Patients' and nurses' perceptions of respect and human presence through caring behaviours: A comparative study

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Abstract

Although respect and human presence are frequently reported in nursing literature, these are poorly defined within a nursing context. The aim of this study was to examine the differences, if any, in the perceived frequency of respect and human presence in the clinical care, between nurses and patients.

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A convenience sample of 1537 patients and 1148 nurses from six European countries (Cyprus, Czech Republic, Finland, Greece, Hungary and Italy) participated in this study during autumn 2009. The six-point Likert-type Caring Behaviours Inventory-24 questionnaire was used for gathering appropriate data. The findings showed statistically significant differences of nurses' and patients' perception of frequency on respect and human presence. These findings provide a better understanding of caring behaviours that convey respect and assurance of human presence to persons behind the patients and may contribute to close gaps in knowledge regarding patients' expectations.

Introduction

The concepts 'respect', 'human presence' and 'caring' are frequently mentioned but poorly defined in the nursing literature, while research evidence suggests that unarticulated similarities exist among a number of nursing sub-concepts such as human presence and caring.[1,2] All these sub-concepts pose a high level of abstraction, and although they are included in many national ethical codes[3–5] and international documents,[6] there is little clarity about what they mean. Evidence also suggests that nurses lack knowledge of nursing codes, adopt a conscious and unconscious use of these codes[5] and fail to proactively use such codes to shape their moral thinking and instead tend to rely on personal values and experiences.[4]

Caring is characterized by Gastmans[7] as a moral attitude in nursing, explaining that both the internal attitude and the external actions of a nurse are encompassed within the notion of caring behaviour, which is inherent in the moral practice of nursing. The 'moral value' and the ethical significance of caring in nursing are expressed through authentic human presence and the acceptance of the patient as a person in need of help, which is manifested as 'respect'.[7] Other authors have placed caring into a cohesive, context-specific interpersonal process[8,9] defined by an authenticity[10] that is characterized by intimate relationships, preceded by the nurses' moral foundation and having consequences for both the patient and nurse.[2] Caring and human presence have many overlapping components[8,9] in the sense that they both appear to involve interpersonal sensitivity, expert nursing practice and an intimate reciprocal relationship between the patient and the nurse.

The focus of respect as expressed in professional codes includes individuality, autonomy, dignity, privacy and other values and responsibilities. Gallagher[10] goes beyond this range of 'objects' and introduces three components of a meaningful and professional approach to respect in nursing practice, that is, acknowledgement, preservation and engagement.

The nursing literature presents abundant empirical evidence on caring, as shown in meta-synthesis studies,[1,8] literature reviews[11,12] and more recently in systematic reviews of caring behaviours.[13] Research has also revealed an incongruence between patients' and nurses' perceptions of caring and the importance of nursing behaviours that convey caring.[14]

Although human presence is a concept representative of caring behaviours within the nursing profession,[15] this is less explored and is often confused with other concepts, such as caring, empathy and support, or is fragmented into numerous sub-concepts.[1,15–17] Human presence is an interpersonal process characterized by sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances, which results in enhanced mental well-being for both nurses and patients and improved physical well-being for patients. Godkin and Godkin[15] offer an interesting approach, suggesting that caring behaviours mature and move from bedside presence to clinical and healing presence, supporting previous metaphysical ideas of physical, psychological and spiritual presence.[16] More recently, a meta-synthesis analysis of human presence in

nursing identified 14 qualitative studies in which nurses and patients define 'presence' as a close physical proximity that includes availability, attending to patients' personal needs and sensitive communication.[1,10] However, investigations related to the singular concept of presence remain immature, and the tendency to combine or confuse the term with caring inhibits useful analysis and understanding of the concept.

Theoretical and empirical literature on respect are even rarer,[10] although the concept has been explored in relation to other concepts such as dignity[18] and autonomy,[19] and has been described as a human right[10] or as an antecedent of caring.[10] The concept of respect has been studied in different settings, such as in forensic psychiatric studies on nurse–patient relationships.[10,20] It is described as a virtue – an action that requires exercise of moral imagination, meaningful engagement and authenticity – and not merely as an appearance.[10] However, although respect is fundamental to ethical nursing practice, it has not been adequately explored empirically. As a result, little knowledge exists that identifies how nurses develop, maintain and express respect for the patients they are caring for.[21] Evidence is also lacking concerning patients' perceptions on nurses' behaviours that convey presence and respect. In addition, no reports are available concerning nurse–patient interactions on planned care and whether these interactions are based on presence and respect.

Aims

The aims of this study were to answer the following questions:

1. What are the differences, if any, in the perceived frequency of respectful behaviours in clinical care between patients and nurses?
2. What are the differences, if any, in the perceived frequency of behaviours assuring human presence between patients and nurses?

Methods

Study design and setting

A multi-centre descriptive and correlational design was adopted. Six countries (Cyprus, Czech Republic, Finland, Greece, Hungary and Italy) were involved in this study.

Participants

The nQuery Advisor statistical software was used to determine the appropriate sample size for this study. The estimations required (for a 90% power level to be achieved, $\alpha = 0.01$) at least 223 completed questionnaires from patients and 150 completed questionnaires from nurses.

Both the patient and nurse samples were recruited from hospitals chosen by each partner country according to availability and proximity. The inclusion criteria for patients are as follows: hospital stay for at least 2 days (48 h) in a surgical general ward (in order to have received nursing care and be able to judge it), evidence of cognitive awareness, ability to communicate in their native language and willingness to participate in the study. A total of 1971 questionnaires were distributed to patients and 1659 were returned (response rate = 84, 17%). Questionnaires with missing data were removed, and a total of 1537 questionnaires were used for analysis.

Nurses were also recruited in terms of proximity. The inclusion criteria for nurses were as follows: being registered as nurses, willingness to participate, with at least 1 year of work experience, with direct contact with patients and working in the same surgical department where the patients are confined. A total of 1567

questionnaires were distributed, and 1195 were returned (response rate = 76, 26%). Questionnaires with missing data were removed and 1148 were eligible for the analysis.

Measure

The six-point Likert-type (1 = never to 6 = always) Caring Behaviours Inventory (CBI)-24 was used in this study. This instrument is a short version of the CBI developed primarily by Wolf et al.[22] It is based on Jean Watson's Transpersonal Caring Theory[23] and has contributed to the validation of that theory. The CBI-24 is used to explore the perception of the frequency of caring behaviours as practised by nurses/received by patients (the higher the mean of responses, more frequently the caring behaviours are perceived). It has been used in different clinical settings (oncology and surgical departments)[24] and can be administered (the same version without changes) to both patients and nurses. It measures four factors: CBI-Assurance of Human Presence (eight items), CBI-Knowledge and Skill (five items), CBI-Respectful Deference to Others (six items) and CBI-Positive Connectedness (five items).[24,25]

Preliminary authorizations to the use of the CBI were requested and obtained from its author (Wolf, personal contact, 2008). Agreements were also obtained for the copyright of each translated version, and the author agreed to any modifications that the research group has considered necessary.

The instrument was translated into the participating countries' languages by forward-and-back translation processes[26] and submitted to a national panel of experts for assessment of content validity. Each English-translated version was compared with the originals in an international meeting involving the study partners; agreement was established on the semantic and content equivalence of each item. Further advice was obtained by the author on the administration process and on other queries that arose during the meeting. A pilot study among 30 clinic nurses from each participating country preceded the main data collection to test the questionnaires in terms of clarity of instructions and content. No changes were required at this stage.

Data collection procedures

The main data collection was carried out from September to November 2009. Contact persons, appointed by each country partner, were responsible for distributing the CBI-24 accompanied by a demographic data sheet and a cover letter explaining the aims and the voluntary nature of the study and assuring about the anonymity of the collected data. Patients and nurses meeting the inclusion criteria were verbally invited to participate in the study. Patients who agreed to participate were given the questionnaire and instructed to return it sealed in an envelope (provided) to a closed box specifically prepared in each country (located at the ward nursing manager's office), on the day of their discharge from the hospital. Similarly, nurses were asked to return the completed questionnaires, sealed in an envelope (provided), in a closed box located at the ward manager's office. Verbal reminders to nurses for returning the questionnaires were made 1 and 2 weeks after their distribution in order to increase the response rate.

Authorizations and ethical issues

The widely accepted ethical standard by Beauchamp and Childress[27] was followed in this study. The Minister of Health of Cyprus (Y.Y. 5.14.02.4(2)) and the Cyprus National Bioethics Committee (EEBK/EΠ/2008/1) approved the research protocol, as Cyprus was the coordination point for the project. According to the ethical policy of each country, approvals from internal review boards and/or ethical committees were obtained by each participating country. Each participant was free to participate, refuse or withdraw at any time, without any consequences. The return of completed questionnaires from both nurses and patients was considered as consent for participation. Completed questionnaires were sent by each participating country to the project

leader country (Cyprus), using safe procedures. In each country, data were protected securely (both in electronic and paper form) and had restricted access.

Data analysis

Statistical analysis was centrally performed by the project leader country (Cyprus). Data were analysed using SPSS v16 for windows (SPSS Inc., Chicago, IL, USA). Preliminarily, CBI-24 internal consistency was assessed: Cronbach's α was 0.94 for the nurses' sample and 0.96 for the patients' sample. Demographic data were analysed using descriptive statistics, such as frequencies, percentages and means and standard deviations (SDs). For the purpose of analysis, ordinal data (Likert-type scale) were combined into two categories. The first category incorporated the options 'never', 'almost never' and 'occasionally', whereas the second category incorporated the options 'usually', 'almost always' and 'always'. The first category was considered as showing a negative practice/experience towards presence and respectful behaviours (less frequently practised by nurses/experienced by patients), and the second category was considered as showing a positive practice/experience (more frequently practised by nurses/experienced by patients). Percentages were calculated to analyse ordinal data (frequency of behaviour reported). Analysis was performed on an item level, using the two factors under study (respect and presence). The chi-square test was initially performed to examine possible differences among patients and nurses on the items of the two factors. However, because in all tests, a number of cells in the contingency table have an expected count of <5, it seemed more appropriate to use the Fisher's exact test for testing differences.[28,29]

Results

Description of the samples

A total of 1565 patients and 1148 nurses, from 88 wards of general surgery from 34 hospitals of six different European countries, participated in this study.

Patients: The patients' mean age was 54.4 (SD = 16.7) years, and the mean days of hospitalization was 9.7 (SD = 11.9) days. Most of the patients (51.2%) were women, had previous hospital experience (76%) and had a planned admission for their current hospitalization (67.7%). The majority of the patients had a secondary (40.6%), primary (24.7%), college (20.6%) or university (12.7%) education, and a small minority was not educated at all (1.5%). Most of the patients had undergone some kind of surgery (80.8%). Almost 92% perceived their health condition to be between fair and very good.

Nurses: The nurses' mean age was 38.1 (SD = 10.2) years, and their mean working experience was 15.5 (SD = 10.3) years, while their experience in the surgical unit was 9.4 (SD = 8.5) years. The majority of the nurses worked on a full-time basis. Most of them were women (91.9% female nurses and 8.1% male nurses). With respect to nursing education, 41.5% reported as having a diploma in nursing (3 years), 27.6% had a bachelor of science in nursing, 2.7% had a master's degree and 27.9% reported as having a 2-year nursing education.

Respectful deference to others

As presented in Table 1, differences of opinion between nurses and patients are statistically significant on all items included in the factor Respectful Deference to Others (p < 0.001), with the exception of the item 'attentively listening to others'. Although the tendency of both patients and nurses was to answer towards the positive side of the scale, it is interesting to note that the percentage of patients who gave negative

Table 1. Patients' and nurses' ratings on the category 'Respectful Deference to Others'

Item	Total	Negative side of the scale, n (%)	Positive side of the scale, n (%)	Chi-square (df = 1)	p value
Q1: Attentively listening to the patient	N: 1144	104 (9.1)	1090 (90.9)	0.154	0.695
	P: 1552	148 (9.6)	1404 (90.4)		
Q3: Treating the patient as an individual	N: 1139	76 (6.7)	1063 (93.3)	40.33	<0.001
	P: 1539	223 (14.5)	1316 (85.5)		
Q5: Supporting the patient	N: 1141	126 (11)	1015 (83.9)	17.662	<0.001
	P: 1542	259 (16.8)	1283 (83.2)		
Q6: Being empathetic or identifying with the patient	N: 1136	157 (13.9)	979 (86.2)	44.579	<0.001
	P: 1535	372 (24.2)	1163 (75.8)		
Q13: Allowing the patient to express feelings about his or her disease and treatment	N: 1124	122 (10.8)	1002 (89.2)	20.064	<0.001
	P: 1521	281 (18.4)	1240 (80.9)		
Q19: Meeting the patient's stated and unstated needs	N: 1125	93 (8.3)	1032 (91.7)	35.707	<0.001
	P: 1480	239 (17.1)	1241 (83.8)		

N: nurses; P: patients.

Table 2. Patients' and nurses' ratings of the category 'Assurance of Human Presence'

Item	Total	Negative side of the scale, n (%)	Positive side of the scale, n (%)	Chi-square (df = 1)	p value
Q16: Returning to the patient voluntarily	N: 1122	224 (20)	398 (80)	20.5	<0.001
	P: 1498	414 (27.6)	1084 (72.4)		
Q17: Talking with the patient	N: 1123	142 (12.6)	981 (87.4)	47.811	<0.001
	P: 1503	350 (23.3)	1153 (76.8)		
Q18: Encouraging the patient to call if there are problems	N: 1125	23 (8.8)	1059 (94.2)	32.153	<0.001
	P: 1500	187 (12.5)	1313 (87.5)		
Q20: Responding quickly to the patient's call	N: 1123	59 (5.3)	1064 (94.8)	45.708	<0.001
	P: 1494	197 (13.2)	1297 (86.8)		
Q21: Helping to reduce the patient's pain	N: 1124	29 (2.6)	1095 (97.4)	12.746	<0.001
	P: 1499	81 (5.4)	1418 (94.5)		
Q22: Showing concern for the patient	N: 1125	46 (4.1)	1079 (95.9)	21.025	<0.001
	P: 1500	129 (8.6)	1371 (91.5)		
Q23: Giving the patient's treatments and medications on time	N: 1120	32 (2.9)	1088 (97.2)	0.922	0.337
	P: 1500	50 (3.6)	1449 (96.4)		
Q24: Relieving the patient's symptoms	N: 1122	36 (3.2)	1086 (96.8)	4.811	0.028
	P: 1496	74 (5)	1422 (95.1)		

N: nurses; P: patients.

answers is much higher than the percentage of nurses. For example, patients' negative answers in the item 'treating the patient as an individual' (14.5%) are more than double that reported by nurses (6.7%), and the difference is statistically significant (p < 0.001). The same picture can be seen in all items, with the larger gap being in the item 'being empathetic or identifying with the patient' (negative answers, 24.2% for patients vs. 13.9% for nurses; p < 0.001), 'allowing the patient to express feelings about treatment and disease' (negative answers, 18.4% for patients vs. 10.8% for nurses; p < 0.001) and 'meeting the patients' stated and unstated needs' (negative answers, 17.1% for patients vs. 8.3% for nurses; p < 0.001). A careful look at Table 2 would also show that compared with patients, nurses' answers are more frequently on the positive side of the scale, and the difference is statistically significant.

Assurance of human presence

The test results of the eight items incorporated in the factor Assurance of Human Presence as well as the significant statistical differences between patients and nurses are presented in Table 2. As in the case of Respectful Deference to Others, patients' percentages are higher on the negative side of the scale than those reported by nurses. For example, the item 'talking to the patient' was negatively rated by 23.3% of patients and only 12.6% of nurses (p < 0.001). Similarly, the item 'responding quickly to the patient's call' was negatively rated by a higher percentage of patients (13.2%) when compared with nurses (5.3%), with a statistically significant difference (p < 0.001). Patients' and nurses' perceptions on the item 'showing concern for the patient' were also significantly different (p < 0.001), with more patients reporting negative feelings (8.6%) when compared with nurses (4.1%). Another interesting finding is that less patients (94.5%) than nurses (97.4%) report receiving/providing help to reduce the patient's pain (p < 0.001) or to relieve their symptoms (patients 95.1% vs. nurses 96.8%, p = 0.028). However, there is agreement on the technical aspects of nursing, where patients and nurses similarly rated the item 'giving medications and treatments on time' (patients 97.2% vs. nurses 96.4%, p = 0.337).

Discussion

The results of this study revealed that there is a lack of convergence between nurses' and patients' opinion on the perceived frequency (provided and received, respectively) of respectful behaviours in clinical care and caring behaviours that convey assurance of human presence. Although some differences were expected, the most important finding is that nurses report performing certain nursing behaviours more frequently than patients perceive, in almost all of the questions asked. On the patients' side, there are more responses towards the negative side of the frequency scale when compared with the nurses' responses. This shows an incongruence between nurses' and patients' perceptions on the frequency of provided/received nursing care, and this observation is supported by the literature.[14]

Behaviours perceived as human presence

A mismatch between the patients' and nurses' perceptions of the frequency of caring behaviours assuring human presence has emerged in this study. The patients in this study experienced a lack of communication with nurses, which is relevant both to the concepts of human presence and respect, and is an important strategy for maintaining dignity in care.[30]

However, beyond personal characteristics, cultural background and educational background, the nurse–patient relationship is influenced by many other factors that are out of the nurse's control. For example, the caring environment[31] and some organizational factors (e.g. high workload)[32] could be poorly perceived by patients but are highly perceived by nurses, resulting in a dissonance between patients' and nurses' expectations in caring behaviours. In detail, nurses could more frequently perceive performing some behaviours that express human presence according to the environment where they work, while patients might less frequently perceive the same behaviours according to their expectations.

The findings of this study might also be considered in light of the complex nature of nursing practice where priorities need to be continuously defined. In their answers, the nurses expressed their perceptions towards the entire group of patients; however, because of the differences in patient needs, the nurses possibly enacted their human presence differently in terms of frequency among these patients. Patients experiencing cognitive decline or confusion and patients in their first or second post-operative day were excluded from this study. These last two types of patients have a high requirement for nursing care, so their perceptions were not collected. On the other hand, each patient has expressed his or her personal

experience or at least the experience as it had occurred in his or her hospital room (in some hospitals, shared with one or two other patients).

Our findings might also be a consequence of a general shortage in nurses and other issues in clinical practice that are related to economic crisis. Many hospitals have reduced the available nursing positions by introducing nurses' aides, and this has substantially decreased the possibility for the nurses to stay with patients. Nurses are also called in every day for several administrative tasks that are well recognized as non-value-added care. In these activities, they spend a lot of time away from the patients. Under this perspective, it is not surprising that the 'technical'-based items of the human presence factor, such as 'giving medications on time', did not show a different frequency between patients' and nurses' perceptions, while 'relational'-based items were perceived differently by the two groups. Nurse shortages, changes in the skill mix and hospital settings may have assured essential levels of care based mainly on technical aspects but took away the opportunity for performing 'soft' caring behaviours. This is more worrying when caring behaviours concern relieving patients' symptoms, helping reduce pain,[33,34] or showing concern because this side of caring is less perceivable by patients than what nurses believe.

Although the majority of the patients in this study positively rated the care provided by nurses in all aspects of Assurance of Human Presence, the findings show that there is still space for improvement. For example, almost one-fourth of the patients were not satisfied with the frequency that nurses talk to patients. This is a very important aspect of nursing care, as very often patients need another person to talk to and to listen to them, not necessarily to complain but to express their current emotions (e.g. anger, sorrow). Talking to patients shows concern about them and that their opinion is being taken into consideration; it is also a great opportunity for nurses to assess the patients' health condition, to recognize in advance their deterioration and, ultimately, to reassure, educate and inform and improve their own communication skills. It also contributes to the establishment of a trusted relationship between nurses and patients, which may make patients progressively more willing to participate in their own care.

The degree of improvement in human presence related with individual (e.g. education) or organizational (e.g. workload skill mix or non-nursing tasks attributed to nurses to compensate for the lack of hospital resources) factors should be evaluated to identify the appropriate level of interventions necessary for further improvement. For example, the standards of nursing education on human presence are not defined in the European level. Also, in several countries, patients complain of the lack of availability of nurses at the bedside and a general shortage of nurses, but there are no standards on the minimum nurse-to-patient ratio in hospitals.[35] The role of policies should also be considered when reflecting on the level of improvements needed. Items related to human presence could be sensitive to environmental/organizational factors; for example, they should reflect national health service, hospital or ward policies. At the time of data collection, a worldwide economic crisis was arising, affecting national health services. A between-country and within-country approach could better address improvement strategies to ethically manage the public economic resources, in order to provide better care in a cost-effective way.

Respectful deference to others

As with Assurance of Human Presence, the majority of patients and nurses positively rated the care received/provided under Respectful Deference to Others. Nevertheless, there was also a marked difference on this item, with the patients reporting less frequent perception of care. An important issue of respect – involving 'treating patients as individuals' and 'meeting their stated and unstated needs' – was rated lower[36] by patients in the positive side of the scale, suggesting differences in perception of what 'individualized care' means and confirming a divergence of opinion between patients and nurses.[37] Notably, among the 1565 patients involved, few answers were collected in particular for the item 'meeting their stated and unstated needs', probably because the meaning of this item is too complex for the patients to understand.

In a dyadic patient–nurse relationship, it could be useful and ethical to deepen the same phenomenon in the perspectives of both actors, for example, by assessing the degree of respectful behaviours patients perform towards nurses. Currently, there is growing research interest on incivilities in health-care settings[36,38] in relation to uncivil behaviours of patients, caregivers, supervisors and physicians towards nurses. In an uncivil organizational environment, unethical relationships exist among team members, resulting in low group cohesiveness[39] and possibly decreasing the desire of nurses to perform respectful behaviours towards their peers. For this reason, a multi-source assessment on the occurrence of lack of respectful behaviours among nurses is needed to understand the antecedents.

Implications for practice

A mismatch between patients' and nurses' perception of the frequency of human presence and respectful behaviours in clinical practice has different implications for the nursing community at different levels. At the individual level, periodically evaluating the congruence between patients' and nurses' frequency of perception might prompt nurses to critique their own attitudes and maintain their sensitivity towards patient needs. At the team level (individuals and ward), strategies to improve the patient–nurse relationship might be offered by continuing education centres as a lifelong learning strategy. Also, in times of resource scarcities, organizational strategies might help nurses set relational priorities aiming to address their human presence within the group of patients they care for. At the educational level, specific standards of competence might be discussed and established, supporting students in their achievements with educational and tutorial strategies. At the organizational level, recruitment and skill-mix policies consistent with providing high-quality nursing care should be developed.

On the other side of the ethical relationship, it is necessary to consider not only the patients' rights but also their duties in the health-care setting in order to ensure a mutual respectful relationship.

Limitations

Although this study is the first of its kind to be conducted in Europe in terms of sample size, and although every effort was made to achieve a high level of validity (use of the same protocol by all partners, sample estimation and group meetings), some limitations must be taken into consideration when interpreting the findings. First, the lack of randomization and the use of a convenience sampling method might have affected the generalizability of the findings.[40] Also, because patients and nurses were selected on the basis of their proximity to researchers, they might have had common perceptions on caring behaviours, and this might have introduced a selection bias. Second, the variability in education level among nurses in Europe may have also influenced the study findings. In addition, certain geographical factors may have also influenced the findings, as some countries gathered their data only from major hospitals in specific areas, mainly for reasons of accessibility. Finally, the use of self-completed questionnaires might have led to a self-report bias.[41]

Conclusion

Contemporary nursing is in the middle of continuous anti-theses between caring as a humanistic profession; the limited economic and human resources and the legal, political and technological frameworks of health-care systems. This article might trigger the ongoing debate about the nature of caring and how nursing puts caring into practice through behaviours that address the specific needs of the person being cared for and convey the values of respect and human presence. Caring is a complex process involving the actions and interactions of patients as well as those of nurses; therefore, exploring the patients' perspective together with

nurses' views, coming to some agreement towards a shared definition of nursing phenomena and concepts and then translating them into practice, is of utmost importance.

Conflict of interest

The authors declare that there is no conflict of interest.

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