THE RESPONSES OF CONSUMERS TO CARING
AND NONCARING EXPERIENCES
DURING HOSPITALIZATION

by

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ABSTRACT

The current focus of health care reform is on improving quality of care, health care processes, and outcomes while decreasing costs. Researchers have found that “caring” is an important component of quality health care from the consumer’s perspective. Patient responses to “caring” experiences may facilitate recovery and well-being. Responses to “noncaring” may actually interfere with therapeutic outcomes and the patient’s well-being. Experiences during hospitalization can greatly influence the consumer’s perception of the quality of health care received, and his or her ability to cope and adapt in an unfamiliar and sometimes threatening environment.

This study describes the responses of consumers to “caring” and “noncaring” experiences during hospitalization from the perspective of consumers. The researcher interviewed 20 patients who had undergone orthopedic surgery in an inpatient setting at approximately 5 days postadmission to the orthopedic unit, and again 8 weeks later in their home environment. Participants were asked to describe their responses to caring and noncaring experiences during hospitalization; how they elicit caring from providers; what they do to prevent or protect themselves from noncaring; and what helps them recover from noncaring experiences. The researcher also examined how Swanson’s mid-range theory of caring fit with consumers’ descriptions of caring and noncaring experiences in an orthopedic surgical setting.

Four themes emerged from responses to caring experiences: “The Way,” “Mutual
Knowing,” “Demonstrating Expertise,” and “Being in Tune.” The themes emerging from noncaring experiences are, “The Way,” “Not Knowing Me,” “Doubting the Provider’s Expertise,” and “Being Unresponsive.”

Patients responded to caring experiences by being encouraged to get through or endure, having decreased anxiety and more calming, developing a positive attitude, having hope for recovery, understanding the plan of care, building trust, and perceiving healing faster. In contrast, when receiving noncaring patients described feeling emotionally upset, suffering physically, not understanding the plan of care, losing trust and security, feeling unsafe, having anxiety about subsequent health care and providers, and utilizing protective and preventive approaches to cope and protect themselves. Interventions emerged that may allow providers to begin to facilitate recovery from noncaring. Responses to caring and noncaring greatly influenced the consumer’s well-being, perception of the quality of health care received, and his or her satisfaction.
To Lynn and Ranae
and all of my patients,

who have told me their stories and trusted me enough to share their joys and their sorrows. You have been my teachers and helped me realize how important it is for us as professionals to think about and understand the meaning of our behaviors as we provide health care to our patients, not just sick or diseased bodies, but real people with human pains, sensitivities, emotions, and responses.
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CHAPTER 1

INTRODUCTION

Statement of the Problem

Hospitals are an important component of our health care system. The American Hospital Association (1994) reports that there were 33.2 million admissions in 1993, the latest year for which statistics are available, at a cost of 301.5 billion dollars. Hospitalized patients must adapt to an environment and experiences that traditionally have not been perceived as “user friendly.” Such experiences include unusual routines; uncomfortable procedures; loss of privacy and control; and potentially radical changes in role, self-image, and body image all superimposed upon serious illness. Thus, experiences during hospital care can have a great impact on consumers’ well-being and their perceptions of the quality of care they receive (Naylor, Munro, & Brooten, 1991).

“Caring” is found to be an important component of quality from consumers’ perspectives (Ludwig-Beymer et al., 1993; Naylor et al., 1991). Studies suggest that relationships between providers and consumers consisting of caring characteristics have the most positive influence on consumer satisfaction (Megivern, Halm, & Jones, 1992; Naylor et al., 1991). Caring is also linked with positive patient outcomes (Benner & Wrubel, 1989; Larson & Ferketich, 1993; Valentine, 1991a, 1991b). Caring and noncaring experiences during hospitalization may significantly influence not only the consumer’s satisfaction with
health care, but also the therapeutic outcome both during and after hospitalization.

The meaning of “caring” to patients within hospital settings has been investigated in a number of studies. The construct of caring is consistently described by consumers as involving highly competent technical practice that includes vigilance and availability (Brown, 1986; Burfitt, Greiner, Miers, Kinney, & Branyon, 1993; Cronin & Harrison, 1988; Larson, 1984; Ludwig-Beymer et al., 1993; Sherwood, 1988; Swanson, 1990) combined with a nurturing interactional relationship in which the consumer is treated as an individual (Brown, 1986; Burfitt et al., 1993; Cronin & Harrison, 1988; Frieswick, 1991; Ludwig-Beymer et al., 1993; Sherwood, 1988; Swanson, 1990). Unsolicited letters to hospital administrators, patient satisfaction questionnaires, and quality of care surveys support these descriptions (Ludwig-Beymer et al., 1993). Responses to these characteristics of caring probably facilitate the achievement of recovery and well-being.

“Noncaring” has been investigated with “caring” in three studies (Frieswick, 1991; Riemen, 1986a, 1986b; Vaughan-Cole & Rigdon, 1988) and anecdotally in studies that focused on caring (Burfitt et al., 1993; Lemmer, 1991; Sherwood, 1988). Noncaring treatment, as described by patients, includes incompetence and negligence; failure to meet emotional or physical needs (Frieswick, 1991; Lemmer, 1991; Sherwood, 1988; Vaughan-Cole & Rigdon, 1988); being physically present, but emotionally distant; being irritable; and treating patients as objects via hurrying, belittling, devaluing actions, and rough handling (Burfitt et al., 1993; Lemmer, 1991; Riemen, 1986a, 1986b; Sherwood, 1988; Vaughan-Cole & Rigdon, 1988). Noncaring experiences exist even in well-respected hospitals and account for unnecessary anxiety, vulnerability, and “trauma,” as described by patients and their families (Lemmer, 1991; Riemen, 1986a, 1986b; Sherwood, 1988; Vaughan-Cole & Rigdon,
Responses to noncaring experiences probably interfere with the achievement of therapeutic outcomes and well-being.

Although the meaning of caring and noncaring experiences during hospitalization has been studied descriptively from professional nurse and patient perspectives, responses to caring and noncaring experiences have not been studied. Given the current focus of health care reform on improving health care processes and outcomes while decreasing costs, this is a significant area of study. The processes and outcomes of caring and noncaring experiences during hospitalization are important. Consumers’ descriptions of instances of caring and noncaring suggest that their responses to these experiences may affect therapeutic outcomes of hospitalization, satisfaction with health care, future management of illness, and subsequent choice of health care providers.

**Statement of Purpose**

The purpose of this study was to describe the responses of consumers to caring and noncaring experiences during hospitalization from the perspective of consumers. In addressing their responses, patients also described experiences that were perceived by them as either caring or noncaring. The specific aims of this study were as follows:

1. Describe the consumer’s short and longer term responses to caring experiences during hospitalization.
2. Describe the consumer’s short and longer term responses to noncaring experiences during hospitalization.
3. Explore interventions that are reported and perceived by consumers as being helpful in recovering from noncaring experiences during hospitalization.
4. Evaluate the fit of Swanson’s mid-range theory of caring (1991, 1993) with caring and noncaring experiences described by consumers in an inpatient, orthopedic surgery setting.

**Research Questions**

The following research questions were addressed in this study:

1. What do consumers describe as their responses to caring experiences during hospitalization?

2. What do consumers do to elicit caring from health care providers?

3. What do consumers describe as their responses to noncaring experiences during hospitalization?

4. What do consumers do to prevent or protect themselves from noncaring experiences during hospitalization?

5. What helps the consumer recover from noncaring experiences during hospitalization?


**Background and Significance**

As a Psychiatric Liaison Clinical Nurse Specialist providing emotional support to patients and their supportive others in medical, surgical, and critical care settings, I have listened to many anecdotal descriptions of consumer experiences during hospitalization. The specific stories shared by patients seem to be chosen because of their positive or negative impact. These stories suggest that caring and noncaring interventions from health care
providers constitute an important part of the consumer’s hospital experience. These anecdotal accounts also suggest that caring experiences may motivate consumers to participate more fully in their treatment plans and thus facilitate therapeutic outcomes. Noncaring experiences, in contrast, seem to divert attention and energy away from a healing focus and towards the mobilizing of defensive and protective behaviors in order to cope with the unsettling responses to health care providers and the hospital environment, and to minimize receiving other noncaring experiences.

A cursory review of the written comments of patients who completed satisfaction surveys at a university hospital reflect the components of caring described earlier: “Nurse X was efficient and quick to respond to my calls”; “Nurse X was kind, respectful, and concerned, contributing greatly to my speedy recovery”; “Nurse X was very attentive and extra caring”; “I was very impressed by Dr. X. She seemed to be very interested in me, and made my husband comfortable and at ease while waiting”; “Dr. X was very positive and I felt well taken care of, listened to, and included in decisions”; and “Dr. X paid particular attention to my needs.”

Noncaring experiences were also described: “One nurse was really grumpy all the time, she seemed as if it was an inconvenience”; “No one offered personal care that was not ordered. A little TLC means a lot”; “When I pushed the call button, it took 10-15 minutes for someone to come”; “At times I felt the doctor became offended because I asked questions, questions that were important to my health”; “Doctors did not explain procedures well. I was not aware of upcoming tests”; and “My doctor has superb surgical skills. I am angry and disappointed he did not work with me on pain control, he was insensitive to post-op pain.”
Watson (1988) suggests “that both nursing and medicine are moving out of an era in which cure is dominant into one in which care takes precedence” (cited in Swanson, 1993, p. 161). She noted, however, that “more is known about treatment and cure than about healing and caring processes” (cited in Swanson, 1993, p. 161). Consumer experiences during hospitalization need to be studied to understand factors that may promote healing in the hospital environment and beyond.

The current focus in health care reform upon quality of care without increased cost has produced a need for more understanding of experiences during hospitalization, and how these experiences influence patients, from the consumer’s perspective. Awareness of responses to caring and noncaring experiences will add to the body of knowledge about caring and quality of care. Sensitization to the effects of caring and noncaring experiences from the consumer’s perspective may result in a more critical appraisal by health care providers of approaches to clinical practice. Understanding responses to caring experiences may result in reinforcement of positive provider behaviors, and increased consumer and provider satisfaction. Conversely, understanding responses to noncaring experiences may result in changes in, or the elimination of, negative provider behaviors in order to more effectively facilitate therapeutic outcomes for consumers during and after hospitalization. Finally, an understanding of the processes and effects of caring and noncaring is vital in teaching the delivery of efficient and effective health care.

**Theoretical Context**

Multiple perspectives and conceptualizations on caring are represented in the literature; there is no consensus, but rather various views. Theories have been criticized for
being abstract, vague, and not based upon or derived from the clinical realities of practicing nurses (Morse, Bottorff, Neander, & Solberg, 1991; Morse, Solberg, Neander, Bottorff, & Johnson, 1990).

Watson's work at the Center for Human Caring is a predominant force in the theoretical development of caring. Watson describes nursing as the philosophy and science of caring, with the goal of attaining and maintaining health or dying peacefully. She views human caring as a moral imperative or ideal that provides the basis for all nursing actions. Transpersonal caring reflects adherence to a moral commitment of viewing human beings as wholes (i.e., mind, body, and spirit), maintaining the individual's dignity or integrity, and nurse-person (patient) relationships that involve mutuality and the nurse's ability to detect what the other person is feeling (Watson, 1979, 1985). The values and assumptions of her theory of caring "reflect a metaphysical, phenomenological-existential, and spiritual orientation that draws upon Eastern philosophy" (Fawcett, George, & Walker, 1989, p. 149).

Gaut (1983) stated "that caring actions must be judged solely on the welfare of the person being cared for" and that the "necessary and sufficient conditions" for caring include

1. Awareness and knowledge about one's need for care.
2. An invitation to act, and actions based on knowledge.
3. A positive change as a result of caring, judged solely on the basis of the welfare of others. There must be [sic] also be an underlying value and moral commitment to care, along with a will to care. (cited in Watson, 1989, p. 227)

Watson (1989) identifies 10 carative factors "that form a structure for studying and understanding the caring process" in nursing:

1. Formation of a humanistic-altruistic system of values.
2. Nurturing of faith and hope.
3. Cultivation of sensitivity to one's self and others.
5. Promotion and acceptance of the expression of positive and negative feelings.
7. Promotion of transpersonal teaching-learning.
8. Provision for a supportive, protective, or corrective mental, physical, sociocultural, and spiritual environment.
10. Allowance for existential-phenomenological-spiritual forces. (pp. 227-228)

These carative factors “require an intention, caring values, knowledge, a will, a relationship, and actions” (Watson, 1989, p. 227), i.e., Gaut’s conditions for caring.

Swanson, a former student of Watson, has empirically developed a mid-range theory of caring (1991, 1993) which served as the theoretical context guiding this study. The heritage of this theory is Watson’s work. Swanson’s mid-range theory was inductively derived and validated through three phenomenological studies in separate perinatal contexts: (a) women who miscarried; (b) pregnant women at social risk; and (c) caretakers (i.e., nurses, parents, physicians, a nurse administrator, social worker, and biomedical ethicist) of vulnerable infants in neonatal intensive care (Swanson, 1990; Swanson-Kauffman, 1986a, 1988a, 1988b).

Swanson (1991) defines caring as “a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility” (p. 165). She further describes caring as acting in a way that preserves human dignity, restores personhood, and avoids reducing persons to the moral status of objects. Swanson (1993) emphasizes key words in this definition:

Nurturing (growth and health producing); way of relating (occurs in relationships); to a valued other (the one cared-for matters); toward whom one feels a personal (individualized and intimate); sense of commitment (bond, pledge or passion); and responsibility (accountability and duty). (p. 354)
Swanson claims that this definition is not limited to nursing and that it should apply to all caring relationships. The mid-range theory of caring, therefore, may be applicable to health care providers across all disciplines in their relationship with patients.

Swanson's theory of caring involves five "overlapping processes" or dimensions: maintaining belief, knowing, being with, doing for, and enabling (see Figure 1). The five overlapping caring dimensions and their subdimensions are considered the major structural components of caring. They are the dimensions of the "over-arching phenomenon" of caring. These processes are not considered unique to nursing, but are proposed as common features of caring relationships in general. The overlapping processes of maintaining belief, knowing, being with, doing for, and enabling, are shown as they structurally relate to each other in Figure 1. These processes are not mutually exclusive and, "in fact, their relationship to each other may be hierarchical" (1993, p. 357). Although the processes may appear linear as diagrammed, many actions within a particular process can directly impact the patient's well-being (Swanson, 1993). The following assumptions relate to Swanson's (1993) mid-range theory of caring:

1. Persons who become patients (i.e., consumers) are viewed as unique beings who are in the midst of becoming and whose wholeness is made manifest in thoughts, feelings, and behaviors. . . . [Each person's life] is influenced by a genetic heritage, spiritual endowment and capacity to exercise free will. (p. 352)

"Free will equates with choice and the capacity to decide how to act when confronted with a range of possibilities." Free will is influenced by each individual person's limitations. These range of possibilities are not "equally available, acceptable and desirable to all persons" (p. 352).
The Structure of Caring

Maintaining Belief

Knowing

Being With

Doing For

Enabling

Philosophical attitudes towards persons (in general), and the designated client (in specific)

Informed understanding of the clinical condition (in general) and the situation and client (in specific)

Message conveyed to client

Therapeutic actions

Intended outcome

Client Well-being

Figure 1. The Structure of Caring by Kristen M. Swanson, Image: Journal of Nursing Scholarship. Reprinted with permission.

The structure of caring as linked to the nurses' philosophical attitude, informed understandings, message conveyed, therapeutic actions and intended outcome.
2. Persons both influence and are influenced by the environment or context in which they exist. “Realms of influence are multiple, including the cultural, political, economic, social, biophysical, psychological and spiritual realms” (p. 353). It is helpful and important “to consider the demands, constraints and resources brought to the situation by the participant(s) and the surrounding environment” (Klausner, 1971, cited in Swanson, 1993, p. 353).

3. Health is delineated by Smith (1981) as the “absence of illness; ability to perform one’s roles; capacity to adapt; and as the pursuit of eudemonistic well-being” (cited in Swanson, 1993, p. 353). Nurses focus on assisting patients to attain, maintain or regain the optimal level of living or well-being they choose given their personal and environmental demands, constraints and resources. Well-being is living in such a state that one feels integrated and engaged with living and dying. . . . To experience well-being is to live the subjective, meaning-filled, experience of wholeness. (p. 353)

Healing is reestablishing well-being.

These assumptions are important in this present study because each perceived caring and noncaring experience is influenced by the patient’s uniqueness and the environment or context. These factors combine to contribute to the consumer’s response.

“The proposed structure for the theory [mid-range theory of caring] depicts care as grounded in maintenance of a basic belief in persons, anchored by knowing the other’s reality, conveyed through being with, and enacted through doing for and enabling” (Swanson, 1993, p. 357). Processes described by Swanson include both the technical and supportive care which meets or exceeds the values and expectations of consumers with clients’ well-being the ultimate goal and intended outcome of provider caring.
The processes are described here as Swanson (1991, 1993) relates them to the nursing profession:

*Maintaining belief* is defined as “sustaining faith in the other’s capacity to get through an event or transition and face a future with meaning” (1991, p. 165). It involves holding others in esteem and believing in them, maintaining a hope-filled attitude with realistic optimism, and includes going the whole distance or enduring with them through their experiences of living and dying. The one caring enables the other to chose a path filled with meaning within the demands, constraints, and resources of the other’s life. Maintaining belief in the other’s capacity to get through events or transitions to achieve a future with meaning and possibilities, in both living and dying, is considered the philosophical underpinning of this model and of professional health care roles.

*Knowing* “is striving to understand an event as it has meaning in the life of the other” (1991, p. 163). The care provider avoids assumptions about the meaning of an event, centers on the patient, and assesses thoroughly the experience of the one cared for. When “knowing,” the provider desires to understand the personal reality of the patient, and allows the selves of both provider and recipient to be engaged.

*Being with* “is being emotionally present to the other” (1991, p. 163); choosing to mindfully be there. It goes a step beyond knowing to include becoming emotionally open to the other’s reality and conveying the message that the other’s experience matters to the one caring. This is conveyed by sharing in the meanings, feelings, and lived experiences of the one cared for, and being available and able to endure with the other. An important part of being with is the caregiver’s responsibility to maintain boundaries and not burden the patient so that the patient has to take care of the caregiver.
Doing for "is doing for the other what he or she would do for... [him or herself] if it were at all possible" (1991, p. 164). It involves therapeutics performed on behalf of the patient’s long-term well-being. This care is comforting, anticipatory, competent, skillful, protective of the patient’s needs, and delivered in a manner that consciously preserves the dignity of the other. It may hardly be noticed consciously, nor will it reinforce the indignity of dependence upon another for care. If done well, it slips into the background.

Enabling is “facilitating the other’s passage through life transitions and unfamiliar events” (1991, p. 164) using expert knowledge for the betterment of the other to facilitate the other’s capacity to grow, heal, and/or practice self-care. Enabling includes providing information; giving emotional support by allowing and validating feelings; and assisting the one cared for to focus on his or her situation, concerns, and alternatives. Enabling highlights the enhancement of self of both the caregiver and the recipient. This enhancement is facilitated by the caregiver’s actions of substitutive care, or doing for when the person is unable to do for oneself, and by promoting self-care. Enhancement of self is contrasted to the diminishment of self of both the caregiver and the recipient by the provider’s misdirected actions of doing more than is necessary to conserve energy and provide dignity. It is important to note the difference in this positive definition of enabling as opposed to its more negative connotation in the codependency literature (Beattie, 1987).

Swanson’s theory (1991, 1993) was utilized to support this investigation of responses to caring experiences, to ascertain whether the theory extends to encompass noncaring experiences and responses to noncaring, and to begin to determine if caring and noncaring are dichotomous or on a continuum in relationship to each other. The researcher selected this caring theory because of its (a) clinically based development; (b) postulated
generalizability to health care providers in general, rather than being restricted to the discipline of nursing (Swanson, 1991); and (c) postulated generalizability by Swanson (1991) to other health care contexts or settings.

Swanson claims that “nursing is informed caring for the well-being of others” (1993, p. 357) and that nursing is not the only profession whose practice involves informed caring:

Data derived from other health professionals and parents in the NICU study and the congruence of the theory with some of the nonnursing literature (Mayeroff, 1971; Gilligan, 1982; Noddings, 1984) . . . [supports] generalizability [of this theory] to relationships other than those occurring just in nursing. (Swanson, 1991, p. 165)

Health care team members provide care collaboratively, affecting each other’s clinical interventions and the consumer’s total experience; therefore, it is important to consider the impact on patients of the health care team as a whole.

The caring processes of Swanson’s theory may also be generalizable to other health care settings:


This theory has been developed in clinical settings involved in the care of socially at-risk adults during pregnancy and the first year postpartum, adults following loss of a fetus or baby, and families and caregivers in a neonatal intensive care unit. Participants in these studies experienced loss and grieving. I have observed in my hospital clinical practice that these are common stressors and processes experienced by patients in varied environments in response to changes in functional level and health during hospitalization. The fit of Swanson’s theory of caring in an orthopedic surgical setting was evaluated in this study.
**Definition of Terms**

For the purpose of this study, the following terms are defined:

*Caring:* “A nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility” (Swanson, 1991, p. 165). Caring relationships include five overlapping processes: maintaining belief, knowing, being with, doing for, and enabling (Swanson, 1991, 1993).

*Noncaring:* Incompetence and negligence; inconsiderateness; failure to meet emotional or physical needs; being physically present, but emotionally distant; being irritable; and treating patients as objects via hurrying, belittling, devaluing, and rough handling (Burfitt et al., 1993; Frieswick, 1991; Lemmer, 1991; Riemen, 1986a, 1986b; Sherwood, 1988; Vaughan-Cole & Rigdon, 1988).

*Consumer:* The hospitalized patient.

**Assumptions**

This study is based on the following values and assumptions:

1. The purpose of health care is the consumer’s well-being.

2. Caring and noncaring experiences are influential forces during hospitalization.

3. Noncaring may interfere with the goal of reestablishing well-being following illness and hospitalization, whereas caring experiences may facilitate well-being.

4. Consumers are able to recognize and describe experiences during hospitalization in which they were the recipients of caring and noncaring.

5. Consumers are able to recognize and describe their responses to caring and noncaring experiences during hospitalization.
6. Consumers are able to recognize and describe what they do to elicit caring and to prevent or protect themselves from noncaring.

7. Consumers are able to recognize and describe what is helpful in recovering from noncaring experiences.
CHAPTER 2

REVIEW OF RESEARCH

Research literature on caring and noncaring related to hospitalized consumers and their health care providers is reviewed in the first three sections of this chapter. The first section presents literature on caring and noncaring from patients’ perspectives followed by a section on caring and noncaring from nurses’ perspectives. Literature that combines and compares caring and noncaring from both patients’ and nurses’ perspectives is then reviewed. In addition, section four of this chapter discusses studies that relate consumer perceptions of quality and satisfaction to characteristics of caring. This chapter is organized in this manner because perceptions of caring and noncaring appear to be influenced by whether one is the recipient of care or the deliverer and by the specialty area in which the provider-patient interactions occur. Each section concludes with a summary. Summaries for the first two sections (i.e., patients’ perspectives and nurses’ perspectives) will include study findings and how they relate to Swanson’s theory of caring.

Patients’ Perceptions of Nurse Caring and Noncaring

Several studies have described “caring” in hospital settings from the view of health care consumers (Brown, 1986; Burfitt et al., 1993; Cronin & Harrison, 1988; Frieswick, 1991; Larson, 1984; Riemen, 1986a, 1986b; Sherwood, 1988; Swanson, 1991; Swanson-Kauffman, 1986a, 1988b).
Larson (1984) studied patients' perceptions of caring using a sample of hospitalized cancer patients. This population was chosen because cancer patients were believed to be "experienced" patients and to have frequent contact with nurses. In her work, Larson interprets caring by providing a definition of its outcome. The outcome of caring for the consumer is the achievement of a sense of feeling cared for by the nurse. By experiencing the caring of nurses, patients should gain a sense of well-being and safeness. Caring is conveyed to patients through specific actions by the nurse and through the accumulated experience of nurse behaviors in the interaction with the patient.

Larson (1981) developed the Caring Assessment Instrument (CARE-Q) to measure those nursing behaviors that are perceived as conveying caring. In this study of cancer patients (Larson, 1984), a convenience sample of patients (N=57) was obtained from many different units within two community hospitals (i.e., one urban and one rural) and a large teaching and research hospital. Both team and primary nursing models were represented amongst these units. The purpose of this study was to determine the most and least important caring behaviors using the CARE-Q instrument. Perceptions of the most important caring behaviors reflect considerable divergence. Nine patients agreed on, "Puts the patient first no matter what else happens" and six patients agreed on, "Knows how to give shots and I.V.s . . . and manage the equipment." Four of the 10 items ranked as most important, by mean scores, were in the "Monitors and Follows Through" subscale, followed by three in the "Accessible" subscale, two in "Comforts," and one in the "Trusting Relationship" subscale. The nurse caring behaviors ranked as most important by patients (i.e., highest mean score items) were, "Knows how to give shots, IVs, etc., and how to manage the equipment" and "Knows when to call doctor." Subjects show little agreement
on the least important items. Five of the 10 least important items were in the “Trust
ging Relationship” subscale; two in the “Comforts” subscale; and the remaining items were from
“Accessible,” “Explains and Facilitates,” and “Monitors and Follows Through” subscales.
The two lowest rated behaviors were, “Asks patient what name he/she prefers to be called”
and “Checks out the best time to talk with the patient about changes in physical condition.”
Competence in performing clinical skills is reported as more important to the majority of
patients than psychosocial skills, which are important only after basic physiological needs
are met.

Larson continued her work by studying nurses’ perceptions (1986) and then by
comparing nurses’ and patients’ perceptions of the most and least important caring behaviors
(1987). Several replication studies have been done and will be discussed in the third section
of this chapter.

In a phenomenological study, Riemen (1986a, 1986b) interviewed 10 nonhospitalized
adults (five female and five male) who had prior experience with nurses. This study focused
upon the “essential structure” of a caring or noncaring nurse-client interaction from the
client’s perspective. The participants were selected at random from a pool of eligible
students, faculty, and staff from a university. Interviews were conducted to obtain verbal
descriptions of perceptions of caring and noncaring interactions with nurses. Participants
were asked to describe a personal interaction with a nurse that was caring and how it felt in
that interaction. Participants were also asked to respond to the same questions for a
noncaring interaction.

Three common themes of caring and noncaring interactions emerged from Riemen’s
study:
1. The nurse’s presence

2. The client’s uniqueness

3. Consequences

The nurse’s “existential presence” of caring means that the nurse’s physical and mental presence is available for the client’s use not only when the client calls, but also when the client needs the nurse’s presence, but does not solicit it. “He or she is voluntarily or willingly and consciously present” (1986a, p. 102). The noncaring nurse is “present only to get the job done (1986b, p. 34). The physical presence is available briefly or not at all even when solicited. In caring interactions, the nurse recognizes the patient as “a unique, thinking, feeling human being” (1986a, p. 103). The nurse’s caring recognition of the “client’s uniqueness” occurs by really listening and responding to the client as a valued individual. The noncaring nurse is unaware of the client’s uniqueness due to not really listening and appearing too busy. Actions of the nurse that are degrading and belittling cause the client to be devalued as a unique individual. “Consequences” of caring interactions include feeling comfortable, secure, at peace, and relaxed; whereas noncaring interactions result in the client feeling frustrated, scared, depressed, angry, afraid, and upset.

In the article focused upon the noncaring data of this study, Riemen (1986b) identifies more completely clients' perceptions of noncaring by grouping their significant statements under the following headings: (a) “Being in a hurry and efficient,” (b) “Doing a job,” (c) “Being rough and belittling patients,” (d) “Not responding,” and (e) “Treating patients as objects.” Riemen (1986a) states that caring “is not only what the nurse does in the way of physical acts of assistance, but what the nurse is” (p. 103). Being available and really listening are reported to be some of the most important aspects of caring.
In another phenomenological study, Brown (1986) studied perceptions of caring of medical/surgical patients with non-life threatening conditions using a convenience sample of 50 patients, ages 22-65, who were hospitalized 2-5 days. Participants were asked to describe an experience (i.e., “critical incident”) in which they felt cared for or cared about by a nurse. Participants were asked to describe this critical incident in terms of what they needed and what the nurse did. A Likert-type instrument was developed and used to determine the importance of nursing behaviors rated as indicators of caring.

Data were analyzed to identify the process through which caring occurs. Eight care themes are found:

1. “Recognition of individual qualities and needs” is characterized by modifying care to personalize and fit unique needs, and doing something “extra” that is not normally required.

2. “Reassuring presence” is characterized by the nurse being comforting, reassuring, and supportive.

3. “Provision of information” is characterized by both formal and informal teaching about the patient’s condition, treatment, and the hospital environment.

4. “Demonstration of professional knowledge and skill” is characterized by the nurse taking immediate and effective action in urgent situations.

5. “Assistance with pain” is characterized by direct actions to relieve pain and actions to help the patient manage the pain.

6. “Amount of time spent” is characterized by the nurse taking more time than is actually necessary to do something for the patient, and being patient, slow, quiet, and not rushed. The actions are important, but are less important than the time spent.
7. “Promotion of autonomy” is characterized by interactions validating the patient’s responsibility and right to participate in decisions, and recognizing and using the patient’s knowledge of self.

8. “Surveillance” is characterized by keeping the physical condition of the patient under watch. The emphasis is on the safety of the patient.

Two patterns of combined themes are found with further analysis. “What the Nurse Does,” the first pattern, includes demonstration of professional knowledge and skill, surveillance, providing information, and assisting with pain. “How the Nurse Does,” the second pattern, includes recognition of individual qualities and needs, promotion of autonomy, amount of time spent, and reassuring presence (Brown, 1981/1982). Time spent is found to be an underlying theme in the majority of critical incidents (Brown, 1986). A four-part process of care emerged: (a) a patient’s perception of a need or wish that he or she cannot satisfy, (b) accurate recognition and acknowledgment of the need by the nurse, (c) action taken to satisfy the need that is perceived by the patient as beneficial and congruent, and (d) the action conveys to the patient that the nurse recognizes and appreciates “the patient’s worth and competency to know and attend to self” (1986, p. 61). 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)” (1986, p. 61). Both the nurse’s actions and how those actions are performed are important.

Swanson-Kauffman (1986a, 1988b; Swanson, 1991) also conducted a phenomenological study that combined elements of ethnography and grounded theory to guide data collection and analysis. The question that guided this study was, “What
constitutes caring in the instance of miscarriage?” Twenty married women, who had experienced miscarriages prior to 16 weeks gestation, were selected by purposive sampling. Participants were asked to describe their miscarriage experiences and caring needs. Data were collected via two interviews. Professionals and nonprofessionals are found to convey caring through five categories: (a) knowing, (b) being with, (c) doing for, (d) enabling, and (e) maintaining belief. These categories became the five caring processes of Swanson’s theory of caring. “Knowing” is communicated as personalized, comforting, supportive, and healing care, in contrast to nonknowing which is perceived as mechanical, routine, impersonal, and cruel. “Being with,” which goes beyond knowing, is described as feeling with the woman who miscarried. “Doing for” describes the woman’s need to have others do things for her at the time of her loss. “Enabling” describes caring that allows and assists the woman to grieve and get through the loss. Giving information, which serves as permission to grieve, is important and validating in this enabling process. “Maintaining belief” indicates the others’ belief in the woman’s capacity to get through the loss and decide about future pregnancies, and is the provision of hope.

In a descriptive study, Cronin and Harrison (1988) identified nursing behaviors perceived as indicators of caring by hospitalized patients after myocardial infarction. After transfer to a transitional unit, a convenience sample consisting of 22 patients were interviewed using an open-ended question and the Caring Behaviors Assessment (CBA). The CBA is a Q-sort instrument developed by the researchers and used in this study consisting of 61 nursing behaviors ordered in seven subscales “that are congruent with Watson’s carative factors” (p. 377). Research questions focused on identifying (a) nursing behaviors perceived as caring; (b) the most and least important caring behaviors; and (c)
whether patients' perceptions of caring differ with sex, age, education level, number of CCU admissions, or length of CCU stay. The relative importance of each identified behavior, analyzed by mean scores, reveals that nursing actions that focus on physical care and monitoring are most indicative of caring. Extra individualized aspects of care are less important in the critical care setting. The most important items in descending order were, “Know what they are doing”; “Make me feel someone is there if I need them”; “Know how to give shots, IVs, etc.”; “Know how to handle equipment”; “Know when it is necessary to call the doctor”; “Do what they said they will do”; “Answer my questions clearly”; “Be kind and considerate”; and “Teach me about my illness.” No significant differences in perceptions of caring are found on the basis of sex, age, education level, number of CCU admissions, or length of CCU stay with one exception; participants who had previously been in a CCU rated the subscale “Expression of positive/negative feelings” higher than those participants who had not.

Sherwood (1988) studied hospitalized, postoperative adult patients’ perceptions of what the nurse did for and with patients that demonstrated caring. A convenience sample of five males and five females recovering from general surgery were interviewed. Patterns that emerged were developed into common themes and then grouped to form five categories within caring:

1. Assessing Needs--what was needed or expected,
2. Planning Care--preparation and knowledge for managing care,
3. Intervening--response to needs,
4. Validating--evaluating nursing action and participant’s condition, and
5. Interactional Attitude--positive, growth producing interactions. (p. 2133-2134B)

In addition, patients described both mental and physical responses to demonstrations of
caring. The researcher recommends further study to determine the effects of caring on consumer recovery. Unsolicited variations on the themes of caring include anecdotal descriptions of noncaring. Noncaring characteristics “centered around impersonal interaction, lack of information, no action nor help, incompetence, hurrying, and nonavailability” (p. 2134B).

The primary purpose of a descriptive study by Frieswick (1991) was to describe hospitalized patients’ perceptions of caring and noncaring experiences. This study followed an interpretive paradigm of research and analysis. It attempted to both describe human experience as it appeared and to understand the significance of the experience to the individual. Data were analyzed through an interpretive paradigm with metaphors used to present the findings. Five metaphors are identified that describe patients’ experiences of caring: (a) caring is treating one like a member of a family; (b) caring is treating one as a person, not a patient; (c) caring is understanding how I feel; (d) caring is putting one back together (i.e., the power to heal); and (e) caring is going out of your way. Four metaphors are identified to describe experiences of noncaring: (a) noncaring is abandonment, (b) noncaring is a lack of competency, (c) noncaring is not listening to what I’m saying, and (d) noncaring is shame and humiliation. Findings indicate that nurses may not fully appreciate the importance of surveillance to patients. Providing frequent surveillance and assistance with physical needs are described as caring actions by 78% of the participants. Care providers who demonstrate a holistic view of the patient and an understanding of the patient’s personal needs are perceived to be caring. The emergence of a hierarchy of nursing and medical care is suggested by these data.

A descriptive study that utilized aspects of grounded theory methodology focused
upon parents' experiences of bereavement following perinatal losses through stillbirth and neonatal death (Lemmer, 1991). This study attempted to determine what bereaved parents perceive as helpful expressions of caring. The intent of this study was to “develop a description of the human experience of perinatal bereavement that would sensitize health care providers to the needs and concerns of bereaved parents” (p. 476). Criteria for inclusion specified married mothers and fathers who had experienced a third trimester stillbirth or neonatal death between 3 weeks and 14 months previously. Fifteen couples were selected utilizing convenience sampling from two NBICUs, a genetics clinic, and three self-help SHARE support groups. The total sample involved 28 parents with 2 fathers refusing to participate. An interview guide with three questions was utilized:

1. When you think of the people who have helped you most to get through this experience, what is it they have said or done that you found helpful?
2. Who were those people?
3. What were caring actions of the nurses (and physicians) who have cared for you during this time of loss? (p. 478)

Content analysis was utilized to analyze the data concurrently with subsequent interviews. Findings regarding perceptions of caring by nurses and physicians are divided into two major categories: (a) “taking care of,” which includes those activities that are designed to meet the physiological and safety needs of the mother and baby, and family informational needs by providing expert care and information; and (b) “caring for or about,” which includes those activities that demonstrate sensitivity to and empathy for the parent’s emotional pain of bereavement with the desire to help them through it. Caring for or about focuses upon providing direct emotional support, providing individualized, family-centered care, acting as a surrogate parent, facilitating the creation of memories, and respecting the
rights of parents. These categories and their subcategories are reported by Lemmer to resemble Swanson-Kauffman’s (1983, 1986) “doing for” and “enabling” categories.

Parents’ perceptions of noncaring are most often related to unmet emotional needs; however, issues of failure to meet physiological or safety needs are also included. These perceptions of noncaring are most often expressed when emotional needs are not met (Lemmer, 1991). Mothers were critical of issues that “focused primarily on nurses’ failure to acknowledge or respond appropriately to the loss as they carried out routine tasks” (p. 485); seeming busy and insensitive. Fathers were displeased “when nurses failed to answer call lights promptly, when they seemed reluctant to give pain medication, or when they were perceived to inflict pain” (p. 484). Some parents perceive noncaring nurses and doctors as failing to recognize the family’s unique needs by not knowing how to talk about death, not being able to understand, and being too busy. In this study, commonly mentioned problems are:

(a) care providers’ failure to validate their perceptions of what individual parents wanted with respect to their care, (b) physicians’ failure to communicate treatment plans and prognoses for individual babies with the nursing staff, and (c) nurses’ failure to report relevant information about a family’s preferences of needs during shift reports. (p. 486)

Time constraints and failures in communication between care providers and parents and among care providers themselves are “often at the root of the tensions” (p. 486).

Burfitt et al. (1993) studied patients’ perceptions of nurse caring exhibited by professional nurses in critical care and descriptions of the meaning of these demonstrations of caring. This study utilized a phenomenological approach. Thirteen hospitalized patients (six female, seven male) who were in a medical or coronary critical care unit for at least 48 hours were interviewed within 48 hours of the transfer from the unit. Participants responded
to two open ended questions: “(1) Think about your experiences while in the critical care unit. How did the different nurses demonstrate caring in what they did for you and with you? and (2) Try to describe for me how you felt when the nurses demonstrated caring” (p. 493).

Patients did not separate their observations of caring behaviors from their feelings elicited. Both are incorporated into three categories: (a) vigilance, (b) mutuality, and (c) healing. “Vigilance” is alert watchfulness. It consists of attentiveness, highly skilled practice, going beyond the basics, and nurturing as subthemes. “Mutuality” is “an awareness of having engaged in a reciprocal process” (p. 495). The subthemes of mutuality include nurse attributes such as nice, helpful, great, and professional, and family involvement. “Healing” consists of lifesaving behaviors and energy-freeing acts as subthemes. This study concludes that “caring in a critical care unit is attentive, vigilant behavior on the part of the nurse. This vigilance embodies nurturance and incorporates highly skilled, technical practices, as well as basic nursing care and beyond” (p. 489). Caring is viewed by the researchers as a mutual process in which healing is the outcome.

In this study (Burfitt et al., 1993), patients talk about noncaring behaviors directly, indirectly, and via contradictory descriptions as they describe caring. Descriptions included irritability, rough handling, and not doing the job as if waiting for someone else to do it. In addition some behaviors are found to be simultaneously caring and noncaring, or too much caring related to patients’ continual assessments and treatments.

**Summary**

Nine studies about caring from the consumer’s perspective were reviewed; two of which also studied noncaring (Frieswick, 1991; Riemen, 1986a, 1986b). Patient populations
included cancer patients in acute care (Larson, 1984); medical-surgical patients with non-life threatening illnesses (Brown, 1986); postpartum patients who had experienced miscarriages, stillbirths, or neonatal deaths (Lemmer, 1991; Swanson-Kauffman, 1986a, 1988b); patients postmyocardial infarction (Cronin & Harrison, 1988); general surgery postoperative adults (Sherwood, 1988); and patients postmedical and coronary critical care (Burfitt et al., 1993). Two studies did not specify specialty areas (Riemen, 1986a, 1986b; Frieswick, 1991). Most samples were not controlled for severity of illness, number of hospitalizations, length of stay, or demographics.

Seven of the studies were qualitative descriptive studies. Five of these utilized phenomenological approaches (Burfitt et al., 1993; Brown, 1986; Riemen, 1986a, 1986b; Sherwood; 1988; Swanson-Kauffman, 1986a, 1988b), one utilized aspects of grounded theory (Lemmer, 1991), and one utilized an interpretive paradigm with metaphors (Frieswick, 1991). Two of the studies were quantitative descriptive studies; both utilized descriptive correlational approaches (Cronin & Harrison, 1988; Larson, 1984).

Findings indicate that consumers perceive both technical or instrumental competence and affective or expressive competence as caring. These studies support Swanson’s (1991, 1993) definition of caring and the caring processes: “knowing,” “being with,” “doing for,” “enabling,” and “maintaining belief.” Competence in performing clinical skills is more important than providing emotional support, if a patient is forced to make a choice (Cronin & Harrison, 1988; Larson, 1984). Rather than choosing a priority; however, the consumer values what the nurse does (knowing and doing for), how the nurse does it (knowing, being with, doing for, and enabling), and what the nurse is (maintaining belief, knowing, and being with) in combination (Brown, 1986; Frieswick, 1991; Sherwood, 1988; Swanson-Kauffman,
The nurse’s presence and surveillance (being with), especially when not solicited, and recognition of the client’s individual uniqueness (maintaining belief and knowing) through really listening (being with) are identified as important characteristics of caring (Brown, 1986; Burfitt et al., 1993; Frieswick, 1991; Lemmer, 1991; Riemen, 1986a, 1986b; Swanson-Kauffman, 1986a, 1988b). The importance of availability and utilizing expert knowledge and skills to assess and meet needs is emphasized (knowing, being with, and doing for) (Burfitt et al., 1993; Brown, 1986; Cronin & Harrison, 1988; Larson, 1984; Swanson-Kauffman, 1986a, 1988b). These nursing actions must be delivered in a sensitive, empathic, and enhancing manner that offers encouragement, hope, and promotes mutuality, healing, and autonomy (maintaining belief and enabling) (Brown, 1986; Burfitt et al., 1993; Cronin & Harrison, 1988; Frieswick, 1991; Lemmer, 1991; Swanson-Kauffman, 1986a, 1988b). Caring is a mutual process of nurturing and highly skilled technical practices. Consequences of caring include feeling comfortable, secure, at peace, relaxed, experiencing a freeing of energy, and healing (i.e., well-being) (Riemen, 1986a). The emphasis on specific characteristics of caring seem to vary according to specialty area. For example, bereaved populations place emphasis on sensitivity and understanding (Lemmer, 1991; Swanson-Kauffman, 1986a, 1988b), whereas critical care populations place emphasis on vigilance (Burfitt et al., 1993).

Two studies (Frieswick, 1991; Riemen, 1986a, 1986b) asked patients to describe their perceptions of noncaring. Other studies discovered anecdotal findings regarding noncaring (Burfitt et al., 1993; Lemmer, 1991; Sherwood, 1988). Findings indicate that consumers experience noncaring when nurses are in a hurry, impersonal, and efficiently present, just to get the job done without listening and responding to them as individuals (Burfitt et al., 1993;
Frieswick, 1991; Lemmer, 1991; Riemen, 1986a, 1986b). Patients feel devalued and degraded when being treated as an object and by rough and belittling actions (Burfitt et al., 1993; Riemen, 1986a, 1986b). Noncaring is perceived as failure to meet physical or emotional needs, abandonment, and incompetency (Burfitt et al., 1993; Frieswick, 1991; Lemmer, 1991). Some behaviors and routines in critical care can be simultaneously perceived as caring and noncaring (Burfitt et al., 1993). Consequences of noncaring for the consumer include feeling frustrated, scared, depressed, angry, upset, afraid, shamed, and humiliated (Frieswick, 1991; Riemen, 1986a, 1986b).

**Nurses’ Perceptions of Nurse Caring Behaviors**

Several studies have described caring from the view of the nurse as a professional health care provider (Chipman, 1991; Forrest, 1989; Ford, 1981; Kahn & Steeves, 1988; Larson, 1986; Mangold, 1991; Morrison, 1989; Ray, 1987; Wolf, 1986). Ford (1981) surveyed 192 professional nurses regarding their definitions of caring, descriptions of caring behaviors, and examples of how they model caring in their nursing roles. The convenience sample of nurses included three subsamples: (a) members of the state nurses’ association, (b) nurses working in education, and (c) nurses practicing clinically. In this descriptive study, 81 nurses (42%) responded. Each questionnaire was analyzed separately and summarized into content units which were then classified into categories. The three subsamples agreed upon two major categories regarding definitions of caring: (a) genuine concern for the well-being of another and (b) giving of oneself. Nursing actions included in this definition are listening, empathy, and respect. Regarding the most representative behavior of caring and the behavior used during role modeling, listening was
the only category agreed upon. The relationship oriented or affective domain is identified as caring in this study.

Affective nursing behaviors are also identified as most important in “making patients feel cared for” by a convenience sample of 57 nurses (Larson, 1986). The sample consisted of nurses who provide care to cancer patients in two acute-care settings. The instrument used in this study was Larson’s CARE-Q. The behaviors selected as being most important in descending order were listening, touching, allowing expression of feelings, individualizing care, talking to patients, realizing the patient knows him or herself best, perceiving the patient’s needs, giving a quick response to calls, putting the patient first, and giving good physical care.

Wolf (1986) asked a convenience sample of 97 nurses from secondary and tertiary health care settings to select and rank words described as caring using the Caring Behavior Inventory (75 words and phrases on a 4-point Likert scale). The 10 highest ranked words or phrases in descending order were attentive listening, comforting, honesty, patience, responsibility, providing information so the patient can make informed decisions, touch, sensitivity, respect, and calling the patient by name. Most of these descriptors also fall within the affective domain of nursing.

Using a phenomenological approach and a small purposive sample of eight critical care nurses in a suburban medical center, Ray (1987) interviewed nurses asking, “What is the meaning of caring to you in the critical care unit?” Five themes that include maturation, technical competence, transpersonal caring, communication, and judgment/ethics express caring in this study. Caring emerges when the nurse (a) grows: a maturation process in which the nurse receives satisfaction from interpersonal relationships and recognizes one’s
own mortality; (b) achieves technical competence; (c) bonds through giving and receiving via touching, forming an attachment—an emotional investment, meeting inner fears, making the patient feel safe, offering compassion, being emotionally and physically present, and comforting—relieving pain; (d) communicates collegiality with the other nurses and physicians, and by being with, talking to, listening, keeping the family informed, and establishing a rapport with the patient and family; and (e) understands the conflict within “suffering and sadness; in grief and death; in trust and decision” (p. 168). Caring is trust among patients, families, nurses, and physicians. It is “choice” for patients and “right decisions” from providers. Caring in this critical care setting is identified as a moral and ethical process involving both human and technical aspects. This study found that it was only after a nurse reached a “comfortable level of technical competence” that the nurse “concentrated more fully on the needs of the patient and family” (p. 169).

Forrest (1989) also used a phenomenological approach in a study of 17 staff nurses (2 male, 15 female) in a university hospital. The participants were asked, “As a nurse, what is caring for you?” The nurses who responded to study advertisements posted around the hospital and in the hospital newsletter were in staff positions on medical, surgical, psychiatric, and pediatric units. Two broad classifications emerged from the data. Under the first classification, “What is caring?” two theme categories of involvement and interacting are derived. The “essential structure” of caring is

first and foremost a mental and emotional presence that evolves from deep feelings for the patient’s experience. Being able to put oneself into the patient’s position is the source for the depth of feeling which allows the nurse to “put the patient first” in both mind and action. (p. 818)

Caring actions are described as arising “from feeling with and for patients,” and as
interactions developed from “anticipating needs and responding to subtle cues” (p. 818).

The second classification, “What affects caring?” includes the five theme categories of (a) oneself, (b) the patient, (c) frustrations, (d) coping, and (e) comfort and support. There is a potential “dilemma” in either caring too much or caring too little. Caring intent and actions are described as being influenced by “one’s own background and learning, one’s feelings and responses to patients, patient responses, and the frustrations experienced at work” (p. 818). The capacity to care is described as being sustained through teamwork and by comfort and support from coworkers and supervisors. In other words, the nurse who feels cared for can be caring with patients. Fellow nurses whose actions seem noncaring in the manner in which they treat their patients create frustration and disappointment. A limitation in Forrest’s study is that given the volunteer nature of the sampling the subjects may represent unique views or exemplars in nursing.

Twenty-five charge nurses were interviewed about themselves as “professional carers” (Morrison, 1989) using Kelly’s personal construct theoretical framework and the Repertory Grid Technique (Bannister & Fransella, 1980; Fransella & Bannister, 1977; Kelly, 1955, cited in Morrison, 1989). “Stratified informant sampling” (Smith, 1981, cited in Morrison, 1989) was utilized to select individuals occupying leadership roles. Participants included males and females working in general, psychiatric, pediatric, and midwifery specialty areas in hospital and community settings. Nurses were asked to rate “myself as a carer” and “how I would like to be as a carer (ideal self)” using a bipolar construct and a seven-point rating scale. This made it possible to identify discrepancies between nurses’ perceptions of “themselves” and their “ideal selves.” The degree of discrepancy was measured by a simple difference score, with discrepancies assumed to be indicative of a need
for personal change. Within the possible 0-48 range of difference scores, the range observed was 1-20 with a mean difference score of 10.96. All of the participants perceived shortfalls in themselves. Interestingly, 12 of the participants did not rate their caring ideal in the extreme high end on some elements. These participants described protecting themselves from stress and burnout; the personal costs of caring from their view. The author acknowledges that there may have been some problems that could have arisen from the self-rating procedure and “the fact that an 'ideal self' . . . [was] under consideration” (p. 423). Participants may not honestly report value-laden perceptions of self.

Kahn and Steeves (1988) chose a purposive sample of 25 nurses (19 female and 6 male) in their first quarter of a masters degree program considering this “group in transition” ideal for eliciting thoughtful reflection. The students were recruited by a letter of invitation and practiced in a variety of settings. The study utilized a hermeneutical design to explore the meaning for nurses of a caring relationship between nurses and patients. Interviews were structured around three areas of content: (a) words/phrases synonymous with caring along with contextual descriptions, (b) clinical exemplars from clinical practice that illustrate caring, and (c) specification of semantic principles underlying the meaning of caring. Participants “were asked to relate the language they used in talking about the nurse-patient relationship and stories from their practice illustrating the presence and absence of caring” (p. 201).

Data analysis was guided by three heuristic questions: (a) “What is the meaning of caring?” (b) “What conditions elicit caring?” and (c) “What conditions limit caring?” The “overall structure of caring” includes four themes:

1. ideological context
2. liking as the basis for caring

3. praxis, or the actions of the nurses in face-to-face encounters with patients

4. attributions for caring

The “ideological context” theme includes caring categories such as the belief that caring (a) “underlies professional identity,” (b) “requires seeing persons as unique individuals,” (c) “requires compassion and empathy,” and (d) “requires therapeutic relationships” (p. 205). Caring can be limited by distance and objectivity. The “liking” theme includes caring categories such as “fitting with someone,” liking someone, friendship, and “is reciprocated through personal recognition” (p. 207). Caring is absent if there is animosity and an inability to get along.

Central to caring is the “praxis” theme which includes caring categories such as physical and nonphysical actions, insisting on independence, actions to improve the status of patients, communication, and being an advocate and liaison. Praxis conveys caring if actions are not done in a mechanical or routine way. The “attributions” theme contains “factors that form during the encounter between nurse and patient” (p. 211). This theme includes the reasons why caring relationships are or are not developed. These reasons center around praxis. Caring is elicited when

(1) Patients are in dire circumstances
(2) Patients have multiple, psychosocial problems
(3) Patients rely on the nurse
(4) Patients are alert and personable
(5) The nurse can make a temporal investment.

Caring is limited by

(6) Temporal circumstances
(7) Factors that are the nurse’s responsibility
(8) Patients’ actions that cause problems
Patients’ unwillingness to communicate
Patients’ poor self-images. (p. 209)

This study indirectly addresses the ethical implications when caring is dependent upon the patient exhibiting likable behavior.

Second-year diploma students (N=26) were asked to describe “critical incidents” in which they observed nursing behaviors conducted in caring and noncaring ways (Chipman, 1991). This qualitative study was conducted to clarify the meaning and value of caring at a school preparing to adopt Watson’s theory of caring as their theoretical curriculum guide. Data were analyzed by searching for emerging themes and categories via comparisons and contrasts. Nurse behaviors considered caring are described in humanistic terms and categorized as follows: (a) “giving of self,” (b) “meeting patients’ needs in a timely fashion,” and (c) “providing comfort measures for patients and families” (p. 172). None of the respondents described technical competence as caring nurse behaviors. Noncaring behaviors are categorized as (a) “not giving of self,” (b) “not meeting patient’s needs in a timely fashion,” and (c) “not providing comfort to the patient, or aiding in his discomfort” (p. 174).

Mangold (1991) identified senior baccalaureate nursing students’ perceptions of effective care behaviors and compared areas of agreement and disagreement between student and professional nurses using Larson’s (1981) CARE-Q. Each group consisted of 30 volunteers, with all 60 participants (57 female, 3 male) returning their instrument. Students and professionals disagreed on only 6 of the 50 items. Student nurses ranked care behaviors by subscales from the highest to lowest as “comforts,” “explains,” “monitors,” “anticipates,” “accessible,” and “trusts.” Professional nurses ranked “trusts” the highest followed by
“accessibility,” “anticipates,” “monitors,” “explains,” and “comforts.” Both groups agreed that “listens to the patient” was the most important behavior.

**Summary**

Nine studies about caring from the nurse’s perspective were reviewed. Nurse populations included diploma program students (Chipman, 1991), baccalaureate program students (Mangold, 1991), incoming masters students (Kahn & Steeves, 1988), state nurse association members (Ford, 1981), staff nurses in a variety of settings (Forrest, 1989; Larson, 1986; Ray, 1987; Wolf, 1986), charge nurses (Morrison, 1989), nurses working in education (Ford, 1981; Mangold, 1991), and masters level nurses in education and management (Mangold, 1991). Most samples were not controlled for educational level, experience, or demographics.

Five of the studies were qualitative descriptive studies. Two of these were descriptive; one utilized interview questions (Chipman, 1991), one utilized a survey (Ford, 1981); two utilized phenomenological approaches (Forrest, 1989; Ray, 1987); and one utilized a hermeneutical design (Kahn & Steeves, 1988).

Four of the studies were quantitative descriptive studies; of these, three were descriptive correlational. Two studies utilized Larson’s CARE-Q (Larson, 1986; Mangold, 1991), one utilized the CBI (Wolf, 1986), and one utilized a bipolar construct scale (Morrison, 1991).

Findings indicate that nurses identify caring as occurring primarily in the affective domain. In several studies (Larson, 1986; Mangold, 1991; Wolf, 1986) the most representative caring behavior is listening (Swanson’s knowing and being with).
Descriptions of caring include genuine concern for the patient’s well-being, giving of oneself, involvement, emotional presence, interacting, listening, empathy, respect, touching, allowing expression of feelings, individualizing care, talking to patients, and realizing the patient knows him or herself best (maintaining belief, knowing, and being with).

In many of the studies, there is only an occasional mention of patients’ needs, technical skills, and giving good physical care (doing for and enabling). The phenomenological and hermeneutical studies all include technical competency in one category or theme of study findings (Forrest, 1989; Kahn & Steeves, 1988; Ray, 1987). The remaining categories or themes are focused upon the affective domain. The study done in a critical care setting (Ray, 1987) identifies caring as a moral and ethical process (maintaining belief and knowing) involving both human and technical aspects. Technical competence (doing for and enabling) seems to be a prerequisite for caring to occur in a critical care setting. Findings of these studies focus mostly on the “knowing” and “being with” processes in Swanson’s theory (1991, 1993). “Maintaining belief,” “doing for,” and “enabling” are often not included.

Nurses indicate that characteristics of themselves and of their patients are issues in their descriptions of caring when asked about what elicits, affects, and limits caring? Caring is described as arising from feeling with and for patients, and liking patients (Forrest, 1989; Kahn & Steeves, 1988; Morrison, 1989). Caring is affected by nurses’ background and learning, nurses’ feelings and responses toward patients, and patients’ responses toward nurses (Forrest, 1989). Caring is elicited when patients are in dire circumstances, have multiple psychosocial problems, are relying on the nurse, and are alert and personable (Kahn & Steeves, 1988). Nurses address a potential dilemma of caring too little or too much, the
phenomenon of burnout, and the personal cost in their descriptions of what affects caring (Morrison, 1989). The capacity to care is described as being sustained through the comfort and support of colleagues. The nurse who experiences caring is then able to offer caring (Forrest, 1989).

Two studies that focused on the meaning of caring also asked about noncaring via stories illustrating the absence of caring (Kahn & Steeves, 1988) and critical incidents about noncaring ways (Chipman, 1991). Another study reported anecdotal findings of noncaring (Forrest, 1989). Findings indicate that nurses perceive noncaring to mean when nurses do not give of self, do not meet the patient’s needs in a timely fashion, and do not provide comfort to the patient, or aid in his or her discomfort. Noncaring also means care done in a mechanical or routine way (Chipman, 1991; Kahn & Steeves, 1988).

Nurses also describe noncaring as nursing care that is limited by various factors. Limiting factors include (a) issues related to the nurse such as distance and objectivity, temporal circumstances, animosity, an inability to get along with the patient, and factors that are the nurse’s personal responsibilities; and (b) issues related to the consumer such as patients’ actions that cause problems, patients’ unwillingness to communicate, and patients’ poor self-images (Kahn & Steeves, 1988).

**Patients’ and Nurses’ Perceptions of Caring**

Several studies have described caring from the view of both providers and consumers (Keane, Chastain, & Rudisill, 1987; Komorita, Doehring, & Hirchert, 1991; Larson, 1987; Lemmer, 1991; Mayer, 1987; Swanson, 1990; Valentine, 1991a, 1991b; Vaughan-Cole & Rigdon, 1988; Wolf, Giardino, Osborne, & Ambrose, 1994).
Some studies have compared provider and consumer perceptions using a descriptive correlational design (Keane et al., 1987; Komorita et al., 1991; Larson, 1987; Mayer, 1987). These studies used Larson’s CARE-Q (1981) to compare patients’ versus nurses’ priorities regarding the most and least important caring behaviors. Many replications of Larson’s work comparing nurses’ and patients’ perceptions have been done on different specialty patient populations. Replications include oncology, medical-surgical, and rehabilitation patient samples (Keane et al., 1987; Komorita et al., 1991; Mayer, 1987).

Larson (1987) compared 57 cancer patients’ and 57 professional nurses’ perceptions of most and least important nurse caring behaviors. The samples were taken from her two previously discussed studies (1984, 1986). A marked difference between consumer and provider perceptions is noted. Significant differences are found between the two groups in three subscales and in 19 of the CARE-Q behavioral items. Items on the “Monitors and Follows Through” subscale are rated significantly higher by patients than by nurses, and nurses rated items on the “Trusting Relationship” subscale significantly higher than did patients. Patients perceive nurse behaviors as caring when the behaviors “demonstrate being accessible, monitoring, and following through” (p. 191). Nurses perceive comforting and trusting relationship behaviors as most important in making patients feel cared for. Patients rate caring as instrumental actions, while nurses rate caring as expressive actions.

Keane et al. (1987) replicated Larson’s work using the CARE-Q with rehabilitation patients (n=26) and nurses (n=26). In this comparative study there is a fair amount of consistency between the groups: 6 of the 10 highest mean items were chosen by both groups. Both patients and nurses rated “knows when to call the doctor” as the most important caring item, and “monitors and follows through” and “is accessible” as the most important
subscales. A difference between groups is the emphasis patients placed on the "anticipates" subscale compared to the nurse group. Both patients and nurses rated "volunteers to do little things for patient" and "suggests questions for patient to ask doctor" as least important caring behaviors. Patients rated "tells patient of support systems available" lower than nurses did. This study presents patient results that are similar to previous studies. The nurses' results, however, differ from previous findings. The researchers attribute this difference to a rehabilitation nursing philosophy: Rehabilitation nurses emphasize "self-care practices and patient active participation before affective behaviors" (p. 184).

In another replication of Larson's work, Mayer (1987) compared 28 oncology nurses' and 54 cancer patients' perceptions of the most important and least important caring behaviors using the CARE-Q instrument. Patients ranked the most important nurse behaviors as "knows how to give shots, I.V.s etc., and how to manage the equipment"; "is cheerful"; "encourages the patient to call if he/she has problems"; "puts the patient first, no matter what else happens"; and "anticipates that the 'first times' are the hardest and pays special attention to the patient during the first clinic visit, hospitalization, or treatment." Least important behaviors were, "helps the patient establish realistic goals" and "checks out with the patient the best time to talk with the patient about changes in his/her condition."

Nurses ranked the most important behaviors as "listens to the patient"; "allows the patient to fully express feelings about his/her disease and treatment, and treats the information confidentially"; "realizes that the patient knows himself the best and whenever possible includes the patient in planning and management of his/her care"; "touches the patient when he/she needs comforting"; and "perceives the patient's needs and plans and acts accordingly." Least important behaviors included "volunteers to do 'little things' for the
patient,” and “is cheerful.” Patients value technical instrumental activities from the “monitors and follows through” and “accessible” subscales, whereas nurses value affective expressive activities. There is agreement between nurses and patients that “professional appearance,” “asks the patient what name the patient prefers to be called,” and “suggests questions for the patient to ask the doctor” are not important caring behaviors.

Komorita et al. (1991) conducted a study that identified nurse educators’ perceptions of the most important and least important caring behaviors that make patients feel cared for. An additional purpose was to determine if perceptions of nurse caring behaviors differed according to the nurse’s age, experience, functional area, or clinical specialty. The researchers used an educationally homogeneous sample because previous authors had not controlled for educational level differences. The CARE-Q tool was utilized. Findings of nurse educators (n=72) were compared with masters prepared practitioners and managers (n=38) and the patient perception data from Larson’s study conducted 7 years earlier (Larson, 1984). Purposive sampling was utilized with the CARE-Q being mailed to 113 master prepared nurses.

Findings in this study show that nurses’ perceive the “trusting relationship,” “comforts,” and “explains and facilitates” subscales as the most important in that order. Patients’ perceive the “monitors and follows through,” “accessible,” and “anticipates” subscales as most important respectively. Nurses selected the largest number of behaviors as least important from the “monitors and follows through” subscale, which was the subscale most important to patients. Patients value “knowing how to give shots, IVs, etc.,” “knows when to call the doctor,” “gives good physical care,” “gives treatments and medications on time,” “is well organized,” “responds quickly to the patient’s call,” and “checks on patient.”
None of these concepts are ranked as the 10 most important by nurses. In fact, “gives treatments and medications on time” is 1 of the 10 least important behaviors as perceived by nurses. Patients emphasize competency in technical skills and availability (i.e., “monitors and follows through” and “accessible” subscales) whereas nurses emphasize listening and trusting relationships (“comfort” and “trust” subscale). Patients value activities that represent being “cared for” while nurses place importance on behaviors that indicate being “care[d] about.” There is some evidence that the perceptions of older nurses with more experience are more similar to the perceptions of patients, but the researchers are concerned that this finding could have been due to “chance” (i.e., type 1 error) in view of the large number of behaviors and groups tested and the small sample size.

This study’s (Komorita et al., 1991) data “clearly supports previous findings reporting the different perceptions of caring by nurses and patients” (p. 28). It is unclear whether differences regarding the level of importance of particular caring behaviors are due to (a) an actual incongruence between provider and consumer perceptions, (b) the fact that this study compared nurse data and patient data that were not collected concurrently (Larson’s patient data was published 7 years previous to the master’s educational level data), or (c) issues with the complexity of the Q-sort instrument methodology used in these studies that may have influenced results. Potential issues include data collection procedures, the forced choice format, the trust subscale having a different number of items, and data analysis validity issues (Brown, 1993). Due in part to some of these issues, Larson has revised the CARE-Q (Larson & Ferketich, 1993). The new instrument, The Caring Satisfaction Questionaire (CARE/SAT), will be discussed under the next section of studies related to quality and satisfaction.
Additional qualitative studies have been done that include both providers and consumers. "Support," a concept now considered similar to caring and overlapping within the construct (O’Berle & Davies, 1992), was the focus of an explorative descriptive study (Vaughan-Cole & Rigdon, 1988). This study sought conceptual clarification of “nursing support” by comparing the perceptions of nurses (n=15 female) and patients (n=15, seven female and eight male) on inpatient surgical units. Participants were asked, in semistructured interviews, to describe supportive and nonsupportive experiences with nurses. Responses included patients’ contextual descriptions of their thoughts, feelings, behaviors, and the nurse’s response. Support is viewed similarly by patients and nurses as a reciprocal and interactive process. Through content analysis the following three categories and their themes are identified: (a) “Person Focused Interaction,” which includes communication, encouragement, comforting, guiding through teaching and counseling, and listening; (b) “Health Focused Interaction” includes responding to needs and availability; and (c) “Advocacy.” Both physical and psychological dimensions are found in every patient’s and nurse’s description of support.

In this same study there is a discrepancy between consumer and provider descriptions of nonsupport. From the patient’s perspective, the categories include (a) “Negligence”: a lack of nursing action related to requests or needs, (b) “Inconsiderateness,” and (c) “Incompetence.” It is noted that participants shift away from the interactive perspective in which they described support. Patients focus specifically upon nurses’ behaviors, describing what the nurse did or did not do. In contrast, nurses acknowledge awareness of their nonsupport and describe (a) annoying characteristics of patients, (b) their own personal feelings about a situation, and (c) multiple environmental factors as obstacles to providing
support. Nurses often provide the context or reasons why support is not given.

Swanson (1990) conducted a phenomenological study focused on providing care in newborn intensive care (NICU). The sample included nurses (n=5), physicians (n=4), mothers (n=5), fathers (n=2), a NICU nurse administrator, a social worker, and a biomedical ethicist. Informants were interviewed one-three times from 45 minutes to 2.5 hours. Subjects were asked, “What is it like to be a provider of care in the NICU?” The goal was to capture the essence of providing care in such an intensely complex, technical, and “meaning-intensive” environment. Interview data were supplemented with observational data via attendance at ethical rounds and “hanging out” in the unit. Data were gathered over the course of 1 year. A reduced model of four care processes of providing care in the NICU emerged from the data. The concurrent processes are (a) “caring,” which includes knowing, being with, doing for, enabling, and maintaining belief; (b) “attaching,” which includes communicating and performing; (c) “managing responsibilities” includes taking on, maintaining, and letting go; and (d) “avoiding bad outcomes,” which includes directing action and inhibiting action. Caring, attaching, managing responsibilities, and avoiding bad outcomes are said to take place “in a complex context in which the whole story is hard to come by” (p. 70). A circularity is reported regarding the concurrent processes influencing each other. The five caring processes identified in a previous study (Swanson-Kauffman, 1986b) were redefined from the direction of the one cared for to the direction of the one caring, and from the context of miscarriage to more generic definitions of the processes.

A study of matched pairs of nurses and patients in concurrent situations may clarify discrepancies between provider and consumer perceptions of caring. Valentine (1991a, 1991b) used this approach within a large naturalistic study. Nurse-patient matched pairs
congruence was measured in specific encounters between postoperative patients recovering from hysterectomies and their nurses for the shift. Ninety-one patients and their nurses completed a 61-item Likert-type patient caring questionnaire (PCQ) or nurse caring questionnaire (NCQ). The questionnaires, developed in an earlier phase of this study, were completed at the end of the shift and mailed separately, so not all pairs remained matched. The pool of matched pairs included 58 patients and their nurses. Thirteen cases were dropped for having the same response on all items leaving a final pool of 45 matched pairs. Four scales are derived from each questionnaire (PCQ and NCQ): (a) “Attributes of the nurse”: affective, cognitive, and ethical; (b) “Professional vigilance”: technical competence, responsiveness, and knowledge; (c) “Interactional”: teaching/learning, communication, and physical comfort; and (d) “Importance”: dependent aspects such as holding hand and hugs.

The individual paired item correlations from the matched questionnaires were averaged to derive a congruence score. The mean correlation for the group of matched nurse-patient pairs is .18: a low correlation. Congruence scores range between -.07 and .60. These findings suggest little congruence between caring scores; patients and their nurses neither agree nor disagree about the caring which occurred in their encounter. Patients show more variation in their responses than nurses. Nurses’ answers ranged between 3 and 5, while patients used the full range (i.e., 1 to 5) of responses. “This restricted range of responses for nurses affected correlations and other relational analyses” (1991b, p. 108), and made it more difficult to show relationships.

Wolf et al. (1994) described dimensions of the process of nurse caring using a convenience sample of nurses who worked in hospitals (n= 278) and patients (n=263) who had been in secondary or tertiary hospital settings. Nurses were obtained from computer lists
provided by a hospital and a RN-BSN program. Patients were recruited from a hospital data
to the revised Caring Behaviors Inventory (CBI), a 43-item instrument that was revised from
6-point Likert scale to a 4-point Likert scale. An exploratory factor analysis, using the
principal components method with varimax rotation, identified a five dimension factor solution of nurse caring: (a) respectful deference to others, (b) assurance of human presence,
(c) positive connectedness, (d) professional knowledge and skill, and (e) attentiveness to the
other’s experience. Caution is suggested regarding findings because this is a preliminary
study. The convenience sample combined nurses and patients and cannot be replicated.

Summary

Eight studies that include consumer and provider perceptions of caring were reviewed. Six studies utilized quantitative designs; four used Larson’s CARE-Q to compare
and patient perceptions (Keane et al., 1987; Komorita et al., 1991; Larson, 1987; Mayer, 1987), one study utilized the PCQ/NCQ to study matched nurse-patient pairs and
their congruence in perceptions of caring (Valentine, 1991a, 1991b), and one study used the
revised CBI to combine patient and nurse perceptions of caring dimensions (Wolf et al.,
1994).

Two studies utilized qualitative descriptive designs; one used an exploratory
descriptive approach to compare patients’ and nurses’ descriptions of support and nonsupport
(Vaughan-Cole & Rigdon, 1988), and one study used a phenomenological approach to
understand providing care in NICU (Swanson 1990). Swanson’s study included many types
of caregivers in the NICU, professionals, and parents to gain a more in-depth understanding
of the essence of providing care in this setting.

The purpose in six of the studies was to compare patients’ and nurses’ perceptions (Keane et al., 1987; Komorita et al., 1991; Larson, 1987; Mayer, 1987; Valentine, 1991a, 1991b; Vaughan-Cole & Rigdon, 1988). Findings in three of the studies which utilized the CARE-Q indicate a discrepancy in perceptions of caring between patients and nurses (Komorita et al., 1991; Larson, 1987; Mayer, 1987); however, the fourth study which utilized the CARE-Q found congruent perceptions. This study (Keane et al., 1987), conducted in a rehabilitation setting, compared nurses and patients within the same unit. The other three studies obtained samples from a variety of settings. It is possible congruence would be found more consistently if patient and nurse samples are obtained from the same hospital unit. In addition, the CARE-Q's complexity and methodological issues may have impacted findings. Findings from studies collecting data with the CARE-Q need to be viewed with caution, particularly due to its forced choice limitation. Larson has since revised this instrument (Larson & Ferketich, 1993). Valentine’s study (1991a, 1991b) utilized the PCQ/NCQ on matched pairs within the same unit and found neither congruence nor incongruence between patient and nurse perceptions of caring. Methodological issues are cited as probably influencing these results. Wolf et al. (1994) did a preliminary study using a revised instrument with a combined patient and nurse sample to describe dimensions of caring.

The study on support (Vaughan-Cole & Rigdon, 1988), which utilized a sample of patients and nurses within the same setting, demonstrates agreement between patients and nurses regarding descriptions of support, but a discrepancy in descriptions of nonsupport. Nurses and patients describe perceived personal characteristics of the other in their descriptions of nonsupport.
Some study findings indicate that there is a discrepancy between nurse and patient perceptions of caring. It is unclear if this disagreement is due to an actual incongruence in perceptions or study methodology issues.

**Satisfaction and Quality Related to Caring**

A challenge for health care providers is having the ability to provide competent quality care as reflected in professional standards of practice while simultaneously meeting the patient and family’s consumer expectations. Receiving the consumer’s response of satisfaction with one’s nursing care is a rewarding experience. Caring has been linked with patient responses of satisfaction (Benner & Wrubel, 1989; Valentine, 1991a, 1991b).

In a study by Valentine (1991a, 1991b) the purpose was to define caring and then explore the interrelationships between caring, components of the hospital system, and health outcome variables. This study combined qualitative and quantitative methods. The data collection were organized around Stufflebeam’s Context-Input-Process-Product or CIPP model; a decision-oriented evaluation framework (Stufflebeam & Shinkfield, 1985, cited in Valentine, 1991a). The CIPP model “focuses attention on systematic examination of multiple facets and relationships surrounding a given human service phenomenon” (p. 60); caring in this instance. The study was designed in four phases: context, input, process, and product, with each phase answering one of the following research questions: (a) “How is caring defined in this setting and how can it be measured? (context).” These data were used to develop “a data-supported model of caring” (1991a, p. 61); (b) “What is the relationship between caring and productivity factors (input).” This phase focused on an accounting of staff availability, patient acuity, and the work load index; (c) “To what degree does caring
occur between nurses and patients in particular encounters? (process).” This component focused on the perception of caring and congruence of nurse and patient caring questionnaires (NCQ/PCQ); and (d) “What is the relationship between caring and selected health outcomes? (product).” This phase tracked selected outcome measures. Outcome measures were (a) satisfaction with nurses (SATN), satisfaction with overall hospital rating (SATOHR), and hospital of preference (OP 12); (b) length of stay (LOS); and (c) postoperative complications (POCs) assessed via medical record review.

Fifty-nine matched nurse-patient (the patients were postelective hysterectomy) pairs completed the NCQ/PCQ questionnaires at the end of the shift and were asked to write a narrative about their interaction. Stepwise multiple regression relationships were explored to determine the contribution of productivity measures. Overall, patient scores on caring are “relatively insensitive to productivity factors,” whereas nurses’ scores are “somewhat sensitive to changes in census, workload, and acuity” (1991a, p. 65). Another stepwise multiple regression was done to explore combinations of input (productivity) and process variables (perceptions of caring) to see which contributed the most to variances in outcome measures and could be used as “predictors” of outcome variables. “The caring questionnaires did a better job of showing a relationship between nurse-patient interactions and outcomes” (1991a, p. 65) than did the productivity measurement systems. Resources or productivity (input variables) did not contribute significantly to the variance in outcome scores. The measures of satisfaction with nurses and hospital preference (SATN and SATOHR) are significantly moderately related to one another, but are not found to be related to LOS or incidence of POC. The variable that contributes the most to variance in satisfaction with the hospital is “the patients’ scores for the affective, cognitive, and ethical
attributes of the nurse” (1991a, p. 65). Satisfaction with nursing is most often accounted for by patients’ scores for the nurses’ professional vigilance, although patients’ past hospitalizations and perceptions of caring interactions also affect how satisfied patients are with nursing. Variance in patients’ hospital preference is consistently accounted for by their interaction scores with nurses. The greater the interaction scores, the more likely the consumer will choose that hospital again.

A quality assurance study developed and implemented a measurement tool to evaluate the degree of patient and family satisfaction with the care provided by critical care nurses (Megivern et al., 1992). The importance of themes, within the expressive and instrumental domains identified in the caring literature, in relationship to satisfaction was explored in a focus group of five family members and interviews with 26 patients and family members during their “loved one’s” stay in the medical, surgical, or cardiovascular critical care unit. Examples of some of the topic areas were personal characteristics looked for in nurses, expectations regarding the ability of nurses to recognize individual qualities and needs, the importance of availability, and characteristics of “essential” consumer education. Family members are reported to have been included because of the family-focus of critical care and because of many patients’ inability to remember their critical care experience. Content analysis was utilized to identify common themes. Patient and family data were combined because of similarities in their themes. The satisfaction survey developed was then pilot tested with a convenience sample of 36 consumers (12 patients, 20 family members, 4 unidentified) obtained via notices in patient and family lounges. Descriptive statistics determine the highest satisfiers to be as follows:

- The way the nurses showed concern and compassion.
• The patience of the nurses who cared for the patient.
• The caring attitude of the nurses.
• The way the nurses watched over the patient.
• The way the nurses on all the shifts worked together in the patient’s care.
• The encouragement of nurses about how the family could help the patient.
• The way the nurses were comfortable in answering questions.
• The timeliness of information provided by the nurses about the patient’s condition and treatment.
• The way the physicians communicated with patients and families.
• The way the nurses responded to the patient’s needs for pain management.
• The proficiency of nurses at the technical aspects of the patient’s care.
• The family support group meeting in the unit. (p. 14)

No significant differences are found in satisfaction levels between units or gender. Qualitative responses to the open-ended questions are categorized according to the “instrumental” and “expressive” domains. Positive and negative comments reported reflect the characteristics of caring and noncaring found in caring studies.

Larson revised the CARE-Q sort into the Care-Satisfaction Questionnaire (CARE/SAT), a visual analog scale that measures patient satisfaction with caring behaviors (Larson & Ferketich, 1993). The CARE/SAT measures perceptions of caring and also satisfaction with care. It has been utilized to study patients’ perceptions of whether caring occurred and if there was satisfaction with nursing care. The instrument measures both caring and noncaring behaviors.

Larson and Ferketich (1993) believe that “to determine the effect of caring, nurses need to focus on the recipient of the care: the patient” (p. 690). Therefore, the effect of caring is determined by assessing the recipient, or consumer’s satisfaction with the caring they experienced from nurses during hospitalization. This study compared adult medical-
surgical patients’ satisfaction with caring practices of their nurses in four hospital settings: two teaching and research hospitals (n=88) and (n=32), one research and catastrophic hospital (n=130), and one community hospital (n=18). Findings indicate that the community hospital patients are significantly different with more “enabling nurse caring” and less “benign neglect.” A limitation of this questionnaire is that it asks patients to rate all of their nurses’ caring or noncaring practices at once; therefore, a nurse who stands out positively or negatively could represent opinions regarding all of the nurses involved in care. In addition, administration of the CARE/SAT “varied somewhat” (p. 699) in the four settings; some participants responded before discharge while others responded after. The size of the groups also varied.

Ludwig-Beymer et al. (1993) conducted a grounded theory study to define patient perceptions of quality care and caring, and to compare patient satisfaction with quality of care using three methods of data collection. Three indicators of perceptions of quality, (a) unsolicited letters to hospital administrators, (b) patient satisfaction questionnaires, and (c) quality of care surveys were utilized to define hospitalized patients’ perceptions of quality of care and caring. A 479-bed religious-affiliated medical center was the setting for this study. The unsolicited letters to administrators, patient satisfaction questionnaires, and quality of care surveys were analyzed via constant comparative analysis.

Two core categories of perceptions of quality are identified: (a) “global experience,” which includes attachment, community, consistency, healing environment (i.e., comfort and caring), and life events as patterns; and (b) “quality nursing care experience.” Regardless of data collection methods, hospitalized patients’ identified six common components of quality care which the researchers grouped into two broad areas: (a) “a calling of the head,”
characterized by capability (i.e., competent, efficient, knowledgeable) and communication; and (b) a calling of "the heart," characterized by caring, respect, enthusiastic encouragement, and a willingness to go the extra mile. Rapid nurse response, a knowledgeable nurse, communication, and courtesy are key components. The congruence of these findings with previous caring research is noted by the researchers. Perceptions of quality of care are important. "Quality care is a complex issue. . . . patient perceptions of caring behaviors influence patient satisfaction with the care received and decisions to return to a particular institution for care" (p. 50).

The maintenance and improvement of quality is also stressed in health care reform reports and recommendations (Kaiser, 1993; Harrington, Feetham, Moccia, & Smith, 1992; Huefner, 1992; Leavitt, 1994). President Clinton's Health Security Act would have created a National Quality Management Council to apply performance measures, expand quality research, and disseminate quality reports (Clinton, 1993). The governor of Utah, Michael Leavitt, is chair of the national-level Governors' Commission on Health Care. Governor Leavitt's plan (1994), developed by the Utah Health Care Policy Option Commission also chaired by the governor, is called the "Utah Healthprint Plan." The plan is described as a blueprint for market-oriented health care in which quality maintenance and enhancement is one of the plan's four targets. Developers of the plan anticipate that the quality of health care will improve if competition is based not only on price, but also upon the measurement of quality. Under the Utah Healthprint Plan, consumers would be provided information on patient satisfaction with care received from health care facilities via health plan report cards. These report cards are expected to provide incentives to health care providers to improve their provisions of care.
Summary

Four studies were reviewed that relate quality of care or satisfaction with care to characteristics of caring (Larson & Ferketich, 1993; Ludwig-Beymer et al., 1993; Megivern et al., 1992; Valentine, 1991a, 1991b). These studies consisted of qualitative and quantitative components.

Professional vigilance and nurse-patient caring interactions contribute to satisfaction measures with posthysterectomy patients. Nurse-patient caring interactions contribute to the choice of providers and returning to the same provider (Valentine, 1991a, 1991b). Caring characteristics are amongst the highest patient satisfiers in critical care units (Ludwig-Beymer et al., 1993). Larson linked satisfaction with caring by revision of the CARE-Q into a CARE/SAT questionnaire that measures characteristics of caring and noncaring and satisfaction with nurse caring (Larson & Ferketich, 1993). Using three different methods of relating satisfaction with the quality of care in a large medical center, caring characteristics are a major part of the consumer definitions of quality. Negative comments related to dissatisfaction reflect the characteristics of noncaring (Megivern et al., 1992).

Overall Summary

Most studies focusing on caring have been done at the exploratory descriptive or descriptive correlational levels of research development, using both qualitative and quantitative designs. Qualitative descriptive studies have focused upon definitions, descriptions, perceptions, incidents of caring, and how caring is modeled (Chipman, 1991; Cronin & Harrison, 1988; Ford, 1981; Frieswick, 1991; Wolf, 1986). Phenomenological
studies have been done regarding what caring means, how it is demonstrated, describing the lived experience of caring, and the essence of providing caring (Brown, 1986; Burfitt et al., 1993; Cronin & Harrison, 1988; Forrest, 1989; Ray, 1987; Riemen, 1986a, 1986b; Swanson, 1990; Swanson-Kauffman, 1986a, 1988b; Valentine, 1991a, 1991b). Qualitative studies and approaches have focused upon contributing a greater depth of understanding regarding the meaning of caring and noncaring.

Quantitative studies have focused upon the most and least important caring behaviors. Larson’s CARE-Q sort has been utilized to describe and compare the most and least important caring behaviors perceived by patients and nurses (Keane et al., 1987; Komorita et al., 1991; Larson, 1984, 1986, 1987; Mayer, 1987). Comparing nurses’ and patients’ perceptions across several studies strongly suggests that a discrepancy exists in perceptions of which caring behaviors are most important. Findings indicate that some nurses perceive caring as the affective art of nursing without placing an emphasis on technical skills and care. Staff nurses in three hospital settings and diploma students view caring as primarily the supportive or affective portion of nursing care (Chipman, 1991; Ford, 1981; Forrest, 1989; Wolf, 1986). Acute hospital staffs and incoming master and baccalaureate students’ mention technical competence within their descriptions of the meaning of caring (Kahn & Steeves, 1988; Lemmer, 1991; Ray, 1987; Swanson, 1990). Critical care nurses emphasize the importance of achieving technical competence and also the moral and ethical process (Ray, 1987; Swanson, 1990). Studies that compared patients’ perceptions and nurses’ perceptions of caring asked for general perceptions of caring. The samples were often not from the same hospital units or settings. It is possible that there would be more congruence in perceptions if studies are conducted in the same settings or with patient-nurse pairs.
In contrast to the findings from some studies of nurses’ perceptions that caring reflects affective interaction, the consumer defines caring as the complementary delivery of both technical and supportive care. It appears that technical competence (Swanson’s “knowing,” “doing for,” and “enabling”) is a prerequisite to affective competence (“maintaining belief” and “being with”) from the patient’s perspective (Brown, 1986; Burfitt et al., 1993; Cronin & Harrison, 1988; Frieswick, 1991; Keane et al., 1987; Komorita et al., 1991; Larson, 1984, 1987; Mayer, 1987; Riemen, 1986a, 1986b; Sherwood, 1988; Swanson, 1990; Swanson-Kauffman, 1986a, 1988b; Vaughan-Cole & Rigdon, 1988).

Findings of studies on quality of care and satisfaction with care demonstrate that characteristics of caring contribute to the level of satisfaction and perceptions of having received quality care (Larson & Ferketich, 1993; Ludwig-Beymer et al., 1993; Megivern et al., 1992; Valentine, 1991a, 1991b).

Nurse behaviors and characteristics that consumers describe as caring include accessibility, monitoring, and following through on actions (Larson, 1984); the demonstration of professional knowledge, skill, surveillance, a reassuring presence, recognition of consumers’ individual qualities and needs, promotion of consumer autonomy, and time spent with consumers (Brown, 1986); actions focused on physical care and monitoring (Cronin & Harrison, 1988); assessing needs or expectations, managing care, responding to needs, evaluating nurse actions toward consumers and the consumer’s condition, and a positive, growth producing interactional attitude (Sherwood, 1988); treating consumers like people, understanding, putting the consumer back together (i.e., demonstrating a power to heal), going out of one’s way (Frieswick, 1991); attentive, vigilant behavior that includes nurturance and highly skilled technical practices, lifesaving actions,
and personal attributes (Burfitt et al., 1993); and “a calling of the head,” “a calling of the heart,” respect, enthusiastic encouragement, and a willingness to go the extra mile (Ludwig-Beymer et al., 1993).

Swanson’s (1991, 1993) caring processes are reflected in these findings. The caring literature has begun anecdotally to look at the consequences of caring for both the consumer and the professional nurse.

Noncaring has not been the primary focus of study. Five studies include noncaring within their study of caring (Chipman, 1991; Frieswick, 1991; Kahn & Steeves, 1988; Riemen, 1986a, 1986b; Vaughan-Cole & Rigdon, 1988). Only anecdotal findings regarding noncaring are reported from other studies. Noncaring treatment, as described by patients, includes incompetence and negligence; failure to meet emotional or physical needs (Frieswick, 1991; Lemmer, 1991; Sherwood, 1988; Vaughan-Cole & Rigdon, 1988); being physically present, but emotionally distant; being irritable; and treating patients as objects via hurrying, belittling, devaluing actions, and rough handling (Burfitt et al., 1993; Lemmer, 1991; Riemen, 1986a, 1986b; Sherwood, 1988; Vaughan-Cole & Rigdon, 1988).

Nurses indicate characteristics of themselves and of their patients as issues when asked what affects and limits caring (Forrest, 1989; Kahn & Steeves, 1988; Morrison, 1989). Nurses also address the potential dilemma of caring too little or too much, the phenomenon of burnout, and the personal cost in their descriptions of what affects caring (Morrison, 1989). Two studies asked about noncaring via stories illustrating the absence of caring (Kahn & Steeves, 1988) and critical incidents about noncaring ways (Chipman, 1991). Findings indicate that nurses perceive noncaring to mean when nurses do not give of self, do not meet the patient’s needs in a timely fashion, and do not provide comfort to the patient,
or aid in his or her discomfort. Noncaring also means care done in a mechanical or routine way (Chipman, 1991; Kahn & Steeves, 1988). Nurses also describe noncaring as nursing care that is limited by issues related to the nurse, factors that are the nurse’s personal responsibilities, and issues related to the consumer (Kahn & Steeves, 1988).

The effects of caring and noncaring experiences on short and longer term responses have not been studied, nor has recovery from noncaring experiences. An important next step in contributing to the research literature on caring is to study the responses to both caring and noncaring experiences during hospitalization from the consumer’s perspective. In addition, it is important to understand noncaring in more depth. Consumer dissatisfaction with noncaring experiences and behaviors initiated to prevent or protect oneself from noncaring may negatively impact the achievement of therapeutic outcomes during and after hospitalization. It is important to understand how to facilitate recovery from noncaring experiences in order to refocus energy into healing. It is important, as well, to understand how providers can prevent such noncaring experiences.
CHAPTER 3

RESEARCH METHODS

Design

The research design was chosen to fit the purpose of this study: to understand responses to caring and noncaring experiences during hospitalization from the perspective of consumers. This purpose was achieved using an exploratory descriptive design. Consumer responses to caring and noncaring experiences during hospitalization have not been previously studied; therefore, where little is known about a subject, an exploratory descriptive design is appropriate.

Setting

This study was conducted on an inpatient unit in a university hospital setting in the Intermountain West. The surgical unit chosen for the setting of this study admits elective orthopedic surgery patients; nonelective, trauma orthopedic surgery patients; and patients admitted for gastrointestinal surgery. The unit has a maximum capacity of 35 beds, 60 to 80% percent of which are filled with orthopedic surgery cases. Typical orthopedic surgeries performed include (a) prosthetic knees and hips; (b) back fusions, instrumentations, and laminectomies; (c) shoulder instrumentation and repair; (d) hand and digit instrumentation and repair; (e) sports injuries; (f) trauma fracture and dislocation repair; (g) surgical
intervention for metastatic bone disease; and (h) surgical intervention for orthopedic infections.

The university hospital is a five state regional secondary and tertiary care facility. The region has a conservative dominant religious group that significantly influences cultural, political, and economic decision. Predominant values reflect an emphasis on family, education, work ethic, and church life.

The second interviews were conducted in the participant’s own environment. This setting was chosen with the intent of obtaining data from outside the hospital environment. Within a hospital environment, patients may feel limited regarding what can safely be said about hospital experiences because of a fear of retribution from professionals upon whom they are dependent; despite guarantees of confidentiality. Conducting the second interview 8 weeks following discharge was chosen to give patients time to (a) adjust, (b) choose compliance or noncompliance with treatment recommendations, (c) make decisions about follow-up care, and (d) gain perspective regarding hospital experiences.

**Sample**

Nonprobability purposive sampling was utilized for this study in order to appropriately select informants according to research needs. A purposive sample of 20 orthopedic surgery patients was obtained. Orthopedic surgical patients were chosen because the immobility associated with orthopedic surgery often results in greater dependency and longer hospitalizations than many other diagnoses.

Eligibility criteria for the selection of subjects included (a) 18 years of age or older, (b) postorthopedic surgery, (c) able to speak and read English, (d) hospitalized on a general
orthopedic surgery unit for 3 to 5 days, (e) assessed to be without cognitive impairment, (f) able to participate in a 1 hour interview, and (g) able to indicate or sign written consent.

Among the 20 participants, 11 were admitted for planned, elective surgery, and 9 were admitted for acute trauma and surgery related to injuries. Eight of the participants were male and 12 were female. The types of surgery for which these patients were hospitalized included (a) hip surgeries, (b) fractures and multiple fractures, (c) back surgeries, (d) neck surgery, and (e) digit reattachment (see Table 3.1). Ages in this sample ranged from 18 to 73 years. Religious affiliation was varied with 11 being members of the Church of Jesus Christ of Latter-day Saints (LDS/Mormon), two being Catholic, three Protestants, and four not subscribing to any religious preference. Patients were from varied geographic locations.

Eligible patients were identified via discussions with the orthopedic unit charge nurse, primary nurses, and/or nurses assigned to the patients. Subjects were selected from patients admitted directly to the orthopedic unit for elective surgery; patients undergoing nonelective surgery due to traumatic accidents; and patients transferred from critical care settings, not more than 1 week after admission. Most patients were receiving the usual postoperative pain management medications and were on bedrest with limited mobility, except for physical therapy treatments.

Ability to participate in interviews required a coherent mental status with effective pain relief. The researcher asked the charge and primary nurses for their assessment of all prospective subjects’ cognitive status during the selection process. As the prospective subject was recruited into the study, the researcher also assessed mental status, including cognitive functioning, by observing the participant’s ability to remain alert and understand the study purpose and consent procedure. If a subject had been assessed to be incoherent,
Table 3.1
Demographics of Sample

<table>
<thead>
<tr>
<th>Type of surgery</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back Surgery (Pseudoarthrosis, Spinal stenosis, Lumbar Disc, Fusion)</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Hip Surgery (Prosthetic, Acetabular Dysplasia TIO)</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Neck Surgery (Cervical Disc)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Digit Reattachment</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Leg Fracture (IM Rodding)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Arm Fracture (Humerus)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Multiple Fractures (Radius, Femur, Clavicle, Rib, Patella, Pelvis, and Lumbar)</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

the interview would have been stopped and the subject would not have been included in the study. Six patients declined to participate in this study, one male and five female. Reasons given for refusing were (a) not feeling well enough due to pain or nausea (n=3) and (b) not wanting to participate in an interview and answer questions (n=3).

The aim of sample selection in qualitative research is to obtain a sample that is both appropriate and adequate (Morse, 1986). This was accomplished by selecting participants who had the required knowledge and the ability to convey information on the phenomena being studied. Purposive sampling provided an adequate and appropriate sample, which is
necessary for attaining optimal validity and reliability in a qualitative study (Morse, 1986, 1989).

Appropriateness refers to the extent to which the choice of informants and method of selection “fits” the study purpose as determined by the research question and the stage of the research (Morse, 1989). A test for appropriateness was done to evaluate whether the sampling methods used and the resulting sample facilitated understanding of the research problem. The purpose of this study was to understand the responses of patients to caring and noncaring experiences at an exploratory descriptive level of research. Subjects were selected from orthopedic surgery patients who met the eligibility criteria and gave consent. Initially, informants whose experiences were considered typical by the charge and primary nurses were interviewed. Later, informants whose experiences were considered atypical or different were included. Three patients who are health care providers were selected and may well have served as inside experts. Two patients had been in an intensive care setting prior to the orthopedic unit. This sample was selected to reflect variation in age, gender, and elective versus nonelective surgeries since perceptions of caring may be influenced by these factors. The orthopedic surgery population provided variation along these dimensions.

Adequacy refers to informational adequacy: the sufficiency and quality of the data (Morse, 1989). Comprehensive, relevant, and detailed data are necessary in qualitative studies. The underlying assumption in purposive nonprobability sampling is that all subjects in a setting are not equally informed about the knowledge sought by the researcher; therefore, informants need to be selected who are best able to meet the informational needs of the study. In qualitative research, adequacy is attained by the completeness and amount of information rather than the number of cases. Data collection and analysis occurred
concurrently in an effort to reach understanding and saturation. Sampling is a continuous process requiring an awareness of the “thin” areas of data and the needs of the study. A test for adequacy was done to (a) evaluate the relevance, completeness, and amount of information obtained and (b) determine whether saturation had been achieved and if the data made sense regarding the research questions. These data were determined to be relevant and complete, and the sample of 20 participants was found to be adequate in reaching saturation while assuring variations in elective and nonelective admissions, types of orthopedic surgeries, ages, and genders.

Procedures

Data were collected via individual interviews of participants. Twenty patients were interviewed during their hospitalization at approximately 5 days postoperatively on the orthopedic unit, and 19 patients were interviewed again 8 weeks later in their own environment. One participant declined to be interviewed the second time because of scheduling difficulties. The initial interviews were conducted at the patient’s bedside in the orthopedic unit after completion of the consent form (see Appendix C). Demographic data were collected at this time (see Appendix A). The researcher used a semistructured interview guide developed for this study (see Appendix B). Piloting of this interview guide established that patients were usually able to handle the number of questions in a single interview.

Initial interviews took about 1 hour and were audiotaped and transcribed. Privacy was promoted by requesting the staff not to interrupt, thus assuring patient comfort and quality of data. Field notes were taken regarding nonverbal behavior of participants observed by the researcher, symptoms verbalized, the environment, and interruptions during the
interviews. Given the university hospital “people intensive” setting of this study (i.e., the large numbers of providers and other hospital staff), the acuity level of the patients, and the fact that most rooms are double occupancy, the researcher and participants had to tolerate occasional interruptions. On one occasion the researcher had to return to conclude an initial interview due to the patient being called by the operating room for a second surgery.

The second interview took place in the patient’s own home setting (n=7), motel room (n=1), or via their home telephone (n=10) 8 weeks later. Data from participants who were personally interviewed in their home setting and those interviewed over the phone were compared for differences that might reflect the difference in interview format. The second interview utilized an adaptation of the initial interview guide. During the second interviews the researcher did “member checking” allowing her to clarify her understanding of participants’ perceptions. Most of the second interviews also included a discussion with participants of patterns which were emerging from the ongoing data analysis. These second interviews provide data triangulation by looking at the phenomena at a different point in time (Kimchi, Polivka, & Stevenson, 1991; Knafl & Breitmair, 1991). The goal of triangulation in this instance was to investigate the congruence of patients’ perceptions of their responses to caring and noncaring over time (i.e., during hospitalization and 8 weeks later). Patients’ perspectives were also obtained in two different settings (i.e., hospital and home environment) for the purpose of achieving completeness. The intent of completeness is to add more depth by investigating various dimensions of the domain of interest.
Analysis Of Data

Interview audiotapes were transcribed, tapes were listened to, and transcriptions were checked for accuracy. Field notes were examined. The data were then content analyzed. The basic purpose of content analysis is to organize and simplify the complexity of the data into meaningful and manageable themes or categories (Patton, 1987). At this basic manifest level, the analysis was based directly upon what participants said or how they talked about caring and noncaring. At the latent level, the researcher went beyond the transcription of what was directly said and coded the meaning of participant responses to caring and noncaring to infer what the caring or noncaring meant in order to understand the impact for participants as was suggested by Fox (1976).

Content analysis consists of three concurrent flows of activity: “data reduction, data display, and conclusion drawing/verification” (Miles & Huberman, 1994 p. 11). These three streams are “interwoven before, during, and after data collection in parallel form, to make up the general domain called 'analysis'” (Miles & Huberman, 1994, p. 11-12). Data reduction began anticipatively as the study was developed and were ongoing throughout. Interview data were initially organized according to research questions. As data collection proceeded the transforming process included “writing summaries, coding, teasing out themes, making clusters, making partitions, [and] writing memos” (Miles & Huberman, 1994, p. 10). First level coding involved summarizing data via identifying patterns or regularities which could then be sorted into a single unidimensional concept, thus assuring internal homogeneity among items within a category. Pattern coding grouped the summaries into overarching themes or constructs, analogous to cluster-analytic and factor-analytic devices used in statistical analysis. According to Miles and Huberman (1994), pattern coding has the
following important functions: (a) "it reduces large amounts of data into a smaller number of analytic units," (b) "it gets the researcher into [data] analysis during data collection," and (c) "it helps the researcher elaborate a cognitive map, an evolving, more integrated schema for understanding [what is happening in] local incidents and interactions" (p. 69). Folio VIEWS 3.1, a computer data management program, was utilized to facilitate first level coding and pattern coding. Throughout this process the researcher "memoed" (i.e., the writing up of ideas about codes and their relationships, thinking deeper with conceptual intent, and refining and expanding codes). Data reduction was part of data analysis and facilitated data display, conclusion drawing, and verification.

Data display via networks within Folio VIEWS was the second major flow of data analysis activity. Displays of first level and pattern codes organized the information into compact visual form according to research questions, and Folio VIEWS’ query function linked the codes to examples within the interview text. Justified conclusions could then be drawn from the data.

The drawing of conclusions and their verification were the third stream of data analysis. This process was actually initiated near the beginning of data collection as the researcher began to decide what things meant, "noting regularities, patterns, explanations, possible configurations, causal flows, and propositions" (Miles & Huberman, 1994, p. 11). The analyst "holds these conclusions lightly, maintaining openness and skepticism" (Miles & Huberman, 1994, p. 11) through data analysis until the conclusions become "increasingly explicit and grounded" (Glaser & Strauss, 1967, cited in Miles & Huberman, 1994, p. 11) as verification was determined. The verification process included "second thoughts" with an excursion back to transcripts and field notes and review among colleagues to develop
intersubjective consensus in order to establish confirmability and validity as Miles and Huberman recommend (1994).

The three types of data analysis activity, (a) data reduction, (b) data displays, and (c) conclusion drawing and verification, and data collection itself are considered the interactive, cyclical process of the qualitative analyst (Miles & Huberman, 1994).

Validity and Reliability

Research is valued in the scientific community to the extent to which it meets the criteria for validity and reliability. Quantitative and qualitative research have different purposes and outcomes; therefore, the same criteria for validity and reliability cannot be used. In qualitative studies, the criteria for scientific rigor include truth value (i.e., internal validity), applicability (i.e., external validity), consistency (i.e., reliability), and neutrality (i.e., objectivity) (Lincoln & Guba, 1985; Sandelowski, 1986). Lincoln and Guba (1985) have operationalized these alternative trustworthiness criteria for naturalistic paradigms using analogous terms: credibility for truth value, transferability for applicability, dependability for consistency, and confirmability for neutrality.

Credibility (i.e., internal validity), which assesses the truth of the findings, was achieved via (a) triangulation across data collection procedures by utilizing interviews; (b) negative case analysis via interviewing both typical and atypical patients; (c) peer debriefing by discussing the research with members of the dissertation committee who checked that coding procedures were representative, determined that conclusions contain typical and atypical cases, and helped the researcher explore issues by raising difficult questions; and (d) “member checks” during the second interview which is recommended (Lincoln & Guba,
1985). In addition, two patients who have experienced major surgeries and several hospitalizations read the transcripts and concurred with the findings.

Transferability (i.e., external validity) is the fit or applicability of findings to other situations, such as different units in the hospital, or other hospital settings. Transferability was achieved through purposive sampling, the collection of “thick” descriptions of data via in-depth interviews, and analysis of surveys of patients hospitalized on orthopedic units. The sampling process also facilitated attainment of transferability via the selection of elective and nonelective, and typical and atypical admissions with variability in age and gender. The resulting data base should allow for the transfer of judgments and decisions resulting from the findings of this study to other contexts (Lincoln & Guba, 1985).

Dependability (i.e., reliability) was ensured by the consistency of the data collection methods and the data itself. Confirmability is the neutrality or reduction of bias in the findings (i.e., objectivity). Confirmability is achieved when credibility, transferability, and dependability have been established. Both dependability and confirmability were achieved in this study through an audit trail in which two dissertation committee members followed the study’s logic processes, and upon review of the data, findings, interpretations, and recommendations obtained the same, or a comparable conclusion. A residue of raw records and a decision trail were kept to facilitate this audit. In addition, a reflexive journal which includes the data collection schedule and logistics, methodological decisions, and personal catharsis was kept by the researcher.
Limitations

1. Part of the care provided by professionals may be transparent to consumers as it “blends into the background” as Swanson describes in her “doing for” process (Swanson, 1993). Therefore, consumers may not be aware of some of the interventions being implemented and will not be able to describe these interventions or specific responses to them. An imbalance occurs in that patients may very well notice not doing for and may address these experiences while not noticing and addressing the doing for actions.

2. Consumers are often unaware of some of their needs unless professionals explain them and enable consumers to meet those needs; therefore, consumers may not be aware of needs they do have and may respond accordingly. Examples include providers teaching about postoperative coughing and deep breathing; and teaching about grieving, which then gives permission to grieve. When providers enable patients to understand their specific needs consumers then move to a higher level in their responses.

3. Some consumers may not have reported incidences of noncaring, either because of their own personal philosophy, fear of retribution by providers, or due to a response to the researcher or interview.

Protection of Human Subjects

Approval to conduct this study was obtained from the participating university’s Institutional Review Board and from the Nursing Research Committee of the participating university hospital. Written informed consent (Appendix C) for the elective and nonelective surgery participants was obtained on the orthopedic unit. Participants were assured that confidentiality would be maintained throughout this study, and informed of their right to
refuse answering any question and their right to withdraw from the study at any time. Transcriptions of the interview audiotapes and field notes were identified by numerical code only with names and the associated codes known only to the researcher and kept separately from the data.

This study posed minimal risk to the participants. Although there was the possibility of fatigue from the interview length and/or emotional distress as a result of the focus of the interview, the researcher is experienced in interviewing skills and in working with hospital consumers to minimize distress. Arrangements were made for back up psychiatric or social services for a patient’s distress, had they been needed. No patient indicated any emotional distress stemming from either interview.
CHAPTER 4

CARING: RESULTS AND DISCUSSION

Introduction

Patients described caring and noncaring experiences with nurses, physicians, and physical therapy providers during their interviews. The interviewer began by asking patients to describe experiences that stood out to them during their care on the orthopedic floor; therefore, participants chose whether they brought up positive or negative experiences. These experiences consistently depicted caring or noncaring. If participants did not clearly state whether the experiences were perceived to be caring or noncaring during the course of the interview, they were asked for clarification. Seventeen participants described both caring and noncaring experiences; three patients described only caring experiences. Of the 20 participants, 12 began the interview by recounting caring experiences and 8 initially volunteered noncaring experiences.

The researcher concluded from observation during the interviews and comparison of transcripts that there were no differences in perceptions or descriptions of caring and noncaring experiences between the first and second interviews for 17 participants. The remaining 2 patients had been assessed to be without cognitive impairment at the time of the initial interview, but could not remember parts of their hospital experience during the second interview due to sequelae from head injuries that had more of an impact than expected in one
case, and were not detected in the other. Of note however, was the issue of expressing anger regarding noncaring experiences. Some patients seemed reluctant to express anger at the first interview, but were more open and able to express it during the second interview in their home environment. Some patients also seemed hesitant to bring up negative experiences and emotions during the first interview, but were more comfortable discussing them during the second interview.

There were also no observable differences between genders in responses to caring and noncaring either during the interview or in a comparison of transcripts. The only difference noted between elective and nonelective surgeries was that nonelective participants emphasized the way providers handled them, appreciating providers being careful not to hurt them any further. Lastly, there were no differences observed from second interviews conducted in patients’ homes versus interviews conducted over the telephone.

This chapter addresses the analysis of the interview data related to the research questions focused on caring. The results for research questions one, two, and six regarding responses to caring, eliciting caring, and examining the fit of this data with Swanson’s theory of caring are presented and discussed. Results and discussion regarding noncaring will be addressed in Chapter 5. Implications and discussion concerning results from both caring and noncaring are found in Chapter 6.

There are four caring themes that emerged from this study. After these themes are presented, responses to how patients elicit caring from providers will then be addressed. This chapter will conclude by examining the fit of this data to Swanson’s mid-range theory of caring with Swanson’s caring processes found in italics. This section will only include
“caring” themes. The noncaring themes will be discussed in relation to Swanson’s caring processes in Chapter 5.

**Caring Experiences and Responses**

This section addresses research question one: What do consumers describe as their responses to caring experiences during hospitalization? Caring experiences described by patients in this study are grouped into four themes: The Way, Mutual Knowing, Demonstrating Expertise, and Being in Tune (see Table 4.1). Subthemes that emerged from each theme are italicized in the presentation of the themes. Although these themes are interrelated and result in a cumulative and synergistic “caring” effect, each theme is presented separately with examples of patients’ descriptions of caring experiences and their responses to them. Examples are presented to highlight each theme; however, the example may also include one or more of the other themes.

**Caring Theme 1: The Way**

The first theme began the moment the patient met the provider and continued to be important throughout the patient’s stay. “The Way” is defined as: providers interact with and treat me as a human being. This theme concerns the manner or “way” in which the provider interacted with and treated the patient. Common descriptors used by patients to describe providers they perceived as caring included “concerned,” “caring,” “personal,” “nice,” “friendly,” and “accepting.” The patient’s perception that the provider was communicating with him or her as an individual was of great importance. Concerned, personal, and friendly emerged as the first subtheme in “the way.”
### Table 4.1

<table>
<thead>
<tr>
<th>Themes</th>
<th>Definitions</th>
<th>Subthemes</th>
</tr>
</thead>
</table>
| The Way             | The way providers interact with and treat me as a human being | Providers:  
  — Are concerned, personal, friendly  
  — Are willing  
  — Are gentle  
  — Use humor  
  — Offer a positive attitude |
| Mutual Knowing      | Providers know me and my history and make a connection with me | Providers:  
  — Know me as a person  
  — Know my medical history  
  — Offer a kind of friendship and allow me to see their humanness as well as professionalism  
Patients:  
  — Know providers' routine patterns of caregiving and what to expect (i.e., caregiver continuity) |
| Demonstrating Expertise | Providers have knowledge, know what to do, and will take care of me | Providers:  
  — Sit down and offer information with explanations, and answer questions in an interactive format  
  — Include me in discussions and decisions regarding my care  
  — Are organized and efficient  
  — Are qualified and willing to ask for help when needed |
| Being in Tune       | Providers anticipate my needs and meet them when possible | Providers:  
  — Check on me, anticipate my needs, and are responsive to my needs  
  — Alert me when they will be unavailable for a period of time  
  — Treat me as a whole person |
All the nurses and all the doctors have been very nice . . . [treating it] as a family matter instead of, oh, he’s a stranger . . . And they were personal instead of we’re dealing with John Doe here and we’ve just got to get him up and get him out. They always asked about the family . . . on more of a personal basis than doctor-patient and nurse-patient thing.

I’ve had some really nice nurses . . . They are concerned and they visit with me . . . as much as they can.

It seemed like everybody was more accepting I think . . . it was like . . . you can just talk to me and I can talk to you back, as human beings . . . The people have been really nice . . . they’ll talk to you and they share their experiences also, and they want to hear about yours and so you’re friendly; that kind of thing.

The nurses that have been assigned to me have been very compassionate, and they listen and they give some credibility to what you’re saying.

Another important part of “the way” theme was the patient’s perception that the provider was willing to help. This willingness aided patients in dealing with the level of dependence they had on providers and the resulting issues of feeling burdensome, uncomfortable, and awkward. The patient’s dignity was thus maintained at a time when the balance of power was tipped in favor of the provider. By conveying a willingness to help, providers assisted patients in tolerating this change in power and allowed them to express their needs.

You used to do these things for yourself and now you have to have help to get up and go to the toilet. You know, that’s really not a very comforting feeling. So these people by coming in here and treating me like a human, and treating me like a real person and not talking down to you really helped out quite a bit . . . That’s the way I like to be treated.

Some of them went overboard to help you.

It’s more, it’s I think going a little bit farther than just performing a function . . . You could have somebody . . . on the other end of the extreme where somebody would come and just over baby you to the point where you would feel . . . intimidated like . . . the individual didn’t have confidence in you or your ability to do things for yourself.
When the button was pushed and when I needed to go to the bathroom, they were there. . . . I have a very active, heavy duty bladder. . . . Because I was sitting on an orthopedic bedpan, which is small and flat. . . . I was overflowing and we kept changing the bed, and it became a running joke. . . . Every time I needed to pee and they needed to change the bed they were there with the bedpan and to change the bed, and to change out the linen, and to change out all of these extra blue absorbent pads, so it became a joke and nobody ever said anything about, “Good grief, woman. . . . Keep it under control.” . . . There was this camaraderie, this sense of team.

Everyone’s really willing to help. . . . That makes me feel gratitude towards them, whereas if they were doing it grudgingly I wouldn’t feel comfortable, but I do feel comfortable. . . . You trusted them more. . . . where they’d help you it’s just a family so to speak . . . like you’re an important person, and if they didn’t it’s like you’re a nuisance . . . then you’d build a wall.

Those patients who were hospitalized for nonelective, postaccident or trauma surgery emphasized the value of the nurse helping them to get comfortable, being gentle with them, and being very careful not to hurt them.

I had an older nurse that helped me with the bed baths and she was really kind and gentle, and careful that I didn’t get hurt because it was quite painful to move about.

I think the way they handled me I didn’t have the pain response that I would have had if they were handling rough, and I didn’t have the agitation by being in a lot of pain at the time. . . and so I was able to relax.

An important part of this theme was that of the provider projecting a positive attitude and using humor when interacting with patients. A positive attitude and humor seemed to convey a sense of hope and encouragement to patients. Patients’ response to a provider’s positive attitude, in communication and interaction, was to perceive and acquire a sense of hope for recovery. This attitude helped the patient have courage to “get through” or “endure” the experience.

Laughter is healing, smiles are healing. Just as medication heals, I think that laughter and a smile heals also, and with the particular [physical] therapist that I had, with their personalities, they offered that.
In particular the physical therapy people when they come by daily to get you out of bed . . . did have good humor about them and they did keep their spirits up . . . When you’re in the hospital bed and you’re not able to move a lot then I think it’s very important to keep your positive attitude, and they were helping to generate a positive attitude with their attitudes and their behavior when they come in to see you.

The ones that did have a sense of humor, they do help you get through the painful time. Make[s] you kind of forget some of the things.

The actual physical therapy department . . . stands out in my mind as being very positive. . . . It was come in and converse with you like a friend, somebody that they were just going to help. . . . Everything they said was upbeat, “We’re going to do this and so what if it takes us two or three tries. We’re going to do this, we’re going to get this done.” And they’re very reinforcing, very reassuring in that way, and I think very positive in this situation because you feel so down.

In addition to helping patients get through or endure, a positive attitude decreased the patient’s level of anxiety and worries about prognosis.

Even when I was in the emergency room and had just gotten in the accident they were laughing with me and joking with me, so it kept my spirits up and I didn’t have to think about what was wrong with me.

Patients who perceived positive attitudes from caregivers made response statements such as, “It makes me feel good,” or “You feel like you’ll get better.” Positive attitudes seemed to be very important to patients in a vulnerable state. Perhaps because it was so difficult for patients themselves to feel positive in this situation they needed to soak in, or borrow a positive attitude from the staff. Patients tried to carry this attitude with them throughout their recovery.

If you feel more positive about everything that’s going on . . . [if] the nurses and doctors treat you in a personal manner, your body’s going to heal quicker . . . and it’s easier to go through what you’re going through when they treat you that way.
It [offering friendship] gives a more positive outlook and then in the end a quicker recovery because if you’re positive you’re going to recover faster. . . . If you leave feeling positive and you’ve received not only good care, but personal care, you’re going to take that home with you and that will carry out through your healing time because you will think back to that.

They [nurses] kind of make you feel like you was [sic] something and that you were just gonna get better in a hurry. . . . The positive approach . . . they spoke of being positive and there was nothing that couldn’t happen if you had the right attitude.

That [positive attitude] still holds, and that’s particularly in light of the new prognosis which is significantly slower. That still is really important, so that’s one of the things that I’m carrying with me.

When “the way” providers interacted and communicated with patients was positive patients reported feeling less anxious, more able to begin building trust, and more motivated to work in physical therapy.

They [nurses and physical therapists] . . . helped me to keep my spirits up and to push myself . . . to what I can do . . . I think you have to kind of push yourself if you want to get better, like getting up and doing some things instead of just laying here. You just kind of have to push your body to get better.

Patients perceived that the cumulative response, or benefit from providers interacting in a caring “way” was to help them heal faster and recover more completely.

And there was [sic] a few nurses throughout this past week that I felt like I would come back and see because I had a start of a friendship. And I think that’s important to any caregiver to offer a friendship to their patient. . . . It gives a more positive outlook, I think . . . then in the end a quicker recovery because if you’re positive you’re going to recover faster.

That’s [love and caring] the most positive thing that a patient could experience in a situation where they’ve just seen their whole life devastated, if it’s only for six, eight months, or for the rest of their life. I think to see somebody who’s actually caring or loving, that’s there because they want to be there, not because they’re here to earn a buck, it makes you feel that there are people out there that care about you and there are people that want to help you . . . It’s really, really helped pull me through because the time is so tough when you sit and think about what your life is going to [be] like for the next
six months and stuff. And the more positive things that affect your life, I think, while you’re going through the first couple of these problems, is going to get . . . me through emotionally; psychologically, it’s going to get me through.

Caring Theme 2: Mutual Knowing

The second theme identified was that of providers taking the opportunity to fully know patients as real people. “Mutual Knowing” is defined as: providers know me and my history, and make a connection with me. “The way” providers interact with and treat the patient is an initial prerequisite and ongoing requirement for getting to know the patient and making a connection with him or her. In return, some patients placed a great importance on getting to know their providers. As nurses, physicians, and physical therapists came in to assess and get to know the patient it was also an important process for the patient to do the same with the providers.

Providers know me as a person was the first subtheme that emerged in this theme. Patients perceived providers as getting to know them and connecting with them when the provider paid particular attention to the medical history, understood the significance of the current health care experience, and treated them as human beings. Patients emphasized how very important it was for them to know that their providers were personable, knowledgeable, able, and intending to give them quality care.

The first day I went in to see [the doctor] before my first surgery, we went in and we sat down, and we were talking to him and he says, “I’m an old Texan.” . . . What it meant to me was the fact that he wasn’t . . . in it just for money, money, money. He acted like he really cared about me. . . . He knew me. When I’d walk in the office he knew who I was and he’d call me by my first name. . . . He’d come up and put his arm around my shoulders, and it was . . . personal touch. . . . He says, “I want to be your doctor.” . . . I knew I found a doctor that was going to help me, that was going to take care of me. . . . I probably cried most of the way home because I . . . was so relieved. . .
I had one neurosurgeon . . . that gave me 10 to 15 minutes of his time. . . . He says, “You’re diabetic. . . . I can’t help you. . . . I suggest you go home, you lay on the floor, and you suffer with this till you die.”

I enjoyed getting the nurse that I already knew . . . especially in my case, where I have some obvious results from my previous surgeries with the facial paralysis and things. . . . [If] I had the same nurses come in all the time I didn’t have to go through the whole story [previous medical history] with each one of them and try to explain it to them before they could take care of me.

Patients appreciated when the provider asked personal questions and offered friendship in a way that showed he or she regarded them as someone of value.

Most of the physicians I’ve dealt with have been very, very good, very caring . . . personal caring. I like a doctor to know a little about me. I don’t want him just to stand here and read out of my chart . . . . I expect them to be able to come in and sit down with me and talk about my care.

He was one of the three doctors who was waiting for me to say good-bye the . . . morning I left . . . . He was one of the ones who said, “In our three lifetimes we may never run into your problem again, but we learned an awfully lot from you,” and then he essentially . . . gave me what I will call a high five . . . . I mean, there was a real acknowledgment that we had done this together . . . . It was very positive. I think it was positive for him. I know it was positive for me.

Patients also wanted providers to talk about themselves or their experiences, allowing the patient to see humanness as well as professionalism.

And when they tell me about them[elves], when they say, “Well, my husband does whatever and I have four children,” and [they] talk about their families, that gives me a good feeling . . . . What you’re about, I think, is a two way exchange of--a mutual exchange of personal information.

For the patient, knowing the provider also included getting a sense of that provider’s routine and pattern of caregiving. Patients expressed having a need to know what to expect.

Friday night and Saturday night I had a nurse named X . . . . and I think because she’d been here, I kind of knew what to expect and anticipate . . . things a little bit more . . . that helps.
Patients emphasized the importance of *caregiver continuity* inasmuch as continuity was seen to facilitate the process of knowing them. When there was continuity, the patients felt that their nurses, physicians, and physical therapists “caught on” more quickly if there were any changes, positive or negative, in their condition.

I think that . . . has helped to have, to be able to work with some of the same nurses because they know where you’re at . . . compared to yesterday. They can see the changes. . . . Even yesterday . . . when X was here she made comments, “Oh, you’re doing so much better today than yesterday.” And for me, that really buoyed me up and really made me feel a lot better than if it would have just been somebody else that just came in and didn’t have any reference point.

With continuity, the patients could relax and feel more secure because they knew what to expect from their provider and that provider’s routine. Patients also believed that continuous care providers could be more “in tune” and available because of their knowing what needs to expect.

. . . you have some familiarity there too. . . . I think when you have somebody, you know their name, you kind of know what they expect . . . it helps me have a lot more confidence and trust in what’s going on because I think there’s enough uncertainty.

I did a couple of times [have the same nurse] . . . that’s the ones you got along best with. . . . It made me trust more. You’re more open and you ask questions, and you feel like they know because you went through some of the things with them, and so basically it just opens the doors.

“Mutual knowing” between patients and providers seemed to be a prerequisite to patients feeling “comfortable” or secure with their health care, and contributed to the development of confidence and trust in the care providers offered. Patients also responded to mutual knowing by having a decreased anxiety level.

As far as the way the nurses and doctors treated me, there’s a trust there because they kept me informed on what was going on. . . . That’s building a
relationship of trust; them getting to know my personal side and also letting me know what’s going on with my hand.

They took the time to look at your whole total picture and they many times would come in and say, “Now, I brought you this kind of tape because I know you’re allergic to surgical tape,” or “Do you think because that knee is messed up, do you think you can do this, or do you want me to help you another way?” You know they read the information, or they at least followed your case and knew... That makes a world of difference, I think, in how you recover. It calms you down, it helps you to focus a little bit if you’re nervous or scared.

Caring Theme 3: Demonstrating Expertise

While getting to know providers, patients looked for cues to assure themselves that those providers had knowledge and expertise. The third theme identified is “Demonstrating Expertise” and is defined as: providers have knowledge, know what to do, and will take care of me. This theme includes patients perceptions of providers as knowledgeable, and applying that knowledge in their plan of care and use of current technology. The provider sitting down and offering information with explanations about the plan of care and recovery, and answering questions in an interactive format were described as ways providers demonstrate expertise.

He [the doctor] went on to show me my MRIs and to tell me exactly this is what he figured I needed... He gave me complete information... he gave me reasons why... If he wouldn’t have, I wouldn’t have done it [the surgery]... I trusted him. I trusted everything he said to me... His qualities are knowledge and belief in what he says... in his diagnosis and his treatment [plan].

They [doctors and nurses] explained everything real well and really put my mind at ease, so that I could know I didn’t have to worry about it like I would normally. I wasn’t in the dark about it.

Patients valued the provider sitting down and taking the time to communicate, and perceived this as a way that providers showed knowledge and expertise, and that their
knowledge was being applied to the care that was delivered. This application of expertise projected competency of the provider and patients valued competent providers. It was critically important to patients that all providers be able and willing to answer questions and explain information.

... [the physical therapist and nurses] say, “Okay, this leg is the one you’re supposed to use even though you can’t use it,” and they explain why. And so it helps me to understand and be more patient with why it’s not working properly.

The physical therapists are really pretty good. Usually they know how to set you up and help you get up and down, and they keep right there so you don’t fall.

After talking to the surgeons, they reassured me that ... the chances were a lot better than it was explained before. ... They sit down and explain every detail that they will be doing, and what the chances were ... they were really thorough. They were the most thorough surgeons I ever met in my life. ... So I knew what was going on and I knew right out front what was going to happen. ... It more or less calmed me. That way I was assured they’d do the best they could do and there was nothing that was being hid behind my back. ... And that made me feel real good.

As demonstrated in the above example, patients particularly valued thoroughness and a positive attitude in their physicians. If patients perceived visits as only social interactions, they became concerned. Patients wanted physicians to ask them how they were and to assess for any problems, either physical or in the care they were receiving. Also, patients perceived attending physicians as experts when, and if, these physicians were available, accessible, and actively in charge of their care.

I really didn’t talk to him [the surgeon] very much in the hospital. He’d just come and see how I was doing ... Now that I’ve seen him more [outpatient follow-up] I’ve gotten to know him better, and I have more trust in him because it seems like he’s real competent and knows what’s going on. ... When he was talking one on one in the room and let you know what exactly is going on with your knee, and if you have any questions he’ll answer them
as best he can. And he just seems to be real caring . . . really taking the time to see what the person wants, needs.

Patients expressed the importance of being included in conversations, and in participating in discussions and decisions regarding their care.

The sense of team was that I was able to create what I felt was a good working relationship. . . . I am the only one who knows what everybody said to me, so I was able to say, “Skin care says this, PT says this, and we need to check on this.” . . . I felt it important I pay attention to rounds, that I knew who was there . . . that I be willing to answer questions and explain things and listen.

Additional characteristics that conveyed knowledge and expertise to patients was their perception of the provider as being organized, efficient, qualified, knowing when things needed to be done, and having a willingness to ask for help with a procedure when necessary.

I don’t know if she [the nurse] had a list that she went by, but she seemed like she knew when things needed to be done and . . . she seemed very organized that way. I enjoyed it.

. . . [the nurse] couldn’t . . . put an IV in. They called for someone else to do it right away. And not all the nurses did that, but the nurse that I was with the majority of the time, she did. And that meant a lot to me. Rather than being poked and prodded over and over again until they could accomplish it, they went and got someone else that could do it. . . . That took a lot of trauma away.

When patients received care they perceived as expert they responded by feeling enough trust and understanding in their plan of care to allow their providers to do their jobs and take care of them. Being able to turn over the responsibility for their care during this vulnerable time allowed patients to further relax, feel reassured, and secure.

It calms you down, it gives you a sense of security . . . when they share information with you.

She [the physical therapist] explains everything in detail, takes time, explains everything so you know exactly what she’s doing, so you don’t get nervous or worried. And when they have a big instrument on you and they’re gonna
take it off and start moving your arm that’s been crushed, I was scared about
that, and she talked real slow and explained it and says, “We won’t do
anything to hurt you,” and ... was very calm ... and got me real comfortable.

They were very aware of the traction splint, knew very much how it worked
and where it needed to be positioned, so it wouldn't hurt me when they
moved me. And they were just alert to all the little injuries, so that what they
did didn't intensify anything. I was very reassured, very comforted. ... I was
able to relax knowing that even on this airplane that there was somebody that
was going to take care of me. ... And when they worked with me they
portrayed to be very knowledgeable and very professional.

Caring Theme 4: Being In Tune

The fourth caring theme was that providers be in tune with patients. “Being In Tune”
is defined as: providers anticipate my needs and meet them when possible. This theme
represents the cumulative and synergistic effect of the three previous themes. Being in tune
was described by patients as “checking,” anticipating needs, giving more caregiving, being
responsive to needs, and alerting the patient when the provider was going to be unavailable
for a period of time.

I have had one nurse here that he came and checked on me regularly whether
my light was on or not. And he would set his watch to the time, about 15
minutes prior to when I usually needed pain medicine. ... And if he was
going to be tied up in another room or doing something else, he made it a
point to come and tell me that, “I’ve got a real serious patient two doors
down” or whatever, “I may be in there, but I’ve got so and so out here that’s
supposed to be helping me watch you, so if you need anything she can help
you.” ... He really cared. ... It made me feel really reassured that he thought
of me in such a way that he was caring enough to go out of his way.

She [the nurse] just popped her head [in] and indicated that she was going to
be done [in] ... about an hour and asked me if I needed anything. ... It
makes you feel like you’re more a part of what’s going on, as opposed to just
being a fixture, and that everything’s operating around you.

If they’re efficient, they’ll check and see if it’s done ... well, they check how
you feel and if you need medicine. ... To begin with I was using a bed pan
... and I had a lot of gas ... she [the nurse] prepared ahead the commode [it
had to be ordered] because there was no way I could go to the bathroom . . .
and so that’s better to sit on one of them than a bed pan. . . . She did
everything she could. . . . It gives you a lot of respect for them.

As shown in the last example and the next one, anticipating needs and knowing what
to do about them were also important.

At the time, I hadn’t had it [knee] sutured. . . . I remember I [skin] was
sticking because my whole side had been road rashed basically and it was
quite painful sticking to the cast, and one of the nurses gave me Teflon paper
so it wouldn’t stick and that was, it was a miracle. I just loved it . . . you
actually . . . build a bond with people that help you when you’re down.

Knowing when a patient really just needs space or wants to be left alone is also a part
of providers being in tune.

Well, some of them [the nurses] are really good to stay out of my hair. . . . I think it’s nice we can get past asking questions and the nurse can . . . just
know . . . what I need and what I want, and what I expect. . . . One of the
male nurses, he’s really good at making himself available. He doesn’t come
ask me, “Is there anything I can do for you?” but he’ll make himself
available, and if I think of it I can grab him.

Another aspect of being in tune is combining psychological and spiritual needs with
the physical, i.e., using a holistic approach. Postaccident patients were forced into an
unexpected and suddenly vulnerable state, usually dealing with a great deal of pain, having
gratitude that they had survived thus far, and having fears of whether they would ultimately
survive.

It’s a high risk surgery because a hemangioma bleeds a lot and we knew that
going in. They [the nurses] were also very supportive Tuesday because
Tuesday was the day that we had to start thinking about those things you
think about if you’re going to die. And so Tuesday was the day that they
were there when I needed paper and a clipboard to write a will, and to do
advance directives and to leave instructions behind. So considering where I
was, they were very good.

Both elective and nonelective patients had to deal with the unknown concerning their
future. Questions arose pertaining to the extent of their injuries, degree of disability, and the permanence of the damage. Patients wondered how much function they would recover and what they would have to live with. Patients needed their providers to allow them to grieve, but to be positive and hopeful, yet realistic. Patients did not want their providers to appear negative.

I play sports all year around and my . . . thumb is very necessary for the sports that I play, and whether or not I’m going to have that thumb is a pretty big stress on me, and they’ve helped me out a lot in dealing with the fact that it’s still there and it’s got a good chance. And then there’s also the possibility that maybe it won’t work. But they’ve never been negative as far as my hand goes. They just try and keep me in reality . . . I think they’re telling me the way it is.

The cumulative response to providers “being in tune” with their needs included patients feeling reassured regarding their providers’ care and trustworthiness. See Table 4.2 for a summary of patients’ responses to caring experiences.

When a caring attitude was projected and knowing occurred, a bond was frequently established. When this bond was established it was as if the patients and care providers were saying “mutual knowing” had been accomplished. The provider could then convey to patients knowledge and expertise, and that he or she was available to the patient and “in tune” with them. It seemed, to the researcher, that only after these four themes occurred did patients feel free to openly share their true physical status with providers and to state their needs.

Patients perceived that caring behaviors facilitated a quicker postoperative recovery and a more comfortable health care experience; therefore, patients attempted to elicit caring from providers.
Table 4.2

Patients’ Responses to Caring Experiences

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<th>Responses</th>
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<tr>
<td>• Feel encouraged to get through or endure</td>
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<tr>
<td>• Have decreased anxiety and increased calming</td>
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<tr>
<td>• Take in a positive attitude</td>
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<tr>
<td>• Have hope for recovery</td>
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<tr>
<td>• Understand the plan of care</td>
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<td>• Build trust</td>
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<td>• Perceive healing faster</td>
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**Eliciting Caring**

This section addresses research question two: **What do consumers do to elicit caring from health care providers?** Patients described what they did to invite caring from their providers in general terms that were not specific to particular experiences. The patterns described by patients included getting to know providers on a personal level, reflecting a positive attitude, and trying to be upbeat as much as possible.

I would talk with all of my nurses and things and try to get on a very personal basis with them, and try to keep them to where they thought of me as not just a patient, but as somebody that could be a friend, or could be nice, and not just somebody that pushed the call [light]. . . . I didn’t want to come across that way at all. I wanted to come across as a very compassionate patient and would appreciate any extra help, and I think I got that out of most of the staff.

I also felt that their other frustration was with patients who essentially turned over the responsibility for their health to the health care system, essentially said . . . “You take care of me because I’m paying you. I will lie here, you will do the work.” . . . I was consciously doing it [teamwork philosophy with
patient responsibilities] differently and I was letting everybody know . . . and I got a huge response, a very positive response.

One patient attempted to teach providers how to best meet her needs.

[Nurse X] is still kind of new, but he’s teachable . . . and so I’m willing--I’m able to teach him . . . that, “Do you want to give me a warm washcloth or a cold washcloth?” . . . And so then he’ll think of it next time.

Patients reported cooperating with and helping providers when possible, and being tolerant and patient.

I understand that some of the patients are pretty tough to take care of. I try not to complain. I’m patient and pain is pretty tolerable.

I try to help out as much as possible in the position I’m in, which isn’t very much, but I try . . . just pick myself up here and do this . . . and just keep a positive attitude, I think is really important.

One patient advocated using a teamwork approach to elicit caring.

Every new nurse who has come in has been on my team. My job has been to learn who she is and what she likes. . . . They have been willing to open up a little bit . . . they have been willing for me to help and I’ve been willing to help. It’s important for that to happen. I know not to ring the bell when everything is going crazy out there . . . and so my job as a patient has been to be responsible to what they needed and they have been really good.

It may be said that patients made an effort to become “good patients” by being friendly, cooperative, and accommodating.

This concludes results related to caring and responses to caring. These data will now be discussed in relation to how it fits with Swanson’s mid-range theory of caring.

Discussion of Caring Findings and Relationship to

Swanson’s Mid-Range Theory of Caring

This section addresses research question six: How does Swanson’s mid-range caring theory (1991, 1993) fit with consumers’ descriptions of caring and noncaring experiences in
an inpatient orthopedic surgery setting? During data collection and analysis the researcher made a conscious effort to “bracket” Swanson’s processes, a technique described by phenomenological researchers, until themes for caring emerged from the perspectives of, and descriptors used, by patients in this sample. The intent of bracketing was to limit the influence of Swanson’s theory on the researcher’s initial data analysis for this sample. In the final phase of analysis, the four themes of caring that emerged from these data were then compared and contrasted to Swanson’s work.

Swanson’s processes can be seen within interview examples presented in the previous section on caring and responses to caring, and within the themes that emerged from this study’s data. Patients’ perceptions of caring in this study consistently included the five processes in Swanson’s theory and support this mid-range theory of caring. The researcher found that each theme of caring was similar to and reflected one or more of the five processes; however, there was not always a one-to-one correspondence between Swanson’s processes and the themes emerging from this study. Other than the individual researcher’s interpretation, this may reflect a difference in patients’ emphasis on the various aspects of caring because of the setting. It may also be related to the fact that the emphasis in this present study was on patient responses to caring. In any case, there was a somewhat different grouping and labeling of themes which may contribute to a fuller understanding of how caring is communicated to patients. The four themes of caring described by this sample from participants’ caring experiences are now discussed in relation to the five processes of Swanson’s caring theory.

*Maintaining belief* “is sustaining faith in the capacity of others to get through events or transitions and face a future with meaning” (Swanson, 1993, p. 354). *Maintaining belief*
corresponds in large part to the caring theme in this study termed “The Way.” It was a very integral and important process for the patients in this study to perceive providers projecting a belief in their ability to get through or endure the postoperative period; in coping with pain, dependency, and imbalance of power issues; and in coping with the uncertainties about future abilities and adjustments to disabilities. *Maintaining belief* was facilitated through the positive attitudes, encouragement, and humor that providers conveyed to patients in “the way” they delivered care during the postoperative stage. Patients described the importance of having provider support, with providers being concerned, personal, friendly, willing, and gentle, in getting through the events and transitions of recovery from both trauma and surgery; elective and nonelective. Nurses and physicians having positive attitudes and providing encouragement were perceived as sustaining for patients which gave them hope during recovery. It was important to patients that physical therapists displayed positive attitudes, fun, and humor when helping them do the hard therapy work. This facilitated motivation for the patient to work hard and regain lost function. When providers offered their belief or faith in the patient’s capacity to transition through this health care experience to a future with meaning, patients described carrying this belief throughout their recovery. Thus, “the way” providers interacted with the patient was an important component in his or her *maintaining belief* and sustaining hope.

*Knowing* “is striving to understand events as they have meaning in the life of the other” (Swanson, 1993, p. 355). Swanson’s definition seems to reflect the themes of “The Way,” “Mutual Knowing,” and “Being in Tune” which emerged from this study. Patients emphasized the importance of providers knowing them on a personal level; knowing their medical histories; and understanding the meaning, to the individual patient, of the current
trauma and/or surgery. Also, providers interacting with patients, “being in tune” with them, and allowing patients to perceive themselves as being viewed personally and as unique individuals were frequently described during caring experiences. Patients emphasized knowing as a mutual process and not a process occurring predominantly from the provider to the patient. Some patients expressed how important it was for them to also know their providers, both professionally, through their caregiving routines, and personally. This emphasis is somewhat different in this study sample from Swanson’s description of knowing. Several patients used the term “friendly” to describe “the way” they wanted to interact with providers in order to make a connection with and get to know them. Patients expressed the desire to have their providers treat them with the positive regard they would show a friend or a person they valued.

“Being with” [italics added], being emotionally present to the other” (Swanson, 1993, p. 355) was reported by patients in this study via their descriptions of feeling support from “The Way” providers interacted with them and cared for them, and also being secure that providers were “Demonstrating Knowledge and Expertise” and applying it to the care they were providing. Being with also reflects some aspects of the theme “Being in Tune” that emerged in this study. Some patients described the importance of the nurse’s presence to help them through the first hours after surgery when they felt confused and alone. Patients described establishing bonds with providers, feeling gratitude for their presence, and being listened to. Surgeons sitting down and talking with patients about their care was extremely valuable to participants. Patients who experienced trauma were especially appreciative of a provider’s presence that showed sensitivity to their pain, their grief, and the level of dependence they felt. Patients expressed how much they needed and valued being given a
message from the provider that they mattered and would be taken care of. This allowed patients to feel important, have further security, and gain a hope for recovery.

*Doing for* “simply put, is doing for the other what they would do for themselves if it were at all possible” (Swanson, 1993, p. 356). This process was described by patients in “The Way” that providers came across to them interpersonally when providing physical care, providers “Being In Tune” with them, and through the patient’s perception of receiving expert and knowledgeable care, i.e., “Demonstrating Expertise.” Providers displaying a willingness to do for the patient was important to these postoperative patients, especially when they felt out of control and highly dependent on providers. The demonstration of expertise by providers posttrauma, during surgery, and postoperatively was particularly important to the participants in this study, perhaps because of the amount of control these patients must turn over to providers to subject themselves to surgery, and the level of trust that this requires. “Being in tune” with patients’ physical needs, especially pain and fears posttrauma and/or postoperatively, allowed providers to offer comfort, anticipate needs, and meet those needs while still preserving the patient’s dignity. When doing for was projected as willing and “in tune” with patients’ needs, concern about being a burden slipped into the background and allowed patients to feel secure and taken care of, and place their focus on recovery. In addition, provider efforts toward comforting and decreasing anxiety allowed patients to trust and build confidence in the care they were receiving.

*Enabling* is “facilitating the other’s passage through life transitions and unfamiliar events” (Swanson, 1993, p. 356). Enabling includes coaching, informing, explaining, allowing, supporting, helping, guiding, assisting, offering feedback, and validating to facilitate the other’s capacity to grow, heal, and/or practice self-care (Swanson, 1993). The
process of *enabling* is reflected in all four caring themes that emerged from this study. *Enabling* within this orthopedic surgical setting involved the facilitation of gradually developing independence, in contrast to the dependent state experienced by these patients immediately postoperatively. This level of dependence and its discomfort seemed to frighten many patients and cause them to wonder if they would ever get better. *Enabling* was facilitated in this study when participants were given time and adequate information concerning their condition, care plan, and expectations concerning their recovery, which are included in the theme “demonstrating expertise.” Patients valued intimate physical care from nurses when needed, delivered in a positive and willing “way,” so as to maintain their dignity. They also valued having continuity with providers which facilitated “mutual knowing,” which could then allow them to gradually progress to more independence as able. This continuity allowed providers to offer meaningful feedback if, and when, there had been improvement from the previous day. Patients also expressed the importance of physical therapists talking them through and explaining each step of moving their bodies during therapy. *Enabling* with a positive attitude was critically important to these patients’ sense of hope.

Swanson’s theory of caring was found to apply and is generalizable to this study sample’s context of inpatient, acute postoperative patients. It also generalized beyond nursing practice to include care given by other providers. This caring theory applied to patients’ perceptions of experiences with nurses, physicians, and physical therapists. This study extends the applicability of Swanson’s theory of caring to acute care, inpatient postoperative settings and across multidisciplinary teams of health care providers.
**Summary**

A focus of this study was responses to caring. Although responses to caring have not been the focus of previous studies, results in this study supported previous anecdotal findings reported as consequences of caring (Riemen, 1986a) including feeling comfortable, secure, at peace, and relaxed. Responses to caring expressed by patients in this current study included (a) feeling encouraged to get through postoperative recovery, (b) having decreased anxiety and increased calming, (c) taking in a positive attitude, (d) having hope for recovery, (e) understanding the plan of care, (f) building trust, and (g) perceiving healing faster.

Patients in this study emphasized the demonstration of expertise in addition to the traditional affective components described as caring. Swanson’s definition (1993), used to develop this study, is adapted here to draw in the four themes that emerged from this study. Caring is defined as providers delivering health care in a nurturing “way” related to a valued other, toward whom one feels (a) a personal and professional sense of connection and commitment, (b) a “mutual knowing,” and (c) a responsibility to demonstrate expert and knowledgeable clinical care that is (d) “in tune” with that valued other’s needs.
CHAPTER 5

NONCARING: RESULTS AND DISCUSSION

Introduction

This chapter presents the analysis of the interview data related to the research questions focused upon noncaring. The results for research questions three, four, and five regarding responses to noncaring, the prevention of and protection from, and recovery from noncaring are presented and discussed. This chapter then presents discussion concerning the four noncaring themes in relation to Swanson’s caring processes and concludes with a discussion of findings in noncaring.

Noncaring Experiences and Responses

This section addresses research question three: What do consumer’s describe as their responses to noncaring experiences during hospitalization? Noncaring experiences described by the patients in this study also fell into four themes that reflect the reverse of those experiences identified as caring: The Way, Not Knowing Me, Doubting the Provider’s Expertise, and Being Unresponsive (see Table 5.1). Each theme is presented separately with examples of patients’ descriptions of noncaring experiences and their responses to them. Subthemes that emerged in each theme are italicized. After these four themes are presented, responses of patients who observed their roommates experiencing noncaring and volunteered
Table 5.1
The Noncaring Themes Defined With Subthemes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Definitions</th>
<th>Subthemes</th>
</tr>
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<tbody>
<tr>
<td>The Way</td>
<td>Providers do not interact with and treat me as a human being</td>
<td>Providers are:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Impersonal, rough, or brusque</td>
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<tr>
<td></td>
<td></td>
<td>—Unwilling to help</td>
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<tr>
<td></td>
<td></td>
<td>—Just doing a job</td>
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<tr>
<td></td>
<td></td>
<td>—Rude or discount my questions</td>
</tr>
<tr>
<td>Not Knowing Me</td>
<td>Providers do not know me as a person or my history</td>
<td>Providers:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Do not know me as a person or my medical history</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Discount my questions</td>
</tr>
<tr>
<td>Doubting Expertise</td>
<td>Providers do not seem to know what to do and do not take care of me</td>
<td>Providers:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Do not give me adequate information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Do not include me in discussions concerning my care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Are not available or actively involved in my care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Give me conflicting information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Seem unskilled at some procedures they perform</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Seem to have missed or created a problem and do not keep me safe</td>
</tr>
<tr>
<td>Being Unresponsive</td>
<td>Providers do not respond to me or my needs</td>
<td>Providers:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Ignore or forget my needs or requests</td>
</tr>
<tr>
<td></td>
<td></td>
<td>—Do not answer my call light in a timely manner</td>
</tr>
</tbody>
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their perceptions concerning this are included. Again, although an example is presented to
highlight a particular theme, it may also include one or more of the other themes.

**Noncaring Theme 1: The Way**

The first theme identified in noncaring concerns the manner or the way in which the
providers interacted with and treated their patients. “The Way” defined as: providers do not
interact with and treat me as a human being. This theme focused upon providers who

*interacted in an impersonal, rude, or brusque manner.*

I remember one time buzzing for something. I don’t know if I needed to
move or if I had an alarm go off or whatever, but I remember I had said
whatever it was that was wrong, and the nurse that was here [said], “State
again,” and that kind of surprised me. ... To me, that seemed very kind of
almost military oriented.

[My housemate] went to the receptionist in the waiting room and said that she
was family, and Dr. X would not talk to her. ... I was appalled. ... I was
very angry about that. ... My roommate is my primary caregiver at home and
she’ll be the one that will be taking care of me. ... They were supposed to
report to her all the information and everything, and they pretty much
discounted her all along, even though I had made it very clear before I went
into surgery ... [that she had] durable power of attorney and all of the things
written to give her permission to make any medical decisions. ... I do expect
them to honor my wishes when I come into the hospital. ... It puts more
stress on me.

Noncaring “the way” also included those providers who treated their patients *roughly.*

... that wasn’t good enough. ... The RN comes in here ... and she physically
kind of just picked--grabbed me by the shoulders and told me, “It’s time to
get up X. It’s the only way to get you well is to make you get up now and do
it.” ... I guess they couldn’t wait because ... she just kind of took upon
herself ... to just go ahead and grab me by the shoulders, pull me up,
twisting me in a way that I thought my staples were going to come out.

I told [the respiratory therapist] he needed to put the bed down and so he put
the bed down a little bit, and when he did that released all the pressure that
was going on in between myself ... the bed and the cross piece here, and
basically my back gave out. I fell backwards. My head hit the rail here so
hard that it made the telephone ring. He didn’t bother to pick me up, say he was sorry, “Are you all right,” or what. And just kind of made like it didn’t even happen. And then he got kind of peeved because I couldn’t cough hard enough to blow up any specimen to put into the cup. . . . He watched me fall backwards. . . . It didn’t make any difference to him if I was okay or not.

Providers who were perceived by patients as noncaring were described as not being nurturing or just doing a job.

Rolling me, there’s a way they handle the situation. Sometimes some seem more nurturing than others . . . some it’s more, “Let’s get it over and get it done.” . . . But there are others where . . . it seems like there’s more . . . humanity involved. . . . I mean . . . we could put a rock in the bed and we could perform the functions on the rock, roll the rock and whatever. . . . It makes you wonder who’s on shift . . . who’s out there now and what kind of a mood are they going to be in.

Others, it’s usually the kind that are part-time or want to quit anyway, and they’ll do what they have to, but they forget things. . . . Well, doing as little as possible and I guess waiting for when her shift was over. . . . Even though she might have felt she was doing her job, her mind wasn’t all there for the patients. . . . Well, I was just kind of glad when the shift was over.

They [the surgeons] don’t realize that it may be an every day occurrence for them, but for a patient . . . it isn’t. It disrupts their entire lives. . . . I’d like to see some more doctors come in who have more of a nursing attitude [nurturing]. . . . The doctors . . . don’t have that human touch . . . that . . . personal care.

Providers were seen as uncaring when they projected an unwillingness to help or take care of patients’ needs. This perceived unwillingness was very upsetting to patients who were unable to care for themselves. This participant began to cry when recounting this next example.

I was telling the nurses that I was having trouble urinating and it seemed like they didn’t believe me. . . . They’d let me—just let the bell ring. . . . It felt degrading to me, but at the same time, I didn’t want to interrupt them because they made me feel they were always going . . . out of their way. . . . I kind of like overheard them [nurses], and it was like inconvenient to them to come and do that [empty the bedpan]. . . . It was like, “Oh God, there it [call light]
goes again,” that attitude. . . . That’s when I started doing what I did, just holding back and hurting inside. . . . It makes me mad.

Providers who did not seem to listen and/or discounted questions asked by patients were perceived as being rude and noncaring.

I do expect that if they ask you questions, that they take the time to hear your answer, and not cut you off or discount it, or say, “Well, that’s not relevant.” It may not be relevant for what their motive is for being in here, but it’s relevant to what my question was. . . . I . . . had tried to ask . . . about going home because I didn’t know if I could sit up in a car for any length of time, and I tried to explain that I was coming from [a distant city] . . . and I didn’t know if I should try to fly home or if I’d be able to go in a car. . . . I don’t know if over time I’m going to have more pain sitting on an airplane or if I’m going to have more discomfort from trying to lay in the back seat of a jeep. . . . My roommate was asking them [the doctors] what they thought and they just totally shut her down and said, “Look. Well, how you get home is really of no concern to us.”

From recovery . . . I came here. . . . and then I laid here probably for at least a good four hours and then finally rang for somebody to come and move me. I tried to move myself a couple different times and couldn’t. . . . It was just the uncomfortableness of being in one spot for so long. And then this nurse came in and she was rude. She was very rude. I asked her if she could please move me and she said she did not have the time . . . at this point and [if] she found time she would be back . . . turned around and left. . . . I was mad . . . it was such a mental traumatic strain. . . . If it wouldn’t have been for [hospital roommate and visitor] . . . I would have had to start screaming in here, “Get in and move me.” . . . If I would have been in here by myself I’d have had to. . . . I don’t know why she said that because I wasn’t rude to her or anything. . . . All she would have had to do is come in and say, “I will be right back . . . hang tough for me for five more minutes.” . . . In fact, I didn’t even have a chance to . . . answer. . . . There was nothing. . . . I started to cry, and then X [visitor] came around the corner and . . . said, “Well, you just lay here for just a minute and I’ll go find you help.” . . . I was just so emotionally upset. . . . If it wouldn’t have been for these two . . . I . . . could have died over here without no one knowing. . . . They [roommate and visitor] were my saviors. They’re pretty much who got me through it.

Patients’ responses to noncaring “the way” included emotional upset, anger, anxiety, and forming the opinion that this type of provider should not be in the health care profession.
I was really getting angry and fed up with the service of the staff around here. . . . Well, it took me a few days. I was kinda upset and pretty irate . . . over it. . . . In fact I was so upset that the next time that she came back . . . I thought she was gonna do it to me again.

I felt like he was in the wrong position, that he should find some kind of employment to his liking, and something he enjoys and puts a little care into. He’s not a people person and shouldn’t be working with people.

I just thought he didn’t want to do it [move me]. . . . I just didn’t think he needs to be in the medical profession.

Patients also felt very alone when they perceived by “the way” the provider interacted, that they did not matter to the provider, or that the provider did not care about them.

Usually there’s nurses all over, but this morning particularly nobody seemed to be showing or anything. . . . Well, it makes you wonder if they care. You can hear them out there, a bunch of them laughing.

**Noncaring Theme 2: Not Knowing Me**

The second theme that emerged as patients described noncaring experiences was providers not showing a personal interest in them by taking the time to get to know them as individuals with a personal history. “Not Knowing Me” is defined as: providers do not know me as a person or my history. Patients reported that some providers seemed to not know them as a person and were not familiar with their medical history or rushed over it. Often what seemed important to patients regarding their history or something that previous providers had told them was discounted or ignored by current providers.

He [physician] doesn’t listen . . . he sort of has . . . his agenda . . . when he comes in, and anything that you say to him outside his agenda doesn’t seem to get heard and doesn’t seem to be given any respect . . . . Like the blood transfusion thing that I had yesterday which was a major screw-up, that happened partly because they didn’t listen to what I had told them in my history . . . because I’ve had allergic reactions to blood transfusions . . . . Listen[ing] to the particulars that you share with them, such as I had . . . an
allergic reaction to blood transfusions . . . are sort of critical factors, or at least important factors to your medical history . . . that could have helped prevent that situation.

I’ve been told by every doctor I have ever gone to . . . that anybody that operated on my leg should be majorly concerned. . . . And yet no one here gave it any credibility. . . . Maybe they know new things now that they didn’t know then and it isn’t as big of a problem. . . . All they have to do is share that with me . . . just [to] alleviate the fears. . . . It scared me to the point of almost not having the surgery. . . . I just majorly had a panic attack to the point where I was crying, couldn’t get my breath. I didn’t know if I should go through with it.

Also, providers who made judgments, medical or otherwise, about patients without knowing them or their history were considered noncaring.

The doctor . . . made a lot of judgments on my health care based on some, I don’t know what kind of scientific data that he thought he had, but basically told me that I needed at least two weeks in his department because of the brain damage I sustained in the accident. Yet, all my neurosurgeons have said I don’t have any injury. . . . I was trying to figure out how he could make that determination because he’s talked to me for three minutes. He asked me about five different questions and the one that I couldn’t get. . . . I told him I got confused. I was counting backwards and I messed it up. . . . [I felt] pretty bad. I didn’t want to have anything to do with him. . . . There was no way that I was going down there with this doctor. . . . The doctor that was here before him . . . she talked to me the Friday before and we had already discussed the whole situation, and she was very concerned and caring and totally opposite from him.

It was like they don’t know me, they just know that I’m hurting, that I’ve got a bad back. They don’t know what happened to me [my history]. That’s what hurt me.

Patients viewed this deficit as preventing providers from understanding them and their worries, and the cause of problems that could have been prevented, or as a potential cause of future problems. An additional response to this noncaring theme was a stated intention to change providers for future health care.
I had already made up my mind at that point that when I’m out of this hospital, I’ll find me somebody [else] because this guy’s not going to look at me.

**Noncaring Theme 3: Doubting Expertise**

The third theme, “Doubting Expertise” is defined as: providers do not seem to have knowledge, know what to do, and do not take care of me. This theme occurred when patients perceived cues during their care that caused them to question the provider’s level of knowledge and expertise, or at least whether they were receiving the best care available. Patients reported that some providers did not take the time to give them enough information in order to understand the plan of care, and *did not provide adequate information* before surgery to allow the patient to know what to expect regarding treatment, pain, and the expected pace of recovery. These communication deficits contributed to patients’ doubts regarding the knowledge and expertise of their providers and was very upsetting to patients. The participant who described the second example was crying as the experience was addressed.

. . . how soon will you be from the IV to ice chips, and how soon will you be able to go on liquids. . . . I guess it’s going to happen, but not having gone through this type of surgery before, I’m uncertain as to what the timetable is for . . . recovery. How quick your functions return to normal, how quick bowels return to normal, what type of pain is normal, and how intense should it be? . . . I kind of found myself doing a comparison there [with roommate] thinking, “Man, I’m not progressing fast enough because I’m not even to this stage yet.”

I kept telling them that I couldn’t swallow. I mean, it felt like this big lump there and I guess if they would have just explained it to me. I haven’t ever had that before and my husband explained it the next day that they put a tube down. . . . But it felt like I couldn’t even breathe. . . . I thought something was in there. . . . I kept digging down there. . . . I kept saying this is hurting me, I can’t get it up. . . . I thought when I told them that I had to cough, that this big lump was in there, that he’d do something, but he didn’t even raise me up
or anything. And the nurse before that had said, "You’ve been on your back all day long. You have got to get moved, so when the next nurse comes in I’ll have them move you a little bit." So when the next nurse came in I said, "Would you just..." I needed to be moved. And he says, "Oh no, you’re okay." And so I stayed there the whole night. . . . It was just a long night.

In the middle of the night . . . I remember he [the nurse] came in and had a flashlight . . . I kind of wake up and here’s this flashlight shining in my face . . . and then he was talking about taking some tubes out. . . . I found myself even wondering is this a real nurse, or is this somebody that’s just kind of gotten in the hospital . . . Nobody had talked to me previously about anything happening and I wasn’t sure if it was supposed to come out or not . . . so I was kind of apprehensive to have anybody do anything that I hadn’t been given any information about previously.

Some patients expressed concern about not being included in discussions or in the decisions concerning their care, and perceived this exclusion as occurring because of a lack of expertise or knowledge on the part of the provider.

You would hope that since it’s your body that you would obviously be an equal member of the team and . . . even be able to pull rank on the team because it is your body. Quite frankly, I never felt that way. I never felt that I was equally seen as any part of any team in that hospital.

Another concern for patients was whether the attending physician, who was frequently described as “my doctor,” was available and involved in their care. If the provider did not seem available, or involved, this was perceived by patients as noncaring. Knowing that the attending is available, was perceived by patients as a way in which the provider conveyed his or her expertise in delivering the plan of care. Some patients spoke highly of residents working with them; however, they still referred to the attending as their doctor, and needed to know that he or she was actively involved and supervising their plan of care.

The main doctor, I haven’t seen but very little of him, but he’s been fine on those [times]. . . . It just felt like he had to take a very small portion of his time and talk to you and show kindness, and really tell you what they thought to expect. . . . He’s such a busy man that it’s hard to get a word with him. In
fact, when I checked out I wanted to ask him some questions and [I found out] he was in X [out of town]. . . . At the time it did [bother me].

We had no idea [that surgeon was leaving town], he didn’t tell us. . . . It was a big surprise. . . . So that’s kind of uncomfortable.

Patients doubted providers’ expertise when they received conflicting information from different current providers, or did not feel that their recommendations from their own intuitive body sensing were listened to.

He [the pain doctor] told me . . . to punch the button every time I needed it, every time it hurt. He told me that I wouldn’t get more than one dosage every ten minutes . . . but to punch it every time because sometimes we forget . . . he told me not to go by the clock. . . . [The nurses] told us to try and go every ten minute, to watch the clock, and we did watch the clock. And so we missed a lot of the dosages. . . . I hurt. . . . I was upset because I’d gone through pain I didn’t need to go through because of the fact that we had a lack of communication.

I kept saying that this IV wasn’t working and she [the nurse] wouldn’t do anything about it. And because she was working with the blood, trying to get the blood in, and the blood was going too fast and it was hurting, so she was hot-packing. . . . It irritated me that she wouldn’t take the time--I mean, she kept shaking it and saying it was fine, but I knew it wasn’t. It wasn’t flowing. . . . I guess what I was worrying about was that I got my pain medicine through that IV. . . . It was a little panicky.

I told them . . . I had a stomach ache, “Can you come back in about a half hour or a few minutes?” . . . That wasn’t good enough. He went to one of the RNs . . . and told her I refused to get up. . . . Instead of trying to bulldog people into getting things done when it’s convenient on their time, they should try to accept when it’s convenient for the patient and what’s the patient’s time.

Patients also doubted providers’ expertise when they felt that problems were missed or created by their providers.

I was pumped full of morphine and I was going through a major bad allergic reaction to the morphine itself. . . . I had told her [the nurse] when she came in . . . she had asked me what my pain was rated and I said, “Well, my back pain is rated a five . . . but my head . . . is a ten,” because I had such an excruciating headache and my eyes had puffed so bad from the morphine. .
She did not do anything about it. Well, she [visitor] went out and got X and then told X about my excruciating headache too, and he came immediately and stopped the morphine. I couldn’t believe that.

I found out that [the doctors] did not check my allergies that I do have and one of the medicines that they were giving me was making me very ill. The medicine they gave me was one of the medicines that could have killed me. Three student residents the doctor that was overseeing all three of them or any of the nurses on that floor didn’t catch the meds that they were giving me were toxic to my body. So that scared me it was just panic. I couldn’t believe that they’d done that. I assumed he [doctor] knew what he was doing. I mean, I trusted him, but I thought he checked my chart. So after I found out it made me mad and angry inside that he did all that to me anyway. [He] didn’t listen to my recommendation of my own suggestion [for pain medicine] and give me something that almost knocked me out anyway, made me sick.

In addition, if patients perceived that providers were not skilled at the procedures they performed, or had concerns that providers would not keep them safe and prevent them from getting injured further, this contributed to the questioning of the provider’s knowledge and expertise.

He [physician] had said that he was going to come earlier in the day so we waited all day long and that night he came and just says, “Do you want to just have it [switching from cast to brace] tomorrow?” And I said, “Well, I’d rather have it tonight.” And so he took it off, my cast, and put this [arm brace] on and then left, but he hadn’t locked it or anything. My husband just says, “This thing is moving.” It shouldn’t be moving so he just kept fooling around with it till he got it to work. And so I guess if he [physician] would have come and said, “I’m really not capable of doing this. You have to wait until tomorrow,” I would have understood.

When I left the orderly, the one that comes and takes you to your room didn’t have any idea she tried to get me into the car and she picked me up, and my ribs and my clavicle had been broken and she picked me up from under my arms and I was just in agony, and she didn’t know how to get me into the car. And I was just crying because it was so painful I felt sorry for the next patient that she had And I didn’t think she was trained at all. I was a little angry for her to hurt me like that.
Patients also worried that damage had been done to their surgery that could possibly result in decreased positive outcomes from the surgery and more physical impairment.

My concern was going through . . . dangerous surgery to just have it blown by someone’s inconsideracy to be careful enough to make sure that [falling] doesn’t happen to a patient.

**Noncaring Theme 4: Being Unresponsive**

The fourth theme, “Being Unresponsive” is defined as: providers do not respond to me or my needs. Providers were perceived as noncaring when they were not available or responsive to patients. Examples described include providers’ ignoring or forgetting about patients’ needs and requests, *not answering call lights in a timely manner*, and not being helpful.

I even pushed the nursing call light and had to wait 45 minutes or an hour to get somebody to come in. It’s frustrating . . . when you see people going by the door that don’t stop in to see what you need, that’s frustrating. And I was definitely alert for a lot of those times and needed my pain medicine.

A couple of times I’ve had to wait 20 or 30 minutes. The woman in the bed next to me actually fell . . . down in the bathroom and tried to turn on the button, and no one came . . . and Dr. X was finally the one who came in and picked her up off the floor. . . . I don’t think that there’s . . . an excuse for that.

All I wanted was that they respond to your call like when I was getting my bath. It’s kind of hard to give you[rself] a bath, sponge bath, when you only got [sic] one . . . arm. . . . It took me an hour and twenty minutes to get my sponge bath. By the time I was done I was sopping wet from doing it and nobody came to check me. . . . I figured she’d come back in to . . . help me . . . rinse off and help me get my robe back on and stuff, and she never came back in.

Feelings of powerlessness regarding the noncaring situation were manifest in descriptions, such as “can’t change a thing,” or “can’t do anything.”
It kind of reminded me—put me in... kind of like a gestapo deal.... When you’re telling them you’re so physically challenged that you cannot get up right now and they’re pulling on you, with a broken back, a collapsed lung, and a broken... arm, pulling you into position, what can you do?

... feeling not quite in control of the situation. I felt sort of intimidated, which is not something that I normally feel.

Additional responses that patients described were heightened levels of anxiety and taking risks trying to do things for themselves that they couldn’t or shouldn’t do.

I’m thinking of one [nurse] that was just on part-time and she really didn’t care if she worked or not.... I assumed she’d stay out there at the nurses’ station until somebody got the button hot... so I got up [with walker] and... I went to the bathroom.... I don’t think they wanted me up that soon.... [I] felt it was a chance for me.... There was a risk, but nothing come [sic] out of it.

... So what I’d do is take my urine and stick it inside the tub [bedpan by the bedside], and let it build up until where I’d actually push and make it feel comfortable for myself so it wouldn’t interrupt them. After two hours I’d tell them to come and get it.... People shouldn’t be treated that way.... They shouldn’t be degrading to people like that.

It made me so angry and I was bound and determined to move.... Now maybe I’ve done myself more damage, but I moved. I moved on my own... I did not have a choice.... I was scared. I didn’t know what I could do to damage this.... I knew I’d had this fusion.... I was having to grab onto this bar and totally flip me over to the other side [to turn by herself].... I was scared that I was doing more damage to myself.... I didn’t hear any pops... any grinding... any noise.

See Table 5.2 for a summary of patients’ responses to receiving noncaring.

**Observations of Noncaring**

If patients did not have a noncaring experience themselves, but observed one being experienced by their roommate, it also affected them significantly. Given that they were also receiving care from the same facility and some of the same providers, patients could imagine a similar experience happening to them and felt threatened.
Table 5.2

Patients' Responses to Noncaring Experiences

<table>
<thead>
<tr>
<th>Responses</th>
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<tbody>
<tr>
<td>• Emotional upset--a range of feelings such as frustration, anger,</td>
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<tr>
<td>fear, intimidation, panic, humiliation, shame, and abandonment</td>
</tr>
<tr>
<td>• Physical suffering</td>
</tr>
<tr>
<td>• Do not understand the plan of care</td>
</tr>
<tr>
<td>• Loss of trust and security</td>
</tr>
<tr>
<td>• Feel unsafe</td>
</tr>
<tr>
<td>• Anxiety about subsequent health care and providers</td>
</tr>
<tr>
<td>• Utilize protective and preventive approaches to cope</td>
</tr>
<tr>
<td>• Take risks to fill own needs</td>
</tr>
</tbody>
</table>

The lady next to me had some ulcer [that needed to be cleaned] and she [doctor] comes in and she goes, “Okay in five minutes we're gonna. . . .” She [roommate] goes, “Oh no you’re not . . . you give me at least 20 minutes so I can get a painkiller,” [it had hurt so bad before]. . . She wanted to do it for her superior doctor . . . and the doctor was kind of upset. She kind of left angry. . . . [The doctor came back twice, every five minutes] and she [roommate] said, “I’m sorry,” . . . and so she left and she wasn’t very happy about it again. I thought she was very insensitive. It was more for her because she wanted to show the other doctor what she was doing . . . instead of feeling for the patient . . . and that “I’m the doctor,” so to speak. And that’s the type of doctors I stay away from.

In my case, like I said, I thought the nursing staff was excellent, and the woman . . . in the bed next to me, I thought the nursing staff was horrid. . . . Right after surgery [she] went almost, I think three hours without even having somebody come in and take her pulse and blood pressure. She had a very bad experience with the nursing staff and if I were her I would have felt the same way. . . . [When the nurse came in to answer her light] she hollered at her. She said something like, “I’m busy and I can’t do that right now,” and she just marched out of the room. It was amazing. . . . She needed to be turned
a little bit. . . I couldn’t believe it. I was dumbfounded. . . . She . . . didn’t want to put them out . . . she asked for it so kindly and so nicely. . . . We reported it. . . . That’s when we got the other nurse and actually I think the other nurse then ended up taking X . . . Part of the reason was because she didn’t have family there. . . . It was stressful . . . it was frustrating because my having had surgery and knowing the pain I was in I could relate to the pain she was in.

One patient, when observing her roommate receiving noncaring, advised her roommate to respond in the way she herself wished she had done during her own previous noncaring experiences that hospitalization.

She [roommate] was having these dizzy spells for three days and she was here. There was no testing done . . . and she couldn’t believe how she was being treated. I says [sic], “Well, just tell the nurse.” [she was NPO for a test and hadn’t been told what was wrong] . . . so the nurse called and the testing wasn’t set up. . . . So they brung [sic] her some food and then . . . after that she started speaking up, and she got some results because five doctors came in. . . . Well, I felt bad for her, so I told her to say something because I had learned you have to say something or you’re not going to get anything.

All patients responded to noncaring with upsetting, “negative” emotional feelings, and attempted to cope with the situation using their own style. Part of their coping was to protect themselves and attempt to prevent further noncaring experiences. Patients initially described their actions in response to receiving noncaring by telling what they did. These responses were then followed up by the researcher by asking further questions concerning prevention and protection.

**Prevention and Protection**

After experiencing noncaring, patients attempted to handle the situation with their own individual style and subsequently created ways to prevent and protect themselves from future noncaring experiences. This section addresses research question four: What do consumers do to prevent or protect themselves from noncaring experiences during
hospitalization? A pattern emerged whereby patients critiqued their own response and then behaved in ways to attempt to prevent and protect themselves from future noncaring occurrences. In order to protect themselves from noncaring, most patients reported withdrawing from providers they perceived as noncaring, as if preventing the potential of subsequent exposure to more pain, physical and/or emotional, and trauma. Withdrawing meant that they did not put on their light to call the nurse when needed, and they did not interact any more than necessary with the physician, nurse, or therapist who they felt was noncaring. Patients also seemed to hold back communication by saying only what was required of them. There seemed to be an effort by the patient to create a boundary or wall to help him or her feel less vulnerable from receiving future negative experiences. After withdrawing, patients then made an effort to manage their own care by themselves, or with help from their friends, families, or hospital roommates and their visitors.

When you’ve had that experience with somebody on a shift, my tendency is not to call for somebody any more frequently than I absolutely need to. . . . There’s an element of anxiety when you don’t know who the individual is and how they are going to respond.

Like, for instance, it was a warm day and she’d bring the pot of water, and I’m sure it would go all day before she’d refill it . . . in fact, I had my son-in-law fill it a couple of times, you know, ice it up. . . . I know that this button is to call them when you need them. . . . If I had enough to get by, it just seemed like it was better to just get by. . . . and not complain too much.

That’s the only time I really felt at ease was when X [wife] was with me there at the hospital because after I’d been dropped . . . I kind of felt safe that they weren’t gonna do it in front of X.

Every fifteen minutes I was urinating. Finally to the point where the nurses didn’t want to come in. . . . So what I’d do is take my urine and stick it inside the tub [bedpan by the bedside] and let it build up so I wouldn’t interrupt them. After two hours I’d tell them to come and get it.
Well, I decided I wasn’t going to bother them for anything but what I had to have. And I asked my husband to please stay and leave just to go eat, and come back so that he’d be there till it was the latest possible at night . . . because I didn’t want to be by myself.

Some patients reported that they spoke up to providers either in a problem solving fashion or in an effort to warn providers not to repeat the noncaring experience.

My [family] talked me into not raising heck actually because I was gonna complain. I was upset obviously. Laid there for a day and went through pain that was unnecessary. . . . I talked to the doctor. . . . I told him I was upset because I’d gone through pain that I didn’t need to go through.

She’s [housemate] been fairly assertive about asking questions because when we weren’t assertive, they weren’t giving her any information. . . . She’s the one that’s going to be taking care of me and . . . if she doesn’t know how . . . she’s not going to [be able] to.

It seems like she’s [the nurse] got too much to do and doesn’t know where to put her priorities first. . . . Well, that’s when I started voicing my opinion today about it.

One patient stated that he could verbally warn the staff not to hurt him and threaten to sue if they did.

The only thing I know is to tell them verbally beforehand, “If you drop me or hurt me in any way, I will have a lawsuit against you for not doing your job right,” maybe warn them in that way. But, who wants to really go into that with someone.

Several patients, while critiquing their own response to noncaring, stated that they thought about speaking up or wished they had done so. Some patients said that they would talk to the noncaring provider personally, some mentioned they would speak with the person’s supervisor. A few patients stated they would express their anger the next time.

If I think negative about someone, I have to face the person and say, “Look, you really hurt my feelings and I don’t like these thoughts I have in my head about you. I want to just say some things and why--Did I offend you? Bad day? . . . It really hurts people’s feelings and you have to be careful not to do that, especially in your position.”
I know after thinking about it and stuff, I probably shouldn’t have done what I did. I should have said something then and maybe they could have been reprimanded. . . . It’s like [right after surgery] you can’t explain those kinds of things when you’re hurting and you just can’t say.

. . . the next time I came there . . . I told them all I have a broken clavicle and ribs, so don’t touch me.

Well, I about wore the button out, but I suppose I could have been more vocal. . . . Well, I’d like to tell them that there’s a time to play and a time to work.

. . . be more forward. Yeah, I’m kind of shy. There’s a lot of shyness in me. Of course they’re in quite a hurry and I just wasn’t talking that fast.

Some patients analyzed the experience and perceived that a lack of information or understanding was the cause of the noncaring experience. They reported that they would communicate differently by asking more questions, particularly verification questions, and request feedback on their understanding.

I can ask and say, “What are you giving me?” . . . Be more thorough with what my care is being entailed. I can do that now. I feel more comfortable asking that . . . asking for help.

I probably would ask the doctor more questions as he makes morning rounds. . . . And from there, just getting feedback from . . . whoever. . . . And maybe if I would have interacted more and responded back to them, trying to repeat back the instructions that they gave in my own words, trying to see if I did understand what they wanted me to do.

I might ask a few more questions. Just more verification questions to . . . find out if I understood correctly and if this is the way it’s supposed to be done . . . to find out what I need to know. . . . I remember being mad wondering why they wouldn’t have made sure that I understood what they were trying to tell me. Being on medication . . . everything wasn’t clear to me at the time.

Some patients became more wary and on guard when receiving care, watching over, or “hawking” their care as one participant described it.
I don’t trust the hospital staff. You have to watch them constantly to make sure that they don’t hurt you. . . . You get a few that work here that they shouldn’t be here. I started watching . . . closely . . . make sure if he was standing close enough to grab me or catch me if I lost my balance or anything like that. . . . I just make sure that I am a little more wary of it.

. . . that’s probably because I was . . . hawking the situation.

Patients reflected an anticipatory fear as they described praying and hoping everything went okay.

. . . that evening a lot of prayer . . . I can be honest . . . To find my own peace through prayer . . . I could have asked for another nurse to come in just to give another opinion. I guess . . . I was seeking the people that I knew and had received excellent health care from. You know, I was hoping they would be in the next morning.

Some participants emphasized an opinion that they could do nothing preventive or protective, reflecting their perception of powerlessness regarding the noncaring.

There’s nothing I can do until I get out of here. The only thing I can do is just hope really hard that everything goes all right and everything goes smooth. Until I get out of here, I’m going to pray like hell I never have to come back.

A dilemma occurred for some patients in that they perceived one provider or professional group as noncaring, but others as caring. The dilemma was how to obtain care from a provider or professional group perceived as caring without having to deal with the provider or professional group perceived as noncaring. Some patients separated professional groups from each other in that they described the nurses as caring and the physicians as noncaring or vice versa.

The doctors I have I’m really confident with and they’ve walked me through this whole thing . . . Possibly sooner or later I’m going to have to come back [into the hospital]. If it has to happen I know that I’ll trust them [sic] people to do it . . . because I don’t want to go anywhere else . . . I’d grin and bear it. But, I’d pray that I didn’t have them for nurses on my staff or I’d ask them to be removed. I know I’d say something this time . . . I’d ask for a supervisor and I’d talk to her privately.
I would say that if you had to go to X hospital, your quality of work from the physicians would be good to outstanding, but on the whole basis of as far as the quality of the nursing staff, I myself would have to refer to another hospital.

... two things [stand out]. One is some of the friendships that were made while I was there with some of the nursing staff and PT staff. ... We've continued one of the friendships that we made at the hospital. ... The other thing was what an incredible jerk the physicians were. ... Particularly the physicians were rude. I think that this attitude took away from what could have been an otherwise okay experience.

The bad care. ... The total unprofessional, unethical care that ... I received along with many others up there. ... Only right after surgery because the care after that was wonderful. ... I was very upset about it ... very traumatized by it. ... It did definitely stick out in my mind and it's too bad because ... the professional services before that time had been so wonderful throughout the hospital.

The above example illustrates how powerful one noncaring experience can be in the perception of the entire hospitalization, and in subsequent decisions concerning returning to the facility and choice of providers. Several patients wanted to change providers or hospitals as soon as they could or, at the very least, request that the particular provider not be further involved in their care. Patients who experienced noncaring that was perceived as very upsetting or traumatic reported, during the first interview, that they would not return to this hospital setting or to that provider. At the time of the second interview, some participants stated they still would not return to the facility or providers.

If I had to have further surgery with him [physician], I wouldn't most likely. Even though he's the only one that does it, I would not use him again. ... I wouldn't refer to him.

Study real hard next time and make sure that I went to a place that had a good track record for no such nonsense as that. See, I didn't pick this hospital. I was sent over from X.

Some participants, who previously stated they would not return, qualified their statements
during the second interview. This change in decisions about returning may have been related to whether the patient had started to recover from the noncaring experiences between interviews. These patients stated they would return under certain conditions with “on-guard” protective behaviors.

A patient who did not perceive having a noncaring experience offered what she thought prevented her from having these experiences.

It [having positive experiences] requires being a little bit more assertive than a lot of doctors and nurses are taught that a patient ever will . . . ever be expected to do, and probably more than a lot of doctors and nurses are taught that a patient will do or should be. . . . I really have not [had negative experiences]. . . . I think it’s been important for me to get myself up and out . . . of this door and to do it as fast and efficiently as possible and not to whine about it. . . . My job is to take care of me and . . . if I respect the talents and the skills and the time of [providers] . . . if I can smile and say hello and that kind of thing, then relationships are better. . . . My job is to be open and available and positive. . . . Those two things [relationship with providers and taking responsibility for yourself as a patient] . . . people don’t seem to hesitate to come in to help. I know I get smiled at.

Table 5.3 summarizes prevention and protection approaches.

Some ways utilized by participants to protect themselves from or prevent noncaring also initiated a recovery. Specific approaches emerged that patients initially volunteered as ways they tried to get over the experience perceived as noncaring. These responses were then followed up on by the researcher. These responses utilized to facilitate recovery are described next.

**Recovery**

This section addresses research question number five: What helps the consumer recover from noncaring experiences during hospitalization? Several methods were utilized by participants to get over or recover from noncaring experiences (see Table 5.4).
### Table 5.3

**Protection From and Prevention of Noncaring**

<table>
<thead>
<tr>
<th>Patients’ Responses</th>
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</thead>
<tbody>
<tr>
<td>• Critique own response</td>
</tr>
<tr>
<td>• Withdraw from provider/create wall</td>
</tr>
<tr>
<td>• Decrease communication with provider</td>
</tr>
<tr>
<td>• Manage care by self, with help from family and friends</td>
</tr>
<tr>
<td>• Watch over/“hawk” care</td>
</tr>
<tr>
<td>• Speak up to warn and/or problem solve</td>
</tr>
<tr>
<td>• Ask questions to verify understanding</td>
</tr>
<tr>
<td>• Get out of the facility to one’s home environment</td>
</tr>
<tr>
<td>• Change providers</td>
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</tbody>
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### Table 5.4

**How Patients Recover From Noncaring**

<table>
<thead>
<tr>
<th>Patients’ Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tell other people my story (family, friends, and providers)</td>
</tr>
<tr>
<td>• Sort out why it happened</td>
</tr>
<tr>
<td>• Talk with noncaring provider</td>
</tr>
<tr>
<td>• Have caring experiences with subsequent providers and health care</td>
</tr>
<tr>
<td>• Protect and prevent subsequent noncaring</td>
</tr>
<tr>
<td>• Get out of the facility to one’s home environment</td>
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</table>
Most patients found that telling other people their stories helped. They described what happened to them when they experienced noncaring and how they felt about it to family, friends, other providers, and occasionally the noncaring provider. Talking about it was the most frequently used approach to recovering from the experience.

And the follow-up [patient representative], the people that checked up on me . . . and [asked] how I felt about the stay or whatever. That really helps too. . . . I’ve told other people what happened to me too, plus up here I told the nurse too . . . because it should make—like the other nurses won’t do it to somebody else maybe or they’ll say something. . . . I had like ten calls today and it was like everybody was checking up on me to find out what was going on because they knew something happened. . . . Just a few of my good friends is all.

We tend to take a situation like that and make it humorous and relay the story to others. And so that’s exactly what we did. I mean you, the more you tell other people about it and you sort it out and tell some of the bizarre things that occurred, that’s one way of venting frustration is to just tell other people. And that’s basically what we’ve done. And, you know, obviously that’s not good for the hospital. . . . We have some physician friends here in X [out of state] and they were actually thoroughly appalled by a couple of things that occurred . . . and the fact that they even did surgery . . . with my blood count what it was, and both of those things were things that doctors here shared with us that they would not have done.

Patients often described powerlessness related to decreased mobility and increased dependence in their descriptions of noncaring experiences, and the emotional pain they experienced in response to it. Providers who nondefensively listened to these stories, facilitating catharsis, validating the noncaring experience, and expressing regret for its happening helped patients.

He [my new nurse] was . . . so kind and so caring . . . he took care of me all that night . . . turned me many times because I was uncomfortable. . . . I’ve already run through all these little things in my mind to cause her [the nurse that wouldn’t move me] a little trouble, a little grief, to go and make a stink and put in a complaint, but no. I changed my mind on that. He was upset with her also, and then he came and tried to explain to me too about her because when she gets a lot going on and a lot of things happening . . . she
does tend to be snappy and judgmental and stuff and he told me that too. And that’s why . . . I didn’t think of carrying it any further.

Health care providers who apologized for the noncaring experience, whether that provider was the source of the experience or not, had a healing effect on the patient and facilitated recovery.

He [physician] apologized about the whole thing because he realized what had gone on . . . apologized for what happened since the beginning. . . . It made me a little less angry. It made me feel pretty good that he would apologize, because there’s a lot of people that don’t do that. . . . He was adult enough or man enough to realize that someone messed up and that feels pretty good.

Taking care of the problem was the most effective approach to facilitating recovery from noncaring experiences. Those providers who were in a position to effect change and took care of the problem facilitated recovery. Patients who described the problem as being taken care of by care providers presented the most balanced view of their noncaring experience, including the recognition of human qualities in providers. Participants acknowledged that providers had personalities that maybe did not match with theirs, had bad days, and that misunderstandings and mistakes happen.

The nurse that came on was really giggly and as a patient I felt like I had to calm her. I felt she was really nervous with what she was doing. I think it was just personality. Not everyone can help the kind of personality they have, so that’s okay. . . . [Having that nurse] put me on edge a lot.

Having caring experiences with subsequent providers also facilitated recovery.

The only thing that’s helped me get over the feelings is separating the treatment I got from the nurses and staff from the work that the physicians did. The work that the physicians did was outstanding. And how they worked with me and . . . included my family on a lot of things.

Some patients also reported that just getting out of the hospital setting and home to their own environment was facilitative of recovery, as if leaving the emotional pain behind
and regaining a sense of control. Some felt that to recover it was necessary to forgive or let it go.

Well, you know, just the fact that you’re home obviously is about 90% of it.

Well, time kinda heals, you know, but at the time I just felt they weren’t very attentive. . . . Forgive and forget. . . . Yes, in reality they’re--as you know, they’re paid to be on the job, but if they’re not, some people you just have to forgive.

A few patients could not describe recovery stating that the experiences remained traumatic.

It was when they [the nurses] sit there and talk about you and they don’t even know you, and they don’t give you the care they’re supposed to be giving you and go behind your back and you can still hear them talking. That, to me, is degrading. . . . I do a lot of collections and stuff, but I’ve never done people like that, like they did me, never. As far as my experience here, that’s the only thing that will ever scar me, I think, is what they did down there. It was very disappointing . . . it was hurtful. I mean, it hurt. It hurt from the bottom of my toes to my heart . . . and it still does because I have thought about it every day. . . . The hurt is still there. . . . I don’t want that to happen to anybody again.

Participants seemed to recover very individually from noncaring experiences. When patients did not feel comfortable talking about the experience, they described keeping their feelings inside and may have recovered less from the experience. It is possible that some noncaring experiences were not even brought up during the study interviews.

**Discussion of Noncaring Findings and Relationship to Swanson’s Mid-Range Theory of Caring**

The noncaring themes, when contrasted with Swanson’s five caring processes, represent the omission of one or more of the five caring processes between providers and patients. In addition, some noncaring themes include the commission of acts or behaviors
from providers to patients.

“The way” providers interact with and do not treat patients as human beings, nor “know them” results in the total absence of maintaining belief, knowing, and being with. The omission of these three caring processes prevents effective doing for and enabling. When patients did not experience maintaining belief, knowing, and being with from providers, they withdrew from those providers. Patients did not want noncaring providers doing for or enabling them because they did not feel connected with or important to the providers, nor did they trust or feel safe with them. Doing for and enabling, therefore, occurred only in a limited way. If providers committed acts, behaviors, or communications that were rough, brusque, rude, discounting, and/or gave conflicting information, noncaring experiences were then described by patients as more intense and upsetting than actions that were merely omitted.

The absence of knowing in this study includes providers not knowing patients’ medical histories. This was perceived by patients as impacting the competence with which providers do for and enable them. “Doubting expertise” also results in the absence of effective doing for and enabling. When patients received conflicting information or perceived providers as unskilled and/or having missed or created problems in their doing for and enabling, patients experienced increased anxiety and a loss of trust, and then proceeded to put their energy into protective and preventive behaviors. Finally, “being unresponsive” represented a lack of, or deficiency in all five of Swanson’s caring processes. Patients were then not as open and receptive to participate in and receive subsequent caring health care experiences because of their on-guard and protective behaviors.
This chapter will now conclude with discussion concerning the overall process of noncaring.

**Discussion of Findings in Noncaring**

Understanding the processes of responding to noncaring experiences, preventing and protecting oneself from future occurrences, and recovering from noncaring experiences were part of the purpose of this study. An important issue that emerged from this research study was that patients are perceiving and talking about receiving noncaring experiences. There may be providers who are unaware that certain actions or behaviors are perceived by patients as noncaring and that these actions/behaviors exist even in highly respected health care environments. The setting for this study was chosen because, in the researcher’s judgment, health care is delivered in a professional and expert manner by the professionals on this unit. For noncaring to be perceived in a unit with this reputation illustrates the fact that noncaring occurs even in the most ideal health care settings. Providers and health care administration and management need to accept and understand the reality that patients are receiving noncaring. Only after this fact is accepted can movement occur toward understanding and then preventing these experiences from happening.

**The Process of Responding To and Recovering From Noncaring**

Patients’ common responses to noncaring experiences were twofold: (a) They were left emotionally upset and having to cope with negative feelings in addition to coping with the physical reason for their hospitalization and its treatment, and (b) patients handled the situation itself with their own individual style and at the same time subsequently created ways to prevent and protect themselves from future noncaring experiences. These prevention
and protection methods were volunteered by participants when describing what they did in response to receiving noncaring. These responses impacted on the subsequent health care provided and postoperative recovery.

All patients reported some level of anxiety and emotional upset in response to noncaring. Examples of emotional reactions and responses to noncaring in this study included feeling anxious, scared, panicked, helpless, intimidated, unnerved, degraded, shamed, frustrated, angry, guilty, disgusted, and devalued as a person. In addition, some patients felt disbelief at the way they were being treated. Some patients reported the potential for, or having been scarred and traumatized by their noncaring experience. Patients described experiencing a continuum of physical suffering from hurting to agony, and a loss of security and trust in their health care and providers.

As described in this chapter, additional patient responses to noncaring included anticipatory anxiety related to the potential of experiencing noncaring again and a loss of control over who their providers were and what was going to happened to them. Patients attempted to protect themselves by withdrawing from interactions with the caregiver perceived as noncaring, and managing their own care by themselves or with the help of family, friends, and/or hospital roommates and their visitors. In addition, patients often requested that family stay with them as much as possible. Family members (defined broadly as immediate relatives or roommates patients lived with) often initiated staying because of personal observation or experiences of noncaring during the present hospitalization, or from receiving health care in the past.

The primary way patients dealt with noncaring experiences and the emotions generated was to tell their story to other people. They would tell their friends, families, and
other health care providers. In this telling or processing of the experience, patients wanted to validate that it was indeed a noncaring experience, enlist the support of others, search for reasons for its occurrence, and critique their own responses. They expressed their feelings, planned protective and preventive approaches for their future, and hoped by telling their story it would prevent the same occurrence from happening to others. Telling their story seemed to be a response, a method used to plan protective and preventive approaches, and a way to recover from the experience.

As physical recovery became more evident and the level of dependence lessened, patients sometimes questioned whether they had done something to cause the experience, and often critiqued their own responses to the noncaring experience. Postoperative inpatient hospital environments and patients' physical limitations do not enable patients to apply and utilize their usual and most effective coping mechanisms. Patients would question the coping mechanism they had used during the noncaring experience. "I don't know why I did it that way," and "this isn't how I would usually handle it" were common statements. This critiquing of their response reflects the level of dependence and vulnerability during the postoperative period, and the energy expended just going through the physical experience. Unfortunately, protective and preventive approaches often became the focus of patients' energy, rather than physical healing and postoperative recovery.

Summary

It seemed that noncaring experiences perceived by participants in this study either involved omission of acts they perceived as necessary; or commission of acts, behaviors, or communication perceived as noncaring; and/or a combination of both. In addition, patients
were affected differently and to different degrees by noncaring experiences.

Patients who experienced what they perceived as significant noncaring usually felt insecure and unsafe and were likely to regress to trust/mistrust developmental issues, immediately and throughout the remainder of their health care experiences, if recovery was not facilitated. Noncaring experiences consistently upset the patient’s sense of balance during recovery. The feelings provoked by the experience were very upsetting and unsettling to patients. Although it was not specifically stated, the implication was that while positive attitudes helped patients focus on physical recovery, noncaring experiences, and the emotional and physical pain and threat they evoked, took energy away from recovery.

A focus of this study was responses to noncaring. Although responses to noncaring have not been the focus of previous studies, findings in this study supported those reported as consequences of noncaring (Riemen, 1986a, 1986b), including feeling frustrated, scared, depressed, angry, afraid, devalued, and degraded. The responses to noncaring in this study included (a) feeling emotionally upset, which included a range of negative feelings such as frustration, anger, fear, intimidation, panic, humiliation, shame, and abandonment; (b) suffering physically; (c) not understanding the plan of care; (d) losing trust and security; (e) feeling unsafe; (f) having anxiety about subsequent health care and providers; (g) utilizing protective and preventive approaches to cope; and (h) taking risks to try and do for themselves.
CHAPTER 6

IMPLICATIONS OF THE RESULTS OF THIS STUDY

This chapter will discuss factors that influence patients’ perceptions of receiving caring and noncaring from providers. Following this discussion, implications for providers in clinical practice will be addressed. Implications for providers who design and manage health care systems will then be discussed. Finally, recommendations for future research will be presented.

Discussion of Caring and Noncaring Findings

Vulnerability and Influencing Factors

It seems to the researcher that there were levels, or degrees of trauma experienced by patients in this study when they perceived receiving noncaring. The level of vulnerability that a patient felt seems to be the major and recurring theme that influences the patient’s perception of the significance of the experience and whether that experience was caring or noncaring. Vulnerability seems to be the consistent underlying variable throughout all experiences described, and it occurred in every noncaring experience. There also seem to be factors that influence the level of vulnerability felt by patients. Vulnerability links these influencing factors together and explains most of the variation in levels, or degrees, of caring and noncaring perceived. Webster defines vulnerability as being the quality or state of being vulnerable, capable of being wounded and/or open to attack or damage. It seems to the
researcher that vulnerability can also open up a patient to experiencing caring and perceiving it as extremely important and valuable.

Certain factors seem to affect and influence the level of vulnerability, and put patients at risk for perceiving experiences as noncaring and defining those experiences as traumatic. The factors are (a) the level of dependence upon providers, (b) the power imbalance between providers and patients, (c) uncertainty concerning one’s future, (d) the patient’s level of self-esteem, (e) physiological and/or psychological symptoms, (f) aloneness, and (g) unfinished personal issues.

Dependency. One of the challenges in having orthopedic surgery is the temporary lack of mobility and subsequent dependence upon others for even basic physical needs. This dependency leads to, or increases vulnerability and creates emotional as well as physical challenges. During the initial interviews, many patients directly or indirectly indicated an awareness of, and discomfort with, this level of dependence on others, and/or expressed feeling a lack of independence. Concern about being a burden to the staff was also expressed. The level of dependence felt by patients seems to be a critical factor in their perception of the significance of a caring or noncaring experience. If “the way” providers interacted with patients was positive then patients perceived caring and were comforted, decreasing their feelings of vulnerability regarding being dependent. If “the way” providers treated dependent patients was perceived as negative, the interaction was defined as noncaring and the feelings of vulnerability increased. “Being in tune” or “being unresponsive” to patients’ needs in this dependent time also either eased or increased the feelings of vulnerability. The patient would then respond to what he or she perceived as a caring or noncaring experience.
Uncertainty. Uncertainty concerning one’s future is closely related to dependency. Patients often expressed concern wondering if their bodies would “recover,” or if they would become an “invalid” and be dependent on others for care the rest of their lives. There was uncertainty among patients concerning the plan of care and treatment they were receiving during hospitalization, and about information they were given by providers. Patients also expressed uncertainty about the expected pace of recovery and how to take care of themselves after being discharged. The positive or negative manner in which providers “demonstrated expertise” at this juncture was a factor in determining the degree of vulnerability patients experienced. If patients doubted the provider’s expertise their sense of vulnerability increased, they perceived the experience as noncaring, and began to respond accordingly. Conversely, if the provider adequately demonstrated his or her expertise, patients felt less uncertain, less vulnerable, and responded to what they perceived as a caring experience.

Imbalance of power. There is a power imbalance between health care providers and postoperative surgical patients. This is due in part to the patient’s vulnerability and dependence on providers, as well as the traditional hierarchical social structure of health care. This imbalance originates from the fact that one person, the patient, is ill, injured, in pain, medicated, or immobile, and is dependent on another person, the provider, for even basic needs. This dependency reflects the patient’s perception of having a lack of control, or power, to determine one’s own destiny. “Mutual knowing” is perceived as balancing the power somewhat, and would thus be perceived as caring. By “not knowing me,” the provider further tips the scales in his or her favor and the patient’s level of perceived vulnerability rises even more. The patient then labels the interaction as noncaring and responds
accordingly. The imbalance of power is perceived even more acutely if providers are not willing to take the time to share information and educate the patient concerning his or her condition, treatment, or prognosis. Finally, if all that is perceived is noncaring and there is a lack of choice in providers because of insurance limitations and other factors the imbalance of power is further amplified.

**Self-Esteem.** The patient's level of self-esteem seems to be another underlying factor that influenced his or her vulnerability. Acute trauma or illness, or chronic physical or mental illness impacts and may lower a person's level of self-esteem. This seems to occur because of acute or chronic physical symptoms, pain, feeling dependent and helpless, and feeling a loss of control over one's self. Patients who experienced noncaring described evaluating the experience and their response to it. Feelings of "Have I done something to cause this?" and "Why did this happen to me?" demonstrate an uncomfortable shame, guilt, and possibly a low self-esteem in some patients who experienced noncaring. Some patients seemed to feel like they had been bad, like a child, and were being punished, or that they had done something to deserve the noncaring that was received. Perhaps when patients are feeling so vulnerable and struggling to cope, this feeling of shame or guilt is more prevalent. Patients also expressed the thought that maybe the noncaring occurred because they were not handling their recovery experience "as well as they should." Some patients seemed to protect themselves from noncaring to such a degree that their own physical well-being was put in jeopardy, perhaps indicating that maintaining a higher level of self-esteem was seen as more important than even physical health. If the patient is dependent on others for validation of self-worth, noncaring may be very traumatic and threatening, especially during a vulnerable and high stress period of time. Three of the caring and noncaring themes seem to contribute
to or threaten a patient’s self-esteem by alleviating or deepening the patient’s sense of vulnerability. These themes are “the way” providers interact with the patient, positively or negatively; “mutual knowing,” or “not knowing me”; and “being in tune,” or “being unresponsive.”

**Aloneness.** The perception of being totally alone, without support, contributes to a patient’s vulnerability. During the immediate postoperative period patients really are physically “alone” with their pain, postoperative symptoms, and uncertainties about their future. This perception of being alone is made worse when the patient experiences noncaring, and when he or she perceives that no one understands or knows him or her as a real human being. However, if the provider is “in tune” with the patient, and if “the way” the patient is treated is positive his or her perception of aloneness will lessen. Patients felt very alone when they perceived that they did not matter to the provider or that the provider did not care about them. Noncaring experiences also seem to generate feelings of abandonment. Conversely, caring experiences lessened or prevented such feelings of aloneness by decreasing the level of vulnerability.

**Physiological and/or Psychological Symptoms.** The physiological and/or psychological symptoms being experienced by the patient also contribute to feelings of their vulnerability. It seemed as if the more intense or severe the symptoms were the more vulnerable the patient became. Providers “showing expertise” aided the patient’s understanding of such symptoms and reduced his or her level of vulnerability. If patients “doubted the expertise” of the provider their feelings of vulnerability increased. “Being in tune” or “being unresponsive” to the needs of patients will also affect them. If patients perceived receiving noncaring, a method used to protect themselves or prevent further
noncaring was to manage their own care. This could also affect the intensity of physiological or psychological symptoms.

**Unfinished issues.** Previous exposure to noncaring experiences without full recovery leads to, and increases a patient’s vulnerability. Suffering from past noncaring experiences may cause patients to react more strongly or defensively, watch or “hawk” over their care, or display more-than-usual emotional needs. This may put patients at a higher risk to receive more noncaring as providers become defensive or frustrated with their demands. Patients may become labeled as difficult, demanding, and/or time-consuming. Some patients who have experienced multiple noncaring events may develop a dread of medical care and avoid going to the hospital or to medical appointments. Where there is such apprehension a patient may choose to not receive needed health care or, at the very least, delay seeking treatment. This could be a patient’s way of protecting him or herself and preventing any additional trauma. In addition, there may be many other unfinished issues related to patients’ past personal lives. If providers are not “in tune” with the patient the likelihood of him or her perceiving experiences as noncaring increases. “Not knowing” patients and their previous medical history, and therefore treating them in a “way” that may be consistent with past negative medical experiences may further traumatize and cause their level of vulnerability to rise. The responses to such additional noncaring experiences might be greater than anticipated and may unwittingly elicit further noncaring. If, however, patients perceive caring experiences with the provider “knowing” them, treating them in a “way” that is consistently positive and “in tune” with them and their needs, it is possible that recovery from previous noncaring experiences may then occur.

The more dependent upon providers, vulnerable, and helpless patients feel, the
greater the impact of noncaring and risk of emotional trauma. There were levels, or degrees of noncaring experiences, and likewise differences in the intensity of emotional responses and physical sensations. This variation seemed influenced by the features of the noncaring experience itself, physiological and psychological condition of the patient, the patient’s past experiences and unfinished emotional issues, current level of self-esteem, the perceived lack of control and level of dependence the patient had or felt, ability to cope within the hospital environment, and how alone and unsupported he or she felt. This combination of factors result in a critical period during which patients are vulnerable to experiencing and perceiving health care containing any one, or a combination, of the four themes of noncaring, and perceiving these experiences as devaluing, abandoning, and possibly physically and emotionally traumatizing. The vulnerability and uncertainties of postoperative recovery seem to fit this critical time period. During this time patients are physically “alone” with their pain and postoperative symptoms and are more sensitive to perceiving events as noncaring, and when experiencing noncaring, more likely to describe the experience as traumatic.

Caring and noncaring experiences and patients’ responses to them lead to many important implications for providers in the way they care for their patients.

**Implications for Providers in Clinical Practice**

The findings of this study have described the responses to caring and noncaring experiences received by health care consumers in an acute care hospital setting from the consumer’s perspective. It is important for health care providers to understand the effects of caring and noncaring upon their patients. Awareness of responses to caring and noncaring
experiences will add to the body of knowledge about caring and quality of care. Since delivery of health care is currently provided by a multidisciplinary combination of providers, this study included nurses, physicians, and physical therapists. Both caring and noncaring experiences with any individual provider affect not only the consumer, but also his or her family members, significant others, and the friends with whom the experiences are shared. One particularly caring provider can positively affect the quality of care perceived from all other care providers for an individual patient. Likewise, one provider who delivers noncaring can taint or contaminate perceptions of the care delivered by all other care providers.

Patients consistently described caring or noncaring experiences when asked to tell the researcher about experiences that came to mind or stood out to them during hospitalization. Because patients tend to lump individual providers into their professional groups, such as all the nurses in the facility, all my physicians, or physical therapists, individual providers may find themselves represented by a provider that stands out to consumers because of his or her delivery of caring or noncaring health care. This perception that because one nurse was noncaring all nurses are noncaring, or conversely, because one physical therapist was caring so are others, is probably unfair, but this seems to be the way patients compartmentalize providers in determining who is safe or unsafe, or who will provide good care.

As providers move toward the delivery of health care via managed care and capitation, it is imperative that multidisciplinary groups of professionals work toward functioning as effective health care “teams” based upon a collaborative philosophy in order to maximize efficiency and obtain desired outcomes. Providers need to realize that many patients withdraw and do not share information related to their symptoms or progress
candidly and openly when on-guard regarding noncaring. In these cases, patients may not share important information needed for diagnosis and treatment decisions.

One of the important implications of this study is that all health care providers need to become sensitized to the effects of caring and noncaring on consumers, and understand patient responses to these experiences. Provider understanding and sensitization to responses to “caring” and “noncaring” may result in:

- Critical appraisal of approaches to clinical practice
- Reinforcement of caring provider behaviors and sensitivity to behaviors perceived as noncaring
- Decreased negative provider behaviors
- Facilitation of recovery from noncaring
- Decreased patient protective and preventive behaviors
- Facilitation of therapeutic outcomes during and after hospitalization
- Facilitation of faster healing and shorter lengths of hospitalization
- Increased consumer and provider satisfaction

Consumers have become more vocal and satisfaction is being emphasized in the current designs of health care systems. Findings in this study indicate that caring and noncaring experiences influence the consumer’s choice of providers and decisions to stay with or change providers. In addition, patients without the ability to choose providers because of insurance limitations, who are dissatisfied with a lack of caring and/or an abundance of noncaring without recovery, will bog down the delivery of health care because it is much more time-consuming to care for a dissatisfied patient. Providers in clinical practice need to know what their consumers’ expectations are and how to meet them.
Providers need to understand the importance to patients of “mutual knowing.” Caregiver continuity was described by patients as facilitating “mutual knowing.” Patients report that developing a sense of security and trust in the provider was very important. This trust is based upon “the way” that providers interact with them, as human beings, in order to know that they matter to the provider. Trust is also based on the provider demonstrating knowledge and expertise in delivering care, and by the provider connecting or “being in tune” with the patient and trying to meet his or her needs. Continuity of care may not always be possible to achieve with scheduling difficulties, shift work, on-call schedules, or rotations of attendings and residents. Informing the patient about upcoming changes facilitates the maintenance of trust in past providers and provides a good beginning with the new providers.

Some patients’ responses to noncaring and their efforts to protect themselves and prevent further trauma may actually precipitate or invite subsequent noncaring experiences from providers. Patients may be labeled by providers as difficult or time-consuming. Providers may feel defensive, frustrated, and/or helpless regarding effective intervention. Providers may sometimes be surprised at a patient’s level of anxiety or reaction to a situation. It is important to realize that much of this behavior may be an effort at protection and prevention due to past noncaring experiences. It is important for providers to evaluate whether the patient is actually responding to past or current noncaring experiences. This could then guide intervention to facilitate recovery.

Several interventions implemented by providers were found to facilitate recovery from noncaring (see Table 6.1). When providers nondefensively listened to patients’ noncaring experiences, this facilitated catharsis, and aided in the recovery from noncaring. Validation of the noncaring experience helped patients. Health care providers who expressed
Table 6.1

How Providers Can Facilitate Recovery From Noncaring

<table>
<thead>
<tr>
<th>Methods</th>
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<tr>
<td>• Listen to story nondefensively</td>
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<tr>
<td>• Facilitate catharsis</td>
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<tr>
<td>• Validate noncaring</td>
</tr>
<tr>
<td>• Express regret about noncaring</td>
</tr>
<tr>
<td>• Apologize for the noncaring</td>
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<tr>
<td>• Take care of the problem</td>
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regret and apologized for the noncaring experience, whether or not that provider was the source of that experience, had a healing effect on patients. Those providers who were in a position to effect change and took care of the problem also facilitated recovery from the noncaring experience.

Implications for Providers Who Design and Manage Health Care Delivery Systems

Providers who design and manage health care systems need to understand consumer responses to caring and noncaring in order to create health care delivery approaches that facilitate “caring” and minimize “noncaring.” Administrators of health care organizations need to include the findings of this study in designing the delivery of care in inpatient settings. Evaluating the current philosophies of providers, the various professional groups involved, and the environments in which providers work is also important. Values are modeled and disseminated in an organization from those in charge. In order for “caring”
health care to be delivered to patients, this philosophy has to be practiced and role-modeled by management as well as employees. In this era of health care reform, the emphasis is on doing more with less from a financial and staffing standpoint. It is important to realize that the potential for increasingly stressful and noncaring atmospheres exists due to the increase in work load and demands on providers.

Administrators need to consider the effectiveness of “caring” health care from the patient’s perspective versus the ineffectiveness of “noncaring” in order to design efficient health care delivery approaches. Patients state they obtain and maintain hope, develop more motivation, and get better more quickly when receiving caring health care. In contrast, noncaring health care results in preventive and protective behaviors that may include withdrawing from providers, or interacting with more aggression and the use of threat approaches. Either situation is uncomfortable and stressful for providers. These behaviors do not facilitate making connections and establishing “mutual knowing” relationships between consumers and providers. Noncaring requires more provider time involved in delivering care and may result in a slower recovery for the patient. If consumers have repeated noncaring experiences they may become more vulnerable to the physiological process for which they have originally sought health care. This can also result in the development or aggravation of emotional problems. It may be possible for patients who have experienced traumatic levels of noncaring to develop emotional problems from receiving health care resulting in the co-morbidity of a psychiatric illness, which then requires more health care delivery in terms of provider time and cost. Thus, noncaring experiences may impact the patient’s final outcome physically and psychologically.

Utilization of the findings of this study in creative educational/team building
programs within hospital settings that include nurse, physician, and physical therapy professional groups (i.e., multidisciplinary patient care teams) can facilitate:

- Provider understanding of consumer perceptions and expectations
- An increase in the implementation of “caring” health care delivery
- Prevention of “noncaring” during health care delivery
- Facilitation of recovery from “noncaring” in order for consumers to rebuild trust and positive working/partnership relationships with providers
- Retention of consumers
- More open communication regarding symptoms and progress from consumers to providers
- Decreased time and energy spent by providers dealing with preventive and protective consumer behaviors

Throughout descriptions of all four themes, patients expressed their need to feel safe and secure with the providers and their treatment plan. This is a basic requirement in building confidence and trust and developing a relationship/partnership with providers and can be facilitated by continuity in care providers. Expecting patients to repeatedly adjust to new providers without providing any effective transitioning is one of the controlling aspects of our current inpatient health care system. The challenge for the patient to adapt to a new caregiver’s routine, or breaking in new care providers to a routine that works for the patient, is repeated many times. Therefore, a patient’s recovery routine is disrupted many times if health care organizations and care providers are unaware of this process and do nothing to facilitate transitioning. As providers work in increasingly demanding inpatient care environments it seems to benefit them when, and if, they are not repeatedly having to begin
anew with assessment and then function with limited information regarding the individual patient and their care needs. Patients commented that their care could be delivered faster and more “in tune” with their needs, and that they could more easily progress when their provider knew them and was familiar with the plan of care.

When providers must change, facilitating a smoother transition from shift to shift or service to service is important. Transition approaches must keep in mind that patients need to “know” what their care plan is, who are the specific providers involved in their care, who is actually in charge, and that those providers who are involved and in charge are aware of their plan of care. Also, transition approaches need to include an awareness of consumer anxiety about new people and unanticipated changes.

**Future Research**

This study described consumers’ perceptions of caring and noncaring experiences in an inpatient orthopedic setting and their responses to them. Future research to assess consumers’ perceptions of these phenomena in different health care settings and specialty areas is needed. There may be common aspects of caring that are important to consumers across all health care settings and specialty areas; however, consumers may emphasize and respond to particular aspects of caring related to their respective health care problems and settings.

Further study is also needed in the area of noncaring. Again, there may be common aspects of noncaring that are important to consumers across all health care settings and specialty areas; however, consumers may be more at risk for particular noncaring experiences related to their respective health care problems and settings. More understanding regarding
noncaring situations and patients at risk for noncaring experiences would enable researchers to develop intervention approaches that would more effectively prevent and treat or facilitate recovery from noncaring.

Understanding of the roles that caring and recovery from noncaring play in patients’ definitions of quality health care and satisfaction with their care need to be studied. In addition, research needs to be performed to provide understanding of the role caring and noncaring play in complication rates, length of stay, and recovery outcomes.

Finally, research is needed to determine creative and effective methods of provider education and team building to facilitate caring approaches to health care delivery.
APPENDIX A

DEMOGRAPHIC DATA

Participant Name:

Participant Address:

Participant Telephone Number: ( ) ____________

Participant ID#

Date: ____________ Date admitted: ____________

Age: How old were you at your last birthday? ____________

Sex: What is your sex? 1. Female 2. Male

Previous hospitalizations:

Diagnosis: ____________

Household composition: Describe who is in your household.

Marital status: What is your current marital status?

1. Never married 4. widowed

2. Married 5. Live with, but not married to partner

3. Divorced/Separated 6. other (specify) ____________
Racial/ethnic background: What is your racial/ethnic background?

_____ 1. Anglo American  _____ 4. Spanish American


_____ 3. Asian American  _____ 6. Other (specify) _______________

Education: What is the highest grade in school you completed? ______________

Religion: What is your religious preference? Do you practice? ______________

_____ 1. Catholic  _____ 4. LDS/Mormon

_____ 2. Greek orthodox  _____ 5. Protestant

_____ 3. Jewish  _____ 6. Other (specify) _______________

_____ 7. No preference

Involved others: Do you have family or friends that are supporting you now during this hospitalization?

_____ 1. Family  Role of support ______________

_____ 2. Friends  Role of support ______________

Occupation: __________________________

Insurance: Do you have health insurance?

_____ 1. yes  _____ 2. no
APPENDIX B

INTERVIEW GUIDE

1. When you think about this hospitalization, tell me about an experience with your health care that comes to mind?

Observe if positive or negative experience brought up first.

If positive, probe as needed with:

How did you feel during that experience? What did you do because of your feelings? How did you feel after that experience? What did you do because of your feelings? What did you do differently after this experience? Did this experience influence you? How? Will your experience influence your managing your illness/your taking care of your illness and yourself? Will your experience influence your getting health care in the future? How? (Research Question #1)

2. What do you or could you do to have this experience happen again? (Research question #2)

3. Tell me about an upsetting experience you have had during this hospitalization. (Repeat probes as below)

Go to #7

If negative, probe as necessary with:

How did you feel during that experience? What did you do because of your feelings? How did you feel after that experience? What did you do because of your feelings? How did you handle the situation? Did this experience influence you? How? What did you do differently after this experience? Does your experience influence your stay in the hospital? Will your experience influence your managing your illness/your taking care of your illness and yourself? Will your experience influence your getting health care in the future? How? (Research question #3)
2. What do you or could you do to prevent this experience from happening again? What did you do differently after this experience? (Research question #4)

3. How did you handle the situation? Have you gotten over the situation? (Probe with what helped you deal/cope with it, what did you do or not do? What could your health care providers have done to help you cope with/handle the experience? (Research question #5)

4. What would you change about your health care? (Research questions #2 and #5)

5. Tell me about a positive experience you have had during this hospitalization. (Repeat probes as above. Research question #1)

6. What do you or could you do to have this experience happen again? (Research question #2)

7. What does quality mean to you when you receive health care? Can you describe quality in one word? (Research question #6)

8. What does caring mean to you when you receive health care? Can you describe caring in one word? (Research question #6)

9. What does noncaring mean to you when you receive health care? Can you describe noncaring in one word? (Research question #6)
APPENDIX C

INFORMED CONSENT

Responses of Consumers to Experiences During Hospitalization

Principal Investigator: Grace Forsythe, MSN, RN,

Doctoral Student

You are asked to participate in a study designed to learn more about your experiences during hospitalization from your perspective, as a patient. The researcher will interview twenty patients.

Your participation in this study involves completion of two interviews with the researcher. The interviews will last about 60 minutes. The first interview will occur 3-5 days after your surgery in the hospital setting. The second interview will occur six weeks later in your home setting at a mutually agreeable time. Your participation in the second interview will include feedback to the researcher about the accuracy of her interpretations of your contributions during the first interview. It is estimated that this verification process will take about 30 minutes.

There are minimal risks associated with the interviews. If you become fatigued during the interview, the interview may be stopped and continued later. If you become uncomfortable with the interview you may stop it at any time, and you may choose to withdraw from the study at any time without any jeopardy to your medical or nursing care. There are no additional costs associated with participating.

It may be of benefit to talk about your hospital experience. The information obtained in this study will help health care professionals to better understand how experiences during hospitalization effect you as the consumer of health care. This study may lead to improvements in consumers’ experiences during hospitalization.

There are no alternative procedures; however, you may elect not to participate in this study.

With your permission the interviews will be audiotaped by the researcher and later transcribed. All information obtained during your interviews will be kept confidential. A
code number will be associated with your responses in place of your name. The tapes will be identified only by the code number. There will not be any identifying names on the tapes, nor will your name be available to anyone. The tapes will be erased once the study is completed. Reports of study results will contain no identifying information.

You may contact Grace Forsythe about this study and any related questions by calling her at home # 487-3145. If you have questions regarding your rights as a research subject, or if any problems arise which you do not feel you can discuss with the investigator, please contact the Institutional Review Board Office at (801) 581-3655.

Participation in this research study is voluntary. You have the right to withdraw at any time without any jeopardy to your medical or nursing care.

I have read the above information and have received a copy of this consent form. I consent to be a participant in this study.

Signature of Participant  Date

Signature of Witness  Date
REFERENCES


