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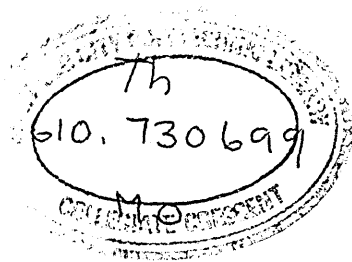# THE MEANING OF CARING INTERPERSONAL RELATIONSHIPS IN NURSING

by

PAUL ANTHONY MORRISON

A thesis submitted to the Council for National Academic Awards in partial fulfilment of the requirements for the degree of Doctor of Philosophy

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THE MEANING OF CARING INTERPERSONAL RELATIONSHIPS IN NURSING

PAUL ANTHONY MORRISON

ABSTRACT

This thesis explores nurses' and patients' perceptions of caring relationships in a hospital context. An attempt is made to discover the meaning these caring relationships have for the nurses who provide care and for the patients who participate in this process. The nurses enter into the caring relationship as voluntary and professional participants. The patients come into hospital because of illness. The relationship entered into is claimed to be a caring relationship yet little is known about the personal experiences of the participants.

In the first part of the study the repertory grid technique was used to structure interviews with 25 experienced nurses. Personal constructs were elicited and rated during the interviews. Six major themes emerged from a content analysis of the constructs. These were: personal qualities, clinical work style, interpersonal approach, level of motivation, concern for others, and use of time. The personal cost of caring for the nurses surfaced as a significant aspect of the caring relationship.

In the second part of the study 10 nurses and 10 hospitalised patients were interviewed. These were analysed by means of a method grounded in interpretive phenomenology which focuses on the informants' lived experiences. Nine general themes emerged which captured the nurses' experiences of caring relationships. The themes were: patient dependency, patient circumstances, effectiveness, emotional involvement, stress, preparedness, ward constraints, role uncertainty, and personal benefits. The patients' experiences of being cared for were embodied in four general themes quite different from the nurses. The themes were: vulnerability, self-presentation, service evaluation, and other concerns.

The thesis provides many details about the perceptions of caring relationships through the exploration of the lived experiences of nurses and patients in hospital. An extended picture of caring relationships in nursing has emerged. The need to take account of both the professional and consumer perspective is emphasised as it highlights important discrepancies between the views of carers and those they care for. Professional carers must be able to understand the patient in order to care in a personalised way and the approach used here demonstrates how this understanding can be achieved. Such an approach could also be used in nursing practice. The findings and methods used here should also be of interest to other helping professions and consumers of health care.

PREFACE

Denzin (1989) emphasised recently how the biography of the researcher is a crucial element in any interpretive research endeavour:

> Interpretive research begins and ends with the biography and the self of the researcher. The events and troubles that are written about are ones the writer has already experienced or witnessed firsthand (Denzin 1989, p.12).

As the thesis unfolds an interpretive approach is adopted for developing an understanding of the informants lived world and the biography of the researcher becomes an important aspect in developing that understanding. The biography of the researcher is part of the hermeneutic circle (Heidegger, 1962). It is essential therefore that the important facets of my own background and experience, which have shaped the research reported here, are portrayed from the outset. This should provide the reader with the necessary background details about my own interests and development and set the research within a particular and personal context.

In the late 1970's and early 1980's I trained as a psychiatric and general nurse, but became very dissatisfied with the mundane stress of working as a nurse. On many occasions I felt that I was nothing more than a small cog in a very large first aid station which dealt with chronic emergency cases who returned to the hospital setting again and again with the same complaint. I left the health service and became a full time student of psychology at university. I chose psychology because I wanted to learn more about myself and other people. However, the training in psychology was very traditional. As well as the standard topics in the field of psychology, there was a comprehensive course on research design, methods and statistics with a commitment to the experimental method as the method of choice in research. Qualitative methods were frowned upon because they could not establish 'causal' links between variables, did not lend themselves to laboratory based research and were very much more difficult to analyse. In my desire to be a good psychologist I followed the traditional approach diligently.

On returning to the world of work in the health service I wanted to continue to do research but found that most of the frameworks which I held dear as a psychology student, were of little use in the context of *real patients* and *real nurses* at work. Here there was no laboratory, no experimental apparatus or statistical packages. Instead I met ill people who needed help and professionals who claimed to be helping them. Some revision of my ideas was necessary. There was a need to explore new frameworks so that I could commence a postgraduate study which focused directly on the nurse and the patient. The notion of a 'caring relationship' captured my attention: why do some nurses really care? why are so many nurses uncaring? why are patients so appreciative of anything that is done for them in hospital? does a professional training as a nurse make a caring nurse? Changes in the delivery of care such as the emphasis on community care also helped to focus my attention on this area. As a charge nurse

I saw many patients being discharged into a community which could not possibly support them.

A small number of texts were found to be stimulating and challenging during a period of initial reading and preparation for the project. Three in particular proved particularly challenging: Giorgi's (1970) *Psychology as a Human Science: a Phenomenologically Based Approach*, Keen's (1975) *A Primer in Phenomenological Psychology*, and Reason and Rowan's (1981) *Human Inquiry: a Sourcebook of New Paradigm Research*. These seemed to provide a framework for studying the things I found to be of interest. However, my previous training and conditioning encouraged me to be very cautious about how to proceed, and I couldn't discard all of my earlier training and take up these new (to me) approaches wholeheartedly. These approaches were attractive to me because they focused on people in real settings as opposed to a laboratory. They offered techniques for collecting and analysing data and acknowledged the importance of the role of the researcher as well as the informants.

My earlier training reinforced the need for precise measurement, control, and rigour so I had to continue my search for a method which would allow me to tap elements of both approaches and establish a compromise. The theory of personal constructs (Kelly, 1955) appeared to provide some of the *structure* which was an integral part of my earlier training in psychology as well as some of the *freedom and creativity* which I found in the work of Giorgi (1970) and Keen (1975). Personal Construct Theory (PCT) allows the researcher to tap the informant's perceptions of his or her world and attempts to capture these perceptions in a very organised manner that is easily analysable.

The principal stages in the study are summarised in figure 1. The first part of the research described in this thesis shows how Personal Construct Theory and the Repertory Grid technique were used to structure interviews with a group of experienced nurses to explore their perceptions of (1) caring relationships and (2) their perceptions of themselves as professional carers. The process of doing these essentially qualitative but well structured interviews encouraged me to use an even more qualitative approach in the second part of the study. After the grid-centred interviews were completed and analysed, the most important questions which emerged from the findings could not be answered quantitatively. In addition, by that time I had completed much more reading about phenomenological research methods and felt confident enough to undertake more qualitative work.

The second part of the thesis starts with a description of existential phenomenology and phenomenological research methods. This approach was used to structure and analyse qualitative interviews with nurses and patients in hospital and followed on naturally from the first part of the study. The main focus was on how the nurses involved in the research experienced *caring for another person* and how the patients in hospital experienced *being cared for*.

PART ONE	
Methods of Data Collection	Methods of Analysis
Interviews with a strategic informant sample of ward sisters and charge nurses using the repertory grid technique (n=25)	Content analysis and calculation of simple difference scores for each informant
PART TWO	
Focused in-depth interviews with nurses of different grades (n=10)	Grounded in interpretive phenomenology
Focused in-depth interviews with hospitalised patients (n=10)	Grounded in interpretive phenomenology

Figure 1. Summary of the principal stages in the study.

One of the major problems I faced during this time was the fact that I was employed on short term contracts for the duration of the study. Data was collected in a hurried fashion because I did not want to have to set up a new programme of research, had it been necessary to move to another job during the study. This factor has not seriously hindered the quality of the data which I acquired.

As part of my general research education I completed a 9 hour course on the use of the mainframe version of SPSS at the University of Wales College Cardiff and undertook a programme of guided reading in research methods which included the following: Ashworth et al. (1986), Bryman (1988), Douglas (1985), Ginsburg (1979), Miles and Huberman (1984), Orenstein and Phillips (1978), Reason and Rowan (1981), and Skevington (1984).

Getting the thesis to its finished state has been an arduous but invaluable learning exercise. During the course of doing this research I learned a great deal about the theoretical and practical issues involved in human research. This thesis therefore is a reflection of my own personal and academic development over the last five years. I have tried to ensure that the thesis is readable, interesting and relevant to a range of professional helpers and nurses in particular. I believe that researchers have a responsibility to write in a fashion which is understandable to their informants, subjects, consumers and colleagues. If the findings and approaches used in this thesis are to be used in applied areas, then the thesis itself must appeal to a diverse audience. My ambition has been to produce something of practical use, for as Kurt Lewin the social psychologist said:

Research that produces nothing but books will not suffice (Lewin, 1946, p.35).

As with most projects of this nature the number of specific tasks and sub-goals necessary to complete the overall project is enormous. I found it particularly helpful to break up the task into discrete units of work. This process helped to clarify my own thinking and development. Several sections of my early attempts at writing up parts of the thesis have been published in modified form and include the following:

Morrison, P. (1988) Nurses' perceptions of caring. *Nursing Times*, 84, 9, 51. (Chapter 4).

Morrison, P. (1989) The caring attitude: nurses' self-perceptions. *Nursing Times*, 85, 4, 56. (Chapter 4).

Morrison, P. (1989) Nursing and caring: a personal construct theory study of some nurses' self-perceptions. *Journal of Advanced Nursing*, 14, 421-426. (Chapters 3 and 4).

Morrison, P. (1990) An example of the use of repertory grid in assessing nurses' self-perceptions of caring. *Nurse Education Today*, 10, 253-259. (Chapters 3 and 4).

Morrison, P. (1991) The caring attitude in nursing practice: a repertory grid study of trained nurses' perceptions. *Nurse Education Today*, 11, 3-12. (Chapters 3 and 4).

Morrison, P. (1991a) *Caring and Communicating: The Interpersonal Relationship in Nursing.* Macmillan, London, (with P. Burnard). (Chapters 1, 2, 3 and 4).

Morrison, P. (1991b) *Caring and Communicating: Facilitators' Manual.* Macmillan, London, (with P. Burnard). (Chapters 1, 2, 3 and 4).

ACKNOWLEDGEMENTS

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CHAPTER 1
ALTRUISM, HELPING AND CARING IN PSYCHOLOGY

Introduction

This chapter introduces some of the theoretical frameworks which have guided research into altruism and helping behaviour in the field of social psychology. These provide a background for the present study. Much of the research has been criticised however and the grounds for this criticism are reviewed. The empirical work on altruism and helping in social psychology may provide useful leads and theoretical frameworks for researchers exploring the professional helping role. The concept of caring or psychological care has recently emerged in the literature on professional helping relationships, but it remains a neglected area of clinical research. The notion of the caring relationship within the context of nursing practice forms a crucial part of the present study.

Altruism and helping behaviour in social psychology

The concept of altruism has a long history in social science research (Brown, 1986; Krebs and Miller, 1985). In spite of the considerable interest in the field for many years, it is only over the last 20 years that the study of altruism and helping behaviour has become a major force in social psychology (Smithson et al. 1983), with a thriving research domain (Clark, 1991). A number of strands of investigation have evolved but only those approaches which are directly relevant for the present study are mentioned here. These may be classified under the heading of social-psychological studies of altruism.

Social-psychological studies of altruism

The social-psychological study of altruism which was greatly influenced by Auguste Comte (1798-1857). Comte coined the term 'sympathetic instincts' of man, and believed that the 'purpose of an advanced society was to foster the love, and even the worship of, humanity...' (Rushton and Sorrentino, 1981, p.10). This strand embraces a number of different approaches including: social learning; equity theory; personal or situational factors which influence helping, and attribution theory.

(1) The social learning approach

In this approach helping may be defined as a process that is learned from other people through the mechanisms of reinforcement, observation and role modelling. Helping behaviour may be conditioned by reinforcement, whereas unsociable behaviour may be punished (Rushton, 1980). The social learning approach has been found to be especially useful in studies of how children learn to help others. Fisher (1963) for example, found that reinforcement could be used to increase sharing behaviour in four year old children. Others have also reported that helping and altruistic behaviour are facilitated through good role models (Bryan and Test, 1967).

However, the extent to which this model may be used in the present study is limited because of its narrow and specialised range of application with children. The theory is also very general and this too is a limitation of the approach when trying to understand a complex social setting like a hospital ward. Nevertheless, the role of professional socialisation in an institutional setting should not be overlooked (see chapter 8). In a professional context, established team members play an important role in the training and education of learners and untrained staff. They are important role model figures.

(2) Social exchange theory

Another approach which spans the social-psychological area is social exchange theory (Baron and Byrne, 1987). Social exchange theory is characterised by the idea that social behaviour may be considered in terms of rewards and costs which are governed by the norms of *equity*. These norms emerge in society so that when an individual helps another individual, he or she can expect to be rewarded according to the cost of the effort needed to help that other person. The rewards-costs equation needs to be kept in a state of *balance*, if it is not, then the helper may experience distress. When a balance is achieved and people feel they have been treated fairly, they are more likely to be cooperative. In normal social interaction some individuals will try to minimise their costs and maximise their

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benefits. While this theory appears rather simple and mechanistic, it does have relevance for the present study. The costs of establishing and maintaining caring relationships with patients is constantly reviewed by hospital staff (see chapters 4 and 6).

(3) *Selected variables used to predict helping*

Less theoretically expansive approaches have tried to identify relatively distinct variables which have been used to predict helping in a variety of settings. Two major trends have been described. The first trend focuses on studies which attempted to identify stable personal characteristics or traits. The second trend centres on the distinctive properties of the particular setting in which help was given. The personal attributes identified with some consistency are personal norms such as *a sense of moral obligation to help* (Schwartz, 1977), and *empathy* (Coke et al., 1978). The context too has been found to be influential in determining whether or not help was given. For example, the perceived seriousness of the situation; the possible cost to the helper; and the perceived competence of other helpers have been found to influence potential helpers (Smithson et al., 1983).

Researchers working within this approach tend to employ specific scales or other quantitative social-psychological research techniques to measure relevant variables. The aim is to establish statistical correlations between these sets of variables. In the present study no specific measures or behaviours were used in this way, so the approach is not particularly relevant here. However, some of the findings to emerge from these studies may be relevant to those of the present study. Approaches which concentrate on particular variables used to predict helping may be criticised for the heavy emphasis placed on hypothesis testing. While such an approach may lend itself to tightly controlled research design, it ignores the need for research which attempts to discover new experiences or phenomena. As a direct result of this orientation, the basis for the selection of particular variables is often unclear.

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Criticisms of the traditional approaches

These traditional approaches to the study of altruism and helping behaviour have been criticised. Much of the research has been of limited use in applied or professional fields such as teaching, medicine, nursing and other helping professions. One reason for this lack of application stems from the dominance of positivist methodology in the research. Smithson et al. (1983) summarised this weakness as follows:

> The dominant tradition in social psychological research has been an experimental, laboratory-based mode of inquiry. Researchers using this approach attempt to understand important social behaviour through the control and manipulation of factors which influence simulated forms of the target behaviours. This research reflects a positivist philosophy of science and a limited deterministic view of human action (p.2).

Consequently, much of the research completed to date has been criticised on the grounds of having low external validity in the real world, having a limited perception of human action and experience, lacking a cumulative body of research and being politically and socially conservative (Smithson et al. 1983). In addition, in those studies where realistic field settings have been used, there has been a tendency to make unwarranted assumptions and to use:

> ...small inconsequential helping acts to represent large scale phenomena such as caring and empathy (Smithson et al. 1983, p.5).

In a recent review of helping behaviour Eagly and Crowley (1986) proposed another important weakness in much of the social-psychological research on altruism when they highlighted the fact that studies often ignore long term and established relationships within groups and institutions. Moreover, many of the studies have effectively ignored the professional norm of caring for clients and patients. These studies therefore make only a limited contribution to the professional context. Eagly and Crowley (1986) stated that:

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Helping has been studied almost exclusively in brief encounters with strangers in field and laboratory situations and not in long-term role relationships within families, small groups, or organisations (p.286).

The discrepancy between the laboratory centred research and the *practice of professional helping* in areas such as medicine, social work, teaching, clinical and educational psychology and nursing is significant. In all of these 'helping' professions it has been *assumed* that most people come into them to help other people. However, little is known about this helping desire, even if it does exist, from then on. The laboratory research which has been reported is generally so far removed from the day to day work of these professional groups that there is a need to focus specifically on these groups in their professional role and within specific contexts.

The attribution theory approach to study helping

The attribution theory approach may offer potential for studying professional helping relationships. This approach may be considered social-psychological in orientation and has been successfully applied to professional settings. Attribution theory deals with the ways in which people attribute *causes* to their own behaviour and the behaviour of other people in a social context. People generally try to understand *why* they acted in a certain way under certain conditions by attributing their behaviour to *personal* or *environmental* factors. The theoretical foundations can be found in the work of Fritz Heider (1958) and the approach is phenomenologically grounded, making it particularly pertinent for the present study. Heider emphasised the importance of conscious experience within his approach as follows:

> Our concern will be with 'surface' matters, the events that occur in everyday life on a conscious level, rather than with the unconscious processes studied by psychoanalysis in 'depth' psychology (Heider, 1958, p.1).

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Heider (1958) claimed that this commonsense or naive psychology had great relevance for the scientific study of interpersonal relationships because it attempted to explore peoples' perceptions about the world in their own terms and legitimised these personal accounts as data deserving of scientific scrutiny. Later influential developments in the theory can be found in the work of Jones and Davis (1965) and Kelley (1972). Jones and Davis (1965) emphasised the attribution of internal motivations and were concerned with the way in which people infer lasting characteristics about others from their behaviour. Kelley (1972) on the other hand focused on the perceived cause of an event or course of action.

Applications to social problems and helping
The attribution theory approach has been successfully applied to a range of social problems (Graham and Folkes, 1990), including attempts to reduce interpersonal conflict (Baron, 1985); promoting an understanding of the reactions of people to the victims of serious crimes such as rape (Kanekar, Pinto and Mazumdar, 1985); in the field of marital difficulties (Holtzworth-Munroe and Jacobson, 1985); and learning difficulties (Wilson and Linville, 1982). Attribution theory has also been employed in studies of helping behaviour. Weiner (1980) for example emphasised the mediating role that affect has on helping. When an individual perceives another person in need of help, he *attributes* the cause of this distress to internal or external factors. Where an internal or controllable cause has been attributed the observer may feel anger or disgust and refuse to give help. On the other hand, if external or uncontrollable causes of the distress have been attributed then the observer may feel sympathy and concern and more likely to help (see chapter 8). A number of empirical studies offer support for this rather general theory (Barnes, Ickes and Kidd 1979; Meyer and Mulherin, 1980).

The potential of attribution theory for studying professional helping
In a recent book on social psychology Howitt et al. (1989) stated that:

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> Common sense, let alone careful observation, would suggest that a key characteristic of humankind is the kindly, caring, co-operative, and helping relationships which humans frequently form (p.94).

Attribution theory offers one of the most promising ways of exploring these helping relationships which form part of everyday human existence and especially within the professional domain. This viewpoint has been echoed by Rajecki (1982) who suggested that:

> ...two factors deserve primary consideration in any general accounting of altruism. We use attributional processes to decide whether a particular victim deserves help, or whether we are generally helpful persons. On the other hand, normative influences, either personal or social, tell us if we ought to help. An analysis based on these two factors will reveal a great deal about the attitudinal basis of prosocial behaviour (p.261).

It is assumed by Rajecki that the relationship between attitudes and helping behaviour is a relatively unproblematic one, while others maintain that *behavioural intentions* rather than attitudes are more reliable predictors of overt behaviour (Fishbein and Ajzen, 1975; Ajzen and Fishbein, 1980). A number of studies have reported high correlations between intentions and voluntary behaviour (Ajzen, 1988). Clearly a great deal of research remains to be done to clarify these issues within the professional helping relationship. Commenting on the general lack of knowledge about the relationship between the helper and the client Wills (1982) wrote:

> ...it is not at all clear what processes are involved in an effective helping relationship. We need a better understanding of the psychological processes involved in the development of a productive interpersonal relationship between a helper and a recipient (p.xxi).

Altruism and caring in nursing

Much of the social psychological research literature on altruism and helping may have seemed to nurse researchers in the field to be unconnected to caring and

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nursing. The obvious links between these areas has recently been recognised (Benner and Wrubel, 1989; Leininger, 1988) but has not lead to research which bridges the divide between these disciplines. The present study may provide a starting point on which later research could be developed. Such an approach should lead to fruitful dialogue between researchers in social psychology and nurse researchers who share a common research interest in the field of altruism, caring, and helping. In particular, in the present study we are concerned with the realm of discovery rather than the realm of hypothesis testing (Reichenbach, 1952), and to bring out the phenomenology of caring which will provide a rationale for the selection of particular variables for research on altruism and caring in a professional context in the future.

The emergence of caring in professional helping relationships

In recent times the notion of 'care' or 'caring' has emerged from the professional literature as a primary consideration for the helping professions. The role of informal carers within the community has been addressed mainly from a sociological orientation (see for example Dalley, 1988). A great interest has also developed in the field of applied psychology especially in the provision of psychological care by other professional groups, in counselling and psychotherapy (Hall, 1990, Wallis, 1987). The profession of nursing has also claimed caring as a crucial consideration for the practice of nursing (RCN, 1987; Watson, 1985).

Informal and professional caring

Caring as womens' work

A number of sociological studies have explored the notion of caring as it relates to the role of women in society and the direct impact of this ideology on women as informal and professional carers. Caring was generally perceived as being synonymous with the role of women since it was:

> ...often seen as women's work and is closely identified with what women are supposed to be doing for their families in any case (Abbott and Wallace, 1990, p.5).

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Furthermore, the aspiration of 'professionalism' for the caring professions of nursing and social work, may prove to be unattainable because of the perceptions people have about the nature of caring and the lack of clarity about what it means:

> ...the idea of 'professionalism' serves contradictory functions in the case of the caring professions. On the one hand professionalism defines and enhances the nature of these occupational groups. On the other, given the uncertain nature of the knowledge bases to which they lay claim, it constrains the ways in which they are able to define their tasks and lays them open to attack on the grounds of structurally unprofessional conduct (Abbott and Wallace, 1990, p.8).

The practice of caring in the community

In community settings, the role of women as informal and unpaid carers has been scrutinised. This strategy has been particularly relevant in view of the policies for promoting the concept of care in the community. Dalley (1988) examined the policy of community care and argued that it was based on 'feminist ideology' which resulted in the burden of community care being placed upon women in the community. She argued for the new model of community care - the 'collective care' model - in which the whole community plays a role in caring for the sick and elderly. Caring for people in the community places a huge physical, emotional and financial burden on the informal and unpaid carers (usually women) who look after sick and elderly relatives (Braithwaite, 1990; Finch and Groves, 1988; Nolan and Grant, 1989; Stacey, 1988). There is also a growing recognition of the role in men as informal carers (Parker, 1990). This type of research in the community may help to shape future social policies and ensure that scarce resources are allocated to those in the community with the greatest need.

Criticisms of much of the research which has been conducted in community settings has emerged recently. Gubrium and Sankar (1990) declared:

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Indeed, the simple task of defining what is caring-how it is variously understood by those concerned-seems to be furthest from the minds of most researchers. Concepts have been defined, variables selected, hypotheses formulated, measures and scales constructed, and data analysed-all as if the basic meanings and concepts of the home care experience were known. Few, if any, have bothered to ask whether care, caring, and caregiving are the same or contrasting orders of experience (p.8).

Moreover, they suggested that:

Caregiving may defy meaningful measurement...If meaningful measurement is possible, however, then it will only be after far more basic research on the phenomenon has been conducted (Gubrium and Sanker, 1990, p.9).

An ethnographic approach was recommended in an attempt to address these and other criticisms, and provide policy makers with the quality of information necessary to develop successful policies for caring in the community. It is interesting to compare this generally sociological perspective of caring as women's work with a psychological one. Following a meta-analysis of helping literature which focused specifically on gender and helping, Eagly and Crowley (1986) noted that male helping was commonly seen to be heroic and chivalrous, whereas female helping was perceived to be nurturant and caring.

The nature of psychological care
Care and caring have emerged from the psychological literature as central processes in all the helping professions. A number of psychologists have recently begun to explore more fully the contribution of applied psychologists to our understanding of the notion of care and caring in a professional setting (Hall, 1990; Wallis, 1987). In a discussion of standards of care within the caring professions, Wallis (1987) stated that '...measuring the *quality of psychological care* is more a matter for psychologists - and for *"occupational" as well as "clinical"* *ones...*' (p.125).

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Hall (1990) provided 'an analysis of care and caring from a primarily psychological perspective' (p.129). He described a four component model of caring which included: (1) a set of beliefs or philosophy which influenced the practice of care; (2) a specific set of goals derived from the philosophy; (3) a collection of caring acts; and (4) a set of accompanying emotions and feelings. According to Hall's analysis, caring is essentially an interpersonal encounter built around these four components.

The quality of care and consumer evaluation of care and services are currently very popular goals for the managers of professional caring services. In their desire for objective measures of professional care many managers of caring services may be tempted to employ instruments which purport to measure the quality of care. Hall (1990) however, has cautioned against the 'very real risk that care will come to be equated with the score on readily available measures, many of which portray a unidimensional or narrow view of care...' (p.141). Hall then goes on to outline a wide range of areas which applied psychologists may wish to address if a clearer understanding of the process of caring relationships may be arrived at. He urged greater psychological interest in the process of caring and asked:

> Much of the caring literature seems far removed from the immediate care of individuals: what can we contribute uniquely to understand the caring process and experiences? (Hall, 1990, p.142).

There is an obvious need for a psychological approach to understanding the experiences of professional carers and patients. This study describes one approach to the problem and focuses specifically on the work and experiences of a group of nurses and the experiences of a group of patients receiving care.

Caring in psychological therapy
A number of psychological therapies have examined what caring might mean in therapeutic practice. Rollo May (1972; 1983) for example, drawing on the

philosophy of Heidegger, explored the notion of 'care' as an essential process in existential psychotherapy. The care he referred to is a rather special kind however, it is a way of being which guides human action and experience.

> Care is a state in which something does *matter*; care is the opposite of apathy. Care is the necessary source of eros, the source of human tenderness...Care is given power by nature's sense of pain; if we do not care for ourselves, we are hurt, burned, injured. This is the source of identification: we can feel in our bodies the pain of the child or the hurt of the adult (May, 1972, p.289).

Though inspired by Heidegger, May's notion of care does not equate with his. For Heidegger 'care' assumes great importance and is described 'as the basic constitutive phenomenon of human existence' (Macquarrie, 1967, p.78). In other words, the notion of care is what constitutes a person as a person. Without care in this sense, the person is not a conscious Being immersed in the world. Care is therefore one of the essential characteristics of human beings. This understanding of the notion of care no doubt underpins the common sense understanding of care and caring relationships which nurses have and which forms an integral part of the thesis. But here we are concerned with a much more specific 'caring for patients' which nurses are assumed ideally to show.

Smail (1987) also argued that 'taking care' was a most valuable part of the process of therapeutic interaction in psychotherapeutic settings but acknowledged the difficulty of marshalling evidence to support this claim because it runs counter to the traditional ways of seeing and thinking about such things. The description of the process of 'taking care' is however rather vague.

Psychological care in nursing practice

Nurses have frequently used the term 'nursing care' to denote a wide range of ideas including technical skills, hotel services and emotional support. However, a number of accounts of psychological care for nurses have been suggested. Hyland and Donaldson (1989) for instance described how some of the major

domains of psychology can contribute to the psychological care of patients in clinical settings. They offered four main themes as the basis for providing psychological care within nursing. These were the holistic model of care; the role of communication; the importance of individual differences and the right of the individual to self-determination. This is a valuable scheme which is echoed in the work below, but it is not empirically based.

A scheme for providing psychological care by nurses and other professionals has also been outlined by Nichols (1985). This framework of skills included the ability to be able to monitor the psychological state of individual patients; the need for nurses to be able to represent the client's psychological needs to other groups such as doctors; the provision of emotional care; the giving of accurate information; counselling skills; and the facility of a co-support system to help nurses deal with stress.

The phenomenon of caring

One of the problems which limits all of the earlier discussion is the issue of definition. What does it *mean* to care for another person? How is caring *experienced* by those who give care and those who receive it? One analysis of the meaning of 'care' can be found in the phenomenology of human Being (Heidegger, 1962). We noted earlier that 'care' assumed great significance in human existence. Moreover, Heidegger claimed that care (*Sorge*) was also the source of will.

Heidegger (1962) described a number of ways of *'Being-in-the-world'* which are related to the notion of care. The first of these is 'concern' (*Besorgen*) and as we have seen this essence of the person emphasises the many ways in which man is bound up with the world: 'To be in the world is to be concerned with the world, to be engaged in ceaseless interaction with the things we find within the world' (Macquarrie, 1973, p.84). But concern may be manifested in two distinct modes. On the one hand we can attend to something and look after it, make use

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of something, consider, discuss and so on and these are all modes of concern (Heidegger, 1962). In contrast, we can also leave undone, neglect, abandon or ignore and these too are examples of 'deficient' modes of concern '...in which the possibilities of concern are kept to a 'bare minimum' (Heidegger, 1962, p.83). Both modes are however modes of concern and involve some form of interaction with the world.

Elsewhere, Heidegger discusses caring for others, a quite distinct line of discussion, described as 'solicitude' (*Fürsorge*) and which includes nursing the sick. According to Heidegger, solicitude can be displayed in a negative or positive mode. In deficient or indifferent modes of solicitude, people do not 'matter' to each other, and Heidegger suggested that this mode characterised most of our everyday human relationships. However, positive solicitude may present itself in two extreme ways. On the one hand, it can 'leap in' for the individual and lead to:

> ...one who is dominated and dependent, even if this domination is
> a tacit one and remains hidden from him (Heidegger, 1962, p.158).

On the other hand, positive solicitude may 'leap ahead' of the individual in a way which is authentic and liberating. It is:

> ...a kind of solicitude which does not so much leap in for the Other
> as *leap ahead* of him...not in order to take away his 'care' but rather
> to give it back to him authentically as such for the first time. This
> kind of solicitude pertains essentially to authentic care-that is, to
> the existence of the Other, not as a 'what' with which he is
> concerned; it helps the Other to become transparent to himself *in*
> his care and to become *free for* it (Heidegger, 1962, pp.158-159).

Dunlop (1986) suggested that Heidegger's approach offered possibilities for exploring the meaning of caring in nursing. This particular perspective is taken up in the second half of the thesis and forms the basis for analysing qualitative interviews with nurses and patients (see chapters 5-8).

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Another well know account of the process of caring is described by Milton Mayeroff (1971). He provided a philosophical analysis of the meaning of caring in human relationships to try and answer the questions raised above. He attempted to describe caring and to show how this process can give meaning and order to a person's life. His book 'On caring' is often quoted and referred to by nurse researchers and writers in the field.

On caring (Milton Mayeroff)

In Mayeroff's description, caring is a process which offers both the carer and the cared for person opportunities for personal growth. The primary aspects of caring in the analysis included: knowledge, alternating rhythms (learning from experience), patience, honesty, trust, humility, hope, and courage.

Knowledge

According to Mayeroff, to be able to care for someone, we must know certain things about them. But there are definite limits to what we need know in order to care for others. We cannot know very much about what is best for the other person when it comes to their personal or emotional life. It is tempting, when someone has personal problems to offer them advice. Such advice is only rarely helpful. In professional settings a basic level of competence and knowledge are needed to look after sick people.

Alternating rhythms

In any relationship that we have with another person, whether in the family, with friends or with colleagues *intensity* of the relationship fluctuates. Sometimes we feel very close to the other person, sometimes we feel quite distant. According to Mayeroff, this is an example of the 'alternating rhythms' of any caring relationship. No relationship can stay intense and close for any length of time. There seems to be a natural cycle in the caring relationship. There is another sense of the term alternating rhythms. This is the idea that we may have to continuously modify the ways in which we react to another person. Sometimes,

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one approach works. On another occasion, another is required. People vary from day to day so what works with them one day does not necessarily work with them on another. That is to say that since we last saw someone, lots of things have happened to them, they have changed and become other than they were.

Patience

Caring for another person requires time and patience. A relationship needs time too for people to get to know each other. Caring relationships, whether with friends or with patients, cannot be rushed. In another sense, too, patience requires tolerance. We need to appreciate that other people are not the same as us. Great patience is needed when caring for certain types of patients too. The very ill, very dependent and disabled may demand much of the professional carer to achieve even small goals.

Honesty

Honesty is a positive thing according to Mayeroff. It is not simply a question of not doing things like telling lies or deceiving the other person but involves being open to sharing with them exactly how we feel. It involves being able to tell them the truth, whether that truth consists of factual information that they need, or whether it is concerned with our feelings for them. A prerequisite for being able to be honest with other people is being able to be honest with ourselves. A necessary requirement for being honest with others, then, is a degree of self-awareness, of being able to honestly appraise our own thoughts, feelings, beliefs and values.

Trust

For Mayeroff, trust is a clear requirement for caring. Just as we have to learn to allow a child to find things out for himself and to make mistakes for himself, so, with adults we must be able to trust them to learn from their own experience, to make decisions for themselves and so forth. Trust also involves an element of risk taking and accepting that other people find things out in their own way and

live their lives. The risks for patients are usually greater since they need help and have to ask for professional help.

Humility

To care for another person, Mayeroff believes, is a great honour. If another person trusts themselves to us, we need to be aware of the great responsibility that this involves. There is a need to stay humble and to appreciate our own inadequacies and limitations. If we are not humble, we are likely to feel an overvalued sense of our own knowledge and views. To be humble suggests that we have much more to learn. In the caring relationship, if we stay humble we stay open to new learning and to finding out more about the other person.

Hope

To care for another person is to imply that we believe in their ability to overcome problems and adversity. We cannot care without hope. If we do, we may just as well abandon the whole enterprise. To care at all suggests hope. Hope is also contagious and to care for others is to inspire others and to encourage them to hope for themselves. In professional settings however, nurses and doctors often do care for patients and their families when there is *no hope*. Clearly hope is not an essential ingredient for professional caring relationships.

Courage

A lot is at stake when we care for someone else. Despite our efforts or hope, they may not recover or, less dramatically, they may not care for us. The norms of equity which were mentioned earlier in the discussion of social exchange theory may be violated and so to care is something of a gamble. Just as we cannot know the future, we cannot anticipate the outcome of our caring. Thus to care takes considerable courage. It takes courage, too, to share ourselves with another person. Whilst caring may not always be a reciprocal relationship, it is likely that we will need to give of ourselves in the caring role. We may also need to tell the person for whom we are caring things about ourselves.

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The general thesis of this account is that caring can influence peoples' lives in a significant way and lead to a more fulfilled existence. These are broad principles of caring. One important problem with this analysis is that these principles may not be specific enough to apply to *all caring situations*. Mayeroff is concerned with caring in the most general sense as a guiding ethic in human relationships. His analysis was not meant to be confined to caring in a clinical or health care setting and does not fit neatly into the professional domain. Van Hooft (1987) argued that:

> It becomes clear as one reads further into Mayeroff's text that the interpersonal relationship of which he speaks is one of greater singularity and intimacy than is appropriate in a nursing situation (p.30).

Van Hooft is perfectly correct in my view. While there are occasions when a nurse may become involved with patients in a very intimate way, this level of intimacy is not possible, nor even desirable in my view in a professional relationship, because of the requirements of the role of professional carer. Van Hooft (1987) urges nurses to abandon the notion of caring as a fundamental value in nursing and substitute the concept of 'professional commitment' in its place. A caring attitude would still be necessary but it would not assume a primary position in the professional arena.

The change in emphasis which Van Hooft calls for has some merit, but it is not likely to come about easily since the concepts of care and caring are very strongly embedded in both the practice and theory of nursing. In addition, there is a growing awareness of the need to develop a clear understanding of these concepts as they relate to nursing practice, education and research. Consequently a number of research studies into the caring experiences of nurses and patients have already been completed (see chapter 2).

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Paid to care (Alastair Campbell)

An alternative and more applied portrayal of professional caring can be found in work of Alastair Campbell (1984; 1985) who employs a theological perspective to professional caring. Campbell (1985) has discussed the paradox of health professionals being *paid to care* for others. It is possible to question whether or not care can be prescribed or carried out as an intentional, professional act. It was also noted earlier in this chapter how a great deal of caring in the community is completed by unpaid carers. It seems likely that the professional caring relationship is different to other caring relationships, if only in the sense that in a professional caring relationship people do not have the degree of *choice* about caring that exists in most other day to day relationships.

In a theological analysis of professional care Campbell (1984) described caring as a form of 'moderated love'. This notion suggested that professional caring relationships were carefully bounded (or moderated) both by custom and by statute. The term 'skilled companionship' (Campbell, 1984) was preferred to that of 'carer' as a description of the relationship that exists between the paid health professional and his or her patient. According to Campbell companionship may be differentiated by the following characteristics:

Closeness without sexual stereotyping

Unlike caring the notion of companionship is usually devoid of a sexual connotation. Companionship can help to get around the perception of sexual stereotyping such as those commonly found in the health care context: caring as womens' work or the suspicion with which men in nursing are typically viewed. Also, and perhaps more contentiously, the idea of romantic love is less likely to be an issue in companionship as it may be in caring.

Movement and change

Because the idea of companionship is less intense than a full caring relationship, it is more open to movement and change. The carer and the one being cared for

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are less dependent on each other than is the case in a caring relationship so both can develop and grow at his or her own rate. The other point about movement is that the companion is the person who 'travels with' the other person, who assists, encourages and supports the other to recovery or death. The concept of movement is totally absent in those forms of institutional care where the prevailing norms are stasis, unchanging routine, resigned acceptance and lack of hope. In these circumstances the concept of companionship is lost.

Mutuality

Companionship suggests mutuality. In accompanying another person we share the relationship and each supports and helps the other. The *degree* to which this is possible in the nursing field is a matter of some contention. Carl Rogers (1967) suggested that the relationship between the one being helped and the helper *is a mutual one* in therapy. In contrast, the philosopher Martin Buber (1966) disagreed with Rogers and suggested that because the patient comes to the professional for help the relationship can *never be a mutual one*. On the question of mutuality he wrote:

> He comes for help to you. You don't come for help to him. And not only this, but you are *able*, more or less to help him. He can do different things to you, but not help you...You are, of course, a very important person for him. But not a person whom he wants to see and to know and is able to...He is, may I say, entangled in your life, in your thoughts, in your being, your communication, and so on. But he is not interested in you as you. It cannot be. You are interested in...in him as this person. This kind of detached presence he cannot have and give (Buber, 1966, p.171).

The issue of mutuality has been discussed in detail by Friedman (1985) (but see chapter 8).

Commitment with defined limits

Companionship requires commitment. The companion has to be prepared to invest time and energy in the relationship. However, an important difference

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between the relationship between lovers and friends, and the relationship between companions and those being accompanied, is the fact that the companionship relationship has more explicit limits. In a friendship, those limits are worked out, informally and tacitly. Quite often friends do not try to define the limits of their relationship. The same can be said of the relationship between lovers.

On the other hand, the companion in the health care setting works within a specified code of conduct which offers the broadest outline for the relationship. The relationship is then further delineated by nurses informal concept of what is professional. Most nurses have a picture of what is and what is not acceptable in a relationship with patients, which has been learned from working with colleagues. This professional limiting of the relationship makes it different in an important way to other sorts of close relationships. May (1972) identified four different types of love in human relationships including: (1) *sex* or libido, (2) *eros* - the drive to procreate, (3) *philia* or friendship, and (4) *agape* or *caritas* or the love entailed in looking after others.

Another practical constraint on the companionship relationship in nursing is time. Nurses work specific shifts and a precise number of hours in the week. They see the people they care for limited periods and at pre-arranged times. The nurse also has to make decisions about how *much* time she can spend with a particular patient. If she has responsibility for more than one person, it is likely that she will have to decide how best to allocate her time to the various people she has to care for.

Relationships based on friendship are affected by time but the time factor is usually of less importance because it does not actually place serious limitations on the relationship. Friends normally *choose* the times that they meet whereas nurses usually have pre-determined times for meeting the people and fostering caring relationships. In the case of lovers, time becomes important again, but in a different way. Lovers tend to want to spend as *much* time with each other as

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is possible. Campbell (1984) suggests that the term skilled companionship avoids some of the problems associated with caring in nursing and is a more fitting description of the type of caring (or even loving) relationship that occurs between a nurse and her patients.

Summary of the chapter

Some of the main theoretical frameworks for studying helping behaviour in social psychology were examined briefly and important criticisms of these were noted. Many of the theories developed tended to be general and too closely tied to the laboratory style research from which they developed. One particular strategy which may lead to more fruitful research in professional settings is the attribution theory approach. This approach has already been successfully applied to the practice of professional helping. The concept of caring has emerged in professional helping relationships as an important dimension of professional helping roles including psychological therapy and nursing practice. In addition caring has also been studied within community settings since most of the caring for sick and disabled people is done by their family members in home settings.

Additionally, the notion of care assumes great importance within the phenomenological framework developed by Heidegger but this type of care is not directly related to the caring that is an integral part of nursing practice. The philosophical analysis offered by Mayeroff cannot be easily applied to the domain of professional nursing practice. Campbell put forward the idea of skilled companionship in a effort to outline more closely what professional caring entails. The accounts proposed by both Mayeroff and Campbell are not however based on research. The next chapter examines the close links between the process of caring and the practice of nursing and outlines some of the key research findings.

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CHAPTER 2

CARING AND NURSING

Introduction

This chapter explores the relationship between the process of caring and the practice of nursing. The centrality of care and caring relationships in nursing has been widely affirmed but few research studies have been completed and most of these have been conducted in an American health care context. A critical review of the empirical studies of caring in nursing is undertaken. A range of research approaches has been used to study both nurses and patients perceptions of caring experiences and these include some phenomenologically based studies.

The relationship between caring and nursing

The emergence of caring in nursing

Caring has become a significant topic in the nursing literature in recent years. A number of books on the subject have been published over the last ten years and these have focused on a range of theoretical, research and educational issues related to nursing (see Benner and Wrubel, 1989; Ismeurt et al. 1990; Leininger, 1981, 1988; Watson, 1979, 1985). The range of books and journal publications on caring is extensive and deals with many different aspects of caring in nursing. These focus on diverse issues including: ethics in health care (Downie and Calman, 1987), the relationship between science and caring (Dunlop, 1986), the differences between formal and informal caring (Kitson, 1987a), caring and ethics in nursing (Brody, 1988; Roach, 1987), and the issue of standards of care and quality assurance programmes (Ellis, 1988; Kitson, 1987b). Some of these issues are discussed below.

The role of caring in achieving good nursing practice

The Royal College of Nursing (RCN) recognised the relevance of caring in good nursing practice and standard setting exercises and declared caring to be one of the principles upon which the nurse-patient relationship is founded (RCN, 1987). There is also some support in the literature on caring advocating caring as an

influential determinant of acceptable and desirable levels of nursing care in practice situations (Carper, 1979; Kitson, 1987b). Carper (1979) noted that:

> ...caring as a professional and personal value, is of central importance in providing a normative standard which governs our action and our attitudes toward those for whom we care (p.11-12).

However, the RCN guideline is significant also because it places a great responsibility on nurse managers, educators and practitioners to ensure that the process of caring forms the basis for achieving good nursing care. At the same time, it is a rather curious statement since little is known about the nature and meaning of caring in professional nursing practice. Moreover, as was noted in the previous chapter, even psychologists who claim to have a central interest in 'psychological care' have contributed little to our understanding of the nature of care and caring. Few research studies have been completed to explore for example what the term means, the way in which it affects those who get paid to care, how people learn to care or how professional and informal caring differ. There is an acknowledged need for a rigorous and systematic study of care and caring relationships in nursing if it really is to be a central value which guides professional nursing practice.

The problem of defining a caring relationship

One of the major problems associated with the growing interest in caring in nursing is the problem of definition. Rieman (1983) highlighted this difficulty along with the dilemma of finding an appropriate research methodology for conducting empirical work in this field as follows:

> Although most professionals and nonprofessionals involved in the helping professions state a valued need for caring, little research has been carried out to substantiate in fact what caring really is. There is a rather widely accepted view that caring is growth producing, valuable, and difficult to research. One of the biggest deterrents to researching caring seems to be the lack of value placed on research conducted in other than scientific method,

translated as the method traditionally utilized in the natural sciences. Recent phenomenological research within the fields of sociology and psychology would support phenomenological analysis as a valuable and viable methodology (Riemen, 1983, pp.42-43).

The final comment relates to a central viewpoint of this thesis. In the area of mental health nursing (Barker, 1989) restated the problem of definition when he argued that:

> ...'nursing' and 'care' may be related, but are not synonymous. Nursing is a professional group which has been defined largely in terms of its superficial appearance (e.g. uniforms, status, ritual), and to a lesser extent by reference to some of its 'care-practices'. What has been less clearly defined is in what way these professionals 'care' for people who are patients (p.140).

Others take quite a different view and tend to perceive care and caring as being synonymous with nursing practice (for example see Leininger, 1981a; Watson, 1979, 1985).

A number of authors have attempted to define the meaning of care and caring. Some authors have referred to caring in nursing as a form of loving. Ray (1981) found that:

> ...a conceptual analysis of caring from different perspectives is suggestive of a form of loving (p.32).

She noted however that the orientation of many nurses was greatly influenced by a bureaucratic value system which typified the prevailing culture of hospital life (see chapter 8). Ray (1981) also suggested that while nurses were rewarded for supporting the bureaucratic system, other rewards, such as increased self-esteem, job satisfaction, motivation and the joy of giving were achievable through developing caring relationships with patients.

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McFarlane (1976) referred to nursing as the process of 'helping, assisting, serving, caring', suggesting that nursing and caring were inseparable, and at the same time indicating that some practical activities were involved in the caring process in nursing settings. This point of view was taken up and expanded on by Griffin (1980, 1983) who divided up the concept of caring into two major domains. One of these deals with the nurses' attitudes and emotions, while the other is concerned with the activities that the nurse engages in while carrying out her nursing function. Griffin (1983) described caring in nursing as essentially an interpersonal process, in which the nurse is required to carry out specific role related activities in a way that conveys to the recipient the expression of certain emotions. The activities she has in mind include assisting, helping and serving the person who has special needs. The process is influenced by the relationship which the nurse has with the patient. The emotions of 'liking' and 'compassion' were offered tentatively as important affective responses which are expressed through this relationship. Other aspects of attitude are discussed in chapter 4.

While Griffin's analysis is useful in that it suggests points of emphasis for practitioners, educators, managers and researchers, it fails to provide the type and depth of understanding required of a profession that claims caring as *central value*. In addition, this type of philosophical analysis has the disadvantage of being far-removed from the practice of nursing, and is likely to omit relevant considerations which form an important background for all professional caring relationships with patients, and includes for example the organisational culture; the pressure to conform to the social and groups norms in the work context; stress; workload and so on.

The centrality of caring in nursing practice

The centrality of caring to nursing has been widely affirmed (Briggs, 1972; McFarlane, 1976; Watson, 1979, 1985; Leininger, 1981a; Roach, 1987), while the Briggs Report (1972) claimed that nursing was *the* major caring profession. Indeed, Chapman (1983) suggested that one of the main reasons why people enter

nursing was their desire to help and care for others at their most needy. Chapman (1983) also commented on the 'paradoxical' nature of this motivating force when she wrote:

> Here then is the paradox. We have a group of people who have come into an occupation because they wish to work with and help people, yet they wait until people are sick before offering this help. Not only that, but they allow organisational factors, desire for status and fear of involvement to ensure that although tasks may be done to people, whatever happens they will not get involved with them (p.272).

There is of course an important difference between such a motive and its actual realisation. People can and do offer help to the weak and ill in society without becoming a nurse. Moreover, it may be that the popular image of the nurse, as a person with an implicit desire to care for sick and disabled people, which serves to motivate her to become a nurse, is in fact misleading. Such a view may reflect more myth than reality. People may become nurses for many different reasons such as family links with the job; job security; a desire to travel abroad and work; the positive image of the profession held by members of the public and so forth.

Pratt (1980) also argued that caring was a major driving force for motivating people to enter the profession of nursing. Along similar lines, a specific selection interview has been developed for identifying candidates most likely to be successful in their nursing careers (Selection Research Limited, 1987). A number of themes were identified in the research programme and eight key themes were chosen from these to form the basis of an interview selection framework for nurses in the National Health Service. The eight themes included: focus (the capacity to accept instructions, set priorities and remain committed to the nursing profession), pride (raised self-esteem through achievements at work), activating (a type of assertiveness needed to achieve the right goals), responsibility (feeling a strong sense of psychological ownership of one's work with patients), patient response (satisfaction derived from evidence of improvements in patients),

relator (being able to interact positively with others), caring (a desire to do things for other people and find such work satisfying), and common sense (reduce errors at work, anticipation, being able to deal a number of issues at the same time). However, it was suggested that:

> ...the caring theme will make a distinct contribution in differentiating between those who should and should not enter nursing (Selection Research Ltd., 1987, p.12).

The scarcity of research into caring

In health care education generally caring is a key concept (Bendall, 1977; Sarason, 1985). But it is perhaps ironic that a concept of such importance to nursing has received so little empirical attention from nurse researchers (Partridge, 1978; Leininger, 1981a,b). Commenting on the dearth of research in the area, Leininger (1981b) remarked:

> The relationship between caregivers and care recipients is limitedly known, and yet this relationship appears to be the heart of therapeutic help to clients (p.137).

There is clearly a strong link between the concept of caring and professional nursing practice. What is less clear however, is the precise nature of this link. To assume that nurses have a monopoly on caring and caring values is nonsense (Dunlop, 1986). The nature of nursing is different from other helping or caring professions such as counsellors, teachers and therapists. The most useful strategy to explore the relationship between caring and nursing has been to investigate caring within a particular nursing context, rather than focus on the prescribed rhetoric found in the literature of professional organisations or educational bodies.

Informal carer and professional carer

One useful way forward has been to focus on the similarities between lay and professional caring (see also chapter 1). Although clear definitions of caring and

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nursing are lacking, Kitson (1987a) identified a number of phenomena which she claimed may be found in any caring relationship. She described the bond between lay and professional caring as follows:

> ...rather than being made up of fundamentally different aspects, lay caring and professional caring share the same main attributes which are commitment, knowledge and skills and respect for persons. Where lay caring and professional care differ is in the extent to which professional carers set themselves up as a specialist service meeting the care needs of those who are either unable to care for themselves or others in an acceptable manner (p.164).

A most crucial aspect of the relationship between the informal carer and the cared for person is *commitment*, and Kitson argued that this type of commitment is a vital component of the professional caring relationship found in nursing (see chapter 4). The level of commitment has also been found to be a crucial determinant in research studies of informal carers (Goodman, 1986). Although caring for disabled relatives in the community has been found to exact a heavy toll on carers, commitment is required if *mutuality* is to be found in the caring situation. In a study of family caregiving Hirschfeld (1983) remarked:

> ...mutuality between the supportive and the impaired family members emerged as the major parameter for families managing life with senile brain disease. In the face of immense problems posed by the impact of the decline itself, the implications of caring for a senile brain diseased person and the difficulties rooted in the social environment, mutuality became *the* important variable (p.26).

Despite being under tremendous pressures and strain, successful caregivers gained a great deal from their relationships with the impaired persons. It gave their lives meaning, purpose and understanding.

It has been argued that the role of the nurse is to assume responsibility for caring for a person when the lay or informal carer can no longer cope (Kitson, 1987a,b). The ability of the nurse to integrate the attributes of lay-caring into the

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professional-caring relationship, thus enabling it to be a mutually experienced relationship can have a direct bearing on the quality of care received:

> Quality of care in the professional caring relationship is thought to relate to the extent to which aspects of caring activities implicit in the lay-caring relationship are carried into the professional nurse/patient relationship and made explicit. The ability of the nurse to do this emerges as one aspect of the therapeutic function (Kitson, 1987b, p.155).

It is not at all certain if a 'mutual' relationship can be achieved in a professional context but if this analysis is accurate then the concept of caring has far-reaching consequences for the theory and practice of nursing. However, there is a great need for research into this area before any firm conclusions may be drawn. Important questions must be addressed before policy and practice are changed. For example, the following list of questions ought to be considered: Can the level of commitment required of a paid nurse ever be the same as a relative? Does it need to be? How does the nurse benefit form the relationship? Can the nurse always be a professional carer? What personal processes influence the professional context? How supportive is the professional team for the individual nurse?

Consumer satisfaction and patient perceptions of care

Another strategy used by researchers has been to examine patients' perceptions about the care they have received as a way of assessing consumer satisfaction with health care services. It was suggested earlier that a close link exists between the process of caring and standards of care, quality assurance programmes and consumer satisfaction (Ellis, 1988; Kitson, 1987a,b). In one study, Rempusheski et al. (1988) explored patients perceptions of expected and received care using a grounded theory approach. They generated a list of 6 hypotheses from their analysis of the data. These hypotheses were:

1. A set of service needs exist that if met during a hospital stay, creates a positive perception of care.

2. Other individuals emerge as caregivers when nurses are unable to meet the perceived care needs of a patient.

3. Failure to accept a patient in his or her own space and time results in a power struggle between the nurse and patient.

4. Reciprocity is a function of a patient/family's desire to equalise the relationship with his or her care provider in the form of a symbolic 'payback' for care he or she has or has not received. This has been described in the psychological literature as 'indebtedness' (Greenberg and Westcott, 1983) and may be compared with the social exchange theory discussed in the previous chapter.

5. A critical juncture exists in a person's care experience that mediates future perceptions of care received.

6. Patient satisfaction is a function of the degree to which a set of care expectations is met.

If the expectations of the patient really do influence the way in which patients evaluate the standards of care and their overall level of satisfaction with care, then this is only half of the story. Nurses as professionals are also required to evaluate their care. There is therefore a professional need to define the parameters of nursing practice and to establish what role the process of caring plays in that practice.

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Research into caring in nursing

In an attempt to answer these and other related questions a number of investigators have studied the phenomenon of caring in the context of nursing. Some of the important trends in their findings are described in the next section. A small number of nurse researchers have investigated the process of caring, but most of these have been completed in an American context. The lack of British studies means that the findings of the American studies must be considered carefully because of the wide discrepancies in health care philosophies, resources and practices in these different cultures.

Using a qualitative anthropological design, Leininger (1977) studied the process of caring across a range of cultures over a fifteen year period. Data from almost thirty different cultures was collected. Variations in the belief and value systems of the informants, as well as variations in the practice of caring across these cultural settings were uncovered. Leininger classified a total of seventeen constructs (or ways of perceiving) related to caring. They were: comfort, support, compassion, empathy, direct helping behaviours, coping, specific stress alleviation, touching, nurturance, succorance, surveillance, protection, restoration, stimulation, health maintenance, health instruction and health consultation. As the research evolved, these were subsequently developed into a twenty-eight construct taxonomy of caring.

Unfortunately, many details about the research methods that she used were not reported and this makes it very difficult to check how reliable and valid her findings were. However, the fact that different constructs were found to be more significant across cultures, is particularly important and should caution researchers against the dangers of trying to produce a universal description of caring which might be applied to a number of different cultural settings.

Another approach used to explore what caring is, is to ask those people who have recently received care what the experience of being cared for was like. This was the strategy used by Henry (1975). She employed open-ended interviews with fifty people who had recently received nursing care, and later devised three major categories for classifying caring nurse behaviours. These categories were: (1) what the nurse does, (2) how the nurse does, and (3) how much the nurse does. These findings emphasise the perceived importance of what and how much the nurses does as well as the manner in which she does her work. It demonstrates the relevance of *both* the instrumental and expressive components of caring.

Remarkably, very similar findings were reported in a study by Brown (1981). Again patients were interviewed and asked to describe a specific time or an incident in which they felt cared for by a nurse. The responses were analysed into different categories or content areas using content analysis and two major themes were revealed. These were as follows: (1) what the nurse does, and (2) what the nurse is like. Brown also asked the respondents in her study to fill in a Likert rating scale in order to assess the importance of 'task' and 'affective' components of the care that they had received. These were then analysed using a statistical procedure and the results demonstrated that patients perceived both of the dimensions to be *equally* important. According to these respondents the manner in which tasks were completed was just as important as the task itself. This is surprising, as many people assume, even if at a common sense level, that patients give scant consideration to what the carers are like as long as they get better.

Brown (1986), in a further discussion of her 1981 study, described 8 care themes following interviews with 50 patients who had been cared for by a nurse. The patients were selected from medical and surgical wards. The themes which reflected the patients experiences of being cared for were as follows: (1) recognition of individual qualities and needs, (2) reassuring presence, (3) the

provision of information, (4) demonstration of professional knowledge and skill, (5) assistance with pain, (6) amount of time spent, (7) promotion of autonomy and (8) Surveillance. Furthermore, Brown (1986) reinforced the broad distinction between two major classes of care when she reported that:

> Patients speak clearly to the importance of the nurse meeting their treatment needs (instrumental activities) and doing this in a way that protects and enhances the unique identity of the individual (expressive activities) (p.61).

The role of both of these categories of care - instrumental and expressive behaviours - in determining patients' perceptions of the competency of the hospital, and satisfaction with the quality of care was recognised by Ben-Sira (1983). In this instance, the term 'instrumental' referred to the treatment received by the patient, and 'expressive' behaviour referred to the attitude of the staff in their approach to the patient as a human being. However, the dichotomy between instrumental and expressive nursing roles is problematic. Skipper (1965) noted that the *conceptual distinction* between the nurses' instrumental and expressive roles cannot be upheld easily in practice since whatever the nurse does will have a certain expressive quality about it and will be interpreted by the patient as a particular mode of care. The nurse's nonverbal behaviour for instance will also communicate messages which the patient will decipher. Moreover, Benner (1984) in a discussion of the phenomenon of caring in nursing, warned of the dangers of trying to separate the instrumental and the expressive facets of caring in nursing practice. She suggested that there was a need for a wide range of approaches in research into caring and argued that the expert nurse combines both facets in day to day nursing practice.

In another study, Gardner and Wheeler (1987) examined patients perceptions of the term 'support'. They used a critical incident technique and asked 110 respondents to describe an incident in which they *had* received support and one in which they *had not* received support. Respondents were also asked

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to give some of the reasons why they perceived the incidents as supportive or not supportive. The emphasis in the study was on the nature of the interaction rather than on particular nurses responses or behaviours. The following list of supportive gestures were reported: (1) the availability of the nurse, (2) the physical care received, (3) individual care, (4) control, (5) morale, (6) confidence, (7) problem-solving and (8) information giving.

In contrast, only 37 of the 110 respondents provided a response to requests for incidents which reflected their experiences of feeling unsupported. There was a marked reluctance on the patients' behalf to be critical of the support they received. This was probably because it reflected negatively on the staff, but it could also reveal the fact that they felt well supported during the time of their illness. Of the incidents which were reported, the following series of items were found to reflect the patients' experiences of feeling unsupported: (1) lack of availability, (2) lack of comfort, (3) lacks of treatment or nursing tasks, (4) lack of information, (5) aggressive or rejective nursing attitude, (6) disagreement with the nursing care and (7) lack of reassurance when it was needed.

In another study, patient perceptions of caring behaviours have also been explored in oncology nursing using the Q-sort technique (Larson, 1984). Patients reported that the most important caring behaviour which they observed in nurses were: (1) accessibility (checking patients frequently, responding quickly to call alarms and so on), and (2) monitoring and follow through (knowing when to call a doctor, how to give an injection, and how to manage equipment). Larson (1984) found that the patients' view of caring was quite different to the views of the nurses working in the oncology area who ranked 'listening' and 'comfort' as the most important components of caring. An interesting comparison may be made with the findings of Brown (1981) which were reported earlier, because Larson claimed that patients place greater weight on the their physical needs before psychological needs:

Listening and talking, psychosocial skills highly valued by nurses, appear to become important to these patients only after their basic 'getting better' needs are met (Larson, 1984, p.50).

This finding may well be a reflection of the particular patients taking part in the study. When an illness is life-threatening, the need to survive is likely to become much stronger and any treatment which can help the process seems likely to become critical to the patient.

In contrast to the patient perspective, Ford (1981) asked a sample of nearly two hundred nurses to define caring in their own words and to describe their own caring behaviours. A questionnaire was used to collect the data. Analysis of the data revealed two major categories which reflected (1) A genuine concern for the well being of another and (2) Giving of yourself. Some examples of the caring behaviours provided by the nurses in the study were listening, helping, showing respect, and supporting the actions of others. The nurses' view obtained failed to emphasise the 'task' or instrumental dimension stressed in other studies involving patient perceptions such as the one reported by Brown (1981) mentioned above.

It is well known that many of the task aspects of nursing are undertaken by students or untrained nursing staff (Knight and Field, 1981). If the emphasis in the research is on qualified staff only, then it is not all that surprising to note the accent on *psychological* caring in research involving qualified staff, since they are often not directly engaged in the provision of physical nursing care. Their high status position in the organisation means that they are more often involved with administrative duties.

As an alternative to asking patients or nurses for their views about caring, Ray (1981a) used the method of participant observation, and observed nurses at work, explored their roles, clinical units and documents. Ray observed caring in

the clinical setting and identified 1362 caring responses. When these were analysed, a conceptual classification system of caring was produced which had four important conceptual categories: (1) psychological (cognitive and affective), (2) practical (technical and social organisation), (3) interactional (social and physical), and (4) philosophical (spiritual, ethical and cultural). The practical aspects of caring were again very evident in this study and pointed up the need for researchers to be aware of the way in which the research design may influence the findings. The different approaches used in the research have resulted in quite different descriptions of what caring means to the people involved in the studies.

In another related study designed to explore how nurses met the needs of both terminally and acutely ill patients using grounded theory, Samarel (1989) found the notion of 'caring' to be the unifying principle which helped the nurses to look after these diverse groups of patients. She wrote that the:

> ...commonality of caring, in combination with the hospice nurses' cognitive and affective preparation for their roles, was the unifying thread reconciling the intentions of hospice and acute care.

> The strength of the caring aspect of the participant nurses' professional behaviours was consistently apparent in the ways they interacted with their patients. They strived to show believable concern, to attend to needs within constraints, and attempted to demonstrate an understanding of their patients' situations (p.320).

Phenomenological studies of caring

A number of other research studies have employed a phenomenological approach to studying caring relationships. The phenomenological approach is characterised by its emphasis on the lived experience. It attempts to understand the phenomenon (in this case caring for another person), from the perspective of those individuals being studied. The accent is on depth rather than the quantity of data collected and very strict procedures of analysis must be adhered to (see chapter 5). Riemen (1983; 1986) interviewed 10 subjects who had recently

experienced being cared for by a registered nurse and used a phenomenological method to analyse interview transcripts. Three types of theme were found to characterise both 'caring' and 'non-caring' interactions. Riemen (1986) provided the following framework. Caring was experienced through: the nurse's existential presence, the client's uniqueness and the consequences which lead on from this relationship. Non-caring was experienced through alternative perceptions of these same themes. For example, in perceptions of caring interactions the nurse's existential presence meant that the nurse recognised the client's uniqueness by really listening and responding to him or her as a valued individual. But in non-caring interactions, the nurse's physical presence was to get the 'job' done.

A study of human caring in intensive care units and coronary care units was reported by Ray (1987). Eight nurses were observed and interviewed and this data was subjected to a form of phenomenological analysis. Five themes of human caring in critical care units emerged. The were: the nurse grows-maturation, technical competence, the nurse shares-transpersonal caring, the nurse talks and listens-communication, and the nurse makes decisions-judgement/ethics.

In another very recent study, Forrest (1989) provided a phenomenological analysis of nurses' experiences of caring for patients. In this study only seventeen informants were engaged. Two major categories of response were identified. These were (1) what is caring? and (2) what affects caring? The first category, what is caring? was broken down further into two sub-categories - involvement and interacting. Involvement was captured in the notions of: being there, respect, feeling with and for, closeness; while interacting entailed: touching and holding, picking up cues, being firm, teaching and knowing them well. The second category, what affects caring? was broken down into a further five themes. These included: oneself (own experiences, beliefs, self-appraisal, disagreeing with patient, feeling good about work and learning caring at school), the patient (hard to care for patient and what patients tell you), frustrations (lack of time, nurse administrators, physical environment, fellow nurses, personal stress and

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dilemmas), coping (focusing on immediate tasks, talking, unwinding and protecting self), and comfort and support (fellow staff nurses, teamwork and unit supervisors).

One important point about these phenomenological approaches needs to be emphasised here. These approaches represent a particular type of insight into caring relationships in nursing. They have lead to a clearer understanding of some of the relevant issues and experiences of those involved, but I have also found these to be somewhat sterile and barren because they fail to bring to life the experiences of the informants. If the researchers had returned to their informants and showed them the distilled findings I am not convinced that in their present form, they would mean a great deal to the informants. If this is the case then this type of analysis is flawed to some extent. The phenomenological approaches above have adopted a type of phenomenology which is closely linked with phenomenological philosophy. There has been a tendency in these reports to attempt to distill the essence of the experience of caring in nursing practice. However, they do not reflect the lifeworld and concerns of the individuals taking part in the research. This may be because of the particular type of approach to phenomenology adopted in the research. The research 'protocols' or raw data, which were analysed often tend to be brief and generated from selected informants judged to be 'articulate'. The findings have tended to be removed from the real context out of which they were generated. They have to some extent become the property of the researcher. But more significantly, their understanding of phenomenology tends to be eidetic at the expense of what is existentially descriptive.

In contrast, the type of approach used in this study is phenomenologically based and focuses on the lifeworld and personal meanings of the informants. Such an approach leads to a much more detailed understanding of the informants point of view and to an extended picture of the lived experience of caring for both nurses and patients (see chapter 5). Within this framework the findings should

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be completely understandable to the informants who took part in the study and should therefore reflect as clearly as possible the lifeworld of the individual informant. This is certainly not the case with the studies discussed above. A cue may be taken from Merleau-Ponty (1962):

> Phenomenology is the study of essences...[but it] is also a philosophy which puts essences back into existence...it is the search for a philosophy which shall be a 'rigorous science,' but it also offers an account of space, time, and the world as we 'live' them (p.vii).

Critique

Most of research studies described above did not provide details about the ways in which the accuracy or truthfulness of the findings was established. Few made reference to any reliability or validity checks and careful evaluation of these studies was made more difficult by these omissions. However, it was apparent that important trends have begun to emerge, and this consistency lends some support to the findings reported above. Furthermore, little attempt has been made to synthesise some of the findings into a theoretical framework, although some already exist in nursing (Watson, 1979, 1985). Nor has any attempt been made to link the research completed in the nursing field with the large body of theory and research in the field of social psychology (see chapter 1). The literature also suggests that the most valuable insights into the caring process must include a patients' perspective *and* a nurses' perspective. However, the importance of relatives also should not be overlooked for they too are another important group who could provide significant insights into the caring process (Nolan and Grant, 1989) because of their immense contribution in community settings.

The lack of theoretical developments

For research to be cumulative it must be linked with a broader context and a range of approaches. In this domain, there has been little or no theoretical coherence and few links with the large body of related empirical work completed

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by social psychologists. Many of the studies of caring reported in the literature to date have failed to use the theoretical frameworks already available in the social psychology literature. One possible reason for this is oversight has been the dissatisfaction with the traditional model of research design built on a positivist philosophy. To ignore completely this huge body of research as a source of ideas and insights has been unwise.

Another possible explanation why the theoretical models developed in social psychology have not been employed by nurse researchers is the researchers' lack of awareness or familiarity with the psychological research. Nurses in academic life may have been too busy building nursing theory and models, instead of applying and utilising theories from social science. However, this lack of awareness or reluctance appears to be gradually fading and an appreciation of the potential is evident in some quarters (Leininger, 1988).

Nevertheless, some nursing theorists have utilised theory from other disciplines. Watson (1979, 1985) described a theory of nursing which drew together a human science approach to research and an emphasis on caring in nursing practice. Many of the ideas are grounded in phenomenological psychology. However, some of the terms Watson uses are unclear and overly complicated: 'carative factors' and 'allowing for the existential-phenomenological-spiritual forces' are examples which will not unfortunately help to unravel the complicated nature of the experience of caring for another person in a professional context. Watson (1985) claims that the carative factors or interventions are brought to life through the interpersonal relationship between the nurse and the patient as follows:

> All of these carative factors become actualised in the moment-to-moment human care process in which the nurse is being with the other person...Human care requires the nurse to possess specific intentions, a will, values, and a commitment to an ideal of intersubjective human-to-human care transaction that is directed

toward the preservation of personhood and humanity of both nurse and patient (Watson, 1985, p.75).

This analysis however, is based on Watson's definition of scientific theory. She described a theory as:

> ...an imaginative grouping of knowledge, ideas and experience that are represented symbolically and seek to illuminate a given phenomenon (Watson, 1985, p.1).

This approach to theory construction has questionable merits. No attempt was made to specify relationships between the ideas and no rationale was offered for their inclusion. Although the human science approach to research described by Watson has much to recommend it, particularly in relation to the exploration of the human experience of nursing and health care, it cannot lead to the production of a single unified theory of nursing. The subtitle of Watson's 1985 book 'A theory of nursing' is impractical for any attempt to produce a broad theory of nursing is likely to fail. Its equivalent in other fields may be a theory of psychology, or sociology or medicine. In a critique of this type of theory building Cash (1990) wrote:

> We argue therefore that this concept of caring as central to nursing has the following problem. If an attempt is made to abstract the term from the many usages and referents into a single concept, then the result is so general that it does not particularise Nursing but rather, is applicable to a wide variety of other professions (Cash, 1990, p.253)

> We have the situation therefore where there is no central core that can distinguish nursing theoretically from a number of other occupational activities (Cash, 1990, p.255).

Approaches which attempt to generate theories of nursing are likely to falter unless researchers identify a number of topic areas which can be systematically

researched and refined. This approach has proved successful in other related disciplines.

The neglected role of the environment

An area which has often been ignored in the research is the physical environment in which care and treatment is given. Canter (1984), an environmental psychologist, suggested that the role of the nurse has evolved in parallel with the changes on the layout, planning and design of hospital wards and units. The advances in treatment and technology led Canter to describe the role of the nurse as that of a 'caring technician'. Canter (1984) summarised a number of research studies which adopted a psychological perspective on hospital environments and asserted that the environmental context in which care was given, had an impact on the way nurses worked and interacted. His analysis was:

> ...that despite the undoubted commitment by nurses to provide a warm and caring context in which to nurse people to better health, the location of nursing within hospitals, paradoxically, sets in motion processes which can distance nurses from their patients. This is because the design and layout of hospitals, geared as they must be to particular functional and technical requirement, carry social and psychological implications as well (Canter, 1984, p.169).

This analysis may have implications for other researchers exploring nurses' and patients' experiences of care in hospitals or other institutional settings. The physical surroundings can change the nature of the experience.

Findings cannot easily be transferred across cultures

Most of the studies reported above have been completed in other cultures. To accept at face value these findings which may influence both nursing policy and practice would be shortsighted. The differences between health care in the UK and America are considerable so valid comparisons are made more difficult whatever the research domain. This has previously been noted in a report on the use of environmental seclusion in psychiatric care (Morrison, 1990a). The

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practice of nursing, the legal structure and the system of nurse education is completely different across cultures. So too are the people and their expectations of hospital and health care environments. It is imperative therefore that nurses in the UK study in detail, the nature of caring relationships.

Synopsis of the research literature on caring in nursing

Two very general themes have emerged from the literature discussed above. The concept of care and caring has been perceived as having both an instrumental and expressive element and this view supports the general notion put forward by Griffin (1983). However, it is surprising how few research studies into the meaning of caring have been carried out in the field of nursing. While some of these have examined patients' views, others have attempted to explore the nurses' perspective. Some differences in the ways in which nurses' and patients' perceive caring have emerged but these require further exploration and description.

A number of important trends have been identified in the literature described above and include the following issues: the practice of nursing which has been described as care and caring embraces both instrumental and expressive actions and behaviours; nurses and patients perceive both of these facets to be important in the process of caring; nurses also tend to perceive expressive behaviour as a more positive indication of caring than do patients; in contrast, patients tended to perceive instrumental nursing behaviour as a more positive indication of caring than do nurses; there is also a lack of theoretical development in the field; the role of the physical environment has been generally ignored in the research; and there is a problem of caring research carried out in different cultural settings.

In a recent paper Harrison (1990) argued that:

There is a clear need to build on and expand existing research and theory related to the phenomenon of caring, and to identify factors in the health care system that will enable nurses to care. Nurse

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practitioners, administrators, educators, researchers, and theorists must continue to work together to ensure that the ethic of caring remains an essential, unique focus for our profession (p.126).

While I share a desire to promote caring in day to day nursing practice and for more research into professional caring, I fail to see how caring is 'unique' to nursing. Other types of professionals also care for the people they look after albeit in a different way.

A brief overview of the approach used

This thesis explores nurses' and patients' experiences of caring relationships in nursing practice. The empirical work was carried out in two stages and is essentially qualitative in nature. In stage one, Kelly's (1955) personal construct theory and repertory grid technique was used to structure interviews with 25 experienced nurses (chapters 3 and 4). Stage two builds on the findings of stage one. A more fully qualitative approach was adopted to structure a further set of interviews with 10 nurses and 10 patients and the analysis of these is grounded in interpretive phenomenology (chapters 5-7).

Although the approaches to both phases of the data collection and analysis are distinct, they nevertheless share some common ground in that they have a phenomenological orientation. A detailed description of both approaches is provided in an attempt to avoid breaching some of the important assumptions about data collection and analysis which can result from combining approaches in the same study. I fully endorse Morse's (1989) view that mixed approaches can lead to a 'sloppy mishmash', at least in the hands of inexperienced researchers. Morse (1989) notes for example how the term 'phenomenology' has been used by some researchers as a synonym for qualitative research. In the following chapters I have provided a relatively detailed account of the background of the two major approaches which I used in this thesis in an effort to ensure that the methodological foundations of this study remain steadfast.

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Summary of the chapter

This chapter examined the concept of caring as it relates to professional nursing practice and research. A review of the research studies conducted by nurse researchers highlighted several trends in the literature, however, relatively few research studies have been undertaken and most of these have been completed in America. A notable discrepancy in the views of patients and nurses was found as well a tendency to conceptualise caring in terms of 'instrumental' and 'emotional' dimensions. The role of the caring environment has generally been ignored in the research literature. In the next chapter the theory of personal constructs is introduced. This theoretical framework was developed by the psychologist George Kelly in the mid 1950's and was used during the first half of the present study.

CHAPTER 3
PERSONAL CONSTRUCT THEORY AND THE
REPERTORY GRID TECHNIQUE

Introduction

This chapter describes briefly the theory of personal constructs. The key characteristics of the theory are discussed initially. The emphasis is on Kelly's approach to understanding people and doing research. In addition, the repertory grid technique which developed as the major data gathering device for the personal construct approach is outlined. Details about the general structure of the interview procedure, the format of the specific grid which was employed, and the methods of analysis are described. The approach was used in the first part of the present study to interview a sample of 25 experienced nurses and explore their perceptions of the meaning of caring relationships.

The personal construct theory approach: general principles

Personal construct theory (PCT) was developed by the psychologist George Kelly (Kelly, 1955). Kelly used the metaphor of *people as scientists*, with their own personal theories about the world and the people and objects in that world, to describe the essence of his approach. He assumed that, 'like the scientist' people made predictions on the basis of these personal theories. If a theory proved itself to be useful for anticipating future events in a person's life, it was preserved by the person as a valid view of the world. If on the other hand the theory was found wanting, and failed to predict the future successfully, then it was revised in subtle ways and used again in this modified form or abandoned altogether.

Keen (1975) described Kelly's approach as essentially a phenomenological one because it accepted personal experience as a domain worthy of scientific research. In his evaluation of the focus on elements and constructs and the relationships between these within the Kellyan approach, Keen remarked that:

> ...although the task looks very intellectual, the emotional flavour of
> our lived experience will come into play just as it does in our
> everyday construing of the world....We have here almost a routine

that can teach the phenomenological-reduction and imaginative-variation techniques for seeing more clearly what and how and why we see as we do (p.65-67).

In contrast, Bolton (1979) is unequivocally disapproving of such an allegiance on the grounds that the personal construct approach is essentially subjectivist and not directly focused on the *essence* of 'lived experience' which is one of the hallmarks of the phenomenological approach. The grounds for both sets of assertions are reviewed in detail by Ashworth (1981). In general, PCT can be seen as over cognitive if it is reduced simply to the findings of grid technique. Tempered by the psychologist's sensitivity to full lived experience, however, it approaches phenomenological psychology.

Although Kelly (1977) affirmed the importance of *human experience* within the PCT framework he also rejected the idea of an affiliation between PCT and phenomenology, as well as existentialism, cognitive theory and even learning theory. In his earlier work he referred to the PCT approach as being 'almost phenomenological' (Kelly, 1955, p.173) but a little further on he noted that:

> ...we cannot consider the psychology of personal constructs a phenomenological theory, if that means ignoring the personal construction of the psychologist who does the observing (p.174).

The type of phenomenology employed within this study does not ignore the 'construction' process of the researcher as Kelly has claimed. Moreover, the experiences of the researcher form an integral part of the research as a whole. While acknowledging the debate about the claimed link between PCT and a phenomenological philosophy, the PCT approach does give informants the freedom to share their views and experiences and in doing so, the opportunity to gain insight into aspects of those experiences of which they were previously unaware.

Chapter 3 : PCT and the repertory grid technique

For Kelly however, the best way to explore human experience was through the PCT framework and the philosophy which underpinned this framework known as *constructive alternativism*. This philosophy emphasises the possibilities that are always available to the individual as he tries to understand his world and anticipate the future. The main benefit of adopting this position was summarised by Kelly as follows:

> Since man is always faced with constructive alternatives, which he may explore if he wishes, he need not continue indefinitely to be the absolute victim either of his past history or his present circumstances (Kelly, 1955, p.43).

This passage reflects the existentialist position which is an implicit part of PCT. It emphasises the active role which people have in making sense of their experiences and in assuming responsibility for their own lives and the decisions they make. On another occasion Kelly commented on the problems of dealing with life as follows:

> The only valid way to live one's life is to get on with it. Man lives best when he commits himself to getting on with his life (Kelly, 1969, p.64).

Personal theories are derived from the *meaning* individuals assign to their experiences. For Kelly then, people as scientists do not react to the events in their lives but to *the sense they make of these events or experiences*. Shaw (1980) summarised this point of the theory as follows:

> Personal construct theory, therefore, is a theoretical position within psychology which accepts the way in which a person attributes meaning to events as a central psychological process. The assumption made is that events do not directly influence behaviour or experience but rather that the meaning attached by the individual to the events has that impact (p.18).

Chapter 3 : PCT and the repertory grid technique

Theoretical issues relevant to the present study

The formal content of PCT has been fully described elsewhere and will not be discussed here (see for example, Bannister and Fransella, 1986; Bannister and Mair, 1968; Kelly, 1955, 1970). However, the individuality corollary, the commonality corollary, and the sociality corollary were of particular interest for the present study because of the assumptions which underpin the use of the repertory grid technique.

The individuality corollary

This corollary states that 'persons differ from each other in their construction of events'. In effect different people may make rather diverse interpretations of the same event. They do so by employing different constructs. If we wish to explore a persons view of the world, we can do so by examining information about the structure and content of that person's construct system. This information may provide others 'with some basis for understanding his psychological processes and predicting his behaviour' (Adams-Webber, 1979a, p.17). From the point of view of the present study this is an important consideration. During the first empirical phase a sample of experienced trained nurses was selected with the specific aim of exploring their construct systems to establish what the phenomenon of 'caring' meant for these people. In this way descriptions of a range of different perspectives were obtained.

The commonality corollary

In contrast, the commonality corollary states that 'to the extent that one person employs a construction of experience which is similar to that employed by another, his processes are psychologically similar to those of the other person'. This corollary focuses on the comparisons which may be made between individuals. Although no two individuals can have the same experience, they can however employ a similar view of the experience:

> ...the point is that having bumped into different sets of circumstances, and worked out their ideas about what these circumstances were all about, they have come to similar conclusions (Bannister and Mair, 1968, p.23).

This is also an important issue for the present study because although a sample of individuals was employed to obtain a wide range of different perspectives of caring, a collective picture was sought by examining the data for common themes and similar constructs.

The sociality corollary

The sociality corollary states that 'to the extent that one person construes the construction process of another, he may play a role in the social process involving the other person'. To be able to engage in social interaction with others we must be able to construe the personal constructions of other people. In this way we attempt to understand the other person's viewpoint. In the present study an attempt is made to gain an insightful understanding of some nurses' constructions of interpersonal caring.

The individuality, commonality, and sociality corollaries together *form the basis of all interpersonal relationships within the PCT framework* (Adams-Webber, 1979a, b). Research into interpersonal relations within this framework has focused mainly on individual differences in the content and structure of personal construct systems with particular emphasis on the ways in which people construe the behaviour of other people in social settings (see Bannister and Fransella, 1986). Explorations of 'commonality' are more concerned with the similarity of content of personal construct systems in the development of interpersonal relationships (see Duck, 1973, 1983; Landfield, 1971). The 'sociality' corollary has also been used to focus research into strategies for achieving effective communication and promoting interpersonal understanding (see Ryle, 1975, 1985). Most of the studies of interpersonal relationships within the PCT framework have

employed the repertory grid technique to collect data and a discussion of this technique follows.

The repertory grid technique

To find out about a person's world it is necessary to ask the person about it. Such an approach has often been frowned upon by some researchers because of the difficulties of establishing whether or not the person will tell the truth. The informant for example may not be consciously aware of a particular experience, or may deceive himself in order to avoid facing unpleasant memories, or indeed he may deliberately present a particular picture of himself to please the researcher (see chapter 9). Traditionally researchers have avoided asking important questions precisely because of these problems. However, within the qualitative framework adopted here, the main focus of the research is not on establishing the 'truth' of a particular incident as in a court of law, but to gain a detailed understanding of the informant's lived experiences.

Harré and Secord's (1972) critique of traditional approaches to research in social psychology advocated the 'anthropomorphic model of man' in research in which people were treated as if they were human beings capable of exerting control over their own actions as well as monitoring and criticising these actions. The major implication of this approach for social psychological research is summarised in the following passage:

> Acceptance of the anthropomorphic model of man leads to the introduction of personal reports as a crucial element in psychological study. We try to justify this by arguing for the *open souls doctrine*, a stand taken in our attempt to bring into behavioural science the phenomenal experience of individuals. The things that people say about themselves and other people should be taken seriously as reports of data relevant to phenomena that *really exist* and which are *relevant* to the explanation of behaviour...It is through reports of feelings, plans, intentions, beliefs, reasons and so on that the meanings of social behaviour and the rules underlying social acts can be discovered (Harré and Secord, 1972, p.7).

If personal reports form an important part of psychological investigations then the most obvious way to collect these reports was to *ask* people about their experiences (Harré and Secord, 1972). This general orientation is similar to the strategy advocated by Kelly in terms of PCT when he suggested that if we really wanted to find out anything about a person's constructs we should ask them directly:

> The simplest, and probably the most clinically useful type of approach to a person's personal constructs, is to ask him to tell us what they are. It is hard to persuade some psychologists that such a guileless approach will work (Kelly, 1955, p.201).

Although Kelly was not the only advocate of this particular strategy in the research process (Epting, 1984), he was certainly one of the most forceful proponents of the tactic.

Qualitative interviews usually produce very large amounts of data which may be difficult and time-consuming to analyse. Interviews structured around the repertory grid technique also produce large quantities of data. However, one of the important advantages (and it is acknowledged that others may see it as a disadvantage) of the repertory grid approach is that it helps the researcher and the informant to organise and structure the data into a format which can be more easily analysed, while at the same time, it tries to capture the informant's view of the world. Kelly devised a number of strategies for exploring the personal views that are held by different individuals such as 'self-characterisation' and the 'role construct repertory test'. But it was a development of this latter test, known as the repertory grid which found most favour with researchers in clinical and educational settings. The repertory grid technique has now become synonymous with Kelly's approach.

Elements and constructs

In order to explore and understand the private world of another person using the repertory grid technique, a knowledge of salient *elements* and *constructs* which that person used to make sense of his or her world is needed. An element may be any object, event or person which a person is asked to consider. The type of elements examined will depend greatly on the nature and purpose of the research. Usually a set of elements is selected by the researcher who then asks the informant to identify important 'likenesses' and 'differences' between these elements. This process leads to the production of a set of bi-polar *constructs* such as 'cruel-kind' or 'self confident-insecure', 'effective-ineffective'. A construct therefore, may be described as a dimension or variable which allows a person to classify a set of elements:

> More generally, a construct is a way in which some things are seen as being alike and yet different from others. A construct is therefore essentially a two-ended affair, involving a particular basis for considering likenesses and differences and at the same time for excluding certain things as irrelevant to the contrast involved (Bannister and Mair, 1968, p.25).

In a research context, the constructs produced are usually in the form of verbal descriptions or words. As was suggested above, these descriptions may *mean* different things for the person who produced it and the researcher, so great care must be taken to ensure there is consistency between what the informant says and what the researcher thinks he said.

Supplying and eliciting elements and constructs

One practical problem which the researcher has to consider is whether to *supply* or *elicit* elements and constructs. Supplying informants with elements and constructs can introduce the risk of influencing what informants have to say. However, even if a set constructs is supplied by the researcher, informants will construe these in a personal way and use them in a way that makes sense for

them. Fransella and Bannister (1977) rightly point out that it is impossible to *supply a construct* since all that can be supplied is a verbal label which the informant construes in his or her own terms. However, there is some evidence to suggest that informants have a preference for elicited constructs over those supplied by researchers (Adams-Webber, 1970). In addition, a number of studies have taken the tendency of informants to rate the more extreme points on elicited bi-polar constructs compared with supplied constructs as evidence of greater personal meaningfulness (Bender, 1974; Warr and Coffman, 1970). This interpretation is not wholly reliable for others have argued that supplied constructs also produce meaningful results (Nystedt, Ekehammar and Kuusinen, 1976). A more detailed discussion of the literature on the debate about eliciting or supplying constructs may be found elsewhere (Adams-Webber, 1979a, pp.23-27; Bannister and Fransella 1977, pp.19-20, 106-107, 113-114; Collett, 1979).

The literature on the issue of supplying or eliciting indicates that decisions have to be made by the researcher after taking a number of points into consideration such as the previous literature on the topic, the informant group, the chosen methods of analysis and so on. While acknowledging the legitimacy of supplying a set of constructs which informants can construe in their own terms, my own feeling is that it is more appropriate to elicit elements and constructs from informants rather than to supply them. The process of completing a grid should not be an intimidating experience for informants. It should be straightforward and easy to use. Allowing the informant to generate his or her own constructs should help them to feel more comfortable with the ideas contained in the grid. The personal elicitation procedure ensures that the approach is closely in line with Kelly's original theory of *personal* constructs.

However, there may be occasions when it is feasible to supply elements and constructs or to combine a selection of elicited and supplied elements and constructs in a particular application of the grid technique, and this has been done effectively in a number of studies (Costigan et al, 1987; Gordon, 1977; O'Sullivan,

1985; Wilkinson, 1982). Supplying elements and constructs may be especially viable when the important elements and constructs which people use have been identified from earlier research literature and provided that the supplied verbal labels are similar to those which are normally used by the informants (Fransella and Bannister, 1977).

General characteristics of the repertory grid technique
There are several different ways in which repertory grids can be constructed and used in the research setting. Fransella and Bannister (1977) outlined the diverse range of grid design and scoring systems which may be used. Much will depend on the aims and objectives of the research, the type of informants accessible to the researcher, the time available, the selected method of analysis and so on. The repertory grid procedure can be used to collect both qualitative and quantitative data in the same study (Morrison, 1990b).

Bannister and Fransella (1986) described four important characteristics common to all repertory grid studies: (1) there is a concern with eliciting from a person the relationship between constructs, (2) the primary aim is to expose the relationship between constructs and elements for a *particular person* without aiming to compare these with larger and more general trends, (3) the format of the technique is especially flexible. There is no fixed procedure since the repertory grid is a technique not a test. Each particular application of the grid should be designed for a specific problem or purpose, and (4) repertory grids are designed so that a range of statistical analysis procedures may be used to help interpret the content of the grids. It is assumed that the psychological relationship between constructs or elements in the grid is reflected in the statistical relationship between constructs and elements.

Reliability and validity of the repertory grid technique
The reliability and validity of a repertory grid is dependent upon the way in which the grid is used. One approach is to employ the grid as a psychometric test in

which both elements and constructs are offered as constants to larger groups or to individuals in test-retest situations. Another approach is to use the technique in studies where discovery is the chief objective. The emphasis here was on qualitative data from a small sample of informants, where the individual's 'lifeworld' (Valle, King and Halling, 1989) was explored, in an attempt to grasp an understanding of that person's view of the world. Used in this way, the repertory grid offers a template for providing idiographic qualitative material. In this type of study, there are few if any constants, apart from the focus of the inquiry.

When a fixed repertory grid is used to survey large samples of people then it is permissible to talk about the reliability and validity of a particular grid. But when individual insights and understandings are sought problems are encountered. A diversity of opinion has emerged amongst grid users. Adams-Webber (1987) for example urged replication of experimental results to establish reliability measures. Whereas Bannister and Mair (1968) argued that:

> Since there is no such thing as *the* grid, there can be no such thing
> as *the* reliability of *the* grid (p.156).

Kelly (1955) preferred to talk in terms of the grid's 'consistency', and referred to experimental evidence which measured the consistency of elicited elements and constructs, (also in Bannister and Mair, 1968). Reliability in repertory grid studies refers to a particular grid in a particular context. A similar position has been put forward with regard to the validity of grid technique (see Bannister and Mair, 1968, and Fransella and Bannister, 1977).

While it is acceptable to question the validity of a particular grid used it does not make sense to ask about the validity of *the* repertory grid. In Kelly's original formulation validity was perceived as being synonymous with usefulness. It is significant that personal construct theory originated as a framework for

observing and understanding *change* in people undergoing therapy in which change is expected, and in this context less emphasis is placed on reliability and validity. The attempt to measure change in this context rules out the usual meaning of test reliability. Grids in themselves are not intrinsically reliable or valid.

In a very practical discussion of validity Yorke (1985) outlined a number of characteristics of grid use which promote validity in a general sense. He considered validity to be '...the potential of a grid to capture accurately the construing of the respondent' (p.385). He suggested a number of technical pointers to ensure valid grid work including: (1) the need to attend to the context in which the repertory grid is to be used, (2) the use of a set of elements which are well suited to the purpose of the study, (3) the importance of considering whether elements and constructs are to be supplied or elicited, (4) the type of elicitation procedures to be used, (5) the assumed shared meaning of supplied constructs, and (6) the assumptions made about the ways in which repertory grids are completed and the computer analysis of grid data.

However, there are other ways of assessing the validity of qualitative findings which are necessary if qualitative approaches can be said to be rigorous (Ashworth, 1987a). One method of choice is to ask participants involved in the research if the findings represent an adequate description of the data (Ashworth, 1987a; Hycner, 1985). On a commonsense level, researchers must ask themselves if a particular use of the repertory grid technique excludes researcher bias as has been suggested (Stewart and Stewart, 1981). If used in a careful and thoughtful way the technique can certainly reduce observer bias considerably. However, even a research interview is subject to the rules and performances found in any social event (Ashworth, 1987a) (see chapters 5 and 9). Great care and thought must be given over to the use of the repertory grids as a focus for interviewing informants.

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Another important issue related to the problem of establishing the validity or accuracy with which informants' perceptions are captured in the repertory grid concerns the need to make notes about each interview. The researcher should note down (as I did) his or her own reaction to what the informant said, and any other impressions or persistent themes about the interviews and the informants (see appendix 1). These ideas can prove to be especially helpful during the analysis of the grid data, although they are not usually recorded on the grid data sheet. They can help to re-acquaint the researcher with the interview setting and the informant some time after the actual interview has been completed. This can prove to be especially helpful when the final analysis of a grid is undertaken perhaps some months after the actual interview. These notes or impressions can help to bring the particular constructs to life for the researcher and serve as an important aid to interpretation. However, the fact that such additional notes were necessary highlights an important weakness in the repertory grid technique.

Outline of the first part of the present study
The PCT approach and the repertory grid interview technique were chosen as a suitable framework for completing the first part of the study. The approach was found to be flexible but at the same time well structured, and provided the researcher with a technique for achieving the initial objectives of the project.

Aims of the study
(1) To interview a sample of experienced nurses and elicit a set of constructs which describes their perceptions of the meaning of caring.

(2) To describe how these individual nurses perceive themselves with respect to elicited constructs of caring.

(3) To analyse both the content of the constructs elicited and the structural relationships between the self and ideal self elements for the informants.

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The repertory grid format

The rating method

To achieve these aims a particular type of repertory grid was chosen. The rating grid format was well suited to the task. Shaw (1980) noted that in practice rating grids were used in approximately 70 per cent of grid studies because they are easier to administer and pose no special problems of understanding for most groups. A number of other advantages of the rating method were noted by Bannister and Mair (1968) including: (1) the flexibility for the informant to allocate any number of elements to either of the construct poles, (2) the freedom to use fine distinctions between elements through the use of a continuous scale, and (3) the fact that the informant is not forced to make a differentiation such as those required when using the ranking method. The rating method thus enables the informant to make subtle discriminations between elements and constructs and is particularly sensitive to change.

Despite these apparent advantages, a pilot study (n=5) was completed to test out a number of different grid forms. In particular, the implications grid and rating grid were tried with a large selection of role elements. The role elements related to professional caring and helping and interviews with up to fifteen elements were tested. A number of different sorting methods such as the 'triad' and 'dyad' modes were also used to elicit constructs. As a result of this pilot, a seven point rating method was adopted which conforms to the recommended number of response alternatives in scale construction (Cox, 1980).

The self-identification method of construct elicitation

Because of the very limited amount of research in this field, it was decided that constructs should be elicited by a self-identification method (Fransella and Bannister, 1977). The self-identification method involved comparing the 'myself as a carer' element with each of the remaining elements selected by the researcher. This elicitation procedure helped to ensure that the constructs were personally meaningful for the individual informants. There is considerable

support for the argument that elicited constructs are more meaningful for the individual than those supplied by the researcher (Adams-Webber, 1979a; Shaw, 1980).

The selection of element role titles

Element role titles were chosen so as to be representative of the area of inquiry, namely how do carers construe caring. The pilot study demonstrated that a small element set (8 elements) would work well while not overloading the informant or taking up too much of their time away from the clinical setting. In addition, a small element set helped to keep the interview interesting for the informant. A small number of role titles was drawn up which reflected different levels of caring, and at the same time offered a varied picture of the types of individuals which informants would know (figure 3.1).

	ELEMENT ROLE TITLES	INITIALS OF THE PERSON DESCRIBED
1.	A caring nurse	
2.	An uncaring nurse	
3.	The most caring person I know	
4.	The least caring person I know	
5.	A person I care a lot for	
6.	A person I don't care much for	
7.	Myself as a carer	
8.	How I would like to be as a carer (Ideal self)	

Figure 3.1. The set of element role titles.

Relating the elements to the elicited constructs

After a set of eight bi-polar constructs had been elicited, the informant had to complete the grid in order to show the ways in which the elements and constructs were interrelated. Each of the elements were presented in turn to the informant

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who had to rate them on the set of constructs that had just been elicited. This elicitation and grid completion procedure resulted in an 8 by 8 grid. Even small grids of this size produce large volumes of data which can be analysed in number of ways. Lansdown (1975) provided a precedent for grids of this size in an exploration of reliability of the repertory grid with young children.

The sampling method

Strategic informant sampling

The sampling method employed has been described as 'strategic informant sampling' (Smith, 1981). In this method the researcher taps persons who are well informed about the social setting being investigated. Typically, individuals occupying leadership roles are selected. The sampling process was executed in two different ways. Initially an 'expert choice' method was employed. This entailed asking the senior nurse managers to provide the names of individuals in the organisation. In addition, a 'snowball' method was used where informants who were contacted at the outset were asked to furnish the name of one other person for the sample (Coleman, 1958). On several occasions informants were asked to recommend other people with different views on the topic.

This type of sampling technique is not at all like the sampling that is used in large surveys where the major concern is to achieve a representative sample of respondents so that the results may be generalised to the population at large from which the sample was chosen. In quantitative research, rules and procedures for generating specific sample types and sizes have been developed. In contrast, few guidelines for the selection of samples in qualitative research have been drawn up (Morse, 1989a). In this part of the study (and in the second part also) the major concern was to select informants who were genuinely knowledgeable about the phenomenon being studied and the context in which it was studied. A good informant in this instance is one who is willing to give up time to share their experiences of the phenomenon being studies in an honest and open way. The

strategic informant sampling procedure used here helped to ensure that an appropriate sample of informants was chosen.

Strategic informant sampling is limited in some important respects however. By selecting only those informants occupying key leadership roles the researcher necessarily excludes others. Nurses subordinate to the ward sister/charge nurse role also have views about the nature of caring which may be quite different from those of the charge nurses and sisters. This issue has been addressed in the second part of the study where a deliberate attempt was made to select informants who occupied dissimilar roles within the nursing hierarchy and who would therefore have different experiences of caring for patients on a day to day basis.

The sample of experienced nurses

A sample of 25 ward sisters/charge nurses was selected. This grade of nurse is reported to be most influential in determining educational opportunities at ward level (Marson, 1982; Ogier, 1984; and Orton, 1981), as well as providing role models for learners and other nurses. The group has also been found to have a significant influence on the work situation and climate (Choppin, 1983; Fretwell, 1982; Pembrey, 1987). This group holds a position of power and influence in nursing practice and were obvious strategic informants. Permission to approach members of staff was provided by South Glamorgan Health Authority and by the Directors of Nursing and Midwifery Services across three hospital sites in the Cardiff area. The informants were chosen from a number of specialty nursing areas in an attempt to get a broad picture (see figures 3.2 and 3.3).

General	Midwifery	Psychiatric	Paediatric
10	8	5	2

Figure 3.2. The distribution of informants working in different areas of nursing and midwifery (n=25).

Community based	Hospital based
6	19

Figure 3.3. The distribution of informants across community and hospital settings (n=25).

Interview procedure

Initial contact with informants

The researcher initially contacted informants by phone and arranged to meet each informant in their working environment. Informants were invited to take part in the project as cooperative participants or co-researchers (Reason and Rowan, 1981). The early contact was used to provide details about the project, the repertory grid (devoid of technical language), and to answer any questions. Confidentially was assured. The researcher also emphasised that the interview procedure was not a test and that there were no right or wrong answers to the issues which would be raised during the interviews. My concern was to explore their views and opinions about caring relationships.

Informants were given the list of role titles (figure 3.1) to be used as elements during the interview and they had to identify and match real people to these titles before the interview and note these down on the sheet. They were instructed to write down only the initials of people as it was not necessary for the researcher to know these. A further requirement was that they should choose different people for each role element. Some informants mentioned how difficulty it was to assign people to negative roles for example, 'the least caring person I know'. However, most completed these without too much difficulty and several reported that they had found it a very thought provoking exercise. Informants were asked to bring the completed list with them at a mutually agreed time when the repertory grid could be administered. To avoid over complicating the situation all technical language related to grids was avoided and the procedure

was described by the researcher as a way of structuring a conversation to help informants to focus and share their ideas, thoughts, and feelings.

Elicitation procedure

During the interviews the informants were asked to consider the role titles in the context of their work as professional carers. The 'myself as a carer' element was compared with each of the others in turn and the informant had to identify important 'likenesses' or important 'differences' between these. Having conveyed this characteristic to the researcher, the informant was then asked to describe its opposite. Semantic opposites for these qualities were then described by the informant. The same manoeuvre was adopted for elements 1-6. Element number 8 (the ideal self) was examined on two occasions as it was felt to be an important role element for looking at potentially salient dimensions.

The practice of asking for semantic opposites, as opposed to asking for differences, produces constructs which can be used more effectively in grids with continuous scales (Epting et al., 1971). However, there is a price to pay for doing so and the researcher must decide whether differences or opposites are used. Yorke (1985) described the researcher's dilemma as follows:

> Each approach has its virtues, but these tend to be related inversely: the 'difference' method may produce the more personally meaningful discriminations, though the production of 'peculiar' constructs creates problems in the completion and analysis of the grid matrix; the 'opposition' method tends to produce 'logical' constructs which are easier to treat as scales, but at the risk to the communication of personal meaning (p.389).

In an effort to try and overcome this intrinsic difficulty of construct elicitation, informants were asked what the opposite of each construct meant for them *personally*. The constructs produced ranged from single words to sentences. Some informants were able to express constructs in a one word, while others used phrases or sentences. My task was one of facilitation - asking for likenesses or

differences, sorting the elements in sequence, and recording construct labels. Occasionally an informant provided several ideas at once. When this occurred, the ideas were referred back to the informant for clarification. The approach to construct elicitation was modelled on the advice of experienced repertory grid users (Fransella and Bannister, 1977; Yorke, 1978):

> ...an easy relationship and a free-flow of discussion between the examiner and subject is the best basis for construct elicitation (Fransella and Bannister, 1977, p.21).

Rating the elements

Informants had to rate the eight elements along the construct dimensions produced. Figure 3.4 provides an example of the score sheet. On the left hand side of the sheet the emergent pole of the construct was recorded, with the contrast pole on the right hand side. A seven point rating scale was provided in the central section. Informants rated the elements to a particular point on each construct by placing a mark at the appropriate point on the scale. These were later converted into scores (1-7) on an 8 by 8 matrix (see appendix 1 for an example of a completed grid). The informants were asked to consider each construct scale as a continuous dimension. The outer margins were given verbal labels by the researcher such as 'extremely' or 'always', and the points in between were to be regarded as lesser degrees of intensity.

Because a seven point scale was used a natural midpoint along each construct dimension could be used. The midpoint in the scale was used when (a) the construct did not apply to a particular element, or (b) when both poles of the construct applied equally to an element or (c) the informant was uncertain or did not know how to respond. When the midpoints of the scales were used, informants were asked to specify *how* they were being used and this was noted down on the grid sheet. This information is important in the interpretation and understanding of the grid and especially so in clinical situations (Beail, 1985). All

but one of the 25 informants used the midpoint of some of the construct scales. However, when the midpoints were employed, they generally indicated that both sides of the constructs applied to particular elements.

EMERGENT POLE	ELEMENT (1) A caring nurse	CONTRAST POLE
Keen to explore feelings	√ - - - - - -	Ignores feelings
Inappropriately authoritarian	- - - - - - √	Able to select appropriate leadership style
Gives of themselves freely	√ - - - - - -	Constantly unavailable
Lacks awareness of others	- - - - - √ -	Awareness of others
Expresses emotions freely	- √ - - - - -	Thinks more about emotions
Obviously tense	- - - - - - √	Appears relaxed
Sensitive approach	√ - - - - - -	Thoughtless approach
Impatient	- - - - √ - -	Calm and confident

Figure 3.4. A section of completed repertory grid showing how one element was rated on the elicited constructs by informant number 25.

Grid analysis

Focus on structure and content of the grid

There are essentially two approaches to the problem of analysing repertory grids (Bannister and Mair, 1968). One involves looking at the *structure* of the data while the other involves focusing on the *content* of the construct system. Both approaches have been used in the present study.

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The decision not to use statistical analysis

A wide range of statistical procedures exist for analysing repertory grids (see Bannister and Mair, 1968; Beail, 1985; Easterby-Smith, 1981; Fransella and Bannister, 1977; Rathod, 1981; Shaw, 1980; and Yorke, 1985). Careful consideration is required when using the more complex analysis procedures because of the risks of inappropriate analysis and interpretation (Bell, 1988; Yorke, 1989). Carver (1978) argued boldly that '...statistical significance testing has involved more fantasy than fact' (p.378). Moreover, one of the most influential advocates of personal construct theory and the repertory grid technique warned that:

> ...grid method is a Frankenstein's monster which has rushed away
> on a statistical and experimental rampage of its own, leaving
> construct theory neglected, stranded high and dry, far behind
> (Bannister, 1985, p.xii).

Mindful of these warnings, which also subvert the phenomenological adequacy of PCT, it was decided not to employ any of the available statistical analysis packages because of the risk of producing trivial results. In addition, the design of the grids ensured that I was able to retrieve the sort of information which was essential for successfully achieving the aims of the project. Complicated statistical analysis would have added little. The small size of the grid meant that a simple difference score could be calculated to explore the relationship between constructs for each individual informant and to examine the relationship between the self and ideal self elements.

Content analysis of the constructs

Content analysis was used to categorise the 200 constructs generated by the informants (Berelson 1952; Mostyn 1985; Stewart and Stewart 1981). This technique has been used in repertory grid studies of personal relationships (Duck, 1973) and in an evaluation of training practices in social work (Lifshitz, 1974). Duck (1973) devised a four category scheme to classify the constructs people use

in the formation of friendships. The four categories were: (1) psychological, (2) role, (3) interaction and (4) other constructs. Lifshitz (1974) found differences in the types of constructs employed by experienced and trainee social workers. The latter group tended to use concrete descriptive constructs such as age, sex and so on, while their mentors used more abstract constructs related to ideals and values.

Landfield (1971) also employed a form of content analysis in a study of psychotherapy, while Neimeyer et al., (1984) described a content analysis technique for classifying constructs about death. Furthermore Honess (1985) has argued that the analysis of content or themes is just as important as the structural relationships in grid data, but that much of the research has ignored the significance of content. The use of content analysis is controversial because of the uncertainty over exactly what is analysed - the manifest or the latent content. A number of researchers have recommended that *both* types of content should be used (Berg, 1989; Holsti, 1969; Smith, 1981). Holsti (1969) suggested that:

> It is true that only the manifest attributes of text may be coded, but this limitation is already implied by the requirement of objectivity. Inferences about the latent meanings of messages are therefore permitted but...they require corroboration by independent evidence (p.14).

Interpretation of the latent content is unavoidable. Viney (1988) has discussed the issue of interpretation in relation to personal construct theory. She argued that interpretation involved a:

> ...two-way interaction between people, each with his or her own interpretation of their situation and the capacity to act and react. Psychologists are, in personal construct terms, trying to construe the construction process of another. They are trying to enter the interpreted world of the other (p.372).

Moreover, interpretation is based on the assumption that 'it is possible for one person to tap the inner world of another' (Viney, 1988, p.374). The content analysis was qualitative in the sense that the constructs elicited from the informants were interpreted by the researcher.

(1) *The content analysis in action*

The 200 constructs were written onto small index cards and sorted into similar categories and labelled. In order to minimise researcher bias repeated sorts were completed and colleagues analysed the constructs independently as recommended by Carney (1972). In addition, three of the informants were asked to examine the findings which emerged from this analysis. The process of engaging colleagues and some of the original informants was extremely useful. The initial findings were gradually refined following discussions with both groups.

The content analysis principles outlined by Stewart and Stewart (1981) were used. The constructs (both poles) provided by the informants were written onto small cards and sorted by the researcher into homogenous content areas or categories. Then each category was given a label corresponding to the type of content. A number of colleagues were asked to check the match between content type and the label supplied by the researcher. They were invited to offer alternative labels if they so wished. This resulted in one new category being generated and a minor revision of two of the other labels. Then all the constructs were assigned to the category labels. A small number of constructs were marked to indicate to the researcher their category allocation and colleagues were asked to sort these into the category framework. In this way reliability checks for the category labels and for the assignment of individual constructs were undertaken (Stewart and Stewart, 1981).

Some of the constructs were difficult to classify and appear to fall into more than one category. The main reason for this appears to be the bi-polar nature of the constructs. Although few in number, they have been allocated to

one category only in this instance. Stewart and Stewart (1981) suggested that a shortage of constructs which overlap into more than one category should be taken as a sign of a good category scheme. Ultimately the quality of the category scheme depends on how broad or general the category scheme is to be. If the categories are very broad then it is likely that there will be much more room for constructs which overlap into more than one category.

(2) *The structural relationship between elements*

The purpose of the research stressed a comparison of the 'myself as carer' and the 'ideal self as a carer' elements. This was accomplished by calculating a simple difference score (Bannister and Mair, 1968), between the numerical ratings for each of these elements (see figure 3.5).

Similarities or Differences	Self	Ideal Self	Contrasts	Difference Score
Concerned for people	2	2	Disinterested in peoples' welfare	0
Rude	6	7	Polite	1
Kind	2	1	Harsh	1
Narrow-minded	6	7	Flexible ·	1
Happy	2	2	Depressive	0
Selfish	5	6	Gives freely of oneself	1
Effective	3	1	Workload orientated	2
Genuine	2	1	False	1
Total difference score				7

Figure 3.5. Section of the grid from informant number 19 showing the constructs, the pattern of rating for the self and ideal self elements and the total difference score.

In this instance a '1' means that the left hand pole of the construct applies while a '7' means that the right hand pole of the construct applies. The values in

between these two extremes refer to lesser degrees of application. The difference score was calculated by subtracting the rating for the self from the rating for the ideal self on each of the eight constructs provided by the informant, and then adding these together to give an overall measure of difference between these two elements.

Summary of the chapter

This chapter introduced the theory of personal constructs devised by the psychologist George Kelly and emphasised the relevant sections of the theory which apply to the present study. In particular the individuality, the commonality and sociality corollaries of the theory were highlighted. One of the main data gathering devices used within the personal construct theory approach is the repertory grid technique and a particular type of repertory grid format was developed for structuring interviews with a sample of 25 nurses. The major aim of these interviews was to explore the nurses' perceptions of the phenomenon of caring in nursing practice. Two approaches to analysis were discussed; content analysis and simple difference score calculations. The results of these interviews are discussed in the next chapter.

CHAPTER 4

NURSES' PERCEPTIONS OF CARING

Introduction

In this chapter the findings of the repertory grid interviews with 25 informants are described and discussed. The constructs produced by the informants were analysed in two ways. In the first instance, the pool of constructs were analysed using content analysis and six major themes were found to emerge from the data. In addition, simple difference score calculations revealed discrepancies between the self and ideal self elements for all of the informants. These results are discussed below. The findings which emerged from these interviews helped to shape and direct the second part of the study reported in the following chapters.

The findings

Themes discovered in the content analysis

Figure 4.1 displays the six themes which emerged from the content analysis.

Category	Number of constructs	Percentage
1. Personal qualities	69	34.5
2. Clinical work style	51	25.5
3. Interpersonal approach	35	17.5
4. Level of motivation	22	11
5. Concern for others	14	7
6. Use of time	9	4.5
Totals	200	100

Figure 4.1. The six category scheme developed from the content analysis procedure.

It conveys the complex nature of caring nursing practice. The six category scheme has been modified slightly from the one described elsewhere (Morrison 1988, 1990b, 1991). These categories represent important dimensions of caring in clinical nursing, and embody a description of the caring process which has not been detailed before.

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Discrepancies between the self and the ideal self

The emphasis in the previous section was on the content of the constructs in the search for common themes, and to provide an overall picture of these nurses' perceptions of the meaning of caring. However, the interview and rating procedure also allowed the exploration of how the informants evaluated their own performance as professional carers. This was done by comparing the values for the self and ideal self elements and calculating simple difference scores (Bannister and Mair, 1968; Easterby-Smith, 1981; Honey, 1979) between these elements for each of the informants. This analysis procedure focused attention on the structure of the data within each grid. From these scores it was possible to see how informants perceived themselves on their own constructs and to identify discrepancies between themselves and their ideal picture of themselves.

Figure 4.2 summarises the general pattern of responses. Discrepancies were found to exist for all 25 informants although the degrees of disparity varied.

Possible score range	0-48
Actual score range	1-20
Mean difference score	10.96

Figure 4.2. Difference scores between the self and ideal self elements for 25 informants.

The possible range of scores is 0-48, where 0 indicates no discrepancy between these elements, and 48 indicates that these elements are at opposite ends of the construct pole for all constructs. The mean difference score for the group was 10.96. On many of the constructs small differences were noted. On others, much larger discrepancies were found.

Ideal profile of the professional carer in nursing

A profile of a caring nurse as seen by these informants was developed using the six category scheme and many of the actual constructs elicited from informants.

The profile is therefore grounded in the language which practising nurses use on a day to day basis and could be used for constructing larger grids in survey type research. The profile was produced by selecting the most frequently cited constructs (caring pole) in each of the categories. Only those constructs mentioned on two occasions or more were considered, and these are organised hierarchically so that the most frequently cited constructs are listed first. This profile has been developed on the basis of common constructs and it has been assumed that similar constructs reflect shared understandings across this sample of nurses. The caring nurse may be described as possessing the following characteristics:

Personal qualities. This theme focused on the personal qualities which informants used to identify caring individuals. The caring nurse possessed a wide range of personal qualities which appear to have little to do with training and professionalism. These are the qualities which people bring with them into the job. The most important personal qualities identified by the informants were: kindness; genuineness; patience; calmness; a sense of humour; helpfulness; honesty; being relaxed; assertiveness; compassion; consideration; flexibility; a pleasant disposition; tolerance and understanding.

Clinical work style. These are constructs which are directly related to the nurse in clinical practice. They reflect the way in which caring nurses work and practice and several of these referred explicitly to patients and clients. The caring nurse: treats people/patients as individuals; tries to identify patients needs; is knowledgeable; is experienced; is organised; puts the patient first; is reliable and skilful.

Interpersonal approach. These constructs referred to the approach of the caring nurse with particular reference to her interpersonal relationships with others in a working context. The caring nurse was: empathic; approachable; a good listener; sensitive; easy to get on with; polite; a good communicator and

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respectful of a person's views and feelings.

Level of motivation. These constructs referred directly to the nurses degree of motivation in her work. The caring nurse was perceived to be: very interested; conscientious; committed; motivated and involved.

Concern for others. These constructs described the theme of unselfishness. The caring nurse was seen to: put others before herself and to give freely of herself.

Use of time. These constructs referred to the way in which the caring nurse managed her time. The caring nurse: always has time for people.

Discussion

The six category framework presented in figure 4.1 shows the number and proportion of constructs allocated to each of the categories. The proportions vary considerably, for example 'personal qualities' accounted for 34.5% of the construct pool while 'use of time' accounted for only 4.5%. These proportions do not necessarily indicate importance, perhaps the strong commonality of particular constructs may be a direct result of a low number of synonyms. The nature of the category types too was diverse. It included; the personal qualities attributed to individual carers; the style of clinical work; the way in which carers interacted with others; the level of motivation; their concern for others; and the way in which they make use of their of time.

The themes are not mutually exclusive for the scheme is qualitative in nature. A small number of the constructs appear to fit into more than one category. When this occurred, I referred back to the original grid and to my notes about the interview, and on the basis of that information opted to classify these constructs into a particular category (see appendix 2 for the complete breakdown of the content categories).

The psychological orientation of the constructs

The framework provides a picture of caring in nursing practice. It is grounded in the views of experienced practising nurses. Surprisingly, very few constructs relating to physical care emerged, but a great many could be referred to in a general sense as 'psychological'. The strong psychological orientation in the constructs produced may be accepted at face value as a snapshot picture of this group's perception of caring. This would in part support the view of caring as a particular 'attitude' (Griffin, 1983; Rajecki, 1982) and provides many details about the specific facets involved.

This argument is only partially true however since nursing is also very much a 'doing' occupation. Dunlop (1986) reinforced this fact as follows:

> ...nursing remains embroiled in physical care which involves contact with the mess and dirt of bodily life, even while it is aspiring to the 'cleaner' caring that deals with people's minds and emotions. But to the extent that it is able to shed physical care, nursing becomes increasingly hard to distinguish from other occupations who make their living and justify their involvement by recourse to caring in its emergent sense...care of the body remains an important part of nursing practice (p.664-665).

The instrumental facet of nursing practice which was widely recognised in other studies (Ben-Sira, 1983; Brown, 1981), has not emerged in this part of the study. Unlike some of the earlier studies, the importance of what the nurses 'do' (Henry, 1975, Brown, 1981) has not appeared with any force. Because informants were given freedom to produce their own set of constructs during the interviews, it is unlikely that the use of the repertory grid procedure influenced the type of constructs which they produced. This finding however, may be partly explained as an artefact of the particular sample of informants employed in this part of the study although there is no evidence that this was the case.

The possible influence of impression management

All nurses of charge nurse grade had a managerial function which ensured that they had fewer opportunities to provide bedside nursing care. Their role then, may prejudice their views about caring in nursing. The sample of nurses occupying leadership roles employed in this part of the study may be compared with Taylor and Bogdan's (1984) description of the 'institutional standard bearers' (see also Goffman, 1968). These are the individuals who manage the impressions of institutions outsiders acquire during time spent visiting institutions. In this sense informants may have provided me with data which reflects the current emphasis on psychological needs, in order to convey to me as an outside researcher, a particular impression of the institution and their work within it. This impression may not include other relevant dimensions of caring. However, it is not possible to say why this should be so.

The emphasis on personal qualities

The large proportion of constructs classed as personal qualities was very surprising. All of the sample were highly trained and experienced nurses, yet the findings suggested that caring is a process which may have very little to do with training and experience, and considerably more to do with the personal traits and characteristics which individuals bring with them into the field of nursing, in their view.

A number of personal qualities have also been suggested by Rogers (1967) as being the essential personal qualities of an effective counsellor. Rogers (1967) described three central ideas; unconditional positive regard, empathic understanding, warmth and genuineness. These and other qualities required of the counsellor have been described and linked with caring by Burnard (1989). It was significant that these qualities emerged in the repertory grid study reported here. While only one of the informants actually mentioned counselling or counselling skills, it was apparent that the qualities identified by Rogers were also considered by many of the informants to be essential to the practice of caring in

nursing. In an analysis of psychotherapeutic relationships Todres (1990) noted that the 'individual's capacity to help is more of a human than a technical enterprise' (p.44), and warned of the dangers of therapists becoming too technically orientated.

The list of qualities produced here could be used in a number of ways to explore the perceptions of different groups of nurses, for example in selection procedures for nurses and in staff appraisals. The repertory grid format may prove to be particularly useful in practical applications of this nature. However, much more refining work would need to be completed before these applications could be achieved. In addition, studies which examine the socialisation process in nursing students could employ some of these qualities and see how students' perceptions change over time and at different points in training courses. It would also be interesting to find out if some clinical areas encourage these more than others. Furthermore, it would be fascinating to know how the perceptions of these qualities varied in staff working with institutionalised elderly people compared with staff looking after patients in ITU, or with hospital and community nurses.

Clinical work style

While few constructs related to the physical care of the patient were generated during the interviews it was clear that the informants did not ignore practical considerations altogether. The way in which caring individuals carried out their daily work was another important facet of caring in practice. The second largest category demonstrated this. The clinical work style of caring individuals in practice was captured in their desire to treat patients as individuals and the way they aspired to meet the patients' individual needs. These ideas may reflect the beliefs or philosophy which influence the practice of caring for another person in a professional context (Hall, 1990).

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Not only that, in clinical practice caring nurses were characterised by their extensive knowledge, experience, organisational ability and their desire to put the patient before the concerns of the doctors or other colleagues, in such a way as to be an advocate of the patient. Many of these characteristics have also been identified by Benner (1984), who comments on the importance of clinical knowledge and experience as follows:

> We cannot afford to ignore knowledge gained from clinical experience by viewing it only from simplified models or from idealised, decontextualised views of practice (p.219).

In clinical settings, caring nurses could be relied upon at all times and they delivered their care in a skilful manner.

Interpersonal approach

A third important theme to emerge focused on the interpersonal approach of the caring individual. This was not so surprising given the tremendous amount of research into different aspects of communication in the health care field generally and the nurse-patient relationship in particular (Morrison and Burnard, 1989). Many of the characteristics in this category have already been identified in the literature as the characteristics necessary for developing effective counselling and helping relationships with clients (Burnard, 1989; Egan, 1982; Truax and Mitchell, 1971), and as a basis for providing psychological care (Nichols, 1985). These included empathy, sensitivity, being a good listener and good communicator, respecting a person's views and opinions. Larson (1984) noted however that these interpersonal skills may assume importance for the *patient* only after he or she is well on the road to recovery.

It was also interesting to note the presence of other constructs, such as being 'easy to get on with', being 'polite', which affect the quality of many forms of normal social interaction outside of the professional context. Caring is essentially an interpersonal process. A patient experiences a sense of being cared

for, or indeed a distinct absence of this emotion, by the way the nurse approaches. Commonsense considerations like good manners, the ability to listen to people and empathy, should not be overlooked if a caring approach is to be fostered.

Level of motivation

The next largest category focused on the carer's level of motivation. It is widely assumed that people become nurses because of their desire to help others (Chapman, 1983; Pratt, 1980). In daily nursing practice, motivation, commitment and involvement were also seen by this sample of informants as important constructs which typify caring behaviour. Similarly, Kitson (1987a) noted the value of commitment as an essential ingredient of caring nursing practice.

Goffman (1968) in his analysis of the underlife of a public institution, wrote that:

> Involvement in a social entity, then, entails both a *commitment* and an *attachment* (p.159).

He mapped out a useful distinction between commitment and attachment to the work of the organisation such as a hospital. Commitment specified the implicit undertaking of the employee or carer to meet the official requirements of the job, while attachment referred to the emotional bond (if any) which the employee might feel for the job and the organisation. This analysis could be applied to the way in which nurses perceive themselves and other carers. It is in fact attachment which nurses are pointing to when using the term commitment because of the implicit emotional undertones contained in some of the other categories such as 'concern for others' and 'interpersonal approach'.

Motivation is one of the critical concepts which influences how nurses perceive each other. Students new to the world of nursing work quickly learn how damaging it to be perceived by other members of staff as being unmotivated.

Good team members are those who are conscientious and committed to the tasks at hand. They are involved in the work. Students' ward reports often refer to their level of motivation and very caring qualities. Ironically, this may be a sign that the student has immersed herself in the 'work of the ward' rather than the patients in need of human care.

Concern for others

This category described how the caring nurses were concerned for the welfare of others. They tended to 'put others before themselves' and were able to 'give freely of themselves' to other people. The opposite pole of nearly all of the constructs described in this category was 'selfish'. This theme is similar to the findings reported by Ford (1981). She described two major categories used by nurses to define caring: a genuine concern for the well being of others and giving of oneself. Benner and Wrubel (1989) claimed that 'concern' for others can be a source of motivation. This claim may provide a link between this category and the previous one, level of motivation. Concern for others may function as a compelling motivating drive for caring individuals. Trice (1990) also found the notion of 'concern for others' to be an important theme for providing meaningful life experiences in elderly people.

However, because of the stress and strain involved in being so concerned for others, it is unlikely that individuals could adopt this philosophy in their work all of the time. It may be an important source of stress for many nurses. To display constantly a concern for others in an altruistic way must entail some personal cost for the individual. However, the theme 'concern for others' was an important theme used to identify caring individuals. It involves a conscious giving of oneself in order to help other people in need.

Use of time

One of the most common reasons offered by nurses for not caring for patients in the way they would like to care is the lack of time available to do so. Nearly forty years ago Goddard (1953) wrote:

> ...there is little time available to the nurse to enable her to establish
> human contacts with patients and relatives (p.148).

More recently, MacLeod Clark (1985) also suggested that this may be true, while Hockey (1976) asked nurses what they would do if they had more time available for patients. Several categories of response emerged but 'communication' was the first priority identified by the sample of nurses involved in the study and this included talking and listening to patients, providing reassurance and explanations, and more personal contact. The constructs which constitute this particular theme at one level reinforce the earlier claims of other studies that nurses have in fact little time for developing close interpersonal relationships with patients. This was certainly true of the community midwives interviewed. One of the these informants told how she had to make eighteen house calls on the day before the interview.

But the constructs also allude to a different understanding of the theme 'use of time'. It suggested that caring nurses have the ability to make themselves available to the patient or colleagues no matter how busy they are. In contrast, uncaring nurses may 'rush' around because they 'always have something else to do' or actually 'pretend to be busy'. This interpretation is a tentative one for the moment, but it should not be overlooked. Nurses may have very good reasons for avoiding close contact with patients. None of the other studies of caring have emphasised the important role which time plays in caring for people in hospital. Patients get better or die within a period of time. The daily work of the nurses is constrained by time. The nurse can only do a certain amount for a particular patient because she also has to look after other patients, or perform certain

administrative duties.   Time becomes crucially important for the nurse in attempting to care for patients.

The discrepancies between the self and ideal self

All of the 25 informants produced some discrepancies between the self and ideal self elements which was quantified using the simple difference score. Difference scores were assumed to indicate the need for personal change.   Figure 4.2. summarises the range of discrepancies between the self and ideal self elements for this sample of nurses. One reason for these discrepancies was that it was impossible to live up to 'ideal' standards in a professional working context. However, it is also notable how 12 of the informants set limits on their 'ideal self' in terms of the way they rated this element.

Reserved rating of the ideal self element

This aspect of the rating procedure assumed importance unexpectedly during the interviews and is illustrated in figure 4.3.   Three of the ideal self values are marked with an asterisk. It was expected that the ideal self element would be rated on the *extremes* of the construct dimensions. But on constructs 2, 4, and 5 this did not occur. The reason for this emerged during the interview when the informant was asked why she rated the ideal self in this manner since there was no obvious need for restraint. The informant said that to place herself at the extreme end of the of these constructs '... may result in me being physically and emotionally drained'. This informant had serious doubts about *always* 'giving freely of herself', being 'over-protective', and 'empathic'.

A total of 12 informants of the sample of 25 completed the grid in a similar fashion and a small number of informants conveyed similar reservations about the use of extreme values on the scales of some constructs. This surprising finding indicates the sensitive nature of grid centred interviews, but more importantly however, it suggested that the caring being considered here was not some obscure concept, being discussed at a purely theoretical, abstract level, but

was a lived experiential process which was very costly to the carer. These informants appeared to have a picture of the ideal self which was actually achievable.

Similarities or Differences	Self	Ideal Self	Contrasts	Difference Score
1. Safe	2	1	Dangerous	1
2. Selfish	5	6*	Gives freely of themselves	1
3. Compassionate	3	1	Doesn't see others' needs	2
4. Lacks awareness	5	5*	Over-protective	0
5. Empathic	3	2*	Lacks sensitivity	1
6. Insecure	6	7	Mature	1
7. Tolerant	7	1	Intolerant	6
8. Kind	1	1	Disinterested	0
Total difference score				12

Figure 4.3. Section of the grid from informant number 12 showing the constructs, the pattern of rating for the self and ideal self elements and the total difference score.

The role discrepancies outlined above may well be an important source of personal conflict and stress. It is interesting to note that a number of psychological theories have pointed to the way people struggle to minimise conflict of this nature. The theory of self-consistency outlined by Lecky (1961) explored how the individual changed to avoid tension and contradictions. Similarly, Festinger's theory of cognitive dissonance, described how people try to reduce the feelings of discomfort experienced when they were confronted with situations which were contrary to their own beliefs and views of the world (Festinger, 1957). Rogers (1965) also discussed how one of the goals of psychotherapy was to enable the 'self' and 'ideal self' to become more compatible.

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If nurses also try to reduce the level of 'inconsistency' in themselves, then the method of comparing 'self' and 'ideal self' may prove to be a very useful way to explore self-perceptions and to judge the degree, and direction, in which any changes occur. In this way, we may be able to learn a lot more about nurses' perceptions of themselves as carers, and about how different aspects of their work influence their self-perceptions. Learners in particular could benefit from close monitoring throughout their training.

Why do these discrepancies exist?

There are several possible explanations for these differences (Morrison, 1989) including the following:

(1) *Unrealistic expectations*

If the work of the nurse is to care for people, and this is what she has been trained to do, why should these discrepancies occur so consistently? A number of possible explanations may be suggested. First, the nurses who took part in the study may have set unrealistic expectations of themselves. The standards they set for themselves were unattainable. But this was certainly not the case for the 12 informants who rated the ideal self element so cautiously.

(2) *Inadequate training*

Second, the discrepancies may in fact be the result of inappropriate or inadequate training for the job which they now do. The group may lack the knowledge and skills necessary to fulfil their caring role. An orientation to care for others has always been assumed to be an implicit motivating force for becoming a nurse and that this desire was refined by following a course of training and education.

(3) *The impact of the organisational culture*

Third, it is possible that the system of values which can be found within the 'organisational culture' (Sathe, 1983; Schein, 1984) may be quite unlike the values which were cherished by the individual nurses working in the organisation (see

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also chapter 8). So technical competence may be valued more than interpersonal (caring) competence within the organisation, and this may have influenced the way in which the nurses perceived themselves as carers. One the one hand, they felt the need to develop close caring relationships with patients and clients. On the other hand, the goals of efficiency and effectiveness were so prevalent within the institution, that the nurse had little choice but to conform to the dominant ethos of the organisation.

Another related factor may be the way in which the system of education prepares individual nurses to implement change and advance nursing practice. It could be argued that the present system adopts a 'hero-innovator' strategy (Georgiades and Phillimore, 1975), in the hope of producing caring individuals capable of transforming the institution into a person-centred and caring one. Such an approach is naive.

> This then is the myth of the hero-innovator: the idea that you can produce, by training, a knight in shining armour who, loins girded with new technology and beliefs, will assault the organizational fortress and institute changes both in himself and others at a stroke. Such a view is ingenious. The fact of the matter is that organizations such as schools and hospitals will, like dragons, eat hero-innovators for breakfast (Georgiades and Phillimore, 1975, p.315).

(4) *The personal cost of caring*

However, one other possible explanation of the discrepancies found between the self as a carer and ideal self elements must be considered. It was noted that when the informants were asked to rate all of the eight elements on the construct dimensions a particular pattern of ratings emerged in many of the interviews. Further questioning of the informants revealed that the *personal cost of caring for the carer* may be the primary reason for this finding. This can be seen clearly in figure 4.3. in which the reserved pattern of rating for the ideal self element highlighted the potential stress entailed in caring for others.

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Comments received from other informants supported this position. Several suggested that rating the ideal self on the extremes would result in: 'burnout'; 'stress'; and being 'unhealthy for both the carer and the cared for person'. Another said that 'other priorities in the caring process' prevented her from placing herself on the extreme values. These ideas would seem to support the general assertion that the work of the nurse is intrinsically stressful (Marshall, 1980; Shouksmith and Wallis, 1988), and like other professions with a client centred emphasis, nurses are likely to experience burnout (Pines et al., 1981).

Similarly, Larson (1990) described a study which explored some of the internal stressors or 'secrets' nurses held. She noted several important themes including feelings of inadequacy, one-way giving, anger, and over involvement; being subject to too many demands; adopting a strategy of emotional and physical distance from patients; wishing for a patient's death; and a desire to get out of the situation. Several reasons for these secrets were suggested by Larson (1990) in particular the tendency for self-blame, unrealistic self expectations, and discrepancies between the real and ideal images of the self as a helper. Very similar explanations have been used to account for the findings reported here.

The findings are generally similar to other studies, in that they emphasised the demands placed upon carers. Others have reported that caring for people is both physically and emotionally exhausting. In community settings, Hirschfeld (1983), and Goodman (1986) have described the immense strain that caregivers experience. Whereas others have reflected on the potentially harmful effects of caring nurse-patient relationships (Hyde, 1976; Llewelyn, 1984, 1989). Hyde (1976) stressed the need for carers to care for themselves because this positively enhanced the carers' potential for caring for others. Llewelyn (1984, 1989) argued that close interpersonal (caring) relationships are more demanding, but they are also more effective, and offer opportunities for personal growth and development. This emphasis can also be found in Mayeroff's descriptive account of the caring

process (Mayeroff, 1971). The impact of stress in nursing is examined further in the discussion of the second part of the study.

(5) *Other possible explanations*

The unexpected pattern of rating may also be in some part explained by focusing on changes in the ways nurses perceived their caring role. It is expected that these nurses are taking active steps to promote independence amongst patients. If we keep this goal in mind, we are able to re-interpret some of the verbatim explanations provided by informants to account for the surprising pattern of ratings. In particular, 'other priorities in the caring process' and 'unhealthy for both the carer and the cared for person', may be indicating, albeit implicitly, the nurses' appreciation of the need to promote greater patient independence.

The ideal profile

It is clear that the ideal description of a caring nurse is unrealistic and places enormous expectations upon the individual nurse. It would be impossible for nurses in clinical practice to meet these high standards *all* of the time. However it is not intended to be a prescriptive set of standards, but is offered as a basis for understanding some important facets of the caring process of nursing practice. It should not be assumed however, that the nurses in the study failed to achieve extremely high standards of care in their daily nursing practice from time to time. Benner (1984) for example, noted the outstanding care provided by many nurses in her research and recognised their significant contribution to patient welfare.

The analysis of the self rating procedure revealed how many nurses in the sample had identified boundaries which clearly limited their expectations of themselves. The patterns of rating the ideal self element showed this. Moreover, the repertory grid procedure, as it was used here, may provide a very useful and uncomplicated mechanism for exploring nurses perceptions of themselves in different contexts or at different times.

Evaluation of the use of the repertory grid technique

The repertory grid interview procedure worked extremely well. Many new details about the ways in which nurses' perceive other caring and uncaring individuals have surfaced. The findings demonstrated a reasonable level of agreement with earlier research studies. In addition, new ways of perceiving caring relationships have been described from a particular psychological perspective. The repertory grid procedure also allowed informants to examine themselves as carers and this produced interesting insights into the nurses' world. A number of procedural issues about the use of the repertory grid technique must be addressed here.

The problem of self rating

Asking informants to compare 'themselves' with an 'ideal self' image was not without its problems. The fact that an ideal self element was used may influence the type of things that informants communicate. It may lead the informant to produce views and opinions about caring in nursing practice which they may not normally have considered or perceive as relevant. Rating both a self and an ideal self along the construct dimensions could also have influenced the informants. The informants had prior knowledge of the procedure which may have suggested to the informants that they should rate themselves less favourably because they had to rate an ideal self element immediately afterwards. One way around this difficulty would be get independent raters, for example other practising nurses or indeed patients, to complete the scale, and to compare both sets of scores. However, even this procedure has its own problems, particularly when patients are asked to evaluate nurses' performance.

The use of a self rating procedure carried certain risks (Crowne and Marlowe, 1964). In particular, could the respondent be relied upon to report honestly their self-perception when some of the constructs were so value laden. This difficulty, common to most self assessment procedures was summarised by Cook and Selltiz (1973) as follows:

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Self report measures have a number of characteristics that make them susceptible to distortion of overt responses. The purpose of the instrument is obvious to the respondent; the implications of his answers are apparent to him; he can consciously control his responses. Thus a person who wishes to give a certain picture of himself - whether in order to impress the tester favourably, to preserve his own self-image, or some other reason - can rather easily do so. This difficulty has long been recognised, and in recent years it has been investigated under the rubric of 'social desirability' (pp.370-371).

A number of measures were adopted to reduce the likelihood that social desirability would influence the self rating process. Cook and Selltiz (1973) described several of the most widely used tactics as follows:

Among the simplest, and most frequently used, approaches to making it easier to give answers that may be considered undesirable are assurances of anonymity, statements to the effect that 'there are no right or wrong answers' or that 'people differ in their views on these things', emphasis on the importance of honest answers in order to contribute to scientific knowledge or some other presumably desirable outcome, efforts to build up rapport between questioner and respondent and to create the impression that the questioner will not disapprove of whatever views may be expressed (Cook and Selltiz, 1973, p.371).

In addition, a number of other aspects of the procedure may have helped to minimise the effects of social desirability. Firstly informants provided their own scale dimensions. Second, from the initial meeting the informants were fully aware that they would be asked to rate all the elements including the self and ideal self. Third, some familiarity between the researcher and informant developed over the two meetings. Fourth, informants were told about the project well in advance of the interview and their awareness of the project helped to develop an atmosphere of trust during the interviews. The decision to use a self rating scale was a calculated gamble, but the results obtained seem to indicate that it was a worthwhile exercise. Valuable new insights emerged about nurses' perceptions of themselves as carers.

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Why should the nurses be so self-critical?

A number of possible reasons for the self-criticism of the nurses involved in the study have been posited above. These must remain speculative for the moment. Some of the comments made by the informants offered clues about the reasons for this finding. Further research was needed to probe to a deeper level the views and personal experiences of professional nursing carers. While some of the informants identified large discrepancies in their own performance, others were apparently quite satisfied. The results of the self rating procedure were informative and challenging, but I was left with a feeling of unease because of the speculative nature of my explanations for this finding. The study was incomplete and it is apparent now that a new direction was needed if alternative explanations for these findings were to be obtained. This was one factor which helped to shape the contours of the second part of the study.

Problem of getting behind the constructs represented by the words

One of the major problems associated with the use of repertory grids is the problem faced by every repertory grid researcher, of making sense of what is essentially a collection of words, numbers and personal meanings (Yorke, 1989). Both layers of analysis provided above, the content analysis of the construct pool and the difference scores for each informant, have been useful and valuable. New insights have emerged into the ways in which caring has been conceptualised by this sample of experiences nurses. New questions had emerged which had to be addressed in order to refine and further explain some of these findings.

However, the problem of synthesising the informant's point of view as represented in the grid data remains. Yorke (1989) argued that attempts to do so were likely to result in 'impoverished' accounts of the informant's world of experience. The crucial dilemma facing the researcher is how to get behind the constructs and understand the individual informant. In this particular application, the use of a laddering manoeuvre during the elicitation procedure may have helped somewhat, but I doubt that this would have made a significant difference.

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Certainly the laddering technique used during the pilot interviews was not very successful. An alternative strategy was required if deeper probing and understanding was to be achieved.

Dunlop (1986) highlighted the importance of context in developing insight into the text representing the informants views and experiences. So a more qualitative method was needed and seemed to me to be the only sensible way forward with this particular project. There was little benefit to be had from adopting a particularly quantitative approach during the second part of the study. Such an approach would have resulted in tidier and more easily analyzable snapshots of what might be happening, but would perhaps be of little interest or significance to those in clinical settings.

Omission of other staff and patients

Another important limitation of this part of the study was the concentration on particular strategic informants (Smith, 1981). While the merits of this type of sampling have been readily identified, one important limitation is the exclusive concentration on particular grades of staff. It was suggested earlier that such an approach may lead to people defending a particularly favourable picture of what in fact goes on on a day to day basis in hospitals and other institutions. Taylor and Bogdan (1984) described the individuals who perform this task as the 'institutional standard bearers'. The role of these individuals is crucial since:

> Every organisation faces the possibility that its legitimising myths may be shattered. Black shadows fall between what organisations say they do and what they actually engage in: between their espoused goals and everyday practices. Studies of human service organisations reveal a great discrepancy between formal myth and actual reality: mental hospitals do not cure, nursing homes do not comfort, reform schools do not save, drug centers do not rehabilitate, and job training programs do not train (Taylor and Bogdan, 1984, p.221).

The danger of accepting at face value the portrait of caring in nursing practice as it emerged during the analysis of the repertory grids was obvious. Further details had to be collected from a range of informants. These had to include members of the nursing profession with differing levels of status and selected from within the institutions involved in the study. Furthermore, any attempt to describe the process of caring in a detailed way had to include a patient perspective. It was assumed that since patients are active consumers of care and caring relationships, they should know something about being cared for. The need to include a patient viewpoint was identified in chapter three. A range of other relevant concerns about interviewing informants, such as 'power', 'status', and 'impression management', is discussed later on in the thesis. Many of these apply equally well to repertory grid centred studies, but a discussion of these is best left until later.

Summary of the chapter

The repertory grids were analysed initially using contents analysis and six key themes were found which could be used to classify all of the 200 constructs generated from the interviews. A simple difference score calculation was used to uncover important discrepancies between the self and ideal self elements. A number of possible explanations for these findings were offered, and important limitations of this part of the study were considered. Other important issues related to interviewing are discussed in later chapters. A new approach to the second part of the study was needed in order to address some the limitations identified here and to attempt to understand what caring and being cared for meant for the informants in their own terms. The next chapter outlines the phenomenological approach which was adopted for the second part of the study.

CHAPTER 5

PHILOSOPHY AND METHOD IN HUMAN RESEARCH:
UNDERSTANDING THE LIFEWORLD

Introduction

In the second part of the study a different, more fully qualitative approach was chosen, explicitly grounded in existential phenomenology. In this chapter some of the theoretical and practical issues related to interviewing informants from this perspective are outlined and discussed. The phenomenological approach to research in health care and nursing is sketched initially. This approach provided the basis for interviewing and analysing a further set of interviews with nurses and hospitalised patients as informants. The chapter closes with an outline of the key stages in the analysis of interview transcripts.

Requirements of the methods chosen for part two

In order to address some of the criticisms identified in part one of the study several criteria had to be achieved. The methods adopted for part two had to be appropriate. In the initial plan for the whole project, it was envisaged that part two should be much more structured and quantifiable. However, the questions which emerged during the analysis of the repertory grid interviews could not be addressed in this way. A new and more qualitative strategy was needed.

The approach had to be able to answer the following questions: why were the nurses found to be so self-critical? how could we get a better understanding of the personal constructs represented by the words? how is caring experienced by nurses and patients? is the view of the patient similar to that of the nurse? In addition the emphasis on personal qualities in the first part of the study suggested that the methods chosen for the second part should focus on personal lived experience more closely. Furthermore, the approach had to include the views of a range of other staff, not occupying leadership roles within the organisation, and patients. In short, a move in direction of phenomenological depth was chosen, rather than empirical generalisation to a population. The research continues to explore the realm of discovery rather than justification (Reichenbach, 1952).

Qualitative approaches to research

There are many approaches to qualitative research techniques (Filstead, 1970; Lofland and Lofland, 1984; Taylor and Bogdan, 1984; Marshall and Rossman, 1989). However, a common purpose which many of these approaches share is the focus on the natural social setting as opposed to the world of the tightly controlled laboratory. In support of qualitative approaches, Marshall and Rossman (1989) claimed that:

> ...the strengths of qualitative studies should be demonstrated for research that is exploratory or descriptive and that stresses the importance of context, setting, and subjects' frame of reference (p.46).

In recent years, the qualitative approach to research has become extremely popular in the field of nursing research (Field and Morse 1985; Morse 1989; Munhall and Oiler, 1986).

The place of phenomenologically based research in nursing

The phenomenological approach (Spiegelberg, 1982) is one approach which has gradually gained wider acceptance in the field of qualitative nursing research. There are several advocates of the approach as it applies to studies in nursing (see Drew, 1986; Holmes, 1990; Omery, 1983; Swanson-Kauffmann and Schonwald, 1988; Watson, 1985). One early example of this approach which involved nurses is the study of professional socialisation by Olesen and Whittaker (1968). They used the phenomenology of Alfred Schutz to demonstrate how the 'uninteresting world of everyday living' (the silent dialogue) had a powerful influence over the nursing culture.

Pointing out the merits of a phenomenological approach to research Keen (1975) wrote:

> Phenomenology does not yield new information in the way that science pushes back the frontiers of knowledge. Its task is less to

give us new ideas that to make explicit those ideas, assumptions, and implicit presuppositions upon which we already behave and experience life. Its task is to reveal to us exactly what we already know and that we know it, so that we can be less puzzled about ourselves. Were it to tell us something that we did not know, it would not be telling us anything about ourselves, and therefore it would not be important (p.18).

Van Manen (1990) expressed a similar point of view as follows:

So phenomenology does not offer us the possibility of effective theory with which we can now explain and/or control the world, but rather it offers us the possibility of plausible insights that bring us in more direct contact with the world (p.9).

The phenomenological approach is very different to the traditional approach employed in social science research. Phenomenology is an attempt to really get the know how another person is experiencing their world. Such an endeavour has the potential to be especially useful in professional helping and caring relationships.

Phenomenology and health care

Kestenbaum (1982a) argued a case for the use of existential phenomenology in health care research on the grounds that it provided a powerful set of techniques for exploring patient and professional viewpoints which could be used in practice. It offered a:

...perspective for the elucidation of the experience and reality of illness and that illness as it is *lived through* by the patient...the existential meaning of illness, of illness-as-lived, and to address issues pertinent to such an understanding and perspective (Kestenbaum, 1982a, pp.vii-viii).

A further advantage of the phenomenological perspective is that it can foster the development of a diverse range of understandings of illness, health and health care workers. Kestenbaum (1982b) argued that:

...phenomenology can help the culture of medicine and health care to expand the ways in which it thinks about the phenomenon of illness; it can insistently remind health professionals that illness is an experience and is intelligible as an experience. This experiential perspective makes it possible for phenomenology to elucidate illness both in its personal, individual manifestations and in its general or universal expressions...Thus, the promise of phenomenology...is not limited to its use in improving patient care. In grasping the intelligibility of illness as a lived experience, phenomenology helps us to understand something about ourselves, our possibilities and our limitations (p.16).

Moreover, it was claimed that:

A phenomenological sense clearly is fundamental to most care-giving and helping functions typically associated with nursing, and for this reason it is not surprising that nurses traditionally have been concerned with how the sick experience their world (Kestenbaum, 1982b, p.21).

Some theoretical frameworks developed in nursing have explicitly adopted a phenomenological viewpoint. Benner and Wrubel (1989), Paterson and Zderad (1988) and Watson (1979, 1985) have all described approaches to nursing which are grounded in existential phenomenology. More popular applications may be found in the work of Sacks (1985) and Kleinman (1988). Sacks attempts to bridge the gap between the fields of neurology and psychology by developing an psychological understanding of the impact of neurological illness on his patients. While the focus of Kleinman's approach is to discover the psychological impact of chronic disease on patients and their families. These popular versions provide moving and illuminating accounts of patients' and physicians' lives.

The existential-phenomenological approach to lived experience
The historical development of the phenomenological movement (Spiegelberg, 1982) and phenomenological psychology (Giorgi, 1970) have been well documented. Within this framework, the existential-phenomenological approach to psychology was adopted for interviewing informants during the second part of

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the study (see Valle and Halling, 1989). The roots of the existential component of the approach may be traced to the philosophical thinking of Sören Kierkegaard (1813-1855). His concern was with the important themes which characterise the day to day problems of human existence. On helping and caring for another person he wrote:

> If you really want to help somebody, first of all you must find him where he is and start there. This is the secret of caring. If you cannot do that, it is only an illusion, if you think you can help another human being. Helping somebody implies your understanding more than he does, but first of all you must understand what he understands. If you cannot do that, your understanding will be of no avail. All true caring starts with humiliation. The helper must be humble in his attitude towards the person he wants to help. He must understand that helping is not dominating, but serving. Caring implies patience as well as acceptance of not being right and of not understanding what the other person understands (Kierkegaard, 1859, cited in Davis and Fallowfield, 1991).

A phenomenological methodology was provided by Edmund Husserl (1859-1938), the founder of the philosophy of phenomenology. Husserl's contribution lay in the emphasis he placed on the need to study human consciousness and experience in a methodologically rigorous way by focusing on the experienced world or lifeworld (*Lebenswelt*). This approach attempts to study everyday experience as it is lived pre-reflectively and to develop deeper insights into the lived world of human experience.

Spinelli (1989) outlines the three major components of Husserl's phenomenological method: (1) there is an emphasis on the need to *bracket* or set aside our expectations and assumptions so that we can be open to our current experiences and accurately interpret them; (2) there is a need to *describe* the conscious experience as fully as possible without attempting to explain it in an effort to arrive the *essence* of that experience; and (3) it is assumed that all aspects of the description are treated as equal, no attempt is made to organise

them hierarchically. The emphasis on the need to describe the essence of a phenomenon as it is consciously experienced represents a point of discontinuity between Husserl's phenomenological method and Kelly's personal construct theory (see chapter 3).

Alfred Schutz, building on the work of Husserl, was concerned with the way in which people render the social world intelligible and meaningful. In addition, Schutz was troubled by the growing influence of positivism in the social sciences. These principal concerns have been captured in the following passage:

> The world of nature as explored by the natural scientist does not 'mean' anything to molecules, atoms and electrons. But the observational field of the social scientist - social reality - has a specific meaning and relevance structure for the beings living, acting, and thinking within it. By a series of common-sense constructs they have pre-selected and pre-interpreted this world which they experience as the reality of their daily lives. It is these thought objects of theirs which determine their behaviour by motivating it. The thought objects constructed by the social scientist, in order to grasp this social reality, have to be founded upon the thought objects constructed by the common-sense thinking of men, living their daily life within the social world (Schutz, 1962, p.59).

According to Schutz (1962), the social scientist is somewhat removed from the people he is trying to understand so that:

> The constructs used by the social scientists are, so to speak, constructs of the second degree, namely constructs of the constructs made by the actors on the social scene, whose behaviour the scientist observes and tries to explain in accordance with the procedural rules of science (p.6).

If understanding is to be achieved, then the scientist must take on board the lifeworld of those he seeks to understand. In effect the social world:

...must be examined by the social scientist in terms of the actor's own interpretation of his or her action and its motivational background (Bryman, 1988, p.52).

The approach which Husserl advocated was primarily concerned with the description of essences in human experience, however, an alternative approach developed primarily from the work of Heidegger (1889-1976) which synthesised the philosophies of existentialism and phenomenology. The emphasis within this approach was on human existence - existence *precedes* essence (Heidegger, 1962; Sartre, 1948, 1956), and this accent effectively elevated the question of *existence* to a position of prime importance for this type of phenomenology (Macquarrie 1973). The fundamental focus within Heidegger's (1962) scheme is *Being* and the meaning which Being has for human existence which is bound firmly to the world. Heidegger used the term *Dasein* to describe a human being, which literally means 'being there' but is usually translated into English as being-in-the-world and stressed how 'Dasein always understands itself in terms of its existence...' (Heidegger, 1962, p.33). The ability to be aware of our existence is a uniquely human capacity.

Moenkemeyer (1962) summarised the change of emphasis in Heidegger's approach as follows:

> The phenomenological reduction of the contents of consciousness, the pure intuition of their essences, leaves out of account the fact that this consciousness and its contents, our attitudes and acts, arise from and during the realisation of our existence (p.99).

All notions of 'subject' and 'object' are therefore rejected in this scheme. The emphasis is on the need to understand the different modes of being which characterise day to day existence. Understanding can be achieved through hermeneutic or interpretive analysis. Heidegger regarded 'his approach to the study of human existence as hermeneutical' (Valle and Halling, 1989, p.15) so an outline of the hermeneutic circle is provided next.

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The hermeneutic circle

The word 'hermeneutics' originates from Greek mythology. The God 'Hermes' was responsible for bringing messages from the Gods down to humans and because of the difficulties of communicating between the gods and humans, Hermes was both a messenger and an interpreter. Hermeneutics is basically 'the study of understanding, especially the task of understanding texts' (Palmer, 1969, p.9). However, Valle, King and Halling (1989), in drawing attention to the connections between hermeneutics and existential-phenomenological psychology, point out that:

> ...understanding a text is not possible if one approaches it in a purely academic or intellectual fashion...[scholars] emphasise the critical role of one's own personal, existential engagement with the text (p.15).

In addition, Packer (1985) described hermeneutic research as:

> ...an attempt to study meaningful human phenomena in a careful and detailed manner as free as possible from prior theoretical assumptions, based instead on practical understanding (pp.1081-1082).

The hermeneutic circle provides a framework for engaging in interpretative research. It is a process which helps the researcher to see the separate parts of the study in relation to the study as a whole and to see the whole study in relation to the different parts. Each time an interview is completed or another attempt is made to analyse a transcript or to write up the progress of the study, the hermeneutical circle is entered and exited. The whole research process is in effect a circular process. The hermeneutic circle has three distinct but interrelated stages: (1) fore-understanding; (2) an interrogation of some social phenomenon; and (3) a period of reflection on the fore-understanding and these are discussed briefly below.

Fore-understanding

Every researcher starts his investigation with some knowledge or assumptions about the domain of inquiry. Heidegger (1962) suggested that 'An interpretation is never a presuppositionless apprehending of something presented to us' (pp.191-192). Sometimes this understanding is vague and general at other times it may be very specific. For example, before commencing this study I had trained and worked in a number of general and psychiatric nursing settings. The practical aspects of nursing were nearly always enjoyable and I believe that I was a reasonably good nurse. I cared for (most of) the people I nursed. I wanted to help them. However, I found the work somewhat frustrating because so many patients returned to hospital with the same problem. Sometimes I found the work stressful and felt angry but I tried not to let this show to my colleagues.

When I started to read about the relationships between nurses and patients I began to question nurses' claim to be a caring profession, for I had seen very little evidence of what I believed to be caring relationships during my training and work experience. A few of the nurses I worked with really did care about the people they looked after and their work. Some others could only be described as manipulative and very selfish individuals. Others had little interest in the work, it was just a job. The specific context and professional role also influenced how some people approached their work. Some of the individuals I knew at work were frankly nasty during working hours and completely different away from work. These experiences have obviously shaped my view of the work of the nurse.

When I came to write down some of my own views and opinions about this domain the following ideas were included: (1) as a nurse I saw patients being ignored by nurses and doctors and were treated as objects; (2) paradoxically, patients were so thankful for the care they received which was sometimes of a very poor standard and provided by an uncaring system of individuals. Patients seemed to be indebted to the health care system; (3) I believed that many nurses were too busy to talk to patients; (4) I was surprised that the most junior and

inexperienced nurses were often left to deal with the most difficult and hopeless cases. However, I can still remember how as a student I eagerly awaited the power, influence and status which accompanied the position of staff nurse or charge nurse.

Interrogation of the social phenomenon

Setting out from this position of fore-understanding, the researcher then explores some phenomenon through interviews with informants and the text derived from the interviews is analysed in a very comprehensive manner. Rich and detailed descriptions of the experience are sought. In this instance nurses were interviewed and asked about their experiences of caring for patients while patients were asked about their experiences of being cared for. The interviews are shaped by the fore-understanding as is the process of entering into the analysis of these interview transcripts.

Reflecting on fore-understanding

The third stage of the hermeneutic circle involves reflecting on the presuppositions following a careful analysis of the interview data which has been collected. In this way, a new understanding of the phenomenon may be arrived at as it did in this particular study. Charting my own beliefs, concerns, prejudices and so on made me acutely aware of and able to grasp the informants' concerns, beliefs and experiences. The ability to take account of the nurses' and patients' lifeworlds proved to be a particularly enlightening experience for me. The depth and clarity of meaning which emerged allowed me to consider my previous insights in a new light. The hermeneutic circle is a continuous process throughout the whole study. The researcher is constantly reviewing each of the three components of the circle in terms of the whole.

Bracketing and fore-knowledge

The role of bracketing in the analysis

The phenomenological methodology which Husserl developed may be characterised by the phrase 'back to the things themselves', and a crucial process in this method is bracketing. Bracketing is not appropriate within the hermeneutic framework adopted here for within the hermeneutic circle, fore-understanding plays a critical role in the research process, so it would be inadmissible to talk about bracketing and fore-understanding at the same time. The need to be able to recognise the biases and prejudices of the researcher cannot be 'achieved by bracketing or forgetting all our prejudgments and prejudices' (Bernstein, 1983, p.138), because these personal concerns and orientations play an important role in the research. However, it is certainly possible to suspend a number of our biases and being aware of bias can minimise its impact on our experience, understanding and interpretation (Spinelli, 1989).

In Kvale's (1983) account of the hermeneutic interpretation of interview data, he wrote about the essential tension between a state of presuppositionlessness and the requirement of a 'sensitivity to, and fore-knowledge about, the topic of the interview' (Kvale, 1983, p.178). He conceded that the process of total bracketing is an ideal rather than a realistic possibility and then went on to suggest that the researcher requires both:

> ...a foreknowledge of the theme as well as being able to bracket his presuppositions and be open to the emergence of new aspects of the theme of investigation (Kvale, 1983, p.188).

This position has also been supported by Hycner (1985), who recommended that the researcher list explicitly all those presuppositions of which he is aware. At certain points in the analysis of the interviews it was necessary to set aside my own views and judgements in order to arrive at an accurate description of what the informants had said. During the analysis of the patient interviews I felt I had made sufficient progress to be able to discuss the findings with one of my research

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supervisors. It became abundantly clear to me after only a very short time into the tutorial, that I had let my experience as a nurse cloud my attempts at understanding what the patients had said. Once I had realised this I was able to re-analyse the interviews and arrive at a much more accurate representation of the informant's lifeworld.

The lifeworld as the focus of study

The emphasis on the lifeworld of the informant

The lifeworld is the world of experience as it is lived and not some remote imagined world outside of the individual's existence. The lifeworld is the starting point for investigating psychological existence. Van den Berg (1972a) provides a description of the key areas which must be addressed when an understanding of a person's lifeworld is sought. Four major domains are discussed explicitly: (1) the relationship between the individual and his worldly environment; (2) the relationship between the individual and his body; (3) the individual's life history in time; and (4) the communication that exists between the individual and others. A fifth concern that is not explicitly mentioned by Van den Berg is the individual's sense of self. These criteria formed the basis for exploring the lifeworld of informants.

The attitudes and skills required of the researcher

Wertz (1983) provided a very clear and comprehensive account of the approach which must be adopted in the interpretative analysis of interview data. These are outlined briefly below in the form of essential attitudes and skills. In practice however, it is difficult to maintain a very clear distinction between these. For the novice researcher, the approach outlined by Wertz is a daunting one. His reflective account is obviously the result of a considerable amount of experience and involvement with research data which lends itself to this form of comprehensive analysis. Nevertheless, his sketch of the required attributes of the researcher is one which I have attempted to follow in this part of the study.

The attitude of the researcher

The researcher needs to develop an empathic familiarity with world as described by the informant. Van den Berg's (1972b) account of the hospital room is a particularly lucid account of the type of approach needed. The meaning of being ill takes shape for the patient through exploring: time (his past, present and future); his surroundings (noticing small details in his room such as the view or the wallpaper which assume great significance); his body (now a sick body); and other people (the pattern of interactions with relatives, doctors and visitors). The analysis should be slowed down so that sufficient time is available to allow insights to emerge and be given adequate consideration, even small and apparently insignificant things may assume great importance in the research. The researcher tries to suspend belief about the validity of the informant's experience and considers the informant's experience from a distance so that the researcher's attention moves from objects to their meanings in the individual's lifeworld.

The skills required of the researcher

The ability to use an existential baseline to focus the research within the day to day life of the informant is particularly important. The researcher needs to distinguish the important constituents which give meaning to the life of the informant and to reflect on the decisions made about how important themes are revealed. The researcher must have the competence to grasp implicit meanings and the capacity to think through possible relationships between emerging themes. The ability to see recurring themes within a diverse range of possibilities as well as the capability of interrogating opaque areas by adopting an attitude which Wertz refers to a 'hermeneutics of suspicion' to the data are also important research skills.

The use of imaginative variation to appraise the data under different circumstances and the ability to reflect on existing conceptual formulations or models and use these in the analysis of interview data are also essential skills. Finally, the researcher needs to use language to express the findings in terms

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which capture and describe the informant's lived experience and continually returns to the original naive descriptions in order to verify, modify or change the psychological meanings that have emerged from the analysis.

Practical issues in the interview procedure

The issue of sampling

Like the strategic informant sampling technique used in the earlier stages of the study (Smith, 1981), the selection of informants at this stage in the study was guided by a specific rationale. The selection of informants in field studies is:

> ...a different procedure from the selection procedures associated with the statistical sampling in survey research. For in field research informants are selected for their knowledge of a particular setting...[and may] point towards further investigation that needs to be done in order to understand social settings, social structures and social processes (Burgess, 1984, p.75).

With regard to sampling the staff, nurses occupying different roles were selected because this strategy had the advantage of selecting informants from different status levels within the organisation where the study took place (Strauss et al. 1964). The criteria for selecting patients were more open. Patients had to have been in hospital for several days and be well enough to talk. Ten nurses and ten patients took part in this part of the study. Figures 5.1 and 5.2 summarise the two groups of informants who took part in this phase of the study.

At another level, the researcher had to decide when to finish interviewing informants. While all of the interviews were different in some ways, the researcher had to identify a point when the interviewing had to finish. This was done by provisionally analysing each of the taped interviews on the day it was completed, and noting the point at which no new themes were found to emerge across informants. Glaser and Strauss (1967) for example used a similar saturation point in their grounded theory approach.

GRADE OF STAFF	SEX		TOTALS
	MALE	FEMALE	
Staff nurses	2	3	5
State enrolled nurses	0	1	1
Student nurses	0	1	1
Nursing assistants	0	2	2
Charge nurses	1	0	1
TOTALS	3	7	10

Figure 5.1. Summary of the nursing staff selected for interview.

TREATMENT AREA	SEX		TOTALS
	MALE	FEMALE	
Medical	4	2	6
Surgical	2	2	4
TOTALS	6	4	10

Figure 5.2 Summary of the patient group selected for interview.

Ethical approval for the project

Ethical approval for the project was achieved through the South Glamorgan Nursing Research Ethics Committee. This proved to be particularly relevant when interviewing the patient group. Of the ten patients interviewed, four became emotionally upset during the interview. While this was in itself very important during the analysis of the data for those informants, it made me acutely aware of what was going on in the interviews. This particular aspect of the interviews with patients is discussed in chapter 8.

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Permission to approach the patients and staff were obtained from the consultant physician responsible for the patients who took part in the study and the managers of the nursing services. The patients were selected by the researcher in consultation with the ward staff so that no patients who were acutely ill were chosen (see Drew, 1986). The researcher then approached the patients and informed them about the nature of the project. Patients were then asked to participate in the research and reassured that anything they said would be in confidence.

The nursing staff were approached similarly. The researcher got the names of members of nursing staff and then went to the wards and discussed the project with individual nurses. Again participation was voluntary.

A sample of both nurses and patients was necessary because the caring actions and feeling of the nurses could only be experienced through looking after real patients. Kelly and May (1982) stated that:

> ...the role of the caring nurse is only viable with reference to an appreciative patient (p.154).

Similarly, patients experienced being cared for through their relationships with nurses and other staff. Van den Berg (1972b) considered the relationship between the nurse and the patient to be particularly important:

> The nurse has a very definite and extraordinarily important meaning in the life of the patient. The hospital physician usually lacks the time to talk with the patient often enough and long enough; visitors are allowed only a few hours a day; it is the nurse who, because she is there night and day, is quite often far more intensely 'with him' than the doctor or the visitors. Every nurse knows how great and how hard to bear are the responsibilities which go with this close association. She also knows that the dangers of this association are not at all imaginary (p.12).

The method of taping interviews

A good tape recording device was needed to tape the interviews. The Sanyo Compact Cassette Recorder (Model M1120) was tried out and found to be satisfactory. It was small and simple to use and could be placed strategically to pick up the dialogue of the interview accurately. It could also be powered by battery and mains which meant that the researcher could be flexible about where the interviews took place.

The context in which the interviews took place

Most of the interviews took place in or around a practical ward setting. Usually a side ward or examination room was available which was quiet enough and private enough for an interview. This had the advantage of not taking staff away from the ward for lengthy periods and ensured that they were available at all times just in case there they were needed on the ward promptly. The patients too felt more comfortable being interviewed close to the ward which was their temporary home. One disadvantage of interviewing in a clinical environment was that occasional interruptions and distractions inevitably occurred.

Criteria for assessing the reliability and validity of the findings

One of the most frequently made criticisms of qualitative research is that it lacks rigour because standard forms of reliability and validity cannot be demonstrated (Brenner, 1985; Brink, 1989; Brown and Sime, 1981; Knafl and Howard, 1984; LeCompte and Goetz, 1982). It is claimed that the approaches used in qualitative analysis cannot produce truths and laws of human behaviour, and the methods used to analyse data are prone to subjectivity. Kvale (1987) challenged this criticism by emphasising the essential difference in the interpretative process:

> In social research, there may be an implicit demand for objectivity
> in the sense that statements have only one correct meaning and the
> task of the interpretation is to find this one and only meaning.
> Contrary to this demand, a hermeneutical mode of understanding
> implies a plurality of interpretations (p.29).

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Independent validation of the findings

One method of checking the accuracy of interpretations is to get judges to analyse some of the interview transcripts independently. The meanings arrived at by the researcher will depend on the types of questions asked of the text being analysed, the researcher's background and experience, and the context in which the data has been generated (Hunt, 1989). In order to help the independent moderator to analyse the text, the researcher must provide many details about the approach and analysis procedures to ensure that:

> ...a reader adopting the same viewpoint as articulated by the researcher, can also see what the researcher saw, whether or not he agrees with it (Giorgi, 1975, p.96).

However, honesty and openness will not guarantee that the difficulties of demonstrating the reliability and validity of findings are overcome. It is impossible for an independent judge to assume fully the attitude of the researcher in his attempt to check the accuracy of the researcher's analysis. The independent judge has his own fore-understanding about the nature of the phenomenon being investigated. Nevertheless, independent validation was a sensible option because it provided another level of verification even if it was somewhat imperfect.

Returning to the informants

Another way in which the findings may be validated was to discuss the analysis with some of the participants (Hycner, 1985), in an effort to ensure that I had accurately grasped what the informant said. This strategy too is problematic. Ashworth (1987b) noted an essential problem in returning to the informants. On the one hand, the informant may demonstrate an eager acceptance of the interpretation offered by the researcher. On the other hand, the informant may show a resistance to being really understood. These tactics '..are based in a fundamental anxiety about self presentation' (p.16).

There are of course a number of more practical matters which may influence the way in which the informant reacts to the analysis. The time lag between interviewing an informant and returning with a detailed analysis of the interview may be considerable. The informant's memory for the events discussed during the interview may fade and the perceptions of the informant can vary so that issues which seemed important to him or her six months ago, have now become trivial. Despite these potential problems I did return to some of my informants and presented my interpretation of their interviews as a way of checking the validity of these interpretations.

Other strategies used to achieve validity

Hycner (1985) also recommended other tactics to promote validity. He suggested that the researcher must ask himself if the findings 'ring true'; question the extent to which the findings fit or challenge current literature; and consider carefully the way in which the research is evaluated by the scientific community following publication. Many of the important issues relating to the validity of qualitative research have been debated in Kvale (1989).

There was no simple way of demonstrating the accuracy or truth of the findings of this or any similar piece of qualitative research. Unlike quantitative studies, where reliability and validity can be 'proved' statistically, qualitative studies reflect more honestly the essential engagement of the researcher with the research and the informants employed in the study. The aim here has been to convey some of the difficulties I had during the study, in order to show that my approach has been as rigorous as it could have been within the limitations of available time and the experience of the researcher. One further method of evaluating a piece of phenomenological research was described by Van Manen (1990). He refers to the phrase 'phenomenological nod' which was used by Buytendijk in one of his lectures, as a way of commenting on the quality of phenomenological research:

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...a good phenomenological description is something that we can nod to, recognising it as an experience that we have had or could have had. In other words, *a good phenomenological description is collected by lived experience and recollects lived experience-is validated by lived experience and it validates lived experience* (p.27).

The phenomenological analysis of interview data

Giorgi (1985a) identified 'caring' as one of a range of human experiences 'both individually experienced and perceived in others at one time or another' (p.1), and therefore a topic well suited to investigation using the existential-phenomenological framework and methods employed here. In recent years a number of guidelines have been published. The procedures described by Giorgi (1975, 1985b); Hagan (1988); Hycner, 1985; Polkinghorne (1989) and Wertz (1983) were found to be especially helpful and were adopted as primary sources for the present study. While these sources differed in some detail they share a common purpose of trying to describe phenomena from the perspective of the informants used in their individual studies. The purpose of phenomenological data analysis according to Polkinghorne (1989) is to:

> ...derive from the collection of protocols, with their naive descriptions to specific examples of the experience under consideration, a description of the essential features of that experience. The researcher must glean from the examples an accurate essential description of their contents and the particular structural relationship that coheres the elements into a unified experience (p.50-51).

In the present study many of the principles common to all of these earlier analytic descriptions have been embraced and I applied these to my own area of interest, namely how 'caring' is experienced by the patients who are cared for in a hospital setting and by the nurses who care for patients. The purpose of the phenomenological method is to make sense of the data so that the world of the informant is clearly understood. Each stage of the analysis procedure is designed

to ensure this is achieved in a rigorous manner and offers the opportunity for independent validation.

The staged analysis procedure may be divided up into four principal parts and these are summarised in figure 5.3 while full details about the interviews may be found in appendices 3-7. The appendices include a step by step description of the analysis procedure of one interview and outline the ways in which the principles of interpretive phenomenological analysis have been used in this study. The worked example of one interview analysis (appendix 5) should help the reader to grasp many of the difficulties associated with this type of qualitative analysis and provide useful teaching material for those interested in such an approach to analysis.

PART	DESCRIPTION
1.	A focused interview with each informant was taped and analysed initially on the same day. A verbatim transcript of the interview was completed at a later date and divided into natural meaning units.
2.	The transcribed text was restated in the third person and reorganised into distinct content areas. These content areas were given initial labels.
3.	The central themes to emerge from the interview which communicated the informant's perceptions about the experience of caring or being cared for were outlined.
4.	A comparison of themes was made across interviews in an effort to discover common themes. In addition the findings of the nursing group and the patient group were compared. A general re-examination of the literature related to the research was undertaken so that the findings could be located within a particular research context.

Figure 5.3. Summary of the principal stages in the interview analysis.

Summary of the chapter

This chapter discussed the transition from the personal construct theory approach used in the first part of the study to a more fully qualitative approach grounded in existential phenomenology. Phenomenologically based approaches to research have become more widely used in health care and nursing settings. The existential-phenomenological approach favoured here provided a framework for conducting a further set of interviews with nurses (n = 10) and hospitalised patients (n = 10) to explore their experiences of caring for patients and of being cared for in a hospital setting. Some of the important theoretical and practical concerns inherent in using this approach were described and discussed. The next two chapters provide details of the results.

Chapter 5 : Philosophy and method in human research

CHAPTER 6
CARING FOR PATIENTS

Introduction

The organising principles used to present the findings in this chapter are described initially. The findings from the interviews with nursing staff are presented in the form of 9 general themes which captured the nurses experiences of caring for patients in hospital. The general themes are presented and the differences within these which captured the individual concerns of each nurse are systematically examined. The names of all the informants referred to here and in chapter 7 have been altered.

Nurses' experiences of caring for patients

Organising principles

The findings derived from the type of analysis used here are typically plentiful. A structure is needed for organising the findings so that they can be communicated effectively and with clarity. A number of conventions have been employed here in order to achieve this objective. The general themes which emerged from the analysis of the transcripts are presented initially. These themes are numbered 1-9 and bolded. Under each of these general themes a number of component themes are presented. These convey the rich variation within the general themes and capture the concerns of each individual informant. The descriptive phrases used to capture these component themes mirror closely what individual informants said during the interviews. These component themes are listed alphabetically. On occasions it was necessary to employ a third level of organisation to convey some of the subtlety entailed within some of the component themes. An italicised descriptive phrase capturing the theme is used for this level of subheading.

The following example may help to reinforce this structure. The first general theme to emerge was: **4. Calculated emotional involvement with patients.** A number of component themes were found to exist under this more general heading. These included: (a) Risky emotional involvement; (b) Choosing to be

involved; (c) Controlled involvement was more helpful; (d) Varied levels of attachment; (e) Quickly forgot about patients; (f) Unfair expectations on patients and so on. On occasions it was necessary to employ a third level of organisation to convey the kind of variation within some of the component themes. An italicised descriptive phrase capturing the theme is used for this level of subheading. Within the component theme (a) Risky emotional involvement for example, the following subheadings are used: *Needed to review the level of emotional investment*; *Limited emotional investment needed*; *Cautious self-disclosure*; and *Patients may expect too much*.

Extracts from the interview transcripts have been included occasionally as evidence in support of a particular theme and to give a flavour of the interviews as a whole. These are enclosed within double quotation marks to emphasise the fact that they are selective narratives of what informants actually said. The information enclosed within brackets throughout the chapter is provided to identify individual informants. The individual nurse informants are identifiable by the letter N and a number (1-10). The remaining numbers enclosed with the brackets refer to the specific meaning units in the text.

General themes emerging from the nurses' accounts

A total of nine general themes emerged and included the following: 1. Hopelessly dependent cases; 2. Felt impact of the patient's dreadful situation; 3. Did their best for patients; 4. Calculated emotional involvement with patients; 5. Constant awareness of the stressful nature of the work; 6. Superficial preparation for the job; 7. Constrained by the ward environment; 8. Coped with a demanding and uncertain role; and 9. Personal benefits derived from caring for others. These are described in more detail below.

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1. Hopelessly dependent cases

A most striking aspect of the nurses' accounts was the type of case almost all of the staff recalled and described in detail. The term 'hopelessly dependent cases' captures vividly the type of patient which elicited caring responses in these nurses.

(a) Terminally ill and frightened

Jeff looked after a young intelligent lady with a family (N1: 1, 2, 22) who had terminal cancer (N1: 43).

> "She got to the stage of her illness where she was very frightened, extremely frightened. That's why she was admitted and she didn't really know what to expect. She had terminal cancer" (N1: 4-6).

She wanted to know everything about the treatment and the side-effects (N1: 25-30, 33-35). She was worried about what her husband would do after her death (N1: 45) and her son who was very frightened when her hair started to fall out as a result of the treatment (N1: 32).

(b) Faced a lonely and inevitable death

Emma, a young staff nurse, looked after another long stay patient who was dying of cancer and waiting for a hospice place (N3: 2, 3, 103, 104). She shared a four bedded room (N3: 95, 96), but even with others she was alone (N3: 97). The patient's needs were clear cut (N3: 107).

> "...she was very dependent in a physical way because of the pain that she was in and the problems that she had with just getting about. She needed help with basic physical care so she could have a bath, stand up, get out of bed..." (N3: 37-44).

(c) Deserving of care

Steve looked after a twenty-six year old patient who was very depressed and admitted after an overdose of insulin (N2: 1-4). Initially the patient need a lot of physical care, he was in a mess (N2: 5, 6, 13-16, 51, 66, 67). The patient had a low opinion of himself (N2: 30, 33).

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"...I think we struck a chord because he was so obviously depressed, it was just an illness and he didn't do anything to deserve it..." (N2: 7-9).

He was deserving of care (N2: 26-28). Steve liked the patient because he was a trier (N2: 23, 24, 65). He was not a good socializer (N2: 50, 52-54).

(d) Depressed and dependent

Three of the staff focused on one particular patient. Trudy got to know another long stay patient (N5: 36) who became very dependent and couldn't do anything for herself (N5: 7, 8, 17, 18, 19, 20). She was thoroughly investigated (N8: 88). She was also very demanding (N5: 21, 43; N8: 67-69, 76, 77), she could make Trudy's life hell if she wanted to (N5: 38-41, 45). Occasionally the patient was more active and normal (N5: 13-16; N6: 8, 9, 15-17, 26, 27, 29; N8: 80-82). She withdrew into herself (N5: 11, 59). In spite of the difficulties the staff and other patients actually liked the patient and were helpful (N5: 1, 2, 55, 56), but the patient did not respond to others (N8: 79).

Trish and Aine nursed the same depressed lady (N6: 1, 4-6, 36, 104; N8: 1, 3, 5-8, 10-16, 19). The patient was rejected and lost her dignity (N6: 55, 78), she was difficult to communicate with (N6: 19, 24, 25), she was incontinent (N8: 59, 60). Trish felt that the patient's family should have been more involved (N6: 71-77). Her husband did not want to spend money on the patient (N8: 54-58). Trish felt she appreciated what was done for her (N6: 28), she liked the patient but not because she was so helpless (N6: 3, 59, 60).

(e) Faced traumatic surgery alone

Mona nursed an elderly lady who needed heart surgery (N7: 1-3, 5, 9, 10, 14, 15). The illness happened suddenly and the lady was separated from her husband who was abroad:

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"...her husband is still in Canada and it must be awful for her..." (N7: 12, 13, 16).

Her relatives could not visit her (N7: 4, 11, 19). The patient was frail, helpless and dependent (N7: 6, 32). She was weak and frightened (N7: 18, 34).

(f) Chronic disability and depression

Ruth looked after an elderly diabetic patient who had both legs amputated. She suffered several complications before she died (N9: 1, 4). The patient's family could not cope with her (N9: 3, 57, 58). The patient became depressed and needed total nursing care and other forms of therapy (N9: 5-7, 11, 27), especially when she was depressed (N9: 18). The patient needed constant assessment and support (N9: 8, 23, 28). In spite of her disabilities, the patient was a real trier, a personality on the ward (N9: 50, 51).

(g) Needed a life-saving heart transplant

Dan looked after a family man in his forties with a cardiac condition brought on by alcoholism (N10: 1, 2, 25, 25, 28). He needed a heart transplant to save his life (N10: 3, 4, 26). The prognosis was poor and the patient knew this (N10: 23, 24). While on the waiting list for a transplant the patient suddenly got worse and died (N10: 5-10, 76, 77, 93). Dan found looking after the patient difficult. The patient was nice, did not complain and was able to care for himself most of the time (N10: 11-15, 39-42). At the time of his death he needed everything done for him (N10: 16, 17, 19, 20, 106, 111). At the end he was nursed alone in single cubicle (N10: 105, 107).

(h) Dependent and starved of attention

Cath nursed an elderly patient with breathing difficulties who was very distressed and dependent. He did not receive much attention from the permanent staff.

"...He was very dependent on me and other nurses..." (N4: 4, 5, 8, 9, 12, 13, 19, 52).

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"...I felt he was totally starved of staff attention..." (N4: 87, 88).

It was her first ward placement and she took a more open view of things. She was not under pressure (N4: 25, 33, 24, 248).

2. Felt impact of the patient's dreadful situation

The second major theme to emerge reflected the impact on the staff of the dreadful situations in which these patients actually found themselves. Some facing death, severe pain or chronic disease and disability. The nurses were moved by the situations which patients had to deal with.

(a) Felt sorry

Nearly all the nurses 'felt sorry' for the patients they cared for. The patient's depression made an immediate impact on Steve (N2: 7), he felt sorry for the patient (N2: 10, 11, 25, 31, 32, 34, 62-64). Trish and other staff felt sorry for their patient (N6: 7, 49, 53, 173, 174). Mona felt sorry for the old lady and wanted to help (N7: 8, 40, 151). Aine felt sorry for her patient (N8: 74) because she was neglected by her family (N8: 75) and just wanted to die (N8: 17, 18, 23-25, 30, 31). Dan felt sorry for the patient because of the lack of hope:

> "...I don't know really, I felt sorry for him in a way but not in the way you'd see something on the telly. I think mostly I felt sad because I would probably have known sooner than him that we weren't going to be able to do anything for him..." (N10: 29-32).

(b) Helpless or able to help

Cath felt helpless (N4: 2, 3), so did Mona (N7: 39).

> "...feeling quite helpless about it...like not being able to do things that I'd want to do about it, and do things that I thought were appropriate..." (N4: 2, 3).

Aine felt that she could do nothing more for the patient (N8: 129, 130):

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"We'd done everything possible" (N8: 130).

While Steve sometimes felt that his efforts did not matter to the patient (N2: 213). Other nurses however were moved by a feeling of being able to help the patients in spite of the awful circumstances in which the patients found themselves. Jeff felt that he could do a lot for the frightened patient (N 1: 21), so did Steve, Trish and Dan (N2: 12; N6: 64, 71, 72; N10: 44-46, 50).

(c) Wanted to give

Cath felt emotional about caring for her patient because he was in distress (N4: 1, 6, 61). She just "felt for patients" (N4: 258-263) and this triggered a caring response (N4: 268).

> "...the emotion of feeling wanting to make it alright. I wanted to give something of myself though I don't know which category it goes in, its still a feeling of wanting to make it alright for somebody else but being prepared to give out to somebody else" (N4: 273-276).

(d) Felt anger and revulsion

While Trish felt sorry for the patient she also felt angry because of the lack of progress (N6: 50-52) and the crippling effects of illness on patients generally (N6: 185-189). Anybody could end up just like the depressed patient (N6: 54). Although Trish realised that looking after the patient's basic needs was important, she nevertheless felt revulsion when she had to clean up the patient's mess for the first time:

> "...the thing was I just talked myself into thinking it was something else, now I find it quite easy but that was the first time I had to clean anybody, you see this could be coming into it...she was the first real patient then, that I did everything for but I did feel revulsion the first time" (N6: 65-69).

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(e) Worried and concerned about the patient

The patient reminded Emma of her mother who was of similar age (N3: 60). Emma was concerned that the patient was someone's mother and could have been her own (N3: 62). She worried about the patient who became part of her life (N3: 75, 80). Looking after the patient raised questions about dying (N3: 63-65). She found it difficult to think about dying and felt that she was not coping (N3: 66-68). Many 'why' questions were raised (N3: 69, 71-74).

(f) Sense of loss and sadness

The death or transfer of patients provoked a feeling of sadness or loss in several nurses. Aine felt a sense of loss and sadness when the distraught patient was transferred to another ward where her prospects were not good (N8: 4, 32-35, 40, 42-44). Ruth's patient was being prepared for discharge when she died suddenly (N9: 24-26):

> "I certainly felt very sad the day she died cause I came back after days off and the whole ward was just like...nothing...It was as quiet as anything and you simply knew something had happened, and I really felt very very sad...we were all pretty choked up...we were just getting plans for home ready, suddenly it was all gone and that was it" (N9: 42-49).

The ward was not the same after the patient had died (N9: 52-54). It was sad to look back (N10: 73-75). Jeff was also very upset by the death of the patient (N1: 12, 19, 20), it was difficult to handle (N1: 42). On the day she died, he was called back to the ward to see her (N1: 63) and he felt guilty because he was not with her when she died (N1: 64). Not being able to follow up patients was disruptive to the continuity of care. Emma wanted to see the patient after she had gone to a hospice but couldn't (N3: 77-79). It was disruptive to care for the patient in one place and not see the patient after she went to the hospice (N3: 81, 82, 83). Cath also worried about what would eventually happen even after she had left the ward (N4: 117-120).

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3. **Did their best for patients**

This general theme summarises how the nurses perceived the effectiveness of the way in which they actually cared for the patients.

(a) Spent time with the patient

An important first step in caring for patients was the nurses ability to spend time with individual patients. The level of physical care needed by the patient tended to influence the amount of time the nurses actually spent with the patients. Jeff sat with the patient and got to know the family well (N1: 3, 7, 8, 14). Cath spent a lot of time with the patient doing things like feeding him (N4: 14, 16, 17, 95). Trudy spent every spare moment with the patient (N5: 48-54, 58). Trish and Aine also gave the patient time (N6: 12; N8: 45, 47). Dan was 'just there with him a lot of the time' (N10: 22).

Ambivalent about time consuming patients

Spending a large amount of time caring for a particular patient often posed problems for the staff. Aine and other staff for example, realised how much time they were giving to the patient (N8: 90, 91), and this meant the other patients were neglected (N8: 85-87, 89).

(b) Helped the patient to cope

The nurses helped the patients to cope with their situations in various ways.

Undemanding acceptance

Steve helped the patient to cope with low self-esteem (N2: 29, 35), but not by just telling the patient to 'cheer up' (N2: 35, 55, 56). He realised that the patient was very alone and frail (N2: 37, 38) and did not make demands on him (N2: 39-42). Steve tried not to frighten the patient (N2: 43, 45). Aine accepted the patient but not her behaviour (N8: 63-65).

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Tried to provide a therapeutic environment

Steve tried to provide an environment conducive to psychiatric improvement in an unstructured way (N2: 46-49, 129). He needed an imaginative approach to interact with the psychotic patient (N2: 57-60).

Adaptable approach

Steve gave the patient more time (N2: 130-132) and focused on activities of daily living because it suited the patient's condition (N2: 133-135). He adapted his approach to meet the specific needs of the patients (N2: 260-269).

(c) Gave personalised and sensitive care

This theme showed up in a range of ways. One nurse, Emma, found herself constantly aware of the patient's need throughout the day (N3: 20, 21). She put things within reach of the patient to reduce boredom and made sure she had a drink, something to read, and her glasses (N3: 15-19). Emma got a vase for the patient's flowers (N3: 22, 23). Her approach was holistic (N3: 24). Emma wanted to help the patient to do the things she couldn't do for herself (N3: 45).

Treated the patient as a worthy person

Emma cared for her as a person (N3: 48-50), she wasn't treated like an object on a production line (N3: 27). Emma wanted to give the patient something tangible so that she felt that she mattered (N3: 85-87):

"...I just wanted to give her worth maybe..." (N3: 88).

Trish also thought that a caring approach was one that recognised that a patient was a person (N6: 210).

Sensitive to the needs of the patient

Sometimes Emma felt in a very invasive situation: being a twenty one year old bathing an older patient (N3: 33, 34). There wasn't a lot of privacy but Emma

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made sure that curtains were properly shut (N3: 35, 98). All the care given by Emma was gentle (N3: 4-7), she allowed the patient to do what she was able to do (N3: 8). She involved the patient in her daily care by asking if she wanted soap or talc and so on (N3: 9-13). Trudy asked patients what they needed and went from there (N5: 133). However, some nurses did not display a sensitive awareness of the patients' needs. Trish found it hard to take when other nurses spoke to the patient in a silly manner (N6: 57, 58, 63).

(d) Tried to promote independence

The nurses tried to promote independence in patients rather than take over the situation and do everything for them. Some tried to help the patients to help themselves (N4: 15, 18, 45-47, 62; N8: 22, 26; N9: 19-22) or involve them in decisions about their care (N5: 22, 23, 25). Trudy tried not to do too much for the patient until it was absolutely necessary (N5: 60, 61).

Recognised the danger of promoting dependence

One of the problems of doing too much for the patients was the danger of promoting dependence. The key to success was to strike a balance between doing too much and neglecting the patient. The hazards of helping to make some patients more dependent were recognised (N5: 10; N6: 11, 31, 32, 39, 40-45). However, Trish could not stand by and watch patients starve (N6: 47), it was hard to draw the line (N6: 46, 48). Aine could not sit and watch the patient doing nothing for herself (N8: 20, 21), she did too much because of a shortage of staff (N8: 92, 93). And Ruth knew that the high level of physical care may have promoted dependence on the staff (N9: 15-17). Mona's patient did not pose similar problems (N7: 33). The danger was greater with the long stay patients (N10: 120-124).

(e) Paid attention to detail

Another approach used by the nurses was to focus their attention on small but significant aspects of patient care. Many details have been sketched under other

thematic headings in this chapter and only a few example are mentioned here to highlight this theme. Cath was acutely aware of things which had relevance for the patient. She took off the oxygen inhaler when it was not needed, and put gauze on the mask to prevent soreness (N4: 53-56). She remembered to put the patient's glasses on (N4: 22), she joked with the patient about his sore feet (N4: 23). Her achievements with the patient surprised her clinical tutor (N4: 10, 11). However, Cath was upset that many things were not done for the patient when she was not there (N4: 20, 21, 48-51, 57, 58, 62, 63). Trish ensured that the patient was seated near the window or close to the television (N6: 86-88). Aine read magazines to the patient (N8: 48-50). Other specific examples were:

Took the patient home
Several staff on the psychiatric ward made an extra effort to take the patient off the ward and to her own home when she asked and when the staffing level permitted (N5: 29-34, 66; N6: 21-23, 79-82; N8: 51-53).

Toilet training
Toilet training was initiated to help deal with an incontinent patient but the programme was eventually left to unqualified or untrained staff. The qualified staff gave up the toilet training programme and left this difficult job for the students (N8: 62, 66).

(f) Attended to patients' basic needs
Several nurses had to provide a lot of basic nursing care for the patients they care for. This included washing, dressing, feeding and lifting patients. In a way, caring was demonstrated through looking after the patients' basic needs (N2: 17-22; N5: 3-6, 9, 35, 47; N6: 10, 18, 20, 56, 68, 70, 84, 89-92; N8: 9). Physical needs got priority (N6: 85, 97).

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(g) Physical care helped to develop an empathic response

In addition, providing physical care for patients played an important role in developing an empathic understanding of the patient's situation. In this way, closer relationships with patients were formed. Caring physically provided openings to care and support the patient emotionally and psychologically (N3: 51-53). The intimate physical care offered Emma a way to become more caring (N3: 46, 47, 120). Empathy was a quality which assumed great importance for the nurses in building close relationships. Jeff was sympathetic towards other people (N1: 73, 75), but he developed a genuine empathy for patients and built close relationships (N1: 74, 76-80). Empathy involved being able to identify with what the patient went through and seeing things from the patients' perspective (N2: 61; N3: 181, 182, 190; N7: 152, 154, 156-160), it helped patients (N2: 238, 240). An empathic understanding was needed if people were to respond (N3: 185). A note of caution was offered by Steve however, for being too empathic could result in wrong decisions being made (N2: 239, 242). Caring had to do with gentle doing (N3: 189), it involved physical care (N3: 191). Cath concentrated on the patients who needed a lot of physical care (N4: 100, 101). It was easier to talk to patients when there was something concrete to focus on (N4: 104). Giving physical care provided a way in to develop a relationship with a patient (N4: 107-109).

Cath spent time with those patients with fewer physical needs in the afternoons (N4: 89, 92, 102, 103, 110-113). For Dan, looking after the physical needs of patients was:

"...an outward sign that you're caring for them..." (N10: 114, 115, 118, 119).

Physical care therefore assumed great importance in establishing relationships with patients.

Seriously ill patients stayed longer

Emma worked on a busy medical ward as a student (N3: 1, 94, 99-102), and wanted to care for everybody (N3: 105, 106). But only the very ill patients stayed long enough to allow her to develop relationships (N3: 112-116). It was harder to communicate with patients with fewer physical needs (N3: 117-119).

(h) Optimistic rapport

Another approach employed by the nurses was to adopt an air of unwarranted optimism while in the company of patients. Mona for example, prepared the patient for her operation (N7: 17, 27, 28, 30, 41-45). She tried to get to know the person, not just a patient (N7: 153). Dan also tried to boost the patient's morale and this lifted his own spirits (N10: 34-37). Dan could not be honest about the patient's poor chances and uncertain future (N10: 33, 38, 43).

Told the patient not to worry

Although Mona knew the operation was risky she told the patient not to worry (N7: 20). She emphasised the good things pre-operatively (N7: 22-25, 76, 77). She discouraged the patient from thinking too much about the risks and urged patients to think about getting better (N7: 26). Patients were always very nervous because they were so close to a big operation (N7: 75) and she wanted to ease their nerves and make them happy about having the operation (N7: 78).

Tried not to let on

Dan tried not to let on to the patient that he knew the score and encouraged him to answer his own questions (N10: 51-53). He tried not to fuss around the patient too much and wanted to carry on with nursing care in a routine way (N10: 87-89). He did not want the patient to feel that he was being over attentive and wondered if he was playing it right (N10: 90, 91). The patient however, probably knew the prognosis in any case (N10: 92).

(i) Dedicated during working hours only

Steve was dedicated to caring for others (N2: 322, 323) but he reserved this dedication for working hours only, it was not his whole life (N2: 324-326). He was just a nurse doing a job (N2: 184-186, 230, 231). Few nurses had religious enthusiasm for the job (N2: 327). Cath felt caring when she was on the ward because that was where it made sense (N4: 293-296). But discussions about patients outside work bored her (N4: 291, 292, 286-298).

(j) Important interpersonal skills for helping

Listened to the patient

One important skill which Jeff and Dan employed was listening. Jeff did not say much he 'just listened' (N1: 46, 47). Dan encouraged the patient to talk about how he felt and offered him a listening ear (N10: 60). He was just there for the patient to talk to (N10: 47-49).

Coped with probing questions

Some patients asked tricky questions and these had to be coped with. Dan found that the patient began to ask probing questions about his condition and fishing to see if Dan gave anything away (N10: 97-99). Dan thought carefully about how to respond and felt awkward to have to watch what he said (N10: 94, 95, 100-102). He realised that the patient knew a lot more about life than he did (N10: 56, 57). While Dan's guarded manner helped him to cope with the situation, it may not have been very helpful for the patient.

Encouraged the patient to talk

Jeff talked to the patient generally at first and later about dying (N1: 9, 10). The patient was glad Jeff could talk about dying (N1: 11), and she was able to express her worries about dying and her feelings (N1: 16, 17, 51). She knew she was dying and wanted to talk (N1: 44, 52). Jeff encouraged her to talk and she did (N1: 49, 50).

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Patient was free to talk

Emma tried to provide an atmosphere of privacy so that the patient was not afraid to ask for things and was not afraid of Emma (N3: 32). She realised that Emma meant what she said (N3: 26). It was just Emma and the patient behind the curtains and the patient felt free to talk (N3: 28, 29, 59).

Gave information

Another aspect of good nursing care was giving information. Jeff kept the patient and her husband informed (N1: 23, 31, 36, 37), but could not answer all her questions (N1: 38-41). Dan did not have answers for the patient but he was able to give the patient facts (N10: 54, 55).

Caring interpersonal approach

Trudy felt that caring had a lot to do with the way a person talks to another person, good carers talked to patients in a quiet, polite and relaxed way (N5: 154-158). Good carers are patient and reassure the patient (N5: 159, 160), they listen and give the patient whatever feeling he or she needs (N5: 124, 131, 132).

4. Calculated emotional involvement with patients

A fourth major theme to emerge focused on the level of emotional involvement that the staff developed with their patients.

(a) Risky emotional involvement

The risks of becoming emotionally involved with patients were widely acknowledged. There was an emotional investment in everything Steve did (N2: 273, 274, 290), and he felt too exposed to trust patients (N2: 275), he did not want to be abused and hurt (N2: 276). He did not want to invest emotions in patients and run the risk of stress when things went wrong like other nurses (N2: 216-219, 220). Emma also recognised that being involved meant that she could get hurt (N3: 165).

Needed to review the level of emotional investment

Steve felt that he had let himself slip into a rut and he did not invest as much of himself as he ought to and needed to review things (N2: 285-287). He experienced conflict about what he should be able to do for a person without reservation (N2: 210-212).

Limited emotional investment needed

Steve did not need to feel much for people to care for them in a professional context (N2: 69, 70). Nurses did not need to be especially caring they just needed to be like other people when they offer help in the street when someone collapses (N2: 73, 74). He cared for people because they were other human beings and it was a normal response (N2: 75-77). Steve felt that the very best carers were rare and required selflessness (N2: 202, 203). Aine on the other hand got very involved with the patient (N8: 2).

Cautious self-disclosure

Some patients wanted to talk a lot (N7: 68, 69), but Mona did not want to tell too much about herself for fear of getting too involved (N7: 102). She kept the talk light-hearted and drew the line (N7: 103, 104).

Patients may expect too much

One of the problems of over involvement with patients was that some patients expected Mona to give too much time to them (N7: 56, 57). Getting to know the patient was important but not to the point of getting too involved (N7: 52, 55). Aine found it difficult to come to terms with the feelings which a deliberate lack of involvement generated (N8: 145-152). She needed a shield against some patients (N8: 140, 153, 154).

(b) Choosing to be involved

Caring however, involved making decisions about getting involved with patients. Caring for Emma meant being involved (N3: 70, 76, 163, 164, 177) and having

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great concern (N3: 183). She wanted to be involved in the work (N3: 84, 178) and had to choose to get involved or not (N3: 214, 215, 229).

> "For me there is the internal dimension of choosing to care, to be concerned about people and that they matter to me. This is an internal choice..." (N3: 209-211).

Cath too was happy to be involved with the patient (N4: 126-128). Caring for Aine too meant getting involved with patients (N8: 131), but she tried not to get involved with dependent personalities (N8: 132-137).

(c) Controlled involvement was more helpful

It was important that any involvement did not get out of control. Cath didn't feel that the level of involvement with the patient was out of control (N4: 129), and what she felt was not unreasonable (N4: 130, 131). She hadn't reached a point where she felt she had given too much of herself (N4: 314, 315). The ward situation controlled Trudy's emotional involvement (N5: 138, 139); loving was inappropriate (N5: 134). She was not supposed to become attached to patients or show a lot of affection for them (N5: 135, 137, 144). But sometimes she did love the patients and showed affection (N5: 136, 140-143). Ruth needed to have control over her emotions in order to be helpful (N9: 159-162, 181-184, 197, 210, 211). As a nurse she had to draw the line and stay in control (N9: 208, 209), though there was a very fine line between caring and being too involved (N9: 185, 186). An empathic understanding helped Ruth not the get caught up in the problems she had to deal with (N9: 175-179) but sympathy was unhelpful (N9: 174).

(d) Varied levels of attachment

Although Trish was told not to get too attached to patients she did become attached and gave a lot of loving to the patient (N6: 13, 14, 30, 37, 38). She was inclined to get attached to the long stay patients (N6: 98-100, 103, 207) and it

entailed risks (N6: 34, 35, 216, 217). In acute care Dan had few opportunities to form attachments to patients (N10: 180-183).

Determined by time

The rapid turnover influenced the way in which patients were perceived and the type of relationships which were formed between the nurses and patients. Dan saw most admissions as 'patients rather than persons' (N10: 188-192). When Dan did not like someone he treated them like a patient (N10: 184-186) for he had several different caring roles (N10: 193).

(e) Quickly forgot about patients

One strategy for dealing with involvement was to quickly forget about the patients once they had left the ward as Mona did (N7: 58, 59, 165). She never became too involved with patients unlike other nurses she knew (N7: 60-64, 178), because it could be too upsetting when a patient dies (N7: 65, 66). Mona was 'hard' (N7: 167). She comforted herself in the knowledge that she did her best for patients (N7: 67).

Importance of ending the relationship successfully

It was important to be able to round off a relationship successfully when patients went home (N9: 189-191). A mutually agreed ending was an unsaid thing (N9: 192-195). There was risk of being used as a crutch if this was not done successfully (N9: 187, 188, 198-201, 218).

(f) Unfair expectations on patients

While the risk of involvement for staff were considerable, the risks for patients were even greater (N2: 291, 292). In a psychiatric setting, Steve expected everything from the patient and recognised how unfair this was (N2: 277, 278):

> "Perhaps it is justified because they are the ones who are ill and
> they're going to get better afterwards, so perhaps they ought to take
> a risk. I'm not doing it for my health so why should I take a risk.

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I mean perhaps that is justification, it might not be. I don't know what to do about it" (N2: 279, 281-284).

(g) *Difficult to distinguish professional caring from loving*

The relationship between caring and loving patients was examined. For some nurses love had nothing to do with caring (N2: 237), loving was for outside (N2: 270, 271). Loving was too big a risk to take (N2: 272). Professional caring relationships did not involve love (N3: 90-94, 192, 193-196). But Cath saw caring as a part of the process of loving, while loving was a more long-term thing (N4: 264-267). However, Cath could not easily distinguish between caring and loving in work (N4: 269-272). It was not necessary for carers to love patients (N6: 182). Mona thought that loving was not appropriate in nursing (N7: 163, 164), except perhaps when looking after children (N7: 161, 162).

(h) Loving response sometimes shown to patients

In contrast, some of the nurses believed their care to be a form of loving. Trish sometimes 'put on' a controlled sympathetic response for patients (N6: 175, 176). She did not love all the patients but got near to loving (N6: 177-180) and it was different to sympathy or empathy (N6: 181). Aine also loved some patients 138, 139, 141-143), so did Ruth (N9: 204-206). Ruth felt that there was a fine line between loving and caring for someone (N9: 196, 202, 203, 207, 215-217). Dan believed that caring was an early stage of loving and caring was part of the work of the nurse (N10: 176-178), but loving and sympathy were not necessary to give care (N10: 179).

5. **Constant awareness of the stressful nature of the work**

Another general theme was the stress experienced by staff in their work. Most of the nurses were stressed by the work, but the sources of stress varied considerably.

(a) Constant worry

The lack of a break from the constant worry of the job was felt by a number of nurses. Jeff needed a release valve because he thought about things twenty four hours a day (N1: 101-105). Emma was stressed because she took her work home with her (N3: 166) and could not just switch off at the end of the day (N3: 167). She felt as though she lived with the problems her patients were working through (N3: 168). Dan found himself worrying about the patient at home (N10: 79-86, 160, 171-173). If he worried too much and could not cope he might end up not coming to work because it was too much (N10: 174, 175). Stress got in the way of caring for Emma (N3: 228) while Mona found it stressful when she asked herself if she had done enough for patients (N7: 126, 127).

Stressful days off

It was even more stressful to worry about the ward when not on duty as Emma did (N3: 169, 170). It was hard to suppress those feelings without having someone to talk to (N3: 171-173). Jeff felt that caring individuals will always worry:

> "People who have this intrinsic core thing - they will worry about the ward and patients even though that can be extremely stressful, and it can affect you psychologically. Sometimes I had sleep problems. It can affect you both physically and emotionally" (N1: 106-110).

(b) Wrong attitudes produced stress

The attitude towards work also produced stress in some of the nurses. Steve had the wrong attitude and it produced stress (N2: 200, 201, 225, 233, 236). He had a chip on his shoulder (N2: 208, 209, 215, 221) and took things personally (N2: 226).

Expected abuse

The nurses who worked on the psychiatric ward shared a similar expectation of abuse from patients. Steve expected no thanks, but abuse and poor pay (N2: 205-207, 214) and felt abused (N2: 232). He wanted to care and tried not to let his

expectations influence him so much (N2: 228, 229). He did not want to be abused and hurt (N2: 276). Trudy also found it stressful to accept abuse from patients, she felt angry (N5: 116-122). Outside of work it was different (N5: 126, 127, 130). Sometimes patients were nasty and could not help themselves (N6: 151, 157).

(c) Sending patients back home

One student nurse, Cath, found it particularly stressful to send patients back into the environment which she knew contributed to their illness. She sometimes felt helpless (N4: 211-214). It was stressful and sad (N4: 207, 218) because she recognised that many of them were not going to remain well in their own environment:

> "...you know that they are not going to stay at whatever you've got
> them to...knowing that they're going home and that a lot of things
> that sort of precipitated their coming into hospital I guess they're
> still going to be there. I think that is partly the never-endingness
> part of the job....you can't ever whittle it down" (N4: 219, 224-227).

Cath had to accept that there were some things which she could not do anything about (N4: 312, 313).

(d) Heightened awareness of personal vulnerability

Two of the nurses became acutely aware of their own vulnerability. Cath found it hard to look at patients and think it could be her (N4: 215, 216), while Dan realised how well he was when looking after a dying patient (N10: 78) and how it could have been him (N10: 61-65, 72). He thought about how the patient's wife must have felt facing the likely death of her husband (N10: 66-71).

(e) Listening to and watching ill people

Having to listen and take on board the pain and suffering of others was stressful. Cath found it difficult to listen to upsetting things which patients told her (N4:

217), and nursing dying patients was sad enough to make her cry (N4: 208-210). She found it hard to watch people struggling against illness (N4: 228).

(f) Stressful colleagues

The relationships between colleagues was a source of stress for some of the nurses. The nearly all female workforce was stressful (N4: 229-233), and the hierarchical system was a burden (N4: 234, 238). Cath felt intimidated by the unapproachable doctors (N4: 235-237). Ruth also came into conflict with doctors about what was their responsibility. She was not prepared to cover up for them (N9: 104, 105, 109, 110). Mona also found colleagues a source of stress (N7: 129), sometimes all the girls together were 'bitchy' and couldn't get along (N7: 130, 132-134). Ruth found it stressful to watch lazy and uncaring doctors (N9: 96, 163, 165, 166) because they sometimes put patients at risk (N9: 164, 167, 168). Dan also found it very stressful to chase up doctors, physiotherapists and pharmacists (N10: 140, 161, 162).

Blamed by the doctors

Mona had to chase up the new doctors and show them what to do (N7: 135, 136, 146). But some doctors did not care enough to sort out really ill patients (N7: 124, 125, 137) and then blamed Mona when a patient got worse (N7: 138). She took the blame for most of the things that went wrong and it was stressful (N7: 139, 140, 141, 145).

Changing practice of colleagues was difficult

As a new and inexperienced staff nurse Ruth found that it was not easy to change the established practices of colleagues even with research findings or by being in charge of the ward (N9: 79, 93, 94, 97, 111-114).

Disagreed with doctors about the need for surgery

The quality of life provided on the ward for one patient was questioned by Ruth (N9: 62, 68). She did not see the point in carrying out a second amputation since

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the patient was in a terrible state already (N9: 63-65). After the second operation the patient went downhill (N9: 9, 10, 66). It would have been better not to operate (N9: 67).

(g) Felt unable to challenge established attitudes

As student Cath had a different attitude to the qualified staff (N4: 35, 36, 41-44). The staff were critical and judgemental of patients (N4: 37, 38), they were unsympathetic or irritated (N4: 29, 30, 134-136). Although she did not go along with experiences nurses' views about patients (N4: 151-153), Cath felt unable to challenge the experienced staff (N4: 39, 40, 138. 139, 174). She lacked the confidence (N4: 148-150) and was more reserved in work (N4: 84, 85, 124, 125).

Did not stir things up

Cath wanted to be able to say what she felt and have it accepted (N4: 175, 177-180). She did not want to antagonise staff and get the degree students a bad name (N4: 140-147, 162-164). Trudy, a nursing assistant in a psychiatric ward also had some disagreements with the trained staff but asked herself:

> "Do you say something or do you keep quiet because you can't stand a full scale war..." (N5: 89, 90, 123).

The staff worked together (N5: 57).

Guilty disobedience

The qualified staff told Cath to limit her time with patients because of the risk of being manipulated and being used (N4: 165-168). However, Cath on the other hand felt that her time with patients could be used productively (N4: 169, 170). She felt guilty because she did not do what she was told to do (N4: 171-173). Trish felt guilty about spending too much time with one patient, other patients needed company too (N6: 93-96, 101, 102). While Aine was able to look after other patients only occasionally (N8: 78).

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(h) No time for the students

The relationship that Cath had with the qualified staff was very formal. There was a division between the qualified staff and the students (N4: 65, 66). Many students did not look forward to going on the ward (N4: 67, 68). Cath did not work with any of the qualified staff because there wasn't enough time (N4: 69-70). Trained staff saw degree students as other people to be allocated work (N4: 72-74). Cath really wasn't noticed during her stay on the ward (N4: 187, 249).

Unapproachable trained staff

The trained staff were unapproachable and spent their time at the ward desk (N4: 71, 75-79). It was hard to talk to the staff (N4: 86, 90, 91) and Cath had no opportunities to talk with the qualified staff about patients (N4: 121, 122). Outside of work however:

> "...the staff were really friendly...it was like everything suddenly changed because the situation was different. They were talking to me like an ordinary person, it was strange..." (N4: 80-83).

(i) Short student placements

Cath found that working as a student on the ward was stressful because she never really got into it, her time there was too short (N4: 239-245). However, she did learn a lot quickly moving from ward to ward (N4: 246, 247, 257).

Never accepted as part of a team of carers

One problem Cath faced as a student, was being accepted into the ward team. She felt that she was never accepted into the ward system like the regular staff (N4: 250. 251) so she had to make a big effort to get to know many different people again after each new move (N4: 252-256). However this experience may have a positive side to it for many inexperienced nursing students spend more time with patients because they have not as yet become 'team members'.

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Fragmented care

One of the consequences of the student placement system was the fragmented care students gave to patients (N4: 220, 221). She had few opportunities to influence people and patients (N4: 222, 223, 307, 308).

(j) *Observing suicidal patients*

In the field of psychiatric nursing the observation of suicidal patients was identified as particularly stressful. Trudy experienced extreme stress and panic when observing suicidal patients (N5: 100-103).

> "You start counting the hours until it's time to go home. When you do go home you're still thinking about it and can't relax. It takes a while to unwind. A lot of the time you feel like I've got to go back to work in so many hours and it's going to start over again...you have to have eyes everywhere..." (N5: 104-108).

The decision to include interviews with both general and psychiatric nurses in the same study is justified on the grounds that both roles have much in common. Many psychiatric patients need general nursing care when they are admitted to a psychiatric unit and many people who have attempted suicide end up being admitted to a general hospital initially while still actively suicidal. Both types of nurse need a range of skills to be able to deal competently with these patients.

(k) Difficult relationships with patients

Some of the nurses also found that relationships with difficult patients were stressful.

Personal feelings had to take a backseat

Trudy found it stressful when her personal feelings had to take a backseat in case they interfered with a patient's well being (N5: 109). She found it hard to block out her own feelings (N5: 110-115).

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Not getting through to patients

Trish experienced stress when she was unable to get through to the patient (N6: 148-150, 158).

Patients competing for attention

Having several patients compete for her attention was another source of stress for Trish and sometimes she had to ask the patients to be reasonable (N6: 152-156).

Not liking patients

Trish found it stressful when she did not like a patient or a patient did not like her (N6: 159, 160-162, 167). When this happened she left these patients to other nurses (N6: 168-172). It was difficult to like everybody (N6: 192). Trish was not good with patients when she was under stress (N6: 163-166). Aine was limited when she could not get on with some patients (N8: 174).

Patients lacked confidence

Mona was stressed by patients who asked her questions and who did not have confidence in her ability:

> "It all depends on the type of patients you get. You'll have some
> patients who will question everything that you do and don't have
> any confidence in you at all. You can get quite worked up..." (N7:
> 147-150).

Patients constantly unloaded their problems

Aine found it stressful when patients unloaded their problems and expected her to have all the answers (N8: 109) which she did not have (N8: 110-115, 120-124). It was also straining to have to listen to the same problems repeatedly (N8: 116-119). Some patients wanted to maintain contact outside of hospital, but Aine needed time away from work (N8: 179, 180)

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(l) Shortage of staff increased stress

Aine thought that nurses did not spend enough time with patients because there was a shortage of nurses (N8: 46, 98, 84, 97). The staff were under stress because:

> "...on an acute ward the delivery part of care isn't always the same from day to day..." (N8: 83).

(m) Lack of positive results

Aine was stressed by a lack of positive results when a particular line of care didn't work out (N8: 125, 126). She had to try other approaches to the problem (N8: 127, 128).

(n) Physically and emotionally drained

Ruth found the work very wearing.

> "...it can take a lot out of you. If you've got somebody who's physically and mentally, you know, psychologically demanding, and you've gone home some days feeling absolutely drained. You haven't got anything else to give to anybody...you just want to be left alone..." (N9: 135-139).

She pushed herself too far (N9: 140-142) and patients demanded a lot of her psychologically (N9: 143). The workload was often stressful. Dan found that not being able to complete what he wanted to do because of changing ward circumstances was stressful, the high dependency patients had to get priority (N10: 158, 159). Heavy workloads were stressful and resulted in physical and mental exhaustion (N10: 166, 167).

(o) Ways of dealing with stress

In order to be able to continue to care for patients, the nurses had to learn to cope with the routine strains and stresses associated with the role of the nurse. Failure to deal adequately with these stresses may lead many students or even

qualified nurses to find alternative employment. A range of possible strategies was identified.

Positive results made stress more tolerable

While Steve could not cope well with stress (N2: 222-224), Emma talked to other nurses (N3: 174-176) and found that seeing patients recover made the stress more tolerable (N3: 179, 180).

Get away to recharge the batteries

Some nurses made an effort to get away from the situation. Emma had to get away and take a break to recharge her batteries:

> "...I have to get out. When stress levels are very high I feel that I want to withdraw. When you have a difficult incident on the ward I feel like I could make it go away. It's all related to stress. I don't think it's something that you really mean, it's just that you reach the limits of what you can give and I need a break to recharge the batteries" (N3: 230-234).

Keeping up to date relieved stress

Jeff tried to keep up to date as a way of relieving stress. It enabled him to give accurate information to people (N1: 70, 71).

Set limits

Steve felt that most people had a limit to their ability to care (N2: 307). He drew the line when work interfered with his personal life (N2: 308-313), or patients were too demanding emotionally (N2: 314). Not to set limits was untherapeutic (N2: 315).

Personal relationships were sustaining

Personal relationships were also found to be helpful. Cath found that her relationships outside of work helped to sustain her (N4: 305, 310). But sometimes giving too much in relationships outside of work limited what she could do in

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work (N4: 309). Feelings in relationships were important to the survival of relationships (N4: 286, 287).

Tried not to let it show

Another strategy which Dan adopted under stress was to try not to let it show. He did not want to panic other members of staff (N10: 163-165). He became accustomed to the uncertainty in the working environment and did not think about it (N10: 169, 170).

Kept up appearances

Much was expected of Ruth who had to put on an act when she felt in a vile mood (N9: 144-146). Some days it was really difficult to keep up (N9: 147, 150) an 'air hostess' mask over the things that were niggling her (N9: 148, 149). She could not be herself because it was not what the patients expected (N9: 152), they were too busy being ill to be interested in her life (N9: 153). She had to give the patients what they wanted (N9: 154-158).

6. Superficial preparation for the job

Nearly all of the nurses commented on their training and preparation to care. A distinct theme to emerge was the belief that the people could be trained to carry out nursing procedures but not any form of emotional caring response.

(a) Received a procedural training devoid of emotional content

Jeff was trained to care for people through physical care skills (N1: 88-90). He had some training in interpersonal and social skills too (N1: 91, 99) and these helped his ability to care to develop (N1: 100). It was not possible to train people to care in any emotional sense (N2: 293-296, 303). Trish thought that people could be trained to carry out procedures but not to care (N6: 196, 204). Mona thought that people could be trained to do nursing procedures which were caring (N7: 168-170). People who were not really into caring did it for the money or

dropped out (N7: 174, 175). It was more difficult to train people in the feeling side of caring (N7: 171-173).

In contrast, Steve's training helped him to care properly (N2: 78). Caring was a skill and could be taught (N2: 288, 289, 302, 304), and for nurses caring was a set of professional skills (N2: 306). The training involved learning how to provide a proper psychiatric environment (N2: 297-300). Training did not involve teaching students to have the appropriate emotions (N2: 301), for caring was an attitude that people have along with other things (N2: 305). Cath believed that her training as a nurse had nothing to do with caring (N4: 279, 280), and people could not be trained to care because training meant doing things without thinking (N4: 277, 278). Nurse training provided knowledge and helped her to organise her care (N4: 281-284). Ruth believed that it was not possible to train someone to care for another person (N9: 219, 232-234), it had to be part of the person (N9: 220, 221, 237, 238, 250, 251).

Training showed people what was expected of them (N5: 162), it helped them to achieve self control and keep their views to themselves (N5: 163). Training enabled nurses to answer patients' questions and give basic care (N5: 145, 149, 164, 165). It helped nurses to cope with emergencies (N5: 166-168). Trained carers could react in unexpected but effective ways (N5: 173), while an untrained but caring person could make matters worse (N5: 174-176). Nursing brought out caring qualities (N5: 169, 170, 171, 177). Not caring enough could also lead to a wrong reaction to a patient (N5: 172). Emma felt that training could contribute to the process of caring but not the feeling (N3: 198, 199). The things that could be taught about caring reflected caring without meaning (N3: 208). Aine thought that the training which the students received in the school was not always appropriate for the real world (N8: 161-166). Ruth wanted more psychology in her training (N9: 235, 236) and Dan felt that students could be trained to do the procedural aspects of caring (N10: 194, 195) as he himself was

trained (N10: 197, 198). He learned patience and understanding from other caring nurses (N10: 201-203).

Inadequate training and preparation for the job

Jeff felt inadequate and unable to give advice (N1: 48, 54, 58, 65). He was ill prepared to cope with dying and terminal illness in his basic training (N1: 55-57, 59, 61, 62). He felt alright giving physical care (N1: 60).

Need to experience care to give care

Aine felt that it was important to experience care before it was possible to care for another person and not all students could do this (N8: 169-173).

Too busy learning to be a nurse

The processes of caring and nursing came together over a period of time in Ruth's case. Initially she was busy learning how to be a nurse (N9: 239).

Glorified medical secretaries

Many people saw nursing as a job which they were paid for and did the work in a different way (N9: 245-249). Some nurses were very efficient but had very little to do with the patients, they acted like 'glorified medical secretaries' (N9: 240-244).

Opportunities for students

It was important that students have opportunities to care for patients and Ruth felt that students could be encouraged to care by seeing the patient as a person (N9: 222-224). Students should be encouraged to get to know the patients and admitting a patient offered a good opportunity for developing a close relationship (N9: 225-228).

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Trained to be all starch

Trish believed that good carers went above and beyond the call of duty (N6: 206). Many nurses were not carers:

> "...I met loads of nurses that are damn well nowhere near carers. They do what they are supposed to do as a nurse, but the caring part doesn't come into it...you don't have to be there all starch..." (N6: 33, 202, 203, 206, 208, 209, 211-214).

(b) Needed training in physical and psychological care

Emma believed that physical and psychological care were different (N3: 216-213) and felt it was important to teach nurses to treat people as individuals worthy of care (N3: 200-207, 224). Not everyone agreed. Cath didn't see any relationship between caring and professional nursing (N4: 299-303) but caring influenced her professional conduct (N4: 304). Similarly, Mona described professional caring as being able to do everything for the patient and act appropriately as the patient's condition changes (N7: 180). It was important to keep up to date to ensure that she got the patient's problems sorted out (N7: 181-183).

(c) Needed an intrinsic capacity to care

The training which most of the nurses received emphasised the procedural aspects of caring for patients. This was counter balanced by a belief that good carers had an intrinsic capacity to care.

Intrinsic capacity

Jeff had an intrinsic capacity to care which was part of his make-up (N1: 92-95, 98), but not everyone had this capacity (N1: 96). Nurses needed this intrinsic capacity to care for others (N1: 97). Emma also felt that caring was partly intrinsic (N3: 197), she was not conscious of being taught to care (N3: 212, 213). Cath felt that caring was just her (N4: 285) but nursing was just a job like any other (N4: 188, 189). Her decision to become a nurse was just matter of circumstance (N4: 288-290). Trudy believed that people had to want to do it, it

had to be part of them (N5: 146-148, 161). Caring was part of the person (N6: 197-201; N10: 196, 199, 200):

> "I don't know, it's just something they enjoy doing, they want to do.
> It's part of their personality. That's what they enjoy doing, that's
> what they want to do" (N5: 150-153).

Socialised caring outlook

Jeff felt that his socialisation influenced the way he perceived other people (N1: 82-86). Perceiving other people was an important aspect of caring for them (N1: 87). Mona also felt that the feeling side of caring was built into people from childhood and throughout life (N7: 176, 177), so did Ruth (N9: 229-231).

Needed a caring attitude

Emma felt that caring was a gentle and concerned attitude (N3: 108, 109, 184, 235) and being interested in people (N3: 186). Emma felt that caring showed in interpersonal communication (N3: 187, 188). Aine felt that carers needed an attitude of being interested in helping people to solve problems (N8: 155-160) and most people had this caring attitude (N8: 167, 168).

7. Constrained by the ward environment

Another important theme to emerge was the belief that the environment designed for nursing patients was sometimes unsuitable for that purpose and constrained the nurses capacity for caring for patients.

(a) Unsuitable ward environment

It was not good to have a psychiatric ward in a general hospital (N2: 120-122, 124-128), because of the difficulty of observation (N2: 125). He had to provide a therapeutic environment although the setting for the ward was totally wrong and prevented him from doing so (N2: 106-109). The ward was a daunting place for

others (N2: 44, 123). Trish on the other hand described the same ward as being well set up (N6: 221, 222) and busy (N6: 83).

The burden of physical care on a psychiatric ward

Physical care was not essential on a psychiatric ward (N2: 159), but patients with physical care needs got more attention (N2: 160). Steve was not good at giving physical care (N2: 161-163, 169), he disliked the patients with physical problems (N2: 164). Physical care was hard to do and unusual on the ward (N2: 165-168). People expected Steve to be able to provide physical and psychiatric care (N2: 170). He was caught out before when patients needed physical care and it was embarrassing (N2: 171, 172).

Dehumanising system

Steve believed that the whole system of care was dehumanising for the patient (N2: 243, 244). He tried to reverse this process (N2: 245-247). Emma found that the system she worked in limited her ability to care and got in the way (N3: 225, 226). Steve thought about his role as a professional carer (N2: 79-81, 83). He believed that the system of care ensured that caring was only a small part of his work (N2: 82).

(b) Much time wasted on paperwork

As a staff nurse, Steve wasted much of his time on paperwork (N2: 84, 85, 89, 90) which was only remotely related to caring (N2: 86, 87, 104, 105). It was however, a form of indirect care (N2: 99-101) which someone had to do (N2: 102). Paperwork could also be used to 'look busy' and shy away from clinical work (N2: 95-98). Doing the paperwork was not right (N2: 103), the emphasis in Steve's work was wrongly placed (N2: 88).

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(c) Limited resources

The short supply of facilities like flannels and soap on Steve's ward sometimes limited what could be done for patients (N2: 319). There was a lack of private space for patients (N8: 181, 182).

(d) Authoritarian consultant was dominant

It was difficult for Ruth and other nurses on a busy ward (N9: 69-71, 75) with an authoritarian consultant who gave out orders and then disappeared (N9: 74-78). The nurses were not allowed to assess things like patients' dressings (N9: 95).

(e) The influential role of the ward sister

Ruth believed that the ward sister's had a crucial role to play in providing care for patients and promoting developments and changes (N9: 258, 259).

(f) Wasted time walking up and down the ward

Ruth wasted much of her time walking up and down Nightingale wards to get things because the lay out of the ward was poor and inappropriate (N9: 256, 257). The workload, available time, and atmosphere on the ward also affected Ruth's ability to care for patients (N9: 252-255).

(g) Tried to ensure other staff kept the standards up

As a staff nurse Ruth was responsible for maintaining standards. She had to keep an eye on other staff to make sure that standards were alright (N9: 98, 169-171), she felt responsible for the standard of care (N9: 172, 173).

(h) Limited time

Time assumed great importance in caring for patients because it determined the quality of care given to patients and the ability of staff to implement new ideas.

No time to follow initiatives through

Steve found that it was difficult to get time to follow initiatives through from start to finish (N2: 136-141). A lack of staff was only part of the problem (N2: 142-144). He felt he would be able to do more of what he wanted to do as a charge nurse (N2: 156-158). Mona found it stressful when the ward was busy and there was no time to finish anything (N7: 128), or care for patients continuously (N7: 184, 185).

Needed more time for patients

It was important to be able to balance time for one patient against time for another (N2: 316-318). When time was short Steve had to weigh up what could be done for one patient with what could be done for another (N2: 320-321). Although Trudy, an unqualified nurse, had more time for patients than the trained staff, she did not have sufficient time to build up a one to one relationship with patients (N5: 71, 183-186). Mona hadn't the time to do little extra things for patients (N7: 95-99) and talk to them (N7: 45, 100, 101, 105). She did not get a chance to know the patients (N7: 47-50), and build up patients' confidence in the staff (N7: 53).

Made time for tearful patients

Mona did not mind if she cut short conversations with 'chatty' patients (N7: 72, 73), and if patients really needed to talk or were tearful and upset, she would make time for them (N7: 70, 71, 74).

(i) Personal limitations

Aine broke off relationships with patients to go on holiday (N8: 175) and was limited by a lack of professional expertise in some areas such as coping with bereaved relatives (N8: 176-178). When Ruth felt ill or had a bad day she did not work well (N9: 260, 261).

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(j) Good wards were less constraining

In contrast, some of the nurses worked on good wards. Jeff found himself working on a demanding ward which was also caring (N1: 67).

Good rapport between doctors and nurses

There was a clear division of responsibility between the doctors and the nurses (N1: 66). While Dan worked on a ward where there was a good rapport between the doctors and the nurses (N10: 113) and a spirit of teamwork (N10: 109, 110), even in busy circumstances (N10: 103, 104, 108).

Well run wards helped patients

Mona worked on a good ward which was not under stress (N7: 84, 86, 87, 94). It was well run and this helped the patients (N7: 90, 91). The patients noticed how things were on the ward and were relieved to be back from ITU after surgery because it was less frightening (N7: 79, 80-83, 92, 93).

Friendly and competent staff

The staffing levels were good and the staff were competent (N7: 85, 89). There was a relaxed atmosphere and the friendly staff helped patients to relax (N7: 54, 88).

8. Coped with a demanding and uncertain role

Nearly all of the nurses engaged in some form of appraisal of their role as professional carers. They had to cope with the inherent demands which the role placed on them.

(a) Doubts about being a nurse

Steve was unsure if he really wanted to be a nurse (N2: 71), he did not see himself as a caring person (N2: 72). He sometimes asked himself:

"...why am I here?" (N2: 182).

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Ruth felt she had to decide on her role (N9: 108).

(b) Experience promoted self-confidence

Although Emma had more time for patients as a student, she lacked confidence (N3: 135). As a staff nurse she was more self-confident (N3: 136, 137, 140). The role of staff nurses was more fulfilling (N3: 138), she had more information to give people and others were less likely to question her professionalism (N3: 139). Her experience helped her to give better care and assess patients needs. People expected more of her now that she wore a blue uniform (N3: 141).

(c) Freedom to care

Trish thought that her role as a nursing assistant gave her the freedom to care and do what she felt was appropriate for patients (N6: 105-109).

(d) Wanted to help others

Trish wanted to help all patients (N6: 184) and she could not stop herself being a carer even if she did not like a patient (N6: 191, 195). She realised that this job was the job she wanted to do (N6: 2), she was a 'mother cluck' person (N6: 205).

(e) Role ambiguity

A number of the nurses experienced a sense of ambiguity within the roles they had. Steve found it difficult to define the role of the psychiatric nurse (N2: 91-94). He knew a lot about other disciplines and what they could offer (N2: 113, 114). Steve had a lot of informal training on how to set up a therapeutic environment (N2: 110-112) and some training in group work (N2: 115). He knew about symptoms and cures and could discuss the drugs in an informed way (N2: 116-118). Along with others, he provided 'safe hands' for people to recover in (N2: 119). He was confused about what the staff nurse should be doing (N2: 145). Cath found that aspects of her role as a student prevented her from caring for patients in a way that she wanted to care (N4: 132). Sometimes she had to ask colleagues things and this broke up the interaction (N4: 158, 161). Having to

admit to the patient that she didn't know something conveyed a lot to patients and altered the relationship (N4: 159, 160). A qualification and further experience and knowledge may help her in the future (N4: 133, 154-157).

As a nursing assistant, Trudy found that her restricted training limited her ability to care (N5: 178, 179). She did not tackle situations in which she was unsure (N5: 180-182). Sometimes she had to ask permission to do certain things (N5: 67) and was unable to answer questions (N5: 68-70). Sometimes, the rules and regulations which had to be followed prevented her from caring for patients as she wanted to (N5: 63, 65). Trish, another nursing assistant, was sometimes asked to do unimportant or stupid things by the qualified staff when the time could have been better spent with patients (N6: 110-120). Not knowing about medicines was a minor drawback for Trish and prevented her from caring for patients as she wanted to (N6: 218-220).

(f) Role conflict

The qualified staff nurses found that the manager-carer role which they were expected to fill was a source of conflict. Too many different demands within the role prevented things from being followed through (N2: 146-153). It was difficult for Steve to decide what was more important from one day to the next (N2: 154). Emma found the manager-carer conflict difficult to resolve (N3: 145-148). As a staff nurse, Ruth felt the emphasis was on management not care (N9: 90), even though patients were her first priority (N9: 102, 103, 212-214). Dan's role as a staff nurse prevented him from caring for patients as he wanted to, his time was taken with administration (N10: 125-127, 141-145). There was a greater emphasis on management as a staff nurse (N10: 128-136), while students and enrolled nurses did more with patients (N10: 137). Dan missed the intimate contact with patients (N10: 138, 139).

Management got in the way of patient care

Emma found that management stopped her from looking after patients and caused frequent interruptions when she was with patients and relatives (N3: 121-134). Aine's time for patients was limited by being in charge of the ward (N8: 94-96, 99, 100). She had to concentrate on the risky psychotic patients (N8: 101, 102). Just being with the patients caused Ruth difficulties in her staff nurse role (N9: 106, 107). She was unable to actually give physical care and time to patients (N9: 72, 89, 91, 92, 99-101). Mona on the other hand was a state enrolled nurse, who wasn't bogged down by management tasks like those in charge (N7: 107, 110). She was able to give basic care and develop technical skills like giving intravenous drugs (N7: 106-108).

Pressure to conform

Emma was under a lot of pressure to conform to the traditional view of the staff nurse (N3: 149, 150). Other staff expected her to meet their needs before those of the patient (N3: 151-153).

Patients did not bother the qualified staff

Patients perceived the qualified staff and doctors as being too busy. Aine thought that patients perceived the qualified staff and medical staff as having no time (N8: 103), so they did not bother the staff but talked to the students instead (N8: 102, 104, 105).

Limited experience as a manager

While management assumed great importance within the role of staff nurse, Ruth was expected to function as a manager with very little support and experience. She was thrown in at the deep end (N9: 83). She learned quickly that she could not do it all and had to accept it (N9: 80-88).

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Another issue was study time. Dan thought that study days also took time away from patients but recognised that this knowledge could be used to benefit the patient in the long term (N10: 146-149).

9. Personal benefits derived from caring for others

The nurses derived a lot of positive benefits from caring for patients despite the stresses and strains involved in the work.

(a) Patient responded positively

Emma's patient recognised her interest and concern as caring (N3: 14, 25, 30). Patients could recognise caring nurses by the way they did the observations (N3: 110, 111). The patient responded positively to Cath's efforts (N4: 8, 24, 27, 28, 181), he smiled (N4: 191), and was appreciative (N4: 31, 32). Cath enjoyed being with the patient (N4: 64), she asked to be allocated to him (N4: 59, 60).

Support was appreciated

Mona's support was gratefully appreciated by the patient (N7: 7, 35). She helped to relieve the patient's loneliness (N7: 36). The patient was relieved when the operation was finished (N7: 38).

(b) Got through to the patient

Ruth gradually got to know the patient and was able to get through to her when other staff could not (N9: 2, 12-14, 32-34, 36-38, 40, 41, 59-61). Ruth tried to involve the depressed patient even when she was unresponsive (N9: 29, 30). When she talked to the patient she expected a response (N9: 31, 39). Sometimes she got one (N9: 35).

(c) Positive contribution was gratifying

Making a positive contribution was rewarding for Steve (N2: 180, 204), though positive results did not always happen (N2: 173). Steve got a sense of satisfaction

because he was happy with his professional contribution (N2: 189-192, 195-199). Sometimes Steve expected positive results to boost his own self-esteem (N2: 234, 235). Cath felt good to see people get better and go home (N4: 204-206).

Minimal influence on the patients' recovery

The lack of results with patients was not Steve's fault (N2: 277) and sometimes the results had nothing to do with him (N2: 174-175). Some patients did not expect him to have any effect (N2: 178).

Needed to see results

Steve found that patients expected tablets and then to get better (N2: 179). Just giving out tablets was soul destroying (N2: 180). When he started on the ward he didn't think he needed to see results (N2: 183) but now he did (N2: 187). A suicide on the ward was failure (N2: 193, 194).

(d) Seeing patients as friends

Steve got a lot of satisfaction from seeing patients as ordinary people and friends who he shared things with (N2: 248, 254). It wasn't always possible to do this (N2: 257). Occasionally Steve went drinking with patients which was not professional (N2: 249-251), but it sometimes got positive results (N2: 252, 253, 255, 256). It was important to be able to get patients to accept care (N2: 258, 259).

(e) Being appreciated by patients

Patients were grateful to Emma and she enjoyed that feeling (N3: 156, 157, 162). Cath felt good that the patients wanted to talk to her (N4: 92, 93) and needed her attention (N4: 114-116). Talking to patients helped to motivate Cath (N4: 96-99, 105, 106) and made her feel good (N4: 182-186). Trish was happy to be appreciated by the patients even though it was her job (N6: 127-131). Some patients saw her as a jailer however, and Trish didn't like the way they looked at her (N6: 189, 190).

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Felt nice to be noticed

Aine also achieved satisfaction in trying to help people overcome their problems (N8: 36, 37, 106) and she was pleased when patients noticed her (N8: 38, 39).

Positive feedback

Ruth liked the warmth and feedback she received from patients which other jobs could not provide (N9: 123-125, 134). The feedback about her care was always good (N9: 126-128).

Felt needed

Trish got a lovely feeling of being needed (N6: 135, 137-139, 140-142) which she hadn't experienced in other jobs (N6: 135, 146, 147).

(f) Doing something worthwhile

Trish liked working with people and liked the feeling of caring because she did something to help the patients get well (N6: 121-126, 143-145, 193, 194). Mona enjoyed surgical nursing and the quick turnover, she felt as though she was really doing something for sick people (N7: 111-113). Dan needed to do something worthwhile and satisfying (N10: 116, 117, 153-157).

(g) Enjoyed the sense of achievement

The sense of achievement which caring for others provided was recognised by several nurses. Sometimes the patient responded and this gave Trudy a sense of achievement (N5: 24, 26-28, 42). Occasionally the patient was emotional and kissed Trudy (N5: 37). Trudy enjoyed achieving things with patients (N5: 85, 86, 92), and establishing a trusting relationship in particular (N5: 93-99). Ruth enjoyed meeting with people and achieved job satisfaction (N9: 115, 116). She was pleased to be able to help somebody (N9: 117, 118), especially through education (N9: 119-122). Dan felt good when he achieved what he set out to do for patients and left the patients in a comfortable condition (N10: 151, 152).

(h) Learned a lot about people

Jeff learned a lot about peoples' problems and how they coped with them through caring for others (N1: 13, 19, 24, 68, 69). So too did Cath (N4: 191-203). Trudy found looking after and getting to know people interesting and enjoyable (N5: 72-76, 91). She got along with most people (N5: 88) and learned a lot from patients which helped her to be aware of her own reactions to things outside work (N5: 77-84, 128, 129). Aine also learned a lot about relationships (N8: 107).

(i) Personal development

Ruth benefitted by developing and changing personally. She grew up quickly and it brought out qualities which would not have emerged otherwise (N9: 131). She became responsible, respected and trusted (N9: 132, 133).

Explored personal feelings

Emma benefited by having the opportunity to look at her own feelings (N3: 154, 155).

Work helped her to cope with death

Mona learned how families coped with death (N7: 114-117), she became less frightened (N7: 118, 119). She learned how to reassure bereaved families and used this skill outside of hospital (N7: 120-123).

Increased self-esteem

Emma found that caring increased her self worth (N3: 158), it gave her a sense of being trustworthy and of being trusted (N3: 159, 161). Not all patients responded to her however (N3: 160).

Summary of the main findings

The description of the nurses' experiences of caring for patients is very detailed so a summary of the main themes and major subheadings is provided below to serve as a reminder of the central issues and concerns of the nursing informants.

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1. Hopelessly dependent cases

(a) Terminally ill and frightened
(b) Faced a lonely and inevitable death
(c) Deserving of care
(d) Depressed and dependent
(e) Faced traumatic surgery alone
(f) Chronic disability and depression
(g) Needed a life-saving heart transplant
(h) Dependent and starved of attention

2. Felt impact of the patient's dreadful situation

(a) Felt sorry
(b) Helpless or able to help
(c) Wanted to give
(d) Felt anger and revulsion
(e) Worried and concerned about the patient
(f) Sense of loss and sadness

3. Did their best for patients

(a) Spent time with the patient
(b) Helped the patient to cope
(c) Gave personalised and sensitive care
(d) Tried to promote independence
(e) Paid attention to detail
(f) Attended to patients' basic needs
(g) Physical care helped to develop an empathic response
(h) Optimistic rapport
(i) Dedicated during working hours only
(j) Important interpersonal skills for helping

4. Calculated emotional involvement with patients

(a) Risky emotional involvement
(b) Choosing to be involved
(c) Controlled involvement was more helpful
(d) Varied levels of attachment
(e) Quickly forgot about patients
(f) Unfair expectations on patients
(g) Difficult to distinguish professional caring from loving
(h) Loving response sometimes shown to patients

5. Constant awareness of the stressful nature of the work

(a) Constant worry
(b) Wrong attitudes produced stress
(c) Sending patients back home
(d) Heightened awareness of personal vulnerability
(e) Listening to and watching ill people
(f) Stressful colleagues
(g) Felt unable to challenge established attitudes
(h) No time for the students
(i) Short student placements
(j) Observing suicidal patients
(k) Difficult relationships with patients
(l) Shortage of staff increased stress
(m) Lack of positive results
(n) Physically and emotionally drained
(o) Ways of dealing with stress

6. Superficial preparation for the job

(a) Received a procedural training devoid of emotional content
(b) Needed training in physical and psychological care
(c) Needed an intrinsic capacity to care

7. Constrained by the ward environment

(a) Unsuitable ward environment
(b) Much time wasted on paperwork
(c) Limited resources
(d) Authoritarian consultant was dominant
(e) The influential role of the ward sister
(f) Wasted time walking up and down the ward
(g) Tried to ensure other staff kept the standards up
(h) Limited time
(i) Personal limitations
(j) Good wards were less constraining

8. Coped with a demanding and uncertain role

(a) Doubts about being a nurse
(b) Experience promoted self-confidence
(c) Freedom to care
(d) Wanted to help others
(e) Role ambiguity
(f) Role conflict

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9. Personal benefits derived from caring for others

(a) Patient responded positively
(b) Got through to the patient
(c) Positive contribution was gratifying
(d) Seeing patients as friends
(e) Being appreciated by patients
(f) Doing something worthwhile
(g) Enjoyed the sense of achievement
(h) Learned a lot about people
(i) Personal development

Summary of the chapter

The findings to emerge from the interviews with nurses are presented. They provided a very rich and detailed analysis of what it means to care for patients in a professional nursing context. The context in which caring interpersonal relationships plays an important role in determining the precise nature of that relationship. The nurses were constantly aware of the stresses and constraints imposed by the system. The level of involvement with patients was influenced by the nurses' need to be able achieve positive feedback for her efforts on the one hand and avoid the risks and stresses entailed in over-involvement with patients and work on the other. In the next chapter the views and experiences of patients are examined.

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CHAPTER 7
BEING CARED FOR

Introduction

In the previous chapter nurses' experiences of caring for patients in hospital were examined in detail and these provided a very detailed but rather one-sided account of the lived experience of professional caring relationships. The need to take account of patients' experiences is crucial since patients are the main consumers of professional caring relationships. A patient perspective is required to deepen our understanding of the meaning of the experience of caring and being cared for. In this chapter therefore, the findings from the patient interviews are presented in the form of 4 general themes which typified the patients' accounts of their experiences of being cared for in hospital.

Patients' experiences of being cared for

Organising principles

The organising principles used for presenting the findings in this chapter are similar to the those described in chapter 6. The results described here are however quite different from those in the previous chapter so the organising principles are recounted here to avoid misunderstandings. A number of conventions have been employed here to ensure that the findings are communicated effectively and with clarity. The general themes which emerged from the analysis of the transcripts are presented initially. These themes are numbered 1-4 and bolded. Under each of these general themes a number of component themes are presented. These convey the rich variation within the general themes and capture the concerns of each individual informant. The descriptive phrases used to capture these component themes mirror closely what individual informants said during the interviews. These component themes are listed alphabetically. On occasion it was necessary to employ a third level of organisation to convey some of the subtlety entailed within some of the component themes. An italicised descriptive phrase capturing the theme is used for this level of subheading.

The following example may help to reinforce this structure. The first general theme to emerge was: 1. **Crushing vulnerability**. A number of component themes were found to exist under this more general heading and included: (a) The hospital environment was strange; (b) Anxiety about being treated like an object; (c) Positive impact of being treated like a person; (d) Shattering impact of cancer; (e) Traumatic investigations and surgery; (f) Cancelled operation was a major setback; (g) Anxious suspicion and so on. Very fine variations were contained within some of these component themes so a third level of organisation was used. Within the component theme (b) Anxiety about being treated like a person for example, the following subheadings are used: *Ignored during the handovers*, and *Public discussion of personal details was embarrassing*.

Extracts from the interview transcripts have been included occasionally as evidence in support of a particular theme and to give a flavour of the interviews as a whole. These are enclosed within double quotation marks to emphasise the fact that they are selective narratives of what informants actually said. The information enclosed within brackets throughout the chapter is provided to identify individuals informants. The individual patient informants are identifiable by the letter P and a number (1-10). The remaining numbers enclosed with the brackets refer to the specific meaning units in the text.

The general themes emerging from the patient interviews
The four major themes which surfaced from the interviews with patients were: 1. Crushing vulnerability; 2. Adopted a particular mode of self-presentation; 3. Service appraisal; and 4. Personal concerns of the patient. These are now described in more detail.

1. Crushing vulnerability
Patients experienced being cared for during a time of distressing vulnerability. The emotional upheaval of being ill and in hospital set the scene. The things that nurses and doctors did for the patients and the way in which these things were

done conveyed to the patient a feeling of being care for. Sometimes patients felt both cared for and uncared for during their stay in hospital through the actions and sensitivities of the staff.

(a) The hospital environment was strange

The hospital environment was experienced as a daunting place for a number of patients. It was unpleasant, big, strange and nerve racking (P1: 3, 54, 64). This strange environment led some to become aware of their vulnerability; James for example stated:

> "I don't like being in a situation that I don't know what to do" (P2: 24).

Zoe was frightened and wondered what would happen to her (P8: 1, 2, 4). In hospital, strange people came to talk to her and to take blood samples (P8: 3). Other patients did not like being in hospital and were there because they had to be there; James did not like hospital and was there under duress (P2: 4, 5). Some patients adapted to the strange environment and came to see it as not such an intimidating place. Those who had several admissions to hospital or stayed for a length of time became accustomed to it (P2: 1, 50). But one patient, Martha, who spent several weeks in hospital after extensive surgery, cried sometimes because hospital just got to her (P7: 93).

(b) Anxiety about being treated like an object

Some patients found that being in hospital induced anxiety about being treated like an object; Florence had a dreadful fear of being made to feel like a number (P1: 19; P5: 40, 49). She tended to talk too much when she was nervous (P1: 49, 50). James also expressed uneasiness and:

> "...did not want to become just a name on a sheet of paper" (P2: 13).

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James was able to overcome this difficulty by communicating with others (P2: 15). Other patients were less fortunate and were disappointed with the personal side of the care they received in hospital (P5: 55). Hugh for example found that his feelings were ignored completely by staff (P5: 50, 51). Hugh found that he was:

Ignored during the handovers
The handover period was usually conducted at the foot of Hugh's bed and he was ignored by the staff. Hugh really wanted the nurses to talk *to* him (P5: 41, 45-48), but instead the staff talked *about* him:

> "...its almost as if you're being talked about and are not there. You know 'this is Mr. D. who had a bath'...I'm here..." (P5: 33, 44).

In addition Hugh found that the:

Public discussion of personal details was embarrassing
During the handover which was carried out in front of the patients, the distinct lack of privacy embarrassed Hugh:

> "...I don't think it should be done in front of the patient, being talked about is....embarrassing" (P5: 42, 43).

Not only that, this type of handover system wasted time and was unnecessary according to Hugh (P5: 52-54).

(c) Positive impact of being treated like a person
In contrast, several patients commented on the positive impact of being treated like a person.

Being treated like a person promoted recovery
Some patients suggested that the feeling of being treated like a person had a positive effect on their wellbeing. Although the staff did nothing spectacular for Florence (P1: 21, 26), they just made her:

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"feel like a person, you know, not a number..." (P1: 22, 27, 31, 40).

And being treated like a person helped her to relax (P1: 2, 6) and recover (P1: 88, 89).

Felt good to be called by your Christian name
Patients cherished being called by their first name. It seemed to symbolise a need to be treated like a person rather than an object or number and this view was shared by several patients. It felt good when staff knew the Christian name of the patient, though not every patient appreciated being called by their first name (P1: 9, 10, 20, 66-69; P6: 9; P10: 85) for example:

> "I'd rather be called by my Christian name and I feel more at home. And I think this status of being Mrs. David or Mrs. Jones is past you know..They call us here Eileen and so on..." (P3: 28-31).

One patient, Eileen, expressed the need for caution and felt that nurses should not call *all* patients by their first names (P3: 26).

Staff did not make patients feel small
The approach of the staff made an impact on patients too. Staff did not make Florence feel small (P1: 30), they were friendly and treated her like a workmate (P1: 23, 28, 29). Whereas Eileen felt that nurses would always respect her wishes (P3: 32). Tim had a more positive experience when he returned to the ward after being to another hospital. When he came back one of the nurses hugged him and he really felt good:

> "When they seen me come back here last week young Jane got hold of me as if she hadn't seen me for donkeys years, as if I was a long lost brother or something. They made me feel somebody..." (P4: 76-78).

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(d) Shattering impact of cancer

Two of the informants who took part in the study had recently been diagnosed as having cancer. It had a tremendous impact on the lives of both patients.

The need to know the truth

Both patients developed cancer and were in hospital for treatment. They spoke of their need to know the truth about the condition and the future. Tim told of his need to know the worst (P4: 4) but the doctors would not tell him directly (P4: 3). He felt better after finding out the truth (P4: 60) but was very hurt because his wife was told about the cancer before him (P4: 6, 61, 62). Al asked the professor looking after him to tell him everything (P10: 26).

Discovery

Tim was eventually told he had lung cancer (P4: 5, 7-10) and when he was told about the cancer he went cold (P4: 11, 12), he just:

"...went to pieces..." (P4: 25).

Over time he had grown to accept that fact that he had cancer (P4: 64). Al was another patient who developed cancer. At first he discovered a mole on his back which was diagnosed as skin cancer after an operation (P10: 5, 19, 36, 37). The professor told him he had cancer and it was very serious (P10: 27-29).

Thoughts about death and dying

Tim saw many different doctors on account of his rare condition (P4: 43), and thought that he was dying because so many doctors came to see him (P4: 44). His nervous disposition led him to think the worst (P4: 45). Al on the other hand was fearful about going into hospital in case it was terminal (P10: 18, 20, 30-31). Al thought about his life:

"...life is sweet. I've got a little car, a wife and two nice children and we go and do things. Not a lot of money but its nice. You

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know...after working all your life and retiring now comes the sallow days" (P10: 68-71).

He too felt that he could accept whatever was in front of him because he was older and more experienced (P10: 33-35, 65-67).

Hope without guarantees
During his first operation, Al had a melanoma removed and the operation went alright (P10: 4, 6), but there were no guarantees even though everything had been done (P10: 7-10). Another lump was discovered at out-patients and a second operation was needed (P10: 11-15). The second operation went alright (P10: 16, 17, 22-25). Now he would have to wait and see (P10: 32).

(e) Traumatic investigations and surgery
Lengthy and drawn out investigations were found to be traumatic for Tim (P4: 13-15) but the staff were supportive (P4: 16). High blood pressure was another complication and required a move to another hospital to get it down (P4: 26-29), he felt better when the blood pressure settled down (P4: 30-32). Al had to undergo two major operations for cancer.

(f) Cancelled operation was a major setback
After all the preparation and investigations the operation for Tim was cancelled. This was a real blow (P4: 17, 19) and a further source of anxiety because he assumed that the cancer had spread to his kidneys (P4: 18, 21). Tim calmed down after hearing that the operation was not cancelled altogether (P4: 20, 23), the doctors wanted all the results to be alright before the operation (P4: 46, 47). Eventually Tim got news that the operation would proceed and he rejoiced at this news (P4: 48).

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(g) Anxious suspicion

Tim, who discovered that he had cancer during his stay in hospital did not expect to be pampered (P4: 87), if he was pampered or the nurses spent too much time with him, he would have suspected something:

> "If they kept on I'm sure I'd think there was more wrong than is actually the case. That's how I would feel if they pampered me too much..I'd know. That I do believe" (P4: 85, 86).

(h) Surrendering independence was distressing

Martha spent a long time in hospital and found it was hard to rely on other people and give up her independence (P7: 1, 23-26). She felt awkward to be helped to the toilet P7, 28). She was not able to sit up after the operation (P7: 44), and became even more dependent after the second operation (P7: 46). It was very distressing and upsetting:

> "...I found it very difficult, very upsetting. I really thought that after six weeks I was going back to stage one" (P7: 47, 48).

Gradually regained independence

Her independence was regained gradually however. Staff had to do everything in the beginning (P7: 29), but they were able to judge what she could do for herself (P7: 31-34). Then staff left things ready for her and let her get on with it (P7: 43). Al on the other hand regained his independence soon after his operations and went home quickly (P10: 45-48).

(i) Coping with bodily disfigurement was traumatic

Martha had two operations involving large skin grafts (P7: 35, 45), she found it very difficult to look at the operation site:

> "...and just to see it to start with is the worst bit, you feel like fainting..." (P7: 36, 37).

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However, she could not escape from the operation site (P7: 38, 39). She realised she had a stoma (P7: 40), and eventually reached a stage where she looked after herself (P7: 41, 42).

(j) Difficult being away from home for a long time

Because Martha was away from her home and relatives for such a long time she felt like she needed something to make up for being away from home (P7: 84). Although she was told that it would take two or three weeks by her own doctor (P7: 50, 51) she had already spent eight weeks away from her family (P7: 49). Martha wanted staff to spend more time with her like the other patients (P7: 57, 58), and talk normally to her (P7: 85, 86). Other people made her feel different in herself (P7: 59, 60).

(k) Felt like a smelly mess compared with the nurses

Zoe messed the floor because she had diarrhoea and felt awful because the nurse had to clean it up (P8: 80-85). She compared herself to the nurses who were well groomed (P8: 117), and felt like a smelly mess by comparison (P8: 118).

(l) Felt forgotten about

On one occasion Ed felt forgotten about because he had to wait for a long time for the doctor to come. He waited five and a half hours for the doctor to come and set up a drip (P9: 37, 38). He concluded that the staff must have been very busy to neglect him so:

> "...as I was saying there were other things doing and all. I don't suppose they can be in two places at once. But you're not the only one I expect there were others worse than I was like, that needed attending to" (P9: 39-42).

2. Adopted a particular mode of self-presentation

In order to survive in the environment patients had to adapt to the specific context. They had to 'fit in' by whatever means were available to them. Several

patients noted changes in their own behaviour as a result of being ill and in hospital. They adapted to the situation by adopting a particular mode of self-presentation.

(a) Sheepish obedience

Some patients became very obedient; Florence did everything that the staff told her to do (P1: 43):

"Maybe I'm a bit sheepish" (P1: 76).

She looked to professionals when things went wrong (P1: 77-79) with blind faith. James made sure he gave the correct information and did not waste the staff's time (P2: 65, 66), he did what was asked of him (P2: 67). Tim, an extremely nervous patient met with lots of medical students on account of his rare condition when his nerves let him (P4: 94-96), because he felt he would be foolish to be awkward and uncooperative (P4: 97, 98). George made it easier for the staff to take blood and was very cooperative during investigations (P6: 95).

(b) Conforming to ritualistic practice

Another strategy was emphasised by George; the need to abide by the ritualistic practice of the medicine round (P6: 88, 93). He was not allowed to collect medicine but would collect his own tea from the trolley (P6: 87, 90). He believed that regimentation was necessary for survival (P6: 89, 91, 92, 94).

(c) Unusually friendly and cheerful

Several patients adopted a cheerfulness which was unfitting for the situation in which they found themselves. One tried to be liked by the staff and hoped the staff saw her as a cheery sort of person and enjoyed nursing her (P1: 44-47). She did not feel obliged to be cheerful (P1: 51) for Florence was generally a cheery person (P1: 52, 53) and she hoped the staff did not mind looking after her (P1: 48). Others also tried to be cheerful (P2: 68, 69; P4: 69-72). However, one long

stay patient, Martha described her stay as being as happy as it could of been in the circumstances (P7: 93).

(d) Provided a frank and honest account

George offered another tactic, he ensured he answered staff's questions honestly and told the truth about his excessive drinking (P6: 96, 97):

> "They asked me and I told them the truth and helped in that way. That's all part of the system, the set up. I mean it's stupid to tell them one pint a day when I'm drinking fourteen. But some people do these things" (P6: 100-104).

(e) Helpful camaraderie amongst patients

Another strategy was to help other patients; Florence tried to help other patients settle into the ward (P1: 55, 56) though she did not see herself as a goody-goody person (P1:57). Eileen was not desperately ill or in need of a lot of physical care (P3: 46, 50, 51) and found that she spent her time completing meal cards for the elderly patients and helping out generally at mealtimes (P3: 17, 18, 47, 48, 55). She did not however take over the situation (P3: 56). Helping other patients was enjoyable (P3: 57), Eileen wanted to help the staff in any way she could (P3: 53, 54, 58, 60). Al got on well with people (P10: 79) and suggested that the patients on the ward became pals. There was a camaraderie between patients (P10: 60-62).

(f) Reluctant to ask questions

Patients were generally reluctant to ask questions about their care and treatment. It would appear that patients were not encouraged to ask questions of the staff. If they did ask questions, the staff employed subtle tactics (eg. letting the patient know how busy they were; giving the impression that the patient was being a nuisance or providing incomplete answers to the patient's questions), in order to ensure that a detailed questioning did not occur.

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Needed to keep up to date

The issue of whether to ask questions and seek out information was important to several patients. Some patients refrained from asking questions altogether, while others confined their questions to the sort of questions where there was a "yes" or "no" answer (P2: 31-34). Patients were aware of their lack of knowledge; there was a lot going on that James did not know about (P2: 25). On some wards patients were better informed and not all patients needed to ask questions. George had no need to ask many questions because he was kept up to date with accurate information and pictures (P6: 62-65) and his questions were answered (P6: 66).

Did not want to bother the staff by asking questions

It did not appear that patients were encouraged to ask questions; nobody told James not to ask questions (P2: 35). While Hugh felt like a nuisance for asking questions and particularly of doctors (P5: 62). Tim did not want to bother the staff by asking probing questions (P4: 42, 55, 56), he felt that staff could not give an honest answer until the test results were known (P4: 57). Tim felt confident that the staff would tell if anything was wrong (P4: 59).

Infrequent requests for more information

Infrequently, a patient became more confident and asked questions as they did (P2: 26, 29, 30), even though other patients did not ask questions because they felt it was not right (P2: 27, 28). When questions were asked the staff answered these as best they could (P2: 36).

(g) Kept interpersonal encounters superficial

Another strategy which some patients employed was to keep interpersonal encounters brief and superficial. James deliberately set limits on the contact he had with others. He became part of a patient group (P2: 9, 10), but these encounters were limited (P2: 16-20). He made sure that permanent relationships were not established (P2: 21) even though the relationships he did have made him

feel cared for (P2: 22, 23). Nor were close relationships with nurses developed, some preferred to keep their distance (P2: 51, 52)

> "It's me. That's the way I am, that's the way I've lived. I'm an ex-headmaster, I've had to learn to draw lines" (P2: 53-56).

George kept to himself and read (P6: 53, 56), he did not go looking for conversations (P6: 57) but talked constantly to his wife during the visiting time (P6: 54, 55). Another patient Ed felt that the nurses did what they had to do and no more (P9: 7, 20, 22-24, 26, 27, 30).

(h) Tried not to be a nuisance

Several patients tried not to be demanding or bother staff, they tried not to be a nuisance (P5: 87, 90; P7: 87). James kept out the way especially when the staff were ill-tempered:

> "...they come on to a shift at seven in the morning after getting up
> at six and people can get up out of the wrong side of the bed. If
> you notice that, you know to keep your head down" (P2: 48, 49).

When Ed was recovering he just spent his time marching up and down the ward outside of his room (P9: 8). Martha suggested that not being a nuisance meant that other patients got their share of care (P7: 88). She did not feel guilty about asking for help (P7: 89), but sometimes she was made to feel guilty (P7: 90).

(i) Provided a sense of purpose for the carers

Florence felt that she was able to provide the carers with a sense of achievement (P1: 41), while Zoe felt that seeing people get better helped nurses to do their work and provided a sense of purpose (P8: 87, 88, 115, 119, 120), particularly since many nurses were Christians (P8: 122, 123, 125). Not everyone felt this way, Martha felt that she had very little to give back to the carers (P7: 91, 92).

(j) Deference and gratitude for the carers

Al always displayed good manners and thanks to the carers who looked after him (P10: 90, 92), he really appreciated what was done for him (P10: 91). He always called the nurse "nurse" (P10: 73, 75, 80, 86). George wanted to give money to the NHS (P6: 111, 112) and felt many others would do the same (P6: 113).

(k) Admiration for the hard working staff

There was a lot of admiration for the work done by the staff for other people (P5: 4-6, 31, 37-39), and a belief that nurses did not do the job just for money (P5: 85, 86). Zoe could not understand how the nurses did some of the awful jobs which they had to do but was very glad someone did it (P8: 74, 76, 78, 79, 86, 121). She suggested that the nurses were dedicated (P8: 75). George stressed the view that nursing was partly a vocation (P6: 37, 38, 79-83), and a vocation was necessary for survival at work (P6: 84-86). The younger nurses especially had the vocation (P6: 35, 36). Florence felt that it was possible to train nurses to care (P1: 73) as long as it was part of their make-up (P1: 74).

3. **Appraised the symbolic services**

The routine hospital facilities and resources and the manner in which staff interacted with the patients was evaluated by the patients. Generally these evaluations were positive but there were instances where patients were overtly critical of their care. It is possible that the resources, the service and the people involved in delivering day-to-day care came to be seen as the living symbols of a caring service, since none of the patients actually got to know the nurses well during their stay in hospital.

(a) General level of satisfaction with caring staff

There was a general level of satisfaction with care received and many patients genuinely appreciated what was done for them; they were satisfied with the level of care (P1: 5, 16, 17; P2: 7, 8, 37; P6: 1, 2; P7: 2, 9, 63, 64; P9: 1, 3, 35, 36; P10: 1, 21, 41-43, 72). The staff were very caring and good (P1: 1, 7, 18, 58-60; P2: 57,

58; P3: 3, 5, 41, 49), while others commented that none of the nurses were especially caring (P1: 35; P9: 21; P10: 84, 89). Ed felt that hospital was the best place for him (P9: 2). In other hospitals James found that the staff were not so caring (P2: 59-63). Florence felt good knowing that the staff did their best for her (P1: 14, 15).

Limited but satisfactory level of nursing care

Not every patient had a lot of nursing attention; some did not have any real nursing only tests (P1: 36-38), or limited nursing pre-operatively (P6: 17, 30). James was very happy with all the attention he received from the consultant down to the nurses (P2: 11). The staff let the patients know they were there for them (P2: 12). All did not need a lot of physical care (P10: 44).

High levels of nursing care needed

Other patients needed lots of physical care. Zoe for example, needed to be helped in and out of the bath initially (P8: 72, 73, 77), and help to walk (P8: 89). Gradually she became more independent (P8: 90) and needed less help now. The nurses brought the equipment to her and let her do her own dressing now (P8: 91). One patient, Tim, spent nine weeks in four different hospitals but he was treated the same in all of them (P4: 37, 38).

(b) Friendly but diplomatic staff

Several patients commented on the positive effect of having friendly staff (P1: 8; P3: 23-24, P4: 2, 33, 65, 73; P6: 7, 8, 10). Nobody was rude to Tim in hospital (P4: 39). It made some feel at home (P3: 22), and improved the work done by doctors and nurses (P3: 25, 27). The informal and friendly atmosphere was helpful for Eileen (P3: 33). The nurses were always smiling (P4: 82, 93). Zoe also commented on the friendliness of the staff but she noted how careful and diplomatic the staff were when talking about her condition (P8: 18, 29)

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"Well, they're very pleasant, they're very careful what they tell you. I asked when I will get better, what caused it and so on. But they're always very very careful and very diplomatic what they say...." (P8: 93-96, 98, 99).

(c) Nurses asked what the patients needed

Martha was confined to bed for some time and without frequent visitors found that most nurses asked if she needed washing or shopping done (P7: 61, 66). One student nurse actually took her dressing gown home and washed it for her (P7: 62, 77). Nurses also brought in magazines for her to look at (P7: 65).

(d) Felt safe and trusted the nurses

Martha trusted the nurses and felt at ease with them (P7: 3, 8). She felt safe because they held her firmly when she was getting into the bath (P7: 4), though some nurses made her feel safer than others (P7: 5).

(e) Technical competence was appreciated

Many patients praised the skill and expertise which characterised the nurses performance. Injections were administered competently and sensitively (P3: 34-36) and blood samples were taken speedily (P3: 37). Staff also ensured medicines were given on time (P3: 38). Tim noted how the steroid medications were reduced gradually (P4: 50). Zoe commented that the experienced nurses were good at handling drips and dressings and so on (P8: 125, 127-129) and this was not always true of less experienced nurses (P8: 129).

The nurses had to wash Ed and clean up any mess that he made (P9: 4-6, 15), but he still got a sore on his back (P9: 16-18). The nurses got the sore better (P9: 19). Al was impressed by the willingness with which help was given (P10: 49, 51), and the way the staff checked his wound and dressed it (P10: 50, 52). Eileen appreciated the speed with which she was admitted to hospital (P3: 13), she was glad to be in hospital (P3: 14), and stayed for five days (P3: 39). Zoe too was very ill on admission and appreciated being looked after (P8: 7-11, 90). Nurses

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made constant checks on the patients and responded promptly when someone rang a call bell (P3: 6, 7, 9, 10). Another patient also commented on the constant checks made by the nurses (P4: 79-84; P5: 22, 23). The nurses were always on their toes (P3: 11) and earned their money. Ed had to use the call bell a couple of times and the staff responded promptly (P9: 31-34).

(f) The approach of the staff was sensitive and calming

The nurses ability to calm Tim, a very anxious patient without resorting to the use of tranquillizers was important (P4: 51-54, 91), for Tim believed that the nurses did not know that he had cancer (P4: 34, 88). When Al came into hospital he was very apprehensive but the staff quickly dispelled any fears that he had (P10: 2, 3).

Watched the carers in action from a distance

George watched the nurses and doctors in action from a distance (P6: 15) and could not help overhearing things (P6: 19-23), as the nurses calmed a very frightened patient (P6: 25). The caring nurses just sat with the frightened patient (P6: 24, 70-72) and could not have done more (P6: 77, 78), they arranged for a social worker to help the patient's wife (P6: 73, 74, 76) and instilled confidence into the patient (P6: 75). The caring doctors and nurses helped another patient who was very upset (P6: 18, 27-29).

Aware that the nurses understood her loneliness

When Martha's husband came to visit her at the weekend the nurses gave her husband a spare meal so that he could stay with her (P7: 67). The nurses knew he had to travel a long distance to be with her (P7: 69).

(g) The accommodation and hotel services were reasonable

Several patients mentioned the importance of accommodation and hotel services during their stay in hospital. These aspects of their experience of being care for are important for many patients. The quality of the food was good (P4: 40; P6:

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3; P8: 17) and the bed linen was changed daily (P3: 2, 19), but the china was cracked and ought to have been replaced (P3: 20, 21). Zoe found the hospital clean and the atmosphere caring (P8: 134). At times the ward was short of staff particularly at weekends (P3: 1).

(h) The devoted students were constantly available

The student nurses were singled out for their attentive care and devotion (P7: 70-76). The younger nurses were good (P6: 4). One student introduced Florence to other patients on the ward and she felt much easier as a result (P1: 61, 62, 64, 65). Patients did not mind being looked after by the students nurses who had to get experience (P1: 70-72). Another patient commented on the constant availability of the students (P3: 42).

The students took time and talked

Several patients referred to the contact they had with students. Students spent more time with the patients and got to know them better (P5: 27, 69; P7: 78, 79), they were caring (P7: 80). Some of the experienced students were very used to talking with patients (P5: 28, 34). The students took time to talk (P7: 6, 7) and share a bit of their life (P7: 81), Martha's relationship with students was on a personal and professional footing (P7: 82, 83).

The students listened and tried to answer questions

Talking to the students helped to keep Hugh's spirits up (P5: 70-72) because they were very helpful (P5: 74). They listened to Hugh (P5: 75-77) and tried to get answers to his questions (P5: 68). Sometimes they tried to answer questions beyond their experience (P5: 79, 80). The students were able to use a range of approaches with him (P5: 78).

Appreciated the students who stayed late

Martha needed lots of physical care and she appreciated when one of the students stayed on late to complete her care (P7: 21, 22).

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Not all of the patients were particularly appreciative of the students approach. Ed, who had little contact with students, noted that the students went around with the doctors as he expected in hospital (P9: 28, 29).

(i) Helped to get through the miserable nights

The nights were mentioned by several patients because that was a time Zoe found to be particularly uncomfortable, she could not sleep very well (P8: 102). She was tired and miserable and fidgety at night (P8: 103) and found it upsetting to be woken up so early in the morning when she wanted a lie in (P8: 133). Other patients coughing at night disrupted sleep (P3: 12). However, some patients found the night staff to be particularly helpful because they made tea during the night to help patients sleep (P2: 44-47; P8: 113, 114). While Zoe found the night nurses to be genuinely interested and skilled in making her comfortable (P8: 39, 47-49, 100, 101, 105-112, 130). The night staff were pleased to see Zoe and asked how she was getting on and said that her wound was getting better (P8: 50-53).

(j) Did not get to know nurses well

On the whole, patients did not get to know any of the nurses well (P1: 33, 34; P4: 89, 90; P6: 52; P10: 38, 39, 76). Contact was limited to tablet time (P6: 11, 14, 67), and some did not see a need to get to know the nurses well (P6: 16). But patients saw the learners more often because they came to do the observations (P4: 91).

Minimal contact with qualified staff

Hugh did not speak to the sister on the ward (P5: 25), and was surprised by the fact that the qualified staff had so little time for patients (P5: 29, 36, 57). Other wards made time for patients (P5: 35, 56, 58). The lack of contact with staff made a big difference to the patients' day (P5: 30, 32). On one ward the qualified staff found things for the students to do if they found them talking to patients (P5: 73).

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Superficial contact with nurses

When contact was established with the nursing staff it tended to have a superficial quality. George just passed the time of day with staff (P6: 105), while some interactions were limited to the nurse asking the patient to get off his bed so that it could be made up and little else (P6: 12, 13). In contrast, Ed did not get to know any of the nurses well (P9: 20), they did not mean a thing to him (P9: 25) and did not talk to him except when they worked on him (P9: 43). He did not want them to talk to him (P9: 44).

Busy staff

Patients generally perceived the staff as being too busy to talk to them or that other more serious patients needed attention more urgently. Eileen commented on the excellent staff nurse who was just too busy (P3: 43, 44). Several patients commented that the nurses were too busy and did not have time to talk (P6: 59, 61; P8: 19, 20, 27, 28, 30):

> "The nurses didn't talk about the operation because they're awfully busy, they'll talk to you yes. 'How are you today? How's your wound? Lets have a look at it, that's fine that's coming on nicely'. That sort of thing. But I mean they are awfully busy and there is a lot of physical work attached..." (P10: 54-59, 88).

It was suggested that the really ill patients needed lots of attention and rest (P10: 82), and the staff got on with their difficult work (P1: 24, 42). It was also suggested that staff movements were responsible for the lack of time available to the patients (P3: 40), while other patients were not bothered by staff movements (P10: 77, 78, 81, 83). Another patient noted that some staff gave the impression of being short of staff (P7: 18), while others were always relaxed and ensured that patients were cared for (P7: 19, 20).

(k) Nothing was too much trouble

The attitude of caring nurses was captured by several patients in this phrase. Zoe felt that the staff were very busy but noted that nothing was too much trouble for

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these busy staff, they put themselves out for her (P8: 40, 46), they got the phone for her on many occasions so that she could phone home (P8: 42). However, she did not like asking for the phone because it had nothing to do with medical care (P8: 43). On another occasion the staff got her iced water when it was very hot outside (P8: 44), they gave her everything within reason (P8: 45). Al too felt able to ask the staff for anything because nothing was too much trouble (P10: 40, 53).

(l) No front - just genuine nurses

Tim commented that there was no front to the nurses attitude it was always for his well being (P4: 35), and it was genuine (P4: 66, 67). An example of the genuine response of the staff was given when the patient reported that sister and the staff nurse on the ward cried when they found out he had cancer (P4: 74, 75). Hugh described the approach of the students which was genuine and not patronising (P5: 81-84).

(m) Displayed a caring attitude in their work

The nurses had time for the personal touch which was a crucial aspect of caring for George (P6: 31, 39, 40), they had a caring attitude (P6: 32, 33, 34) and it showed in the way they cared for patients (P6: 68, 69).

(n) The doctors were approachable

The doctors too were singled out for comment; the doctors were good and introduced themselves (P1: 11, 12). The doctors allowed Florence to ask questions (P1: 13). Others felt that the doctors and the treatment were exceptional (P4: 1, 41, 49, 63).

(o) Key criticisms of the staff

Several important criticisms of the staff emerged also.

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Rude staff

George commented on the rude tea ladies one of whom almost threw the tea at him (P6: 5), and about the auxiliary nurse who was particularly rude (P6: 6, 41-51). Zoe had an upsetting argument with a rude receptionist about her diet (P8: 54-66), she became very angry and felt like hitting the receptionist (P8: 70). The nurses were however, very soothing (P8: 67-69, 71).

Hurried approach of the nurses provoked anxiety

Martha needed extensive nursing care after surgery and did not like it when the nurses were in a rush especially when she was in pain (P7: 10, 12, 13). Being rushed made her feel on edge (P7: 14, 16), and the nurses tended to dash through their work when they were short of staff (P7: 1, 17). Zoe, another patient who needed regular baths noticed that the busy auxiliaries were constantly trying to get her into the bath (P8: 31-37) and felt she was slotted into a regime (P8: 38).

Kept in the dark

Some patients felt that they were not given enough information about their care and treatment. There was a general lack of information on some wards (P5: 59), sometimes patients had to ask what their tablets were for (P5: 61). Hugh did not like to take the tablets unless he knew what they were for (P5: 62). Some patients were not told why certain things were done:

> "...there's a definite lack of information. They do things but you
> don't know why half of the time" (P5: 63, 64).

It was suggested that staff were trained to keep people in the dark (P5: 65). The blame for not informing patients was placed with the doctors and nurses (P5: 66, 67).

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Boredom

Hospital became boring for Zoe after a while (P8: 12), she needed more things to do (P8: 13-16). When she became depressed she began to think about the mistakes she had made in her past (P8: 24, 25) and she did not want to have time to think (P8: 26). She tried to talk to other patients to occupy herself (P8: 5, 6) but would have liked the staff to spend more time with her (P8: 21-23).

Poor nursing practice

Eileen commented that staff gave the elderly patients too much food which was later wasted so she ordered smaller portions on the meal cards (P3: 15, 16).

4. Personal concerns of the patient assumed great importance

Sometimes the personal concerns of the patient both inside and outside of the hospital situation were of crucial importance to the patient. These personal concerns may not always be recognised by the staff because they spend so little of their time with patients. Yet these concerns may have a direct influence on the patients' perceptions of his world and his reactions to the immediate context in which care is experienced.

(a) The treatment was primary

The treatment was seen by James to be the really important aspect of being in hospital; the right treatment was the important thing (P2: 3, 6), the staff nurses role was to ensure patients got the right treatment (P2: 38, 40). Patients could not afford to miss out on their treatment (P2: 39, 41-43). James saw the role of hospital as one of diagnosis and cure (P2: 2, 64). Ed could not keep his food down and had to have an operation to put things right (P9: 9-14) and that was all.

(b) Frustration of being in hospital

Hugh was very frustrated at being in hospital because there was nothing seriously wrong with him (P5: 1-3) and to have to stay in bed (P5: 16-19) was disheartening. Hugh had to ask for a bottle (P5: 12, 24) during his short stay (P5: 9). He was

able to look after himself most of the time (P5: 16, 20, 21) and did not need a lot of direct nursing (P5: 7, 8, 10-12, 14, 15).

(c) Felt let down by the GP

Florence talked about the her GP who was very supportive when her husband died, he was always available (P1: 80, 81). Later, she felt let down by the practice; felt let down by other members of the practice who lacked patience with her and now her GP (P1: 82, 86, 87). She had to insist that her doctors made an appointment with the surgeon (P1: 84, 85).

(d) Mother's recent death

Eileen was recently bereaved. Being in hospital in the company of elderly patients convinced her that old people would be looked after more appropriately in a half-hospital (P3: 4).

(e) Terrible previous admission

George described his previous admission which was most disappointing unlike this time (P6: 106, 110). He was discharged early with a damaged kidney because of a shortage of beds (P6: 107), and no results were sent to his George's GP (P6: 108). It was terrible experience (P6: 109).

(f) Concerned about the family and close friends

Martha's mother was far away and needed an operation to save the sight in her one good eye (P7: 52-54). Her mother and her husband were all the family she had (P7: 55). Martha hoped that they would both get better together (P7: 56). While Ed did was very concerned for the one visitor who came to see him everyday (P9: 45), for she had to travel a long way and it took up much of her day (P9: 46-48). In addition, Ed's visitor had arthritis in her leg and it was very difficult for her to get around (P9: 49-50). He was very upset by this.

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Summary of the main findings

The description of the patients' experiences of being cared is very detailed so a summary of the main themes and major subheadings is provided below.

1. Crushing vulnerability

(a) The hospital environment was strange
(b) Anxiety about being treated like an object
(c) Positive impact of being treated like a person
(d) Shattering impact of cancer
(e) Traumatic investigations and surgery
(f) Cancelled operation was a major setback
(g) Anxious suspicion
(h) Surrendering independence was distressing
(i) Coping with bodily disfigurement was traumatic
(j) Difficult being away from home for a long time
(k) Felt like a smelly mess compared with the nurses
(l) Felt forgotten about

2. Adopted a particular mode of self-presentation

(a) Sheepish obedience
(b) Conforming to ritualistic practice
(c) Unusually friendly and cheerful
(d) Provided a frank and honest account
(e) Helpful camaraderie amongst patients
(f) Reluctant to ask questions
(g) Kept interpersonal encounters superficial
(h) Tried not to be a nuisance
(i) Provided a sense of purpose for the carers
(j) Deference and gratitude for the carers
(k) Admiration for the hard working staff

3. Appraised the symbolic services

(a) General level of satisfaction with caring staff
(b) Friendly but diplomatic staff
(c) Nurses asked what the patients needed
(d) Felt safe and trusted the nurses
(e) Technical competence was appreciated
(f) The approach of the staff was sensitive and calming
(g) The accommodation and hotel services were reasonable
(h) The devoted students were constantly available
(i) Helped to get through the miserable nights

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(j) Did not get to know nurses well
(k) Nothing was too much trouble
(l) No front - just genuine nurses
(m) Displayed a caring attitude in their work
(n) The doctors were approachable
(o) Key criticisms of the staff

4. Personal concerns of the patient assumed great importance

(a) The treatment was primary
(b) Frustration of being in hospital
(c) Felt let down by the GP
(d) Mother's recent death
(e) Terrible previous admission
(f) Concerned about the family and close friends

Summary of the chapter

The findings from the patients interviews were presented. These may be compared with the nurses views which were given in the previous chapter. The experience of being cared for as a patient is quite different to the staffs' perspective of caring for patients. Like the staff, the patients' experiences are centred around their own unique concerns. However, the patient is in an extremely vulnerable position while the staff have power, status and more control over their immediate concerns. These contrasting perspectives highlight the importance of taking the view of the other in understanding what it means to be a patient in receipt of care in hospital. In the next chapter, both sets of findings are discussed.

CHAPTER 8
DISCUSSION

Introduction

This chapter discusses both the nurses' and patients' accounts of their experiences of caring and being cared for. The interview transcripts were analysed using a method based on interpretive phenomenology. Nine major themes characterised the nurses' accounts and four major themes captured the patients' experiences. Every detailed issue which was found in the previous two chapters is not discussed here, since many of these reflect the concerns of particular individuals. However, the major themes are discussed fully. The results of part one are also referred to at appropriate points in the text.

(1) The nurses' views of caring relationships

The nurses' accounts of the relationships they developed with patients are very detailed. They reflect not only the immediate interpersonal contact with patients, but also the relevant issues that are an integral part of the nurses' working life. These issues undoubtedly influence the development of caring relationships in practice.

Caring was elicited by hopelessly dependent cases

The theme hopelessly dependent cases emerged from a variety of sources. A most noticeable aspect is the chronicity or hopeless life facing patients. All of the 10 nurses described cases which had this characteristic feature of hopelessness. It seems that these are the sorts of patients which elicit caring responses from nurses at a practical level. All patients are not automatically cared for in the way in which the patients described here have been care for. These patients obviously needed to be cared for; they were highly dependent; in dire straits medically or lonely and facing inevitable death. They were, as we have seen, in extremely vulnerable positions. It is interesting to note that less vulnerable patients did not elicit the emotions and reactions of the nurses interviewed here. What happens to those patients who are not in such dreadful circumstances and stay in hospital for only a few short days? Are they treated with the same level of care and

concern which these patients were? Probably not. This is another area which needs to be researched carefully.

The role of attributions in eliciting caring responses

One way in which we can attempt to understand the psychological processes which underpin the nurses accounts, is through the use of attribution theory (see chapter 1). To do this the interviews with nursing informants must be considered at another and more detached level. The informants were asked to describe an incident or time when they felt they had really cared for a particular patient as the focus for the interview. All of the staff did this, but the type of incident recalled seemed to be of a particular type. Most of the informants recounted patients who were very seriously ill or dying; these patients lacked knowledge and information about the condition; they stayed in hospital for a considerable period of time; a good relationship developed between the staff and the patients; some form of emotional bond was established between the two; the patients were very appreciative of the things the staff did for them; the vulnerable patients became dependent and compliant.

The attribution theory model of helping (Weiner, 1980, 1986) may prove to be particularly helpful in understanding how the nurses came to care for these particular patients. Weiner (1980, 1986) stressed the mediating role of affect on helping behaviour. In the cases or incidents described by the informants, the nurses saw the hopeless, helpless or vulnerable patients and may have attributed external or uncontrollable causes of the distress or illness. This was usually followed by feelings of sympathy or concern for that patient and a greater likelihood that help and high quality care was given to the patient. The nurses really wanted to help and do their best for patients. This brief application of attribution theory could be usefully explored in further studies into the field of professional helping and caring. Some examples of the types of covert attributions and labelling which carers apply to particular patient groups may be found elsewhere (Jeffrey, 1979; Kelly and May, 1982). This analysis is incomplete

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however because it has ignored the influence of context and professional role. It is important to keep in mind that the individual nurses are also part of a larger caring system which can and does influence all those who reside within its walls.

Learned helplessness

The analysis of the incidents recalled by the nursing informants suggested that the patients may have surrendered their independence to the institutional care system. So as part of their expressed vulnerability, the patients were often not able to do much about their circumstances. They are in hospital asking for expert help. This process has been described as learned helplessness (Seligman, 1975) and can have serious disadvantages:

> Institutional systems are all too often insensitive to their inhabitants' need for control over important events. The usual doctor-patient relationship is not designed to provide the patient with a sense of control. The doctor knows all, and usually tells little; the patient is expected to sit back 'patiently' and rely on professional help. While such extreme dependency may be helpful to certain patients in some circumstances, a greater degree of control would help others...This loss of control may further weaken a physically sick person and cause death (Seligman, 1975, pp.182-183).

A reformulation of the theory of learned helplessness in humans was reported by Abramson et al (1978). Personality and cognitive processes were emphasised and so the impact of learned helplessness on humans could be understood in terms of the attributions people make about their own lives and immediate circumstances. This further supports the potential of attribution theory for research into the work of nurses and other professional carers and for understanding the world of the patient or client.

It is interesting that these patients elicited very strong caring responses in the nurses. Helplessness or hopelessness may provide a powerful stimulus for the carers to respond in a particular way. There is however, a danger that nurses and

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doctors may actively foster this type of learned helplessness, a point openly acknowledged by a number of the nursing informants interviewed here. Paradoxically, patients are often encouraged to be excessively compliant and unquestioning in their approach to the staff. Several modes of patient self-presentation are described later. Those who do ask questions or are in any way deviant or try to maintain some measure of control over what is happening to them, run the risk of becoming unpopular and being 'sanctioned' by the staff (Stockwell, 1972; Lorber, 1975). It may be impossible for a patient to have 'control' over a chronic illness, but he could have some say in the type of treatment, or his remaining life. According to Seligman, the institutional setting is responsible for negative changes in the patients' behaviour and state of mind. Hence, the larger context in which attributions are made needs to be accounted for.

Doctors and nurses are also part of the institutional environment so they too have an important role to play and contribute to the process of learned helplessness. Paradoxically, doctors and nurses must promote independence in their patients if recovery and health are to be achieved. We cannot be sure how these process are related until further research has been completed. Moreover, the likely outcomes of this system of care for the short stay patients and those who require long stay care, is probably quite different. It should also be borne in mind that institutional care can be misguided and paternalistic (Gadow, 1980). It can unintentionally harm people.

Felt impact of the patient's dreadful situation
This theme also fits in neatly with the attribution theory description just outlined. The nurses reacted to the felt impact of the patients' dreadful situations and this theme may help us to understand how the nurses came to really care for these particular patients. The nurses themselves were moved and distressed by the dreadful situations in which the patients found themselves. They felt 'sorry' for the patients; some felt helpless while others felt able to help. They were worried,

concerned, and experienced a sense of loss and sadness when patients died or were moved to another ward. The nurses' emotional reaction to what was happening to the patients may have been achieved through some form 'fellow-feeling' as described by Scheler (1970):

> It is indeed a case of feeling the other's feeling, not just knowing it, not judging that the other has it; but it not the same thing as going through the experience itself (p.9).

This emotional response by the nurses seemed to lead on to the next major theme. It enticed the nurses to do their best for the patients.

Did their best for patients

Physical care was the outward symbol of caring

The nurses provided comprehensive nursing care for the patients. The nurses spent time with the patients; they helped patients to cope; they dispensed personalised and sensitive care; they tried to promote independence in their patients and paid attention to small details. The nurses attended to the patients basic needs and through providing physical care for the patient, the nurses were able to develop an empathic understanding with the patient. The nurses may have assumed responsibility for taking care of the patients (Kitson, 1987a,b). The physical care given to the patient now assumed greater importance compared with the first part of the study. It support the claims that what the nurse actually 'does for the patient' is important (Brown, 1981; Henry, 1975).

Unwarranted optimism encouraged patients and staff

Several nurses also adopted an optimistic rapport with patients, although this approach was not always warranted because of the poor prognosis which many patients had. They told the patient not to worry; and tried not to let on about the seriousness of the patient's condition. This may have served also to lift the morale of the staff. Some patients will however be lifted by positive encouragement and a hopeful outlook.

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Needed interpersonal skills to deal with patients

Some of the nurses mentioned important interpersonal skills which could be used in developing helping relationships. Listening to the patient; encouraging the patient to talk; giving information and having a caring interpersonal approach were singled out. These skills were also evident in the repertory grid part of the study and hence reinforce their importance in dealing with patients and relatives.

Physical care offered a bridge to the patients' inner world

The role of physical care in providing opportunities for nurses to really care for patients is particularly important. There is a recognised custom in most hospital wards that the most junior and untrained nurses deliver the physical care to patients. This general practice minimises the opportunities for the more highly skilled nurses to really care for patients. In seems that in order to promote a more caring response nurses need to be actively engaged in physically caring for patients. Unfortunately, within the nursing profession, trained nurses themselves tend not to value or are not allowed to value the physical aspects of care. This research highlighted the crucial role of performing physical care tasks for patients in hospital. At one level these apparently mechanical or procedural duties are the tasks which have to be done for the patient in need. On another level they provide the practising nurse with opportunities for developing close psychological relationships with patients. Here the instrumental and expressive elements of caring for another person are merged (see chapter 2). The end result is that the patient experiences a very real sense of being cared for, while the nurse achieves a sense of satisfaction and accomplishment.

Menzies (1970) has argued that providing physical care for patients through task allocation creates a barrier to psychological care. However, the findings from the present study indicate that physical care furnishes the nurse with a 'way in' to the patient's psychological world. The profile of the physical activities of the nurses work must be reemphasised. This has important implications for the practising nurse. In a discussion of nursing care of the elderly, Evers (1986) noted

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how basic care had become devalued both from a medical and nursing perspective. Many apparently routine and mundane tasks are perceived by the nurses as unimportant or of so little importance that they may be carried out by the least skilled members of the workforce. There are several possible reasons why this occurs but one of the main reasons may be the influence of the organisational culture on individual nurses.

The influence of the organisational culture

The organisational culture (Pettigrew, 1983), has already been identified as an important factor which influenced the way in which the informants in the first part of the study rated their own performance as carers. This needs to be reemphasised here also. According to Schein (1984):

> Organisational culture is the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems (p.3).

Thus, lack of involvement, refraining from expressing emotions, being subordinate and uncritical may be some of the basic assumptions which are part of the culture of nursing. These and similar assumptions maintain practice rituals as well as patterns of thinking, feeling and behaving which convey much about the institutional setting and the way in which care is managed. Physical care has become unfashionable because of its low status in the system. Unfortunately, the physical needs and concerns of the patients may become of secondary importance. The general devaluation of physical care minimises nurses' opportunities for caring for patients in a fuller sense. However, the introduction of schemes of care such as primary nursing (Giovanetti, 1986; MacGuire, 1989a,b) may help to redress this imbalance.

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Sathe (1983) recognised the profound influence which the organisational culture may have on different aspects of organisational life such communication, cooperation, commitment, decision making and implementation of decisions. He stated that if:

> ...culture guides behaviour in inappropriate ways, we have efficiency but not effectiveness (Sathe, 1983, p.10).

Nichols (1985) also suggested that a hospital culture which emphasised technology and cure, tended to provide poor quality and insensitive psychological care to clients. If this situation is to be remedied, then enormous changes in the structure and fabric of the organisational culture of most institutions is needed. However, changing organisational cultures is time-consuming and difficult and should be done in a progressive and step by step manner (Cope, 1984). Promoting change through administrative decrees is often unsuccessful because the established values within the organisational culture have a powerful influence of daily activity (Sofer, 1955). Positive changes in practice must be planned for and achieved in an evolutionary way.

Organisational culture also affects patients and can lead to a heightened feeling of the vulnerability experienced by the patients taking part in this study. Zaner (1982) asked:

> What, after all, can it mean 'to care' in that commonly accepted term 'health care'? Stripped of rituals, guises and disguises, what is called health care most often goes on among strangers, in settings which seem structured more to encourage that to ameliorate strangeness: the large, highly bureaucratized, technologised and impersonal urban health centers. In these, it is as common as coffee to find one's treasured privacy and integrity compromised and assaulted and even one's confidential condition at the daily disposal of anonymous people and databanks (p.42).

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It is noticeable how the experienced informants who took part in the first part of the study produced personal constructs about caring which were predominantly psychological in their orientation. The nurses of different grades interviewed during the second phase also provided many similar words and phrases to describe their experiences. The second group of nursing informants however, were selected from different grades of staff from student up to charge nurse. Most of these staff were engaged in providing physical care for patients. Their perceptions of caring was couched in their daily work.

The nurses who took part in the first part of the study were more experienced 'institutional standard bearers' and were more concerned with the management of the ward. The method of interviewing in both groups was different and this too could also have played a part in producing two different perspectives. While many similarities emerged across both groups of nursing informant, the most striking difference was the different emphasis on the physical aspect of caring for patients.

Calculated emotional involvement

Throughout most nurse training courses students are warned about the dangers of getting too involved with patients. Here we find that most of the nurses became involved with patients of their own volition. There was an acute awareness of the risks entailed in emotional involvement with patients. It was suggested that being too involved with patients could lead to errors of judgement. Getting involved in the work was a matter of choice and it was important for the nurses to be able to have some form of controlled involvement since this was ultimately more helpful for the patient. The level of attachment to patients varied from nurse to nurse, some nurses became very attached to patients while other quickly forgot about the patients as soon as they were discharged home. Some of the nurses felt that loving had nothing to do with caring for someone in a professional context, while others showed loving responses to patients. One nurse recognised that the patients too had a lot at stake. The patient had to

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expose themselves and give everything to the staff. This was perceived as being unfair because it reinforced the power of the staff and the vulnerability of the patient.

The need to establish balance

Nurses had to make an evaluation of how involved they became with patients. On the one hand they needed to be involved in the work with their patients if they were to get positive feedback from the patient, a point also noted by Field (1984). On the other hand, getting involved with patients was very risky. Controlled involvement is more effective. But risks have to be taken if positive feedback was to be achieved. Getting involved with patients was a rhythmical process which ebbs and flows, influencing the quality of care for patients as it does so. This idea can be linked with previous discussions of involvement with patients. Dunlop (1986) for example, noted how nurses are being asked not to get too close or too involved with patients. On the other hand, they have to face the question of how they would feel if it was their mother, father, brother or sister who needed someone to care for them. She introduced the terms 'separation' and 'linkage' to capture the inevitable conflict of caring which this divergence can generate:

> Thus one achieves something like 'caring' in its emergent sense as it is applied in the public world - a combination of closeness and distance, which always runs the risk of tipping either way (p.663-664).

Over-involvement

Benner and Wrubel (1989) described caring as the process which established what 'matters' to people. On account of this, caring may also be a source of great stress:

> Because caring sets up what matters to a person, it also sets up what counts as stressful, and what options are available for coping.

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Caring creates possibility. This is the first way in which caring is primary (Benner and Wrubel, 1989, p.1).

If the carer is to be allowed to care for another person she must be able to keep these processes in a state of equilibrium. She has to be able to balance the patient's need for emotional support and involvement, with her own needs for positive self-esteem and the ability to make a professional contribution to the patient's health. The nurses makes an appraisal of the potential costs and benefits. Over-involvement can lead to experiencing physical and psychological stress, but so too can under-involvement.

Ironically, a widely held value in the curriculum of nursing education is the need to avoid getting involved with patients because it can lead to over-involvement:

> Overinvolvement may take the form of identification with the patient and may overwhelm the nurse with fear and anxiety. The nurse feels as if he or she knows and feels the patient's pain...Overinvolvement as helper may raise excessive needs to 'control' and dominate the situation to ensure that one's own interests are protected. Boundaries between self and others become blurred, and the one caring may take on the role of omnipotent rescuer, overlooking the responsibility, integrity, and resources of the person and the situation (Benner and Wrubel, 1989, p.373-374).

> The remedy for overinvolvement is not lack of involvement but rather the right kind of involvement (Benner and Wrubel, 1989, p.375).

Along similar lines, Goffman (1968) drew attention to the characteristics which differentiated 'people-work' from other forms of work including the need to provide moral and humane standards of care and the need to take account of the inmates' statuses and relationships outside of the institution. A third characteristic feature relates to the staff's management of emotional ties with inmates:

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...human materials differ from other kinds, and hence present unique problems, in that however distant the staff tries to stay away from these materials, such materials can become objects of fellow feeling and even affection. There is always the danger that an inmate will appear human; if what are felt to be hardships must be inflicted on the inmate, then sympathetic staff will suffer (Goffman, 1968, p.79).

This fellow-feeling or affection was described in terms of an involvement cycle as follows:

> The capacity of inmates to become objects of staff's sympathetic concern is linked to what might be called an involvement cycle that is sometimes recorded in total institutions. Starting at a point of social distance from inmates, a point from which massive deprivation and institutional trouble cannot easily be seen, the staff person finds he has no reason to refrain from building up a warm involvement in some inmates. This involvement, however, brings the staff member into a position to be hurt by what inmates do and what they suffer, and also brings him to a position from which he is likely to threaten the distant stand from inmates taken by his fellow staff members. In response, the sympathetic staff member may feel he has been 'burnt' and retreat into paper work, committee work, or other staff-enclosed routines. Once removed from the dangers of inmate contact, he may gradually cease to feel he has reason to be wary, and then the cycle of contact and withdrawal may be repeated again (Goffman, 1968, p.79)

Goffman's vivid description captures the sort of lived experience which accurately characterises many nurse-patient relationships and fits with the data reported here. It shows how nurses may cope with anxiety which involvement with patients can lead to in the hospital setting.

In a study to explore anxiety and stress in nurses, Menzies (1970) found that nurses protected themselves from anxiety through the use of a range of defence tactics. These included: splitting the nurse-patient relationship; depersonalising the patient and ignoring the significance of the individual; detachment and denial of feeling; the elimination of decision making through

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routine task performance; and the avoidance of change. Despite these defensive tactics, Menzies (1970) claimed that they were ineffective in removing or modifying the anxiety experienced by the nurses. In a very recent paper, Morse (1991) reported a research study in which interviews with 86 nurses were analysed using the grounded theory approach. A major theme to emerge from the analysis was the concept of 'negotiating the relationship' between the patient and the nurse. This process entailed 'involvement' and 'commitment'. Morse does not however recognise that any form of negotiation must occur from different perspectives. In this instance, the patient is in a vulnerable position while the nurses is in a position of control and power (Robinson, 1968; May, 1990). The impact of the status and position of the individuals absorbed in these negotiations must be more fully understood. This issue is also discussed later in the chapter. It would be particularly interesting to learn about the ways in which nurses define the boundaries of their level of involvement with patients. This is not something which nurse educators address but it does seem to be particularly important for individual nurses in practice.

Tolerated the stressful work

While the nurses cared for patients and were emotionally involved with them at a safe and controlled level, they were also very conscious of the stressful nature of the work of a nurse. This awareness formed an important background concern. There were many sources of stress; the constant worry about the ward even on days off was common. In psychiatric areas a number of the nurses mentioned an expectation of having to accept abuse from patients. Sending patients back to a home environment which precipitated illness was stressful for one nurse. Being aware of one's own vulnerability; listening to and watching to ill people and having stressful colleagues were all sources of stress. Colleagues in particular were frequently identified as sources of stress: disagreements with doctors, being blamed by the doctors for inappropriate patient management or trying to initiate change in colleagues were emphasised. Furthermore, it was stressful not to be able to challenge the established attitudes or to work as a student in a ward

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where the trained staff had no time for students and were unapproachable. They made the student's life difficult.

Sometimes the relationships with patients were stressful especially when the nurses' personal feelings had to be kept in check, or it was impossible to get through to the patient. Patients sometimes competed for the staff's attention. Some patients were not liked by the staff who still had to look after them. Occasionally patients questioned the nurses and lacked confidence in them. At other times the patients unloaded their problems. Other sources of stress included observing suicidal patients on a psychiatric ward; the shortage of staff tended to heighten the stress levels; the lack of positive results; and the physically and emotionally draining effect of the work. The nurses developed ways of dealing with the stresses entailed in the work. Some found that positive results made the stress more tolerable; others got out of the situation, tried to keep up to date, set limits, derived strength from their personal relationships or simply tried not to let it show. What is surprising here, is the way in which the stress was perceived by the nurses as being an aspect of their daily work. It was another thing to be dealt with and had to kept in check. It was made tolerable by the fact that it was transient or was counter balanced by the positive feedback derived from the work.

Several issues which the nurses regarded as sources of stress have also been identified by Shouksmith and Wallis (1988) and included: workload and interpersonal relations with colleagues and patients. The nurses in this study however, identified an additional range of specific stresses including the following: just being with ill patients constantly, taking verbal abuse from patients, not being able to challenge the established system, observing suicidal patients, patients who lacked confidence in the nurses' ability, and sending patients back into unsuitable home environments.

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In the repertory grid part of the study, the personal cost of caring was identified as a powerful source of stress on the carer (see chapter 4). The second part of the study has reinforced this assertion and mapped out in great detail many factors in the complex web of stress which influences the nurses at work. Nurses must learn to support each other in their demanding role if they are to learn to cope with stress. This is not something which can be easily achieved in practice. The socialisation process which all learners are exposed to ensures that fear, anxiety, distress or other strong emotions are rarely if ever acknowledged. Expressions of emotions are seen as a sign of personal frailty and weakness, rather than a sign of human vulnerability which patients and nurses experience on a day to day basis.

Incomplete preparation for the job

Another common theme found in the nurses' accounts was the belief that their training was in effect a superficial preparation for the work which they were now engaged in. The training which they received tended to be a procedural training devoid of emotional content. However, the procedural aspects of training were important since they enabled nurses to do technical things for patients. But the cases described here and the nurses reactions to these convey a powerful emotional component in the lived experience of the nurses. The nurses felt a need for training in physical and psychological care. Training as a nurse did not automatically produce good carers, an intrinsic capacity for caring for others was needed to start with. This was a type of attitude or outlook which was socialised into people from an early age. Nurse training provided a set of technical skills which could be added to this outlook. The findings of the repertory grid part of the study produced many of the important psychological characteristics which good carers possess.

The need for appropriate training

This theme contains an important contradiction. On the one hand, the general public recognises nursing as a caring profession which trains people to care for

others. On the other hand, the nurses themselves perceive their training as having nothing to do with caring and caring relationships. Caring was seen as an intrinsic capacity. The nurses also recognised a deficiency in their own training. Their training lacked attention to the emotional aspects of caring for another person which was an essential part of the work. In some respects, this is not at all surprising. Nurse training courses have only begun to take on board some of the more human aspects of nursing care. Interpersonal communication skills for example, have only become an integral component of nurse training in the last decade, and these are some of the skills which are needed.

Furthermore, the preferred methods of teaching these interpersonal caring skills are not well understood and widely applied. Burnard (1990) found important discrepancies between the nurse tutors' and nursing students' perceptions of what was 'experiential learning'. Much work remains to be done if the theory of experiential learning is to be used effectively in teaching institutions. These methods do appear to offer one approach to helping nurses deal with emotional issues in their work and prepare them for the reality of nursing practice. However, changes in the teaching style will not automatically result in changes in nursing practice. Nurses and patients are often socialised into particular roles. Olesen and Whittaker (1968) described the professional socialisation process in nursing as one which required a true change in the identity of the nurse. This change was only acquired gradually. The system of education in nursing which incorporates both a college or school component and a clinical or work related component may be a source of role ambiguity which has to be dealt with during a course of training (Ashworth and Morrison, 1989). The training has to enhance the nurses ability to care for patients in practice situations.

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Constrained by the ward environment

The environment influenced work practices

Another relevant theme to emerge was the nurses' awareness of the ways in which the wards constrained rather than facilitated the nurses' capacity for caring for patients. Canter (1984) has already mentioned the need to consider the role of environment in health care institutions. Here we have evidence of how the structure and running of these ward environments affected patient care. Sometimes the effect was positive but mostly it was not. Sometimes the wards were simply unsuitable as environments for caring for patients. They served to dehumanise the patient or were not able to cater for the patient's physical needs.

The time used on completing the necessary paperwork took time away from patients and was perceived by several nurses as wasted time. Time again has emerged as a crucial factor in structuring the nurse's day and the type of work she carries out. From the patients' point of view, the trained nurses' contribution to their care may seem trivial. Resources were limited on some wards or an authoritarian consultant who dominated the ward routine and practices. The design of the wards sometimes meant that nurses wasted time walking up and down fetching things. Having to keep an eye on other staff to ensure that the standards of cared were up to scratch constrained what one staff nurse could do. Sometimes personal limitations such as lack of skill inhibited some nurses.

Limited time

A major constraint was simply the limited amount of time for following initiates through; or for dealing with patients. The use of time also emerged from the grid interviews. Here however, we have a more sophisticated view of what occurs. The role ambiguity and role conflict which the nurses experienced meant that they could only divide up their work into prioritised components. For those with a managerial function, management assumed priority. Time for the clinical elements of the job were therefore limited. However, not all wards were constraining. On some wards there was a good rapport between the nurses and

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the doctors; the staff were friendly and competent and these well run wards helped patients. The role of the ward sister was crucial in providing care for patients and promoting developments and changes in the system, a view raised in the first part of this study. Further research into what constitutes a 'good' ward would seem valuable for both staff and patients.

Coped with demanding and uncertain role

It was clear that nearly all grades of nurse had to cope with difficulties and uncertainties of the role. All of the nurses appraised their role position within the system. Some expressed doubts about being a nurse. Others found that as they became more experienced they also became more self-confident. There were some differences in the ways in which the grades of nurse perceived their position. One of the nursing assistants for example felt that she wanted to help patients and was free to care for them unlike the trained staff who were engulfed in administration.

A number of the nurses experienced role ambiguity. They were unsure about their role and what was expected of them and this uncertainty caused them to be anxious about what they could and could not do competently. Lack of clarity of this nature imposes restrictions on what a nurse can do. Others experienced role conflict, which occurred when two or more components of the job required incompatible responses from the nurse. A good example of this sort of conflict is the manager-carer dichotomy which proved particularly troublesome for the trained nurses. They were expected to conform to the traditional view of the nurse as manager with little or no training or expertise in management. Although role ambiguity and role conflict have been identified as sources of stress in nurses (Shouksmith and Wallis, 1988), this was not reinforced in the present study. It seemed that these difficulties were an essential part of the role of the nurse which had to be coped with rather than essential sources of stress.

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The benefits of caring

In spite of the problems and constraints posed by the ward system and the stresses and strains imposed on the nurses, there were many personal benefits which the nurses derived from caring for patients. Most of these stem from the caring interpersonal relationships which the nurses established with their patients. The positive responses from the patient; getting through to the patient; making a positive contribution to the patients well-being; sometimes seeing patients as friends; being appreciated by patients; doing something worthwhile were experiences which the nurses enjoyed. In addition, the sense of achievement and personal development, together with the fact that the nurses learned a lot about people were important benefits for the nurses and were perceived positively.

A tentative model was outlined earlier which highlighted the shifting ebb and flow of caring for another person in nursing. The enormous benefits which the nurses achieve must be reinforced here. If the nurses did not get some positive feedback for their efforts it is probable that they might fail to give of themselves in the way in which the nurses here gave of themselves to patients. They would be too conscious of the risks and of being involved in the work and with their patients. The personal benefits help to keep the process alive by balancing out the stresses, strains and risks which caring for another person on a human level entails.

Nurses must be constantly making decisions about what they have done or do or should do for the patients they care for. They must weigh up the pros and cons of human involvement with patients. When a nurses decides that the risks are too great, as surely all nurses do from time to time, she can withdraw or avoid the patients, or focus her attention on the basic requirements of care needed by the patient. She can make the patient an object. Such a strategy will enable the nurse to perform her duties 'competently', but the quality of the care received by the patient will not be of a high standard. Nor will the nurse's goal of achieving positive feedback be realised. This approach to understanding the nurses'

dilemma may be understood in terms of the equity theory described briefly in chapter 1. It is a rather limited understanding however, because it does not take account of the patients' world.

(2) The patients' accounts of being cared for

These were dramatically different from the nurses accounts and reflect the issues which dominated the patients' lives during their stay in hospital. Only four major themes surfaced from the analysis of the patient interviews. Within these however, there was tremendous richness and variety of individual experience.

The vulnerability of patients

A dominant theme which captured the patients' experience of being cared for was the vulnerable position in which they all found themselves. They were at the mercy of the illness and professional care system. Their crushing vulnerability was foremost in their minds. The hospital environment was a strange and daunting one for some of the patients. It was not seen as a helping sanctuary but a place of fear and anxiety.

Patients as subjects or objects

Many patients were extremely anxious about being treated like an object while in hospital. Some of the patients were ignored as people and their personal details were discussed in public. In contrast, other patients commented on the positive effect of being treated like a person while in hospital. It helped to promote recovery and made them feel good in themselves. This distinction may be similar to the I-It and I-Thou types of relationships described by Martin Buber (1958) and relates to the concept of mutuality discussed in chapter 1. In a discussion of the role of existential advocacy in the nurse-patient relationship, Gadow (1980) outlined an important distinction between the different modes of access which nurses and patients have to the patient's body as follows:

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Because patient and nurse have fundamentally different modes of access to the patient's body, and thus experience it in opposite ways, their understanding of it differs. The patient understands her body as a unique reality that cannot be expressed through types or generalisations. The nurse understands the patient's body as part of the world of objects, and therefore, most effectively approached through clinical categories. She is, of course, ultimately concerned with the patient as a unique human being, but she addresses the body's phenomena as instances of general types of phenomena...In their involvement with the patient's body, the patient is oriented toward uniqueness, the professional toward typification (p.89).

In drawing attention to the impact of illness on a person's life, Van den Berg (1972b) ignored the medical concerns but observed the:

...changes in a sick person's existence, the changes in his life which suddenly confront a person when he finds himself ill (p.17).

The anxiety and vulnerability associated with being treated as an 'object' was also captured by Van den Berg (1972b) as follows:

One of the most painful experiences of the sickbed is to discover again and again that one has become an 'object'. The 'sick body' is a thing at the disposal of the doctor and the nurse far more than it is with the patient himself. To discuss him in his presence is more evidence to him that he has become an object (p.97).

This experience contrasts sharply with the positive experience observed when the doctor is really 'with' the patient:

Even before he [the doctor] enters the sickroom he is 'with' the patient. There is no gap between them (p.121).

In similar vein, Drew (1986) described the terms 'exclusion' and 'confirmation', which seemed to parallel the notions of caring and uncaring. While Goffman (1968) described a similar type of experience as being treated like a non-person as follows:

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...the wonderful brand of 'non-person treatment' found in the medical world, whereby the patient is greeted with what passes as civility, and said farewell to in the same fashion, with everything in between going on as if the patient weren't there as a social person at all, but only as a possession someone has left behind (p.298).

This theme of crushing vulnerability was vividly highlighted by two patients involved in the research who developed cancer and which assumed great importance in their lives. Finding out about the cancer had a shattering impact on both patients. They had to face up to their fears about death and dying and learn somehow to cope with the diagnosis and whatever the future had in store for them. Other patients faced traumatic investigations or surgery or had their operations cancelled at the last minute. One patient harboured an anxious suspicion about his condition. One patient became very distressed by the fact that she had to surrender her independence to the staff. Some patients were lonely and felt forgotten about, while another felt like a smelly mess compared with the young nurses who looked after her.

This crushing vulnerability emphasised each patient's need for sensitive nursing care. Inappropriate or tactless handling could have devastated each patient. Only one patient from the ten interviewed was overtly critical of the general care he received. He was made to feel like an object not a person. He had little say in his overall management, he was ignored during the handovers, his personal details were discussed publicly by the staff, he had little contact with the trained staff. All these subtle and not so subtle actions made him feel like an object. Nehring and Geach (1973) suggested that patients were reluctant to be critical of hospital staff and the care they received because of fear of reprisals by the staff.

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Self-presentation in hospital

Survival tactics

The vulnerable patients had to survive in the hospital environment by whatever means they could. They had to adjust to illness and hospitalisation. They needed to be perceived by the staff as people worthy of care. Several strategies of self-presentation were used by the patients. Some became sheepishly obedient or conformed to the ritualistic practices of the ward. However, excessive compliance motivated by fear can be unhelpful and lead to what Ley (1988) calls 'malignant compliance'. Others became unusually cheerful and friendly in a situation which was terrifying and anxiety provoking for the patients and probably for their relatives as well. These strategies of self-presentation are likely to be well received by the staff. Cheerful, deferential and compliant patients are much more 'popular' than articulate, awkward and questioning patients. People who work in hospitals tend to take the environment and all its trappings for granted. Patients, relatives and others unfamiliar with the setting see it as an alien place and are often struck by an uncertainty about how to fit in.

Other patients slotted in by providing a frank and honest account of their home and life circumstances. They made no attempt to cover up aspects of their lives which they might do normally in different social situations. One patient for example, told the staff exactly how much alcohol he drank even though it was obvious that he was rather concerned about his own level of drinking. He confessed. Another strategy used by patients was to develop a friendly camaraderie amongst themselves. This strategy was also found by Coser (1962). In this way they had other people to talk to during the day and could exchange stories about their conditions and daily progress. When it came to asking questions, patients were reluctant to ask questions of the staff. Coser (1962) noted how new patients on a ward quickly learn 'what' to ask and 'what not' to ask, and 'who' to ask. While Ley (1988) argued that patients' reluctance to ask questions stems '...mainly from over-deferential attitudes towards doctors (p.16). Patients kept their interpersonal encounters superficial, filled with idle talk about

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the weather and so on. Patients were careful to ensure that they were not perceived by the staff to be a nuisance. They did not want to bother the staff or alienate them. In another research study, Waterworth and Luker (1990) emphasised the importance of 'toeing the line' as a patient.

Respectful admiration for the staff

Some patients felt that by being a patient in hospital they also provided a sense of purpose for the carers, for without patients there would be no nurses to look after them. Many patients showed admiration, deference and gratitude to the carers. It seemed almost to be an expectation of the role of being a patient to do so, and most patients fulfilled this requirement unquestioningly. Showing admiration for the dedicated staff ensured that patients would be seen in a positive light by the staff. In a discussion of the social rules governing deference and demeanour, Goffman (1956) noted how the expectations of one group confers an obligation on another group to behave in particular ways. The nurses expectation of conforming and compliant patients may lead patients to behave in a certain fashion.

One patient commented on the way he spoke to the nurses. He always addressed the nurses as 'nurse' no matter how well he knew the nurse involved. This had the effect of reinforcing the unequal status which separated the nurse and the patient. It was an overt mechanism for displaying deference to the staff. This type of relationship is obviously not one of equals because the carer seems to be giving all of the time and receiving little in return. The imbalance may be compared with the notion of reciprocity discussed in chapter 2. However, the deferential mode of presentation which many patients adopt may well serve as a means of legitimising the professional and caring role of the nurse. This legitimisation process may be enough to satisfy the norms of reciprocity.

It was also interesting how staff used the christian names of the patients. Many staff took the liberty of calling patients by their christian names even

though many of patients were older and more senior than the nurses. This strategy too may empower the staff and increase their status over the patients. The patients liked being called by their christian names because it made them feel human, even if it meant being an extremely vulnerable human. The nurses were also empowered to touch patients and perform intimate and highly personal tasks. This capacity was never questioned by patients.

The demeanour of both patients and staff (Goffman, 1956) also played a role in determining the behaviour of nurses and patients. The patients were dressed in night attire although only one or two of them needed to be at the time of the interviews. The nurses were dressed in their uniform, with coloured epaulettes, pens, notebooks and so on, all of which instantly displayed their grade and level of expertise to patients and visitors to the ward. The demeanour of the patients and nurses helped to reinforce the differences in status and position in the hospital. The balance of power was very one-sided.

Power in the professional helping relationship
The issue of power in helping relationships has not been addressed adequately. A small number of writers have however, noted the influence of power in the helper-client relationship. Guggenbühl-Craig (1971) described an analysis of the work of professional carers and helpers including therapists, doctors and social workers which revealed a desire for power over clients amongst these professional groups. Criticisms of the established and accepted ways of receiving care have been hard hitting. In a discussion of the consequences of institutionalised care for the sick person, Parsons (1951) noted that:

> ...the combination of helplessness, lack of technical competence, and emotional disturbance make him a peculiarly vulnerable object for exploitation (p.445).

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In a direct attack on the medical professional health care system Illich (1975) stated that:

> A professional and physician-based health care system which has grown beyond tolerable bounds is sickening for these reasons: it must produce clinical damages which outweigh its potential benefits; it cannot but obscure the political conditions which rendered society unhealthy; and it tends to expropriate the power of the individual to heal himself and to shape his or her environment (p.11)

In addition Illich described three types of iatrogenesis which resulted from an inappropriate amount of power in the hands of doctors. These included clinical iatrogenesis (errors in treatment); social iatrogenesis (dependence on care, drugs, and other forms of medical technology); and structural iatrogenesis (characterised by the individual's loss of power over his own life and health). Nurses also hold power over patients and the drive for nursing to become more 'professional' can only increase this power.

Service appraisal

One important aspect which tended to dominate patients' lives in hospital was the way in which they were looked after and the quality of the care which was received. Rempusheski et al. (1988) suggested that services created a positive perception of care in hospital. In patient conversations, doctors often achieve the status of 'heroes' and nurses are seen as 'dedicated and extremely hard working and underpaid individuals'. In this study, patients were generally satisfied with the care that they received. It is difficult to see how the patients could be critical of a system which, along with serious illness, made them so vulnerable and dependent. Their attention was focused on things which may seem unimportant to the staff. The friendliness of the staff was important to patients. The fact that the staff bothered to ask patients what they needed and the ability to make the patients feel safe influenced their perceptions. The technical competence of the staff in giving injections and other procedures was appreciated. The approach of

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the staff was sensitive and calming. All of these issues are relatively simple and straightforward elements of the nurses daily work.

Symbolic hotel services

Another aspect of the service which was appraised more objectively was the standard of hotel services offered to the patient. The accommodation and hotel services provided in the hospital are not often considered by the staff as important. Indeed, in some units nurses have absolutely nothing to do with the provision of meals and drinks for patients and have little say in the quality of the service provided. While this may seem reasonable to some, it ignores the importance of these 'hotel' facilities for patients. Having clean bed linen, or a clean and uncracked cup to drink out of have symbolic meaning for the patients. They convey to the patients a message that he or she is a person worthy of care, and not an object.

The patients interviewed here were reasonably satisfied with the hotel services they received. The students in particular were mentioned by several patients, they were constantly available and took time to talk to the patients. Some of the patients found the night staff to be particularly good because the night was the time when they needed help to sleep or make themselves comfortable. The night staff made them tea or offered them drinks in much the same way that a patient might get up in the night and make herself a drink.

Interestingly, the patients generally did not get to know any of the nurses well. They had minimal contact with the qualified nurses which was usually superficial in nature, the trained staff were too busy. This supports the general tendency for much of the basic nursing to be done by the learners in particular or untrained staff (Knight and Field, 1981; Robinson et al. 1989). Patients saw the caring attitude of the nurses; nothing was too much trouble and their response to patients was genuine. Approachable doctors too were appreciated.

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Some criticism of the hotel services did emerge however. Some of the tea ladies and receptionists were overtly rude to patients. Interestingly, when I was told about these ugly scenes, it was quickly pointed out to me by the patients concerned, that these rude 'staff' members had nothing to do with the nursing staff, they were receptionists or tea ladies. Patients also complained of being kept in the dark about their treatment and management; others complained that there was nothing for them to do during the long days, they were bored. Some patients saw evidence of poor nursing practice. It is interesting that any criticism of the system emerged at all. Typically patients are very reluctant to voice any criticism of the staff to anyone remotely involved in the system. This may be the result of an implicit rule of patienthood - never criticise. For criticism is likely to lead to patients being labelled 'good' or 'bad' (Lorber, 1975; Kelly and May, 1982) or unpopular (Stockwell, 1972) and treated accordingly.

These apparently insignificant aspects of care in hospital should not be overlooked by professional carers. For patients they are crucially important, at least in terms of their psychological well-being, and likely to influence their satisfaction with the quality of care received. These aspects of care may not rank as important as life-saving surgery, but to most patients who come into hospital, they are nevertheless important. Many of these elements of the service can be easily monitored and high standards maintained. If nurses appreciate the significance of these facets of care they can take account of them when monitoring and evaluating the service they provide for patients.

Personal concerns of the patient
The last major theme which reflected the patients experience was the personal concerns of the patient during their stay in hospital. These were issues which assumed great importance for the patients but were of little interest to the staff. They served as important reminders of their lives outside of hospital or of their current concerns and relationships. They emphasised the sorts of difficulties which relatives or friends of the patients had to deal with. They focused the

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patients' attention on the outside world. The treatment was a primary concern for some patients. They wanted to get better and that was all. These patients saw their stay in hospital as an ordeal which had to be undergone. Relationships with staff were of little importance. Getting better was the most important thing in their lives. Another patient felt frustrated at being in hospital because he did not feel particularly ill. Nobody wanted to be in hospital unnecessarily. His frustration was heightened by the fact that he felt as though he was treated like an object in hospital. Another patient was very upset by the behaviour of her GP and his colleagues in the practice and discussed this at length during the interview.

The mother of one of the patients' had died recently, now here she was in hospital, ill and upset by her mother's recent death and uncertain about what would become of her. Another patient thought about his previous admission to hospital which was terrible. He contrasted that admission with his present experience of hospital. Others were worried about their family and close friends, they felt cut off and lonely. Two patients became very tearful when they told me about the distances their relatives had to travel just to visit them, or the problems of ill health their relatives had. These concerns were important for the patients and must have influenced the way they responded and reacted to the hospital situation. None of these patients developed close relationships with nurses so they had few opportunities to express their anxieties to the staff.

It is also curious that they were so willing to disclose these concerns to a stranger/researcher during relatively short interviews. Additionally, four of the ten patients became emotionally upset during the interviews and cried for a very short period. All quickly regained their composure and continued with the interview. After the tape recorder was switched off I sat with these patients for a short while and talked generally. On leaving the ward I mentioned to the nurse in charge that the patient had become upset and asked if someone could check in on the patient later on. It is unclear why these patients became emotionally

upset but one possible explanation may be the fact that someone actually took time to talk to them about their illness and experience in hospital and this intervention emphasised the intensely vulnerable position in which these individuals found themselves.

Refocusing on physical and psychological caring

What has emerged from this study most powerfully, is the significance of caring for the whole person. Nurses, and particularly trained nurses, must try to re-immerse themselves in caring activities, both physical and psychological. As students or inexperienced staff nurses they have focused on the physical dimensions of caring for patients. But as trained and more experienced nurses they have assumed higher status and power and have alienated themselves from the patient. To a large extent this alienation is brought about by the system of delivering nursing care, with its hierarchical structures and the role of medicine as a model for nursing. Dunlop (1986) noted how the history of the meaning of caring has a:

> ..complex past...including its negative and lower order associations,
> which may prove hard to shift, because they are so embedded in
> the background meanings. It seems to be no accident, in other
> words, that 'cure' is associated with a high-status, predominantly
> male occupation, which jealously guards access to the term, while
> 'care' is relegated to women...(p.662).

The separation of caring into instrumental and expressive components may lead to more difficulties by dissecting nursing work into low status (attending to the basic needs of the patient) and high status (administering medicines, doing doctors' ward rounds, administration and so on) has. A synthesised perspective has been advocated recently:

> In caring for sick people, many aspects of whose being-in-the-world
> become problematic rather than taken for granted, there is a
> temptation to concentrate either on the troubled body or the
> troubled psyche in order to simplify nursing work, yet what the

nursing community agrees is good nursing is neither purely physical nor purely psychosocial. The nurse must thus find her way between the twin temptations of physicality and disembodiment (Dunlop, 1986, p.664).

This objective could be realised on an individual basis and some nurses seem to have achieved this already. To attempt to refocus institutional care systems is quite another matter. Much time, energy and resources have already been invested in producing the present system of values and customary modes of nursing practice. However, if there is a genuine concern for the consumers of health care then the system must address the needs of consumers.

Taking the lifeworld view

The frameworks provided by several authors have produced important insights into the meaning of caring relationships (Campbell, 1984, 1985; Mayeroff, 1971; Van Hooft, 1987) and important similarities with the findings of this study must be highlighted. Mayeroff's (1971) notions of knowledge, patience, honesty and trust have all emerged in the present study. In addition, the claim that caring can provide opportunities for personal growth and development was realised by some of the nurses in this study. Personal growth was one of the important benefits derived from caring for others. The fluctuating rhythm of involvement in any personal relationships was also found to characterise caring in nursing practice.

The findings of the study also share some of the important ideas which Campbell's (1984, 1985) analysis of professional caring relationships outlined. Carers have a *choice* about whether to get involved or not and the carer must have a certain set of skills. Caring relationships are also open to movement and change. The concept of mutuality is an important consideration here and has already been noted in other studies (Kitson, 1978a; Hirschfeld, 1983). In Campbell's analysis of 'skilled companionship' mutuality in the relationship was suggested. The results of this study imply that this level of interaction is unlikely to be achieved as a matter of course. The limited commitment which

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characterises skilled companionship was found also in both parts of the present study. Nurses identified personal boundaries of commitment. These authors have however, ignored many of the important issues which carers and indeed cared for individuals have to deal with. They are in some ways too far removed from the daily practice of caring for another person in a professional context. They have overlooked the influence of the system on carers and patients.

The findings produced here also map out many details which could be applied to Hall's (1990) model of psychological care. He focused on a set of beliefs or philosophy which influenced the practice of care; a specific set of goals derived from the philosophy; a collection of caring acts; and a set of accompanying emotions and feelings. However, this model is rather unsophisticated when the complex findings of the present study are considered. The four themes offered by Hyland and Donaldson (1989) as a basis for psychological care in nursing provide another slant and reflect different issues which nurses must address. They mentioned: a holistic model of care, the importance of communication, individual differences and the right to self-determination.

Nichols (1985) included the following list as components of psychological care in nursing: assessment of an individual's psychological state, the need to be able to represent the patient's psychological needs to other professional groups, the provision of emotional care, giving accurate information, counselling skills; and the need for support systems to deal with stress in nurses. It is interesting to note how the present study raised all of these issues and more. The lived experience of caring and being cared for is complicated and it is this complexity which characterises the world of the nurse or the patient. It is crucially important that approaches to studying helping and caring in professional contexts become more aware of the complex world facing informants.

Dilemmas facing all professional carers

All attempts at professional helping including nursing are however undermined to some extent by a number of essential conflicts. Nursing, like other helping professions must tackle these issues directly. Some of the most salient of these conflicts have been discussed in Lenrow (1978), so only a synopsis is provided here. Lenrow (1978) included the following issues: the fact that there is an inherent contradiction in the term 'professional helper'; professional helpers are often seen as distant and different from those they claim to help; the values of the professional helping groups are often in conflict with those they claim to help; and the system of 'organised' care has a direct impact on the individual carer. Lenrow suggests that:

> When a professional's work is embedded in bureaucratic structure,
> his role may be incompatible with helping, in the sense that many
> of his actions are not intended to help and that the clients (or
> students) do not perceive the professional's work as intended to
> help them (Lenrow, 1978, p.279).

In addition further dilemmas result from the fact that the professional carer emphasises technological supremacy in dealing with the problems which an individuals faces; and professional helping is often characterised by a desire to blame the victim for his misfortunes. These and other similar conflicts tend to get in the way of the helping process.

Application of the phenomenological method to practice

Taking the informants' viewpoint seriously

In a critical account of the process of psychotherapy, Smail (1991) argued that many conventional approaches to the therapy situation were lacking:

> ...a systematic elaboration of how the distress which therapists
> encounter in their patients becomes intelligible through being
> placed within the context which gave rise to it in the first
> place...[they] fail to take sufficiently seriously into account the world
> in which psychological subjects are located (p.62).

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It was suggested that psychologists and therapists needed to adopt a broader environmental perspective which acknowledged the important influence of the real world on the distressed client. Such an approach is similar to the lifeworld understanding employed in the present study. The depth of insight gained when this approach is used is clear. The sensitive comprehension gleaned through this method may be used to positively transform the quality of care experienced by patients and their families during a time of distress. Both nurses and therapists can employ this perspective provided that appropriate teaching and training are given. One of the difficulties of achieving this goal is the lack of suitable training materials. Another obstacle is the rather complex and obscure language which is often encountered for the first time.

Perhaps the most significant element has been the scarcity of readable research reports which convey directly the potential of this approach for practice disciplines like nursing, psychology and other caring professions. While several starting points exist (Keen, 1975; Kleinman, 1988; Spinelli, 1989), this study may provide more tangible means of overcoming some of the barriers to application for the novice.

Summary of the chapter

The nurses' and patients' experiences are discussed. Many similarities have been noted with the findings of other studies into caring in nursing and models of psychological care in nursing. The lifeworld perspective which was used particularly in the second part of this study has uncovered the complex nature of professional caring in nursing practice. Opportunities for really caring for individual patients are curtailed by many factors. The importance of providing physical care for patients was emphasised and it provided opportunities for establishing caring relationships with patients. The stressful nature of nursing work and constant risks of involvement have to be dealt with on a daily basis. The preparation received by the nurses for the job of caring was incomplete. The

personal benefits of caring helped the nurses to maintain a balance between over and under-involvement.

In addition, the views of patients, the real consumer of caring services were taken on board. The position of the patient in the world of professional nursing is one of crushing vulnerability. In this context the patients adopt modes of self-presentation which ensure that he or she is seen by the staff as a patient worthy of care. Patients also evaluated the provision of hotel services in hospital, an issue not always recognised by the staff. Nor are the important personal concerns of the patients always recognised by the carers. If the patient perspective is to be recognised and dealt with sensitively, then nurses and indeed other health care workers must attempt to adopt a phenomenological attitude to their consumers. Only then can human care surface in nursing practice.

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CHAPTER 9
CONCLUSION

Introduction

The study concludes with a brief account of some important methodological issues which underpin all human research of this nature. The issues which emerged during the second part of the study are stressed, but many of these apply equally well to the first part of the study. The emphasis here however, is focused on the professional helping relationship. While the technical weaknesses of the approaches used in this study are acknowledged, these have been outweighed by the tremendously detailed insights into the informants' lives. The methods used in the second part of the study in particular have demonstrated an extraordinary potential for applied research. The approach has shown how the gap between the formal, rigorous accounts and down to earth experience of informants may be narrowed.

The pros and cons of being a nurse researcher

The role of nurse researcher is an ambiguous and demanding one. As a nurse with a degree in psychology but little training in psychological research technique, I had to adapt to the role of researcher and it was not always an easy task. Combining the role of researcher and nurse produces both advantages and disadvantages and an acute awareness of the potential pitfalls associated with the transition from practitioner to researcher helped me to overcome some of the major difficulties.

One of the advantages of having some nursing experience stems from the rich background experience which the nurse researcher brings to the research situation. A detailed appreciation of the organisational culture and working life is readily available. The uninitiated researcher on the other hand, may need to take a considerable time if he or she is to acquire this knowledge before embarking on empirical work. I was rapidly able to enter the clinical setting and establish a good rapport with the practitioners and their patients. Introducing myself·as a nurse/research student helped to minimise the suspicion which most

nurses and patients hold about researchers. A second important advantage for the nurse researcher is the familiarity with the 'language' used in the professional setting. This knowledge minimises the risks of misunderstanding the informant's meaning. It can also help to establish a rapport with informants and affords the researcher some credibility with practitioners and patients. I did not have to stop the interviews to check what the informant meant by a particular piece of prose.

Some disadvantages of the combined role of nurse and researcher also need to be considered. The acquired 'inside information' that is part of the role of the nurse may influence the researcher so that important issues and concerns of the informants are overlooked. This inside information constitutes the shared, taken-for-granted meanings which are entailed in group participation. I tried to overcome this potential problem by reading around the issues, talking to colleagues or even individuals unfamiliar with the study, in order to ensure that relevant issues and themes were not inadvertently glossed over.

In addition, as a nurse researcher I had to contend with other problems. Did my role as a researcher carry status? If so did this have any impact on the relationships which I built with informants? How much did my own prejudices influence the interviews and the results? How did informants perceive me? All of these characteristics are likely to influence the research and ensure that any researcher is seen either as a trusted member of the 'team' or a 'spy' in the organisation (Goffman, 1971). There are no easy solutions to these potential problems. Research of this nature is fraught with difficulties of this type. However, progress will not occur unless many of the issues are brought out into the open and addressed. These sorts of issues form the hidden curriculum of any human research.

Self-presentation and impression management
Closely related to the difficulties of being a nurse researcher are the processes of self-presentation and impression management. These two interpersonal processes

underpin all forms of social interaction as well as the social interaction involved in research. Goffman's (1971) dramaturgical model of self-presentation conveyed some of the types of 'performances' which characterise much ordinary social interaction. A more active and deliberate performance is executed through the process of impression management (Tedeschi, 1981), and described by Schlenker (1980) as:

> ...a form of social influence. People affect their own outcomes by attempting to influence the impressions that others form of them. Through words and deeds, we leave impressions on others that shape how they approach and treat us. Controlling these impressions is a means of controlling other's actions, which, in turn, affect our own outcomes for better or worse (p.22).

With this background in mind, we can see how the patients in the research adopted particular modes of self-presentation to survive in the strange and threatening hospital environment in which they found themselves. This strategy helped them to cope at a time of tremendous personal vulnerability. Staff too had many of the strategic trappings of power, influence and status because they worked in a hospital as professional carers. Their professional performances were already tailor made because of their legitimate role within the institution.

On another level, the process of carrying out interviews with hospital staff and patients was also subject to the same rules of engagement. However, this secondary level was much more difficult to analyse and understand because of my own involvement in the research. I had to think about my own performance. I tried not to be judgemental, to listen attentively, to be encouraging and sympathetic, and to react as genuinely as I could to what was said. However, it was only *after* the interviews were completed that I read about these processes more fully. So apart from recognising and acknowledging the possible influence of these two processes on the interview situation, there was no real opportunity

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to investigate these in any detail. The influence of the researcher on the research process as a whole and the relationship between the researcher and the researched has become a major focus of inquiry within social science research (Berg and Smith, 1988).

Other methodological issues

The appropriateness of the chosen methods

The quality of the data supports the appropriateness of the chosen methods although the sample size was small and generalisations from this sort of research are not possible. The aims of the project were successfully achieved. The combination of the repertory grid technique and more in-depth interviews facilitated a deeper understanding of the lived experience of caring and being cared for in a hospital setting. However, some of the following methodological considerations need to be addressed.

The context of interviews

Interviewing nurses and patients in the clinical areas was no easy task. Sometimes the wards were very busy and I was always very conscious of the fact. I did not want to outstay my welcome on the ward. There were occasional interruptions to the interviews and I had to switch off the tape, wait until quiet had returned and then resume the conversation. On the other hand, being in a clinical setting allowed informants to relate directly to their experiences and thus made these experiences more tangible.

The use of critical incidents

The nurses' interviews focused on critical incidents from their own clinical nursing experiences. They had to select a particular patient, a particular case and a particular time. This has the potential disadvantage of producing incidents which may be very highly charged with emotion for the informants and untypical. The strategy runs the risk of ignoring what is commonly done on a daily basis. On the other hand the use of critical incidents brought the interview to life. It allowed

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the informant to relate to a tangible experience and to recall many details and emotions which crystallised that experience. It helped informants to relate their real world experiences rather than be tempted to 'define' caring in the abstract.

Patients as informants

A noticeable difference between the nurses and the patients was obvious after a few short interviews. Several patients found it more difficult to articulate their ideas and to deal in abstractions like 'caring'. This was probably because of the differences in background and eduction. Although some phenomenological researchers urge that articulate informants are chosen, this option seemed wholly inappropriate to me. I wanted to learn about the world of ordinary patients. The interviews with patients were also shorter than the interviews with nurses. This did not in retrospect seem to be problematic. Rich descriptions were nevertheless obtained. In addition, the level of personal disclosure and expressed emotion by the patients may have been a sign that some form of sympathetic rapport with patients was established during the interviews. The length of stay in hospital and the type of illness may well influence the views of patients although no attempt was made to take account of these sorts of distinctions.

Interviewer skill

When I read the interview transcripts some time after the interviews I was horrified. It was hard to understand how I had missed some of the cues which the informants provided and failed to follow up what appear now to be very useful lines of inquiry. As a researcher I was too anxious to get good data and often too worried about my next question. Sometimes I left the ward with a feeling of frustration and inadequacy because the patients were not very talkative. They seemed to talk around their experience. It was only after I had listened to the tape recording of the interview and transcribed it, that I realised how much they had in fact told me. On other occasions I was surprised and felt privileged that some of the informants were so willing to discuss openly their personal world. Occasionally the end of an interview produced a feeling of guilt because some of

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the patient informants so obviously wanted to talk to me, while my major concern was the quality of the data that I was getting. The quality of the data and findings produced here however must serve as evidence of reasonably successful interviews.

Concerns as a nurse

During the course of interviewing patients I sometimes felt ashamed to be a nurse because the ward staff were so obviously blind to the needs of these very vulnerable patients. The ritualised and sometimes inappropriate care given to some patients was also a source of acute embarrassment. The mystery to me was how willing patients were to accept whatever they faced.

Problem of establishing validity during interviews

A number of other factors may influence the validity or truthfulness of the findings. These have been discussed at different points throughout the thesis so only a summary of the key issues will be mentioned here. These include:

- The transient relationship between the researcher and the informant which can lead to a false presentation of self;

- The difficulty of accessing the private world of the informant as represented in the transcribed text and the researcher's interview notes;

- The unequal status between the researcher and the informant; and

- The fact that the context of the interview may inhibit open discussion.

If interviews were conducted in patients' homes for example instead of the ward environment, some of the patients may have felt free to talk about their

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experiences of hospital care and more relaxed. But not everyone would have. Some patients rapidly forget about their stay in hospital and memory for specific details and incidents can quickly become blurred. The nurses on the other hand seemed quite relaxed and happy to be interviewed in a work setting.

The use of a research diary

Keeping a research diary helped me to log in ideas or things I was reading throughout the duration of the study. Things which were noted two years earlier and subsequently forgotten about, could be reconsidered afresh and evaluated for their contribution to the study at a later date. Some of these ideas were not discussed in the thesis, at the time of writing up they had become too peripheral to the study. The practice of keeping a diary was extremely useful to me.

The value of a good word processor

This became an extremely important factor when it came to transcribing and analysing the in-depth interviews. The availability of good word processing software actually helped me to see things which may otherwise have remained hidden. It provided the flexibility and speed needed to experiment with this type of qualitative data. By transcribing the interview tapes I was able to gain a very detailed and intimate knowledge of each transcript.

If I could do it all again

Given the opportunity to carry out the study again I would:

- Do more in-depth interviews;

- Invite the relatives of patients to take part;

- Learn to listen more effectively and let the informants guide the structure of the interviews; and

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- Learn to touch type for speed and to ensure that the analysis of the interviews followed closely behind each interview.

Applications of the study

There are several ways in which this research may be applied to nursing research, education and practice. However, unless there is a willingness and commitment from all spheres of nursing, then this research like many other studies before it, will remain as an academic exercise. It will not as Kurt Lewin argued, provide anything of practical value. I hope this will not be the case. There are four main areas of possible application including nursing: education; practice; research; and applications to other professional carers.

Nurse education and nursing practice

The process of professional socialisation (Davis, 1975; Melia, 1987; Simpson, 1979) has a critical part to play in the development of caring individuals and caring institutions. It should not be assumed that the system of education and the world of work in which caring is administered, always share the same goals. It is clear that they do not (Ashworth and Morrison, 1989; Melia, 1987). Kleinman (1988) asserted that the professional socialisation which many doctors experienced resulted in what he described as a 'disabled' healer:

> Professional training, in principle then, should make it feasible for practitioners to deliver care that is both technically competent and humane whether or not they are personally motivated toward a particular patient or work under threatening conditions. Certain aspects of professional training seem to disable practitioners. The professional mask may protect the individual practitioner from feelings of being overwhelmed by patients' demands; but it also may cut him off from the human experience of illness (p.225).

It is likely that a very similar course of events applies to the socialisation of nursing students. Little attention is paid to the human component of nursing work. In these days of 'market forces' philosophy, it would appear that expensive

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training serves to produce a system which is more concerned with the process of professional care rather than the content (other vulnerable human beings). One possible solution might be to appoint ward managers who have training in management and let the trained nurses nurse. Moreover, it may make more economic sense to employ untrained or less well trained nurses to be the caring sources and acknowledge that the trained nurses (the procedural or technical experts) do not really want to get involved in this aspect of nursing people. This may be the cost of achieving 'professional' status as nurses.

If the implicit desire to care which many learners bring with them to nursing is to be fostered, then good role models and a suitably supportive environment are urgently required (Pratt, 1980). It has been suggested that:

> ...caring is not being learned, because, in general, it is not being
> either taught or demonstrated with sufficient purpose (Pratt, 1980,
> p.52).

It is the responsibility of practitioners, as well as the teaching, administrative and policy making staff to ensure these requirements are not overlooked.

It also remains to be seen how it is possible to get learners and practising nurses to begin to think about their patients from a phenomenological perspective. Obviously some nurses already do, but not as a matter of course. The system does not promote such an outlook, it moulds even the most caring and innovative individuals into organisational functionaries. Training workshops and exercises could be designed and developed. I have myself developed with a colleague some of my ideas into a text and facilitator's manual to try and promote such a perspective in educational institutions. It is however only a first step. Much more work needs to be done. The manual focuses on applications of repertory grid and other assessment techniques for learning how to care and communicate with patients and colleagues (Morrison and Burnard, 1991a,b). The

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next stage in this project will be to develop ways and means of producing more phenomenologically orientated procedures for teaching and training.

Nursing research

The description of the methods used in the study have included sufficient detail to ensure they could be used, and indeed developed by other researchers. While a number of helpful papers exist which convey the essential principles of the phenomenological method used here, few were found to be easily accessible or directly applicable to the field of nursing or psychological health care research. The methodological portrait offered here should prove to be helpful to others attempting to adopt a similar approach.

Applications for other professional carers

It is anticipated that the findings and details about the research techniques used in both parts of the study could be applied to other professional groups. Many of the issues discussed here with special relevance to the work of the nurse, also pertain to the work of clinical psychologists, counsellors, therapists, and social workers in community and institutional settings. Further, these techniques could be employed to develop our understanding of the needs of informal and voluntary carers.

Future research

For particular client groups

The findings of the present study have emerged from a general investigation of caring in nursing practice. Future studies employing a similar approach could be carried out with specific groups of staff and patients. A detailed account of the sort of caring experienced by AIDS patients, cancer patients, the chronically sick and disabled, the mentally ill and the mentally disabled for example could prove to be particularly useful. In addition, studies in these and similar areas could play an important role in the development of policies and practices which are genuinely caring and *reflect a concern for both carer and the client*. At another

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level, these sorts of studies could help to develop theory which really does reflect everyday practice issues. The practitioners of nursing should be particularly vigilant to ensure that the concerns of the clients or patient we claim to care for, are an integral part of the care they receive.

Conclusion

The phenomenological approach advocated here is sophisticated enough to enable practitioners to take account of the lived world which other people experience. If nurses and other health care workers really want to reduce the gap between theory and practice, then the capacity to understand the views of others is an essential requirement. The approach advocated here provides a framework for developing truly caring relationships. Pellegrino (1982) reminds us that:

> The fact of illness afflicts our humanity and diminishes it and renders us less able to function as moral agents and as human persons. Illness wounds, diminishes, and compromises our very humanity and places us in a uniquely vulnerable situation in relation to the professed healer. The relationship of healing is inherently one of inequality, vulnerability. The obligations of those who profess to heal directly - the health professionals - and those who provide the conditions requisite for healing transactions - hospitals, teams, or governments - are grounded in the phenomenon of illness as it is experienced by human persons - and this is the philosophical source of professional morality (p.165).

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Appendix 1

An example of one completed repertory grid

ELEMENTS									
CONSTRUCTS: Similarities or Differences	1	2	3	4	5	6	7	8	CONSTRUCTS: Contrasts
Has a sense of humour	2	7	1	1	4	5	2	1	Dull
Lets personal problems interfere with work	4	1	7	1	7	7	6	7	Professional attitude
Work is this person's life	1	1	1	7	2	7	7	4	Has other interests besides work
Does not respect a person's feelings	7	7	7	1	7	7	7	7	Respects a person's feelings
Has self-control	1	7	6	4	1	6	3	1	Panics
Helpful	1	4	1	4	1	7	1	1	Unhelpful
Has more experience	1	1	1	7	1	3	6	1	Still learning
Tries to meet peoples' needs	1	1	1	1	1	3	1	1	Unaware of needs

ELEMENT ROLE TITLES	
1	A caring nurse
2	An uncaring nurse
3	The most caring person I know
4	The least caring person I know
5	A person I care a lot for
6	A person I don't care much for
7	Myself as a carer
8	How I would like to be as a carer (Ideal self)

COMMENTS ON THE INTERVIEW

Informant 8 was a young community midwife with limited experience in practice. At the time of the interview she had been qualified for less than two years. This general lack of experience was the theme which pervaded the whole interview. It was obvious that her lack of experience had a particular significance for the informant, especially when working with a number of very experienced colleagues. This was reinforced by the way in which she rated herself on the construct 'has more experience - still learning'. The interview procedure worked well in the sense that the informant quickly grasped the idea of using the elements to generate her own ideas about these people. The rating procedure posed no particular problems for this informant.

Appendix 2

Categories produced through the content analysis

1. Personal qualities

	CARING	UNCARING
1	Kind	Unkind
2	Kind	Harsh
3	Kind	Disinterested
4	Possesses unending kindness	Unkind
5	Kind	Selfish
6	Kind	Cruel
7	Sympathetic	Unsympathetic
8	Needs to be more understanding	Lacking in understanding
9	Understanding	Lacks understanding
10	Considerate	Lacks understanding
11	Considerate	Inconsiderate
12	Patient	Abrupt with people
13	Patient	Impatient
14	Very patient	Impatient
15	Very patient	Impatient
16	Tolerant	Intolerant
17	Tolerant	Intolerant
18	Helpful (builds confidence)	Unhelpful
19	Helpful	Unhelpful
20	Helpful	Uncooperative
21	Relaxed	Worried about how others see them
22	Relaxed	Tense
23	Appears relaxed	Obviously tense

	CARING	UNCARING
24	Gently (quietly spoken)	Noisy
25	Calm	Nervous
26	Calm	Constant awareness of how much needs to be done
27	Calm and confident	Impatient
28	Pleasant disposition	Moody
29	Happy disposition	Miserable
30	Smiling	Miserable
31	Happy	Depressive
32	Has a sense of humour	Humourless
33	Has a sense of humour	Lacks a sense of humour
34	Has a sense of humour	Dull
35	Genuine	False
36	Genuine	False
37	Genuine	Uses people (ruthless)
38	Genuine	Untrustworthy
39	Honest	Dishonest
40	Honest	Dishonest
41	Honest	False
42	Aware of own feelings	Unaware of own feelings
43	Has awareness	Lacking awareness
44	Over-protective	Lacks awareness
45	Aware of social pressures (other people are under)	Isolated

	CARING	UNCARING
46	Keen to explore feelings	Ignores feelings
47	Expresses emotions freely	Thinks more about emotions
48	Affectionate	Lacks feelings
49	Loving	Uninvolved emotionally
50	Compassionate	Doesn't see others needs
51	Flexible	Always gets their own way
52	Flexible	Narrow-minded
53	Open-minded	Narrow-minded
54	Assertive	Unassertive
55	Assertive	Cowed (disheartened)
56	Thoughtful	Thoughtless
57	Avoids making value judgements	Makes value judgements about people
58	Compassionate	Vindictive
59	Even-tempered	Unpredictable moods
60	More articulate	Withdrawn
61	Easy going temperament	Argumentative
62	Positive	Negative
63	Vulnerable	Brash self confidence
64	Down to earth	Aloof and arrogant
65	Timid	Over-bearing
66	Mature	Insecure
67	Less stressed	Highly stressed
68	Anxious about people	Disregards others opinions about themselves
69	Would like to be extroverted	Happy to be reserved

5

2. Clinical work style

	CARING	UNCARING
1	Treats people as they would like to be treated	Got no time for the patient
2	Treats people as individuals	Doesn't think too much about the patient's illness
3	Takes individual needs into consideration	Lacks fairness towards people
4	Sees people as individuals	Fails to recognise people as individuals
5	Treats everyone as an individual	Works like a production line
6	Treats people as individuals	Works according to the book
7	Sees individuals as a whole person	Sees patients as 'diagnosis'
8	Identifies patient's needs	Stays close to the rules and regulations
9	Tries to identify patient's needs	Doesn't identify people's needs
10	Identifies client's needs	Unconcerned with client's needs
11	Explores needs with a person	Assumes knowledge of a person's needs
12	Anticipates people's needs	Avoids dealing with needs of others
13	Tries to meet people's needs	Unaware of needs
14	Patients first	Concerned with doing for doctors rather than patients
15	Always puts the patient first	Never puts the patient first
16	More attuned to people at work	Working individually

Clinical work style (continued)

	CARING	UNCARING
17	Establishes good relationships with co-workers	Establishes low morale amongst co-workers
18	More skilled	Less skilled
19	Skilful counsellor	Unskilful counsellor
20	Safe (knows exactly what to do)	Dangerous (in procedures)
21	Somebody I can count on	Unreliable
22	Reliable	Unreliable
23	Efficient	Inefficient
24	Effective (achieves goals set by patient and me)	Workload orientated (Lacking the human touch)
25	Orderly	Sloppy
26	Organised	Disorganised
27	Organised	Disorganised
28	Easy-going	Fussy
29	Meticulous	Blase attitude
30	Striving to improve practice	Complacent
31	Pays attention to detail	Omits attention to detail
32	Able to select appropriate leadership style	Inappropriately authoritarian
33	Gives direct patient care constantly	Not directly involved with patients
34	Provides more teaching for patients, relatives and students	No teaching facilities
35	Has self-control	Panics (not commanding in difficult circumstances)
36	Supports the family group	Doesn't provide support for the family
37	Able to offer more resources	Discharges patients with no backup

7

Clinical work style (continued)

	CARING	UNCARING
38	Explains adequately to patients treatment and care	Ignores psychological needs of patients
39	Has taught me a lot in my career	Lets you do your own thing
40	More qualified	Less qualified
41	Has more training	Not enough training
42	Has a greater knowledge of people	Has a lot to learn about people
43	More knowledgeable	Less knowledgeable
44	Knowledgeable	Not knowledgeable
45	Knowledgeable	Naive
46	Has more experience	Still learning
47	Experienced	Lacks experience
48	Consistent in attitude	Inconsistent in attitude
49	Easy attitude towards work	Flippant attitude
50	Down to earth attitude	Condescending attitude
51	Professional attitude	Lets personal problems interfere with work

3. Interpersonal approach

	CARING	UNCARING
1	Gentle approach to people	Abusive towards people
2	Approachable	Unapproachable
3	Approachable	Unapproachable
4	Approachable	Cold
5	Easy to get on with	Dominant in relationships
6	Empathic person	Dominant in the nurse-patient relationship
7	Empathic approach to people	Diabolical approach
8	Empathic	Not empathic
9	Empathic	Lacks sensitivity
10	Empathic	Lacks empathy
11	Sensitive approach	Thoughtless approach
12	Sensitive	Rude
13	Sensitive	Distant
14	Sensitive to personal criticism	Insensitive
15	Communicates well	Doesn't make an effort to talk to people
16	Communicative	Uncommunicative
17	Listens to people	Does not listen to people
18	Good listener	Over ready to give advice
19	Listens	Doesn't listen
20	Good listener	Lacks understanding
21	Polite	Rude
22	Polite	Rude

	CARING	UNCARING
23	Always polite	Studied discourteousness to patients and relatives
24	Gets on with people	Rude to people
25	Respects a person's feelings	Doesn't respect a person's feelings
26	Respects people's views and opinions	No respect for people
27	Provides emotional support	Lacks feeling
28	Doesn't make people feel small	Sarcastic attitude
29	Doesn't use people	Manipulative
30	Treats people as equals	Chauvinistic
31	Accepts other people	Feels resentful towards others
32	Interpersonal relationships are important	Shallow relationships
33	Easy to be with	Don't feel relaxed in this person's company
34	Strives to provide a personal approach	Impersonal approach to work
35	Warmth	Puts barriers between people

4. Level of motivation

	CARING	UNCARING
1	Highly motivated	Unmotivated
2	Motivated	Apathetic
3	Dedicated	Lacks dedication
4	More committed	Lacks commitment
5	Takes commitments seriously	Lack of commitment
6	Committed	Unfeeling
7	Involved	Detached
8	Involved	Lacks feeling
9	Dynamic	Apathetic
10	Genuinely interested	Apathetic
11	Interested	Disinterested
12	Interested	Disinterested
13	Very interested (in patients)	Lacks interest
14	Very interested	Lacks interest
15	Conscientious	Unwilling
16	Conscientious	Negligent
17	Conscientious	Doesn't do the work they should do
18	Conscientious	Unfeeling
19	Nothing is too much trouble	Only does what she/he has to do
20	Does things for people willingly	Reluctant
21	Work is this person's life	Has other interests (besides work)
22	Feels what she/he does is worthwhile	Feels not needed

5. Concern for others

	CARING	UNCARING
1	Puts others before self	Selfish
2	Puts others need before themselves	Selfish
3	Puts other people first	Selfish
4	Puts themselves out for others	Selfish
5	Gives freely of themselves	Selfish (egocentric)
6	Gives freely of themselves	Selfish
7	Gives freely of themselves	Constantly unavailable
8	Thinks of others	Selfish
9	Unselfish	Selfish
10	Considers others first	Inability to put anyone else first
11	Concerned for people	Disinterested in people's welfare
12	Thinks of others	Self-centred
13	Awareness of others	Lacks awareness of others
14	Doesn't take advantage of people	Uses people to their advantage

6. Use of time

	CARING	UNCARING
1	Always has time for people no matter what	Always rushing
2	Always has time for people	Pretends to be busy
3	Always has time	Rushing around - panics
4	Always has time to talk to people	Always got something else to do
5	Has enough time to deal with people	Hasn't enough time to deal with people
6	Has enough time to deal fully with a person's problems	Lacks time
7	Has time for supporting relationships	Lacks time for supporting relationships
8	Has more time to chat with people	Provides the minimum care allowable
9	Would like to be able to make more time to listen	Pressurised into doing other things (other priorities)

Interview guide used by the researcher when interviewing nurses

Tasks of the researcher

The researcher:

- Explains the purpose of the interview and how the informant came to be selected.

- Gives assurances of anonymity in any written reports arising from the research and states that responses will be treated in strict confidence.

- Suggests that some of the questions may seem unusual because what is suitable for one person may not be suitable for another. Since there are no right or wrong answers he or she should not be worried about this but should do the best he or she can with these questions. The research is focused on *their opinions and experiences*.

- Points out that the informant is free interrupt at any time, ask for clarification from the researcher or to be critical of a line of questioning.

- The researcher tells the informant about his background, training and interest in the research domain.

- The researcher asks permission to tape the interview and explain why this is essential.

Focus of the interview

The researcher asks the informant to describe in as much detail as possible an incident or a time when she felt that she really cared for a patient. The researcher encourages the informant to expand his or her description by asking open questions in an attempt to explore experiences, thoughts, feelings and uncover details about the context in which care was given.

As the interview develops the researcher focuses on the following areas:

- Aspects of the role which inhibit caring.

- The ways in which the informant benefits from caring for others.

- The stresses involved in caring for others.

- The relationship between caring and other interpersonal processes.

- The effect of training people to care.

- The concept of professional carers.

- The limitations on the informants' capacity to care for others in a professional context.

Interview guide used by the researcher when interviewing patients

Tasks of the researcher

The researcher:

● Explains the purpose of the interview and how the informant came to be selected.

● Gives assurances of anonymity in any written reports arising from the research and states that responses will be treated in strict confidence.

● Suggests that some of the questions may seem unusual because what is suitable for one person may not be suitable for another. Since there are no right or wrong answers he or she should not be worried about this but should do the best they can with these questions. The research is focused on *their opinions and experiences*.

● Points out that the informant is free interrupt at any time, ask for clarification from the researcher or to be critical of a line of questioning.

● The researcher tells the informant about his background, training and interest in the research domain.

● The researcher asks permission to tape the interview and explain why this is essential.

● Asks the informant to sign the consent form.

Focus of the interview

The researcher asks the informant to describe in as much details as possible their experience of being cared for in a hospital setting. The researcher encourages the informant to expand their description by asking open questions in an attempt to explore experiences, thoughts, feelings and uncover details about the context in which care was given.

As the interview develops the researcher focuses on the following areas:

● What the nurses did and the way in which they did their work.

- The relationships which developed between the informant and the nurses.

- How the informant perceived caring acts or caring individuals.

- What if anything, the informants gave to the carers.

A description of phenomenological analysis of interview data

In this appendix the procedure used to analyse interviews with nurses and patients has been described in the form of a step-by-step guide. The particular interview used here to illustrate the method is typical of the interviews in general. The patient interviews focused on their experiences of being cared for in hospital.

Rationale for including a description of the analysis of interviews

To include a detailed description like this in a thesis may seem unnecessary to some. However, I have taken the opposite point of view. In reading other theses I have found what can only be described as 'methodological black holes', in which the authors failed to clarify sufficiently well how their results were achieved. This process was a crucial issue for me in completing the project and represented an essential part of this thesis.[1] Furthermore, the guidelines for carrying out this sort of research have tended to be etched out as a series of principles to be followed and have not reflected the difficulties confronting the novice researcher. I found only one thesis (Hagan, 1988) which proved sufficiently helpful in this area. My intention here therefore, has been to map out as fully as possible, the important stages in the analysis for other researchers in this field or those who may wish to use the approach in their studies. At the same time I hope to convey the importance of this process in completing the research. Every detail and thought process of the researcher cannot be recorded, but all of the more tangible stages have been included here.

The need to provide a detailed description of the method was emphasised by Keen (1975) when he wrote:

> When what is understood is understood only interpretively, as in psychology, the grounds for that interpretation, the contours of meaning in the investigator's experience, must be exposed. The phenomenological reduction, imaginative variation, and interpretation are ways to make the investigator's meanings clear to himself. To describe their operation in the research project itself is to make them clear to the reader or listener. Therefore, phenomenological writing is very strenuous, and every phenomenological analysis is in some sense also a self-analysis. Such is the price (and rewards) of rigor (p.40).

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[1] I had planned to include this appendix as a chapter in the thesis to convey the importance of the analysis process to the overall study. However, it detracted from the flow and readability of the thesis and had to be relegated to an appendix.

Stages in the analysis of interview data

The purpose of the phenomenological method is to make sense of the data so that the world of the informant is clearly understood. Each stage of the analysis procedure is designed to specify how this may be achieved in a rigorous manner and offers the opportunity for independent validation. The staged analysis procedure may be divided up into four essential parts.

Part 1

An interview with one informant was tape recorded and analyzed initially on the same day. Then a verbatim transcript of the interview was divided into natural meaning units. This part of the analysis comprises stages 1-4 of the analysis procedure outlined below.

Part 2

The text was restated in the third person and reorganised into distinct content areas. These content areas were given initial labels as described in stage 5 below.

Part 3

The central themes to emerge from the interview which communicate the informants perceptions about the research domain were outlined. This matches with stages 6-8.

Part 4

A comparison of themes was made across interviews in an effort to discover common themes. In particular the findings of the nursing group and the patient group were compared. A general re-examination of the literature related to the research was undertaken so that the findings could be located within a particular context. This coincides with stages 9-11.

Stage 1: Interview with the informant focused on their experience of being cared for in hospital

The interviews were taped using a small battery operated tape recorder in a quiet room close to the ward where patients were being nursed.

Role of the researcher

I asked questions of the informant in order to elicit their perceptions about the experience being studied with the help of an interview guide developed out of the earlier work and literature. Leading questions were kept to a minimum, and where possible the direction of the interview was dictated by the responses of the informant. However, the interview was focused to some extent since it was

influenced by a particular experience under investigation, the findings of the first part of the study and my own presuppositions.

Stage 2: Provisional analysis of the taped interview on the day of interview

On the day of the interview I listened to the taped recording and noted down key content areas on the interview write-up sheet (see appendices 6 and 7). In addition I noted:

- Initial ideas which might prove helpful in the later analysis of the interviews;

- Any methodological difficulties or successes; and

- Any personal emotional responses.

I also kept a diary about the research project and noted any ideas, suggestions, or questions which occurred to me. Other researchers have noted the importance of keeping a record or diary during fieldwork (Schatzman and Strauss, 1973; Lofland and Lofland, 1984). Mills (1970) also suggested that researchers should keep a file in which:

> ...there is joined personal experience and professional activities, studies under way, and studies planned. In this file, you, as an intellectual craftsman, will try to get together what you are doing intellectually and what you are experiencing as a person. Here, you will not be afraid to use your experience and relate it directly to various work in progress (p.216).

Role of the researcher

I listened to the recording and made notes about the content themes. The emphasis was on the *content* of what was said rather than on the *form* of what was said. Expressions of strong emotional reactions (such as laughter or tears) were also highlighted at this point. In addition, I also noted my own reactions to the interview situation.

Stage 3: Verbatim transcript of the interview

Each of the interviews were transcribed by me and this resulted in text to be analyzed. Transcribing was a time consuming task and each of the interviews required between two to eight hours to complete.

Role of the researcher

I spent many hours listening to the tapes and transcribing these in long hand. At this stage expressions of strong emotions or reactions of the informant were noted also. Although this task was especially time consuming it had the advantage of

ensuring that I became very familiar with each of the interviews. When all the interviews were transcribed, I transferred these onto a word processor to assist in the next stage of the analysis.

Stage 4: Initial identification of the natural meaning units

This process allowed me to organise the text and made further analysis more manageable.

Role of the researcher

I combed through the transcript and numbered in sequence, the natural meaning units or blocks of text which 'express a self-contained meaning from a psychological perspective' (Polkinghorne, 1989, p.53). Meaning units were identified as changes in the subject matter or the activities being described. The meaning units were discriminated and numbered sequentially on the transcript. Wertz (1983) noted how this process of combing through the text line by line helped the researcher to pay attention to what was said and the manner in which it was said. At this point also notes or emphases were added to the text to indicate points of relevance (for example where the informant became very emotional or there was an interruption in the flow of the conversation).

Stage 5: Discovering and labelling of the central meaning of each unit as intended by the informant

The meaning units were restated in the third person to assist in the identification of the central meaning.

Role of the researcher

I tried to establish what was said in each meaning unit and summarised these in short phrases. Things that were obviously not relevant to the research were put aside (for example someone comes into the room and leaves again). A crucial consideration in this process was the need to set aside my own presuppositions, values, judgements and so on to avoid influencing and distorting *the meaning as intended by the informant*. At this point also imaginative variation was employed to ensure that the central meaning was not distorted in any way. This entailed 'imagining the appearance of the phenomenon against the backdrop of various horizons in an attempt to see what the total phenomenon means' (Keen, 1975, p.38).

Stage 6: Interrogation of each of the meaning units to test its relevance for understanding the informants experience

The meaning units were examined to explore how they were relevant to the informants experience. The text was then reorganised into similar central themes.

Role of the researcher

I attempted to enter the lifeworld of each informant and van den Berg's descriptions of psychiatric (1972a) and physical sickness (1972b) proved particularly helpful here. Then I tried to summarise the informants main concern at each point, with a phrase which captured the central meaning. All the meaning units had to be accounted for and when the same meaning occurred at different points in the text, these were put together under a similar theme which accurately described them both. When a number of meaning units were found to reveal different aspects of a similar and more central theme, these were gathered together and relabelled under this more general heading.

Stage 7: The researcher adopts a specific 'set' to understand and analyze the text

The specific purpose of the research becomes the focus for understanding what the informant has said.

Role of the researcher

The perspective I adopted was my desire to understand how nurses and patients perceived giving and experiencing care in a hospital context. I held a number of presuppositions and beliefs about this process. These were recorded before the interviews. While these may influence the researcher throughout all the stages of the research, at this point even greater care was needed to refocus and suspend these in order to minimize their potential to influence the analysis. The concept of the lifeworld of the individuals taking part in the research was crucial for understanding how care is given or experienced against a backcloth of hospitalisation. The awareness of presuppositions and the attempt to enter the lifeworld of the individuals taking part in the study helped me to ensure that the descriptions were grounded in the informants' point of view. Each of the central themes was then investigated to assess how it helped to describe the experiences of the nurses and patients taking part in the research.

Stage 8: The researcher restates the main themes which emerged in stage 7

The analysis procedure was assessed by independent judges for comparison and to appraise the accuracy of the analysis technique.

Role of the researcher

A detailed description of the analysis procedure was given to a number of independent assessors who were asked to carry out their own analysis of the interview in accordance with the procedures described here. Differences were noted and discussed to arrive at a consensus view of what has been said by the informant.

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Stage 9: Comparison of the general themes across interviews

An attempt was made to discover common themes between the nursing informants (n=10) and the patient informants (n=10), and to identify themes which were specific to each group. Themes which were specific to individuals were also identified.

Role of the researcher

I tried to establish if there were themes common to both of the informant groups, and to see if the groups had common themes within them. This was done by looking for themes which may be described as having a more generalised orientation, however, the individual findings were kept in view to avoid over generalising. In addition, the researcher adopted a 'questioning' attitude towards the data to ensure that the themes provided a coherent and understandable description of the informant's experiences and not the researcher's own views.

Stage 10: Presentation of the results in relation to the specific research interest

The results to emerge from the previous stages of the analysis were presented in the context of the specific research interest.

Role of the researcher

The general themes arising out of the analysis were used to illuminate particular aspects of the experience of caring and being cared for in a hospital setting. The emphasis of the researcher provides a definite direction in terms of what is applicable in this process, but not one which has influenced the generation and identification of specific categories.

Stage 11: Comparison of previous research with the findings of the present study to establish commonalities or discrepancies

An attempt was made to link the findings with relevant literature and theoretical frameworks.

Role of the researcher

I examined previous research findings and theoretical models which provided a context for the findings to emerge from the present study.

A worked example

The remaining section of this appendix provides a worked example of this method of analysis (see also appendices 6 and 7). A verbatim transcript of one patient interview is provided and this and is worked through methodically until a series of central themes have emerged which capture the informant's world. This example should enable the reader to grasp more fully some of the key stages

involved in analysing qualitative interview data in accordance with the framework described here.

Verbatim transcript of the interview with informant

A focused and open-ended interview with an informant was carried out and taped. An initial analysis of the interview was performed on the same day and recorded on the interview write up sheet. A verbatim transcript of the interview was divided into natural meaning units. This part of the analysis comprises stages 1-4 of the analysis outlined below.

Introduction to the informant cared for in hospital

Martha was a lady in her late thirties and was in one of the Cardiff hospitals for extensive skin surgery. She travelled down from her home in the north of England because the surgeon here was especially skilled in this type of surgery. He mother and husband were all the family she had alive and both were still at home in the north. After the nature of the research was explained to Martha the interview was started.

Start of interview

PAUL Can you describe in your own words, what it has been like, being cared for, during your stay in hospital?

MARTHA Well it's quite difficult really when you've always been used to doing things for yourself, to rely on somebody else (1). But I felt, really the nurses here are, most of them have been very good (2), and you felt you know, you can put your trust in them (3). When at first they say 'Get out of bed,' you think 'My God I can't get out of bed'. You know they keep such a firm hold on you and things like that and then you start to feel safe should I say. You need to feel safe with them (4). You know there's some nurses who make you feel that more than others (5).

PAUL OK. What is it about those people you feel safe with? What are they like?

MARTHA I think because they take a bit of time to talk to you (6), as well, they don't just nurse you but talk to you as well, so you feel at ease with them (8). I find the auxiliary nurses are very good (9). What I don't like is when they are in a rush (10) especially when they're short staffed and tend to be dashing about (11), and you've got something that hurts (12) and you know you're going to have to get out of bed, get in a bath with it and things like that (13). You think 'My God, they're going to be in a rush' (14). I don't want to be rushed (15). It gets you all on edge (16).

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PAUL Does that just happen with certain people or is it because they are short staffed?

MARTHA Last week they seemed to have been pretty short of staff (17). But some people do give the impression more than others [LAUGHS] (18). Some always seem relaxed (19) and you know that they would get through the day and get everybody done and not bother (20).

PAUL And others tend not to be like that?

MARTHA Mmmm you know like. Last week one of the trainee nurses, she stayed late about two or three nights to finish me off (21) and you appreciate it (22).

PAUL You mentioned that being dependent was very difficult for you. How is that so?

MARTHA Well you're just used to getting up in the morning (23), and you go and make your own drink (24) and you can walk about (25), go to the toilet (26). It's simple things like going to the toilet, where you've got to have somebody else to help (27). It's just awkward to start with (28).

PAUL Do the staff encourage you to be dependent?

MARTHA I think they paced it pretty well because to start with they look after you and see to everything (29). They've judged it pretty well as to what you can do for yourself (30). They leave you to do it then (31), like cleaning your bung (foam dressing) (32), you know seeing to yourself generally (33). They have paced it pretty well (34).

PAUL Did you need a lot of physical care after you had your operation?

MARTHA Well it was quite a big area they took away (35) and just to see it to start with is the worst bit (36), you feel like fainting [LAUGHS] (37) and then you've got to see it twice a day when you get in the bath (38). There's no getting away from it (39) and it I found it difficult while, because I had this stoma (40) and I got to the stage where I was looking after myself (41), I could walk about alright (42). All they used to do were put things in the bathroom and they say 'Your things are in the bathroom, its all ok' (43). When I had my bath I couldn't get back in bed because I can't sit (44), I've either to stand up or lie down [LAUGHS]. And then I had my second operation I had my bottom done (45), and I had to go back to being dependent again (46). I found it very difficult, very upsetting (47). I really thought that after six weeks I was going back to stage one (48).

PAUL How many weeks have you been here now Martha?

MARTHA About eight, eight next Monday (49).

25

PAUL It's really a long and hectic stay for you then?

MARTHA It's not that. The Doctor at Leeds said it would only take two to three weeks [LAUGHS] (50). I got my information secondhand with Professor H. being down here. I got my information from the hospital at Leeds (51).

PAUL You must have family at home there?

MARTHA My husband and mother. Well my mum's waiting to go into hospital (52), she should actually have been and gone except secretaries there have been on strike and they stopped admitting people (53). So she's going in a fortnight's time. But she's blind in one eye and got a cataract on the other so...(54).

PAUL There's a lot going on in the family just now?

MARTHA Well that's all the family I've got [LAUGHS] (55), I think its just as well.

PAUL Hopefully things will pick up soon for you both.

MARTHA Yeah, we might all get better together (56).

PAUL Can you think of any other things which stick in your mind about your stay in hospital?

MARTHA I think somebody to spend just a few minutes talking to you when you're so far from home is nice (57). You know, rather than just walking in, give you pills and walk out again.

PAUL Have you found that people do that?

MARTHA The majority of them do and I find other patients quite nice when they realise that you're from a long way off, they come in and, you know, and have a chat with you (58). It does make a lot of difference. You know, than just being on your own all the time (59).

PAUL Right, so spending a little time with you is important?

MARTHA Yeah, just that few minutes makes all the difference to how you feel in yourself (60).

PAUL And you found that most people do that?

MARTHA Most of them have been very nice, and they have asked me if I need any shopping or anything (61). One of the student nurses took my dressing gown home and washed it you know, and then brought it back for me (62). I can't grumble.

PAUL   You're obviously a very popular character here [BOTH LAUGH]. Anything which made your stay more bearable or even painful?

MARTHA   Well not really, I just think that I've been well looked after (63), I can't grumble. I've been at Leeds hospital six weeks and I'd much prefer the staff here. They're a lot nicer (64).

PAUL   Could you describe what the nurses have done for you that make you feel cared for?

MARTHA   They've given me magazines, they've brought them in for me to have a look (65). They've asked if I want washing doing, if I need any shopping (66). When my husband came up, they've always been nice, if there's a spare meal, they've always brought it in so he can stay here with me rather than have to go out for a meal and come back (67). Because they realise that when he comes down by train he spends nine hours travelling and three hours visiting (68). So I think they understand things like that and try and get him a cup of tea and that when he gets here (69). They've been nice.

PAUL   How would you describe the nurses' attitude?

MARTHA   I think my favourites are the student nurses (70). If they stay as they are now when they get qualified they'll have some good nurses (71).

PAUL   What is it about them?

MARTHA   The student nurses will come on and they don't seem to dash about (72). They'll come in and do things at a nice pace and talk to me (73). Things like that. The qualified nurses seem to dash about and don't get anywhere if you know what I mean [LAUGHS] (74).

PAUL   have you got to know any one nurse well?

MARTHA   There were one when I first started but I don't know her name because they move around a lot (75). She told me about her boyfriend and things at home and if she were having any trouble and things like that (76). She moved onto a different ward. And then there's J who washed my dressing gown for me (77), she's just going back into school this week (78). We both started here together. She admitted me, and I was her first patient on here (79).

PAUL   Would you describe those people as being caring in their approach to you?

MARTHA   Yes.

PAUL   What other things make you describe them as caring?

MARTHA Well you can have a conversation with them (80). They are willing to share a bit of their lives with you (81). You know, and exchange it that way rather than it being just a work or hospital footing (82).

PAUL Is there a tendency to keep things on a work or professional footing?

MARTHA I think that sometimes they can do (83) and it's just, it's not that you're being nosey, it's just that when you're in here and alone you feel that you want something to make up for being away from home while you're here.... [BECOMING VERY TEARFUL AND EMOTIONAL BUT WANTS TO CARRY ON WITH THE INTERVIEW] (84).

PAUL So you want people to talk normally with?

MARTHA Yeah (85)....I Do (86).

PAUL Do you feel that as a patient you have been able to give something to those who care for you?

MARTHA Well, I try never to be a nuisance [LAUGHS] (87), I think that is about the biggest thing you can do. Because I mean everybody's got to have their fair share of time, they can't just look after you, they've got other patients (88).

PAUL But with your extensive surgery, you must have needed lots of help? Did you feel guilty calling for assistance?

MARTHA No, not with most of the nurses (89), it might only have been the odd time but whoever came...

PAUL Were there occasions when you were made to feel guilty?

MARTHA Yes, but not generally (90).

PAUL Are there other things which you have given to the carers?

MARTHA I don't know, that's difficult (91)..... Other general things that happen in life, like one day I was washing my hair and I used that polytar shampoo and the nurse said 'What do you use this for?' and I told her it was for a sort of dermatitis. She said her boyfriend had that. So I told her all about it and that it can come through nerves and if something is upsetting you. She said 'It is you know, his business hasn't been going so well'. So I told her to go to the doctor's and get it sorted out because it can make you lose hair. Just general things like that...(92).

PAUL I've got no other questions, are there any other comments you would like to make?

MARTHA No, other than that I've been quite happy, happy as you can be stuck in hospital (93). I've not been unhappy, I do cry but that's because hospital gets to you (94), its not because anybody hasn't done their best.

End of interview

Restatement of text and labelling of main content areas

The text was restated in the third person and reorganised into distinct content areas while preserving the meaning as intended by the informant. The meaning units were arranged under initial labelling phrases or statements which helped to reduce the amount of text for subsequent analysis. These labels were used to identify a particular type of behaviour, feeling or event. This part of the analysis represents stage 5 as described above.

EVALUATION OF PROFESSIONAL ASSISTANCE[2]

Martha found that most of the nurses were very good (2)

The nurses were trusted (3)

The nurses took time to be with Martha (6)

They didn't just nurse her but talked to her as well (7)

The auxiliaries were very good (9)

When there was a shortage of staff the nurses dashed through their work (11)

She felt that some of the staff gave the impression that there were short staffed (18) while others are always relaxed (19) and will ensure that everybody gets cared for (20)

There was a shortage of staff at times (17)

She felt safe with the nurses because of the way they kept a firm hold on her when she had to get in and out of bed (4)

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[2] In this appendix I have used block capitals and bold lettering to emphasise the meanings conveyed to me by the informant. This process helped to condense the volume of text and made the analysis more manageable. In addition, this method of organising the transcripts may be employed very successfully with the help of sophisticated word processing software.

There was a difference between the nurses... some made her feel safer than others (5)

Martha felt at ease with the nurses (8)

Martha felt that she was well looked after (63)

Although she spent six weeks in Leeds hospital she found the staff in Cardiff much nicer (64)

She was told by her doctor in Leeds that her stay in Cardiff would take only two to three weeks (50) but this information was given to her second hand by the hospital in Leeds (51)

THINGS THAT PEOPLE DID

Most of the nurses were very nice and asked if she needed any shopping and things like that (61)

One student nurse took Martha's dressing gown home, washed it and brought it back for her (62)

The nurses brought in magazines for her to look at (65)

The nurses asked if she needed any washing done or needed anything from the shops (66)

When her husband visited the ward the nurses brought in any spare meals so that he could stay with Martha rather than have to go for a meal and come back to the ward later (67)

The nurses were aware of the fact that Martha's husband must travel down to see her by train which means that he spent nine hours on the train in order to spend three hours with her (69)

THE STUDENT NURSES

Martha's favourites were the student nurses (70)

One of the trainee nurses stayed on late to complete Martha's care (21) and she appreciated it (22)

She suggests that if they (the student nurses) remain the way they are now they will be very good nurses (71)

When the student nurses came on duty they didn't dash about (72)... they came and did things at a nice pace and talked to Martha (73)

The qualified nurses seemed to be dashing about without getting anywhere (74)

The students moved around a lot (75)

Martha got to know one of the students well and the talked about her boyfriend and things at home and other things like that, but she moved on to another ward (76)

Martha also got to know another girl (J) who washed her dressing gown (77)... she also left the ward and went back into the school (78)

Martha and J (the student nurse) started on the ward together, J admitted Martha onto the ward (79)

Martha saw these nurses as caring because she could have a conversation with them (80)... and they were willing to share a bit of their life with her (81)

There was an interpersonal exchange rather than having things on a purely work or hospital footing (82)

THE IMPACT OF LONELINESS

When she was alone in hospital Martha felt that she needed something to make up for being away from her home and family (83)

Martha spent eight weeks in hospital (49)

Martha felt that since she was so far from home that it would be nice if someone could spend a few minutes talking to her, rather than just walk in give out the tablets and walk out again (57)

The majority of people did spend some time with her and especially the other patients (58)

Having people spend time with her made a lot of difference to her (59) and it helped her to feel different in herself (60)

Sometimes staff can keep the relationship on a work/professional footing (83)

She felt that she needed something to make up for being away from home during the time she was in hospital and alone (84) [VERY EMOTIONAL AND TEARFUL]

Martha wanted people to talk normally with her (85, 86)

Martha did not feel guilty asking most of the nurses for help, but there were a couple of occasions when she did (89)

She was made to feel guilty occasionally but generally not (90)

Martha felt that her stay in hospital was as happy as it could have been (92)

She cried from time to time because hospital got to her (93)

SELF-PRESENTATION

She tried not to be a nuisance to the staff (87) [LAUGHS, KNOWING THAT HER CONDITION DICTATES THAT SHE WOULD NEED A LOT OF HELP AT SOME POINT]

Not being a nuisance was important because it ensured that other patients got their fair share of care also (88)

It was difficult to identify what she could give to the carers (91)

On one occasion she was able to advise a student nurse about a particular brand of shampoo used to clear up dermatitis (92)

PERSONAL DISLIKES

Martha didn't like it when the nurses were in a rush (10)... especially when she was in pain and knew that she would have to get out of bed and get in to the bath and so on (12, 13)

Martha thought to herself 'My God, they're going to be in a rush'(14), she didn't want to be rushed (15) and this made her feel on edge (16)

STRIVING FOR INDEPENDENCE

Martha found it difficult to have to rely on somebody also to do for her (1).

Martha was used to getting up by herself in the mornings (23), making her own drink (24) and walking about (25) and going to the toilet unaccompanied (26)

She found it very awkward to have to have somebody to help her to go to the toilet with her (27-28)

In the beginning the staff tended to look after her and do everything for her (29)

As time went by Martha found that the staff were well able to judge what she could do for herself (30)

Then they left her to do things for herself (31), like cleaning the foam dressing (32) and seeing to herself generally (33)

Martha felt that the staff paced the move towards independence for her well (34)

As she recovered from the operation the staff left everything ready in the bathroom and told her to carry on (43)

After the second operation Martha had to revert back to being very dependent on the staff again (46)... and she found this very distressing and upsetting (47)

After the second operation and six weeks in hospital she felt as though she had gone right back to square one again (48)

After the operation Martha couldn't get back into bed without help because she couldn't sit up, she had to lie down or stand upright (44)

COPING WITH DISFIGUREMENT

A large piece of skin was removed during the first operation (35)

To begin with, it was very difficult to look at the operation site (36)... she felt like fainting (37)

She had to look at the site twice each day when she went into the bath (38)

She couldn't escape from having to look at the operation site (39)

Martha realised she had a stoma (40) and had reached a stage where she could look after herself and could walk about unsupported (41-42)

A second operation followed this time involving the buttocks (45)

CONCERNS ABOUT HER FAMILY

Martha's husband and mother were still in Leeds and her mother was waiting to go into hospital (52) because she is blind in one eye and has a cataract in the other (54)

Unfortunately there has been a secretaries strike on there and her mother has not been admitted (53)

That was all the family Martha has (55)

Martha hopes that they will both get better together (56)

Identification of the central themes in the interview

The central themes to emerge from the interview which communicate the informants perceptions about the research domain were described. These concur with stages 6-8 in the procedural outline. The text was interrogated to examine its significance for understanding how the informant experienced caring in a hospital context. The text was organised around a number of central themes. Independent validation of the analysis procedure was then carried out. The themes were then examined to identify main themes which illuminate the research interest and accurately reflect the experience of being cared for. A main theme was offered and supported by the constituent themes from which it emerged. In the interview analyzed here, a main theme to surface was a feeling of **crushing vulnerability**. The constituent themes were: hospital was a distressing place; surrendering independence was distressing; only gradually regained independence; traumatic disfigurement and loneliness.

Martha experienced being cared for in hospital at a time of:

1. **Crushing vulnerability**

(a) Hospital was a distressing place

SOMETIMES CRIED BECAUSE HOSPITAL GOT TO HER

She cried from time to time because hospital got to her (93).

(b) Surrendering independence was distressing

HARD TO RELY ON OTHER PEOPLE AND GIVE UP HER INDEPENDENCE

Martha found it hard to have to rely on someone to do for her now (1) because she was so used to getting up by herself in the mornings (23), making her own drink (24), walking about (25) and going to the toilet unaccompanied (26).

FELT AWKWARD BEING HELPED TO THE TOILET

Now she found it very awkward to have to have somebody to help her to get to the toilet (27, 28).

COULD NOT SIT UP AFTER THE OPERATION

After the operation Martha couldn't get back into bed without help because she couldn't sit up, she had to lie down or stand upright (44).

34

BECAME VERY DEPENDENT AGAIN AFTER THE SECOND OPERATION

After the second operation Martha had to revert back to being very dependent on the staff again (46).

VERY DISTRESSING TO BE SO DEPENDENT

She found this to be very distressing and upsetting (47), she felt as though she had gone right back to square one again (48).

(c) Gradually regained independence

STAFF HAD TO DO EVERYTHING IN THE BEGINNING

In the beginning the staff tended to look after her and do everything for her (29).

STAFF WERE ABLE TO JUDGE WHAT SHE COULD DO FOR HERSELF

But as time went by Martha found that the staff were well able to judge what she could do for herself (30). They left her to do things for herself (31), like cleaning the foam dressing (32) and seeing to herself generally (33). Martha felt that the staff paced the move towards independence for her well (34).

STAFF LEFT THINGS READY FOR HER AND LET HER GET ON WITH IT

As she recovered from the operation the staff would leave everything ready in the bathroom and tell her to carry on (43).

(d) Traumatic disfigurement

THE TWO OPERATIONS INVOLVED LARGE SKIN GRAFTS

A large piece of skin was removed during the first operation (35) while the second operation involved the buttock muscle (45).

VERY DIFFICULT TO LOOK AT THE OPERATION SITE

To begin with, it was very difficult to look at the operation site (36).

FELT LIKE FAINTING WHEN SHE LOOKED AT THE SITE

Martha felt like fainting (37).

COULD NOT ESCAPE FROM THE OPERATION SITE

She had to look at the site twice each day when she went into the bath (38) and couldn't escape from having to look at the operation site (39).

REALISED SHE HAD A STOMA

Martha realised she had a stoma (40).

REACHED A STAGE WHERE SHE LOOKED AFTER HERSELF

Eventually reached a stage where she was looking after herself and could walk about unsupported (41, 42).

(e) Loneliness

TOLD IT WOULD ONLY TAKE TWO OR THREE WEEKS

Although she was told by her doctor in Leeds that her stay in Cardiff would take only two to three weeks (50, 51).

NEEDED SOMETHING TO MAKE UP FOR BEING AWAY FROM HOME

When she was alone in hospital Martha felt that she needed something to make up for being away from home during that time (84).

ALREADY SPENT EIGHT WEEKS AWAY FROM HER FAMILY

Martha had already spent eight weeks in hospital far away from her family (49).

OTHER PEOPLE MADE HER FEEL DIFFERENT IN HERSELF

Having people spend time with her made a lot of difference to her (59) and it helped her to feel different in herself (60).

WOULD BE NICE IF STAFF SPENT MORE TIME WITH HER

Martha felt that since she is so far from home that it would be nice if someone could spend a few minutes talking to her, rather than just walk in give out the tablets and walk out again (57).

WANTED PEOPLE TO TALK NORMALLY TO HER

Martha wanted people to talk normally with her (85, 86).

OTHER PATIENTS SPENT TIME WITH HER

However, most people did spend some time with her and especially the other patients (58).

2. Adopted a particular mode of self-presentation

(a) Resigned cheerfulness

HOSPITAL STAY WAS AS HAPPY AS IT COULD HAVE BEEN

Martha felt that her stay in hospital was as happy as it could have been (92).

(b) Tried not to be a nuisance

TRIED NOT TO BE A NUISANCE TO STAFF

Martha tried not to be a nuisance to the staff (87).

NOT BEING A NUISANCE MEANT THAT OTHER PATIENTS GOT THEIR SHARE OF CARE

Not being a nuisance was important because it ensured that other patients got their fair share of care also (88).

DID NOT FEEL GUILTY ABOUT ASKING NURSES FOR HELP

Martha did not feel guilty asking most of the nurses for help (89).

SOMETIMES SHE WAS MADE TO FEEL GUILTY

But there were a couple of occasions when she was made to feel guilty, although this was generally not the case (90).

(c) Little to give back to the carers

COULD GIVE NOTHING BACK TO THE CARERS

On the other hand, Martha could not identify what she could give back to the carers in return (91).

ADVISED THE STUDENT ABOUT A TYPE OF SHAMPOO

On one occasion she was able to advise a student nurse about a particular brand of shampoo used to clear up her own nervous dermatitis (92).

(3) Appraised the symbolic services

(a) General level of satisfaction

THE NURSES AND ESPECIALLY THE AUXILIARIES WERE VERY GOOD

Martha found that most of the nurses were very good (2) especially the auxiliaries (9).

NICE STAFF IN THE HOSPITAL

Although she spent six weeks in a Leeds hospital she finds the staff in this hospital were much nicer (64).

FELT WELL LOOKED AFTER GENERALLY

Generally Martha felt that she has been well looked after (63).

(b) Nurses asked what was needed

MOST NURSES ASKED IF SHE NEEDED WASHING OR SHOPPING DONE

Most of the nurses were very nice and asked if she needed any shopping or washing done and things like that (61, 66).

ONE STUDENT TOOK HER DRESSING GOWN HOME AND WASH IT

One student nurse J, took Martha's dressing gown home, washed it and brought it back for her (62, 77).

NURSES BROUGHT IN MAGAZINES FOR HER

Other nurses brought in magazines for her to look at (65).

(c) Felt safe and trusted the nurses

TRUSTED THE NURSES

Martha trusted the nurses (3).

FELT AT EASE WITH THE NURSES

Felt at ease with them (8).

FELT SAFE WHEN THEY HELD HER FIRMLY GETTING INTO THE BATH

She felt safe with the nurses because of the way they kept a firm hold on her when she had to get in and out of bed (4).

SOME NURSES MADE HER FEEL SAFER THAN OTHERS

However, there was a difference between the nurses... some made her feel safer than others (5).

(d) Sensitive approach of the staff

NURSES GAVE HER HUSBAND A SPARE MEAL SO THAT HE COULD STAY WITH HER

When her husband visited the ward the nurses brought in any spare meals so that he could stay with Martha rather than have to go for a meal and come back to the ward later (67).

NURSES KNEW HER HUSBAND HAD TO TRAVEL A LONG DISTANCE TO BE WITH HER

The nurses were aware of the fact that Martha's husband must travel down to see her by train which means that he had to spend all day on the train to be able to spend three hours with her (69).

(e) Students took time and talked

PREFERRED THE STUDENTS BECAUSE THEY DID NOT DASH ABOUT

Martha's favourites were the student nurses (70) they didn't dash about (72).

THE STUDENTS TALKED TO HER AND DID THINGS AT A NICE PACE

They came and did things at a nice pace and talked to Martha (73).

QUALIFIED STAFF RUSHED AROUND WITHOUT GETTING ANYWHERE

The qualified nurses seemed to be dashing about without getting anywhere (74).

THE STUDENTS WOULD BE GOOD NURSES IN THE FUTURE

Martha felt that if the student nurses stay as they were they would be very good qualified nurses in the future (71).

STUDENTS MOVED AROUND A LOT FROM WARD TO WARD

The students moved around a lot from ward to ward (75, 76).

GOT TO KNOW THE STUDENT WHO ADMITTED HER TO THE WARD

Martha came to know J, one of the student nurses well. Martha and J started on the ward together, J admitted Martha onto the ward (79) but had recently left the ward and gone back into the school (78).

STUDENTS WERE CARING BECAUSE SHE COULD CONVERSE WITH THEM

Martha saw these nurses as caring because she could have a conversation with them (80).

NURSES TOOK TIME AND TALKED TO HER

The nurses took time to be with Martha (6). They didn't just nurse her but talked to her as well (7).

STUDENTS WERE WILLING TO SHARE A BIT OF THEIR LIFE

They were willing to share a bit of their life with her (81).

THE RELATIONSHIP WAS GENERALLY INTERPERSONAL AND SOMETIMES PROFESSIONAL

There was an interpersonal exchange rather than having things on a purely work or hospital footing (82). However, sometimes the staff kept the relationship on a work/professional footing (83).

APPRECIATED WHEN ONE OF THE STUDENTS STAYED LATE TO COMPLETE HER CARE

One of the trainee nurses stayed on late to complete Martha's care (21) and she appreciated it (22).

(f) Busy staff

SOME STAFF GAVE THE IMPRESSION OF BEING SHORT OF STAFF

Some of the staff gave the impression that there were short-staffed (18).

OTHER STAFF WERE ALWAYS RELAXED AND ENSURED PEOPLE WERE CARED FOR

While others were always relaxed (19) and ensured that everybody got cared for (20).

(g) Hurried approach of the staff provoked anxiety

DID NOT LIKE IT WHEN THE NURSES RUSHED ESPECIALLY WHEN SHE WAS IN PAIN

Martha didn't like it when the nurses were in a rush (10)... especially when she was in pain and knew that she would have to get out of bed and get into the bath and so on (12, 13).

BEING RUSHED MADE HER FEEL ON EDGE

Martha thought to herself 'My God, they're going to be in a rush' (14). She didn't want to be rushed (15), it made her feel 'on edge' (16).

NURSES DASHED THROUGH THEIR WORK WHEN THEY WERE SHORT STAFFED

When there was a shortage of staff the nurses dashed through their work (11) and there were shortages of staff at times (17).

4. Important personal concerns

(a) Concerned about the family

FAMILY FAR AWAY AND HER MOTHER WAS ILL

Martha's husband and mother were still in Leeds and her mother was waiting to go into hospital to have a cataract removed (52).

MOTHER WAS BLIND IN ONE EYE AWAITING AN OPERATION

Martha's mother was also blind in one eye (54) but her operation was delayed because of a secretarial strike there so her mother has not been admitted to hospital yet (53).

HUSBAND AND MOTHER WERE ALL THE FAMILY SHE HAD

That was all the family Martha had (55).

HOPED SHE AND HER MOTHER WOULD GET BETTER TOGETHER

She hoped that they will both get better together (56).

Analysis of findings across interviews and relevant literature

The themes which emerged in the interviews were compared across interviews in an effort to discover common themes. This led to a number of minor revisions and alterations to the scheme presented above (see chapter 7). The findings of the nursing group and the patient group were contrasted. A general re-examination of the literature related to the research was undertaken so that the findings may be located with a particular context. This coincides with stages 9-11 of the scheme described here and is discussed in chapter 8.

Appendix 6

The interview write up sheet

Informant number:

Date of the interview:

Other relevant details:

1. General summary of what the informant said

2. Tentative ideas about the analysis

3. Methodological difficulties or successes

4. Personal emotional experiences of the researcher

The interview write-up completed for informant P7

The interview write-up sheet was completed on the day of the interview while the final analysis was complete some months after the actual interview. The write-up sheet helped the research to recollect the specific interview and note points of interest during the more detailed analysis procedure. The example given below was used during the analysis of the this interview.

Informant number: P7.

Date of the interview: 18th May 1989.

Other relevant details: This woman was in her late thirties and had come down from the north of England because she needed very specialised skin surgery. She required two operations and had to spend around eight weeks in hospital. Her husband visited weekly but could only stay for three hours. Her mother was also ill and waiting to go into hospital for eye surgery.

1. General summary of what the informant said

- She found it hard to rely on others
- She needed to feel safe with the nurses
- She was at ease with some of the nurses who took time to talk to her
- She didn't like being rushed
- A trainee nurse stayed on late to see to her
- Being helped to the toilet was awkward
- The nurses judged her ability to help herself well
- Other patients spent time talking to her
- Having people around affected the way she felt in herself
- The student nurses did lots of extra things for her
- There was a big difference between the students and the qualified staff
- The students didn't dash and hurry, the qualified staff did
- The caring students were willing to share aspects of their lives with the patient
- She tried not to be a nuisance to the staff
- She cries because she is in hospital
- She felt that she has been well looked after.

2. Tentative ideas about the analysis

- Note that a number of other patients have also described the students or the untrained staff as more caring.

- Staff paying attention to small details like shopping or the dressing gown incident she described seems to be important.

3. Methodological difficulties or successes

- This informant was easy to talk to and was very willing to share her ideas and views with me. I think a good rapport was established quickly.

- She was willing to share her feelings honestly with me about her stay in hospital and her personal life which was obviously of great concern to her.

- The interview had a natural flow to it.

4. Personal emotional experiences of the researcher

- I felt very sympathetic towards this woman because she was such a long way from home and her family and had to stay in hospital for such a long time.

- When I left the ward I thought about her a lot and genuinely hoped that she would make a quick recovery. When she became tearful during the interview I was very moved. I felt that I should forget about my research altogether and try and help this woman. She was adamant that the interview should proceed however.

- Even some time after the interview I still think about this woman and about what actually happened to her eventually.