observation, "patients may have a far greater impact on and responsibility to the health-care relationship than previous provider-patient research has revealed" (p. 391).

In a different study concerning patient communication and patient care seeking, Russell (1996) used participant observation and semi-structured interviews with elderly patients in a long-term care facility to examine care-receivers' insight into "successful care interactions" (p. 309). Russell (1994) found that elders used prior experience -- labeled "insight" -- to manage future interactions with caregivers. Based on the constant comparative data analysis method, Russell describes a care-seeking process consisting of two phases: care eliciting and care engaging. The care-seeking process emerged from experiences with both formal and informal caregivers and was sequential and developmental in nature.

Summary

Most of the research on nurse-patient interaction has focused on the nurse's communication in the interaction, even when the unit of study was the patient. Patient communication has received much less attention reinforcing the idea that nurses have more power in these interactions than patients. Findings that are particularly germane to increasing the understanding of patient communication are those on patient care seeking (Russell, 1994, 1996), although these studies do not explicate the patient's experience of seeking care. In these studies, patients were found to be active participants in the communication process between themselves and their caregivers. Despite these studies, much about this phenomenon remains unknown; the experience of the patient's communication with the nurse needs to be explored, as does the experience of soliciting care in the hospital environment. Patients in the hospital environment experience enormous vulnerability (Carr, 1998; Granberg, Engberg, & Lundberg, 1998; Irurita, 1996, 1999), conflict, tension and dissatisfaction (Bruster, Jarman, Bosanquet, & Weston,

1994; Kools, Gilliss, & Tong, 1999), and confinement, insecurity, and disconnection (Shattell, 2002). What is the patient's experience soliciting nursing care in an environment that produces such feelings? The purpose of this study therefore was to describe patients' experience soliciting nursing care in the hospital environment.

CHAPTER III

METHODOLOGY

The purpose of this study was to explore and describe the patient's experience of soliciting nursing care in the hospital environment in terms of a thematic analysis of the meaning of this experience. This purpose was achieved on the basis of phenomenological interviews with persons who had one or more experiences of soliciting nursing care. Chapter III will offer a brief description of existential phenomenological philosophy that serves to ground the present study. In addition to philosophical issues, it will also discuss the role of the researcher and the sample selection procedures used in the present study. Data collection and data analysis methods will be discussed and issues of integrative validity will be reviewed. Finally, the method of interpretation will be explicated.

Existential Phenomenological Approach

Existential phenomenology derives from a blending of existential and phenomenological philosophy. The Danish philosopher Kierkegaard (1813 – 1855) founded existentialism in the mid-nineteenth century whereas phenomenology was founded by the German philosopher Husserl (1859 – 1938). Heidegger (1889 – 1976), a student of Husserl, was "one of the first thinkers to bring together existential concerns and phenomenological methodology" (Valle & Halling, 1989, p. 6). Hence, existential phenomenology is "that philosophical discipline which seeks to understand the events of human existence in a way that is free of the presuppositions of our cultural heritage, especially philosophical dualism and technologism, as much as this is possible" (Valle & Halling, 1989, p. 6).

The French philosopher Merleau-Ponty, a more contemporary existential phenomenologist, drew on the works of Heidegger and of gestalt psychologists such as Köhler to "cast psychological insight and empirical research into a philosophical system more congenial to a psychological study of human existence" (Pollio, Henley, & Thompson, 1997, p. 5). Pollio et al. (1997) further argue that psychological research from an existential phenomenological perspective must be grounded in Merleau-Ponty's philosophy because "at the center of Merleau-Ponty's philosophy...is his description of the 'lived body'" (p. 5). "Body as lived" is differentiated from "body as object;" nurse-patient relationships bridge the gap between patient experiences of the body as lived and as object. This reintegration or reconciliation of the self (body as lived) with the body (body as object) is within the realm of nursing and an existential phenomenological philosophy grounded in the "lived body" is therefore deemed appropriate for the study of nursing interests.

Unlike the duality of Cartesian thought, the knower and the known cannot be separated in phenomenological thought; the most important concepts in this regard are being-in-the-world and intentionality. Being-in-the-world refers to the idea that the person and the world are co-constituted, in that one cannot exist without the other. According to Merleau-Ponty (1962),

> The world is not an object such that I have in my possession the law of its making; it is the natural setting of, and field for, all my thoughts and all my explicit perceptions. Truth does not 'inhabit' only 'the inner man', or more accurately, there is no inner man, man is in the world, and only in the world does he know himself. (p. xi)

Consciousness is always consciousness *of* something (Merleau-Ponty, 1962). Consciousness is "said to be intentional in nature or to be characterized by intentionality" (Valle & Halling, 1989, p. 11). Intentionality "is meant to emphasize that human experience is continuously directed toward a world that it never possesses in its entirety but toward which it is always directed" (Pollio et al., 1997, p. 7). In order to illuminate human existence, therefore, the researcher must seek a "rigorous description of human life as it is lived and reflected upon in all of its first-person concreteness, urgency, and ambiguity. For existential phenomenology, the world is to be lived and described, not explained" (Pollio et al., p. 5).

Existential phenomenology seeks to "explicate the essence, structure, or form of both human experience and human behavior as revealed through essentially descriptive techniques" (Valle & Halling, 1989, p. 6). Pollio et al. (1997) describe the use of the phenomenological interview as one way to explore lived experience. In order to obtain a rich description of the lived experience, a dialogue must occur where

> one member of the dialogic pair, normally called the investigator, assumes a respectful position vis-à-vis the real expert, the subject, or more appropriately, the co-researcher. In this way, the path toward understanding emerges from the common respect and concern of two people committed to exploring the life world of one of them. (Pollio et al., p. 29)

The patient's experience of soliciting nursing care is a new area of research; in fact, no studies were located that studied this phenomenon. A qualitative approach was warranted in order to explore the patient's experience of soliciting nursing care. Since it was the lived experience of the phenomenon that was of interest, an existential phenomenological approach utilizing the method developed by Pollio et al. (1997) and Thomas and Pollio (2002) was employed.

Sample Selection

The sample for this study was selected on the basis of a purposeful sampling design. Potential participants who were known by the researcher to have had the experience of soliciting nursing care were asked to participate. A snowball sampling technique was used for further recruitment. Three participants gave the researcher a name and phone number of a friend, colleague, or neighbor as potential research participants whom they believed would be interested in talking about their experience. After the interview with the referring participant, this participant contacted their friend, colleague, or neighbor and made the initial inquiry to gauge their interest in talking to the researcher. If amenable, the researcher telephoned the potential participant and, following a verbal agreement to participate, scheduled a time and place to conduct the interview. One potential participant declined an interview after talking to the researcher

approximately 45 minutes on the phone. After describing her experience in detail, she said, "I don't have anything else to tell you."

Participants were included in the study if they had an experience of soliciting nursing care in a hospital setting and were open and willing to talk about their experience. They were English speaking individuals over the age of twenty-one who were not cognitively impaired or experiencing physical distress at the time of the interviews. The sample was comprised of eight participants.

Procedure

Role of the Researcher

According to the existential phenomenological method outlined by Pollio et al. (1997) and Thomas and Pollio (2002), the researcher seeks an active dialogic engagement with participants, from whom a description of some experience is sought. The description is socially constructed through the dialogue between investigator and co-researcher as well as within each individual (Berger & Luckmann, 1966).

The existential phenomenological method used in this study requires a bracketing interview prior to data collection to highlight the researcher's presuppositions. To this end, the researcher was interviewed with the same question and method that was used in the major study. The bracketing interview was audiotaped, transcribed, and analyzed in an interdisciplinary interpretive research group that meets weekly. An analysis of the bracketing interview revealed the researcher's belief in the importance of indirectly informing hospital staff that she is a RN, cautiously, without wanting to intimidate the staff. Another preconceived belief was that hospitalized patients used interpersonal techniques such as being complimentary, "overly" nice, and by doing things for the nurses (for example, ordering pizza for the nursing staff).

In addition to the perceived necessity of interpersonal techniques, including the subtle manner of informing hospital staff that the researcher was a RN, another presupposition pertained to the value of a family member, or possibly someone hired by the patient or family, staying in the hospital with the patient at all times. The patient's advocate could either help with basic needs or act as a conduit to the nursing staff. The researcher believed that it was imperative to have a family member or significant other present during hospitalization.

Pilot Study

The researcher performed a pilot study of the research question with one participant who had the experience of soliciting care from a nurse in a hospital setting. This interview was audiotaped and transcribed and the researcher interpreted the interview transcript in collaboration with the interdisciplinary interpretive research group. Based on the pilot study, the opening research question did not require revision.

Data Collection and Recording

Participants were asked to describe in as much detail as possible what stood out for them or what they noticed about seeking nursing care in a hospital setting. The

specific research question was, "what stands out to you when you think about soliciting care from a nurse?" There was no pre-specified time period between the hospitalization and the interview since "in phenomenological research, the description of an experience as it emerges in a particular context *is* the experience" (Pollio, Henley, & Thompson, 1997, p. 31). According to Pollio, Henley, and Thompson (1997), "existential-phenomenological philosophy provides grounds for believing that reflections emerging in one dialogic context will *not* be incommensurate with, even if different from, those emerging in another context" (p. 34).

Demographic information was obtained immediately after informed consent was given and before the interview began. Interviews were audiotaped and later transcribed verbatim. Names and references to places were removed and exchanged with pseudonyms. The researcher was the only interviewer and transcriptionist of all interviews and corresponding audiotapes. All interviews took place in participants' homes, based on mutual agreement. Interview length varied from 45 minutes to 90 minutes. The equipment and supplies that the researcher used included a tape recorder, pancake microphone, computer, audiotapes, and paper.

Data Analysis

The data was analyzed using the method described by Pollio et al. (1997) and Thomas and Pollio (2002). See Figure 3.1 for a diagram of this procedure. Interviews were transcribed and read in the order in which they occurred. Hermeneutical analysis was performed with each transcript. The researcher analyzed each transcript for meaning units. Meaning units were read from the part (meaning units) to the whole (entire transcript). Three transcripts were read aloud and subjected to line-by-line analysis in the interdisciplinary interpretive research group at the University of Tennessee, Knoxville, College of Nursing. Each member of the research group signed a confidentiality pledge (Appendix A) and the researcher took notes of the analysis of the group. The major outcome of these readings was development of a thematic description for each transcript. An initial structure was presented to the research group to enhance rigor, and interpretations from the research group were considered in addition to the re-reading of all transcripts to finalize the thematic structure. The formalized thematic structure was presented to one participant for response.

Integrative Validity

Existential phenomenology seeks to describe experience as it is lived, with the hope of furthering understanding, not with the intention of explaining or predicting. This interpretive methodology requires procedural rigor but is unlike the reliability and validity of positivistic paradigm research. According to Pollio et al. (1997), in existential phenomenological methodology the "criterion for validity becomes whether a reader, adopting the world view articulated by the researcher, would be able to see textual evidence supporting the interpretation, and whether the goal of providing a first-person

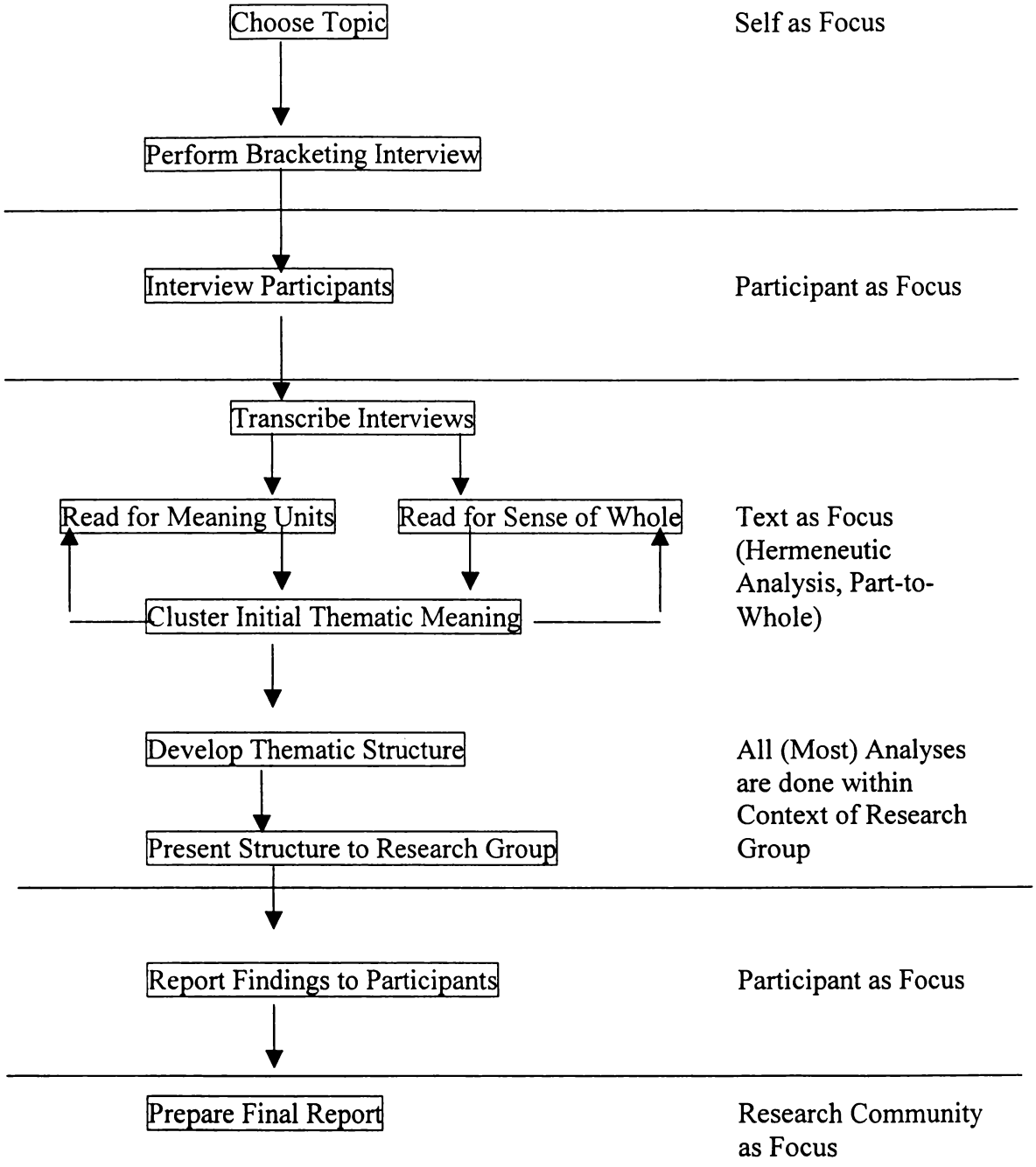

Figure 3.1 Diagram of Research Method.
Source: *The Phenomenology of Everyday Life* (p. 60), by H.R. Pollio, T. Henley, and C.B. Thompson, 1997, Cambridge, UK: Cambridge University Press. Reprinted with the permission of Cambridge University Press.

understanding was attained" (p. 53). "Validity is not determined by the degree of correspondence between the description and reality but by whether convincing evidence has been marshaled in favor of the aptness of the description" (Pollio et al., 1997, p. 53).

Evidential support, according to Pollio et al. (1997) includes an examination of methodological and experiential concerns. Methodological concerns include rigor and appropriateness. In this study, methodological concerns were attended to as a result of adherence to the research method and plan, use of an interdisciplinary interpretive research group, the data analysis audit trail, and participant verification and authentication. Experiential concerns include plausibility and illumination. Plausibility is the degree to which the evidence presented is convincing and credible. Illumination addressed the following question, "does the interpretation provide insight to the reader or evaluator?" (Pollio et al., 1997). The findings from this study are both plausible and illuminating, thereby addressing these concerns.

Protection of Human Subjects

The study was reviewed and approved by the University of Tennessee, Knoxville, College of Nursing Human Subjects Review Committee and the University of Tennessee, Knoxville, Institutional Review Board. The researcher recruited participants from those known to the researcher to have had the experience of soliciting nursing care in addition to three people whom were referred by earlier study participants. The researcher described the study's purpose to all potential participants. Written informed consent was obtained from those willing to participate. A copy of the informed consent form was given to each study participant that included the name and phone number of the researcher should subsequent questions ensue (Appendix B). Participants were informed that they could withdraw from the study at any time. None of the research participants chose to withdraw from the study once interviewing began. There were no incentives offered for participation in the study. All interviews were audiotaped and subsequently transcribed. Names and references to places were changed to protect the identity of the participants. All research materials including audiotapes, informed consent forms, and transcripts were maintained under lock and key by the researcher.

Summary

The purpose of this study was to explore and describe patients' experiences soliciting nursing care in the hospital environment. This chapter included a brief description of existential phenomenological philosophy that served to ground the present study. It also discussed the role of the researcher and sample selection procedures used in the present study. Data collection and data analysis methods were delineated and issues of integrative validity were reviewed. Finally, the method of interpretation was explicated. Findings will be presented in Chapter IV.

CHAPTER IV

FINDINGS

An existential phenomenological approach was used to explore the lived experience of soliciting nursing care in the hospital environment. Open-ended interviews with participants focused on obtaining rich descriptions of that which was figural. In such solicitations, the analysis of these audiotaped interviews resulted in a thematic structure of the experience of soliciting nursing care. This structure was described by participants as emerging from the ground of the experience of the hospital environment.

Context is vital in exploring the particular life-world of each participant. In this sense, an understanding of each participant's circumstance is crucial to existential phenomenological research methods. The context in this study includes both an introduction into each individual participant's life-world, and the more general context of the hospital that grounds their collective descriptions. In this chapter, participants will be represented by means of demographic characteristics (Table 4.1) and vignettes. The environment of the hospital as the ground of the experience of soliciting nursing care will also be described, and a thematic structure of the experience of soliciting nursing care will be rendered. The themes from the structure will be illustrated using specific participant quotations.

Table 4.1 Demographic Characteristics

Pseudonym	Gender	Age	Ethnicity	Highest Education	Reason for Hospitalization
Benjamin	Male	49	Euro-American	Master's Degree	HIV, neuropathy, kidney stones
Francine	Female	65	Euro-American	Bachelor's Degree	Bypass surgery, stent insertion
Pat	Female	64	Euro-American	Bachelor's Degree	Thrombotic Thrombocytopenia Purpura
Nick	Male	40	Euro-American	High School Diploma	Cancer – Burkitt's Lymphoma
Hank	Male	55	Euro-American	Master's Degree	Quadruple bypass surgery
Jolene	Female	33	Euro-American	Master's Degree	Breast reduction, tonsillectomy, liposuction
Monica	Female	52	Euro-American	Bachelor's Degree	Cerebral aneurysm, heart attack
Catherine	Female	29	African-American	Bachelor's Degree	Revision of total hip replacement

Participant Vignettes

Benjamin

Benjamin was interviewed in the living room of his weekend home, which he shares with his partner of many years, located in an affluent neighborhood in a mid-size city in the southeastern United States. Benjamin has AIDS and has had many experiences with caregivers and was open to talk about them. Benjamin is an effeminate gay man who is extremely detail-oriented and very knowledgeable about his disease and medications. Benjamin has been in several studies related to his HIV status and is, therefore, quite familiar with the research process. Most of his care is received at a major teaching hospital and infectious disease clinic, which he describes with great detail. He enjoyed the opportunity to participate in this study and in fact, referred the researcher to a neighbor (Francine) whom he thought would also be interested.

Francine

Francine is a full-time hospice nurse who is nearing retirement. She was verbally engaging and appeared genuinely interested in the study topic, seemingly from her perspective as both patient and nurse. In descriptions of her experience, it was clear that she had some role conflict when she was in the patient role, often identifying with the nurse. She was critical of the care she received, yet she belittled its significance. She said she wanted to get as much of her health concerns taken care of as possible while she had commercial health insurance. She described several incidents of poor care, yet she said it was "no big deal." She was assertive in stating what she wanted from nurses but was less assertive with physicians. She was aware of her inability to assert herself with one physician and stated, "I was a wimp."

Pat

Pat is a retired nurse anesthetist from a mid-Atlantic state. She retired a few years ago, after having been at the same hospital for most of her working life. Since retirement, she has enjoyed traveling across the country in her motor home. Even though she has no intention of returning to work, she maintains her nursing license and anesthesiology continuing education requirements. Aside from having lupus, she is relatively healthy. When she is ill enough to require hospitalization, she much prefers to go to the hospital where she worked since she "gets a fair amount of respect there" and because the staff, treat her as "one of ours." In her description of a hospitalization nearly 20 years ago, she described a negative experience with a nurse with incredible detail. She remembered that the nurse was working a double shift (evening and night shift), that he was having trouble with his girlfriend, and that they had recently broken off their relationship. She recalled that he sped up her intravenous fluids at 9:00 pm because "they were behind" and that he never came back to check on it. She reported waking up gasping for breath complaining that she was in congestive heart failure. In relation to the male nurse above, Pat said, "he was busy." Like Francine, Pat described negative care experiences with nurses but minimized this critique.

Nick

Nick was hospitalized about 10 years ago with a form of cancer most commonly found in central Africa in young adolescent males. In addition to having a form of cancer that was unusual, he also felt somewhat atypical on the oncology unit where all the other patients were either children or elderly. He said the nurses liked to hang out in his room when all his friends were visiting because they were fun. He preferred to have nurses care for him who were older, "more veteranish," and didn't necessarily go "completely by the book." He was appreciative of nurses who listened to him, took his wishes into account, and made him feel more at home. These were the characteristics of nurses whom he trusted and therefore wanted to care for him. Although some negative incidents with nurses were relayed, overall he said he had a "pretty good experience." In fact, after his recovery, he volunteered at the hospital as the "ice cream pusher guy."

Hank

Hank was interviewed in the living room of his home where he lives with his wife and two dogs, in a suburb of a mid-size city in the southeastern United States. At the time of the interview, he had only been out of the hospital for about two weeks after having open-heart surgery. He initially agreed to participate in the study when he was in the hospital, and in fact, was hoping to be interviewed at that time because he was bored. He worked for the same company for many years, in what could be characterized as a stressful position, working well over 40 hours per week. Consistent with his desire to be prepared by knowing what he was getting into, he researched his illness and treatment procedure on the Internet and printed several pages of information to discuss with his doctor. He holds an active life; hospitalization and subsequent recuperation do not fit into his usual pattern. His wife attempts to limit his behavior so he doesn't over exert himself.

His experiences with nursing care in the hospital were good. In fact, he called the nurse manager of the coronary care unit to compliment the nurses who worked with him. He thought it was important to know all their names so he could be sure to give them credit when he called. He has become more empathetic of other people who were ill and unable to work for extended periods of time. In the past, he chastised co-workers who were out of work for an illness, but now, he exhibits care and compassion. He was glad to be a part of a research study and said that he was "already in two other books." Included in his interview was a timeline on how he came to know that he had heart disease and needed surgery. He learned about heart disease risk from an article in his local newspaper. He said he pressured his doctor for six months before he agreed to order a stress test. After the diagnostic work-up, he was immediately scheduled for quadruple bypass surgery. He believes that he would be dead if he had not read that article. He called the author of the article, thanked her for writing it, and in part, credited her for saving his life.

Jolene

Jolene was interviewed in the living room of her home in a new development in a suburb of a mid-size southeastern city. She started her story saying that when she was younger she didn't know she could solicit nursing care. She recalled thinking that nurses

were just supposed to know what was needed and take care of it. She attributed this belief to television because on television, she never saw a patient ask for anything and "the nurse was just always there." She realized that she could and should ask for what she needed when she called her parents at 2:00 a.m. from her hospital bed, in severe pain. She only asked for pain medication after her father told her to, explaining to her that she had the right to do so. After this, she asked for help when she needed it but often did not get the sort of help she had in mind. She did not like being in the hospital, which she described as a boring, foreign place that was "like the twilight zone."

Monica

Monica was interviewed in her large renovated farmhouse in a small town in the southeastern United States where she lives with her husband and three children. She is well known in her community, is involved in many civic organizations, and at one point was voted "Woman of the Year." She likes to talk and enjoys getting to know others. She was airlifted via helicopter from a small community hospital to a larger neighboring city for treatment of a heart attack. She could see the helicopter pad from her hospital room window. When she anxiously realized that her helicopter landed in that spot, she relayed her fear of heights to a caregiver ("one of the guys") whom earlier, she had thought was not very friendly. After this interchange, he became her friend and forever called her "the helicopter lady." She reported that the heart attack was caused by stress and talked about how she was going to try to make changes in her life.

Due to a prior acquaintance, the hospital chief executive officer sent her a card and flowers when she was in the hospital. Since she was afraid that the nurses would not remember her when she was in need, she strategically placed that card "out front and center." If she didn't think the nurses and doctors saw it when they were in her room, she would move her eyes toward it when they were looking at her, hoping to draw their eyes directly to the card.

Catherine

Catherine was interviewed in the kitchen of her home that she shares with her husband and two young children, in a mid-size city in the southeastern United States. She recently had been in the hospital for a revision of a total hip replacement that she had eight years earlier. She characterized her experience with the nurses as good, especially since they were in her room a lot, checking on her. Because she only would call a nurse if she had serious needs, she was comforted knowing that they were very visible and accessible to her should a need arise. She appreciated chitchat from nurses about things other than those relating to her as a patient. She remembered the name of one of her caregivers because of a conversation about hand lotion. She liked it when the nurses paid extra attention to her small son when he visited. She talked about the differences in nurses who worked in orthopedics, labor and delivery, and the emergency room.

Contextual Ground of the Experience

The contextual ground of the experience of soliciting nursing care in the hospital is the patient's experience of that environment. The hospital environment is perceived as confining, dangerous, disconnecting, without possibilities, and stripping of personal identity (Shattell, 2002). While it is not a linear cause and effect relationship, the way in which patients experience the hospital environment contributes to the way in which they solicit care. Care emerges as figure against the ground of the hospital thereby revealing the complete gestalt pattern of the event. The following sections will describe the patient's experience of the hospital environment from Shattell (2002) as the context for results from the current study. The overall thematic structure of the experience of the hospital environment will be followed by a description of each theme.

The Experience of the Hospital Environment

For hospitalized medical patients, Shattell (2002) found that the hospital was a place where patients "had to be." Participants reported having no choice but to be in the hospital, and saw the environment as confining. The environment was viewed as a dangerous place where they were disconnected from others and the outside world. It also was described as a hindrance to participants' individual identities, stripping them of their uniqueness. The predominant theme was "eventually it'll be over." The remaining themes were: insecurity/security, disconnection/connection, no possibilities/possibilities, and not me/me (Shattell, 2002).

"Eventually It'll Be Over."

Participants disliked being in the hospital and longed to leave it. They reportedly reminded themselves, "You have to be in the hospital so you have to be in the hospital. Eventually it'll be over;" "I just thought, endure this, we'll get through it." The hospital was experienced as confined and encased, especially for patients who were unable to move their bodies: "you're...shut up in here." Participants were keenly aware, both literally and figuratively of how to get out of the hospital, how to escape the confinement and to be free. They described biding their time by doing what was expected of them, believing this would lead to a quicker release. They discussed their confinement in relation to the importance of a view of the outside world. Having a window enabled them to look out and experience the freedom that the outside world seemed to grant.

Insecurity/Security.

The hospital environment was experienced as creating feelings of danger and insecurity. Physical symptoms of illness, side effects from medications, and unfamiliar noises at night contributed to patients' experience of the environment as insecure. Physical distance between participants and their caregivers was related to the degree of felt security or insecurity. The environment was perceived as more secure when nurses and doctors were in close proximity to patients. The nearness of supplies and equipment such as medications, phones (to call for help if needed), and gloves also helped participants feel more secure in the hospital environment.

Some participants actively sought ways to increase their experience of security. Increased mobility helped improve feelings of security and freedom. Participants who

had family members stay with them experienced the environment as more secure: "My family has been here and they do a good job of taking care of me." The presence of family not only produced comfort and security, but also supported identity and connection.

Disconnection/Connection.

Patients talked of boredom and loneliness; the hospital was described as an environment in which they felt disconnected from others. Inconsistency and discontinuity in their caregivers created feelings of disconnection. Participants longed to relate consistently to other people such as nurses, doctors, family members, and other patients.

No Possibilities/Possibilities.

Participants described experiencing themselves as being at the whim of an environment where they did not even have control over things that were done to their bodies. The hospital environment was experienced as unsupportive of individual efficacy and personal control. Being-in-the-world, in which power and control were taken by that world, created a perception of no possibilities.

Not Me/Me.

Participants consistently compared facets of the hospital environment to those of their homes. In the hospital, aspects of home that help mirror identity and create comfort were not present. Most often, the hospital was seen as "not me." Patients experienced their personal identities stripped from them and their existence as homogenized. The comfort and identity from familiar food, clothing, and personal objects was missing.

Customary social roles were also not supported by the hospital environment. Roles that were significant to patients outside of the hospital were meaningless inside the hospital. Such concerns were particularly confusing for patients who were also nurses. For nurse-participants, the environment created conflict and confusion in their identities. For example, one nurse-participant spoke of impulses to react when she heard sounds of beepers and IV pumps, having to remind herself that, "I'm a patient."

Thematic Structure of Soliciting Nursing Care

The thematic structure of the experience of the hospital environment as elucidated in the previous study (Shattell, 2002) provides the context from which the experience of soliciting nursing care is perceived. Soliciting nursing care is grounded against an environment that is perceived as confining, dangerous, unyielding, disconnecting, and identity stripping. Set against the ground of a dangerous, disconnecting environment, the thematic structure of soliciting nursing care in the hospital setting consists of an overarching theme of *"make them your friend."* In addition to this predominant theme, two remaining themes are: *be an easy patient* and *try to get them to listen.*

"Make Them Your Friend"

Participants described building relationships as fundamental to soliciting nursing care. The type of relationship they depicted was analogous to friendship, not the type of relationship that might be expected between a client/caregiver or layperson/expert. Conversation and humor were described as ways to develop informal relationships

between participants and their nurses. Study participants described forming relationships with nurses by making friends, using nurses' names, being likable, taking an interest in them, making them laugh, and making them feel liked. Participants spoke of deliberately "building friendships" and "building relationships" in their descriptions of soliciting nursing care. One participant relayed this charge in the following statement: "it is the relationship that you have established."

Some participants used relationships in order to facilitate better care. Participants wanted to stand out and be remembered in case they were in need of nursing care and attention: "I try to take an interest in them so they will...so they will remember me. If I need something they will respond to me." "If you're having trouble with somebody...you've just got to find a way to make them remember you, or come back to you and say, she's a little more than just a slice, or she's just a little bit more." This type of strategic intimacy is particularly vivid in the words of this participant:

> You build the relationship differently...with the older [nurses], I would talk about the hospital and what a GREAT hospital it was and even try to word it to produce POSITIVE conversation...I'd try to talk to them about that kind of stuff, and 'remember the farmers market and remember', you know talk to them about that kind of thing. And then the young ones, I'd just ask them why they majored in nursing and with the shortage and that I was encouraging my daughters to do it. Just bullshit, total bullshit. (Monica)

The interactions described by this participant were calculating since relationships with various nurses were developed differently, based on characteristics of individual nurses. Also evident in this participant's description is that if lower level relationship-building strategies are ineffective, more direct and "forceful" tactics are utilized:

> A person who just comes in and does a job and walks out of the room doesn't set well with me. And I tend to, I can cut up about it and I'll try to make you warm up by making you laugh, but then if you still won't come to me, then I'm either going to get angry, or mad, or force you to do it. I will force you; try to force your hand. (Monica)

Whereas some participants wanted a relationship as a means to bring about better nursing care, others desired and developed a relationship for the relationship itself. Still based on the model of a friendship, participants fostered connections with nurses: "I want them to like me." One approach used by participants was through the use of everyday conversation:

> They are coming in to check on you but they're coming in with a purpose, not just to see how you're doing but they've got something else they need to come in for, maybe just smiling at them and saying hi and trying to start maybe a little conversation with them while they're in there doing whatever they came to do. (Catherine)

Everyday conversation was used by patients to spark talk about subject matter other than those topics relating to them as a patient. Examples of such conversational topics mentioned by participants were family, television programming, and type of hand lotion. For example:

> We would have conversation about my family, or Raymond, or what I did, my work...and I enjoyed that so...I tried to make that conversation, my personality come through...I think there must've been something that made it more attractive to HER as well. (Benjamin)

Connection with nurses that affirmed participants' personal and unique identity was sought in an environment that was experienced as disconnecting and identity stripping. For example, the identity of father and husband was affirmed in this participant's statement: "we talked about the kids and the wife...it was kind of, building friendships." Nurse-participants, to maintain individual identity while connecting with their own nurse caregivers, commonly initiated conversations regarding topics such as clinical specialty and place of employment.

Participants felt more comfortable about their care if they knew and trusted their nurses: "Trusting part I guess. You trust certain ones and you want them to work with you, do your stuff, and the other ones you don't." "I made friends with all the nurses. I always like to know who's taking care of me." In speaking of a relationship that she developed with a nurse, this participant conveyed how trust impacted her care, "[the relationship] makes you feel a lot better or a lot more comfortable about the care that you're getting. It definitely helps." The following participant relayed how communication, trust and comfort with nurses can act as a surrogate if patients were unable to have that with their physicians:

> I think when you are in [the hospital] for healthcare you need to, there's got to be a comfort level, you have to have trust in your, either the people who put you there for the condition which put you there...I think you need to have established enough communication, and if you can't get it with the doctor, you get it with the nurse, you increase it with the [nurse]...so you know what's going on. (Monica)

"Be an Easy Patient"

Participants described "easy patients" as nice, friendly, calm, compliant, and easy to talk to: "I think I'm a pretty easy patient because I'm easy to talk to...some of them in there weren't." Participants described good patients as those who made the nurse's job easier and waited their turn. One nurse-participant spoke specifically of this role, "I kind of understand where the nurse is, overworked, tired, with a lot of pressures, I tend to be much nicer to nurses...that good patient role is very easy to fall into. Harder to complain." In reference to patient compliance, another participant said, "I think when one wants to be perceived as a reasonable, civil, cooperative patient you will do the nurse credit by following orders."

Participants expected a reciprocal process in their care interactions. Participants believed that their response to their nurse affects the care that they get:

> As a patient...your attitude can affect the attitude of the people that are giving you the care. If you are grumpy, maybe they won't try to be extra chatty with you because they know you're not going to chat back. But if you're showing them that hey, I'm interested in what you're saying, then maybe they'll be a little more chatty with you, or not even saying that they wouldn't be as helpful with people that aren't as friendly, but maybe they WERE checking in a little bit more

> because they felt like, hey you know, she's a nice person, let's just see how she's doing while I'm walking past her door. (Catherine)

Unequivocally, Catherine again related this reciprocity:

> I don't want to say the attention, but how the nurse approaches the patient, and the comfort level that she presents to the patient, and then the patient's response to that, has a great deal to do with, to me, with the care they get. (Catherine)

In terms of managing individual presentation, one participant's maxim was this: "If you come across nice, friendly, then people will be more likely to be that way towards you."

As patients in the hospital, participants were sensitive to being labeled by nurses: "I think sometimes a nurse can tell who's an easier patient." Participants believed that being an "easy patient" would increase their chance for quality nursing care. One participant spoke of the importance of being an easy patient to get the nurses to respond to him, "instead of [the nurses saying], 'oh well, it's that dickhead in Room 2. Who's going to go? I'll get him when I get around to it.'"

One participant said it was imperative to be on the "good side of nurses" and discussed doing so by "not rocking the boat." Behavior such as complaining too much, yelling, being grumpy and grouchy, and bothering or burdening nurses kept patients from being on the good side of nurses. Participants were aware of consequences for behavior inconsistent with "being an easy patient" or "being on the good side of nurses": "Nobody wanted to come around Nick, if I was being demanding about anything...if I got demanding they would definitely not come around because they knew that they'd get yelled at." The importance of being an easy patient in the insecure hospital environment evoked feelings of life and death by some participants. In their descriptions of soliciting nursing care, participants perceived that continued life was the result of being an easy patient. For example:

> My life is so important to me. And my health is so important to me...and being concerned about, you know making sure that it is taken care of, and taken care of quickly. And I know that it WILL be if I go through the system as it's set up to operate. So, it's had a huge impact on me. On how I approach hospitals and doctors, and what I have to DO, you know, to get through there. That's not to say that there haven't been times that I've been a little frustrated, but I generally never let it affect me so that I become irate or angry or emotionally upset about it. (Benjamin)

Another participant described an adverse reaction of the nursing staff after her alarmed friend demanded that they call the physician because of her acute confusion:

> Luckily, my friend was there and when I got goofy, carrying on, talking nonsense, she insisted they call the medical resident...the medical resident came shouting and screaming at everybody...there was a little coolness from some of the staff for a few days after that. Staff who had been friendly toward me were all of a sudden going to be super cool professional. (Pat)

In a discussion of the cost of complaining, another participant revealed the vulnerability of her hospitalized friend:

> She was in terrible pain and nobody seemed the least bit concerned about it...we had a scene, finally. Her pastor was there and I was there and her doctor was

> unfortunate enough to come in making rounds, and we both just jumped all over him, that this was INEXCUSABLE and, he did not like us one bit, then the nurses just took it out on Mary because he went back, jumped all over the nurses, and Mary said they would hardly speak to her the last 2 days she was there...the worst part was when they hated her, she just couldn't wait to get out...it's all my fault because...I was the one who caused it, they should've hated me, but they couldn't DO anything to me. (Francine)

In addition to the desire to be an easy patient and therefore avoid negative consequences of social labeling, another aspect of participants' unwillingness to "bother" or "burden" nurses was related to a belief that other patients had more serious needs: "I thought I didn't want to burden them...I just felt like they had more important things to do...I didn't want to take up their time because I thought I had some kind of simple needs." "Unless I'm actually almost dying, I'm probably not going to call the nurse, or unless I'm really in a lot of pain, I'm not going to bother them." The following participant described the enormous personal struggle walking to the bathroom required in her effort to avoid bothering the nurses, even after nurses told her not to get out of bed without their assistance:

> I didn't want to BOTHER the nurses...so, I wasn't supposed to get out of the bed and I was supposed to call them if I needed to go to the bathroom but I didn't and I tried to maneuver, get out of the bed and maneuver myself with my IV stand thing, to the bathroom by myself, and to go to the bathroom by myself. So that was, that probably took 30 minutes. (Jolene)

Participants felt better when nursing staff were visible or "just there" so they could ask for what they needed without feeling like a nuisance. One participant described this sentiment aptly: "I KNOW that's their JOB to be there IF you need them, but it made it easier for me that they were always coming in there, and I didn't have to feel like, 'oh, can you get me this' or 'I need help with this.' They were just there."

"Try to Get Them to Listen"

Participants tried to get nurses to listen to them by asking for what they wanted and by asking questions:

> They told me to get up and walk...the IVs, the catheter...I really felt there could have been a little more help given and I did ask for it. I'm going to need somebody right now...and they were fine, they stayed. (Francine)

If asking questions or asking for what they needed did not result in getting nurses to listen, participants escalated their tactics: "the nurse was not willing to call the doctor, I had to fuss." "Ask questions. Complain, complain, and complain. If you don't get what you need complaining to this nurse on the floor, ask to speak to the director of nursing. It's YOUR LIFE. I was 51; they could've bumped me off!" Some participants became more assertive, even when they were uncomfortable doing so: "Sometimes I feel like you really need to be...I'm not by nature a real assertive person, and it's hard for me to be assertive, but I will."

Nurse-participants used their clinical knowledge to phrase "different kinds of questions that lay people going to the hospital" would not ask. Nurse-participants, whom

in most cases inconspicuously informed nurses that they were also nurses, used their nursing credentials to try to get the nurses to listen: "after people found out that I WAS a medical professional, I got extra consideration." "I did notice some differences after they found out what I did for a living." "I just told her that I would not have the same medicine, but that she had to call the doctor because we didn't have an order for anything else that would work. She didn't like it very much, but, being a prof [professional], a nurse, it's a little easier to insist."

Several participants thought it was "necessary" to have an advocate (family, friend, or significant other) present in the hospital with them "all the time." Advocates helped get nurses to listen when participants themselves were unable to:

> Luckily, my friend was there...she was in the room with me and decided that whatever they had given me was, I was having an adverse effect of, and when somebody came in, she said to them, 'what's going on? I think maybe she's having a bowel problem' and they did not act like they were doing anything about it, so she went out to the desk and pounded on the desk and demanded that they call the medical resident. (Pat)

One participant poignantly asks, "As long as you're capable of complaining, voicing an opinion, asking questions, you probably do okay. If you are not able to do that, who does it for you?"

In many cases, participants felt disregarded by nurses in their efforts to get them to listen. There were many stories where pleas were ignored. One participant begged a nurse to remove his Foley catheter because he knew it wasn't "in right" and "wouldn't work." The nurse said she wouldn't remove it, that "it's working fine;" moments later, urine "was everywhere." He was upset with the "listening skills of the nurses" and in frustration said, "you know the patient might know what he's talking about sometimes in there too." Even the nurse-participants with specialized knowledge experienced not being listened to:

> I had some really bad experiences. I asked for...one of the complications of the chemotherapy was a bowel obstruction...I kept saying for several days, 'hey, there's something bad going on here, I'm not having a bowel movement, I'm not passing gas.' To me it seemed like everyone ignored that. I quit eating before they did anything else about it. (Pat)

In this case, the patient accommodated for the nurses' reluctance to listen. Another example of a participant adjusting to the refusal of hospital staff (a nurse and physician) to listen, is in the case of this non-insulin dependent diabetic participant:

> They'd bring me lunch and it always had fruit or peaches or something sweet, and, 10 minutes later, they'd come and check my blood...they didn't wait 2 hours...and my...sugar was always up, so they were sticking me, giving me insulin, which, I don't TAKE insulin cause my blood's controlled generally...so you know, I said, 'you know, you all got to stop this,' because, it's not going to be right, eating this sweet stuff,' so finally I said, heck with that, I quit eating the fruits, so I just quit eating it...I said that to the doctor on one of his morning visits...but he said, 'don't worry about it,' that 'elevated sugars are to be expected'...So, I mean, nothing changed. I guess that was the only thing that

> bugged me, that's what bugged me the most about the whole experience, it just didn't make sense to me to be giving somebody sugars then checking their blood. (Hank)

Like this participant, most participants did not experience being listened to. In fact, as the participant who was a nurse anesthetist said, "nobody listens to patients. No matter who you are, nobody listens to patients."

Summary

The thematic structure of the experience soliciting nursing care is described in terms of the hospital environment. The hospital environment is seen as confining, dangerous, disconnecting, without possibilities, and identity stripping. An environment such as this was experienced as requiring a structure to the experience of soliciting nursing care, where one has to "make them your friend," "be an easy patient," and "try to get them to listen." The themes that form the structure of the experience are interdependent and interconnected. For example, attempting to get the nurse to listen may result in not "being an easy patient," and therefore strain the relationship you are trying to build. The themes of the experience of soliciting nursing care in the hospital environment are enlightening for nurses charged with the care of patients in the hospital. Discussion of the findings, along with implications for theory, nursing practice, education, and research, will be presented in Chapter V.

CHAPTER V

DISCUSSION

The purpose of this study was to describe the experience of soliciting nursing care in the hospital environment. Eight participants who had this experience were interviewed using an existential phenomenological approach. Interviews were transcribed verbatim and then interpreted by the researcher and an interdisciplinary phenomenological research group. The result of this analysis led to a description of the thematic structure that formed the meaning of the experience as described by participants. The meaning of this experience was situated by the experience of the hospital environment; it is from this ground that the themes of *"make them your friend," be an easy patient*, and *try to get them to listen* surfaced. This chapter discusses the thematic structure of this experience and its implications for theory, practice, education, and research.

Thematic Structure

"Make Them Your Friend"

Participants in this study sought to connect with nurses through attempts of making them their friends. The relationships that patients wanted were similar to friendships where social conversation was a means of connecting with others. Participants used active strategies to get nurses to like them. Methods useful in social settings such as everyday conversation, showing an interest in the other, eye contact, and smiling, were strategies patients used to build relationships with nurses. Participants believed in a reciprocal nature of "being nice and friendly" and hoped that nurses would be nice to them, if they were nice to nurses. The finding that patients rigorously attempt to form relationships with nurses is a contribution to the nurse-patient relationship literature.

Participants believed that the quality of care they received in the hospital depended on having good relationships with nurses. Patients described a desperate situation where the outcome was life or death. For example, "I was terrified I was going to die," "it's like life or death," "it felt threatening...life threatening. The whole process was life threatening." The patients' experience of soliciting nursing care in the hospital could be viewed as a frantic attempt to live, causing the patients' obsequious behavior toward nurses described in this study. This reaction to the environment is consistent with existential philosophy.

Findings in the current study were similar to those by Caris-Verhallen et al. (1998), Cohen, Ley, and Tarzian (2001), and Gibb and O'Brien (1990), who found that social interaction was present and important in nursing care. One participant in Cohen, Ley, and Tarzian's (2001) study of isolation in blood and marrow transplantation spoke of genuine nurse-patient relationships: "[the nurses] seemed really interested in me. Me personally" (p. 602). Another participant in the same study spoke of identity affirming social interaction between nurses and patients: "the nurse would sit there for hours just rubbing me and telling me all her stories and her life...They were like normal people" (p.

602). The desire shown by patients in the current study to build identity-affirming relationships with nurses lends support to Breeze and Repper's (1998) finding that the nurse-patient relationship is an extremely positive nursing intervention based on the patients' need for respect and value as a person.

Evidence of patients' relative success in building relationships was apparent in the numerous incidents where study participants identified nurses by name. Similar to findings reported by Altchul (1971), participants in the current study knew a lot of information about individual nurses. Relationships with nurses were figural in descriptions of experiences of soliciting nursing care. When patients were asked about their experiences, previously established nurse-patient relationships were discussed. These personal relationships accounted for the strong recollection of individual information about nurses who cared for them. This is in stark contrast to findings in the study of the hospital environment where individual nurses were minimally alluded to and never named (Shattell, 2002). In this previous study (Shattell, 2002), participants were asked what stood out to them in the environment and, surprisingly, it was people in the environment, not the physical surroundings that was figural. Interestingly, the individual persons that participants spoke of were generally not nurses; most often they were "ancillary" hospital staff. In the present study, participants were asked directly about their experiences soliciting nursing care, thereby focusing their descriptions on their experiences with nurses. When this was done, participants spoke with great detail of individual nurses with whom they had relationships.

Based on the findings of this study, it can be concluded that patients have a much greater role in developing nurse-patient relationships than the nursing literature suggests. Patients are active participants in the effort to build nurse-patient relationships and sometimes use these relationships to increase their power in an environment in which they feel powerless. Participants in this study believed that a positive nurse-patient relationship increased their chances of quality nursing care. Building relationships with nurses was figural against the ground of a dangerous and insecure hospital environment.

Irurita (1996) studied the patient's perspective of quality of nursing care in a grounded theory study of acute care hospital patients. Consistent with findings from the current study, Irurita (1996) found that "enhancing the development of the nurse-patient (patient-nurse) relationship" (Initial Findings section, ¶ 6) had the "intention and the potential to increase and enhance the quality (and amount) of care received" (Initial Findings section, ¶ 9). Irurita (1996) identified vulnerability as the "basic social-psychological problem shared by the patient participants" (The Patient's Perspective: Vulnerability, ¶ 1). Vulnerability as defined by Irurita (1999) is "being susceptible to physical and/or emotional hurt, harm, or injury, defenceless [*sic*] or weak in relation to self-protection, open to assault" (p. 11). She viewed vulnerability as a threat to personal integrity, which led patients toward actions meant to preserve that integrity. According to Irurita (1996),

> This process [of preserving personal integrity] was used by patients to deal with their sense of vulnerability by increasing control and by protecting, conserving, and restoring their own integrity. Depending on the perceived level of vulnerability, different levels of activity to preserve integrity were needed to

> achieve positive outcomes from the patient's perspective (considered as quality care). (Preserving Integrity, ¶ 1)

Findings from the current study regarding relationship-building strategies employed by patients are consistent with those reported by Irurita (1996). When lower level strategies were ineffective, participants escalated to higher level, more intense ways to get nurses to enter into relationships with them, and in turn, respond when needed.

"Be an Easy Patient"

Participants assumed that nurses labeled patients in the hospital environment. Sociologist and tuberculosis patient Roth (1972) called this process "negotiating for social worth." Patients in the present study negotiated the social labeling process by being nice, friendly, and compliant; by conversing, remaining calm, and by trying not to "bother" or "burden" nurses. They were acutely aware of the difference between "good patients" and "bad patients" and described characteristics of each. Patients much preferred to be labeled an "easy patient" because the alternative, the "bad" or "difficult" patient, carried negative consequences they wanted to avoid.

Breeze and Repper (1998), Carveth (1995), and Finlay (1997) found that nurses often avoided or distanced themselves from patients who they labeled as "difficult." Findings from the present study are consistent with findings from these previous studies in that participants described situations in which they perceived themselves as having been negatively labeled by nurses who subsequently became both literally and figuratively distant. Nurses were observed to become inaccessible to patients who were perceived as "too demanding," "complained too much," or who were "not nice." Some participants chose to "be an easy patient" rather than to take action to "get them to listen" for fear of the negative social labeling that was possible with the latter. This created increased feelings of powerlessness in an environment that already produced this. Consistent with findings from the current study, participants in Irurita's (1996) study of the patient's perspective of quality of care also described the role of the "good patient." Irurita (1996) found that the good patient was "unselfish, uncomplaining, undemanding, and not wanting to ring the bell too often" (Initial Findings, ¶ 6).

"Try to Get Them to Listen"

Participants described trying to get nurses to listen to them. Unfortunately, most of the time they were not successful. In the words of one of the participants who is a nurse herself, "nobody listens to patients." When patients were unable to "get them to listen," they accommodated by adjusting their own behavior. For example, one participant stopped eating because she knew she had a bowel obstruction and another participant delayed eating dinner (that was delivered to his bedside before the hospital staff would check his blood glucose) to ensure that his glucose level would not rise abnormally. In both cases, the patient tried repeatedly to convince nurses, doctors, and other unknown hospital staff of their concerns, and in both cases, their pleas were unheard. Irurita (1996) also relayed patients' stories of nurses who "ignored patients" by "not listening to them."

The importance of having a family member or significant other present with hospitalized patients was an aspect of participants' descriptions of trying to get nurses to listen. For example, refer to Pat's quote in Chapter IV where she said she felt lucky that her friend was with her in the hospital because her friend demanded the nurses call the medical resident. Pat believed that it was only because her friend was present and watching over her that she received the care that she needed. This finding is consistent with that of Kools, Gilliss, and Tong (1999) who reported that "family hypervigilance" was present in their study of the psychosocial needs of young adult hospitalized congenital heart disease patients and their families. Hypervigilance was defined as "being ever present during hospitalization and continually monitoring nursing care to assess staff competence in meeting patient needs" (Kools, Gilliss, & Tong, 1999). One of the patient participants in Kools, Gilliss, and Tong (1999) described the negotiation between patients and families related to patient care: "I told my parents beforehand, hey, take over if you can see that I am having too much trouble on my own, and my parents have." Participants in the current study described similar situations when family or significant others spoke for them when they were unable to speak for themselves.

Implications for Theory

The experience of soliciting nursing care is grounded in the existential ground of the world (environment) of the hospital and this world (the hospital environment) is grounded in others. Interestingly, the existential grounds of body and time were *not* figural in either the current study or in a prior study of the world of the hospital (Shattell, 2002). Prior to interviewing research participants, one might assume that the patient's body would be figural since illness as a bio-medical problem is the predominant reason for hospitalization. Instead, the existential ground of others is predominant in the patients' lived experience of soliciting nursing care within the hospital environment. In addition to the existential phenomenological stance, as described previously, this social world can be viewed from the theoretical perspectives of symbolic interactionism (Goffman, 1959, 1967) and interpersonal nursing theory (Peplau, 1991/1952).

Goffman's Theory of Face Work

Participant descriptions from the current study and from Shattell (2002) simultaneously represented nurses as both "nice" *and* cold and distant, demonstrating patients' contradictory accounts of relationships with nurses. These patients' overall experiences of their nursing care appeared inconsistent with their initial representations of "nice" nurses and "good nursing care." These seemingly incongruent views can be conceptualized from the theoretical perspective of symbolic interactionism.

Symbolic interactionism is a philosophical perspective that originated from George Herbert Mead in the early 1900s and is a social psychological approach to studying the meaning of human action (Schwandt, 1998). Accordingly,

> A person's sense of self emerges through social interaction...a sense of self develops as people (a) imagine themselves in other social roles (seeing themselves as through the eyes of others and internalizing the attitudes of the

generalized other), (b) anticipate the responses of others, and (c) act in accordance with the meaning that things (other people, ideas, events, objects, or situations) have for them. (Powers & Knapp, 1995, p. 166-167)

Goffman (1955) coined the term *face work* to describe interaction rituals in human-to-human encounter. He defined the term *face* as "the positive social value a person effectively claims for himself [*sic*] by the line others assume he has taken during a particular contact" (Goffman, 1967, p. 5). A *line* is "a pattern of verbal and nonverbal acts by which he expresses his view of the situation and through this his evaluation of the participants, especially himself" (Goffman, 1967, p. 5). "Face does not reside in an individual but in the flow of events in an encounter" (Spiers, 1998, p. 29). This management of impressions of and by self and others was described in terms of a theatrical performance (Goffman, 1959) and Goffman (1967) theorized that people interacted in a cooperative dance to maintain the face of self and others.

The coexistence of two opposing views of nurses can be considered through face work theory. The patient's use of flattery may be seen as an attempt to maintain the face of self and other in a care-giving/care-receiving interaction. The patient strives for a favorable impression by the nurse, simultaneously attempting to maintain self-esteem and autonomy. Spiers (1998) advocates the use of face work theory in nursing research on nurse-patient communication since current communication theories used by nursing (stemming from the discipline of psychology) are inadequate to fully "explain how communication is directed by basic human and cultural needs—such as people's need for autonomy or to be part of the group, to be seen as competent, their self-esteem, and values" (p. 25). The use of face work theory can "illuminate how communication in interaction is negotiated and mutually constructed and how specific verbal strategies function in multiple ways to respond to the instrumental demands of the situation as well as the interpersonal needs of both participants" (Spiers, 1998, p. 26).

While face work is seen as universal, threats to face may be even greater in situations in which patients and nurses interact. For example, nurses are frequently in the position of asking probing questions about intimate personal matters and patients in a highly vulnerable health crisis are forced to depend upon nurses for basic needs. Both of these situations are illustrations of common nurse-patient interactions where the potential for the patient's loss of face (autonomy, self-esteem) is high. An understanding of nurse-patient communication from the perspective of face work theory may "provide an alternate lens for examining social phenomena of interest to nursing within the social construction of verbal conversation" (Spiers, 1998, p. 45).

Findings from this study, viewed from Goffman's (1955) face work theory, illuminate the social process of soliciting nursing care. Patients may attempt to act in ways they think nurses expect of them, in turn, saving the face of both nurse and patient. Patients maintain the cooperative dance between making their needs known (related to the theme "try to get them to listen") and by maintaining the face of the nurse by being a nice easy patient (related to the theme "be an easy patient"). Patients' manipulative attempts to build relationships with nurses could be viewed as the seduction of face work. Through the use of face work, patients seek to seduce nurses into caring for them, thereby assuring a safe hospitalization.

Peplau's Interpersonal Relations Theory

In addition to Goffman's (1955) face work theory, nurse-patient communication and the nurse-patient relationship may be conceptualized using Peplau's Theory of Interpersonal Relations (1991/1952). According to Peplau (1991/1952), "nursing is a significant, therapeutic, interpersonal process" (p.16). The nurse-patient relationship is central to this process and can be identified by four stages, orientation, identification, exploitation, and resolution. The goal of the nurse-patient relationship is "to promote forward movement of the personality in the direction of creative, constructive, productive, personal, and community living" (Peplau, 1991/1952, p. 16). Peplau described nursing as the "therapeutic use of self."

Goffman's Theory of Face Work (1955) and Peplau's Theory of Interpersonal Relations (1991/1952) describe, predict and explain patterned interactions between people. The phrase that Goffman uses is "interaction ritual" while Peplau uses "pattern integration." Both Goffman and Peplau describe patterned goal-directed ways in which people interact with one another. Goffman considers face management as the purpose of interaction, whereas Peplau conceptualizes interaction in terms of anxiety management. Goffman's (1967) aim is "to identify the countless patterns and natural sequences of behavior occurring whenever persons come into one another's immediate presence" (p. 2). Both Goffman and Peplau describe human interaction as *performance*. Goffman (1959) uses the term performance "to refer to all the activity of an individual which occurs during a period marked by his continuous presence before a particular set of observers and which has some influence on the observers" (p. 22). In the present study, participants' accounts of reciprocity in interactions with nurses could be viewed as performances. Patients perform for nurses in ways in which they hope will lead to more responsive nursing care. If patients' performances are convincing, nurses will more likely "be there" when patients need them. In other words, performance influences outcome.

Peplau (1991/1952), drawing heavily on the work of Harry Stack Sullivan, describes satisfaction and security as the two goals of interpersonal relations through the use of performance in interactions,

> Performances...are mainly 'security operations'...satisfaction, perpetuation of the species, participation in the ongoing stream of civilization, extension of the self into the community, interdependence are words that denote performances that have to do with affirmation and fulfillment of man's wants, goals, and desires so that new goals can be set and achieved by and for all of the people. (p. 79)

It is straightforward to recognize how interactions with nurses can increase security, especially in the life and death situations patients in the hospital find themselves. Patient performances are designed to fulfill the goal of surviving hospitalization.

Peplau also claimed that the nursing profession could be a social force in promoting change. Through the exploitation of individual therapeutic nurse-patient relationships, personalities would develop and grow and eventually move society forward. This sociological context of Peplau's Interpersonal Relations Theory (1991/1952) is evident in Peplau's own words:

> Human needs are expressed in behavior that has as its goal security or satisfaction of wants, desires, and wishes...when needs are met new and more mature ones emerge...paying attention to the needs of patients, so that personalities can develop further, is a way of using nursing as a 'social force' that aids people to identify what they want and to feel free and able to struggle with others toward goals that bring satisfaction and move civilization forward. Progressive identification of needs takes place as nurse and patient communicate with one another in the interpersonal relationship. (p. 84)

The nurses described by participants in the present study did not seem to use nursing as a "social force" in the way Peplau envisioned. The manner in which patients in the current study described their interactions with nurses does not fit Peplau's description of a social force since nurses did not seem to understand the patients' experiences of hospitalization and care needs.

The present study has depicted patients' contribution to the nurse-patient relationship and to nurse-patient communication. As noted by Peplau (1991/1952), "understanding of the meaning of the experience to the patient is required in order for nursing to function as an educative, therapeutic, maturing force" (p. 41). In a discussion of the orientation phase of the nurse-patient relationship, Peplau (1991/1952) states, "we are interested in *what happens when an ill person and nurse come together* [emphasis added] to resolve a difficulty felt in relation to health" (p.18). In this way, the existential meaning of the experience to both nurse and patient could be therapeutic, however, findings from this study do not support Peplau's theory in that there was no evidence of therapeutic relationships and no evidence of progression through Peplau's stages (orientation, identification, exploitation, and resolution). There was no evidence of patients and nurses working together to solve problems. The relationships that patients described were social, not therapeutic, according to Peplau's standards.

Peplau's theory was initially developed in the late 1940s and early 1950s for use in psychiatric/mental health nursing and during this time period, patients were hospitalized for months and sometimes years. Currently, lengths of hospital stays are short, the acuity of patients is high, and due to the nursing shortage and other healthcare reimbursement issues outlined in Chapter I, there are less registered nurses in the hospital setting. These issues coupled with the findings from this study make it questionable whether Peplau's theory still applies today. The nurse-patient relationship as Peplau had envisioned does not seem to exist in the world of the hospital. Implications for nursing practice, education and research will be discussed in the following sections.

Implications for Nursing

Practice

The concept of the nurse-patient relationship is embedded in nursing practice, education, research and theory. Most disciplinary writings focus on the nurse's role in developing such relationships. Findings from this study contribute to the literature by showing that patients have an equally vested interest in building a nurse-patient relationship. Although the "type" of relationship may be different from nurses' and

patients' points of view, the notion that nurses are in charge of forming these relationships does not tell the whole story. Participants in this study actively sought ways to form relationships, much like what the nursing literature suggests nurses do. This finding supports a small body of prior research that suggested that patients played a greater role in the nurse-patient relationship than previously thought. Not only do patients seek to develop relationships; they do so, in some cases, to enhance their chances of receiving quality nursing care. In addition to wanting a relationship for the secondary gain of quality care, some patients want genuine relationships with nurses for affiliation and connection.

As shown in this study, patients want deeper connections with nurses. A simple smile, a little conversation about topics outside of the "world of the hospital," and a quick hello as a nurse walks by a patient's room are the types of actions that facilitate the connections patients desire. These and other means of association are important to patients and, as this study and others have shown, can be accomplished in a short amount of time (Altchul, 1971).

Patients report an intense interest in social interaction. Findings from this study as well as previous research on the nurse-patient relationship, quality of nursing care, and the experience of hospitalized patients plainly reflect patients' interest in social interaction. Should nursing practice (and education) reexamine the "social versus therapeutic relationship" dichotomy that exists? Purely social conversation that affirms identity and facilitates connection perhaps should be given greater value in nurse-patient communication.

Patients in this study minimized complaints about care that was below appropriate standards of care. For example,

> I didn't see much concern for me as a person. It was like, 'today we're taking out the chest tubes,' 'now we're going to pull [out] that catheter.' There was no teaching. They just had their little check-off list and I was disappointed. But perhaps that takes a special kind of nurse. (Francine)

Francine minimized another negative care experience; "I was all night in a very bloody gown, very bloody sheets. It was just overnight. It was no big deal." Hank's unheeded attempt to get nurses to change the time of his blood glucose test (quoted in the previous chapter) was also minimized. As stated by Hank, "they were just doing what they were told."

Patient participants had a seemingly exaggerated appreciation and understanding for nurses' workloads. They were reluctant to ask for help from nurses because they did not want to take nurses away from other patients with "more serious needs." Nurses need to be aware that patients may have needs that go unspoken due to patients' hesitation to bother or burden nurses. Patient participants appreciated when nurses were "just there" and "checked in frequently" since they could then ask for what they needed (since the nurses were "already there") without having to call them and therefore feel like a burden on the their already arduous workload.

In the words of one participant, "the listening skills of the nurses" is a subject of great interest to patients. Patients' experiences of trying to get nurses to listen were not met with open acceptance. In fact, most attempts to get nurses to listen failed. Nurses

should understand that a patient's experience of his or her body as object is concurrently experienced as body as lived. Nurses could improve their understanding by taking a phenomenological perspective of clients by listening to their experience. Educating patients about their body as object (per the medical model view of the body, health, and illness) is another area where nurses could have a positive impact. Nurses could be more in tune with patients' experiences of their bodies (and illness) and listen to patients with a willingness and appreciation, for patients are the experts.

Education

The nurse-patient relationship as taught in undergraduate nursing education programs includes an emphasis on the therapeutic nature of the relationship, excluding social interaction. Undergraduate nursing students are taught the difference between therapeutic relationships and social relationships and are strongly encouraged to develop the former and not the latter. Patients in this study, however, spoke of the importance of relationships that were based on the model of friendships. The relationships that patients developed with nurses helped patients to connect, trust, and in some cases, facilitate quality nursing care. Should the nature of the therapeutic relationship include more of a social aspect? Should baccalaureate nursing education programs relax their mandate of the dichotomy between "therapeutic relationships" and "social relationships?"

Soliciting nursing care as described by the participants in this study involved a power imbalance in favor of nurses. Patients perceive themselves as powerless in an environment that demands their acquiescence to the structure and routine of nursing and medical care in the hospital setting. Patients attempt to get to know the nurses caring for them in order to trust the care that they provide. To assist in leveling the power imbalance, patients try to solicit care by manipulating ("seducing") others in the environment. Nursing education at all levels (baccalaureate, master's, and doctoral) should take this power structure into account.

Concepts common in nursing education are mutuality through goal setting and decision-making. The experiences of participants in this study showed that these concepts do not often exist in practice, as noted in previous studies (for example, Johnson & Webb, 1995). Patient participants did not experience openness and collaboration from the nurses with whom they came into contact. Nursing education could reexamine these concepts and perhaps reframe how they are viewed and taught. The use of phenomenological philosophy in educational programs might help bridge the concepts from theory to practice.

Research

This study makes a contribution to the research literature because the experience of soliciting nursing care in the hospital setting has not been described elsewhere. In addition, this study contributes to the body of knowledge of the nurse-patient relationship by showing that patients actively facilitate a relationship, which prior theory and research mainly attributed to nurses. The current study further contributes by advancing knowledge of the phenomenological method (Thomas & Pollio, 2002) by using findings from a previous study to connect with those of the current study. The structure of the

experience in the current study directly relates to the structure of the previous study. In this way, the phenomenological method, consequently knowledge, is advanced. According to Merleau-Ponty (1962), "phenomenology, as a disclosure of the world, rests on itself, or rather provides its own foundation" (p. xx-xxi).

The hospital environment of medical-surgical patients was the setting for the current study. Additional research could include a study of inpatient psychiatric patients' experiences of soliciting nursing care in that environment. The experience of family members of medical-surgical patients soliciting care by proxy would also be a future contribution to the research literature. Other institutional settings such as rehabilitation centers, nursing homes and other long term care settings could be studied to further knowledge on patients' experience soliciting nursing care. The study of patients' experiences soliciting nursing care in outpatient settings is another area for further research.

A serendipitous finding in this study that could lead to further exploration is the meaning of "nurse" and "care" from the patients' perspective. Participants in this study described their perceptions of the two concepts (nurse and care) in describing how they went about soliciting nursing care. The "nurse" in the hospital was described as being responsible for duties often unrelated to direct patient contact. Participants perceived nurses as accountable for tasks such as paperwork and answering the phone. Other caregivers, such as nursing assistants or nursing technicians, were in charge of direct patient care. Further research into the patients' perspective of "nurse" would be a fruitful area of study.

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APPENDICES

APPENDIX A

CONFIDENTIALITY PLEDGE OF RESEARCH GROUP MEMBER

I, _____, pledge to maintain confidentiality of all interview data discussed in the phenomenology research group let by Dr. Howard Pollio and Dr. Sandra Thomas at the University of Tennessee, Knoxville. Even though no names of participants or places appear on the typed transcripts, nor are any identifiers revealed during the group discussions, distinctive portions of dialogue or details of events could still be identifiable in some cases. This means that I will not reveal any words, phrases, or possible identifiers of research participants, in any conversations within or outside the university at any time.

Date: _____

APPENDIX B

INFORMED CONSENT FORM

INTRODUCTION

You are invited to participate in this research study because you have had an experience of seeking nursing care in an institutional setting (such as a hospital, rehabilitation facility, or nursing home). The purpose of this study is to explore the experience of seeking nursing care.

INFORMATION
You are eligible to participate in this study if you are at least 21 years old and are willing and able to talk about your experience. You will be interviewed by me at a private location determined by you. The interview will be audiotaped and will last approximately one hour.

RISKS/ BENEFITS
There is minimal risk to you by participating in this study. You may become emotionally upset when talking about your experience of seeking nursing care. The researcher will be aware of this possibility and be sensitive to your discomfort. You can end the interview at any time. Referral to a health care practitioner would be made if requested. There is no direct benefit to you for participating in this study. What we (I?) learn about the experience of seeking nursing care has the potential to help other people in institutional health care settings if nursing care delivery is enhanced.

CONFIDENTIALITY
All study records will be kept confidential. Signed consent forms, interview transcripts, demographic information sheets, and audiotapes will be kept in a locked file cabinet in the researcher's office. The person who transcribes the interviews will sign a confidentiality pledge. Members of the research team will also sign confidentiality pledges. Names and references to places will be replaced by pseudonyms. No references will be made in oral or written reports that could link you to this study.

COMPENSATION
There is no compensation for participating in this study.

CONTACT INFORMATION
If you have questions at any time about the study or the procedures, (or you experience some adverse effects as a result of participating in this study,) you may contact the researcher, Mona Shattell, at **address, **phone. If you have questions about your rights as a participant, contact the Research Compliance Services Section of the Office of Research at (865) 974-3466.

_____ Participant's Initials

PARTICIPATION
Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at anytime without penalty. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

I have read the above information. I have received a copy of this form. I agree to participate in this study.

Participant's Signature_____ Date _____

Investigator's Signature_____ Date _____

Vita

Mona Shattell was born in Syracuse, NY on February 27, 1964. She was raised in Syracuse and graduated from Bishop Grimes High School in 1982. She went to Syracuse University and received a Bachelor of Science degree in nursing in 1986 and a Master's Degree in psychiatric/mental health nursing in 1996. She has held numerous nursing positions in inpatient, outpatient, residential, and community health care settings in practice, education, and administration. She has presented research at local, regional, national, and international conferences. She is a member of Sigma Theta Tau and Phi Kappa Phi honor societies and was selected for inclusion in Who's Who Among Students in American Universities and Colleges. She received her Doctor of Philosophy degree in nursing from the University of Tennessee, Knoxville in May 2002.