

**School of Nursing**

**The Phenomenon of Patient Participation in their Nursing Care-A  
Grounded Theory Study**

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**"This thesis is presented as part of the requirements for the award of the  
Degree of Doctor of Philosophy  
of the  
Curtin University of Technology"**

**November 1998**

## **Abstract**

In recent times there has been an emphasis on patients participating in their own nursing care. Studies have demonstrated that when patients participate in their own care, they experience positive outcomes, such as greater satisfaction with care, a sense of control, decreased vulnerability, and being effectively prepared for discharge. Practising nurses are of the view that patients should be involved in the planning, implementation, and evaluation of care in keeping with nursing's philosophy of provide holistic or patient-centred care. Despite this there is literature to show that nurses' espoused pro-participatory attitudes were not always enacted in the practice setting. There was a paucity of research to explain why this situation existed. Therefore, the purpose of this grounded theory study was to explore, describe, and analyse nurses' and patients' perspectives on the phenomenon of patient participation within the context of hospital nursing practice in Western Australia.

Data were collected through formal and informal interviews with nurses, patients, non nurses, a doctor and relatives, focus group interview with nurses, participant observation, listening to nurses' handovers, examination of nurses' notes, and published literature. Thirty three Registered Nurses and 32 patients from medical, surgical, and extended care wards were formally interviewed. Additionally, 28 nurses and 17 patients were informally interviewed during participant observation. The total hours of participant observation was 142. The constant comparative method was used to analyse the data.

The findings revealed that the basic social problem that faced nurses and patients was incongruence in their understandings of the meaning of patient participation and in their philosophies about nursing care. This had led to nurses and patients adopting three styles of participation, that is, participation inclusion which involved patients participating in all aspects of their care, including making decisions about their treatments, participation marginalisation which encompassed patients participating only in their daily living activities and pain management, and participation preclusion which involved patients not participating in any aspects of their care. This resulted in

nurses and patients coming together with their own different styles of patient participation, which caused conflict in viewpoints about how care should be provided and received at the bedside. Exacerbating the problem of incongruence were the hospital contextual conditions of economic constraints, management structures, presence of technology, and culture of medical dominance. These contextual conditions also modified the process that nurses and patients used to deal with the problem.

The basic social process that nurses and patients used to deal with the problem of incongruence was labelled *accommodating the incongruence* and involved three phases. It was found that varying intervening conditions that affected the nurses, patients, or both, and the day-to-day ward environment modified this process. The first phase, which was labelled coming to terms with the incongruence, involved nurses and patients encountering and acknowledging that there was an incongruence. The second phase, which was termed rationalising the incongruence, involved nurses and patients observing and assessing each other's behaviours. The third phase, which was labelled seeking resolution: minimising the incongruence, involved nurses and patients adjusting their behaviours so as to achieve some balance. This third phase was nurse-driven with patients playing a subsidiary role. This was considered to be due to nurses being at their optimum physical level of functioning and in their own socio-cultural work environment as opposed to patients who were ill and therefore vulnerable. Nurses adjusted their behaviours, depending on the patients' preferred style of participation, by either increasing patients' control and level of participation, as well as increasing their own level of control, to upgrade patients' input; or decreasing patients' control and level of participation and decreasing their own level of control to downgrade patients' input; or alternatively converging patients' control and level of participation to meet with their own style of participation, without them increasing or decreasing their own control. Through converging, the nurses were able to upgrade or downgrade patients' input. From this nurse-patient interactive process, which was dynamic and reciprocal, a theory of patient participation emerged. This was labelled *Accommodating Incongruity*. Implications for nursing practice, management, theory, education, research, and consumerism are discussed and directions for future research are provided.

## Acknowledgments

Throughout this study I was supported and encouraged by my supervisors, family, and friends. Without their input I could not have completed this higher degree. I would like to thank everyone who have assisted me. In particular I would like to express special thanks to the following people.

My principal supervisor Dr Vera Irurita for her time, encouragement, scholarly and personal support, and for sharing her expert knowledge of the grounded theory method;

My associate supervisor Dr Angelica Orb for her advice and input;

All the patients and their families, and the nurses who participated in this study, a special thanks, for without your assistance this study could not be undertaken;

Marie D'Mello for meticulously typing the transcripts;

The Monday night research seminar group for their moral and scholarly support, and friendship;

Lindsay Clarke for helping with the diagrams;

My friend and partner, Bernard Smith for his continued moral support and encouragement throughout the duration of the study, and for holding me up when things got me down. Bernie I can never thank you enough, for without your help I could not have accomplished this task.

I would also like to extend thanks to Curtin University of Technology for giving me time release which was appreciated, the Commonwealth Department of Human Services and Health for a research grant, and the Olive Anstey Nursing Fund.



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## CHAPTER ONE

### Introduction and Statement of the Problem

Patient participation had become the catchphrase in health care in recent times. The concept of patient participation had been defined as:

*being allowed to become involved in a decision making process or in the delivery and evaluation of a service, or even simply being consulted on an issue of care ...* (Brearley, 1990, p. 4).

Health consumer groups were questioning the dependent role of patients within Parsons's theory (1951) of the sick role, emphasising that there should be autonomy and self-determination from the patients' perspective (Avis, 1994; Kim et al., 1993; Lowenberg, 1997). Waddell and Petersen (1994, p. 137) claimed that patients should be empowered through being allowed to participate in their care. This thinking was attributed to ethical, legal, and social reasons (HMSO, 1995; Sutherland, Llewellyn-Thomas, Lockwood, Tritchler, & Till, 1989; Wolfe, Boland, & Aukerman, 1994). There was pressure from professional nursing bodies and consumer lobby groups for nurses to change from a paternalistic philosophy of care to one in which there was patient autonomy and empowerment and provision of holistic care. This was a move away from the traditional biomedical model of nursing care in which the patient played a passive role.

According to Cahill (1996, p. 563), nurses were urged to promote patient participation as a rule rather than as an exception. The author further emphasised that patient participation had become an accepted tenet in contemporary nursing practice as it was seen as an enhancer to promoting patient decision making and dignity. This was implicit in the individualisation of care, which underpinned some nursing theories and models, and which accompanied the nursing process (Bayntun-Lees, 1992; Salvage, 1992). The nursing process was said to allow nurses to assess, diagnose, implement, and evaluate care based on patients' individual needs, as perceived by them and patients respectively. Thus, the effective use of the nursing process required nurses to include patients in their own care (Mallick, 1981). Ashworth, Longmate,

and Morrison (1992) further added that patient participation was crucial because it formed the very fulcrum of the much espoused holistic care amongst nurses.

Funnell et al. (1991) postulated that empowerment was preferable to the medical model that aimed to promote patient compliance, which resulted in patients feeling helpless and unable to become involved. These authors explained that patients were experts on their own lives and that the role of health professionals was to provide information, support, and transfer leadership and decision making to patients (p. 38). This view was supported by Connelly, Keele, Kleinbeck, Schneider, and Cobb (1993) who stated that by promoting empowerment, health professionals facilitated patients to choose and negotiate about their own care. The above authors and Rafael (1995) further stated that patient empowerment was an enabling process that nurses could use to enhance personal control for patients so that they could feel comfortable about actively participating in their own care, if they were well enough. Thus, within the context of professional nursing practice, the notion of participation had frequently been equated to the role patients played in the delivery of care (Saunders, 1995).

It had been suggested by Biley (1992) and Brearley (1990) that the issue of informed consent should be revisited by professional nursing bodies since nurses continued to work within the premise that there was implied consent when patients were admitted into hospital. The authors further emphasised that even though patients gave their consent, it did not necessarily mean that patients did not have a right to make informed decisions about their own care in hospital. These concerns were explicated within documents such as the Patient's Charter (Saunders, 1995) in which it was advocated that health professionals should recognise patients' rights and involve them in their own care if they were able. There was also emphasis, from health professionals themselves, that patients as health consumers should have access to information and participate in their own care (Biley, 1992; Brearley, 1990). The push for patient participation and self-responsibility had therefore resulted in a shift towards a more holistic model of care in nursing practice (Benson & Stuart, 1992; Goleman & Gurin, 1993; Gott & O'Brian, 1990; Moyers, 1993).



Some nurses were of the opinion that patients should participate in the planning, implementation and evaluation of care, in keeping with nursing's philosophy to provide holistic care (Waterworth & Luker, 1990). The concept of holistic care had been defined in nursing literature to encompass care that took into account the patient's biological, psychosocial, social, and spiritual needs (Daly & Watson, 1996). Several authors also stated that holistic care enhanced patient participation and self-responsibility for one's own health (Benson & Stuart, 1992; Goleman & Gurin, 1993; Gott & O'Brian, 1990; Moyers, 1993). Holistic care also alluded to nurses subscribing to the need to encourage patient participation, for the purpose of empowering patients. It had been suggested by Daly and Watson (1996) that it may be easier for nurses to partner with patients if they subscribed to holistic care because the concept promoted complete patient participation and empowerment. The authors further stated that if nurses subscribed to the biomedical model, they were more likely to resort to guiding patients rather than to allow them to make decisions about their care. This was because the biomedical model did not provide nurses with the scope of extending beyond allowing patients to make decisions about their activities of daily living and pain management (Daly & Watson, 1996). For nurses to facilitate empowerment of patients, they needed to give the power and control back to patients, thus making it possible for patients to choose or not choose to participate at whatever level they wanted to participate (Daly & Watson, 1996).

Studies have demonstrated that when patients participated they experienced positive outcomes. These included greater satisfaction with care, a sense of control, decreased vulnerability and stress, and being effectively prepared for discharge (Avis, 1994; Beisecker, 1988; Brearley 1990; Dennis, 1990; Giloth, 1990; Kim, 1985; Meyer, 1993; Murray, 1986). Literature also suggested that when patients participated in care, they experienced increased self-responsibility and independence, and greater compliance with care, which as suggested by several authors, indicated positive patient outcomes and better patient adjustments, which subsequently increased quality of life (Alexy, 1985; Hanucharurnkui & Vinya-Nguag, 1991; Mahler & Kulik, 1990; Wilson-Barnett & Fordham, 1982). Despite these stated positive patient outcomes, and nurses' espoused views, there was literature to indicate that there were discrepancies between nurses' pro-participatory attitudes and the reality of what was

actually practised at the bedside (Kasch, 1986; Kim, 1983; Waterworth & Luker, 1990; Weiss, 1985). There was a paucity of research to explain why this situation existed. Lowenberg's (1989) study showed that health professionals continued to exonerate patients from blame and exempted them from any responsibility related to their health care. This suggested that health professionals tended to hold on to the control of care, which was characteristic of the traditional model of care. Whether this situation was the case with nurses in Australia needed to be explored. Brearley (1990) explained that patient participation was a demand that will not go away and that nurses, as being most involved with patients, needed to take the lead in promoting this very important tenet of nursing practice. This was provided patients were willing and well enough to want to participate in their own care. As Waterworth and Luker (1990) pointed out, patients choosing not to participate was in itself a form of participation and health professionals should respect this patient stance.

Within the health care system in Australia, there were financial constraints that impinged on resources that were available to meet all patient needs during a hospitalisation (Health Observer, 1994). The national health budget had resulted in reduced number of beds available for hospitalisation, leading to hospitals opting for the early discharge program (Health Observer, 1994). Wolfe, Boland and Aukerman (1994), therefore, urged that patient participation was a necessity if nurses were to assist patients to care for themselves effectively once discharged. It had been suggested that allowing patients to evaluate their care as a form of participation will also prepare patients for early discharge (Saunders, 1995, p. 42). The author stated that nurses tended to determine the suitability of discharge for patients through objective measurement of improvement. This, according to Saunders (1995), was not adequate because it was only through subjective evaluation by patients that areas of concerns, which needed to be addressed, were revealed before discharge.

The Diagnosis Related Group (DRG) and Casemix system of funding for hospitals in Australia also reinforced the participation ideal (Cuthbert, 1992; Witham, 1996). Under this system, monies were paid prospectively to hospitals for patient outcomes rather than retrospectively for services rendered. Hence, hospitals aimed to discharge patients as quickly as possible in order to benefit under the DRG/ Casemix system.

This is acceptable if patients do not suffer any adverse effects such as complications from being discharged too early. The question remains, however, whether early discharged patients are able to care for themselves effectively once home if they have not participated in their own care whilst in hospital. It has been suggested that it is only through active participation of patients whilst in hospital that they can be prepared effectively for discharge (Wolfe, Boland, & Aukerman, 1994).

A major problem identified with the body of research that has looked at patient participation is that it has been atheoretical (Cahill, 1996; Teasdale, 1987; Weiss, 1985). There has been an attempt to evaluate the nature of patient participation and its effects on patients with only a “superficial” understanding of the social processes that are crucial to the phenomenon of patients participating in their own care. For example, from the patients' perspective, there is a lack of detailed information on how they feel about being involved or participating in their own care (Alexy, 1985; Avis, 1994; Galano, 1977; Waterworth & Luker, 1990; Willer & Miller, 1976). In Waterworth and Luker's (1990) study, patients were found to be reluctant collaborators rather than to be active participants. Patient ignorance and lack of information have been suggested to be responsible for this (Brownlea, 1987). Avis (1994) purported that perhaps patients have their own agenda by holding on to an instrumental model of participation, which encompasses doing as they are told. This, according to Avis (1994), will impede any scope for patient participation.

There is also a paucity of research that has looked at what nurses actually did at the bedside to promote patients participating in their own care, even though several studies suggested that nurses believed that patients should participate (Biley, 1992; Brooking, 1986; Giloth, 1990; Jacobs, 1980; Weaver & Wilson, 1994). As already alluded to, nurses' pro-participatory views are not evidenced in the practice setting. One suggestion is that nurses, however well-intentioned, may have constraints imposed on them by a health care system that emphasises illness versus individual patient needs, and accountability versus autonomy (Weaver & Wilson, 1994). Another suggestion is put forth by Orb (1993, p. 93) who claimed that nurses, through ignorance, may not fulfil their moral obligations in practice. The author further stated that some nurses may ignore ethical principles and seek rewards such as

power and control over their patients rather than to empower them (Orb, 1993). It is clear that not enough is known about the subject of patient participation and the reasons why nurses are unable or unwilling to enact their espoused views regarding patient participation. This indicated that further exploratory research was warranted.

In Australia, the model of professional dominance in health care has been questioned, especially by consumer groups (Consumers Health Forum, 1991; National Consumer Affairs Advisory Council, 1992). There is a call for a more informed public which should be able to make informed decisions about health and care (Australian Health Ministers' Advisory Council, 1996; Bates & Linder-Pelz, 1990; Davis & George, 1993; Irvine, 1996). It may be argued that even though the above criticism is directed towards doctors on face value, it nevertheless has implications for all health professionals, and particularly nurses. According to Davis and George (1993), the arduous need to cut costs in the health care system in Australia has resulted in a tendency in hospital administrators to lean towards input costs as opposed to patient outcomes. This is especially evident in the area of caring for patients in a holistic way, and in providing care which involves allowing patients to participate (p. 235).

An Australian study by Harrison and Cameron-Traub (1994) found that patients were hesitant to discuss psychosocial issues with nurses because this was "deemed to be outside the bounds of what hospitals and health care were seen to be about" (p. 139). As a result, Davis and George (1993, p. 170) reported that there is vast dissatisfaction in patients about the medical and nursing care that they had received because of the perceived impersonal dealings inherent in modern Australian hospitals. Waddell and Petersen (1994) explained that the rise in specialised tasks, and the conflict between bureaucratic demands and nurses' own occupational priorities, may have resulted in the above situation of nurses not considering patients as individuals with their own needs. It was important therefore to explore this issue further in this study.

In 1995, a survey to investigate the quality in Australian health care, was conducted in New South Wales and South Australia, using 14,000 hospital patient admission records. The results showed that 16% of patients admitted into hospital had suffered an adverse event through iatrogenic causes and that over 50% of these events were

preventable (Watson, 1996). According to Watson (1996), the cost to the Australian government for these preventable events was \$867 million per year. Following this survey, the Commonwealth government set up a Task Force in 1996 to formulate recommendations to increase the quality and safety of health care. In the 1996 report on quality into health care in Australia, the Task Force recommended that there needs to be consumer input in health care by way of patients actively participating in their own care. This encompasses patients having access to information and making decisions about health care, especially in the area of quality definition, monitoring, and feedback (Australian Health Ministers' Advisory Council, 1996). The Task Force drew attention to the central role that patients play in health care, stating that patients expect safe care, information, and communication. It was also stated that patients are dissatisfied with the degree of interpersonal skills shown by health professionals in the provision of care. The Task Force further claimed that patient complaints and litigation often occur because patients are not listened to (Watson, 1996).

It was therefore deemed to be imperative for this study to investigate the phenomenon of patient participation in the hospital setting in Australia in order to explore the social processes that are occurring between nurses and patients. By understanding the complex process of how and when patient participation is enhanced, nurses are able to be more effective, if they choose, to promote this with subsequent positive patient outcomes. Nurses could make it easier for patients to ask questions, answering patients' questions and helping them to cope physically, socially, and emotionally once discharged. This is especially important in light of the focus on early discharge programs that currently is prevalent in hospitals in Australia. It was evident also in the literature that differences exist in nurses' and patients' perceptions regarding patient participation in their own care (Ashworth et al., 1992; Cahill, 1996). Although available research demonstrated these differences, there was a dearth of studies that have resulted in a substantive theory explaining this phenomenon. Little is known about patient participation in nursing practice in Australia. The substantive theory developed from this study should make a valuable contribution to add to the body of knowledge in nursing and provide future directions for research, practice, and education.

## **Brief Literature Review and Rationale for the Study**

A review of nursing literature suggested that nurses should encourage their patients to play an active role by allowing them to participate to a greater degree in their own care (Biley, 1992; Cahill, 1996; Irvine, 1996; Waddell & Petersen, 1994). Nurses are said to provide holistic care for their patients with the use of the nursing process and the formulation of an individualised plan of care. Indeed, it has been suggested by Steckel, Funnell, and Dragovan (1979) that patient participation in the nursing process is essential. The central tenets of the nursing process are said to be patient participation and choices in care (Bond & Thomas, 1992). However, there are individual differences between patients, and nurses need to get patients' input in order to provide holistic care (Mitchell, 1991). For example, during assessment, nurses need to take heed of what patients are experiencing with their bodies rather than exclusively relying on clinical manifestations. Steele, Blackwell, Gutman, and Jackson (1987) found that patients perceived that they participated in their care if they were allowed to ask questions, seek explanations, state preferences, offer opinions, and were listened to. At the most fundamental level, in order to provide individualised patient-centred holistic care, nurses should involve their patients (Brearley, 1990; Greenfield, Kaplan & Ware, 1985; Quill, 1983; Watson, 1996).

As pointed out by Lawler (1991), the provision of holistic care is not occurring a great deal in Australian hospitals. The author stated that the trend towards holistic care has become a rhetoric in nursing because nurses continue to practise in a somological manner, that is, nurses are primarily concerned about taking care of the body with little attention paid to the psychosocial aspects of care. Lawler argued that nurses in Australia adopted the concept of holism due to the perceived need to professionalise nursing and to increase its status. Kermode and Brown (1995) concurred with Lawler, claiming that holistic care or holism is a social construct which nurses have inappropriately applied to patient care in an attempt to address the problem of reductionism in care. These authors suggested that nursing has used holism to further a political agenda to meet its own ends. Ashworth et al. (1992), on

the other hand, claimed that nurses have an inadequate understanding of participation. To nurses, patient participation has merely been thought of as including patients in care plans. The authors further emphasised that a more reflective attitude to participation on the part of the nurse can serve as the fundamental basis of holistic care. Waddell and Petersen (1994) called into question the much espoused biopsychosocial model of nursing, which seemingly is holistic. The authors challenged the actual practice of holistic care, claiming that nursing is still very much dominated by biomedical sciences and that it fails to accommodate the key components of holistic care, that is, patient-centred individualised care. Thus, this study aimed to ascertain the degree to which nurses practised holistic care. As previously explained, the major tenet of holistic care is patient participation. Nurses' understanding of the meaning of patient participation also required exploration.

Current nursing practice accommodates the concept of patient participation. Several nursing theories and models of practice, for example, those developed by Orem, King, Watson, Neuman, Rogers, Lenninger, and Parse to name a few, have as their main thrust patient participation and independence as the goal of intervention (Marriner-Tomey, 1994). Accordingly, there are descriptive accounts from nurses who have attempted to make patient participation a reality in various settings (Brearley, 1990, Cahill, 1996). There is, however, evidence that nurses have had difficulty achieving beyond patient-provider interaction and completing prescribed treatment. Greenwood (1996, p. 6) pointed out that the espoused learned nursing theories and models that new graduates bring to the practice setting are often pitted against the reality of what is expected of them in the ward situation, that is, task-centred care. The graduates soon learn that fitting into the ward routine is of prime importance and that providing patient-centred care is a luxury that they can ill afford, unless workload permits (Greenwood, 1996). Several other authors (Hart, 1991; McCaugherty, 1991; Melia, 1981; Moorhouse, 1992; Quill, 1983; Seed, 1991; Street, 1991) also alluded to the need and desire of graduate nurses to emulate senior nurses' behaviours, which are aimed at getting through the workload as quickly as possible, in order to fit in and to be accepted. These above authors stated that graduate nurses believe that real nursing is what senior nurses actually do at the bedside. Graduate nurses may find that the actions of senior nurses may be in direct contrast to nursing in theory, which is

patient-centred care, to nursing in practice, which is technical and task-oriented care. Greenwood (1996), with support from the above authors, summed up by claiming that the focus of nursing in Australia seems to be physical care, with the role of the nurse seen as getting through the workload at any cost, even to the extent of not focusing on the patient as a person with individual needs. The question of some nursing theories being grand theories with little research behind them has also been raised. As such, their practical application has been challenged by some nurse practitioners (Greenwood, 1996).

The Australian qualitative study by Harrison and Cameron-Traub (1994), which examined 26 patients' perspectives on nursing in hospitals, indicated that patients perceived that nurses were there to follow doctors' orders and to provide physical care. The authors argued that this perception may have resulted from the dominant image of nurses being handmaidens to doctors and the bureaucratic nature of hospital environments that encourage task-oriented care. Patients in the above study also perceived that nurses were busy people and they tended to blame the less than satisfactory care on the system rather than on the nurses. Some patients, therefore, viewed the aspect of receiving psychosocial, emotional, and spiritual care as secondary to physical care, with others considering these aspect of care as non nursing duties. On the whole, patients mainly viewed their role to be one of cooperation with the nurses and did not consider themselves as partners in decision-making. The above study also revealed that patients did not disclose concerns other than those related to physical care because they felt that only physical needs were legitimate and warranted nursing time. It is worth noting that in other qualitative studies patients have described psychosocial aspects of care as essential for high quality care with physical care given a low priority or taken for granted (Brown, 1986; Chipman, 1991; Deeny & McCrea, 1991; Icenhour, 1988; Irurita, 1993; Koch, Webb & Williams, 1995). It may be that in Harrison and Cameron-Traub's study (1994) patients believed that physical care was the priority because of the emphasis placed on it by nurses. Although Harrison and Cameron-Traub's (1994) study was small, it nevertheless was useful. It was conducted in three hospitals and incorporated the views of patients from a range of ethnic backgrounds, which reflected the patient



population in Australia. The study also provided some insights into patients' perceptions of hospital care.

Giloth (1990) stated that perhaps the continued task-oriented nature of providing nursing care has led to patient care being a series of tasks rather than an interactive process between the patient and the nurse. Literature suggested that the process of negotiating and contracting between patients and nurses has not been sufficiently described (Boehm, 1989). For example, it is unclear whether patient participation is initiated by patients themselves because of certain needs or whether their behaviour is in response to the nurse's approach to care. Boehm (1989) went on to state that, although nurses know how to contract with patients, they are unaware that they provide contingencies that shape patients' behaviours. It has been postulated that territorial, social, cultural, and educational barriers from the patients' perspective may have led to imbalance of power, leaving the patient in a weakened bargaining position (Batehup, 1987; Brooking, 1986).

According to Beck (1997), there are implicit power differentials between patients and care givers as indicated by certain perpetuated behaviours between the dyad. This is despite the trend towards a push for a more participative health care encounter between patients and health professionals (Ballard-Reisch, 1993; Branch & Malik, 1993; Ragan Beck, & White, 1995; Smith-Dupre & Beck, 1996). A qualitative study conducted by May (1992) in a Scottish General hospital showed that, even though nurses placed emphasis on knowing the patient and providing individualised care, no attempt was made by nurses to democratise the unequal power relationship that existed between nurses and patients. The nurses in the above study were observed to retain control over the form that interactions took and did not make reciprocal disclosures. In reviewing May's findings, Petersen (1993) argued that nursing's adoption of holistic care is nothing more than a rhetoric, as previously alluded to by Lawler (1991), because nurses continue to exercise power similar to that of doctors over their patient. Patients are also said to lack the necessary knowledge and information needed to make informed decisions and participate in their own care. This, according to Irvine (1996), places patients in a disadvantaged position to be true consumers of health care. The author expressed concern that the lack of knowledge

and information has the potential to prevent patients from voicing an opinion, evaluating their care, and exercising critical judgement, which are characteristic measures of true consumerism. In a study conducted into patients' behaviours in Sydney by Lloyd, Lupton, and Donaldson (1991), it was found that the majority of patients showed trust, dependence, and loyalty to their care givers uncritically, indicating that they were unable to fulfil their role as true consumers.

In relation to power and knowledge in the context of health and illness, much of Foucault's work has been quoted (Armstrong, 1983; Bloor & McIntosh, 1990; Dingwell, Rafferty, & Webster, 1988; Lawler, 1991; Petersen, 1993; Silverman, 1987; Street, 1995). Foucault's work (1975, 1980, 1991) challenged the objectifying of the patient as a body that needs surveillance and monitoring by medical personnel and calls for a connection between the patient as a body and as a subject, meaning the individual. Foucault termed the objectifying of the body as the "clinical gaze" where the main concern for health professionals is to treat the body with little emphasis placed on the psychosocial aspects of care. May (1992) wrote that the subjectification of the patient by nurses can increase patients' control and empower them. Watts (1990, p. 41), on the other hand, stated that nurses must first realise that health care in Australia, like in other countries, is inextricably connected with power and politics. Furthermore, the author wrote that nurses must be empowered themselves to overcome the restraints of their own environment before they can empower patients. According to Watts (1990), it is timely that nurses, through political involvement and confrontation with power holders, reclaim their rights and worth in the health care arena in Australia. Only then will nurses be able to feel empowered, and be able to focus on nursing practice that truly reflects a participatory approach in patient care.

According to Doudera (1985), when patients are competent adults, care givers need to promote and facilitate patient dignity and self-determination by involving them in all aspects of their care. Care givers should recognise patients' authority to make ( or have made by others on their behalf ) decisions affecting their care. The author expressed concern, however, that health care providers are not overly successful in achieving this. For example, quantitative research conducted by Kim (1985) in the United States, using a general medical-surgical ward in an acute care hospital, showed

that nurses generally believed in participative decision making and patient involvement as a value in nursing practice. The study, however, identified that nurses did not always include patients in decision making with regards to the day-to-day care that they received. The reasons identified for causing this were pressure of time, lack of institutionalised process to encourage patient involvement, and situational factors such as routinization of tasks (Kim, 1985). Kim's findings are similar to a Western Australian grounded theory study by Williams (1996) that looked at the delivery of quality care for patients in an acute care hospital setting. The findings showed that nurses equated quality care with the provision of holistic care which is meeting patients' physical and psychosocial needs. The above study, however, indicated that nurses were unable to consistently deliver quality care because of insufficient time to develop therapeutically conducive relationships with patients. Williams's study (1996) clearly showed that there needed to be therapeutically conducive relationships between nurses and patients before any positive interaction could occur. Patients and nurses knowing each other well was identified as an essential criteria for a conducive relationship and for this to occur there had to be sufficient time.

There is literature to show that the higher the degree of personal control that patients have over their care and treatment modalities, the greater is their perception of well being. Being in hospital is a stressful experience and having control in their care has been documented to mediate stress reactions in patients (Dennis, 1987; Jacobs, 1980; Kleinman, 1988; Russell & Schofield, 1986; Waddell & Petersen, 1994). This is supported by Giloth (1990) whose research showed that involving patients and their families in care delivery decreased the stress of hospitalisation and prepared patients more effectively for discharge from hospital. Other literature indicate that the degree to which patients want to contribute to decision making and to have control is contingent upon their belief that they have a high degree at stake for themselves (Dennis, 1985; Folkman, 1984; Langer & Rodin, 1976; Schulz, 1976; Wiens, 1993).

The relevance of patient control is highlighted in a Western Australian study using the grounded theory approach (Irurita, 1993). This study, which looked at nursing care from the patients' perspective, showed that patients considered being allowed flexibility in their daily routine as a measure of control and some degree of

independence. Furthermore, patients stated that they would have appreciated being consulted about the time of discharge so that they could have made the appropriate arrangements rather than being told when to leave. The patients clearly wanted the nurses to negotiate with them regarding their care in Irurita's study. Other studies reveal that the level of adherence to treatment regimes and compliance with care as well as satisfaction with care increased when nurses consulted with patients (Craig, 1985; Kim, 1985; Macleod-Clarke & Latter, 1990; Steckel & Swain, 1977; Webb, Addison, Holman, Saklaki, & Wagner, 1990). In a study by Murray (1986), it was found that, although a high level of patient participation did not alter the level of pain experienced, patients who had actively participated in their own pain management reported a high degree of satisfaction with care. On the other hand, patients whose nursing care decisions regarding pain control were managed by nurses as a routine practice, with only minimal consultation, reported less satisfaction with the care they had received. The above studies highlight the importance of the value of involving patients in their care so that patient outcomes can be improved.

It has been demonstrated that there are differences in the way patients and nurses perceive care and that evaluating the effects of patient participation is difficult because of the multi factorial nature of the problem ( Jacobs, 1980; Smith, Buck, Colligan, Derndt, & Sollie, 1980). A qualitative study conducted in England by Waterworth and Luker (1990), using twelve patients, showed that patients appeared to value being able to trust the nursing staff and "toe the line" rather than to participate actively in their care. The patients in the above study were preoccupied with staying out of trouble and, in order to achieve that, they found out all the rules and adopted the "right behaviour". Even though the patients had misgivings about the care they received from the nurses, they did not complain as they believed that the nurses had to get their work done. Those patients, therefore, were willing to relinquish their freedom and responsibility and just accept the situation (Waterworth & Luker, 1990, p. 972). Explanations for this patient behaviour are provided by Danziger (1978), Haug and Lavin (1981) and Tuckett, Boulton, Olson, and Williams (1987) who postulate that patients see themselves as having a competence gap and therefore expect to take advice on trust and do not evaluate what they are told. In contrast,

adult patients in the United States demonstrated that they wanted to participate in their own nursing care and to have the right to make decisions (Kim, 1988).

A modified grounded theory study was conducted by Biley (1992) to discover patients' feelings about participating in decision making. Even though a state of core category saturation was not achieved because of methodological constraints, the study highlighted the following trends. Patients in the study generally wanted to be involved in decision making; however, there were variations in the degree to which the patients wanted to be involved. For example, patients' perception of being "too ill" was congruent with them not wanting to participate in decision making. Similarly, patients stated that they would like to actively participate in making decisions about non technical aspects of their day-to-day care such as meeting their hygiene needs. In areas of care where patients believed they lacked technical knowledge, especially in the category of "I don't know enough ... Nurse knows best", patients preferred to take a passive role in decision making about their care. Finally, the category, "If I can ...," described the organizational constraints or freedom that restricted or encouraged patients' participation in care (Biley, 1992, p. 414).

Waterworth and Luker (1990) stated that for patient participation to occur there needs to be collaborative decision making between nurses and patients. Kim (1983, p 271) defined collaboration as a process where two or more individuals work together in order to achieve a goal. Accordingly, the author suggested that collaborative decision making is an act of selecting an option among two or more possible alternatives for a prospective action by two or more individuals mutually influencing the decision. This suggests that collaboration involves the use of influence among the individuals concerned in a social decision making situation. The concept of collaboration has been brought to the attention of nurses through writings on the nursing process (Ashworth et al., 1992; Jacobs, 1980). Nurses, for example, have always viewed the patient and their families as active participants in the planning, implementation and evaluation of care (Kron, 1981; Little & Carnevali 1969; Marriner, 1979). Nevertheless, according to Moughton (1982), collaboration with subsequent patient involvement is not always a reality in everyday practice. Findings by Kim (1985) regarding nurses' attitudes to collaborating with patients showed that

although nurses exhibited pro-collaborative attitudes of shared responsibility in decision making with patients whilst giving care, there was an indication that only low levels of collaboration actually occurred between the nurse and the patient. The author went on to state that this incongruence between the pro-collaborative attitude and actual behaviour needed to be explored further.

A quantitative study by Kim et al. (1993) compared patients' and nurses' attitudes about patient-nurse collaboration in Finland, Japan, Norway, and the United States. Findings from that study indicated that, although the nurses and patients in the above stated countries tended to lean towards the consumerist attitude, there were significant differences among the countries and between the patients and nurses. The patients, in general, were also not as strong in their views on self-determination regarding nursing care as were the nurses. The authors claimed that the differences may be linked to various patterns of health care processes and patient-nurse interactions. For example, the combination of a patient with a highly pro-consumerist attitude with a nurse with a less liberal attitude resulted in a situation where the nurse was unresponsive towards the patient's attempts at self-determination causing conflicts for the patient (Kim et al., 1993). England and Evans (1992) stated that collaboration in nursing care decision making may be influenced by attitudes, personal characteristics, and beliefs that the informants (patients and nurses) bring into the situation and by the nature of the situation in which decisions are made. This is highlighted in Kim et al.'s (1993) study that found that Japanese patients were the least challenging of professional authority. The Japanese and the Norwegians were also less consumerist regarding patients' rights to make decisions than the Finnish and the United States' patients. This suggests that the level of collaboration in nursing care decision making between nurses and patients may vary between cultures. No studies which explored the patient-nurse participation issue had been undertaken to date in Australia. The Australian culture is different from that of the above mentioned countries and research into patient participation within this cultural context could reveal valuable data. It was deemed to be important therefore to identify factors that explain variations in patients' views and nurses' pro-collaborative attitudes. Abdel-Halim (1983) highlighted the importance of individual differences and stated that participation is most effective for patients who desire that but not for those patients

who do not wish to participate. There is, however, a tendency in nursing to view participation as “good” and that means it applies to every patient (Abdel-Halim, 1983). The author warned that the appropriateness of participation may vary with patients' medical conditions.

In order for patients to participate in their own care, they need to have access to information and to be allowed the freedom to act on their choices (Teasdale, 1987). Avis (1992) stated that nurses often draw attention to the need for partnership and an informed and participative encounter with the patient. The author argued that nurses tend to give information rather than share information, which can lead to nurses being ineffective in their communication with their patients, which in turn affected participation. A study on patients' views about choice and decision making conducted in a day surgical unit by Avis (1992) showed some interesting findings. Patients viewed the nurses as experts who were working to a set agenda of disease, diagnosis, and hospital routine, and perceived themselves as being ignorant. To this end, the patients waited for the nurses to give them the necessary information rather than asking for information. This inevitably led to the patients not receiving the much needed information for enhancing participation. The patients thus saw themselves as “work objects” who took on a passive role in the care that they received. They also did as they were told because of the fear of losing face as a consequence of the lack of information to make informed decisions (Avis, 1992, p.10). The notion of patients feeling that they are “objects” was supported by Irurita (1993). This Western Australian research also highlighted the need for information which was seen by patients to enhance control in what happened to them in hospital, even though the patients stated that they did not always know what questions to ask.

It could be implied from the above studies that the nurse-patient relationship and its link with information sharing and patient participation needs further exploration.

Roberts and Krouse (1988) supported this implication by suggesting that the nature of the relationship between the nurse and the patient is dependent on the interpersonal style of the care giver. Dharmananda (1992) and Hogan (1993) confirmed that when patients are ill, worried, or scared, it is extremely difficult for them to give themselves permission to ask questions in order to gain information. These authors further commented that many patients have the belief that doctors and nurses know best and

perceive that to question would be taken by health professionals as being rude or exhibiting a lack of trust and/or confidence in the professionals' abilities. To this end, the above authors urged health professionals to invite questions from patients and more specifically to teach patients what questions to ask.

Despite literature highlighting the need for patient participation in their own care, it was not clear to what extent patients and nurses actually demonstrated this consumerist approach, nor was there a clear explanation of the phenomenon of patient participation. There was evidence to suggest that nurses did not always afford the patient the individual right to become involved in the everyday care that they received despite its espoused value in promoting positive patient outcomes (Biley, 1992; McMahon, 1989; Wright, 1986). The question of why the above situation existed needed to be explored. As a starting point, there is literature to support that nurses ideologically value patients' rights and autonomy as they perceive their role to be patient advocates (Kim, 1983). Nurses, however, work in situations where they exercise authority and control over patients (Kasch, 1986; Kim, 1983; McCormack, 1993; Teasdale, 1987; Waterworth & Luker, 1990; Weiss, 1985). There is also the question of whether all patients want to participate in their own nursing care. Could it be argued that patients making a conscious decision not to participate is in point participation? Issues of nurse-patient relationship, information giving and receiving, and patient self-determination in relation to patient participation have been reflected in literature and available research. Current literature is inconclusive and indicates that little is known about the subject of patient participation in their care. Further exploratory research was thus indicated in this area, especially within the context of Australian hospital nursing. In support, Steele et al. (1987) stated that the issue of the patient as a participant in care has waxed and waned for two decades in conjunction with societal interest in autonomy, self-direction, and personal responsibility and that it is timely that nurses take stock of this issue.



## **Purpose**

Available studies and literature so far have identified positive patient outcomes if they participate in their care, nurses' and patients' attitudes about participation, the lack of or minimal demonstration of pro-participatory behaviour at the bedside, and lack of description of the social processes that underpin participation. Whereas much has been written about the required need to involve patients in their own care in keeping with nursing's philosophy to provide holistic care, there is a paucity of cited empirical literature explicating the extent to which patient participation is actually a reality in the practice setting. Although both quantitative and qualitative studies conducted in Australia and overseas have provided much insight into the phenomenon of patient participation, it is appropriate to state that there are still many unanswered questions, especially in the description of the social process of participation. Gaps also remain in relation to patient participation in different contexts.

The purpose of this study was to explore, describe, and analyse nurses' and patients' experience of the phenomenon of patient participation within the context of hospital nursing practice in Western Australia. Using grounded theory methodology, this study systematically examined and described the manner in which patient participation occurred or did not occur in the practice setting as perceived by patients and nurses, through clinical observation, documentation in nurses notes, and as stated by nurse clinicians, managers, doctor, and patient relatives. The study sought to uncover information from nurses and patients and described their understanding, experiences, and interpretations of factors that enhanced and impeded the enactment of patient participation. It also sought to discover and describe the extent to which nurses and patients incorporated the phenomenon of patient participation within the constraints of the bureaucracy of a hospital setting and within the scope of their own beliefs, values, and understanding.

## **Research Questions**

The study was guided by the following questions:

1. How do nurses involve or not involve patients in their nursing care in acute care hospital settings in Western Australia?
2. How do patients perceive and engage or not engage in participation in their own care in acute care hospital settings in Western Australia?

## **Study Objectives**

1. To explore and describe patients' perceptions of participation in their nursing care (including outcomes).
2. To explore and describe nurses' perceptions of patient participation and its outcomes in the nursing care they provide.
3. To observe, explore, and describe the ways and extent to which patients participate in their care.
4. To observe, explore, and describe the ways and extent to which nurses engage in the practice of involving patients in their care.
5. To identify and explore factors that are perceived to enhance or inhibit the phenomenon of patient participation from the patients' and nurses' perspective.
6. To generate a substantive theory which explains the phenomenon of patient participation within the specific context and varying conditions under which this phenomenon occurs and relate this theory with other research findings and existing theories.

## Significance of the Study

This study is of significance for nursing practice, theory, research, and education as it developed a theory that conceptualised the meaning and extent to which patient participation occurred in acute care hospitals in Western Australia. Specifically, it describes the manner in which nurses and patients enacted the phenomenon of patient participation. It also outlines the factors that enhanced and impeded patient participation. Understanding the phenomenon of how and when patient participation is enhanced could assist nurses in Australia to be effective in promoting this with subsequent positive patient outcomes. It makes recommendations based on information that emanated from the experiences of nurses and patients within the context of hospital care. This information provides a firm basis for further research conducted on the topic of patients participating in their own care.

## Overview of the Thesis

This thesis is presented in six chapters. Chapter One provides a brief literature review, the rationale, and the objectives of the study. Chapter Two describes the methodology used to address the study objectives. Chapter Three describes the basic social problem experienced by nurses and patients in the study. Chapter Four provides the hospital contextual conditions that impacted on the basic social problem and modified the basic social process. Chapter Five describes the basic social process used by nurses and patients to deal with the core problem. It also illustrates the way in which nurses and patients understood and enacted the phenomenon of patient participation. The varying intervening conditions that modified and inhibited the basic social process are also included in this chapter. Chapter Six discusses the *accommodating incongruity* theory of patient participation in the context of existing theory and literature and the implications of the findings. It also includes recommendations for nursing practice, management, theory, education, research, and consumerism. Limitations of the study are also discussed in this final chapter.

## Definitions of Terms

The following definitions were used in this study:

**Acute care hospital setting:** Any ward in a public or private hospital that admits acute care patients who are not day cases.

**Agency nurse:** A nurse who is employed by a Nursing Agency and has work assigned to them by that agency.

**Biomedical model:** A model of care that only takes into account the physical aspects of care. It is mainly concerned with the treatment of the body.

**Casual nurse:** A nurse who is employed by the hospital and works for the hospital on a casual basis as needed by the hospital.

**Casemix:** It is a costing formula that pertains to the mix of patients treated in a specific ward or unit over a specific period of time. The casemix is classified in relation to diagnosis related groups (DRG's), ambulatory visit groups (AVG'S), refined DRG's (RDRG's), and patient management categories (PMC's) (Cuthbert, Duffield, & Hope, 1992).

**Clinical pathways:** Interdisciplinary plans of care that outline the optimal sequencing and timing of interventions for patients with a specific diagnosis, procedure, or symptom and which are designed to minimise hospital stay (Ignatavicius & Hausman, 1995).

**DRG's (Diagnosis Related Groups):** Acute care patients are classified into 477 DRG's according to diagnostic categories based on body systems (Cuthbert, Duffield, & Hope, 1992).

**Health care consumer:** An individual who actively seeks out guidance and information from health care providers. He/she makes decisions based on personal motivation, knowledge, and information about the type of treatment he/she wants.

**Holistic care/ holism:** Care that takes into account the patient's biological, psychosocial, social, and spiritual needs. Patients' participating in their own care is an aspect of holistic care (Ashworth, Longmate, & Morrison, 1992).

**Iatrogenic:** Adverse effects caused to the patient as a result of medical intervention.

**Level 1 nurses:** The Western Australian nursing career structure was developed in 1988. It comprises of four specialist streams. These are: clinical, staff development, management and research. Each stream comprises of levels one to four. Level 1 nurses are a combination of newly graduated nurses and nurses with several years of practice. These nurses are only accountable for direct patient care and are supervised by Level 2 nurses (McCarthy, 1987).

**Level 2 nurses:** All positions from Level 2 and above are promotional positions. These nurses are deemed to be advanced clinicians with proven skills in communication, leadership, and management (McCarthy, 1987).

**Patient empowerment:** An enabling process that nurses use to enhance personal control for patients and that which allows nurses to regard patients as subject, rather than object, and as capable of transforming their own realities. To empower patients is to promote a conducive environment where patient feel respected and feel comfortable about making decisions about their own health and care (Rafael, 1995).

**Patient-centred care:** Nursing care that focuses on the individual needs of patients, based on patients' perceived needs rather than care that is pre-determined by nurses. In order to provide patient-centred care, nurses need to invite patients' active participation into their own care.

**Permanent nursing staff:** Nurses who are employed by the hospital on a permanent basis and who are rostered to work on a given ward.

**Self-care:** Activities performed by patients on their own behalf in order to maintain their health and well being. In order to achieve this, patients need to participate in their own care as much as able.

**Shift coordinator:** A senior nurse who is responsible for coordinating the shift. This nurse is usually a Level 2 nurse. This position is rotated amongst the four Level 2 nurses who are normally assigned to a ward.

**Therapeutically conducive relationship:** The development of a positive relationship between the nurse and the patient. A positive relationship is considered to be needed for the delivery of therapeutically effective nursing care (Williams, 1996).

## **CHAPTER TWO**

### **METHODOLOGY**

#### **Overview of the Chapter**

The phenomenon explored in this study was patient participation. The study therefore examined whether or how patients participated in their the own nursing care in acute hospital settings in Western Australia. The study explored and described patients' and nurses' perceptions of the meaning of participation, the extent to which patients actually participated in all phases of their care and the degree to which nurses engaged in the practice of encouraging patients to participate in their own care. The study also identified, explored, and described factors that were perceived to enhance or inhibit patient participation from the nurse's and patient's perspective. The phenomenon of patient participation was examined utilising the grounded theory method to generate a substantive theory which explained the basic social problem encountered by nurses and patients and the basic social process that they used to deal with the problem. In this chapter, the grounded theory method and its epistemology, the grounded theory debate, the research design, the methods of the procedure, sample selection, data collection and analysis procedures, methods utilised to ensure validity and reliability issues, and ethical considerations are described.

#### **Grounded Theory Method**

The phenomenon of patients participating in their own care was studied using the grounded theory method. Originally described by Glaser and Strauss (1967), this method was further developed by Glaser (1978), Strauss (1987), and Strauss and Corbin (1990). The main thrust of grounded theory method is that the discovery and conceptualisation of the phenomenon being examined are extrapolated from or grounded in the data collected. According to Strauss and Corbin (1990, p. 23), a grounded theory is one that is inductively derived from the study of the phenomenon

it represents, that is, it is discovered, developed and verified through systematically collecting and analysing the data pertaining to that phenomenon. Grounded theory involves seeking social processes within a given phenomenon.

The grounded theory method has been used in studies related to health care and nursing (for example, Benoliel, 1967; Corbin & Strauss, 1984, 1988; Fagerhaugh & Strauss, 1977; Glaser & Strauss, 1965; Hutchinson, 1986, 1992, 1993; Wilson, Hutchinson, & Holezmer, 1996). Interest in the grounded theory approach has also been sustained in nursing literature (Chenitz & Swanson, 1986; Stern, 1980; Streubert & Carpenter, 1995; Strauss & Corbin, 1994; Wilson & Hutchinson, 1991). Nurses in the areas of nursing practice, education, and administration have also utilised grounded theory (Biley, 1992; Bright, 1992; Burnard, 1992; Diepeveen-Speekenbrink, 1992; Porter, 1987; Weiss, 1985). In Western Australia, Irurita first used this methodology in her doctoral thesis into leadership processes in nurses (1990) and continued to use this approach in other studies of nursing care (Irurita, 1992, 1993, 1996a, 1996b, 1996c). As stated in the previous chapter, even though qualitative and quantitative research methods have been used to examine the issue of patient participation, there were no clear descriptions or grounded theory of the phenomenon of patient participation in their hospital care (Giloith, 1990; Jacobs, 1980; Teasdale, 1987; Weiss, 1985).

## **Epistemology of Grounded Theory**

Grounded theory stems from the theory of symbolic interactionism as espoused by Mead (1964) and Blumer (1969). Symbolic interactionism examines human behaviour in the setting in which it occurs, in terms of social interaction and shared meanings. Grounded theory is particularly useful for conceptualising behaviour in complex situations. This is because it is based on the premise that people derive meaning from social interaction with other people and that meanings are modified through an interpretative process and use of symbols (Chenitz & Swanson, 1986). Thus, in grounded theory, the researcher needs to understand participants' behaviours as they understand it. This is achieved by learning about participants' interpretation of self in



the interaction, and sharing their definitions. According to Baker, Wuest, and Stern (1992) and Marshall and Rossman (1995), the research interest is in comprehending how people take and make meaning in interaction with others. As patients and nurses come together as dyads during nurse-patient interactions in hospital settings, grounded theory was deemed to be a suitable method for the study of the phenomenon of patient participation.

## **Research Design**

Grounded theory is considered by researchers to be a useful approach when very little is known about a topic or there is a dearth of theories to accurately explain or predict outcomes. This was the case with regards to the focus of this study as there was little research conducted in Australia to explain the phenomenon of patients participating in their own care. Utilising the grounded theory method, hypotheses reflective of theories that emerged from the data were generated and subsequently tested in further data. From this, a substantive theory was generated that accounted for variation in interaction around the phenomenon (Guba & Lincoln, 1982; Reason, 1988).

The aim of using grounded theory was to discover the basic social problem encountered by nurses and patients with regards to patients participating in their own care. The aim was also to discover the basic social process that nurses and patients used to deal with the identified problem or issue under varying conditions and in different contexts. More specifically, the aim of using this method was to discover the central or core process that explained and clarified the interactions between nurses and patients in relation to patients participating in their own care whilst in hospital. For example, it sought to address the question of how patient participation was initiated, when was it initiated, who initiated it and how was it maintained, and what were the enhancing and inhibiting factors? The resultant substantive theory of the phenomenon of patients participating in their own care was compared with existing general and nursing practice theories which espouse patient involvement as their tenet. Hypotheses may be drawn from this substantive theory of patients participating in their own care to form a basis for further research in the area of nursing education,

clinical practice, nursing management, and nursing research. Furthermore, by conducting similar research in different contexts, it may be possible to move the substantive theory into formal theory.

## **Methods of the Procedure**

In using grounded theory, data collection, coding, analysis, and memo writing were conducted concurrently throughout the stages of the study. The major constructs that formed the emerging theory were identified from the data. As the study progressed, theoretical sampling (Glaser, 1978) was used to guide further data collection.

Theoretical sampling involved collecting more data, guided by ongoing analysis, to examine initial categories and their properties and relationships and to make sure representativeness in the category existed by seeking additional informants and other relevant data sources. Following initial interviews, additional nurse and patient informants were approached for formal interviews. Further data were gleaned from attending nurse handovers and conducting an informal interview with a doctor.

Theoretical sampling facilitated the testing, elaboration, and refinement of each category thus ensuring that the relationships between categories were well established and validated (Chenitz & Swanson, 1986). Strauss (1987) described this sampling strategy as an essential step in grounded theory research as directing data collection through the findings facilitated the efficient development of the emerging theory.

Theoretical sampling facilitated the verification of information using different sources, about issues that seemed to be controversial or contradictory within the emerging categories. Negative cases were explored, also using theoretical sampling. Negative cases are cases that inform the researcher that something in the data is different from the rest, hence directing the researcher to look closely at the difference. This adds density and variation to the theory (Strauss & Corbin, 1990, p. 109).

Data collection was modified according to the advancing theory. This involved dropping false leads and asking questions more pertinent to the focus of the study. This was congruent with grounded theory procedures as described by Glaser and Strauss (1967) and reiterated by Streubert and Carpenter (1995, p. 147) who stated

that the researcher should identify essential constructs from generated data and from that the theory should evolve. The procedural steps in the research process (refer to Figure 2.1) are described in detail in this section and included:

1. Raising an awareness of personal beliefs and preconceptions related to the phenomenon through self-interview and journaling to prevent imposing own views on subsequent data collection and analysis.
2. Purposeful sampling where informants with specific characteristics and knowledge in the area of study were selected.
3. Data collection via the use of formal in-depth interviews using open-ended questions, participant observations and informal interviews, use of field notes, participants completing demographic data sheets, examination of nurses' notes on care provided, critical incident observations, and literature searches.
4. Theoretical sampling which is a process of data collection for the generation of theory (Glaser & Strauss, 1967, p. 45). During this stage, data were collected, coded, and analysed concurrently. This facilitated decisions about the type of data to collect next and where to find them, so as to develop the theory as it emerged.
5. Open coding of the data , that is, coding for as many categories (abstractions of the phenomenon observed in the data) that might fit the data.
6. Axial coding or theoretical coding was conducted where data were put together after open coding by making links between the categories and relating subcategories to categories and making them more dense (Strauss & Corbin, 1990). The paradigm model as suggested by Strauss and Corbin (1990) was adopted for this purpose. The model involved the linkage of sub categories to categories by specifying a category in terms of: the causal conditions, the central phenomenon, the context or specific set of properties, the intervening conditions that either enhanced or inhibited strategies to manage the phenomenon, the action/interaction strategies, and consequences of management.

7. Selective coding followed axial coding where the core category was identified and systematically related to other categories validating its development. The core category became the central phenomenon around which all other categories were integrated (Glaser & Strauss, 1967; Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1990).
8. Writing memos and diagramming, that is, the theorising write up of ideas about codes and their relationships as they impacted on the researcher whilst coding (Glaser, 1978, p. 83). Memo writing and diagramming of schemas began when data were first coded and continued until the report was written.
9. Using theoretical sensitivity to see the research situation and its data in new ways, and to examine the data's potential for theory development without trying to fit them into any preconceived views (Strauss & Corbin, 1990, p. 44).
10. Using the constant comparative method of comparing incidents related to each category and integrating the categories and their properties, and elevating the data to more abstract levels. For example, how were the categories defined, the conditions that explained when and why they occurred, the strategies used and the consequences. Through this process, theoretical constructs and their relationships were developed, linking substantive categories and their properties and formulating theoretical codes. Theoretical codes conceptualised the way substantive codes related to each other as hypotheses which were then integrated into the emerging theory (Glaser, 1978).
11. Identifying the core category, which formed the basis around which all other categories revolved.
12. Focusing on the core category of the theory by conducting selective theoretical sampling, coding, and analysis of the data, and writing more memos and diagrams based on the preceding findings.



## Data Collection

The data were collected by a combination of formal, open-ended interviews with patients and nurses and participant observations of patients receiving care and nurses providing care, with informal interviews with nurses and patients to clarify evolving concepts following observations. Demographic data sheets were completed by informants formally interviewed. As well, data were collected through examination of nurses' notes, conducting a focus group interview with seven nurses, and listening to taped handovers. The main source of data was audio-taped formal interviews with 33 nurses and 32 patients as well as informal interviews, during participant observation, with 28 nurses and 17 patients. Short informal interviews with two Nurse Managers, three Clinical Nurse Specialists, a doctor, a nurse who was a patient adviser and eight patient relatives also added to the data source. Examination of nurses' notes allowed the researcher to cross check nurses' written accounts of care provided to patients with their actual performed behaviour that was observed at the bedside. Informal interviews and conversations also took place during participant observations. The use of multiple methods to collect data provided a form of triangulation, described by Denzin (1978) as within-method. This resulted in greater confidence in the internal consistency of the findings.

In keeping with the principles of grounded theory, literature was used as a data source. As the aim of the study was not to test theory or to verify an existing theory, literature was initially reviewed to identify the scope, range, intent, and kinds of research previously conducted in the area of patient participation. This review assisted in focusing the study and prevented leading informants in the direction of what had been previously discovered (Glaser & Strauss, 1967; Streubert & Carpenter, 1995). The brief literature review was used to verify the study's purpose, background, and significance rather than to provide a conceptual framework to guide the study (Chenitz & Swanson, 1986). As the study progressed, the literature was reviewed as an on-going process during data collection and analysis to clarify and compare categories /theory with those in the literature as a data source. Towards the completion of data analysis, however, a comprehensive review of the literature on

patient participation was undertaken in order to place the developed substantive theory within the context of what was already known in existing general and nursing theories on the topic.

### **The Data Collection Period**

The data were collected over a period of three years from 1994 until 1997. The interviews were conducted from October 1994 to December 1997. The bulk of the interviews took place during the first 18 months of commencement of the study. Participant observation (field work) commenced in November 1994 and ceased in June 1997. A total of 142 hours was spent in the field during participant observation. This time excluded “warm up time” and consultation with staff and Management prior to actual field observations.

### **The Sampling Strategy**

The purposive sampling technique was used to select nurse and patient informants for formal interview. The purposive sampling technique required selecting informants who were knowledgeable about the topic and who were willing and able to share detailed experiential information about the phenomenon being studied (Hutchinson & Webb, 1989; Morse, 1989; Walker, 1985). Theoretical sampling commenced following the first few interviews which resulted in the 33 nurses and 32 patients being formally interviewed. A further 28 nurses and 17 patients were interviewed informally during participant observation. These interviews were short as their purpose was to clarify situations that the researcher had observed during participant observation. A focus group interview with seven nurses was held also to explore the full range and variation in one of the identified categories to further guide the emerging theory.

The informants (patients and nurses) came from four hospitals in Western Australia. As the focus of this study was to explore and describe the phenomenon of patients participating in their own care, selecting the sample from a large public teaching

hospital, a large private teaching hospital, a small public teaching hospital, and a small private teaching hospital was considered to be appropriate. In order to fully explore the phenomenon under study, patient informants were sought from ward areas that gave them enough time to be able to participate during their hospital stay. Thus, patients in medical, surgical, and extended care wards were included. An extended care ward from one of the selected hospitals was included because in this area the patients remained in hospital for longer than one week, which facilitated a more complete exploration of patient participation. The patients were selected according to the following criteria:

- A minimum of three days in hospital,
- Ability to speak English,
- Absence of mental and physical impairment which could affect memory or the ability to reflect on, and share experiences, and
- Age being 18 years and over.

It is acknowledged by the researcher that selecting only English speaking informants had limitations for the study. As patients came from different cultural and ethnic backgrounds, excluding those who could not speak English did limit the researcher exploring and describing various cultural aspects and its impact on patients' experiences of participation. This limitation is dealt with in the discussion chapter in relation to the findings. It was decided by the researcher to exclude non English speaking informants because of the difficulties involved with the use of interpreters. There was also the problem of time required to train interpreters to conduct the interviews, the problem of finding someone to translate and type the recorded interviews, and the possibility of misconstruing the informants' real intent. This would have affected the reliability of the interviews. Nevertheless, many of the informants who were able to speak English did come from different cultural backgrounds.

Level 1 and 2 Registered Nurses (as per the West Australian Nursing Career Structure) were selected from the same medical, surgical, and extended care wards that were used for the patient informants. Level 1 nurses were a combination of newly



graduated nurses and nurses with several years of practice. These nurses were only accountable for direct patient care rather than ward management and practiced under the supervision of Level 2 nurses. Although some of these nurses had been practising for a long period of time, they had not elected to apply for the promotional position of Level 2 nurses because of the added responsibility and the professional development required to qualify for a Level 2 position. Level 2 nurses had considerable expertise in their area of practice. They also had proven skills in communication, leadership, and management of staff and patients. Level 2 nurses had greater responsibility and accountability than Level 1 nurses. It was considered suitable to include these two levels of nurses as they worked at the patients' bedside.

### **Profile of nurse informants**

There were 33 nurses in the study who were formally interviewed. Eighteen nurses were Level 1 and fifteen were Level 2. Twenty-six nurses were female and seven were male. The ages of the informants at the time of the interview ranged from 21 years to 54 years (the mean being 35 years,  $SD = 9.46$ ). Eleven nurses were educated overseas, the rest in Australia. Fourteen nurses, of whom four were male, were university educated. Of these, three nurses, one male and two female, were enrolled nurses for nine to ten years before completing the university degree and becoming registered nurses. Six nurses, of whom one was a male, were hospital educated but had since completed the university degree conversion course. Thirteen nurses were hospital educated only, that is, they had undergone an apprenticeship type of education at the hospital with no university education. Of these hospital educated nurses, three had additional midwifery certificates, two had mental health certificates, two had completed the gerontology course, one had a stoma therapy certificate and one had a management certificate. As can be seen from the above profile, two thirds of the nurse sample had university degrees (refer to Table 1).

**Table 1**      **Distribution of Nurse Informants by Level of Education**

Level of Education	Absolute Frequency	Percent	Cumulative Percent
Hospital Based Diploma	13	39.39	39.39
Degree Conversion	6	18.18	57.57
Bachelor's Degree (Nursing)	14	42.42	100.00
Total	33	100.00	100.00

The number of years of experience ranged from one to 32 years, with the mean being 12.72 years ( $SD = 10.35$ ). Twelve nurses in the sample had five years or less nursing experience, five nurses had between five and 10 years of experience, 10 nurses had between 11 and 20 years experience and six nurses had over 20 years experience (refer to Table 2). All the Level 2 nurses had ward co-ordination experience. Twenty of the nurses in the sample worked all shifts, which included morning, afternoon, and night shifts. The rest of the nurses worked mainly morning and afternoon shifts. Two of the nurses worked permanent night shifts on a full time basis. Fourteen of the nurses had worked in their present area of employment between one to two years. Seven of the nurses had worked in their present area of employment between two and five years. Ten nurses had worked in their present area of employment between five and 10 years and two nurses had worked in their present area of employment for longer than 15 years. All the nurses had general medical and surgical experience with one nurse having had ICU experience and another having had palliative care experience.

**Table 2            Distribution of Nurse Informants by Years of Nursing Experience**

Total Years of Experience as Registered Nurses	Absolute Frequency	Percent	Cumulative Percent
1-5	12	36.36	36.36
5-10	5	15.15	51.51
11-20	10	30.30	81.81
>20	6	18.18	100.00
Total	33	100.00	100.00

The ethnicity of the nurse informants varied with eighteen nurses being Australian, six English, three Irish, two Chinese, one Scottish, one Canadian, one Indian, and one from the Philippines. The sample depicted the Australian culture which allowed the researcher to explore the impact of some cultural aspects on the phenomenon of patient participation in relation to nurses.

### **Profile of patient informants**

Thirty two patients were formally interviewed. Eighteen patients were female and fourteen were male. The ages of the informants at the time of interview ranged from 20 to 86 years with the mean age being 59 years (SD = 18.5). Twenty patients in the sample were surgical patients having undergone operations. Four of the informants were extended care medical patients and nine were general medical patients. The number of previous hospitalisations varied. Four informants were first time admissions, twenty had been in hospital between two and five times, five had been in hospital between six and 10 times, two had been in hospital 20 times and one informant had been in hospital for more than 40 times (refer to Table 3). Although informants were selected from four hospitals, several had experienced hospitalisations in other hospitals in Western Australia. This allowed informants to share their hospital experiences from not only the selected, but also from various other, hospitals as well.

Thus, collectively, this provided a myriad of perceptions of patients' experiences from many hospitals in Western Australia.

**Table 3          Distribution of Patient Informants by Number of Hospitalisations**

Number of Times of Hospitalisation	Absolute Frequency	Percent	Cumulative Percent
1	4	12.5	12.50
2 - 5	20	62.5	75.00
6 - 10	5	15.6	90.60
11 - 19	0	0.0	90.60
20 - 29	2	6.3	96.90
30 - 40	0	0.0	96.90
>40	1	3.1	100.00
Total	32	100.00	100.00

The diversity of patients' ethnicities was slightly different from that of the nurses. Twenty of the patients were Australian, four were English, three were Italian, one was Greek, one was Indian, one was Burmese, one was Asian, and one American. As the researcher chose to exclude patients who could not speak the English language, the sample understandably was mainly Anglo-Australians. Nevertheless, the sample did contain a few informants of different cultural backgrounds, which facilitated the researcher to include patients of different cultures and incorporate their views on participation.

Five nurse informants and three patient informants were interviewed twice. One patient and two nurse informants were re-interviewed by telephone. The others were re-interviewed face-to-face. Re-interviewing facilitated the verification, clarification, and elaboration of information obtained from the first interview, and to cross-check information acquired from other sources.

## **Accessing the Sample**

Following approval from the Ethics Committee of the university in which this study was undertaken, letters were written to the Directors of Nursing of the selected hospitals, explaining the purpose of the study and requesting permission to conduct the research. The Directors of Nursing agreed, provided their Ethics Committees gave approval. Copies of the research proposal were sent to the Ethics Committees of all the participating hospitals. When approval was obtained, the researcher was directed by the hospitals to contact the relevant nursing personnel to make arrangements to approach informants.

### **Accessing nurse informants**

The nurses in two medical and two surgical wards from two of the selected hospitals, the nurses in a combined medical/ surgical ward from one hospital, and the nurses from one medical, one surgical, and one extended care ward from the fourth hospital were approached personally by the researcher following shift handover. The purpose of the study and the benefits and risks were explained and informants were given the opportunity to ask questions. The nurses were given an information sheet which gave a brief overview of the research and advised that participation was voluntary and that they could withdraw their consent at any stage of the study (refer to Appendix A). Following assurance of confidentiality, the nurses were invited to be interviewed at a time and place convenient to them. It was also explained to them that a follow-up interview may be required. Advice was given that once written consent was obtained, they would be asked a series of open-ended questions during an interview which would be audio-taped. Further, it was explained that questions would focus on discovering nurses' perceptions of the phenomenon of patient participation (including patient outcomes) and their perceptions regarding factors that enhanced or inhibited patient participation (refer to Appendix B). They were also informed that they would be asked to complete a demographic data sheet (refer to Appendix C) following their interview and that the interview would take approximately 50-60 minutes to complete.

During this period of addressing the nurses, permission was obtained to undertake participant observations of them providing care to patients. In three of the hospitals, it was explained that initially different wards would be used for formal interviews and for participant observations. It was envisaged that nurses may alter subsequent behaviour during observations after they had been interviewed. In the hospital that had combined medical and surgical patients the researcher utilised different sections of the ward for formal interviews and participant observations, again to avoid behaviour changes in nurses. This helped to minimise bias. However, following participant observation, some nurses were informally interviewed to clarify observed behaviour. As well, following participant observation, some nurses were formally interviewed, which helped to validate the data.

### **Accessing patient informants**

Prior to entering the hospital setting, approval was sought from the medical staff to access their patients. In accessing patient informants, patients who met the set criteria and who were ready for discharge were selected at the nurse's handover. This was done in consultation with nurse co-ordinators in the different wards. Patients who had been in hospital for more than three days and who were ready for discharge were selected because it was considered inappropriate to approach patients for interview when they were acutely ill or if they had not been in hospital long enough to have gained adequate experience. After selection, the patients were given an explanation of the purpose of the study and given the opportunity to ask questions. Like the nurses, the patients were given an information sheet about the research (refer to Appendix D). The patients were advised that participation was voluntary and that they could withdraw their consent at any time without penalty or disadvantage. They were informed that their confidentiality would be protected at all times. The patients then were invited to be interviewed at a time and place convenient to them, following discharge, although some were interviewed in hospital prior to discharge. It was explained that a follow-up interview may be required. It was also explained to patients that once written consent was obtained (refer to Appendix D), they would be asked a series of open-ended questions (refer to Appendix E) during the interview which could take approximately 50 to 60 minutes to complete and would be recorded. It

was further explained that questions would focus on discovering their perceptions of the phenomenon of patient participation (including patient outcomes) and their perceptions regarding factors that enhanced or inhibited participation. The patients were informed that they would be asked to complete a demographic data sheet (refer to Appendix F) following their interviews. Permission was also sought from patients to undertake participant observations of them receiving care from nurses. This was undertaken on a daily basis during field observations.

Permission to tape record the interviews was obtained from both nurses and patients who agreed to participate in the study. All the nurses approached agreed to be interviewed and /or to be observed. Except for two patients, all the patients approached gave permission to be interviewed and /or to be observed.

### **Nurse interviews**

One third of the nurse interviews (eleven) were held at the informants' homes. These interviews were organised at a time when the informants were alone, usually between ten and eleven in the mornings when the children were at school, or before the informants commenced their afternoon shifts, or early afternoon before meal preparations. The interviews were held in that part of the informants' homes which were deemed by them to be quiet. All the interviews were performed in an environment that provided privacy. Except for a few occasions when the telephone rang and the interviews had to stop and restart, there were no interruptions during the interview.

The majority or two thirds (twenty) of the nurse interviews were held at the informants' place of employment, mostly in their own time. The interviews were mainly conducted following a day shift, at 3 pm, in the Staff Development Nurse's office. At other times, the Clinical Nurse Specialist's office was used. Both of these offices were situated adjacent to the wards. Six interviews were conducted on completion of a morning shift between 3 pm and 4 pm; four prior to commencement of an afternoon shift between 12 pm and 1 pm; four during an afternoon shift between 7.30 pm and 9 pm; three during patients' rest periods between 2pm and 3 pm; two

were interviewed between 9 am and 10 am and one was interviewed on the weekend after a morning shift between 3.30 pm and 4.30 pm. The offices used for the interviews provided privacy and interruptions were prevented by redirecting the telephone to another extension. Two nurses who worked permanent night shifts agreed to be interviewed at the researcher's home on their nights off.

The questions used in the first round of nurse interview were open-ended and focussed on broad areas. During these interviews, the informants were asked to explain the concept of holistic care, especially in relation to how they achieved it, their understanding of their role and the patient's role, their understanding of the meaning of patient participation, the importance of patient participation, what factors enhanced or inhibited patient participation, the strategies that they used to enhance patient participation, and the problems they encountered in involving patients and how they dealt with those problems. As nursing's philosophy (Waterworth & Luker, 1990) incorporated care based on involving patients in the planning, implementation, and evaluation of care, in keeping with the principles of holistic care, the nurses were asked about this. In addition, the informants were asked to share their perceptions of the context in which they worked and how that influenced the way they provided patient care, especially in relation to patient participation. The answers to these questions were followed up with further open-ended questions to seek clarification and detail regarding the responses and to follow other leads presented by the informants. There was no order used in asking these questions, although care was taken to ensure that questions were asked at a time that seemed most appropriate during the interview.

The interviews commenced with a general question: "What do you understand to be holistic care?"; "How is this achieved?"; "What do you see your role in this to be?" The question on holistic care was asked first because of its relevance to nursing practice and its tenet of patient participation. Once the informants started to speak freely, probing questions were introduced at appropriate times during the interview to explore the topics further. For example, if they gave an array of words to explain holistic care, this was followed up with, "now, can you give me examples of how you achieved all that?" ; or "elaborate for me the sorts of things that inhibited you from



achieving that?"; "How did you deal with those factors?"; "Give me instances where you were able to facilitate patient participation?"; "When and why were you not able to facilitate it?".

As the study progressed, the interviews became guided by the emerging theory. Therefore, more specific questions related to the identified categories were asked incorporating descriptive, structural, and contrast questions. The purpose of these questions was to seek more information on the categories. Follow up interviews were shorter in duration, with the questions being more focused. These were not audio-taped although notes were taken during these short interviews. Three of the informants were re-interviewed by face-to-face interviews. Two of the informants were re-interviewed by telephone. During and following the telephone conversations, notes were taken.

The informants appeared to be relaxed and spoke freely during the interviews. This was probably due to a couple of reasons. Firstly, the informants were reassured again that confidentiality would be safeguarded at all times. Initially, they had been worried that they may be identified in some way, which may have affected their relationship with their superiors at work. Secondly, a few days were spent working with the nurses on the wards getting to know them as people and gaining their trust and acceptance before interviewing them. Even then, some of the nurses were hesitant, admitting that they might not be able to provide the answers that were sought, until they were reassured that there were no right or wrong answers. This immediately put the nurses at ease and the researcher was finally accepted as a colleague. After the interviews, several informants expressed gratitude that they were given the opportunity to discuss and reflect on their practice. For some, it was the first time that they had consciously thought about what they were doing and they spoke of how it made them really think about the positive and negative aspects of their practice. Nearly all the informants stated that they not only enjoyed the interviews but it also benefited them. The informants explained that through the interviews they felt that their voice was being heard and that they were able to express their feelings freely without any reprisal. This perspective could be related to the reported stressful environment in which some of these nurses worked (O'Connell, 1997).

The first-round interviews with each of the 33 informants averaged ninety minutes; the longest went for two hours and the shortest lasted forty five minutes. The tape recorder malfunctioned for part of three of the interviews. In these instances, recall was used and notes were made on the main issues discussed. A total of 49.5 hours of recorded transcribed nurse interviews contributed to the data source for this study with additional notes on subsequent interviews, and notes on informal interviews. Notes were also made on the body language of the informants and overall impressions of the interviews after leaving the informants. This took place away from the main ward areas or in the researcher's car in the case of the interviews being conducted in the informants' homes. This facilitated the transcribed data to be put into context.

### **Focus group nurse interview**

A decision was made to conduct a focus group nurse interview after the first three interviews. This was because there were ambiguities amongst nurses regarding the meaning of patient participation. This method of data collection was suggested by Hawe, Degeling and Hall (1990) as being useful in obtaining a broad range of opinions about issues relevant to the study. Schearer (1981) and Morgan (1988) also stated that this form of data gathering could provide initial information which could form the basis for formal, open-ended interview questions. According to Janis (1982), even though group interaction in a focus group interview could influence comments, it nevertheless allowed for the generation of many ideas. The author further stated that as one informant expressed a view, it was often picked up by others and extended, which in turn facilitated various ideas to be developed. This was evident in the focus group interview, which allowed the researcher to gain various opinions which were then built into the formal interview guide for subsequent interviews.

A focus group interview with seven nurses was held to elicit information about their perceptions of the meaning of patient participation. The nurses who had agreed to participate in the research but were not selected for interview were invited to be in the focus group interview. This interview, which was audio-taped, was held at one of the hospitals between 3.30 pm and 5 pm. The researcher initiated and guided the

interview and asked the informants to describe from their perspective what they viewed as patient participation. The informants spoke freely, allowing for everyone in the group to speak. Notes were taken during the interview in case the audio-tape was not clear as at times more than one informant was speaking. At the conclusion of the focus group interview, the notes were shown to the group to obtain confirmability of what was written down. Consensus on the notes being accurate was achieved in the group. The transcribed tape was also given to the participants in the focus group to review for accuracy.

### **Patient interviews**

The patient interviews were also conducted individually. Nearly a third of the patients (10) were interviewed at home, at a time suited to them, between one and two weeks following discharge. The purpose of this was to minimise perceived threat of disclosing sensitive information whilst still being in the “dependent” patient role in hospital. It was envisaged that patients would speak more openly of their hospital experiences if they were away from the hospital environment and felt less vulnerable (Irurita, 1993). As expected, the informants who were interviewed at home had no problems speaking freely about their hospital experience. They were in their own environment and were relaxed, having resettled into their homes following discharge. Reconfirming interview appointments with patients at home also gave them the opportunity to withdraw from the study if they had changed their minds after agreeing to be interviewed whilst in hospital. None of the patients who had agreed to be interviewed whilst in hospital withdrew their consent when they were contacted to confirm their interview at home.

The interviews were held either mid morning between 10 am and 11 am or in the afternoons between 1.30 pm and 4 pm. The patients with children generally chose to be interviewed in the morning whilst they were at school. The interviews were conducted in a quiet room that provided privacy. This room varied with informants. Four were interviewed in the lounge room, two in the kitchen, two in the family room, one in the dining room, and one in the study. During three of these interviews, the telephone rang and the interviews had to be stopped and recommenced when the

informants had finished speaking on the telephone. At other times, the telephone did not ring. All of the informants cooperated by minimising noise through turning television and radio sets off and shutting windows. This cut down traffic and other extraneous noises from outside.

One problem encountered when interviewing informants in their homes was that a couple of informants wanted medical advice from the researcher. This problem was dealt with by explaining to informants that the researcher was not in a position to give advice and that they should contact their doctor regarding their concerns, which the informants accepted. The other problem, as perceived by informants, was that they sometimes found it difficult to recall their hospital experiences because of the time lapse. A few informants commented that they should have been interviewed in hospital for this reason. However, with appropriate probing questions, the relevant information was elicited from informants.

Two thirds (22) of the patient interviews were held at the hospital immediately before discharge or a day prior to discharge. The reason for interviewing patients in hospital was that they requested it. These patients stated that they would rather be interviewed in hospital when information about their hospital experience was still fresh in their minds. The problem with this was that the patients were still in hospital and were perceived to be vulnerable. It was believed that this could deter them from speaking freely about their hospital experiences. One strategy used to overcome this problem was to reassure the informants about confidentiality and to offer to conduct the interview in the Staff Development Nurse's office, which was away from the main ward area. Once they knew this, most of the informants became relaxed and spoke freely during the interviews. Time was also spent talking with the informants so as to gain their trust and rapport prior to the interviews. The timing of the interviews also helped in that the informants stated that they could speak freely because they were being discharged and this dissipated perceived fear of reprisal from the nursing staff if they were to state negative things about their care. Even then, some informants' behaviour indicated that they were cautious about speaking openly. For example, some informants would start to whisper when they discussed negative issues, such as not being allowed to voice their opinion about their care, during the interview. The

informants would look around several times to ensure that no one was around when they talked about negative aspects of care. As these interviews were conducted in hospital, the researcher was mindful that the timing and the conditions in which the interviews took place may have influenced the stories told by informants. Harrison and Cameron-Traub (1994) support this view by stating that the information that informants gave in hospital was influenced by their particular stage of hospitalisation and that informants' perceptions may have differed at an earlier stage when they were unwell. The authors further claimed that when informants were at home following discharge, they may yet again provide another perspective about their hospital experience because they would have had time to reflect on their experiences (Harrison & Cameron-Traub, 1996, p. 148). In this study, data revealed that patients appeared to voice a greater number of negative hospital experiences when they were interviewed at home than when they were interviewed in the hospital, confirming Harrison and Cameron-Traub's findings (1994).

The patient interviews were conducted at a time selected by informants and were held in the Staff Development Nurse's office. On two occasions, the patients' lounge was used because of the unavailability of the Staff Development Nurse's office. During these two occasions, the researcher made sure that there were no other patients in the lounge. The times selected by the informants were conveyed to the nurses caring for the patients to avoid interruptions to any treatment plans or doctors' rounds. When the interviews were held in the Staff Development Nurse's office, the telephone was redirected to another extension to prevent interruptions. Twelve patients were interviewed between 10 am and 11 am usually before discharge; five were interviewed between 2 pm and 3 pm after the rest period, before their visitors came; two were interviewed between 7 pm and 8 pm when they had no visitors; two were interviewed between 4 pm and 5 pm before their evening meal; and one was interviewed on the week-end between 9 am and 10 am in the morning.

The questions for the first round of patient interviews were open-ended and focussed on broad issues. For example, the informants were asked to explain their understanding of participation in their care, the meaning it held for them, the factors that they perceived to have enhanced and or inhibited their participation and their

perceived role in relation to participation. Other questions related to the notion of information, introduced by the informants themselves, such as the part information played in them being able to participate, who initiated participation, how was it initiated, how did they participate, the extent of their participation in terms of control and decision making, the outcome of their participation, any problems they encountered and how they addressed those. As with the nurse informants, the answers to these questions were followed up with open-ended questions to seek clarification and detail regarding their responses. The questions were asked at appropriate times during the interviews in keeping with the flow of the conversation.

The interviews were commenced with a general question: “Can you share with me your recent experience in hospital?”; “What do you perceive your role to be in hospital?”; “What do you understand about the meaning of patient participation?”; “How did you participate?”; “What sorts of things helped you to participate?”; “What stopped you?”. As the interview progressed, probing questions were asked to explore the topics further. For example, if informants stated that they participated in their own care, it was followed up with a response such as “now, can you give me incidences, examples of how you participated, what did you do?, what did the nurses do?, and how did that feel?”. If the informants stated that they could not participate, they were asked “can you share with me the reasons of why you thought you could not participate and how would you have liked to have participated?”.

As the research progressed, more specific questions related to the identified categories were asked in keeping with the emergent theory. This included descriptive, structural, and contrast questions in order to seek further information on the categories. Two informants were re-interviewed face-to-face and one was re-interviewed by telephone. Subsequent follow-up interviews were shorter with the questions being more focused. These short interviews were not audio-taped but notes were taken.

The first round interviews with each of the 32 patient informants averaged seventy minutes; the longest lasted for one and a half hours and the shortest lasted forty five minutes. The recorder malfunctioned for part of two of the interviews, following

which recall was used to write notes on the main points discussed. A total of 37 hours of recorded transcribed patient interviews also contributed to the data source for this study, with additional notes on subsequent interviews and notes on informal interviews. As with the nurse interviews, notes were made on the body language of the informants and the overall impressions of the interviews after leaving the informants. This took place away from the main ward areas or in the researcher's car in the case of the interviews being conducted in the informants' homes. This facilitated the placing of the transcribed data into context. Overall, the informants stated that they enjoyed the interviews and the majority felt that it was a useful exercise. They believed that research such as this had the potential to bring about change for the improvement of patient care in hospitals and that they were happy to be part of it.

The recorded interviews of both nurses and patients, as well as the focus group interview with the nurses, were transcribed by a typist. Prior to giving the tapes to the typist to transcribe, all names identifying the data with the informants were removed. The typist was also asked to delete any names that were mentioned in the tapes during transcription. The typist was advised of the confidential nature of the data and instructed not to edit the transcripts. Each interview was given a code number, date and time. A separate code book was kept with the informants' names and interview details of date and time to enable contact with informant for subsequent interviews. This was kept in the safe in the researcher's home and only accessible to the researcher. The interviews were transcribed verbatim including pauses and inflections. The Ethnograph software (Seidel, 1988) format which provided hanging indents for speaker identification and a wide right-side margin for coding was used with the typing.

Once transcribed, the researcher checked the transcripts against the tape recordings and any typographical errors were corrected. It was found that in some instances the typist had typed similar sounding words, for example, she would type "allergy" instead of "aversion", "consistent" instead of "consultant" when she could not clearly hear the actual words that were uttered by informants. As the use of incorrect words would distort the meaning of what was stated by informants, the researcher took care

to avoid this. According to Poland (1995), audio-tapes of interview recordings ought to be transcribed verbatim without changing its content. The author advised that editing should be kept to a minimum in order to reduce distortion of the data. By checking the verbatim transcripts, reliability was ensured before analysing the data.

### **Participant observation**

Participant observation was conducted as an additional means of data collection over many visits to the study sites. These involved four hospitals, both public and private and included medical/ surgical and extended care wards. The focus of participant observation was on nurses providing care and patients receiving care with a particular focus on patients' participation. Two of the sites were known to the researcher in the sense that the researcher had previously supervised nursing students at these sites as a clinical tutor. Consequently, at these sites, different wards were selected to those that the researcher had previously worked in whilst supervising students. It was envisaged that the nurses on the wards where the researcher had previously worked may alter their behaviour as a result of knowing the researcher in a different role, thus increasing bias. In order to accurately describe the social process of the phenomenon of patient participation at a high level of conceptualisation, it was necessary to compare formal interview data with actual behaviour (Dreher, 1994; Wilson & Hutchinson, 1991). Participant observation was used to confirm and elaborate on emerging categories and to discover new informant behaviours, as well as variations of behaviour. Participant observation also allowed the researcher to observe behaviour not evident in the interview data. Participant observation, according to Bogdewic (1992, p. 46) and Goetz and LeCompte (1984), allows the researcher to elicit from informants the ways in which they construct their definitions of reality and the manner in which they organise their world. The prolonged periods of social interaction with the informants during participant observation facilitated the collection of data unobtrusively and systematically (Bogdan & Biklen, 1982).

A total of one hundred and forty two hours (142) was completed during participant observation. Participant observation was conducted in all four hospitals with 65.5



hours spent in the first hospital, 34.5 hours in the second, 20 hours in the third and, 22 hours in the last hospital. All shifts were included.

Field notes were written to record the observations and impressions of the interactions, and these perceptions and perspectives of the informants' actions were later coded for analysis. During the observation, field notes were taken in which the main points were noted. Following each episode of observation, which varied in duration, the main points were further elaborated into a tape recorder for transcription and analysis. Informal interviews were conducted with 28 nurses and 17 patients to clarify aspects of the observations. These interviews were short in duration lasting between 10 to 15 minutes. Notes were taken during these interviews and later analysed with other data. The main thrust of these informal interviews was to seek explanation from informants about their behaviour during observation. Information from these informal interviews also assisted the researcher to raise questions to be included in subsequent interviews. In this study, the field notes were used to check for consistency between the information given by informants during interview and their actual behaviour during participant observation. Field notes, in other words, provided an important way to verify espoused behaviour with actual behaviour.

Theoretical sampling was applied to participant observation. As the emergent theory indicated that information acquisition was an important category for patient participation, a decision was made to observe a number of admission procedures and patient teaching sessions. Main points were written down on a note pad and these were later elaborated into an audio-tape for transcription and analysis. Six admission procedures were observed including booked and emergency admissions. Some nurse informants had indicated, during interview, that they provided complete information to all their patients at admission. However, it was observed that these same nurses took only an average of eight to ten minutes to complete a patient admission. The main purpose of observing admission procedures was, therefore, to ascertain the type, the amount and level of information that nurses provided patients, as well as the time nurses spent with patients, during the procedure. Patient teaching sessions by nurses were observed to clarify whether interview comments by nurses that they did not have time to conduct patient teaching were justified. Several nurses had stated that patient

teaching was not rated as a priority because they did not have the time to sit and teach patients.

In order to minimise observer reactivity, two weeks were spent in each of the selected fields prior to commencement of formal data collection. The purpose of this was to get to know the nurse informants and to become familiar with the ward layouts and routines. This allowed for informants to become acclimatised to being observed. This also helped the researcher to become familiar with the normal behaviour patterns of both nurse and patient informants. Participant observation was conducted at varying times which differed during the many episodes of field work. This was congruent with the “spot observation” technique as described by Field and Morse (1985). By using this technique, it was possible to capture the informants’ behaviour in their natural state as they did not know the researcher’s arrival schedule. In order to capture the whole picture of the phenomenon of patient participation in their care, the researcher included a number of ways to conduct field observations. For example, the researcher followed one or more nurses around as they went about giving care or simply sat in a corner of a four or two bed ward and observed. The researcher, however, as requested by the hospitals, did not formally care for patients.

Being a nurse and studying one’s own nursing culture was advantageous. Familiarity with the general framework and inside workings of hospitals, and the values that guided the cultural behaviour in these settings, assisted the researcher in adjustment of behaviour accordingly. Saville-Troike (1982) claimed that if interviews and interactions are to be productive, it is essential, in order to be accepted, that the researcher establish a shared understanding of roles and behaviour evident in a given culture. Understanding is also needed for the researcher to use appropriate language in the setting being studied. Being a nurse also helped with the patient informants. They knew that the researcher was a nurse and thus readily allowed the researcher to observe them in the most private and personal situations, such as being with the nurse when the patients were being administered suppositories, being given bed baths or given shaves pre-surgery

### **Examination of nurses' notes, listening to handover and literature**

Examination of nurses' notes was conducted throughout the period of data collection and analysis. These notes, which were written by nurses at the completion of each shift, assisted in ascertaining congruence/ incongruence about the type of care the nurses stated they provided, their observed behaviour and what they actually documented about that care. This further enhanced reliability of the data being collected. As the study progressed and conceptual categories were identified, literature reviews related to these concepts were conducted on an on-going basis. This helped to expand and clarify concepts and to verify and to elaborate the identified categories and their properties. The researcher also sat in on tape-recorded nurse handovers to cross check whether nurses' interview accounts of encouraging patients to participate was in point communicated to other nurses and whether nurses viewed patient participation as important enough to communicate it to other nurses so that there could be consistency in the care delivery.

### **Data Analysis**

Through the grounded theory approach, all factors relevant to the phenomenon of patient participation from the patients' and nurses' perspective were sought rather than focusing on specific factors selected by the researcher as being significant or meaningful. The constant comparative method of analysis was used throughout the study. This continued until theoretical saturation was attained (Chenitz & Swanson, 1986; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Saturation has been described as a situation where the researcher ceases to obtain any new data about the phenomenon under study (Strauss & Corbin, 1990, p.188). In keeping with the canons of grounded theory, previous steps of the research process was continually checked whilst moving forward in the analysis. This is referred to by Glaser (1978, p. 16) as "doubling-back steps" where current data collection and analysis are checked against previous data collection and analysis.

## **The Constant Comparative Method**

The constant comparative method of data analysis involved comparing every datum with every other datum, rather than comparing totals of indices. This approach, which was first described by Glaser and Strauss (1967), required the data collection, coding, and analysis to be performed concurrently throughout the duration of the study. This method involved initially coding the data to create as many categories as possible. Following that, patterns were identified by comparing incidents across the data during analysis and subsuming some categories under a higher order category or higher level of conceptualisation. Once data emerged that conformed and complied with the identified categories, their theoretical properties were defined. The categories evolved by the researcher searching for incidents from the data that were applicable to each category. This continued until theoretical saturation was reached.

In this research, during the coding and analysis procedures, memos were written and diagrams or schemas of ideas about the categories and their relationships were drawn. Theoretical sampling on an ongoing basis was conducted. Through further refinement of the categories, the interrelationships between them were identified and the substantive theory was developed. By completion of data analysis of the final interview transcripts and participant observation field notes, no new information was identified that did not fit the already identified categories. This demonstrated that saturation was achieved.

## **Data Coding Procedures**

The recorded interviews that were transcribed verbatim were entered into the Ethnograph (Seidel, 1988) computer program. The interview data were formatted to provide a wide right hand margin for coding. Each line of the data was numbered. This permitted the identification of the position of the coded segments within the interview data. The print-outs were then used for coding the data and to identify categories which reflected the meaning of what was occurring in the study setting. Data from transcripts of participant observation, examination of nurses' notes,

demographic information, and the literature were included in the data analysis process to complement the interview data.

### **Open coding**

Open coding, as suggested by Strauss and Corbin (1990) and Glaser (1992), is the first step of theoretical analysis towards the discovery of categories and their properties. Open coding was thus initially used in the coding process as each transcribed interview was printed. The purpose of open coding was to fracture the raw data and give each discrete incident, phrase, or event a name that represented the phenomenon under study (Strauss & Corbin, 1990). This allowed the data to be examined closely with emphasis on detail. The data were fragmented and examined phrase by phrase to ascertain codes that described the meaning of what was occurring in the data. The code words used were sometimes the very words or phrase used by the informants, for example, “toeing the line” was used by some patient informants to describe their perception that they should do as they were told in hospital. Phrases and sentences within the data were given multiple codes if they were identified as describing more than one meaning. For example, one data segment was coded “patient inability”, “reason need more time”, “cause nurse frustrated” and “inhibitors of patient participation”. This open coding process identified more than 100 codes and these codes fragmented the data into small pieces. The constant comparative method, however, facilitated the reduction in this number as concurrent analysis of further data supported, modified, or discarded a number of the codes. Many codes were subsumed into broader code words of a higher conceptual level and some code words became properties of categories. The final code words were written in abbreviated form directly in the wide right hand margins on the print-outs of the transcribed data and then coded into the Ethnograph. The definition of each code word was recorded in detail and stored in a separate file. This allowed for access to the abbreviated code word with its full meaning next to it, which then facilitated the consistent use of the code word. Memos, which described the researcher’s thoughts about possible relationships between the data, were written in a separate book with links to the original data source noted for each.

## **Axial coding**

Axial coding, which is the second level of coding, was used to put the fractured data together in ways that allowed connections to be made between the categories and their subcategories (Strauss & Corbin, 1990). Axial coding resulted in the development of the main categories that were central to the study. In order to identify the relationship between the data, Strauss and Corbin's (1990) paradigm model was used. The model allowed linkages to be made between a category and its subcategories by specifying a category in terms of: the causal conditions that led to the development of the phenomenon; the central happening that occurred; the properties that related to the phenomenon; the intervening conditions that either assisted or inhibited the strategies used to manage the phenomenon; the action/interaction strategies employed to manage the phenomenon; and the consequences of the management. The relationships between categories and between the categories and subcategories were confirmed by returning to the data to verify the evidence and to seek out negative cases. Negative cases included incidents and events that either supported or refuted the statements of relationships between the categories. The categories were compared with each other to make sure that they were mutually exclusive. Repeated questioning of the data and the constant comparison with previous and new data ensured that linkages of the categories with their subcategories was achieved. The hypothetical relationships between the categories and subcategories were verified in the data before they were confirmed to exist. According to Strauss and Corbin (1990), this repeated backward and forward movement through the data is responsible for the grounding of the findings. The developed categories were then integrated into theoretical proposition statements.

## **Selective coding**

In selective coding, categories developed through axial coding are integrated to form a theory. Selective coding identifies the central phenomenon or the core category. The core category is the category with the most explanatory power and to which all the other categories are linked. The core category forms the thrust of the story line. In

this research, the core category became the core problem that faced both nurses and patients. Selective coding also identified the basic social process that was utilised by both nurses and patients in order to manage the core problem. A description of how the categories were related to the central phenomenon was included in the story line. The next step was to provide an analytic account. This involved identifying the properties and dimensions of the core category or problem and relating the other categories to it. This relationship determined how the core problem was managed in varying contexts by both nurses and patients. The categories were then arranged and rearranged to fit the story line as substantiated by the data.

Patterns that demonstrated links between the categories emerged from the data throughout the analysis. Repeated questioning of the data and constant comparison with other data facilitated these patterns to form into clear associations amongst the categories. This added to the specificity of the findings. Following selective coding, hypothetical statements were written that identified the relationships between the categories and the core category and the core process. From this a substantive theory was developed.

## **Memos**

Memos are written notes or records of analysis related to the development of the theory. Diagrams facilitated visualisation of the relationships between categories. Code, operational, and theoretical memos were maintained throughout the duration of the study, as described by Strauss and Corbin (1990). Code memos contained the conceptual labels given to data during the three levels of coding. Operational memos contained directions to the researcher about sampling, questions to ask of the data and what leads to pursue. Theoretical memos contained notes on the researcher's inductive and deductive thinking regarding relevant categories, their properties, dimensions, and variations (Corbin & Strauss, 1990). Sampling, coding, and analysis were continued until saturation of categories was reached and a sense of closure was achieved (Hutchinson, 1986; Strauss, 1987; Strauss & Corbin, 1990). Memo writing and diagramming were conducted as ongoing procedures throughout all stages of this study. This involved writing down ideas or thoughts about the codes, categories, and

theoretical constructs, and the relationships between categories and/ or their properties as they came to the researcher at various stages of data analysis. According to Chenitz and Swanson (1986), memos are written records of the analytical process. Memos enable researchers to know where they have been and where they need to go in the future direction of the research. It is also through memos that hypotheses are recorded, compared, verified, modified, or changed as new data are collected and analysed (Chenitz & Swanson, 1986, p. 108).

In this study, memos assisted in the analysis by encouraging abstract thinking that occurred during data analysis. Questions that arose from the data and preliminary answers were written. As well, guidelines for further data collection were written and other sources of information that might be helpful to move the analysis along were identified and pursued. Diagrams enabled the examination of tentative relationships between the categories. Although the diagrams and memos initially lacked conceptual depth, the relationships within the data became clearer and the conceptual depth of the diagrams and memos increased as the study progressed. Memos and diagrams provided the study with density by closely relating the concepts and they formed the basis of the written report (Strauss & Corbin, 1990). An example of an early general memo written after coding six of each of the nurse and patient interviews is shown below:

March, 10<sup>th</sup> 1996.

*There appears to be varying levels of incongruence with nurse/ patient expectations. The greater the incongruence of expectations between nurses and patients, the greater the variations in levels of patients participating in their own care. So expectations and levels of participation are tied together. There seems to be 3 different levels or styles of participation. At one level, there is mutual partnering between the nurses and patients. There is mutual respect and trust between the two, sharing of information, a close relationship and the nurse acts as patient advocate. In this situation, there seems to be matched expectations. At another level, there appears to be guidance by nurses and cooperation by patients; the main premise being that nurses were knowledgeable and patients expected to be guided as they trusted nurses. Here the expectations seem to be only partially matched. At the last level, there seems to be overshadowing by nurses and patients doing as they are told. There is a perception by nurses that patients are passive recipients of care and therefore should do as they are told. The patients in this situation appear to perceive that if they do not obey nurses orders, their care will be*



*compromised even though they want more active involvement. There seems to be little or no match in expectations.*

The writing of memos assisted in asking further questions about what was happening with the phenomenon of patients participating in their own care. For example, questions were asked such as “So what are the intervening conditions that facilitate the various levels of participation and resultant strategies?; “Under what contexts are they occurring?”, “What strategies are the informants using to deal with the levels?”, “What were the sub-categories that are salient in the category of mismatch of nurse/patient expectations?”, “Are the levels fixed or fluid?”.

Glaser (1978) and Strauss (1987) stated that memos are essential for developing theory. According to these authors, memos provide the means to elevate data to a higher level of conceptualisation. Memos assist in developing properties for categories and help in formulating hypotheses about linkages between categories and/or their properties towards generating theory. Glaser (1978, p. 84) further added that memos are also a means to direct the researcher to place the emerging theory with other theories which have potentially more or less relevance. In this study, the copious memos that were written were sorted and some formed the basis of the report.

### **The Ethnograph**

Analysis of the data was facilitated through the use of the Ethnograph (Seidel, 1988), a computer program designed to manage transcribed data. Once the verbatim transcripts were coded, this program was used to search all data for occurrences of similar codes and categories. The coded segments representing the categories could be retrieved across all data files as single or multiple codes. The program was useful, as well, in enabling demographic data and other variables to be attached to each data file through the use of face sheets or templates. Thus, categories could be tied to demographic data and other variables about informants.

This program involved initial numbering of lines on the transcripts. Once numbered, the hard copies of transcripts were manually code mapped. The coded segments were

then entered into the program by typing in the start and finish line of each of the coded segments. When all the data files were coded, the coded segments were retrieved using the search command prompt. These segments were then printed to provide a hard copy for further comparison and analysis and to identify negative cases

As grounded theory involved the use of the constant comparative method, the Ethnograph enhanced the analysis of the textual data by providing all instances of a code word across all the data files. This made it easier for further development of the categories and to examine the context of each of the coded segments. As it was possible to access all examples of the coded segments, it was easy to analyse all aspects of the data simultaneously which in turn enhanced the reliability of the findings (Conrad & Reinhart, 1984).

## **Reliability and Validity Issues**

A common criticism aimed at qualitative research findings is that they lack reliability and validity (LeCompte & Goetz, 1982; Silverman, Ricci, & Gunter, 1990). Whilst threats to the credibility of qualitative research may differ with those of quantitative research, it is essential that the researcher incorporates strategies in the qualitative methodology to overcome the above mentioned criticism. In this study, rigour was established by maintaining an audit trail. Koch (1993) and Lincoln and Guba (1985, p. 230) described an audit trail as a method in which investigators carefully documented the conceptual development of the study in order to leave sufficient evidence so that other researchers could reconstruct the process by which investigators reached their conclusions. Denzin and Lincoln (1994) claimed that terms such as validity and reliability should be translated as credibility and trustworthiness in qualitative inquiry because they are more reflective of the goals of qualitative research. Moreover, external validity which refers to the generalisability of the findings should not be applied to qualitative research as the sample is not randomised and the variables are not manipulated (Denzin & Lincoln, 1994). According to LeCompte and Goetz (1982), the qualitative investigator needs to address such issues as researcher status

position, informant choices, social conditions and situations, analytical constructs and premises, and methods of data collection and analysis in order to enhance the trustworthiness of the data. To ensure rigour and address credibility and trustworthiness issues, the researcher employed several measures in this study.

With regards to researcher status position, the researcher was accepted as a legitimate member of the group by nurse informants during participant observation and interviews. The researcher had supervised nursing students in two of the hospitals and thus knew some of the staff. Care was taken therefore not to select known informants, especially during participant observation. As patient informants did not perceive the researcher as being part of the nursing team, they readily accepted the researcher and were willing to share their experiences without feeling intimidated. Patients were aware that the researcher was a nurse and thus allowed participant observation. There was no evidence of the problem of power imbalance with the researcher, which was perceived by patients to exist between nurses and patients.

The informants were selected using purposeful sampling as described earlier. The demographic details of the informants were collected. In addition, a description of the physical, social, and interpersonal contexts within which data were collected were included. The constructs and premises of the study will be addressed in the discussion of the research findings. Furthermore, the researcher has attempted to present carefully the methods of data collection and analysis in order to leave a clear audit trail for other researchers.

In order to enhance the extent to which other researchers, using the same data, would agree with the identified constructs, several strategies were used in this study. All the data in this study were collected by the one researcher. The interviews were audio-taped and transcribed verbatim and notes on constant comparative analysis were kept in the form of memos.

The technique of using multiple researchers to corroborate the findings to reduce bias and increase the credibility was identified by LeCompte and Goetz (1982), Patton (1990) and Sandelowski (1986). During the data collection and analysis period, the

researcher participated in a series of grounded theory seminars which provided the opportunity to discuss the analysis, coding, memo writing, and the findings. Members of the seminar group independently coded slices of data and their resulting codes were compared to the researcher's own codes, thus facilitating expansion of perspectives on the data. Preliminary findings were presented to the seminar group, who raised several questions that required returning to the data for further verification. This input assisted in minimising bias. Following preliminary completion of data analysis, the results were given to several study informants, both nurses and patients, to verify for factual and interpretive aspects of the results and for accuracy and credibility of the findings.

At the beginning of the data collection and analysis period, an advisory committee comprising of two independent health consumers, a doctor, a Level 2 nurse, and the researcher's supervisor was set up. Their brief was to progressively act as a "devil's advocate" and sounding board and to discuss the findings in relation to whether it "rang true" for them. The researcher met with this committee every four months on a regular basis until the study was completed. To further ensure credibility of the interpretations, patients and nurses who had volunteered to participate in the study, but were not included because theoretical saturation had been reached, were given the interpretations to comment upon. In qualitative research, Guba (1981) described credibility as equating to truth value. The author further claimed that the constructed reality in the findings must be congruent with informants' perceptions of reality as multiple realities existed in people's minds. Therefore, seeking credibility of the findings from the informants and others with experience of the phenomenon was considered to be essential.

The accuracy of scientific findings was identified by LeCompte and Goetz (1982) as the main strength of grounded theory and ethnographic research. Silverman et al. (1990) described the degree of confidence one can have in the relationships established in the study as being representative of reality. In grounded theory studies, the extended periods of participant observation and the use of constant comparative analysis enables the ongoing refinement of categories and their properties, hence, reflecting reality more accurately. Denzin (1978) highlighted several issues that posed

a threat to the trustworthiness of qualitative studies. These were history and maturation effects, observer effects, informant mortality, selection and regression, and conclusions that were spurious. In this study, steps were taken to avoid these threats.

Historical and maturation effects were dealt with by sampling over a prolonged period of time with multiple forms of data. The core process remained constant, with variations in the level depending on various conditions identified throughout the study. Factors which influenced this core process were identified and described as well as the strategies and actions taken by the informants to deal with them. Maturation effects were dealt with by maintaining field notes on the researcher's interaction with the informants during the course of the study.

During participant observation, care was taken not to allow bias to direct the development of concepts and categories. Care was taken not to force categories on the data. This was congruent with the views of Glaser and Strauss (1967) who stipulated that categories must be grounded in the data before they can become part of the emerging theory. The problem of ceasing further data collection and analysis before reaching saturation was avoided by persistently applying the constant comparative analysis method, theoretical sampling, and seeking negative cases.

Being a nurse with many years of experience, the researcher was aware of her own values, beliefs, and predispositions that may impact upon data collection and analysis. This was addressed by reflection on personal biases during the study. It was suggested by Silverman et al. (1990) that it was inevitable that biases such as these existed and that it was only through conscious effort that their impact on the study could be reduced. Guba (1981) warned qualitative researchers that they ought to be especially aware of the role their biases played when they were the main tool in the data collection and analysis procedures. Guba further advised that qualitative researchers should shift the burden of neutrality from themselves to the data. Hence, before the commencement of the study, through a self-interview, personal thoughts, values, beliefs, and predispositions with respect to the phenomenon of patients participating in their own care were recorded. These were consciously referred to throughout the study to minimise bias on data collection and analysis.

The main preconceptions gleaned from the self-interview was that nurses were task-oriented and did not consciously think about involving patients in their own care. It was also believed that nurses were reluctant to encourage patient involvement because they wanted to remain in control and that all patients were passive and followed nurses orders because they did not want control. Although a few of these preconceptions were evident in the data, some were disproved in the data. Objectivity of the data analysis was ensured by being aware of personal beliefs and preconceptions related to the phenomenon under study. Through this self-awareness, the researcher was able to look beyond assumptions and ascertain what was really going on with the data. In this way, it was possible to accurately portray the reality of informants in the study (Munhall & Oiler, 1986).

During proof-reading of early transcribed interviews, it was evident that several leading questions had been asked. Consequently, the responses following these leading questions were discarded as they were considered to be researcher referenced and depicted the researcher's own perceptions and thus were fraught with bias. The tendency to ask leading questions was corrected in subsequent interviews and a conscious effort was undertaken to prevent re-occurrences for the rest of data collection. In order to sustain self-awareness, a journal was kept containing personal views and feelings.

Miles (1979) reminded qualitative researchers to be mindful of "going native". This was defined as a state where researchers were unable to distance themselves from the study informants, which in turn rendered them unable to observe and analyse objectively (LeCompte & Goetz, 1982). As the collection and analysis of data is labour intensive in qualitative research, there is a potential risk of this occurring because researchers are often overloaded with simultaneous data collection and analysis which results in copious volumes of narrative text. In this study, "going native" was avoided by withdrawing from the research setting for periods at a time so as to reconfirm the researcher's dispassionate status.

Instead of generalisability, qualitative researchers aim for transferability or contextual relevance. In order to achieve this, there needs to be clear identification of the characteristics of the study group, the setting, the constructs generated, and the data collection and analysis techniques. These issues were addressed in this study. Data from formal and informal interviews, participant observation, examination of nurses notes, focus group nurse interview, and literature all contributed to the credibility of the findings. This triangulation of data, as described by Denzin (1978), enabled the researcher to cross check the data to determine the presence and nature of the phenomenon being studied. The credibility and trustworthiness of the data was further enhanced by exposing all stages of the research to constant questioning and evaluation. The purpose of this was to eliminate competing explanations and to identify the best explanation that fitted the observed data (LeCompte & Goetz, 1982).

In order to enhance contextual relevance or transferability, purposive and theoretical sampling was used to develop rich descriptive data. This maximised the variation in data and clearly described the context (Geertz, 1973; Guba & Lincoln, 1982; Silverman et al., 1990; Wilson & Hutchinson, 1991). Consistency of the data was ensured by clearly describing the method of data collection and analysis. This should facilitate other researchers to follow the progression of events (Guba & Lincoln, 1982; LeCompte & Goetz, 1982). Different sources of data were compared with each other, together with reviewing the researcher's journal for assumptions and biases. To ensure "fit" of data, some informants were contacted again after analysis to verify the interpretations of the information collected.

The grounded theory method was followed rigorously throughout the study, which increased the credibility and trustworthiness of the findings. The data were collected, coded, and analysed until saturation of the categories was reached. Saturation occurred when all levels of codes appeared complete and no new conceptual information was available for the development of further categories or properties of existing categories that related to the core process. The data fitted into the established categories and thus provided explanation and prediction of behavioural and contextual variations (Hutchinson, 1986). This demonstrated that the sample size was appropriate.

## **Ethical Considerations**

Permission was obtained from the University's Human Research Ethics Committee and the Nursing Research and Ethics Review Committees of the four hospitals prior to commencement of the study. Permission to undertake participant observation was sought from the four hospitals. Implications for participating in the study as well as an outline of the study's purpose was given to informants. All nurses and patients were informed of the voluntary nature of their participation and that they could withdraw at any time, without penalty or disadvantage to themselves.

Written consent was obtained from informants, a copy of which was given to each informant before entering into the study. Verbal and written permission to audio-tape the interviews also was obtained. The informants were reminded that they could stop the tape recording at any point during the interviews.

To ensure confidentiality of the informants, their names were not used on the recording or on the transcribed data files. Instead, code names were used for the informants. The identities related to these code names, which were only known to the researcher, were written in a code book that was kept separate from the data and kept in a secure place. The typist who was transcribing the interviews was unaware of the identity of the informants and was advised of the confidential nature of the transcripts. Care was taken to ensure that the identity of the informants could not be determined from the citing of verbatim data in the final report. The audio-tapes were erased at the completion of the study to avoid voice identification and to ensure further anonymity of informants.

## **The Grounded Theory Debate**

In using grounded theory, it is necessary to clarify for the reader a personal perspective on this method. As indicated previously, grounded theory was explicated by Glaser and Strauss who co-authored books describing the methodology and who



utilised the method to research health related phenomena (Glaser & Strauss, 1965, 1968). Even though both Glaser and Strauss were using grounded theory, it was apparent to their doctoral students that they were using the method differently (Stern, 1994). In 1990, this difference was evident when Strauss wrote a text on grounded theory with Corbin (Strauss & Corbin, 1990). The text entitled “Basics of Qualitative Research” was written to help novice grounded theory researchers. It detailed a step-by-step guide on how to utilise the method. In 1992, Glaser appraised the Strauss and Corbin’s book as being in breach of the ideology of the grounded theory method, stating that the book was too prescriptive (Glaser, 1992). Glaser further espoused that the data analysis framework, and particularly the coding paradigm, used in the book promoted the forcing rather than the emerging of the theory. Following the unsuccessful attempt to withdraw the book from publication, Glaser wrote a counter argument to Strauss and Corbin’s book entitled “Basics of grounded theory analysis-emergence vs forcing” (Glaser, 1992). The thrust of Glaser’s concerns are that in the Strauss and Corbin’s book there is a suggestion of forcing the data by way of preconceived views about the phenomena being studied. Glaser states that all categories, their properties, and dimensions should emerge from the data. To go into the study with preconceived views will simply “derail” the essence of doing grounded theory which focuses on “discovery” and not “conceptual description” (Glaser, 1992, p. 31). Glaser further explains in his book that researchers need to go into the study with an unbiased view so that they can be confident that their emerging theory will not be forced or preempted by preconceived concepts (Glaser, 1992, p. 32). According to Glaser, the core category should account for everything that is going on with the phenomenon and this should come entirely from the data. As emphasised by Glaser, in this study every effort was made not to force the data.

In Glaser’s 1978 book, “Theoretical Sensitivity”, the use of the 18 coding families and the use of constant comparative analysis is mentioned. This coupled with theoretical coding facilitated theory discovery. In Glaser’s 1992 book, he argues that Strauss and Corbin’s method of labelling and grouping categories through open, axial, and selective coding is unnecessary and that it distracts from theoretical coding. However, according to Melia (1996, p. 377), Strauss and Corbin (1990) did equate axial coding

to theoretical coding and they did emphasise the use of the constant comparative method of analysis.

This researcher is of the opinion that all researchers come with experiential and personal knowledge about the phenomena of their study. It is therefore impossible to enter into a study with absolutely no knowledge about the phenomenon under study. Thus, any ideas that this researcher may have had about the phenomenon of patient participation were simply accepted as potential explanations, among others, about what was going on with the data. To be realistic and to use previous knowledge to help validate and/or discredit data is not forcing the data. It is using one's knowledge to ask questions about what is actually going on and to further investigate the phenomenon. Glaser and Strauss's earlier 1967 book "Discovery of grounded theory" alluded to the strategy known as theoretical sensitivity whereby previous knowledge is used to help the researcher to become aware of the subtleties of meaning in the data and to look closely at data for all possible explanations.

Both Strauss and Corbin (1990) and Glaser (1992) have adhered to the principles involved in using grounded theory in their respective writings. As suggested by Melia (1996), Strauss and Corbin (1990) meant their book to be used in conjunction with earlier books written by Glaser and Strauss rather than to use it as a sole guide. Their aim was to simplify the principles involved in conducting grounded theory research in order to develop a full understanding of the method and related issues. Prior to undertaking this research, a course in grounded theory was undertaken; this provided the opportunity to read all of the earlier works of Glaser and Strauss. It is acknowledged that this researcher has personal views about the phenomenon of patients participating in their own care. Hence, theoretical sensitivity was used to ensure that all the categories, dimensions, and properties emerged from the data. As defined by Strauss and Corbin (1990), theoretical sensitivity refers to the awareness and insight the researchers has about the subtleties of meaning in the data (p. 41). This prevented forcing the data, and premature closure of all possible explanations and variations. As Strauss and Corbin (1990) suggested, self-awareness was used to put personal views of the phenomenon in abeyance in order to look beyond them to allow

what was going on to emerge from the data. The analytical paradigm as described by Strauss and Corbin (1990) was used for this research.

## **Summary**

The grounded theory method was used in this study which sought to explore the phenomenon of patients participating in their own care whilst in hospital. Data were collected through formal interviews with nurses and patients, participant observation (including informal interviews with nurses and patients), formal and informal interviews with non nurses and relatives, listening to nurses' handovers, examination of nurses notes, and literature. The Ethnograph computer program was used to code, sort, and manage the data during analysis. Steps were taken to increase the rigour of the application of the grounded theory method, paying particular attention to issues of credibility and trustworthiness. The data were analysed using the constant comparative method and the analytical paradigm as described by Strauss and Corbin (1990). Data were collected and analysed until saturation of the categories was reached and no new information was forthcoming.

## CHAPTER THREE

### **BASIC SOCIAL PROBLEM- *Incongruence* in Conceptual Understanding of Patient Participation and Philosophy about Nursing Care**

#### **Overview of the Chapter**

This thesis describes a grounded theory study of the phenomenon of patients participating in their own care within the context of hospital nursing practice in Western Australia. The perspectives of both nurses and patients were explored and described. Data analysis indicated that there was a basic social problem experienced by nurses and patients in relation to the phenomenon of patients participating in their own care. The problem, identified as the core category, occurred in two areas and was labelled as *incongruence* and will be described in detail in this chapter. The problem of *incongruence* occurred in the conceptual understanding of the meaning of patient participation and in the philosophy about care between nurses and patients and amongst nurses and patients. The problem was further exacerbated by hospital contextual conditions, which were often not conducive to the ideology of patient-centred care, which encompassed patient participation, and which modified the basic social process. These hospital contextual conditions, described in the next chapter, were noted to be consistently present during the time of this study and were categorised under economical constraints, management structures, presence of technology, and culture of medical dominance. Furthermore, varying intervening conditions present on a day-to-day basis in the acute care setting also modified the basic social process. The varying intervening conditions will be discussed in conjunction with the basic social process used by nurses and patients and will be presented in chapter five.

## Definition of *Incongruence*

In this study, the concept of *incongruence* has been defined as incompatibility or dissimilarity in the conceptual understanding of the meaning of patient participation and in the philosophy about nursing care. This *incongruence* was operationalised, firstly, as a situation where nurses and patients espoused and demonstrated differences in the conceptual understanding of the meaning of patient participation and in their philosophies about nursing care, which resulted in contradictory views about patient participation. Secondly, nurses and patients found themselves in a system, in this case the hospital system, that constituted a context which was not always conducive to the promotion and enactment of patients participating in their own care. Thirdly, varying intervening conditions within the system resulted in nurses and patients enacting the phenomenon of patient participation differently to that which was intended.

## *Incongruence*

The basic social problem encountered by nurses and patients in relation to patients participating in their own care was identified as *incongruence*. There were two areas in which this incongruence occurred and which affected the phenomenon of patients participating in their own care. These included the conceptual understanding of the meaning of patient participation and the philosophy about how nursing care ought to be delivered. The conceptual understanding was defined as the aspect where both nurses and patients internalised the components of what participation encompassed. This understanding varied and included patients participating in their activities of daily living and making decisions about their own pain control and treatment plans at all times, if able, (complete patient input); patients participating in activities of their daily living and sometimes making decisions about their own pain control (partial patient input); and patients not participating in any aspect of their care (no patient input). Philosophy, according to Leddy and Pepper (1993), encompassed individuals' belief and value systems, which subsequently determined the way individuals perceived a

situation or phenomenon. The authors further stated that people's perceptions, based on their beliefs and values, strongly determined their actions. The philosophical stance, as defined from the data, included nurses' and patients' beliefs and values about how nursing care should be provided, that is, whether nurses should fully consult with patients as opposed to partially consult with patients or not consult with them. In other words, beliefs and values varied about whether care should be nurse driven, patient driven, or mutually driven by the nurse and the patient. Also, it embraced the notion of whether nurses should be working with patients as opposed to administering to patients.

It was evident from the data that these two areas of incongruence occurred amongst nurses and amongst patients and between nurses and patients. Properties and dimensions of *incongruence* in the above two stated areas were consistently evident in the data. The hospital contextual conditions in which care was provided and received further compounded the problem. There were also several varying intervening conditions, found within the acute care hospital settings on a day-to-day basis, that were considered to hinder nurses from actively promoting patient participation and patients from actually participating in their own care in any given shift. These varying intervening conditions included those affecting the nurse, the patient, or both, and the day-to-day ward environment.

### ***Incongruence in the Conceptual Understanding of the Meaning of Patient Participation***

Data analysis revealed that there was a tendency towards three different conceptualisations of the meaning of patient participation by nurses and patients. These differing conceptualisations varied between and amongst nurses and patients and these in turn affected the behaviour of both parties. The three different conceptualisations included complete input from patients, partial input from patients, and no input from patients. These differing conceptualisations of meaning, along with varying intervening conditions, resulted in nurses and patients adopting styles of participation which formed a continuum. These were labelled, participation inclusion,

participation marginalisation, and participation preclusion. Participation inclusion encompassed patients participating in their activities of daily living, managing their own pain control, and making decisions about their treatments, if able. Participation marginalisation involved patients participating in their activities of daily living and managing their own pain control, if able, but not making decisions about their treatments. Participation preclusion encompassed patients not participating or only minimally participating in their care. The nurses' and patients' understanding of the meaning of patient participation influenced the expectation and enactment of both parties regarding the degree to which patients actually participated and the extent to which nurses encouraged participation. It was not evident in the data that age, experience, or educational preparation were influential in how nurses conceptualised the meaning of patient participation. There was evidence however, that hospital contextual factors such as, economic constraints, management structures, presence of technology, and the culture of medical dominance did prevent some nurses from enacting their preferred style of participation. Intervening conditions such as patients' medical conditions and ward crises also hindered some nurses from enacting their style of participation.

### **Complete patient input (Participation inclusion)**

When the conceptual understanding included complete patient input (participation inclusion), both nurses and patients understood that participation meant involvement of patients in all areas of care. They were of the view that patients should have input into undertaking their own activities of daily living, be consulted on the type of pain control they had, and be part of the decision making process regarding treatments, if they were able. Nurses and patients perceived that nursing care was a mutually cooperative process. Cooperative process was interpreted in the data as a situation whereby both nurses and patients, in active consultation with each other, selected and engaged in behaviours that facilitated mutually agreed on plans about care. This was congruent with the views of Burckhardt (1986) who claimed that mutual cooperation involved two issues. Firstly, this meant that individuals must want to perform a particular action, and secondly, it meant that the action must be acceptable to the health professional. Nurses and patients with this type of understanding believed that

there should be equal input from both parties, provided patients were well enough to participate and were fully informed. Equal input has been interpreted from the data as both nurses and patients expecting to contribute equally in the care of the patient. Patients expected, and were expected by nurses, to participate in all aspect of their care, if able. An example of nurses' comments in support of the above statement include:

*Participation involves patient input from admission to discharge as long as they are well enough ... to be involved in activities of daily living and decision making ... it means having a voice to speak out re care, evaluating what's been done and refusing treatment if not happy without ramifications from the health professional! (nurse 16).*

*Participating, to me, is patients being involved in their own hygiene care if able, know about their medication and even self-medicate. If they [meaning patient] do not want a particular type of surgery, for example, laparoscopic versus open, then they should be able to choose ... it's up to us, nurses, to provide the patient with the relevant information and be an advocate for them so that they can participate in all aspects (nurse 22).*

Data analysis showed that the nurses who espoused the understanding that participation meant patients being involved in all aspects of their care also advocated for their patients. These nurses were observed to provide comprehensive information to patients, thus placing them in a position to make informed decisions, especially where medical decisions were concerned. This included such situations as whether patients should have chemotherapy or radiotherapy, as reflected by the following comment:

*Well, I encourage self-determination and I encourage patients to seek other options ... they have the right to make their own decisions and if they don't accept a particular treatment that has been recommended by the doctor ... then I support them absolutely one hundred percent if they decide "no" (nurse 30).*

Patient statements demonstrating that they perceived participation to include all aspects of care included:



*I think I can judge for myself the kind of nursing care that I need ... I ask for information because I have got to know what is going on with me ... this is so that I can work with them [meaning nurses] to meet our goals ... I don't look for control in the hospital, I look for cooperation in the things that they are aiming for in helping me get better and move me along the recovery trail (patient 11).*

*As a patient, I am willing to accept that they [meaning nurses] have their expertise but I have mine and we are equal in that way ... I think there has to be mutual cooperation between doctors and nurses and patients ... there should be none of this one-upmanship. ... They need to consult me because I know my body better than anyone, its not like working with a machine! (patient 18).*

From the above comments, it can be inferred that both nurses and patients with this type of conceptual understanding perceived that care should be mutually driven, thus embracing the concept of social equality and patient-centred care. The above perceptions were supported by Ashworth et al. (1992, p. 1430) who postulated that nurses, being part of society, should accept the ethos of individual freedom and responsibility and therefore encourage patients to have input into their care. Some nurses in this study seemed to appreciate that patients needed to be well enough and have the necessary information in order to participate. Therefore, they perceived that they should accurately assess their status and volunteer information to patients without being asked. They believed that nurses should encourage patients to share information with them, for example:

*It is a two-way street between the nurse and patient ... they [meaning patients] are not to lie there passively and be administered to ... we need to provide them with information ... we need feedback from them about how they are going ... I always tell my patients that they have rights and encourage them to ask questions so that they are informed... (nurse 13).*

This comment highlights the point that some nurses want patients to move away from the passive role, as defined by Parsons (1951), and be involved in their own care. It was observed in this research that, even when the patient was too sick to do anything, some nurses still consciously thought about the patient's input and where appropriate consulted with the relatives of the patient about some aspects, whilst guiding the patient until such time as the patient was able.

*If the patients are sick, keeping them comfortable is uppermost in my mind but I still act as their advocate. For example, if the doctor gets really 'gunghoe' and invasive in his treatment, I will try and take him aside and explain that perhaps he should consult with relatives [relatives] (nurse 14).*

Similarly, patients expected to be informed and consulted so that they could participate in all aspects of care. This is congruent with the findings of Salvage (1992, p. 44) whose survey indicated that patients wanted to be given sufficient information so that they could make rational choices in their care. Some patients in this study supported this view:

*I think, they [meaning nurses and doctors] should give you as much information as they can about your stay so you are not under plain dark authority ... I mean a lot of patients have not been in hospital before and they don't know what to expect ... I think patients should know what they are in for, what is going to happen, what is going on so that they can have a say in what is being done ... I mean a lot of patients are scared to death! (patient 8).*

Yet other patients with the same conceptual understanding of participation, that is, that patients should have an input in all aspects of their care, stated that all patients should be given comprehensive information, regardless of whether they were first time admissions or not. These patients explained that hospitals differed in the manner in which they were structured and that each hospitalisation brought different experiences for patients:

*Hospitals are all different and even if you have been in hospital before, you still need to be told everything about what is going on so you are informed. Also you are in for different things and the medical staff and nurses should be aware of this and inform you and work with you ... just because, you have been in hospital before, it doesn't mean that you know everything (patient 13).*

### **Partial patient input (Participation marginalisation)**

Nurses and patients who subscribed to the tenets of partial patient input, or what was interpreted as participation marginalisation, conceptualised the meaning of participation as patients having input into meeting their activities of daily living needs

and sometimes making decisions, if able, about pain control. Nurses and patients with this conceptual understanding of the meaning of participation, perceived that patients should not, and could not, make decisions about their treatment plans. The reason for this viewpoint held by nurses and patients seemed to be related to the perception that patients lacked medical and technical knowledge, as indicated by these comments:

*Often, things are not fully explained to patients about their treatments so they are not in control of the knowledge of what is happening ... they don't have the whole story, so how can they decide? (nurse 10).*

*I don't know if they [patients] can make too many decisions about treatments ... they don't have the knowledge but they can make decisions about pain control, if able, like I say to patients "if you don't want an injection, you can say no or if you don't want a wash, you can say no" ... I always give patients a choice about when they want their shower like in the morning, afternoon, or evening. Little things like forcing them to shower when it is not natural for them can be upsetting ... so we give them a choice and they make the decision (nurse 19).*

*We like the patients, especially post-op [operation], to decide as soon as possible when they want to get up and go for a shower ... we will assist if they need it ... with pain killers, well, a lot of them don't like injections, they have an aversion to injections ... so you offer them an alternative that they can take orally if that is what they want but if we think that the injection is really needed, then we would convince them to have the needle (nurse 5).*

The nurses with the above conceptual understanding of the meaning of participation were observed consistently to allow patients, if able, to make decisions about their activities of daily living. However, if they perceived that their patients' medical condition warranted the ordered type of pain management, they were observed to persuade patients to alter their decision and accept the intervention offered by them. This involved increasing the patients' understanding of the medical aspect of pain control, enabling them to make a decision. On questioning these nurses, they stated that patients often did not understand the importance of keeping the pain under control, which in turn facilitated patient mobility. These views are demonstrated by the following field notes:

*The nurse asked the patient, who had returned from theatre two hours earlier, if she had any pain. The patient gave a score of 5 on the pain scale*

*[range 1-10] and stated that she did not want anything for the pain, to which the nurse replied, "it is important for you to have the pain killer as it would be more difficult to control the pain as it gets worse, and believe me, it will get worse ... you have only just come back from theatre and the pain killer will stop the pain and help you to move about better which will help to get rid of the anaesthetic gases, so how about that injection. I will also give you something for the nausea with the pethidine ok?" The patient thought for a moment and said, "I better have it then because I don't want any breathing problems". The nurse then administered the injection (field notes).*

Some patients were of the same view as nurses with this conceptualisation of the meaning of participation. These patients were of the opinion that nurses "know best" and that they should cooperate with nurses, especially in relation to their treatments, thus giving nurses control in that area. Cooperating with nurses has been defined in the data as patients working in with the nurses and following nurses' directions with regards to treatments and procedures, which sometimes included the type of pain control they received. However, these patients believed that they should make decisions regarding their activities of daily living. They perceived that nurses and doctors were the experts and "gatekeepers" of information and, therefore, they were comfortable about cooperating with nurses and doctors because of the perceived knowledge gap as indicated earlier. This was congruent with statements by Otte (1996) and Tuckett et al. (1987) who claimed that patients often saw themselves as having a "competence gap", and therefore expected to take advice on trust and not question the type of treatments they were administered. The above authors further claimed that patients often did not ask for alternative treatments because of their perception that doctors and nurses would have offered them alternatives if they thought they were needed. In this study, some patients were of the view that nurses and doctors "know best" and believed that doctors and nurses were trained to act in their best interest. As such, patients believed that it was up to the experts to provide them with the necessary information about alternative treatments if they perceived that patients should be given alternatives.

*Certainly they [nurses and doctors] should have, in my opinion, have an overriding say ... they are trained to know better. I am a farmer and not a doctor or nurse ... if they don't know more, they shouldn't be here ... I don't think I should be allowed to make decisions about treatments because I*

*would be making decisions about something that I know absolutely nothing about (patient 12).*

*I think you need to cooperate with everything that goes on because you don't know exactly why some things are being done ... I only know that if you don't have the knowledge, you can't really provide any input ... so you cooperate ... surely they wouldn't be doing anything unless necessary, they know what needs to be done, especially the medical treatments ... I am sure the doctor would have told me about the options I could have if he [doctor] thought that it was warranted (patient 14).*

The Australian study of patients' perspectives on hospital nursing by Harrison and Cameron-Traub (1994, p.153) showed that patients often saw their role as one of cooperation with nurses, especially where treatments were concerned, even though they participated in their own activities of daily living. These authors also found that some patients perceived that doctors were in charge and that nurses were there to follow doctors' orders with little decision making powers themselves. An example of this occurring, in this study, is demonstrated by this patient comment:

*You can take control to a certain extent like what you want to do for the day or if you want the pain killer stopped but treatments don't fall within that parameter ... I suppose you have got to stay within what they say, to get better, so you cooperate with them because I am here to be looked after and the doctors are here to set the program and the sister [meaning the nurse] is here to follow suit ... so what is there but to cooperate (patient 10).*

Analysis also showed that patients with this conceptualisation of participation wanted to cooperate with nurses and to take on a passive role, only as far as treatments and procedures were concerned. These patients, however, expected to make decisions about their activities of daily living and were observed to ask the nurses for the type of pain relief they wanted or to refuse pain relief, if they were able. For example:

*The nurse wanted me to have two panadeine tablets for the pain but I didn't think I needed them ... so I said "I don't have much pain right now, can I leave taking them [tablets] for a while, I'd like to wait and if I can't handle it, I will give you a shout" and the nurse was all right about it which I thought was good (patient 2).*

*I have had the choice when the pethidine came off ... I got them to drop the amount from 15 mls per hour to 9 mls which the nurses did ... because the*

*nurse had told me about boluses, whenever the 9mls was not enough, I would ask for a bolus dose and they [nurses] gave it to me on the backside and it was pethidine and I had control of that ... after the pethidine was stopped, I asked for codral forte and they gave that to me after speaking to the doctor. I don't like taking things for pain and I think you should have control over that yourself ... I don't think they [nurses] should just come in and give it [pain killers] to you because they think you need it (patient 10).*

However, if the patients with the above conceptual understanding of the meaning of participation perceived that they were too ill, or did not fully comprehend what was happening to them, they were observed to be willing to allow the nurses to make decisions for them about pain control. They also accepted any other medications that they were given without question. During interviews, these patients explained that they allowed nurses to make decisions for them because they were ill and felt vulnerable. They perceived that they needed to accept whatever the nurses wanted them to have, especially in terms of pain control, as they did not want to delay recovery. For instance:

*I suppose in the first couple of days, you are really not with it and not really in a position to decide ... you feel so vulnerable during this time, so you look to them [nurses] for looking after you ... so if they think that you need a particular medication or pain killer, you just accept ... all you want is to feel better ... it is different when you are better because you are alert and able to think clearly and decide (patient 3).*

*When you are sick or have had surgery, all you want is for the nurse to be there to help you get better ... I think patients should have their opinion but when you are sick, you sometimes have to let the nurse do whatever is required or whatever procedure needed to be done ... you are not on a holiday camp but sick in hospital ... You don't want the nurses bossing you around but I understand that if I am not feeling well enough, I should cooperate with the nurses so I can get better (patient 6).*

The concept of the above patients giving nurses control because of illness and subsequent vulnerability is supported by Irurita (1993, p. 15) whose research, in Western Australia, showed that hospitalised patients experienced a great deal of dependence during the acute stages of their illness and relied on nursing staff to protect them and to help in their recovery. To this end, they were prepared to cooperate and do as requested by nurses. This was also supported by some nurses in

this study who stated that when patients were ill and in a vulnerable position, they were often easily guided by nurses. An example include:

*In nursing you can generally talk patients around ... often they will say "no" especially if they don't understand but if you explain you can coax them around ... you see, if they are sick, they often put up no resistance at all (nurse 6).*

However, nearly all the patients with the above conceptual understanding of the meaning of participation, as already indicated, expected to be given a choice with regards to meeting their hygiene needs and with activities of daily living. These patients wanted nurses to consult with them about when they wanted the nurses to give them a sponge or an assisted shower, when they wanted the nurses to assist them to mobilise, and when they wanted to retire for the night. The following field notes and patient remarks reflect this point:

*The nurse came into a four bed ward and switched the main lights off and said "time for bed, the pills shouldn't be long". The time was nine thirty in the evening. One of the patients called the nurse over and said "at home , I don't go to bed until ten thirty or eleven, you see, I live on a farm and we don't go to bed early because there are always things to do ... I would like to stay up a bit longer, if you don't mind ... I am happy to go and read quietly in the lounge area " to which the nurse replied, "as long as you don't mind being in the lounge, it's ok with me, I will tell the night nurse that you are there" (field notes)*

*The next day after my surgery, the nurse wanted to take me to the shower in the morning but I told her that I preferred to be done in the evening like I do at home and she was not that keen because she said the shower would do me good but I persisted and even told the nurse that I was prepared to have a wash rather than a shower in the evening if they [nurses] did not have time to assist me in the evening ... the nurse went along with that which was great (patient 29).*

The patients with the conceptual understanding that participation meant patient involvement in activities of daily living were consistently observed to initiate consultation with nurses with regards to meeting these needs. This is reflected in the above field notes and statement when the patients were clearly in control as evidenced by the manner in which the patients informed the nurses of their preferences. The

patients above, for example, did not ask the nurses but, instead, voiced their views about how they preferred their care in relation to activities of daily living.

### **Minimal or no patient input (Participation preclusion)**

With the conceptual understanding of minimal or no patient input or what was termed as participation preclusion, both nurses and patients perceived that participation encompassed patients listening to nurses and doing as they were told in all aspects of their care, including activities of daily living. The notion that there was implied consent when patients were admitted to hospital seemed to foster the perception in some nurses that they were clearly in charge and patients were there to follow orders. Some nurses with this conceptual understanding stated:

*I suppose we expect the patients to follow orders from nursing and medical staff and in some ways to be subservient, it certainly makes our job easier (nurse 21).*

Patients with this understanding of the meaning believed that they should conform and “toe the line” so that they would get the necessary care to recover. Conforming or toeing the line is defined from the data as patients acquiescently accepting the nurses’ orders without question or yielding without question. Patients stated that they did not wish to be labelled as “difficult”, and thus did as they were told. Parson’s theory of the sick role was evident with this conceptual understanding (Parsons, 1951). Both nurses and patients with this conceptual understanding were of the view that patients should take a submissive role in all aspects of their care, that is, to obey the nurses orders without question. Some nurses’ statements indicate this:

*I acknowledge patients have rights but I don’t believe in giving in to what they want ... they often don’t know what is best for them ... so we have to take charge ... we would hope that they [meaning patients] have a positive outlook and conform with us (nurse 11).*

*They can make their own decisions as long as they don’t conflict with my decision in what I am trying to do to get them well ... a lot of hygiene decisions is what they can make I suppose but usually we expect them to fit in*



*with our routine about when they want their shower/wash etc ... I guess they participate by conforming to what we want them to do (nurse 27).*

*Some nurses are driven by the belief that patients should conform, it makes life a lot easier ... I suppose on the whole a lot of nurses are almost a bossy breed so we expect them [patients] to do as we tell them to do (nurse 7).*

*The patient's role is to be obsequious, conform, and do everything they are told ... to make no demands on the nursing staff and to heal up as quickly as they can and learn to follow orders (nurse 21).*

The statements above reflect some nurses' understanding that participation means patients doing as they are told. This was perceived by the nurses to make their work easier, even to the extent that they expected patients to recover quickly, regardless of their medical condition. The aspect of some nurses wanting patients to recover at all cost was supported by some patients in Irurita's (1993) study which showed that some patients were found to be trying to recover because they perceived that they had to recover to be labelled as good patients by the nurses. It was observed in the field that the nurses who espoused this understanding appeared to be interested in doing only technical tasks, which took up their time. Occasionally, it was noted during observations that these nurses would appear to ask patients to participate in their hygiene needs. However, asking patients to participate in their hygiene needs did not seem to be a conscious decision on the nurses' part to prioritise participation and actively promote it. It was evident from the nurses' behaviour in these instances that they asked the patients' input into their hygiene needs simply because it fitted into the repertoire of their work. The drive on these nurses' part appeared to be how to get through the technical tasks and to get the work done within the shift rather than to plan care based on the decision to involve patients in all aspects of their care, that is, meeting hygiene needs, making decisions about treatments, and having input into pain control. Therefore, it may be extrapolated from the analysis that when patients participated in their hygiene care in some cases it was through default because it fitted in with the nurse's work routine. This resulted in some patients being observed to participate inappropriately at times. For example:

*I had come back from theatre [operating] that afternoon, and that evening I asked the nurses if I could get up and go to the toilet and she [the nurse] said*

*"I suppose" ... so I got up and my mother-in law ended up helping me to the toilet because I was feeling woozy with the pethidine drip in my arm. My mother-in law was angry and said "this is slack, they [nurses] should have walked with you to the toilet, because after theatre and being on pethidine, you should have been assisted" ... I could have collapsed and swallowed my tongue and choked! (patient 8).*

The patient above was young and explained that she was annoyed at the nurse for putting her health at risk. When asked why she did not ask for help, the patient stated that she did not feel that she could ask because of the nurse's attitude that she was capable of going to the toilet by herself. The patient expected the nurse to use professional judgement and offer assistance without being asked. The patient also stated that she did not complain about the nurse's behaviour because she felt that it would *fall on deaf ears* and nothing would be done about it anyway. A similar incident had happened to the patient in one of her previous hospitalisations. When she had complained, she stated that she was labelled as a *neurotic* and given a *hard time* by the nurses. This indicated that the patient was prepared to do as she was told, even though she knew that she was participating inappropriately, for fear of being labelled a difficult or bad patient. This patient's view was supported by Irurita's (1993) study which also showed that some patients were prepared to do as they were told for fear of being labelled as difficult.

Some patients appeared to share the above opinions, indicating that they viewed their role to be a submissive one, and did as they were told.

*I think, just try and be a good patient, try and abide by the hospital rules and what the nurses want you to do, not to be difficult ... I suppose to listen to their advice and toe the line (patient 4).*

*I feel the nurse is like a teacher in the classroom. The nurse is in charge of the ward and has the right to use her professional judgement so you do as you are told ... what else is there? ... (patient 1).*

As indicated earlier, toeing the line was interpreted as patients doing exactly as asked by nurses without question. It also included totally complying or conforming to nurses' orders without consideration for their own feelings and even participating in

their own care inappropriately, as highlighted by these patient comments and field notes:

*I think the nurses have got the upper hand ... you are there because something's gone wrong and it's got to be rectified and they know what they are doing ... they [nurses] are the ones that ... well, they have got the upper hand, haven't they ... the patients are really floundering in the dark (patient 5).*

*I think if you toe the line, the girls [nurses] will definitely look after you ... if you don't toe the line, the girls will get their backs up ... you should do what you are told as you are dependent on them ... therefore, you've pretty well got to go along with them ... I think you have to as you have no option (patient 30).*

*One of the patients rushed into the nurses' station shouting that another patient was on the floor in the bathroom. The two nurses at the station hurried into the bathroom and found the patient lying naked on the floor. The patient who was elderly was in hospital following a cerebral vascular accident. "why didn't you ring the bell, Mr X?" asked the nurse, "you should have said you needed some help to wash your feet" to which the patient replied, "I didn't want to bother you, I thought I could do it myself". The nurses lifted the patient back on to the shower chair and began to dry him. It was evident that the patient's right thigh was bruised ... "I guess we have to get the doctor to see you now and next time you must ring, ok?" (field notes).*

The above field notes demonstrate that patients with the conceptual understanding that participation means doing as they are told by nurses were prepared to put themselves at risk of injury for fear of disobeying orders. Conversation with the nurses about the patient's fall revealed that the nurse who took the patient to the shower was aware of the patient's disability but had failed to assess the patient accurately and to assist with the shower. In another patient interview, the patient informed the researcher that she was taken to the shower and left to wash herself one day post major surgery. The patient stated that she felt uncomfortable in asking the nurses for assistance.

*During the shower, I felt dizzy and sick, so I sat down on the chair. I should have called the nurse but she [meaning nurse] had said that I should be ok in the shower even though she told me I could ring ... once I sat down I felt a bit better but had difficulty drying myself, especially with the drip in one arm ... so I used my teeth to hold the end of the towel and, with the other hand, I managed to dry myself somewhat ... in the end I called the nurse because I needed help getting back to bed (patient 28).*

Some patients believed that they needed to toe the line in order to receive safe care. It was disconcerting to note that there was a perception in these patients that if they did not do as they were told by the nurses, their care would be compromised, which could be detrimental to their recovery. Some patients stated that they would be chastised by the nurses if they did not obey orders. The patients perceived that the nurses would punish them by withdrawing or giving incorrect care, which could harm them, such as:

*You have to do as they tell you to do, otherwise, they could give you the wrong medicine or something and then what could you do, you are really in their hands (patient 5).*

Therefore, the patients claimed that they were reluctant to refuse to do as they were told or to question the nurses. Nearly all the patients with the conceptual understanding that participation meant doing as they were told were of the view that nursing staff would keep away from them if they *bucked the system*. This in turn would lead to poor quality care as supported by these nurses' statements:

*It sounds awful but in some cases it is true ... if they [patients] don't conform, their care may be in jeopardy. For example, when the patient rings the bell, the nurses would take their time getting there and then they might see other patients first before actually going to the patient and the patient may have been desperately needing a pan or something or it might be pain relief ... I find that frustrating to see (nurse 16).*

*Sometimes the patients don't get the care if they dig their heels in and yes, it is a reasonable assumption on the patients' part to have this fear because the nurse is in a power position and patients understand this (nurse 2).*

Podrasky and Sexton (1988), in their study into nurses' reactions to patients perceived to be difficult, found that nurses tended to limit communications, withhold information, and were observed to provide only the minimum of care. The above authors' findings are congruent with the findings of this study. Some nurses confirmed to the researcher that patients who were labelled as "difficult patients" often received the minimal of care and were frequently avoided by nurses.

It may be suggested that the above comments from nurses and patients and the field notes reflect some nurses' view that they are in control and emphasise patients' perception of vulnerability whilst in hospital. This was demonstrated in several studies that showed that some patients appeared to value being able to trust nursing staff and toe the line rather than to participate in their care (Biley, 1992; Irurita, 1993; Waterworth & Luker, 1990; Williams, 1996). Some patients in Waterworth and Luker's (1990) study, for instance, were so pre-occupied with being "good" that they took on a submissive role and adopted the right behaviour, even to the extent of accepting unsatisfactory care from nurses. This resulted in patients renouncing their freedom to choose, and acquiescently accepting the nurses' orders (p. 972). In Irurita's (1993) Australian study, some patients stated that they preferred to go along with whatever the nurses wanted them to do rather than complain or voice their opinion. The reason for this was that patients stated that they did as they were told because they feared being labelled as a "nuisance", which was perceived by patients to have implications for the type of care they received from nurses. In other words, patients feared that if they were labelled as a nuisance, then they would be avoided and that they would not receive good care from the nurses.

In this study, some patients with this conceptual understanding of the meaning, as already indicated, equated the nurse-patient interaction to the school teacher-pupil interaction where the nurse was perceived by patients to be clearly in charge. There was also evidence in the data that some patients perceived that they generally lacked information, which further increased their vulnerability, for example:

*I would have liked to have asked a lot of questions of the nurses but I know damn well that I will get no answer because they [nurses] don't seem to want to tell you anything! ... I don't know what has got into them these days, maybe it is administration ... you feel helpless sometimes really (patient 24).*

*As a patient, you have to follow rules and carry out orders ... otherwise the nurses can be devils, they won't listen to you or answer your bell and if you demand care, you would get labelled as a "nuisance" and they don't come near you ... half the time, you don't know what's happening and you feel so dependent on them (patient 5).*

In summarising the different conceptual understandings of the meaning of patient participation between nurses and patients, it was evident in the data that in any given shift, the nurse-patient dyad frequently came together with dissimilar or *incongruent* understandings. This was in conjunction with the observation that there were a few instances where the dyad did come together with matched understandings. Whilst similar understandings did not seem to cause much difficulties, provided contextual conditions were favourable, for nurses and patients in terms of nursing care, dissimilar understandings were observed to be very problematic. The process that nurses and patients used to overcome these differences will be addressed in chapter five, together with the varying intervening conditions that modified the process.

## ***Incongruence in the Philosophy about Nursing Care***

### **Nurses' perspective**

Inherent in the philosophy of nursing, as suggested by several authors, is holistic care, which has as its tenet the concept of including patients in all aspects of their care from making decisions about their activities of daily living to making informed decisions about their treatments (Steele et al., 1987; Pyne, 1994; Macleod-Clark, Maben, & Jones, 1997). Most of the nurses in this study were university educated, where holistic care is usually integrated into the curriculum. Accordingly, some nurses were observed to demonstrate the above belief in holistic care, for example:

*There is definitely a link between power and patient participation ... you get the "battle-axes" [meaning nurses] and they are up here and the patient is down here and it is all coming downhill ... the patient doesn't get a chance and they are fighting an uphill battle before they [meaning patients] even start ... but I am not like that. For me it's a two way thing. I build rapport and I still have authority but we are working together with them [meaning patients]; they are actively participating and having their point of view (nurse 6).*

*I think nurses and patients can be partners even if we come with different skills, provided patients are well enough ... I am probably the one with the information and technical skills but the patient is the one with feelings and experiences ... to share these things together, you are going to come out at the end positive because I can give them the information and my skills if they*

*are needed and they [meaning patients] can tell me how they feel, what they want and how they want something done ... the care is shared (nurse 28).*

From the above nurse comments, it may be suggested that these nurses believed that patients have the right to be fully involved in their own care and that they viewed nursing care as a combined effort between nurses and patients. The only condition stipulated by these nurses was that patients needed to be well enough to fully participate in all aspects of their care. To this end, these nurses were prepared to share their power with patients. They were observed to work with patients by discussing issues with them rather than just doing procedural things to patients, as reflected in these field notes:

*The nurse was asked by her coordinator to perform an “in and out” catheterisation on a 57 year old male patient who had Parkinson’s disease. The nurse went to the patient and said, “Mr C, how are you? I have come to drain your bladder with a temporary catheter like they [meaning nurses] did this morning ... the doctor wants you to have these on a regular basis”. The patient replied, “It was so painful when they did it this morning ... do you have to do it all the time? ... I don’t want it done all the time” to which the nurse said, “Mr C, would you like me to put a permanent catheter in so that it can be left in ... would you prefer that?”. The patient replied, “yes, I would”. The nurse then went to the coordinator and informed her about what she was going to do to which the coordinator replied, “but we can’t do that, the doctors would be mad” to which the nurse said, “I know, but I will take responsibility for it in the morning, I think we should do as the patient wants, he doesn’t have a UTI [urinary tract infection] or anything and I think we should listen to him” (field notes).*

This scenario supports some nurses’ philosophy that nursing care is a cooperative venture between patients and nurses and that care should be mutually driven. The nurse in the above situation, for example, was happy to allow the patient to make his own decisions about the treatment and was prepared to work with him. Furthermore, this nurse was prepared to listen to the patient and advocate for him. When asked by the researcher why the nurse did not consult with the doctor prior to inserting the permanent catheter, she commented,

*Well, it’s late and I know the Registrar and get on well with him ... I didn’t see the point in prolonging the agony for the patient and I had all the*

*equipment there, all handy ... besides, the doctors trust me and my work and I know that I won't get into trouble, it all depends on the nurse (nurse 30).*

This nurse was a Level 2 nurse, and during formal interview she reinforced her views by stating that, for patients to be partners in care, they needed nurses to support them, advocate for them, and provide comprehensive information. The comment below explains her view:

*I give them [patients] as much information as possible and make them aware that they can ask for a second opinion or refuse treatment or just making them aware of their rights as a patient ... I inform them that they don't always have to go along with what the doctor says and by just letting them know that they are a person and that they can say "no" (nurse 30).*

This nurse's remarks were similar to a few other nurses in the study who believed that, if they had good working relations with doctors, they had medical support when they acted as patient advocates. An interview with a doctor revealed that more and more doctors, especially the younger doctors, were aware that nurses were knowledgeable and had a lot to contribute in the team.

*It's up to nurses to make their voices heard by taking on a pro-active role within the team ... we respect nurses who know what they are doing, provide you with relevant information and are not hesitant to speak up for patients and contribute to the case management, instead of walking around and noting what the changes are (doctor).*

Advocating for patients has been well documented as an important role for nurses (Pyne, 1994; Royal College of Nursing, Australia, 1994; Nurses Board of Western Australia, 1997). However, in this study, it was observed that the majority of nurses were reluctant to advocate for patients even though they stated that they perceived advocating for patients to be their responsibility. To be advocates, nurses need to speak up or act on behalf of patients. Nurses need to be prepared to undertake complex and sometimes controversial roles in order to act in the best interest of patients (Sines, 1994). This sometimes involves negotiating with doctors. Sines (1994, p. 899) argued that this stance may be difficult for some nurses, for example, to "be the guardian of patients' rights and be a champion of social justice in providing care", nurses often face opposition from doctors. This is because some nurses



perceive that doctors believe that it is their responsibility to discuss medical treatment issues with patients and not the nurses. One explanation for this perception is provided by Marshall (1991). The author suggested that, as doctors traditionally work independently, they may not appreciate or value nurses consulting with them in the process of advocating for patients. Marshall (1991) further questioned whether nurse advocates would, therefore, receive the support and understanding they need from medical staff. Tingle (1989) added to this viewpoint by stating that, although doctors in recent times demonstrated positive attitudes about nurses being advocates, they still see it their responsibility and role to give patients information and discuss medical treatments with them.

Some nurses in this study, whilst they valued the need for patients to be fully informed, were not able to do so because of their inability to maintain their role as patient advocates. These nurses perceived that some doctors were reluctant to discuss medical protocols and even withheld information about certain aspects of the medical decisions. Consequently, the nurses feared that they may give biased or incorrect information to patients. The nurses followed up by stating that the role of patient advocate required them to be knowledgeable about all aspects of a given medical decision. They expressed concern that they may face litigation if they were to provide patients with the wrong information or alternative methods of treatment. The nurses also believed that, as doctors had the ultimate responsibility for patients, they were the ones most likely to be sued in case of litigation, and thus perceived that doctors had more rights. The nurses felt that, unless doctors were prepared to discuss issues regarding treatments with them, they were not able to be advocates. The majority of nurses in the study also were not observed to be advocating for patients because of the perceived view that medical decisions were clearly in the doctors' domain, as highlighted by this statement:

*Nurses need to point out alternatives to patients so that they can evaluate them and decide what is best for them but this does not happen much as nurses can't really advocate, not in the true sense anyway ... you see, nurses do not want to step over the line ... they see giving alternatives as the doctor's domain, not theirs because doctors think that patients belong to them (nurse 9).*

*I know I should be an advocate but I don't do it much ... you don't want to override the doctor and say too much. Like, if the patient is not happy I'd say to them "why don't you ask the doctor to explain it to you" or "why don't you ask if you can have a second opinion" ... but we [nurses] need to be careful that we don't slander the doctor, yes, I think, you have to be a bit careful there (nurse 26).*

Other nurses were reluctant to advocate for patients because they perceived that they would not get the appropriate support from their peers.

*Being an advocate is not really accepted by nurses ... a few of us nurses who stick our necks out get labelled by other nurses and get a bit of a reputation (nurse 8).*

This comment is congruent with those of Pyne (1994, p. 633) who claimed that the track record of nurses supporting each other in their role as patient advocates is unimpressive. The author also stated that nurses who draw attention to practices that compromise care and advocate for patients are deserted rather than supported by their peers (Pyne, 1994, p. 633). Some nurses in this study were also limited in the understanding of their patient advocacy role. To these nurses, reinforcing the information that the doctors had given patients was the key function of being an advocate. These nurses did not perceive that acting for, pleading for, informing, supporting, or defending the patient were crucial elements to being an advocate (Irurita, 1993, p. 55; Marshall, 1991). The statement below reflects some nurses' lack of understanding of the advocacy role.

*To me, advocacy is supporting the doctor after he has been and explaining the surgery to the patient if the patient does not understand ... if the patient is not familiar, then we have to advocate in the sense that we simplify the meaning of what the surgery entails, what the doctor has said and re-emphasise the operation (nurse 23).*

It may be inferred in this study that, whilst most nurses subscribed to patient advocacy as being their responsibility, only a few were observed to enact this role in the practice setting. It could be suggested, therefore, that the majority of nurses were not fulfilling their role as patient advocates as stipulated in their code of practice. Marshall (1991) explained that nurses fear losing their jobs if they are to speak up for patients' rights,

which may result in a legal battle with the medical profession. The author further stated that, until nurses perceive that their opinions and expertise are valued by colleagues and doctors, they will be reluctant patient advocates.

Despite some nurses subscribing to the philosophy that patients should actively participate in all aspects of their care, there was indication in this study that the majority of nurses did not encourage patients to be fully involved in their own care. As suggested by England and Evans (1992), this could be due to attitudes, personal characteristics, and beliefs that nurses bring to the bedside and by the nature of the situation in which decisions are made. According to Macleod-Clark and Latter (1990, p. 29), patients participating in their own care means more than being involved in a series of activities. The authors further stated that nurses need to acquire a philosophical approach to care that reflects the belief that patients have the right to be involved. Some nurses in this study believed that nursing was task-oriented with the nurse being in the “driver’s seat”. For example:

*I expect them [patients] to accept whatever treatment they are being offered and to basically get well so that they could be discharged ... Yes, I don't expect a lot from them although I want them to be pleasant and appreciative of what I am doing for them (nurse, 18).*

*I think some of us like to do everything for the patient and it is like “our patient” and we don't let anyone else be involved, not even the patient. Also, I suppose we are routinised and ritualised that we tend to put tasks and routine first before our patients, so we take over ... we are so busy sometimes that we just have to get the work done and it is quicker to get it done ourselves (nurse 29).*

The above statements underpin the notion that these nurses perceived that they were clearly in charge and expected patients to comply with their instructions, giving little consideration to the philosophy of holistic care, which encompass patient participation, as illustrated below:

*The patient relinquishes power ... the nurse assumes power - not power ... power is a silly word. I don't know if I like “power” ... it is just that I think patients expect things done for them because they are in hospital and I think*

*nurses expect to do them ... probably rightly so because we have always done them (nurse 20).*

*The nurse went to administer medication to a patient suffering from severe arthritis. She unlocked the patient's drawer and took out 2 disprins and dropped them into a full glass of water. The patient looked at the nurse and said "please don't put them in the water, I prefer to swallow them" to which the nurse replied, "don't worry, these are dissolvable". The patient said, "that is a stupid idea, now I have no choice but to drink this stuff! ..."; "Yes, but you need to drink anyway, ok". The patient picked up the glass and began to drink (field notes).*

The nurse statements and observed fieldwork demonstrate that, even though the majority of these nurses came to the practice setting with the learned philosophy of patient-centred or holistic care, they demonstrated a tendency to resort to task-oriented and nurse-centred care. It was clear that these nurses did not subscribe to the philosophy of patient-centred care at the bedside. It was noted by the researcher that, even though several of these nurses were university educated, as previously mentioned, they still placed a high value on task-oriented care. On questioning the nurses on this issue, several stated that it was an implied expectation in the organisational culture that completing tasks was to be given priority. Salvage (1992) explained that there is literature to show that nurses continue to perceive "real nursing" as doing practical tasks. This has resulted in nursing practice being mechanistic in nature with low priority placed on interacting with patients and actively promoting involvement. Salvage (1992) further stated that there seems to be an unwritten rule that interacting with patients, which is crucial to patient involvement, is not considered by nurses to be important. This view is supported by Henderson (1994), Smith (1992) and Williams (1996). Smith (1992) reinforced the view that nurses still consider routinisation of care, which goes against the ideology of patient focused care, as an inevitable aspect of their work. Henderson (1994) claimed that nurses' entrenched fixation on caring for patients' bodily functions has resulted in nurses equating patients as "recorded bodies", where little is known about patients' psychological needs but everything is known about their biochemical and physiological status. It was from this that Foucault (1975) coined the expression "the clinical gaze". Williams (1996), for example, found in her Australian study that, in

the context of limited time, nurses considered providing physical care as priority whilst interacting with patients was viewed as low priority.

Some nurses in this study seemed to believe that they knew what was best for patients and, thus stated their espoused philosophy to be one in which the nurse took charge of the patient's care. McCormack (1993, p. 341) questioned whether the professionalisation of nurses has allowed them to fall into the rhetoric of thinking and believing that they do know what is best for patients. In doing so, the author further questioned whether nurses are ignoring the real needs of patients. This attitude on the nurse's part is explained in detail in the section under causal factors.

In this study, whilst some patients were satisfied with allowing nurses to take the lead in their care during hospitalisation, they expressed concern that they were sometimes not fully sure of what to do or expect about their care once discharged. In retrospect, patients felt that they should have been given more control over their care in hospital so that they could have cared for themselves more effectively at home. For example:

*When I went home I got my wound wet and it got a bit red and inflamed ... when I went back into hospital, the nurse said I should have kept it dry. You see, in hospital, the nurses always covered it and I didn't need to do anything ... They took care of everything ... I think we should be involved so we know what to do once home (patient 17).*

From the above findings, it may be suggested and summarised that nurses came to the bedside with their own philosophy about how nursing care ought to be delivered to patients. Whilst some nurses in this study held on to the taught philosophy of holistic care, which encompassed patient participation, others expected patients to take either a passive or a submissive role. The nurses with a holistic philosophy of care believed that care was a mutual venture between nurses and patients and subsequently acted accordingly when conditions allowed. As indicated by the data, there were some nurses who operated under the philosophy that "nurses know best" and thus expected patients to be guided by them; yet other nurses with the philosophy that nurses were in control and in charge expected patients to submit to their commands and do as they were told. It was also apparent that the nurses'

understandings of the meaning of patient participation were not always responsible for shaping their philosophy of nursing care. Nurses' internalised beliefs, values, and attitudes seemed to play a major role in shaping their philosophy. This explained why, even though some nurses understood the meaning of patient participation to be involving patients in all aspects of their care, they were still observed to not allow patients to fully participate. Yet, other nurses who understood participation to be all encompassing did allow patients to participate in all aspects of their care. This is congruent with the views of England and Evans (1992) and Macleod-Clark and Latter (1990). These authors stated that nurses' philosophies were influenced by their attitudes and values and beliefs that patients have a right to participate in their own care.

### **Patients' perspective**

Similar to the nurses in this study, patients demonstrated that they also had their own philosophy about how nursing care should be provided and this varied among patients. Data analysis showed that patients' philosophies were influenced by their beliefs which, to some extent, were dependent upon information about hospital care from friends, family, and the media, their previous encounter with hospital staff, mainly doctors and nurses, and the number of hospitalisations they had had before participating in the study. In patients, their philosophy, to a great extent, appeared to influence their conceptual understandings of the meaning of patient participation. Thus, patients' conceptualisation of the meaning of participation was based on their philosophy and the two appeared to be interrelated, with no clear boundaries, unlike the nurses. Some patients in this study verbalised that their philosophy of nursing care encompassed nurses and patients working together in a cooperative manner. These patients believed that it was their body and that they should be fully consulted in the care that they received and take responsibility for their own health. Accordingly, these patients expected nurses to work with them and not simply administer to them. The comments below highlight this view:

*I think it is important to have the right attitude that really it is not someone else that has to get you well ... basically, you have to get involved and get yourself well ... I think the nurses and doctors should be there to boost your*

*confidence and work with you ... you are really responsible for yourself, don't you think? (patient 3).*

*As an individual, I strongly believe that you should know everything that is going on and I think people [meaning nurses and doctors] should tell you the reasons for doing things because really you want to take part in your own care and wellbeing (patient 7).*

*As patients, you should make decisions about everything that happens to you ... it is your body, it's your role to have a say in what happens, for example, I was only having one leg done but I thought they might as well do the other leg since it was six months since I saw the Specialist. So I asked the Registrar and he checked with the Specialist who said that it was ok. I mean if I hadn't spoken up I would have had to wait another six months (patient 9).*

The patients with the above philosophy mainly included patients who had been in hospital previously, at least once. Most of these patients were also knowledgeable about their medical condition through reading literature, being informed by their General Practitioner, or through communication with family and friends who had experienced similar medical conditions. Even though some patients came into hospital with the above philosophy, data analysis indicated that only a very small number of patients were able to enact their beliefs about their care. It was observed that some of these patients had encountered nurses who either believed that patients should be guided or that they should do as they were told. This was seen to cause problems for these patients with some being labelled as “difficult” by some nurses. Data analysis revealed that the type of patients to be labelled as “difficult” were the ones who had successfully engaged in shared care in previous hospitalisations. Unfortunately for these patients, during the current hospitalisation, they had encountered nurses who held the philosophy that nurses were in charge and that patients had to be submissive and do as they were told or “toe the line”. The following patient comments reflect this point:

*I was vomiting so when I rang the bell and suggested that she [the nurse] give me something for it, she just said “see how you go without anything until the doctor comes ... you are not written up for anything, the vomiting should settle without anything”. So I asked my doctor and boy did I get into her “bad books”. She was matter of fact with me after that and only came near me if she had to do something ... it is a dangerous thing if patients get into their [nurse's] bad books, you know, like hell has no fury (patient 31)*

Another patient, who had held a position of authority at work and had knowledge about his medical condition, stated that he had questioned the nurse about the medication he had been given and had received an unfavourable response.

*She just came into the room and said "here are your tablets" and plonked them down in front of me ... when I asked her [the nurse] why she had given me a new pill, she said, "the doctor wants you to have this". When I asked her what it was for, she mumbled about it being a vitamin. So I said, "I am already on that many bloody vitamins, I wish to see the doctor about this please", to which the nurse replied, "I am leaving the tablets, you do what you wish but tell the doctor when you see him" and walked out of the room (patient 15).*

The above patient, who held the belief that nurses and doctors should consult with him about decisions regarding all aspects of his care, was observed to be avoided by some nurses. A few nurses suggested to the researcher that the patient was "difficult" and to reconsider the suitability of interviewing him. This particular patient was also observed to be kept waiting whenever he rang the call bell. Sometimes it was observed that this patient had to wait twenty minutes or more before the bell would be answered as supported by his statement below:

*Every time I rang the bell, they never answered it straight away ... they would walk past and say, "you'll have to wait, you'll have to wait" and sometimes one or two [nurses] would say, "don't think I'm going to take you to the toilet like this all day" so I had to restrain myself. I mean, I have bowel problems ... one day I had to hang on for four hours and that's not right (patient 15).*

However, when the above mentioned patient met up with the nurse who shared the same beliefs as himself, he had no problems with the nurse. For example, the patient had asked some of the nurses on day shift to move the overhead [monkey] bar to the right side of the bed. This was to assist the patient to move easily in bed as he had suffered a stroke and had limited movement on his left side. However, the nurses on day shift had refused to move the bar stating that he could just as easily use the bar from the left side of the bed. According to the patient's statement, when some of the nurses had refused to move the bar he had asked a nurse on the next shift to move the bar.



*When the nurses wouldn't do it [move the monkey bar], I asked this other nurse on afternoon shift. I said "see this monkey bar, how about shifting it to the right side so I can use it, you see, I have no power in my left hand at all" and in a flash the nurse had it on the right side, not a problem for this nurse, now little things like that mean a lot to somebody who is relying on someone else to help them (patient 15).*

Other patients, who believed that they should be fully consulted, were observed to reluctantly allow the nurses to guide them, as they perceived that they were only going to be in hospital for a short time, and stated that it did not bother them too much. As well, they did not want to be labelled as "difficult" and miss out on care.

*Even though I didn't want the injections for the pain, I said "ok" to the nurses because they seemed to think that I needed the injections. So I thought, what the heck, let them do as they want even though the pain was tolerable and I am not one for taking pain killers ... I will be out of here to-morrow (patient 11).*

*The nurse was authoritarian and just came in and said, "you will have to have this done and you will have to have that done" and I thought anything for a quiet life so I went along with what she wanted ... no point in creating any hassles or bad feelings (patient 20).*

It was observed at times that, even when patients with the philosophy that they needed to be consulted were cared for by nurses with similar philosophies, hospital contextual conditions and varying intervening conditions were such that patients and nurses were sometimes unable to engage in care that reflected these philosophies. The hospital contextual conditions will be described in chapter four whilst the varying intervening conditions will be discussed in chapter five together with the basic social process.

Some patients in this study were of the belief that nursing care was nurse-oriented, with nurses guiding or directing them, especially with regards to medical treatments and procedures. However, these patients expected to be consulted in hygiene and pain management care, if able, because they believed that they should have some input into these areas.

*I am not a medical person, I don't know what to do ... so in hospital, I put the nurse that little bit above myself in the procedures and treatments they are doing for me because I am a lay person and I don't understand what's going on ... they have the expertise and knowledge so I am happy with their medical decisions but not with my other care ... I feel I should have a say (patient 6).*

*Yes, definitely, you should look after yourself if you are able and not to lie there like a log ... you should get out of bed and wash yourself if you can and tell them what you need for your pain ... but not treatment like, it's the nurses' domain, you leave the nurse with the medical decisions (patient 12).*

Field observations showed that the patients with the above philosophy were content to allow nurses to take on a dominant role in some aspects of their care. Whilst these patients' behaviours indicated that they exhibited control in deciding about their activities of daily living and pain management, they clearly delegated control to nurses when treatment decisions needed to be made. These field notes reflect this patient stance:

*As the nurse entered the patient's room, the patient said, "I think I will go and have my shower now but before I go, can you give me a couple of panadeines so that I will be ready when you do my dressing after the shower [patient was three days post mastectomy]. The nurse replied, "no worries, Mrs T, I'll go and get you the panadeine while you are getting your things ready" and the nurse left the room and shortly returned with the medication. The patient took the panadeine and went for the shower. "Do you want any help in the shower?" asked the nurse. "No, I will be fine", replied the patient and went to have her shower. After the shower, the nurse cleaned the wound site but left it open to which the patient asked "aren't you going to cover the wound like yesterday?". "No, it doesn't need one ... there is no drainage but I will put a dressing on if you want one" said the nurse. The patient replied, "well if you think I don't need one, in your opinion, it is fine by me ... after all you know what is best" (field notes).*

The above patient, for example, demonstrated taking an active role with regards to her hygiene need and pain control. However, when it came to deciding whether to have a dressing on or not, the patient was willing to let the nurse decide, thus giving the nurse control. It may be inferred from the patient's behaviour that the patient had perceived that the nurse was more knowledgeable and had, therefore, allowed the nurse to decide after she had sought information about the wound from the nurse.

Avis (1994) found in his study that patients demonstrated that they were self-conscious about their lack of knowledge regarding their medical condition and hospital routine. Thus, patients were willing to transfer the decision making responsibility to doctors and nurses because of this perceived imbalance in knowledge (p. 295). The patients in Avis's (1994) study also believed that health professionals worked to their own set agenda, about which patients felt they knew nothing. To this end, they believed that they were the health professional's "work object", as previously mentioned, and were prepared to be directed. Avis (1994, p. 295), however, cautioned that patients adopting the "work object" role could simply be attributed to them trying to maintain integrity and dignity in the face of an unequal relationship. In other words, patients take on a passive role out of a perceived need. This is congruent with the views of Irurita (1996a), whose Western Australian study revealed that the drive for patients to preserve their integrity and dignity as human beings was so strong that some patients were willing to allow nurses to take control even when they wished to be involved. Some patients in this study stated:

*Nurses know more ... the patient doesn't know the treatment or what is happening ... The nurse is just there for the treatment and she must tell you what to do ... she knows what is necessary for you to get well, so you cooperate and follow hospital routine. The nurse certainly has more power, you are basically in hospital to get things fixed so you let the nurse take the lead, especially when you feel so sick (patient 32).*

Some patients in this study were concerned that they may make the wrong decisions, which could be detrimental to their recovery and subsequent health. Therefore, they were willing to let nurses and doctors make medical decisions for them. This is supported by Biley (1989, p. 23) who challenged health professionals, claiming that, perhaps, patients preferred to assume a passive role regarding their treatments because of the fear of making the wrong decision and not because they preferred to be passive recipients of care. The author also argued that patients thus were likely to be content in allowing nurses to adopt a largely directive role and be under some element of control (Biley, 1992, p. 23).

It was also shown in the data that some patients, in this study, were of the belief that nursing care should be totally in the hands of the nurses. As such, patients believed that care should be exclusively nurse driven without any involvement from them. These patients believed that all aspects of their care should be initiated by the nurses and thus expected to follow orders. It was interesting to observe that these patients were reluctant to make even simple decisions such as whether they should go and have a shower or not without the nurses first telling them to do so. These patients were observed to take on the sick role as stipulated by Parsons (1951) and expected nurses to do things for them and to them.

*When you are sick or had surgery, I think it is the nurse's job to do things for you ... that is what a nurse is there for ... to make decisions and to decide when you need this done and that done and when you need a shower because I don't know the medical routine. I think it is up to the nurse to take control of the situation and initiate things by saying "you need to do this or you need to do that" ... I believe that is the nurse's job (patient 1).*

*Nursing care, well, my view is that nurses are there to care for you, to monitor you and to do things for you. In hospital, I know nurses have certain things to get through in a certain order and you wait for them to tell you what to do (patient 23).*

Other patients with the philosophy that care should be nurse driven perceived that nurses should be in control of patients because they believed that the hospital environment was familiar to nurses and not to them. This belief was supported by some nurses who stated:

*I think the nurses are definitely the most powerful to have a say because we are in our own environment and we are in control and we know exactly what is going on whereas the patients don't, so we are at a definite advantage (nurse 14).*

The patients stated that the unfamiliar hospital environment was bound to result in uncertainty for them with regards to what to expect in terms of their recovery. Therefore, they believed that the care that they received should be dictated by the nurses. They also believed that hospitalisation meant fitting in with the ward routine and rules.

*To be cared for by the nurse is what I believe nursing is all about. I wouldn't be needing hospitalisation if I didn't need to be taken care of ... also I am in their turf, so I expect them to tell me what to do, like if they came to my area of work I expect to tell them what to do ... no, I am happy just to lay down and have them [nurses] care for me (patient 4).*

It may be appropriate to suggest that some of these patients believed that nurses were there to do things for them because they perceived that they were sick and therefore needed looking after. Some patients believed that they must be sick if they were in hospital and therefore expected nurses to do things for them even if they were capable, as highlighted by this nurse's comment:

*Some patients who are hospitalised very much take on the role of being sick and they [patients] see you as being there to do things for them rather than you know, to make them better (nurse 11).*

A few patients, who were private health subscribers, were of the view that since they were paying for their hospitalisation they expected nurses to do everything for them, regardless of whether they were capable or not.

*I am paying for a private room and care, so I expect them [nurses] to do everything for me ... I don't think patients should take responsibility for their own care ... my view is that nurses really should care for patients ... that is what the nurses are here for! (patient 7).*

*I go in there and I expect to be looked after very well ... I expect everything around me to be clean and neat and things done for me ... I am in HBF [Hospital Benefit Fund] and in a way I am paying for the nurses' service, so I believe nurses should know what they are doing and tell you what to do so you can recover (patient 1).*

Some patients held the philosophy that nursing care was entirely nurse driven because they believed that nurses do not wish or expect them to have a say in the care that they received. Their philosophy was based on the premise that it was not their place to interfere with the nurses' work and be "difficult" patients. Consequently, these patients were observed to take cues from the nurses and did as they were told in all aspects of their care. These patients believed that nurses expected them to be "good patients" and as such they waited for nurses to tell them what to do. For instance:

*My belief is that I should be a good patient and not cause any problems for anybody. So I expect to do exactly as I have been told to do by everybody in the hospital so I will get better ... I think it is up to the nurses to tell you what to do, that's my view anyway (patient 4).*

*I think, just try and be a good patient, try and abide by the hospital rules and what the nurses want you to do, not to be difficult ... I suppose to listen to their advise, that's my point of view (patient 32).*

The patients with the above philosophy were observed to encounter problems often when they were cared for by nurses with a different philosophy than their own. Some of the nurses perceived these patients as being “difficult” or “bad patients” because of their stance of not wanting to do anything for themselves. This was contrary to what the patients were trying to achieve.

*Small things that they [patients] are capable of doing, they will wait for the nurse to do, even though you know that they can do it ... like the bottle is just next to them but they will ring the bell and they [patients] want the nurse to put it in place for them which is bloody annoying (nurse 9).*

Yet, other nurses were observed to be successful in getting patients to have some input into their own care, hence changing the patients' behaviour. The process that patients and nurses used to deal with the problem of “*incongruence*” in the philosophical beliefs about care and in the conceptual understanding of the meaning of patient participation will be addressed in chapter five.

### **Factors Causing *Incongruence* in the Conceptual Understanding of the Meaning of Patient Participation and in the Philosophy about Nursing Care**

The enactment and promotion of patient participation seemed to be linked to the conceptual understanding of participation and the philosophical stance that nurses and patients took about nursing practice. As previously explained, the conceptual understanding and philosophy were interrelated for patients. However, for some nurses, their understanding of the meaning of patient participation did not always

influence their beliefs. This, intertwined with the hospital contextual conditions in which care was provided and the varying intervening conditions within the hospital system, influenced the phenomenon of patients participating in their own care. In this section, the causal factors of *incongruence* in the conceptual understanding of the meaning of patient participation and in the philosophy about care will be discussed separately for nurses and patients. This was considered to be appropriate as the nurses in this study had been schooled through formal education about holistic care and how nursing care ought to be operationalised and delivered, that is, the idealistic way of providing care. This was different for patients in the study who had not had this formal education. Nursing students, for example, entered nursing programs with their own beliefs and values. However, these beliefs and values may have been changed and expanded in the process of their education, in order to fit in with professional nursing norms (Eddy, Elfrink, Weis, & Schank, 1994). Patients, on the other hand, tended to be somewhat blurred in their perceptions of the understanding and philosophy which were found, in the data, to be based on experiential knowledge and culture to some extent. Their perceptions also appeared to be shaped by information on the phenomenon of participation in the media, what they had learned from other people's experiences, and their own experiences. Therefore, it was likely that the causal factors would be different for nurses and patients. There was also a clear delineation between philosophy and conceptual understanding for nurses because nurses' understandings were found to not necessarily shape their beliefs in all cases. Patients, on the other hand, largely only had their experiential knowledge to base their comments upon. Thus, for nurses, the causal factors of *incongruence* in the conceptual understanding and philosophy will be discussed separately. For the patients, both areas of *incongruence* will be discussed together as the causal factors appeared to overlap. The researcher was mindful, however, that for patients, their understandings of the meaning of participation appeared to be shaped by their beliefs about nursing care.

### **Factors Causing *Incongruence* in Nurses' Conceptual Understanding of the Meaning of Patient Participation**

When nurses came to the bedside, they came with their own internalised conceptual understanding of the meaning of patient participation. However, nurses'

understandings did not seem to influence some nurses' beliefs about nursing care, which seemed to be the driving force regarding how they provided care in the practice setting. Nurses' attitudes, values, and beliefs which shaped their philosophy appeared to be a strong determinant of the extent to which they internalised the understanding of the meaning of patient participation. Therefore, if nurses believed that they should involve patients in all aspects of care, they were observed to internalise the meaning of participation to be all encompassing, and endeavoured to provide care accordingly. This was demonstrated by some nurses in this study. However, some other nurses were observed to be unable to involve patients in all aspects of their care, even though they were able to state the ideal meaning of patient participation. Yet, other nurses were not able to internalise the ideal meaning of patient participation because of factors that will be described later.

Analysis showed that the nurses' conceptual understanding of the meaning of participation appeared to only stem from their acquired knowledge through education and experience in the practice setting. There was evidence in the data that the learned knowledge that some of these nurses brought to the clinical setting, previously as students, was not always accepted as relevant by practising nurses. This indicated that they had experienced a theory-practice gap. Thus, some nurses tended to construe their learned knowledge as purely theoretical with little or no practical relevance because they were not able to transfer learned knowledge, as students, into practice.

### **Inadequate transference of educational knowledge into practice**

Most of the nurses interviewed in this study had a university degree in nursing. It is reasonable to extrapolate that these nurses should have been formally exposed to the notion of providing holistic care, which has as one of its tenets the concept of patients completely participating in all aspects of their care (Bond & Thomas, 1992; Pyne, 1994; Waterworth & Luker, 1990). Examination of nursing education curricula documents indicated that nursing students were taught that patient participation is all encompassing from patients taking an active role in activities of daily living to making decisions about their treatment plans (Cody, 1990; Schober, 1994; School of Nursing, 1997). Despite this knowledge, nurses stated varying degrees of



understanding of the meaning of patient participation contrary to that which they had been taught. From the analysis, it may be suggested that the perpetuation of task-oriented nursing, termed in the data as “utilitarian nursing”, may have been responsible for this dichotomy. Utilitarian nursing was further defined from the data as nursing that addressed the pragmatic aspects of care, which mainly encompassed completing a series of tangible tasks.

### **Utilitarian nursing**

Data analysis indicated that nurses whose philosophical beliefs included patients participating in all aspects of their care, were not always able to operationalise and apply learned knowledge into the practical setting. Some nurses stated that, even though they had been taught about holistic care, they were not able to internalise this concept and apply it because of the perceived expectation of completing tasks in the practice setting.

*Most of the interaction with patients is task-oriented ... all this holism and things ... people have all these wonderful words that mean nothing in the real sense ... no, it's all tasks (nurse 14).*

*The utilitarian aspect of nursing takes up so much of our day that caring and consideration for the patient as someone with their own views and dealing with the educational issues that are so necessary for patients to be involved is grossly neglected (nurse 28).*

*I like to believe that I involve my patients in their care but all I seem to be able to do is do what is medically necessary ... yes, basically do all the things that the doctor wants done ... I just feel as a technician at the moment because you are just doing a job, it is very task-oriented (Nurse 20).*

The nurses stated that, even as students, they were mainly concerned with becoming competent in doing tasks and had little opportunity or had not thought about reflecting on this concept of holistic care. Inherent in the principles of holistic care is the notion of providing not only psychosocial care in addition to physical care but also providing relevant education and information to patients. This is intended to facilitate patients to become involved in all aspects of their care. As the practice

setting was predominantly oriented towards completion of tasks, priority was not given to providing holistic care. Therefore, in essence, some of these nurses had not experienced the application of holistic care and, because they had not experienced it, they had not internalised it. There was also evidence in the data that some nurses were not socialised into the salience of holistic care in the practice setting. Therefore, they had not incorporated the principles of holistic care in their conceptual understanding of the meaning of participation, for example:

*We are not socialised into recognising the importance of interacting with patients and involving them in their own care as part and parcel of holistic care that we learn at uni [university] ... we are socialised into doing things to patients ... we don't have role models or mentors (nurse 30).*

The statement above also alluded to the situation where nurses did not always encounter other nurses who practised holistic care in the clinical setting. This had resulted in the absence of a reference group of nurses who promoted holistic care, whom neophyte registered nurses and students alike could use as role models or mentors. According to Meleis (1975), professional reference groups are essential in the practice setting if student nurses are to embrace learned concepts and gain role clarity. Other studies (Chapman, 1997; Kelly, 1993; Macleod-Clark et al., 1997) support Meleis's view, claiming that student nurses often found their learning experiences in the practice setting related to procedural tasks rather than providing holistic care. Kelly (1993) found in her study that neophyte nurses and students readily succumbed to the pressures of compromise in the ward areas because of their perceived lack of self-confidence and the need to survive. This in turn sometimes led them to deviate from what they had learned about care at university to favouring what was being practised on the wards (Kelly, 1993). The findings of Chapman's (1997) Western Australian study on student nurses clinical experience concur with those of Kelly and suggested that students often faced dichotomy between holistic care that they were taught and task-oriented care practiced on the wards. Therefore, even though, some nurses' philosophical beliefs might urge them to provide holistic care, they were not able to utilise their understanding of patient participation as being all encompassing and provide care accordingly.

According to Clare, Longson, Glover, Schubert, and Hofmeyer (1996, p. 171), new graduates often had to sacrifice their learned beliefs about what constituted excellence in nursing care to task management in the practice setting. This is supported by Australian and New Zealand studies which found that many graduates faced conflict between their professional ideals of holistic care and having to accept nursing as task management (Ambler, 1995; Clare, 1991; Hemmings, 1993; Horsburgh 1989; McArthur, Brooke, & Bruni, 1981; Moorehouse, 1992). Dale (1994) suggested that nursing students come to the practice setting with factual and practical knowledge but that they lack development in experiential knowledge relevant to the contextual meaning of practice.

Some nurses conceptualised participation as patients being involved in their hygiene needs because this involved tangible tasks. The aspect of decision making was not tangible according to some nurses because, as students, they had not been exposed to the situation of patients making decisions about their treatments or pain control. Hence, to these nurses, patient participation meant patients taking part in their activities of daily living and nothing more. It was interesting to note from the data analysis that some nurses' terms of reference for patient participation concepts were very much related to what they were exposed to as students. For example, the nurses who espoused the meaning of participation to be patients being involved only in meeting their own activities of daily living made comments, such as:

*All we did as students was to make sure that we were competent in the practical skills, so you ran around getting as much experience as you could ... you become so task-oriented and after a while you begin to believe that when you let your patients take control of their hygiene and activities of daily living needs, they are participating ... holistic care, well, it's not really practical ... it's like out of sight, out of mind (nurse 26).*

*I know, we were taught to include patients in all areas of care and it is their right but after being on the wards, all you think about is getting the work done that you have to do before you finish your shift ... so we don't think about patient decision making in a big way and I guess over time you forget about it ... also this tends to be reinforced by other nurses and becomes accepted as the norm (nurse 28).*

It may be extrapolated from the comments above that for the learned concept of holistic care to be internalised, espoused, and enacted upon, there needs to be consistent application and reinforcement of it in the practice setting. There further needs to be conditions in the work environment to support the enactment of holistic care. This was further verified, during the focus group nurse interview, when some nurses had to think hard to explain to the researcher the meaning of patient participation because of the above mentioned theory-practice dichotomy. It would seem that those nurses, who as students had not consistently applied the concepts of holistic care in the practice setting, had not embraced this concept as an integral component of nursing care. Greenwood (1993, p. 1471) alluded to the notion of desensitisation of some student nurses during their professional socialisation. The author claimed that the education of nurses often led to nurses compartmentalising, in their minds, concepts for theory separate from concepts for practice. Greenwood (1993) further stated that students also were prone to habituation of examples of poor or less than ideal nursing practice as a result of repeated exposures to such practices. According to the earlier writings of several British authors (French, 1992; Kelly, 1991; Seed, 1991; Wilson & Startup, 1991), Greenwood's (1993) concerns of compartmentalisation of theory and practice concepts, mentioned above, may be prevalent in some nurse education programs in New Zealand and Australia. This compartmentalisation, which may have occurred in the classroom, together with the lack of application of the principles of holistic care in the practice setting, thus, may be suggested to have caused the "*incongruence*" in the conceptual understanding of the meaning of patient participation held by nurses in this study.

A few nurses, however, were able to espouse and demonstrate holistic care, which encompassed involving patients in all aspects of their care. Some of these nurses stated that they had made every effort to apply the concepts of holistic care, even as students, because they believed that all patients had a right to participate in their own care and that they had been given the opportunity to apply their learned knowledge in the practice setting. This reinforces earlier statements that nurses' philosophical beliefs had to be such that they would want to operationalise their understanding of patient participation, such as allowing patients to be involved in all aspects of their care.

*I have always committed myself to giving holistic care to the patient ... to incorporate the whole aspect because I think if you don't give holistic care, then the patient isn't possibly taking a role to be fully involved which is their right, otherwise they are just taking a back seat, which to me is not what care is about ... I was really lucky, I had a good tutor who taught us to involve the patients at all levels of care and she [clinical tutor] used to get us to tell her how we incorporated the patient's input in the tutorials and this is one of the things I remembered (nurse 3).*

Other nurses commented that they persisted in providing patient-centred care because they understood that patients should be involved in all aspects of their care, despite the ethos of some practice settings promoting task-oriented or utilitarian nursing. These nurses claimed that, as students, they had worked with nurses who did not subscribe to the concept of involving patients in all aspects of their care, and who had subsequently attempted to indoctrinate them.

*It is surprising how many nurses have different views about patient participation, but I guess I have changed my views over the years because, as a student, I used to get told that patients were people whom we did things to and they were basically here to take whatever they were given ... you know it is so easy to follow suit but I stuck it out (nurse 30).*

*I have been uni [university] trained and when I was on the wards, I have come across nurses who are so ritualised and routinised and will always put tasks and routine first before the patient or what they want, arresting patient involvement ... but I aim to give patients choices and to be involved and it is tiring sometimes because not all nurses are the same and the patient gets confused ... it is really up to the nurse, it is too easy to fall in line with the ward routine and forget about the patient's needs ... it is only through practice that you get into the habit of consciously thinking about total patient input (nurse 6)*

On the other hand, some nurses had been exposed as students to clinical agencies that had used, for example, Orem's self-care model as their basis for practice. Thus, they had continued to use this model once qualified. The tenet of Orem's model is that patients should be encouraged to be self-caring in all aspects of their care, as able, and which has as its main thrust patient participation and independence as the goal of intervention (Marriner-Tomey, 1994).

*I have been on a ward that used Orem's model of care where we encouraged self-care and the staff tended to use the model, even if it was modified a bit ... we all aimed to get the patient from day one post op [operation] when there is a degree of reliance on the nursing staff to three days post op when they [patients] are pretty well self-caring and independent ... a lot easier if everyone is on the same wave length (nurse 3).*

The above nurses stated that once qualified they continued to use Orem's model because that was what they were used to as students, during their final clinical rotation whilst at university.

*I base my care on Orem's self-care nursing theory so I encourage them [patients] to be involved in their own care as much as possible ... I let them know what's happening and say things like, "what would you like me to do?. Do you feel capable of doing whatever and give them options (nurse 3).*

In summary, it would seem that the majority of nurses were unable to successfully transfer learned knowledge of allowing patients to participate in all aspects of their care, if able, into the practice setting. The main reason for this seemed to be attributed to the lack of promotion of patient-centred care by some practising nurses and the perpetuation of task-oriented or utilitarian nursing in the practice setting. It would also seem that some nurses, as students, had not actively reflected on what they had been taught as a consequence of being directed by some practising nurses to focus on tasks. The other problem that faced these nurses, as suggested by Greenwood (1993), could be the possibility that these nurses, as students, had compartmentalised theory and practice concepts as separate issues. Even though this compartmentalisation was not made explicit in the nurses' comments, there is nevertheless a subtle indication in the comments that is suggestive of compartmentalisation. This, coupled with the above mentioned reasons, could be said to have resulted in *incongruence* in the conceptualisation of patient participation by nurses.

### **Factors Causing *Incongruence* in Nurses' Philosophy about Nursing Care**

Philosophy, as stated earlier, deals with attitudes, values, and beliefs that govern behaviour. As already explained, in this study, the philosophy that nurses held were

observed to be instrumental in the extent to which nurses operationalised and enacted their understandings of the meaning of patient participation, regardless of how they internalised the meaning. Nursing has as its philosophy the notion that patients should become active in decision making and abandon their passive role in treatment and care (Macleod-Clark & Latter, 1990; Royal College of Nursing, 1994). Inherent in the philosophy is the concept of patient participation where nurses are encouraged to give patients the opportunity to be fully involved in their own care (James & Biley, 1989). Empowering patients and allowing and encouraging them to take an active role in their care has been stated as a desired outcome in the philosophy of the nursing profession (Pyne, 1994). According to Appleton (1993), the philosophy of nursing becomes apparent to students through attentive reflection upon their learned knowledge. Nurses are taught that patients are persons of dignity, worth, and integrity and that they should be central to the care being given, that is, the patient should be consulted in every aspect of their care (Appleton, 1993). Despite the above philosophy sanctioned by the nursing profession and taught to students, it was apparent in this study that nurses differed in their philosophies about care. For example, some nurses believed that care should be mutually driven by nurses and patients. Others believed that care should be nurse driven with input from patients only in certain areas, with some nurses believing that care should be completely under their control with no input from patients. This brought into question whether the values taught to students were in reality embraced and enacted by them once qualified (Eddy et al., 1994, p. 257). Data analysis revealed that the causes for the *incongruence* in the philosophy about care in these nurses were mainly related to their attitudes about caring and the influences of role models they encountered in the clinical setting as well as their understanding of the meaning of patient participation.

### **Nurses' attitudes about caring**

The Oxford English Dictionary defines attitude as "an opinion, a way of thinking and behaving, or a viewpoint about something". In this study, nurses' attitudes about caring seemed to influence their beliefs about care. An extension of this attitude to caring included being able to trust patients' capabilities and reinstating the power back to patients.

*You know, it all depends on trust. Well, they [patients] can only participate as much as able in their own care ... you must learn to trust your patients ... like if I decided that my patient can do something for themselves, I trust them and let them do it ... I suppose it's all this fear of, "what if the patient doesn't do it properly?". I don't know, I think some nurses think that if they didn't do something themselves, then it won't be done properly (nurse 22).*

In nursing, caring which involves an activities, as well as an attitudinal, aspect has been considered as an essential component of the therapeutic relationship with patients, according to Olsen (1991). Through caring, nurses are supposed to vicariously experience the feelings and perceptions of patients and to become immersed in patients' viewpoints (Olsen, 1991). The author further claimed that nurses need to engage in self-awareness and actively reflect upon their actions if they are to fulfil their role as caring professionals. According to Griffin (1983), the activities aspect of caring involves nurses' perceptions and judgements about patients' needs at a given time, which predominantly includes completing technical tasks. This, for most nurses, is easily achieved as was demonstrated in this study. The attitudinal aspect of caring relates to moral judgement, which involves respecting the dignity and autonomy of patients even if their autonomy is temporarily relinquished due to illness. It is through this attitudinal aspect that nurses are able to assist patients to do as much as possible for themselves and to maintain their dignity and individuality. This attitudinal aspect, as Griffin (1983) states, is more difficult for nurses to achieve. In this study, whilst most nurses were able to maintain patients' dignity, only a few nurses demonstrated that they were able to give patients autonomy with regards to them participating in their own care.

*With some nurses, the patient doesn't get a chance but I am not like that ... for me, it's a two way thing ... I build rapport and even though I feel that I still have authority, I will encourage working together, by them [patients] actively participating and having their point of view because that is part of caring (nurse 6).*

*Nursing is caring ... the whole part is everything ... like it's me, them [patients], the wound, the op [operation], the BP [blood pressure], whatever, the problem is, it's that person as well and I consider the patient's feelings as important (nurse 7).*



Analysis of the data showed that most of the nurses in this study had no difficulties in completing technical tasks on patients, that is, doing things to patients. They perceived this to be their role as, in their perception, they considered completing tasks as essential to patients' treatments and subsequent recovery. Therefore, these nurses equated doing things to patients with part of their caring role. Some nurses also believed that patients were not knowledgeable in procedures and technical tasks, hence they were of the view that patients were not capable of participating in these procedures and tasks. As a result, some nurses translated the philosophy of nursing that they had been taught as doing things to patients in the practice setting. For example:

*I suppose they [patients] have all these things to be done, drips and drains and so forth ... we have to do them so they can get better, it's all part of the treatment ... so nursing to me is making sure everything is done properly and on time ... I know that we are supposed to treat patients as individuals and to empower them but we don't do that you know ... we are impatient and we have this idea that we are here to do things to patients; that we are here to fix things and we know best (nurse 18).*

When nurses were questioned about the idea of doing things to patients, some stated that they felt that they were not nursing and caring unless they did things to patients. This was experienced to the extent that they disliked looking after patients who had no procedures or technical tasks to be done to them. This was particularly true with elderly patients who were admitted for chronic medical conditions.

*I like a bit of a challenge, that's terrible ... but I prefer patients who have lots wrong with them so that they have all these gadgets and things to be done, even new medications that I have not used before ... it gives me something to learn as I am doing ... I know it is a terrible thing to say but I like to learn these things ... these sorts of patients provide a good learning experience so I can improve as a nurse (nurse 10).*

*As a student, I hated going to wards, especially medical, where patients didn't have much things to be done to them except basic hygiene care ... I missed out on practising some of the skills that I learned and it was so boring ... I couldn't wait to get to semester five where we were able to do lots of things like give IV AB'S [antibiotics] to patients ... you see, you want to feel responsible for them [patients] getting better and that gives me job satisfaction (nurse 17).*

It may be an appropriate assumption to make from the nurses' statements above that some nurses perceived that they were caring if they, through doing things to patients, believed that they had affected the patient's recovery because they were doing the best for patients. These nurses perceived that there was a correlation between what they did to patients and the patients getting better. Nevertheless, other nurses perceived that doing things to patients extended their own learning and knowledge base which, in turn made them better care-givers. Subsequently, over time some of these nurses' philosophy of nursing became entrenched with doing things to patients with limited input from patients. Some nurses in this study, therefore, appeared to be concerned with curing patients as opposed to caring for them, for example,

*I enjoy nursing surgical patients, they get better faster and bounce back fast, especially after all the effort you put in looking after them with all the gadgets etcetera. With medical patients, you can't do much, they are always coming back or die anyway (nurse 24).*

This was supported in a recent New South Wales survey that showed that nursing students preferred to work in high technology areas where the emphasis was on cure rather than looking after elderly patients, which involved little technology and no cure (Stevens, 1997, p. 5).

A few nurses also believed that caring involved doing technical things to patients because this made them feel needed. They stated that being needed gave them a sense of worth and power over their patient.

*I like having work to do for them [patients] rather than them working with me because if they do that, then they don't need me ... you see if they don't need me then they don't need care like drips and drains, you are redundant like (nurse 27).*

One could assume from this comment that some nurses equated monitoring equipment with caring for patients. These nurses seemed to perceive that they were not caring unless they were able to provide technical care. One patient's comment reflects this assumption:

*I was in a single room and was quite sick with lots of lines and drips. The nurses would only come in when the machines' alarms went. They [nurses] seemed so conscientious about accuracy and everything going through on time ... however, when I rang the bell for something, they would not come readily ... it's ten or fifteen minutes before they would come ... I wish nurses would go back in time to a more caring type of approach and possibly give more involved care (patient 31).*

Some nurses perceived that they did not have any power or authority where doctors were concerned. They did, however, believe that they could have control over the patients by doing things to them and by not inviting any input from them. Therefore, their philosophy of nursing was for patients to do as they were told with the nurse clearly in the “drivers seat”.

*I suppose on the whole a lot of nurses are almost a bossy breed ... we have quite a few of the staff with that attitude, I suppose we want them [patients] to succumb to whatever we want them to do and we use terminology that they don't understand, that is alien to them (nurse 31).*

The following field notes demonstrate some nurses' views that they did not have the power or authority that doctors were perceived to enjoy.

*It was late afternoon when one of the patients complained to the nurse that she was in pain. The patient had just returned from a complex procedure in theatre. The nurse checked the medication chart and said to the patient, “You are written up for something but I think you could do with something else for the pain, I'll go and check with the doctor”. The nurse turned to me [researcher] and said, “I am concerned that what he [doctor] has written up is not going to help the pain much, so I'd better ring”. When the nurse rang the ward doctor, he told her that that she was only to give the patient the medication she was written up. The nurse gave the patient the ordered medication, which did not have any analgesic properties. Later that evening, the nurse rang the doctor on call, again asking whether she could give the patient, who was still complaining of pain, an analgesic. The doctor told the nurse to give the analgesic that he would write up later and reprimanded the nurse for waiting so long before requesting the analgesic. The nurse explained, “the question I got asked was, ‘why didn't I give it in the first place?’. So it was turned around to be my fault that the analgesic medication wasn't given ... I wanted to give it but the doctor refused, our hands are tied sometimes ... autonomy without power to do much” (field notes).*

Some nurses' perception that they needed to have control over the patients, coupled with their perception that they do not have control over the doctors, seemed to have shaped their philosophy of nursing to exclude patients participating in their own care. Riemen (1986a) provides some explanations to the above by stating that nurses often see themselves as not being valued by doctors and administrators. The nurses in return, therefore, do not value patients as unique individuals with their own opinions about care. As a result of this, the author further espouses that there is a tendency in some nurses not to actively promote patient involvement in their care.

A few nurses, however, were able to maintain patient autonomy and reinstate the power to patients. To these nurses, the philosophy of nursing meant working with patients and getting as much input from them as possible. Therefore, these nurses were able to operationalise and enact their understanding of the meaning of patient participation as involving patients in all aspects of their care. They were of the view that nurses, overall, needed to change their attitude about their caring role and consciously involve patients in their care, that is, consult with patients in all aspects of their care. Furthermore, they firmly believed that the philosophy that they were taught at university was current and relevant in contemporary nursing practice where the emphasis was on consumerism. These nurses were, therefore, determined to promote their philosophy, regardless of what the other nurses did on the wards.

*You just don't stay static ... I mean everybody should be developing and progressing all the time and not stay with what we had 20 years ago ... we should change from thinking it was the way it was and will always be ... we should move forward instead of staying static ... we should embrace patient self-care as our philosophy of care, we need to learn to let go, I don't know why we are defensive when patients take an active role like voicing their opinions (nurse 2).*

In summary, it is suggested that nurses' attitudes about their caring role is influential in their mode of delivering care at the bedside. Data analysis indicated that the majority of nurses seemed to equate providing technical care with caring and that only such care was crucial to patients' recovery. Some nurses also held the belief that unless they were completing tasks they were not needed, and were thus redundant. A

few nurses, however, were successful in fulfilling the technical and attitudinal aspect of their caring role and were observed to involve patients in their own care.

### **Influences of role models**

It was inferred from the data that the manner in which senior nurses provided care was influential in shaping some nurses', especially junior nurses', philosophy of care in the practice setting, regardless of what they had been taught. Some nurses looked upon senior nurses as role models and expected to emulate their behaviour, believing it to be the right one. As junior staff, some nurses stated that they felt uncertain about their practice and, thus, they looked to senior nurses for support and consolidation in what they had been taught. These nurses claimed that, in order to be accepted into the ward, they needed to observe and follow whatever the senior nurses did with regards to patient care. Some junior nurses explained that there was little mentoring from senior nursing staff to provide holistic care, hence they felt that the concept of holistic care was not supported. This is reflected in the following statement:

*I try from a teaching point of view for new staff to put over the point that we do offer a 24 hour service but there is peer pressure if you like that you must fulfil certain tasks so to speak, but which they [meaning senior nurses] believe ... a lot to do with tradition as well. I think we are getting away from that but there is still quite a degree of that ... I think that the university graduates feel that if they don't conform, they are failing, that they are not good enough. You only need a couple of senior nurses with this attitude for it to really seep through the whole ward basically (nurse 17).*

Other nurses, especially new graduates, claimed that there was peer pressure from some nurses to take control of the care and to tell patients what to do, whether patients were capable or not. A few of these nurses expressed concern that they had encountered such pressure from some nurses who had graduated as recently as two years ago. On observing the nurses who were putting peer pressure on the new graduates, there was evidence that they had become complacent toward the type of care that was given by senior nurses on the ward. On questioning these nurses, it was pointed out to the researcher that some senior nurses clearly did not appreciate

graduates taking more time in their care as a result of them exercising their philosophy of allowing patients to participate. The graduates claimed that they were “*brought into line*” to fit in with everyone on the ward. This was observed to occur particularly on wards where nursing staff were seen frequently to sit at the nurses’ station and chat amongst themselves. One new graduate explained that there was peer pressure to conform to the system, as exercising the philosophy of patient centred care was viewed by some senior nurses as sabotaging the ward’s established system. There was a perception in some new graduates that they would be ostracised if they did not conform.

*The nurse came up to me and she tore strips off me saying, “you haven’t showered this patient and that patient has been showered for you and this isn’t the first time it has happened”. This hurt me, the girl [nurse] was tearing strips off me because I wasn’t working to her level ... I was letting my patients choose (nurse 16).*

When asked about the background of the above nurse who had “*torn strips off*” her, she stated that the nurse was only twenty three years old and was a university graduate but “*she has the attitude of the old style like doing things to patients*”. From this comment, it was inferred that some nurses were still very much entrenched into the traditional routine and task-oriented nursing.

New graduates aligning themselves to senior nurses may be paralleled to Duffy’s (1995, p. 8) comments that highlight that nurses generally tend to internalise the norms and attitudes of the dominant group, especially the medical profession. The author espouses that in trying to emulate the dominant group’s behaviour, nurses often forfeit their own values and beliefs. An earlier Australian study by Duffy (1991) revealed that nurses believed that their practice was shaped by professional socialisation and that the continuation of traditional values by some nurses in the practice setting created conflict in nurses between traditional and non-traditional practice. The nurses in Duffy’s (1991) study clearly identified that the ward coordinators or the charge nurses, as they were referred to in the past, had the power in controlling how care would be provided.

Other nurses reiterated the peer pressure concern claiming that, in order to survive the shock of working in the real world after graduation, they were forced to abandon their philosophy of including patients in their care and resorted to task-oriented care.

Kramer's (1975, 1985) seminal work on how new nursing graduates assimilate into the work force is supportive of this situation. Although Kramer's work was completed two decades ago, her work is frequently quoted in nursing literature.

Kramer (1975, p. 19) claimed that new graduates often face discrepancies between their idealised role conceptions of care and that which are sanctioned and operating in the practice setting. One nurse commented:

*I thought when I finished uni [university], I was going to be independent and professional but you are not independent at all because there are always other staff members who would say, "we don't do that [nursing care] this way on this ward. we do it differently and while you are here, you'll do it the way we like you to do it (nurse 10).*

One nurse explained that there would be ramifications if she did not conform to the way the other nurses provided care.

*If you don't do as they [other nurses] say, they are not going to help you, they are going to turn against you and say, "well, you can do all your work on your own" ... nothing formal but bad vibes like when you have a personality clash or something ... they are less accepting of you and will "dob" you in if you miss a drug! (nurse 33).*

A few nurses, however, stated that they had worked with senior nurses who were excellent role models in that they would encourage new staff to invite input from patients in all aspects of their care. This had assisted some nurses to perpetuate their learned philosophy of providing patient-centred care. Demographic data indicated that the majority of the senior nurses who were observed to encourage patient-centred care had had at least four years or more of experience. They had also been working in the same ward area for a reasonable length of time. For example, some new graduates stated:

*In some wards, even if we are mostly busy, the nurses who are coordinating will allow us to be professional and do our own thing, so you do have the opportunity to provide holistic care where you can actively solicit patient*

*input ... these coordinators are young in their thinking which is refreshing (nurse 12).*

*In this ward, I find it a lot more professional because you have a lot of support from staff ... they don't carry on so much if things are not done to routine, so you can actually plan your care with the patient ... I guess, it all depends on the nurses who have been on the ward a long time, they set the scene for the care (nurse 25, new graduate).*

It was interesting to observe that when nurses who had previously practiced the philosophy of holistic care were sent to work on a temporary basis in another ward, where nurses did not practice holistic care, they appeared to follow the philosophy of the nurses on that ward. When questioned about this change in attitude, the nurses stated that they did not wish to be troublesome or *rock the boat*. They also explained that often they were sent to ward areas that were unfamiliar to them. They further explained that, since they had to cope with working in an unfamiliar area, they felt that they could not challenge the ward staff with their own philosophy. These nurses' aims were to get the work done and leave the ward when their shift finished.

*With the cuts and short staff we often get sent to another ward in the middle of doing something .... You are sent to help out in a ward that you have not worked in or don't know anything about that speciality ... so it is survival, you muck in and do what they [ward nurses] want you to do and leave ... it is impossible to involve patients because you have been sent to get the work done ... you go into survival mode (nurse 8).*

A few nurses talked about “horizontal violence” amongst nurses, claiming that if they did not conform to the influence of the senior nurses or nurses who have been on the ward for a long time, they were subtly punished.

*If you don't fall in with what the staff want you to do, you will know about it ... like if I want to go home a bit early for my evening class at uni [university], the coordinator would ask you to take a shorter lunch break when it is not really necessary ... especially when you don't get off on time most days ... it is “horizontal violence” if you ask me (nurse 33).*

Duffy (1995, p. 16) reported that the notion of “horizontal violence” is prevalent in the nursing literature. This has resulted in powerlessness and the behaviour attributed to oppressed groups, such as horizontal violence, is likely to be counterproductive to optimum nursing practice. When some of the nurses in this study were asked to



explain “horizontal violence”, they stated that it was very difficult to describe it because of the way it was manifested, such as:

*Well, I don't think it is necessarily demonstrated to the person ... the person gets stroppy with you later on and it certainly transfers through to other nurses ... bitching behind your back sort of thing and not wanting to help you (nurse 10).*

A few nurses in this study stated that they had stood their ground and practiced their learned philosophy. However, this was not without stress to themselves.

*When I first came out, I was idealistic and had a lot of energy and I used to consider the patient all the time and give care as I was taught at university, and it is a battle at times because not all the nurses on the wards are like you ... after a while, you switch off and become jaded and do as the rest [other nurses] ... too hard, too much stress (nurse 26).*

In summary, it was interpreted in the data that role modelling and peer pressure had an effect on whether nurses were able to practice according to their philosophy and their understandings of the meaning of patient participation. There was evidence of positive and negative role modelling that nurses encountered, which either facilitated or inhibited them from operationalising and applying their philosophy and understandings of patient participation in the practice setting.

### **Factors Causing *Incongruence* in Patients' Conceptual Understanding of the Meaning of Participation and in the Philosophy about Nursing Care**

As already mentioned, the factors causing *incongruence* in the conceptual understanding of the meaning of participation and in the philosophy about care will be discussed concurrently for patients, for reasons previously stated. Patients' varying previous knowledge and experience of hospitalisation, to a great extent, appeared to have contributed to the *incongruence* in both areas. This related to the number and characteristic of each hospitalisation, the type of surgery or medical condition for which they were admitted, and their previous experience with nursing staff. It was evident in the data that other causal factors of *incongruence* in both areas included the desire to be good patients and attitudes regarding self-care. Patients' attitudes on

self-care appeared to be related to the level of knowledge about their medical condition, their home life, their culture, experience of hospitalisation, age, and information about hospitals from friends, relatives, and the media.

### **Previous knowledge and experience of hospitalisation**

The number of previous hospital experiences varied with patients. For some patients in the study, this was their first hospital experience whilst for others it ranged from their second experience to their fortieth experience. Data analysis revealed that patients' previous experiences appeared to have influenced their conceptual understanding of the meaning of participation and their philosophy about care. For some patients, the experiences they had encountered previously in hospital with regards to their input into their own care and the nursing staffs' approach to their care, seemed to have shaped their understanding and beliefs. If they had been exposed to encouragement from nurses to fully participate in previous hospitalisations, patients perceived that they should have input into all aspects of their care during the current hospitalisations and expected to do so, provided they were well enough. A few patients explained:

*From my own personal point of view I really haven't had much need to complain ... I've always had good care when I have been in hospital ... I never really had a lot of need to feel that my rights have been violated when I have stood up for how I wished things to be done ... the nurses were pretty well supportive and always encouraged me to ask questions if I am not sure and would ask me how I felt about something before doing it (patient 22).*

*When I was in hospital X, the nurses were the same as here ... they would come into the room and ask if there was anything I needed, when I would like the dressing done or when I would like my shower and if I want some help ... the nurses seem to take the cue from me and worked with me ... so I always feel a lot of respect for the nurses ... it's as if they are giving you permission to have a say (patient 6)*

One patient who had been in hospital forty times stated that she was afraid of speaking up and participating in her own care. The patient stated that nurses were generally authoritative and expected patients to do as they were told. This patient

quoted several incidences in various hospitals that substantiated this perception. For example:

*Well, I found from experience that the less you say the better until you are ready to leave because if you make a complaint, which I have done in other hospitals, it goes through the floor [meaning ward] like wild fire and everybody sort of is wary of you, they [nurses] won't come anywhere near you even when you press the bell ... so I found, wait until you are being discharged before you say anything (patient 7).*

The above patient further confirmed that, over the years, she had seen what had happened to other patients if they had voiced their opinions. The patient stated that she had witnessed several times, during her various hospitalisation, that when patients had spoken up about their treatments or care, the nursing staff had kept away from them. She reiterated one incident where she had observed a patient soiling the bed because the nurse took her time in bringing the patient the bedpan. A few other patients supported the above patient's concerns and did as they were asked by the nurses because they too had been previously exposed to care that was nurse-driven and were afraid to compromise their care by demanding an input.

*They [nurses] helped me to walk and sat me in the shower and she [the nurse] said "when you are finished here's the bell ... ring the bell" and I did. I kept ringing and ringing and nobody came (patient 8).*

*The nurse brought my medication and when I queried it with regards to the number of pills, the nurse kept insisting that I was being given the right number. I know my pills and I didn't have four. I refused to take the pills and finally the nurse checked and sure enough, he had given me an extra one. The nurse just came back and said "ah, well, I made a mistake, are you satisfied, just take three and throw the other one into the rubbish bag" (patient 23).*

*I know when I was in hospital for gall bladder and hysterectomy, um, they [nurses] sort of made me feel, "oh, don't worry me, you know ... I'll do the job and that's it" (patient 16).*

In some instances, patients had come across nurses who had tended to guide them in terms of their own care. As a result of this experience, these patients perceived that participation meant being cooperative with the nurses and taking cues from the nurses at the bedside. These patients also equated the caring role of nurses to be one which

called for nurses to be directing and instructing patients. This was mainly due to the perceived knowledge gap that patients had. Hence, when these patients came into hospital, they were prepared to allow the nurse to take the lead as highlighted by these statements:

*I have been in hospital in the past and I know that nurses are pretty good in that they always give you instructions in what they want done ... after all, you wouldn't expect anything else as they [nurses] are the experts. We don't know what the nursing staff know and nursing staff know what individual patient needs are because they [nurses] have the experience ... So I expected to look to the nurse for direction and guidance so that I don't get carried away and do something that might delay my recovery (patient 10).*

*I am an articulate person and I know what I am doing and I had researched my medical condition before the operation but I was not familiar with the medical and technical care that I may need ... so I came into hospital thinking that the doctors and nurses will be instructing me in what I should do to get better ... like they did when I have been in hospital before (patient 21).*

It was noted in the data that the type of previous admissions, that is, whether patients were admitted for medical conditions or for surgical interventions, may have influenced the manner in which patients conceptualised the meaning of participation. The type of admissions also appeared to shape patients' own philosophies of care. For example, some of the patients who were previously admitted for medical conditions had experienced confinement to bed rest. Consequently, these patients had experienced nurses completely caring for them such as sponging them in bed, assisting them with meals, and helping them with toileting. When these patients were able to ambulate, they were discharged, leaving them to believe that nursing care was nurse-driven with nurses administering to them. These patients also perceived that they had participated in their care by cooperating with the nurses.

*When I was in hospital with a massive stroke a few years back, the nurses were very good ... they were very attentive and did everything for me ... they would also explain everything before doing it ... I was really grateful and even when I was getting better, they [nurses] helped me with the shower on the commode chair and I know that I should listen to them [nurses] and do as they instruct me (patient 1).*

Other patients who had previous admissions for surgery had experienced nurses attending to their needs in the immediate post operative period but expecting them to participate as much as possible on the second day of their surgery. The nurses had encouraged these patients to mobilise and attend to their own hygiene needs, sometimes inappropriately, as indicated earlier in this chapter. As a result, some patients' understanding of participation meant doing as much as possible, especially in the area of meeting their hygiene needs. In past instances where nurses had given options to patients with regards to their pain control, patients in subsequent hospitalisations had perceived that participation also included taking control of pain management.

*On the first day after my operation last year, the nurses were in and out of my room checking up on my condition and looking at the drip ... but on the next day, the nurse came in and asked me to go to the shower on my own... I hesitated because I didn't think I could manage ... she [nurse] looked at me and said that she would come back and help me ... I was surprised that they [nurses] expected you to get up and go so soon after the operation. I guess the nurses want you to recover quickly and leave ... this time round, as you know I went in for the gall bladder, so I figured what to expect more or less (patient 28).*

*When I was in hospital before, the nurses would come into our room in the morning and give us all towels to go for the shower ... I would ask the nurse for a bit of morphine before I went ...I didn't mind getting out of bed so soon after the operation but I wanted something for the pain first and they [nurses] gave it to me ... you see I had been on a morphine drip and they had removed it. At least the nurses gave me the pain killer before the shower for which I was grateful ... only thing was that the nurse had to be nearby in case something happened ... after a few days, they would only give me panadol which I didn't mind ...so in a way, I kind of knew what I was supposed to do in hospital and what I could ask (patient 23).*

In summary, it was interpreted from the above comments that some patients' current understanding of the meaning of participation and their philosophy about care was influenced by the care that they had received previously and the type of condition for which they were admitted. There was also evidence that the type of encounter that patients had had with nurses, with regards to the extent that nurses promoted or inhibited patient participation, had influenced their conceptual understanding and beliefs.

### **Desire to be “good” patients**

Some patients in this study were very concerned about being labelled as “difficult “ or “bad” because they equated being labelled with receiving poor quality care, as previously described. To this end, patients put in abeyance their own views, feelings, and attitudes about how their care should be delivered and went along with whatever the nurses wanted them to do. This was evident when stated views by some of these patients during interviews about their care did not match with their observed behaviours. For example, some patients stated that they believed that they should have input into their own care but were not observed to exercise this belief when confronted by the nurses. When asked to explain, some patients claimed that it was better to modify their beliefs and to go along with the nurses’ beliefs about care rather than to risk receiving poor quality care. Therefore, to be perceived by nurses as “good” patients was paramount for these patients.

*I did not want to take the risk of upsetting the nurses and worry about poor care from the nurses if I upset them (patient 24).*

*Nurses run the place [ward] and they control the whole show so you be a good patient ... you don't call on their time too much and don't ring the bell too often .. you must learn to stagger requests so they [nurses] will tell you that you are a good patient. I want proper care so I behave myself (patient 29).*

With the above patients, their philosophy of nurse driven care seemed to stem from their desire to be “good patients” for the nurses. This was supported by Irurita (1993) whose study revealed that some patients felt an obligation to be “good patients”, which was defined as patients not complaining or demanding and doing as they were told. Another study by Waterworth and Luker (1990) showed that some patients believed that they had to behave in a certain manner whilst in hospital and that meant that they had to let the nurse make decisions for them in all aspects of their care. The authors further explained that as far as some patients were concerned, obeying the rules was important because patients wanted nurses to form the right impression. Hence, they went along with whatever the nurses wanted, placing a lot of responsibility on to the nurses (Waterworth & Luker, 1990, p. 974).

It was observed also that some patients were even prepared to defend nurses' unsatisfactory care, claiming overwork, the hospital administration, lack of staff, and inadequate pay as excuses for the nurses' behaviours. These nurses' unsatisfactory behaviours, which one patient termed as "misdemeanours", were therefore accepted by some patients as normal and part of being human. Nurses' behaviours which were found to be unsatisfactory by patients, included nurses not responding to call bells, not offering assistance in activities of daily living when required, and not providing pain relief on time. As already mentioned, some patients were prepared to overlook these unsatisfactory behaviours and stated:

*I am a diabetic on insulin but for the first two days in hospital, I got the wrong meal. I asked the nurses to sort it out but it wasn't until the fourth day that I got the right meal after speaking to the food supervisor myself. I had to chase up the right food when I shouldn't have to ... I suppose the nurses are busy doing other more important things than to worry about my food (patient 5).*

*I was taken to the shower and the nurse had told me that she would come and wash my back for me and help me get dressed but she never came ... I rang the bell but no one came ... in the end, I managed to dry myself somewhat and shuffled back to bed ... I think sometimes the nursing profession is fed up themselves because there are not enough staff (patient 6)*

These above patient statements are similar to views expressed by patients in Irurita's (1993) study, which showed that some patients were hesitant to criticise unsatisfactory care from nurses because they too wanted to be perceived as good patients. They also demonstrated a tendency to rationalise poor care from the nurses. Harrison and Cameron-Traub (1994), in their study of patients' perspectives on hospital nursing, also found that patients tended to blame nurses' slack behaviour on heavy workloads and the system. The above researchers further found that patients were wary of seeking assistance from the nurses because they believed that they would be wasting the nurses' valuable time, and this would create a bad impression of them to the nurses. As a result, the patients in the above studies were found to wait patiently for bedpans or pain medication instead of ringing the bell and asking the nurses. A few patients in this study, however, were genuinely concerned about being "good" patients because of their belief that nurses were doing their best to help them

to recover. This was particularly true for first time admissions. These patients expressed an unconditional trust in the medical and nursing staff to do the right thing by them. Hence, they wanted to do their part and be “good” patients so as not to hinder care that was being given. These patients were observed to follow nurses’ instructions and orders without question, such as:

*I have never been in hospital before ... as a patient you should appreciate that you are in their hands [nurse and doctors] ... virtually, you have to give yourself up to them and have confidence in their care because they know what they are doing ... otherwise you are not going to relax and if you can't relax, you won't get better ... they had to do embarrassing things to me, which can be off putting to people (patient 12).*

Some patients’ perceptions that they have to be “good”, that is, undemanding, compliant, pleasant, and appreciative, as espoused by patients in this study, is supported by Kelly and May (1982). These authors claimed that patients who do not conform to the rules and regulations, as set out by nursing staff, are in danger of being looked upon unfavourably by nurses, which may affect the type of care that they receive from them. It was suggested also by Kelly and May (1982) that nurses inherently dislike patients who are unappreciative. The authors explained that prescribed behaviours have meaning only in relation to other roles and, in this case, the role of the patient in relation to the role of the nurse. The authors further claimed that nurses’ perceptions of caring is only viable in the presence of an appreciative patient and that “nurses tend to take the role of the patient both to make, and to make sense of, their own role. In doing so, nurses label patients as ‘good’ if they confirm the nurses’ role and ‘bad’ if patients deny this legitimation” (p. 154).

In summary, it would seem that the drive on some patients’ part to be “good” patients had to some extent influenced their understanding of the meaning of participation and their philosophy about care. Some patients placed a high value on being perceived as “good” by nurses because of their belief that only “good” patients received quality care. Yet, other patients wanted to be “good” because this was their way of showing appreciation for what the nurses did for them. This was particularly true for first time admissions.



## Attitudes to self-care

From the analysis, it was extrapolated that patients' attitudes to self-care were influential in shaping their philosophy about care and their understanding of what participation meant to them. More specifically, data analysis indicated that patients' attitudes to self-care appeared to stem from what they had been used to in their home life, the level of knowledge about their medical condition, their culture, their age, previous hospital experience of nursing care, and information about hospitals from friends, relatives, and the media.

### Home life

Some patients believed that they should be self-caring as much as possible in the area of meeting their hygiene needs, if they were able. This was because they had managed this task themselves at home and expected to continue self-caring in hospital. Some patients also stated that they would be imposing on the nurses' time if they allowed nurses to do things for them that they were capable of doing themselves. These patients, however, were of the view that the nurses should assist them if they were too ill to self-care, for instance:

*I don't like having to ask, yes I don't like having to put on other people [nurses] all the time ... I like to be independent if I can and I like to handle it myself [own care] like I do at home ... I don't like to ask but I suppose sometimes you have to of course, if you are sick (patient 3).*

*You should do your own showering and things, if you are capable ... it will help you to get better quicker and the nurses can use their time doing more important things like doing dressings and giving out tablets. No, I am an independent person and like to do things for myself, unless I can't ... then only will I ask for help (patient 11).*

From the above comments, it may be inferred that patients who came into hospital with the attitude that they should be self-caring were prepared to continue with this belief and become pro-active in their own care, especially with meeting their own hygiene needs and activities of daily living. The patients' comments above were confirmed by some nurses who stated that it was common for patients who had been used to being independent at home to be enthusiastic about participating in their own

care, especially with regards to meeting their hygiene needs and activities of daily living in hospital. The nurses claimed that it was sometimes difficult for them to keep those patients who want to self-care resting in bed for medical reasons.

*Some patients are so eager to get up and go or you see them struggling to walk after major surgery and your heart goes out to these people ... yet you see others [patients] who lie there like logs and it takes a lot to get them going (nurse 14).*

*Maybe their lifestyle, maybe it is just what they have been brought up to behave like ... to be independent and nothing you can say will deter them (nurse 21).*

As indicated by the above nurses' statements, whilst some patients were keen to self-care, others were reluctant. Data analysis showed that some patients came into the hospital with the attitude that nurses were there to attend to all their needs. During interview, some patients explained that at home their spouse or partner was always there to do things for them and that they expected nurses to care for them because they were in hospital and therefore "must be sick". One patient, for instance, was observed to ask the nurses to feed her when she was quite capable of feeding herself, claiming that it was the nurses' job. This patient, who was two days post surgery, was in her forties and had an intravenous drip in her dominant hand.

*When the nurse went to answer the call bell, the patient said, "I can't eat myself [sic] and you have to help me" to which the nurse replied, "there is nothing wrong with your hands, you can feed yourself". The patient looked at the nurse and said, "that's not the point, you should cut up my food". The nurse explained to the patient that the drip was secure and that she should manage the feed herself. The nurse moved the heart table close to the patient and left (field notes).*

Later, the nurse explained to the researcher that the patient was "difficult" in the sense that she expected the nurses to do everything for her, being a private patient. The nurse also stated that the patient was used to house keepers "running after her" at home. This information had been obtained by the nurse from speaking with the patient on admission.

With regards to medications, patients who were used to self-medicating at home were observed to ask nurses if they could take control of their medications whilst in hospital. This was particularly notable with insulin administration and managing prophylactic cardiac drugs. Patients were observed to be allowed to self-administer insulin if they were well enough and if the attending nurses were pro-participatory in their attitudes. However, with cardiac drugs, hospital policy did not allow for self-administration. The patients were observed to accept the nurses' explanations about the hospital policy and allowed nurses to administer the cardiac medications. However, with mild analgesics such as panadol, some patients who were adamant about self-administration stated at interview that they had resorted to rule breaking and self-administered behind the nurses' backs. This occurred when these patients had encountered nurses who were authoritarian and were not prepared to listen to them or to provide them with adequate pain relief.

*You can ring and they [nurses] come and you say, "look, I'm in dreadful pain" and they'll say "look, it's not time for your next medication" or whatever ... I will tell you something that I am used to taking panadol at home for this chronic back pain ... so I learned not to declare all my medications to them [nurses] when I come into hospital. So when I have pain, I take the panadol myself and I would just think "up yours" ... I think people should be allowed to manage certain medications in hospital like heart pain tablets, panadol for pain and their Ventolin (patient 22, laughing whilst making this statement).*

Some nurses were in agreement with the above patient's comments but with added qualifiers. These nurses stated that patients, when they are in hospital, should only be allowed to self-medicate, if they were able, with certain long term drugs that they had been taking at home. The nurses were careful to state that only drugs such as the Anginine spray, which may be urgently required by patients, should be kept with patients. They further commented that all other drugs should be held by the hospital and administered to patients by nurses as a safety measure. Some nurses, however, believed that patients should administer their own insulin if they preferred to do so and if they were able, as demonstrated by these field notes.

*The nurse asked the patient, "have you done your BSL? [Blood Sugar Level]. The patient replied, "yes, but I haven't had my insulin yet, the night nurse told me not to have my own insulin". The nurse looked at the medication*

*chart and said "the doctor hasn't written up your Actrapid dose, just insulin BD, can you do your own insulin, I'll go and have a chat with the doctor". As we walked away the nurse turned to me [researcher] and said "I don't know why we can't let the patients manage their own insulin if they are ok ... we take it over from them and stuff it up". When the nurse told the doctor, he agreed with her that the patient could give himself the same dose as he had been administering at home (field notes).*

The above patient was observed to be coherent and capable of administering his own insulin. The patient, who had been admitted for the treatment of a leg ulcer, explained to the nurses that he preferred to administer his own insulin rather than wait for them to do it. The patient had been a diabetic for several years and stated that he was capable of managing his own blood sugar testing and insulin administration

Some patients stated that they believed that they should do as much as possible for themselves in hospital because they had always been independent at home, even as children. They believed that they should work with the nurses towards a speedy recovery. These same patients explained that, whilst in hospital, they had witnessed other patients refusing to do anything to help themselves even though they were capable. For example:

*As for me, I am pretty independent and will try doing as much as possible but I have seen some [patients] just refusing to do anything ... perhaps they haven't had much experience in looking after themselves at home ... maybe they were molycoddled at home and have had things done for them instead of being independent, so they expect the same in hospital (patient 11).*

*I didn't want to bother them [nurses] ... I didn't want them to be running backwards and forwards every five minutes ... so I would wait for them to come to me and ask if I was in pain and I assumed they would decide if I should have pain relief or not ... It is the way I have been brought up, not to ask or question anything, and to be independent (patient 1).*

The patient's view of not wanting to bother the nurses in the above statement was confirmed by some nurses who claimed that they sometimes came across patients who suffered from the "don't bother the nurse syndrome". The nurses explained that some patients' beliefs in the need to be inherently independent was so strong that they would do things for themselves even if they were not capable, rather than to ask for assistance. According to these nurses, in some instances, patients of this view had

compromised their health, simply because of their inherent independence and their attitude of not wanting to bother the nurses. Moreover, these patients perceived that they would waste nurses' "valuable" time if they asked for help when they should be doing things for themselves. The majority of patients in this study stated that they believed that nurses were always busy, contrary to the observation that at times the wards were quiet and nurses were not busy. A few nurses explained:

*In my experience, I have come across patients who are so independent that they will not ask you for anything, even if they are in pain ... they [patients] think that we are busy and they go into the "don't bother the nurse syndrome" ... I think patients feel bad that they have to take the nurse away from what they are doing and half the time you are wandering around trying to find something to do ... I think nurses play on this thing about "being busy" when they are not sometimes (nurse 25).*

### **Level of knowledge about medical condition**

The level of knowledge that patients had about their medical condition seemed to play a part in some patients' philosophical beliefs about care and their understanding of the meaning of participation. Even though, as previously stated, some patients wanted to participate in self-care, they were restricted in enacting their beliefs because of their perceived lack of knowledge and information about their medical condition.

Subsequently, these patients waited for the nurses to invite them to participate rather than to initiate care themselves.

*The next day after my operation, I felt ok to go and have a shower by myself but I dared not in case I shouldn't and so I waited for the nurse to come into my room and tell me to go ... I did not want to do anything wrong which may affect my recovery (patient 27).*

*Well again we are coming back to that introspective attitude where we think "well, I like to go and have a shower but better not" ... I mean wait for the nurse to say you can ... just not sure of what I can and can not do (patient 25).*

The patients' comments above were confirmed by some nurses who stated that it was usual for patients who had been used to self-caring at home not to want to do anything because they were afraid of doing something wrong because they were unsure of their medical condition. Patients interpreted doing something wrong as causing delays in their recovery. These statements and field notes highlight this point:

*On the third day, after my kidney surgery, the nurse took me to the shower and said, "you can sit on this chair and shower yourself ... don't worry about the drips and drain, they should be ok ... ring the bell if you need me" ... but I said, "just stand there and help me because I don't want to do something stupid here and end up in this bloody place again ... I don't know where all these are going into [patient pointing to the drip and drain sites] (patient 10).*

The above patient was observed to have an intravenous line, an indwelling catheter, and a drainage bag over the wound site. Even though the nurse was observed to explain to the patient about the drip and drains, this patient was still concerned about the equipment because he believed that he did not understand the technology and, therefore, was apprehensive about its presence. This had resulted in the patient requesting assistance when he was observed to be capable of showering himself because he was knowledgeable enough to perceive that something could go wrong if the equipment was not handled in the right manner. The following field notes also demonstrate that patients' level of knowledge about their medical condition may have influenced their beliefs about care, that is, whether it would be safe for them to participate.

*The nurse went to answer the call bell from the bathroom and found the patient standing naked and shivering. The shower was running. The patient's facial expression was distraught and he was holding on to the urinary catheter with the combine dressing around it. "What is wrong, Mr. X, why aren't you under the shower?" asked the nurse ... "I am sorry but I need you to wash me, I don't want this thing [pointing to the catheter] falling out and causing hassles (field notes).*

The amount of knowledge patients perceived they had, regarding their medical condition, appeared to relate to the extent patients were pro-participatory in their own care. Some patients were observed to have come into hospital with adequate information about their condition. They stated that their General Practitioner had provided relevant information to them and that they had researched their medical condition by going to the library or the internet.

*When I was in the surgery, the surgeon had explained to me about the operation and some pamphlets on it ... I read those and also got into the computer and got more info [information] on the topic ... When I went to the*

*pre-admission clinic, the nurse explained what I would come back with from the operation, so I kind of knew and was not worried about the lines (patient 4).*

Nevertheless, some other patients who were not well informed about their medical condition, as extrapolated from their interview data, believed that they were participating if they followed nurses' instructions and did as they were told.

*I didn't want to say anything or do anything without their permission [nurses] ... I just felt that I have to do what they ask me to do because I am a patient and they know what is better for me than myself ... I couldn't voice my opinion because I didn't know much about my surgery and they didn't tell me (patient 2).*

It was the above patient's first admission into hospital and when asked by the researcher why she had not asked the nurses questions about her medical condition, the patient stated that she was not the type to ask questions. Additionally, the patient claimed that she did not know the type of questions to ask and thus believed that nurses should take control of the nursing care.

## **Culture**

Some patients' cultural backgrounds also appeared to influence their attitudes to self-care. Some male patients came from ethnic backgrounds that were very much patriarchal in nature. In some instances, a few male patients believed that nurses, being predominantly female, should be doing everything for them in hospital. This was despite these patients being observed to be capable of participating in their own care. Hence, these patients came into hospital expecting not to be involved in any aspect of their care. As for decisions about treatments, these patients were prepared to take orders from the doctors as they perceived doctors to be mainly male. The following comments from nurses and patients reflect this.

*Some patients come from ethnic backgrounds where the male in the family gets everything done for them at home so they expect to have everything done for them in hospital, like we had one guy [patient] in and his family used to come in and feed him when he was quite capable to feed himself (nurse 20).*

*The English and Australian patients are stoic and private and tend to resort more to self-care than other ethnic groups who expect you to do every thing. It's their cultural background I guess (nurse 3).*

*When I was in hospital, the patient next to me was demanding that the nurses were getting frustrated with him ... he couldn't speak English very well and he was forever on the buzzer, wanting the nurses to do everything, like he would ring and ask the nurse to pick up something he had dropped and when his family came in, he would have them running around and he [patient] wasn't even old (patient 32).*

One male patient who was from a non-English background stated that he equated the nurse to be like a mother who took care of everything. This patient, who was in his twenties, equated nurses' work with "women's work" and consequently his philosophy of care was that the nurses should do everything for him. Thus, for this patient, the concept of participation had very little meaning.

*Nurses are to me like mothers ... they take care of you and you should let them do their job and care for you ... like at home my mum and sisters do all the housework and cooking and look after dad and I (patient 31).*

This above patient was observed to be labelled as "difficult" by some nurses because he was reluctant to participate in his own care. Podrasky and Sexton (1988) explained that nurses need to be aware that certain patients' behaviours may be culturally conditioned and that they are not necessarily deviant behaviours. Game and Pringle (1983) stated that some patients' views of nursing care are consistent with the notion that nursing work is mainly housework and general healing functions. Some patients therefore view that the nurse's role is one of taking care of their physical needs.

## **Age**

In this study there was evidence that the age of patients may have been responsible for some patients' attitudes to self-care. Some patients, especially the elderly, perceived that nurses were in charge and therefore expected nurses to tell them what to do, even though they were capable of participating in their own care. These patients believed that they could not have any say in how care was to be delivered because of their perceived lack of knowledge, their vulnerability, and the way they



had been treated by some nurses. As well, some of these patients stated that they felt that no one would listen to their opinions because they were “old”. This viewpoint had been reinforced by nurses’ attitudes towards these patients in previous hospitalisations. A few elderly patients explained that they were belittled and treated as children by nurses in previous hospitalisation. This view is supported by Irurita’s (1993) study, which found that some elderly and middle aged patients in hospital perceived that they were treated as children and had experienced frustration and despair. Some patients, in this study, had perceived that their opinions were not valued by nurses and intrinsically believed that they should wait for the nurses to direct and guide them in their own care.

*Some nurses treat you like a silly old lady, like you are a silly old thing ... well, you are senior but to them [nurses] you are another old lady and sort of say, “eat it all up, be a good girl and yes love and no love” ... but me, I don't like that, I don't like being talked down to ... I wish they [nurses] would see that I have all my marbles and listen to what I have to say (patient 5).*

The statement above is supported by Lanceley (1985, p. 26) who claimed that old people are often denied the privilege of reciprocation with health professionals. This left the aged with only compliance and obedience as bargaining tools. Other authors (Hendricks & Hendricks, 1982; Levin & Levin, 1980) have concurred that prejudice and discrimination are often attributed to the aged person because of the stereotype devaluation of the aged in Western society. As a result, Cockerham (1986) and Bond and Bond (1986) declared that hospitalisation has the potential to cause elderly patients to acquiesce and submit to authority. These authors further stated that in some instances nurses have been observed to explicitly exercise control over these elderly patients.

However, other elderly patients were observed to put absolute trust in doctors and nurses. They believed that care was nurse-driven and that participation meant complying with medical and nursing orders.

*Well, I trust the doctors and nurses to get me well ... I believe in doing as asked, not in fighting instructions, so I comply because I know they are right (patient 13, elderly).*

Some nurses concurred with this attitude of patients, stating that some elderly patients were so entrenched in this belief that it was very difficult for nurses to encourage any form of input from them.

*They are older people, they [patients] have grown up with the idea that nurses and doctors are right, that it is their profession and consequently they need to be obeyed, so they acquiesce in most cases (nurse 28).*

*I think it is mainly with the older population ... they think that when they come into hospital, they must obey the doctors and nurses ... maybe it is the generation gap, they won't question and they take everything as gospel truth (nurse 26).*

### **Information about hospital life from friends, relatives, and the media**

There was evidence in the data that information about hospital life that patients had acquired through friends, relatives, and the media may have shaped their attitudes to self-care. This was particularly true for patients who were admitted to hospital for the first time. One female patient who was admitted to hospital for the first time explained that she knew what to expect and do after a hysterectomy operation. The patient further explained that her friend had been in hospital six weeks earlier for the same operation. This patient also had visited her friend and had observed what the nurses expected her friend to do or not to do in terms of self-care.

*I have never been in hospital but my friend was in a while ago for the same operation ... I went to visit her and saw what she was expected to do after the operation ... so I had a fair idea that they [nurses] will be coming in to check on me and care for me as long as I cooperate with them ... I think they got her up the next day (patient 3)*

The above patient's attitude to self-care was that she therefore should cooperate with the nurses and expect to self-care on the day following surgery. A few other patients, who were also first time admissions, claimed that they were surprised that they had to get out of bed so soon after surgery. They stated that it was not like that on

television where the patients were attended to in bed by nurses. Thus, these patients had expected the nurses to care for them in bed for a few days post operation. Some patients also explained that they had expected more interaction with the doctors and nurses and expected to be more involved in decision making about their treatments. One patient quoted the television series "Chicago Hope" as an example.

*On TV, you often see the patient surrounded with doctors and nurses and they talk with the patient and the patient seems so important ... I found in hospital it was not like that ... you are not asked for your opinion most of the time, which I found to be an eye opener and I was disappointed (patient 33).*

The above patient's attitude to self-care was that he had come into hospital expecting to be consulted about his treatment. The patient explained to the researcher that sometimes he was asked his opinion by some nurses but not always. He commented.

*I was waiting for them [nurses] to consult with me about what they were going to do ... Some nurses were good and they would ask me, but others would come in and proceed to do whatever they wanted which I found disconcerting ... after a while, I learned to speak up with some and not others ... I didn't want trouble (patient 33).*

In summarising the causal factors of *incongruence* in patients' conceptual understanding of participation and in their philosophy about care, it was found that patients' previous hospital experiences, and their experiences with nursing staff, in terms of participation, may well have shaped their understanding and beliefs. Moreover, it was evident in the data that the desire to be "good" patients, and their attitudes to self-care factors were influential in how patients conceptualised participation and how they believed care should be delivered.

## Summary

The basic social problem encountered by nurses and patients was *incongruence* in the conceptual understanding of the meaning of patient participation and in the philosophy about nursing care. This *incongruence* which was found among nurses and patients and between both groups was identified as the core category that linked and explained all other categories. Three different conceptual understandings of

patient participation were identified in both nurses and patients. These were labelled complete input from patients (participation inclusion), partial input from patients (participation marginalisation), and minimal or no input from patients (participation preclusion). Philosophically, some nurses believed that patients have rights and that they should fully consult with them and work with them rather than to administer to them. Others believed that they knew best and that they should only partially consult with patients, whilst others believed that care should be totally nurse-driven, with patients doing as they were told. As for patients, some believed that they should be fully consulted, if able, on all aspects of their care, with some believing that they needed to be guided by the nurses and only be partially consulted by them, with some believing that they should not and could not have any input into their own care. It was clear that nurses' operationalisation of patient participation was very much dependent upon their philosophy and the contextual conditions that impacted on care.

There were two main causal factors that led to the *incongruence* in the conceptual understanding in nurses. These factors were identified as: the inability to transfer learned knowledge into the practice setting and the perpetuation of task-oriented or utilitarian nursing. Based on observation, it was apparent that although some nurses could verbalise their understanding of the meaning of patient participation from their learning, these nurses were not able to put the concept into practice. *Incongruence* in nurses' philosophy was attributed to their attitudes to caring and the influences of role models in the practice setting.

Several causal factors of *incongruence* in patients' conceptual understanding of participation and in the philosophy about care were identified. These included patients' past experiences of hospitalisation, their past and present encounters with nursing staff, medical condition for which they were admitted, their need to be perceived as "good" patients, and their attitudes to self-care. This latter was influenced by their home life, level of knowledge about their medical condition, their culture, their age, and information about hospital life from friends, relatives, and the media.

The hospital contextual conditions that compounded the basic social problem and which modified the process will be described in chapter four. It was apparent in this study that even when nurses and patients came together with ideal conceptual understandings and philosophy, they were not always able to enact their understandings and beliefs because of these contextual conditions. The basic social process that nurses and patients used to overcome this problem of *incongruence* in the conceptual understanding and in the philosophy will be discussed in chapter five, together with the varying intervening conditions that also modified the process.

## CHAPTER FOUR

### Hospital Contextual Conditions

#### Overview of the Chapter

In this study, it was found that certain hospital contextual conditions exacerbated the basic social problem of *incongruence* in the conceptual understanding of the meaning of participation and in the philosophy about care, for nurses and patients.

Furthermore, these conditions modified the basic social process that nurses and patients used to deal with the problem of *incongruence* in relation to patient participation. These contextual conditions, which related to the practice setting in which the phenomenon of patient participation was enacted, were found to be consistently present in the hospitals throughout the duration of this study. It was identified in the data that the contextual conditions included economic constraints, management structures, presence of technology, and the culture of medical dominance. In this chapter, these contextual conditions will be described in detail and reference will be made to them when the basic social process is described in chapter five. It was under these contextual conditions that actions and/or interactions were taken by both nurses and patients for dealing with the problem of *incongruence*. Data also showed that the hospital contextual conditions were not always conducive to nurses and patients enacting patient participation according to their individual conceptual understandings and philosophy.

#### Economic Constraints

The health care system in Australia had been subjected to several changes in the previous 10 years, especially in the area of fund allocations. In Australia, the Commonwealth Government distributed substantial funds to the States for health care. However, according to Burns (1998) and Witham (1996), the States had withdrawn, for other use, large amounts of funds allocated for hospitals, leaving

hospitals short of funds. Witham (1996) further stated that this clawback by the States had put hospitals under enormous pressures to cut costs in order for them to manage their reduced budgets. Cuthbert et al. (1992) concurred with the above authors, claiming that once the States had been allocated their funds for health care by the Commonwealth Government, they were free to use the funds as they deemed necessary. For example, Witham (1996) reported that according to Dr Carmen Lawrence, the previous Federal Minister for Health, since 1988 the States had withdrawn about 700 million dollars from their hospital budgets, forcing hospitals to cut costs in providing health care. These cutbacks had resulted in hospitals having to undergo vast restructuring and reorganising so as to cope with the limited funds available (O'Connell, 1997; Paradies, 1996). One major consequence of this restructuring was the reduction in the number of permanent nursing staff being employed by hospitals, frequently leaving wards short-staffed. As a result of these staff shortages, there had been an increase in the number of agency and casual nurses being employed by hospitals (O'Connell, 1997; Irurita, 1993). This effectively meant that the wards had fewer permanent or regular staff compared with agency and casual staff.

### **Staff shortages**

Data analysis showed that being short-staffed exacerbated the problem of *incongruence* and this had implications for nurses and patients in their enactment of patient participation according to their individual understandings and philosophy. Several nurses and patients in this study perceived that the hospitals were grossly short-staffed. The following patient comments reflect this view.

*You have to wait for things to get done around here ... I think it is just lack of staff ... there never seem to be enough nurses to cover the ward (patient 12).*

*I don't call them [nurses] unless I have to but sometimes I have to and then you have to wait ... the waiting can get very tiring ... they always seem to be short-staffed and dashing around and they have got their priorities and lots of patients to look after ... sometimes bells ring for 10 to 15 minutes before someone will answer ... it is disturbing (patient 16).*

Some nurses in the study had similar statements to make with regards to the wards being short-staffed. These nurses were of the opinion that patient acuity had risen in recent years, placing increased demands on their time. The nurses explained that their workloads had increased significantly due to the reduction in the number of permanent staff being employed by the hospitals. They further commented that, even though the hospitals had brought in casual and agency nurses to fill in the gaps, they still experienced high workloads. Some nurses explained that a lot of agency and casual nurses did not always possess the necessary skills and current knowledge about equipment that was used in the hospitals. They also claimed that most of the wards were specialised, and that required special skills beyond the provision of basic nursing care. As a consequence, they had to assist and sometimes supervise the casual and agency nurses so that patient care was not compromised. As more time was spent in assisting agency nurses, permanent nurses had little time to spend with patients and to involve patients in their own care. Nurses in O'Connell's (1997) study also expressed the above-mentioned concerns. Some nurses in this study stated:

*We usually have 5 or 6 patients to look after and you can bet that two will be high dependency and that leaves you very busy ... we used to have more staff on the wards but not any more ... some days you will be lucky to have 2 permanent staff on the ward, the other two will be agency nurses and that can be tricky ... you end up sorting them out half the time (nurse 13).*

*We are short-staffed and we don't have the time to do a lot of things like sit and talk with patients and to get to know them ... we are a busy ward and maybe it is people power, less people power around the place, bells and phones ringing ... I mean it is just less people power (nurse 31).*

As demonstrated in the above comments, nurses and patients perceived that there were not enough nurses to cope with the demands of the wards and to meet all patient needs. This was supported in studies by O'Connell (1997), Irurita (1993), and Williams (1996), which showed that nurses and patients believed that hospitals in Western Australia were short-staffed and that this in turn affected patient care. The nurses in Williams (1996) study, for instance, claimed that they were not always able to provide quality care to patients because they were short-staffed. The increase in the number of agency and casual nurses being used by hospitals, to compensate for the reduction in hospital staff, was emphasised in O'Connell's study (1997). The nurses in



O'Connell's study also complained that they were often faced with working with agency nurses who took up their time.

The situation of being short-staffed was identified by some nurses and patients in this study as inhibiting and/or modifying the process that they used to deal with the problem of *incongruence*. The nurses stated that being short-staffed meant that they had insufficient time to provide holistic care which encompassed patient participation. Lack of time was identified by some nurses as the reason why they were unable to provide patients with information and to sit and talk with them in order to get to know patients beyond a diagnosis. These nurses perceived that patients needed to be fully informed if they were to make informed decisions about their own care. Some nurses agreed that at times they did have the time to provide information and to educate patients. However, they voiced concern that, due to the staff shortages, they were unable to consistently provide patients with the much needed information. Furthermore, they were of the view that adequate information was the precursor to patients participating in their own care. The nurses claimed that they were sometimes called away to work in another ward in the middle of their shift if their ward was not busy. This effectively prevented information sharing and patient teaching, which according to these nurses was usually only possible when the wards were quiet.

*If you are busy and if you have got a very ill patient , you cannot find the time to do any patient teaching ... it really comes down to how busy you are, you cannot afford the time to explain anything to them [patients] which doesn't help them in becoming more involved (nurse 32).*

*With the government cutbacks on money and employment opportunities and things like that, I find that quite often our shift has been cut so you find yourself racing through, trying to get everything done before your shift is completed ... this leaves little time to do things like giving information to patients, which they need to become involved (nurse 8).*

Some nurses claimed that it was imperative that they spend time talking with patients in order to build trusting nurse-patient relationships and to get to know them. These nurses were of the view that it was only through knowing the patients that they were able to assess patients' needs and capabilities regarding participation, for example:

*I think that's good if you've got the time because you might be able to build up a rapport with patients. It might make them feel more relaxed ... they get to know you a bit better and you can get close ... only through trust and knowing you that patients will feel comfortable about telling you what they are able to do, what they can't do (nurse 2).*

The nurses, however, explained that due to the staff cuts they sometimes could not afford the time to sit and talk with patients and to successfully build up trusting nurse-patient relationships. These nurses further stated that it was only through this trusting relationship that issues of negotiation and consultation, which were crucial to patient participation, could occur between nurses and patients.

Data analysis indicated that the situation of being short staffed and having to work with agency nurses may have affected some nurses in promoting patient participation, according to their understandings of participation and their philosophical beliefs about care. For example, some nurses who subscribed to the belief that patients should have input into all aspects of their care claimed that being short staffed prevented them from having enough time to invite participation from patients. These nurses explained that it was faster to complete the work if they did the work themselves rather than to allow patients to participate in their own care, especially if they were busy. For instance:

*I want them [patients] to be involved but when your back is to the wall and you are under pressure, I mean it is much easier to do than to stay and hang around and wait for them [patients] to do because they can take all day ... I can bed bath in 5 minutes flat and I am gone to the next patient (nurse 14).*

Some patients confirmed the above nurse's comments. They stated that when the nurses were busy they were more inclined to adhere to routine and administer to them rather than to ask for their input into their own care. The patients blamed the shortage of staff as hindering them from participating in their own care. The patients claimed that when nurses were busy they expected patients to fit into their routine without question. This was particularly noticeable where activities of daily living were concerned, as highlighted by these field notes.

*The nurse went to the patient and said, "I would like to take you to the shower now" to which the patient replied, "can I have it later, I don't feel like it just yet". The nurse turned to the patient and said, "look, I'd rather get it done now if you don't mind because I'm pretty busy and I'm running behind in my work". Without waiting for the patient to reply, the nurse began to help the patient out of bed (field notes).*

One patient who was recovering from a stroke had to be assertive with the nurses so that she could participate in her own mobilisation. She said:

*This night, they [nurses] seemed to be busy ... so instead of assisting me to get out of bed, they just gave me the bear hug and sort of swang me out of bed ... all very nice and quick and rather easy for them but I needed to develop my independence so I asked them to cooperate and let me do it ... I had to be assertive (patient 11).*

Another patient had the following to say about nurses reverting to routine if they were busy.

*The nurses seem to put everything into a little slot to get through their work ... it is beneficial for them but not for patients. They say "you need to shower before eight in the morning, da, da, da" ... you can tell that they want to shower you and be done with it, which can take away your choice (patient 19)*

### **Use of Agency and casual nurses**

In this study, some nurses were particularly concerned about the lack of permanent staff on the wards. These nurses stated that more and more agency and casual nurses were being called in on a day-to-day basis to care for patients. This was supported by McKimmie (1995) who claimed that a major teaching hospital in Western Australia had spent some 3 million dollars in employing agency nurses, suggesting an increase in the use of these nurses in hospitals. A survey conducted by O'Connell (1996) also found that hospitals were persistently employing agency and casual nurses to supplement their reduced permanent staff numbers. The use of agency nurses, according to some nurses in this study, was not without problems.

*Usually, there aren't enough permanent staff on any given shift, so they bring in agency nurses who make your life difficult, especially if you are*

*coordinating ... you have to supervise them and make sure they know what they are doing ... some of them haven't kept up with the latest technology, so you end up doing their work as well ... also most tend to be very task-oriented, it is just a job to them (nurse 6).*

*We tend to be inundated with agency nurses more and more ... it is very difficult to provide any sort of quality care when these people [agency nurses] are just "blow-ins" who are not particularly committed to the holistic care of the patient ... they do what needs to be done and leave (nurse 7).*

Several nurses explained that agency nurses were not particularly motivated to involve patients in their own care because they were task-oriented and were basically concerned about doing tasks that needed to be completed before they finished their shifts. This stance by agency nurses, according to some nurses, therefore did not facilitate the opportunity for patients to participate, especially in the area of decision making. These nurses further stated that they had experienced instances where some agency nurses had ignored call bells because it was not their assigned patients who had rung. For example:

*I find that some of these agency nurses work under the mentality that they will not answer other people's [nurses'] patient's bells ... I find this mostly with staff who aren't hospital staff, to be honest ... at least we work as a team and help each other ... they [agency nurses] tend to communicate with the shift coordinator only if they are not sure what has to be done (nurse 30).*

The above concern about agency nurses not wanting to work as a team was shared by some nurses who were permanent staff. These nurses explained that the tendency of some agency and casual nurses to provide task-oriented care and to work on their own created difficulties for them, especially when they were trying to promote patient participation. It was claimed that these nurses were not always aware of what patients had been told about their care, the level of information they had been given, and what aspects of patient teaching still had to be covered. This was perceived by some permanent staff to be due to the lack of communication between them and the agency and casual nurses, which added to the already existing problem of lack of communication amongst some permanent staff. They further stated that patients were often left confused about what they should be doing with regards to their own care. This was because some agency nurses' own views about how care should be delivered was not always similar to the views about care of other nurses on the ward. These

factors, and agency nurses' lack of communication with the rest of the ward staff, had added to the problem of *incongruence*.

*It is rather problematic when you are working with staff who do their own thing ... you get the patient involved one day and the next shift or day you have an agency nurse or casual staff doing everything for the patient, so what do you do ... patients get confused too ... I don't think they know whether they are coming or going sometimes (nurse 12).*

Other permanent hospital nurses explained that, whilst agency nurses were sometimes helpful, there was a tendency for them to work like *robots* because they were usually employed on a six hour shift or what was termed in the field as "short shifters, more so than permanent staff. This meant that they worked from seven in the morning until one in the afternoon. The nurses commented that there was an unwritten expectation by the hospitals that agency nurses completed work that was normally done within an eight hour shift in six hours. Consequently, there was a propensity for these agency nurses to concentrate on doing tasks, such as completing observations, administering medications, and doing dressings. Care which included patient teaching and meeting patients' psychosocial needs was often neglected.

*The agency nurses are short shifters, all they tend to do is to get in there, do the work like a robot and finish ... patient care is compromised (nurse 9).*

Some permanent hospital nurses claimed that, as agency nurses finished their shifts at one in the afternoon, the remaining morning staff had the responsibility of looking after the agency nurses' patients until the afternoon staff arrived. This, according to these nurses, affected the continuity of care of patients, which further added to the problem of *incongruence*.

*The continuity of care is disrupted when the agency nurse goes home at 1 pm, the other ward staff are going for their lunch with only a few staff left on the ward to do the work, like fetching patients from theatre, doing the 1'0 clock medications, and doing the 2'0 clock obs ... so how can you do patient teaching and spend time with patients? (nurse 12).*

Another concern, as perceived by some hospital nurses, was that agency nurses were not always familiar with the patients in terms of what they could and could not do in

relation to participating in their own care. This was because agency nurses, in concentrating on task-oriented care, often did not take the time or have the time to get to know their patients. As well, agency nurses only came to the hospital once or when needed, which did not provide them with the opportunity to get to know the patients on a day-to-day basis.

### **Fragmented care**

It was found in this study that the reduction in the number of permanent staff and the use of agency and casual nurses had contributed to patient care being fragmented. Adding to this fragmentation was the way patients were assigned to different nurses each day by Nurse Coordinators. With fragmentation or lack of consistency in the care came the increased likelihood of *incongruence* in the conceptual understanding of patient participation and in the philosophy about care between nurses and patients. This had implications for the process nurses and patients used to deal with the problem of *incongruence*. It was observed that nurses varied in their levels of educational preparation, number of years of experience, knowledge, technical skills, and confidence in any given shift. The permanent nurses were not always assigned to the same patients. It was extrapolated from the data that this occurred because agency and casual nurses were usually assigned to patients whose illnesses were of less acuity. This, according to one Clinical Nurse Specialist, was to assist agency and casual nurses to cope as they were not always familiar with the ward. There was also a high patient turnover because of the early discharge program related to the budget cuts. This meant that permanent nurses on the wards found themselves faced with caring for new patients all the time. New patients were generally more ill and required more attention. During field observations, the researcher found that it was not uncommon for patients to have as many as ten nurses to care for them within a four day hospital stay. A review of patients' case notes also confirmed that it was usual for patients to be cared for by many different nurses during their hospital stay. This is reflected in the following nurse statements.

*I think, one thing in Australia, I've noticed is that because we don't have primary nursing and we are short-staffed, it is difficult for patients to have*

*any worthwhile input ... you see, one nurse may be admitting them and the next day somebody else is looking after them and the next day there might be somebody else again, it lacks continuity ... patients cannot identify with the same nurse, and each of us thinks differently ... it is quite fragmented really (nurse 2).*

*There is no continuity of care ... we are often moved from one section of the ward to another ... everyday a different section and that is difficult to adjust, you know ... you don't get to know your patients to effectively get them to participate (nurse 9).*

It was found that, as they had different patients to look after each day, some nurses sometimes found themselves in situations where they did not know their patients well enough to invite complete participation from them. The nurses stated that their time was mainly taken up in ensuring the stability of patients' haemodynamic status. Hence, they had little time to check with patients what their choices were with regards to their own care. The nurses expressed concern that they were sometimes forced to take over the care from patients because of the high patient acuity and the lack of time to get to know patients. One nurse explained:

*There is more than physical care I know, but most of the time patients are sick and you have to do the observations, medications and prepare them for theatre, for example ... not much time for anything else because of the staffing ... you don't get patient 1,2,3, and 4 and keep that rotation, you get 1,2,3, and 4 for two shifts and then patient 5,6,7, and 8 ... makes it hard because you don't get the chance to know the patients ... most of the time you are busy doing the essentials (nurse 28).*

Additionally, a few nurses claimed that the lack of continuity of care made it difficult for them to cultivate and maintain trusting nurse-patient relationships. As previously stated, some nurses perceived that patients had to experience trusting relationships with nurses before they would feel comfortable about initiating and participating in their own care.

Several patients expressed the same view as the above nurses. Some patients stated that at times they were unsure of which nurses were looking after them, which was confusing for them.

*They change shifts so often, you would be lucky to have the same nurse twice ... sometimes I see my nurse but she is looking after someone else ... I mean you get the medical care but there is no emotional support because you get so many different nurses ... some will talk to you and are nice, others just come in and do what they have to do and go, some will cut out on you (patient 4).*

*I reckon sometimes the nurses seem to be coming and going all the time ... sometimes, you don't know who is looking after you ... they [nurses] just roam in and out ... you don't know how to behave as they [nurses] are all different, for example, you ask one nurse a question and she tells you to ask another nurse because she is not looking after you to-day! (patient 14).*

A few patients complained that they did not know what was expected of them because they were told different things about their care by different nurses. These patients further stated that there appeared to be a lack of communication between the various nurses who were looking after them.

*I think perhaps the nurses could communicate a little bit more between each other so you get a better feed through (patient 28).*

The lack of communication between the nurses, according to these patients, had resulted in patients having to repeat information about their capabilities and views about their care to the nurses. Some nurses were also giving them conflicting instructions about their own care as reflected in these patients' comments:

*I am not the sort of person who picks, picks, and picks but it has been a bit frustrating with different nurses telling you different things ... you sort of think, what am I supposed to do? ... like I have been told to keep my leg up on a pillow by one nurse and to keep it level by another nurse ... so I decided to ask the doctor instead (patient 8).*

*I've asked a few questions on different days and I've heard different answers from different nurses ... some say "yes" and some say "no" to the same question which leaves you quite confused ... it is very frustrating because nurses don't seem to be coordinated in any way (patient 15).*

It may be extrapolated from the above nurse and patient comments that fragmented care had exacerbated the problem of *incongruence* and, furthermore, it appeared to have implications for the process that nurses and patients used to deal with the problem. For example, in the situation where different nurses were caring for the same



patient, nurses did not always get to know their patients, especially in terms of their capabilities and their views about how and if they would like to participate in their own care. Patients, on the other hand, were often left confused because they were not able to relate to consistent staff who knew them and understood their individual needs. Some patients stated that they often found themselves in situations where some nurses would let them have an input into their own care whereas others would take over. This patient's reflection highlights this point.

*One day you get asked your opinion by the nurse, the next day, another nurse acts as though you don't have a brain and tells you what to do, she lets you know who is boss ... some nurses are with you and are nice whilst others are "grumpy bums" and it is best that you do as you are told or else ... sometimes, the nurses are from outside [agency] and you cannot ask them anything, they just come in to do things to you (patient 23).*

### **Changes to handover**

It was highlighted by several nurses in this study that the reduction in staff had resulted in changes to the manner in which handovers were traditionally conducted. The nurses explained that the hour long "sit down" verbal handovers were no longer practiced because there was no overlap time between shifts. Instead, shorter, verbal and taped handovers were being used. This, according to some nurses, affected effective communication about patient care between nurses which in turn exacerbated the problem of *incongruence*.

*We used to have the sit down handover time where we vented frustrations as well as inform each other about patients, like the sorts of day patients had had, how they [patients] were coping and what we were doing with patients to get them motivated ... you know, things that we can't or don't feel comfortable in documenting ... a lot of information gets missed (nurse 9).*

It was observed in this study that the verbal handover took several forms. In some wards, the shift coordinator would verbally hand over to the incoming coordinator. This was observed to occur mainly on day shift. The rest of day shift staff then handed over their individual patients to the incoming staff. In some wards the handover was taped by individual nurses and listened to by incoming staff collectively. The main

problem with this, as identified by some nurses, was that the information was not always current and that it often needed to be supplemented by further verbal comments. The nurses explained that this was not always feasible as agency staff and sometimes permanent staff finished their shifts at one o' clock in the afternoon. Hence, they were not available to provide the extra information to the afternoon shift staff who commenced at 3p.m.

*The taped handovers are done quite early in the shift, usually around 11am if you are on early ... therefore things that happen to patients between 11am and 1pm are not recorded. Sometimes, the morning staff have gone off duty and you don't get the "fill ins" [extra information] that you should get. This makes it difficult to care for patients effectively because you don't have the full picture (nurse 19).*

The other variation was the bedside handover. Some nurses complained that they disliked conducting handovers at the bedside because it restricted them from stating negative comments, especially about patients who had been labelled as "difficult".

*It is awkward when you do bedside handovers because patients can hear what you are saying about them ... so you tend to stick to the basics like what treatments they had done or what obs [observations] they needed. You can't really talk about sensitive issues or concerns about the patient (nurse 16).*

The above nurses explained that they felt threatened in disclosing sensitive information about patients at the bedside. In support, other nurses stated that they would have felt more comfortable in discussing sensitive issues in the traditional sit down handover rather than at the bedside.

*You can say more about patients verbally and in private away from patients. A lot of stuff about patients cannot be documented. We have always passed on information about patients verbally to other nurses ... we have always relied on our oral culture (nurse 29).*

Street (1991) supported the above nurse's comments claiming that nurses tended to function within the operational mode of their oral culture. The author explained that nursing knowledge was transmitted by word of mouth from nurse to nurse and that it contained a rich source of information that nurses used in practice. O' Brien and Pearson (1993) conducted a study on nurses' use of oral culture and found that nurses

obtained knowledge on how to care for patients through word of mouth. It may be suggested that, in this study, some nurses' need to have long sit down handovers to transfer information about patient care through the oral mode may be justified. The use of oral culture was also identified to be prevalent amongst nurses in O'Connell's (1997) study into the clinical use of the nursing process by nurses in Western Australia.

Field observations of the bedside handover revealed that nurses tended to stand outside the door of patients' rooms to conduct the handover. They were also observed to whisper to each other about the care of patients to the extent that some nurses complained that they could not hear clearly what was being said. In many instances, it was observed that patients were not included in the bedside handover. Contrary to this approach, some other nurses welcomed the bedside handover claiming that it provided them with the opportunity to promote patient participation in the handover process.

*I don't mind the bedside handover ... it allows us to see the patient and make a quick assessment on how they look ... you can look at the charts and see what has to be done ... no, I find these handovers [bedside] quite good and patients can ask you questions (nurse 6).*

McKenna and Walsh (1997) concurred with the above nurses, stating that bedside handovers were useful as they allowed nurses to not only welcome patients' input but also to become familiar with their patients and their unique needs (p. 129).

Some nurses expressed concern over the loss of lengthy handovers, stating that they no longer had the avenue to discuss relevant ward and patient issues. They further claimed that the opportunity provided by long "sit down" handovers to socialise, share knowledge about patients, and to reflect with their peers was now denied them.

*We used to have the handover time, a lot of teaching and debriefing went on like someone would say "why is Mrs so and so behaving that way and being difficult" and someone was able to explain, so there was insight about a particular patient ... we were able to communicate the other aspects of care besides what was done to patients, feelings and such like ... but management*

*perceived it to be a waste of X amount of productive hours and we don't have that any more (nurse 13).*

It was suggested from the above comments that some nurses perceived that they no longer had the handover time to discuss patients holistically or to get to know the patients. This was evident in the observation that the information given at handovers tended to be focused upon the physical and procedural aspects of care. Following is an example of a typical taped and verbal handover.

*Mrs X, she is for carbamazine levels this afternoon, on heparin, still on IV. Only nourishing fluids. Been for echogram, not in sinus rhythm. Got a red area on bottom Tolerating a little bit of fluids. Oxygen saturation 92-95 %. Nasal prongs (verbal handover).*

*Mr X, fast from midnight for endoscopy to-morrow. Chest pain this am. Gave anginine with no effect. Dr notified. ECG [Electrocardiogram] done. No changes. Dr said not to worry about it, just observe (taped handover).*

The above examples indicate that the information given at handovers was brief and limited to tasks that needed to be done or were done by nurses. The physical status of patients was provided. However, there appeared to be a dearth of information on the psychosocial aspect of care or any mention about patients participating in their own care. There was also no mention in these handovers about the strategies nurses used or could use to enhance patient participation. Examination of nurses' notes showed that there was much written about the physiological status of patients. There was, however, little or no reference made to any aspect of patients participating in their own care in nurses' documentations, except on the odd occasion when the nurses would write that the patients were able to shower themselves or to ambulate on their own, for example:

*Ambulated to the shower and washed herself. Obs [observation] very good. Has IV, due through at 3 pm. S/P [supra- pubic] catheter in situ- draining. Has abdominal dressing and vaginal pack that has to come out in the morning. She [patient] is on s/c heparin and has been experiencing a bit of pain, gave her droperidol which settled her pain, so must be muscular. IDC [Indwelling catheter] draining well (nurse's notes).*

Data showed that the use of the short verbal and taped handovers clearly aggravated the problem of *incongruence*. As nurses worked with different patients all the time, the chances of them meeting up with patients with dissimilar understandings of participation and philosophical beliefs about care to their own was increased. The shorter handovers, where limited information was communicated from nurse to nurse, added to the problem because there was no time for nurses to discuss beyond physical care that was completed or those which needed to be completed. In other words, the holistic care of patients, which encompassed aspects of patients' participating in their own care, was omitted from the handover reports.

*Handover, I guess is very case oriented. Like, what dressings, the redivacs, the IV's, what their wounds looks like and things like that ... that tends to be all ... not much about the patient themselves (nurse 10).*

### **Early discharge program**

The introduction of Diagnosis Related Group (DRG) and Casemix funding where hospitals were paid prospectively for patient outcomes rather than retrospectively for services rendered meant that hospitals were eager to discharge patients early. This had implications for nursing care because of the limited time nurses and patients were exposed to each other during patients' hospitalisations. Duffield and Lewis (1992) explained that the Casemix method of funding was implemented by the Australian Commonwealth Government to measure patient outcomes rather than for the States to use it to justify hospital budget cuts. In order to increase their funding under the Casemix formula, hospitals in Australia, including Western Australia, had opted for the early discharge program (Health Observer, 1994). This trend was evident in the report from the Australian Institute of Health and Welfare where it was noted that the average length of stay for acute care hospital patients, both public and private, decreased from 4.5 to 4.3 days (Nursing Review, 1997, p. 4). All participating hospitals in this study were observed to have early discharge programs. This added to the problem of *incongruence* in the understanding of participation and in the philosophy about care and modified the process that nurses and patients used to deal with the problem.

As patients' length of hospital stay decreased, the amount of contact that nurses had with patients also decreased. This meant that nurses had less time to work with patients to promote participation in their own care. More specifically, nurses had less time to get to know patients' capabilities and opinions about their care so that they could invite appropriate participation, as this nurse's comment suggests:

*Patients are short term stays these days as they are only in for three or four days so you don't really get to know them that well ...um, no, you know them more in what they are in for than who they are in terms of a person and what they can do and want ... also you don't have the same patients ... you don't really have enough contact (nurse 29).*

Early discharge meant that there was insufficient time for nurses and patients to sort out their differences in their understandings of participation and in the philosophy about care. It was observed in the field that sometimes nurses did not have adequate time to recognise the differences and to adjust accordingly, as supported by this nurse:

*The patient turnover is high on this ward, they [patients] are coming and going all the time ... they are quite sick immediately post-operation and you are kept busy doing physical care ... by the time they are ready to be involved, they are discharged but first you need to find out where patients are coming from and you can't do this always because they are too sick, so you tend to direct them which may not suit the patient (nurse 11).*

Some nurses indicated that the early discharge of patients had resulted in nursing care being "congested". The nurses explained that it was no longer possible to provide care over a prolonged period of time. This was because everything had to be rushed through within a concise time frame, in keeping with the use of clinical pathways which were part of the DRG classification system. Furthermore, they stated that non emergency aspects of care, such as sharing information with patients, teaching patients, and sitting down and talking with patients to get to know them, were difficult to achieve. As previously stated, information sharing and knowing patients' capabilities was perceived by some nurses to be important in patients feeling comfortable about participating in their own care.

*I think the nursing care is congested because like ... on day one, patients should be doing this, this, and this, day two, this and this, and day three after*

*the operation, they [patients] are going home ... it is all pre-determined with clinical pathways. Also, you have to tell them a whole heap of things like "your wound might get red or you might have difficulty passing urine", things that would have happened on the wards but now they happen when patients are home ... with early discharge, we don't have much contact with patients to deal with all the holistic aspects of care (nurse 7).*

The above nurses' concern about fitting in patient care based on the DRG classification and clinical pathways, so that patients could be discharged early, could be suggestive of deterring nurses from providing holistic care. According to Greenwood and King (1995), an Australian study into nurses' clinical judgement when clinical pathways were used showed that its use hindered nurses from providing quality care. This was because clinical pathways mainly emphasised physical care with little regard for the provision of holistic care. Moreover, the authors claimed that, as clinical pathways were medical-oriented, they had a tendency to force nurses towards the reductionist approach to care, which overlooked concepts of holistic or patient-centred care. Greenwood and King (1995) stated that the use of clinical pathways by hospitals had resulted from a need for economic rationalism.

## **Management Structures**

It was evident that nursing management structures within the hospitals added to the problem of *incongruence* and modified the process that nurses and patients used to deal with the problem. Issues, such as staffing and rostering, hospital policies, and type of practice paradigm that was sanctioned by the nursing hierarchy, were identified in the data.

### **Staffing and rostering**

It was observed that a total of 16 to 18 nurses were rostered to work in a ward with a twenty one bed capacity. Some nurses were permanent whilst others were on contract and were temporary. The nurses assigned to the wards were a combination of Registered and Enrolled nurses. Data analysis revealed that most wards had four to five nurses rostered on day shift, four on afternoon shift, and two on night shift. However, as already alluded to, in any given day it was observed that sometimes there were one or two agency or casual nurses among these numbers on the wards,

especially during morning and afternoon shifts. This was due to permanent staff being off sick or lack of permanent staff numbers. At other times, it was observed that when staff had phoned in as sick, the wards were not given agency or casual nurses to compensate for the reduced staff numbers. When asked about this, the Nurse Manager explained that if the wards did not have patients of high acuity, based on the acuity list, then the wards were not given the extra staff. Therefore, it was not uncommon to observe four nurses caring for twenty odd number of patients, which some nurses considered to affect their ability to invite participation from patients. This was observed to occur mainly on medical wards. A nurse in one medical ward explained this:

*We have to fight for staff ... there has been an occasion where there were 26 people and we only had 3 of us [nurses] for morning care and that was difficult ... um, things got done but only the necessary things ... everything else fell by the wayside because you are engaged in chronic medical work, especially with total care patients ... there is no time for anything else ... of course it will be different if some of your patients are self-caring (nurse 28).*

When the nurses on the above ward were asked why they did not ask for extra staff, they stated that management did not always respond to their request for more staff. The nurses explained that sometimes management did not perceive that extra staff were needed because on the previous shift the same number of nurses had coped. From this, it may be extrapolated that management did not always accept the ward nurses' professional judgement and had denied the requests for extra staff. When asked to comment, some nurses stated:

*You could have had a horrendous shift and you coped and you say to management, "look, we need 5 staff this afternoon because of this, this, and this", but management tells you, "but you managed yesterday". I mean what does managed mean? ... do you mean none of the patients have died or whatever ... I mean management don't care, they are only interested in incident forms (nurse 14).*

*The word that comes up in nursing management is "cope" ... can you cope with so many staff?. How did you cope to-day? and what you can cope with to-day becomes the norm to-morrow (nurse 17).*



Furthermore, concern was expressed that sometimes the lack of staff and high patient acuity had forced nurses to engage in task-oriented care. This had resulted in little consideration being given to the provision of holistic care, which encompassed patients participating in their own care. Some nurses stated that they would have involved patients in their own care more if they had continuity of care. As previously stated, nurses were regularly assigned to different patients on a daily basis. In some medical wards, however, it was observed that the nurses were specifically assigned to different patients because of patients' conditions. One shift coordinator explained that sometimes patients were "difficult" or "heavy" so nurses needed to be given respite from them in order to cope.

*I try and allocate the nurses to the same patient to give continuity but if you get someone for want of a better word, "quite difficult" meaning very demanding or "heavy", especially the stroke patients, then it is good to share that patient around with all the nurses so the nurses don't get fed up (nurse 32).*

A few nurses concurred with the above shift coordinator stating that they expected to be assigned to work with different patients because they were "heavy". However, they were of the view that overall they preferred to work with the same patients so that they could get to know patients and invite participation from them, in keeping with providing holistic care. These nurses explained that working with the same patients also allowed them sufficient contact time to sort out differences with regards to understandings of participation and philosophical beliefs about care. The nurses claimed that both nurses and patients needed to be aware of where each was coming from before any negotiations could occur between the dyad.

*I think continuity of care is very, very important to the well being and recovery of the patient ... you get to know them, if they [patients] know you, they will share a lot more information with you ... they will tell you their capabilities and share their views ... you can be holistic in your approach ... the shift coordinators on our ward try their level best to give us continuity of care, like they'd say "oh, you are on to-morrow, I'll give you the same lot of patients" but when patients are "heavy" in nursing ways, then you need a break (nurse 31).*

The rosters were observed to be made up two weeks in advance and reflected a combination of Level 1 and 2 nurses in any given shift. Except for two wards where there were permanent night staff, the nurses on the wards were rostered in turn to work night shifts. The number of nurses assigned to a ward was based on patient acuity and the number of patients on the ward. Whilst the number and level of nurses on the roster seemed appropriate on paper, it was observed that, due to staff sickness and roster changes, the combination of Level 1 and 2 nurses was not always balanced. In one hospital, the Nurse Manager explained that there was an average of 200 roster changes per fortnight. This, according to the Nurse Manager, invariably upset the nurse Level combination on the wards. For example:

*The roster is done two weeks in advance to cover the wards adequately but the nurses change the roster, so sometimes you end up with more Level 1's than 2's on a shift and the Level 1 has to coordinate, which can be difficult for the nurse ... staff sickness is another thing and we have to bring in agency nurses (Nurse Manager).*

Some nurses stated that it was not uncommon for them to be sent off to work in another ward in the middle of their shift. This practice by management had affected the continuity of care and had prevented them from providing care that was patient-centred. The nurses explained that they would plan the care with the patient and organise when they were going to do certain aspects of care such as patient teaching. However, they were not able to follow through with the plan because they were shifted to another ward, which added to the fragmentation of care. Moreover, the nurses stated that they were sometimes sent to speciality wards, of which they had very little knowledge of the nursing requirements. This had forced them to revert to task-oriented care because of their perceived lack of knowledge in the speciality ward. The following nurse statements highlight this point:

*Sometimes, you are literally dragged off the ward in the middle of doing something and haven't had time to say to another nurse, "look, you know this patient ... I haven't yet given him the information or whatever, I haven't explained about the dressings, can you do that for me?". Whether or not, she [the nurse] carries this through is another matter, you know because everyone does things differently (nurse 8).*

*If your ward is quiet and another ward needs staff, you are sent there ... we hate it when we are quiet because we know someone is going to be sent off the ward ... nobody likes this because the ward you get sent to is usually different in speciality ... it is hard enough doing procedures that you don't know much about such as ear irrigation on the ENT [ear, nose, and throat] ward, let alone involve patients in their care (nurse 19).*

The concerns expressed above were supported by some patients who had encountered nurses from other wards. These patients were of the view that nurses from other wards had very little knowledge about their medical conditions and were not aware of what they needed in terms of their care, beyond doing tasks. Some patients explained:

*We have nurses coming, because of the shortage of staff, over from the maternity ward and some from different places, an agency, I think they call it and we don't know the nurses ... they [nurses] don't know where we [patients] are at ... sometimes, this is very hard because the patients lose confidence and there is no follow through with our progress (patient 11).*

Field observations of nurses working in a speciality ward with which they were not familiar showed that there was a tendency for these nurses to adhere to routine and give task-oriented care.

*The patient said to the nurse, "what time am I going to theatre and how much will I be able to do after I come back? ... How many tubes will I have? The anaesthetist said I would have my own pain control button, can you tell me about this?". The nurse looked at the patient and said, "I am sorry Mr um ... um Mr X [nurse had to peer at the headboard to check name] I am not sure ... I am from another ward and I am not sure what will happen, I will get the coordinator, I just need to do your pre-op [operation] obs, o.k? The nurse proceeded to take the patient's vital signs (field notes).*

Data analysis indicated that some nurses were concerned that there was no time allocated for on-going staff development, especially for junior staff. These nurses blamed the staff shortages and lack of overlap time between shifts as the cause for this occurrence. The nurses explained that, in the past, the staff overlap time between 2 p.m. to 3.30 p.m. was used to conduct educational sessions. However, with the short shifts and reduction in overlap time, this was not possible. This was supported by O'Connell (1997) whose study also found that nurses perceived that they were unable to conduct educational sessions due to the short shifts. Some nurses in this study stated that new and junior staff needed to have educational sessions to re-educate

them about providing holistic care for patients. These nurses believed that it was only through providing holistic care that the concept of patients participating in their own care would be realised.

*In the last 12 months, we have had such a high staff turnover ... we have new staff and also the graduates need to be re-educated about how care should be delivered in line with the concept of customer focus and the like ... but in recent times, there has not been much money to release staff for staff development ... staff need time for self-development, which management don't see ... they [management] use the "smoke screen" type of argument which is not effective (nurse 22).*

In summary, it was inferred that staffing and rostering formulas used in the hospitals had exacerbated the problem of *incongruence* and modified the process used by nurses and patients to deal with the problem. Specifically, management's use of agency nurses, inadequate provision of staff to wards when needed, sending nurses to work in unfamiliar ward areas, and allocating insufficient funds for staff development appeared to have resulted in nurses not always being able to enact patient care based on their understandings and philosophy. There was also indication that staffing and rostering had affected the manner in which patients conceptualised and enacted the meaning of participation.

### **Hospital policies**

Certain hospital policies affected the enactment of patients participating in their own care from the nurses' and patients' perspectives. One such policy that was identified in the data was the issue of patients self-medicating. Whereas most nurses agreed that patients' medications should be locked up and administered by nurses for safety reasons, some nurses perceived that patients should self-medicate under certain circumstances whilst in hospital. The nurses claimed that chronic medical patients should be allowed to participate by self-medicating, if they were cognisant and able. This, according to the nurses, would increase patients' independence and control. However, the nurses stated that hospital policy prevented this from occurring. For example:

*I know the hospital policy is to take patients' drugs and lock them up and administer when needed. This is fine with some patients but I think that if*

*patients are not for surgery and are capable, we should let them self-medicate. How many times have patients warned us so we didn't end up giving them the wrong medication ... things like ventolin and insulin can be self-administered but nurses don't always allow this ... I think you need to assess the situation case by case (nurse 9).*

A few patients also believed that they should be allowed to self-medicate if they were able.

*I think if you are capable, you should be allowed to keep and take your own medications ... after all you have been taking the same medications for umpteen number of years and I don't see why I can't continue ... I can understand the nurses' concerns, like people could overdose or something ... no, I think if you are o.k, nurses should let you do it but perhaps oversee it (patient 20).*

It was observed in the field that some nurses went out of their way to empower patients by encouraging self-medication through the use of dossette boxes. These nurses initially consulted with the doctors about allowing patients to self-administer and worked with the ward pharmacist. The nurses checked to ensure that patients took the correct medications and spent time with patients teaching them about the various medications. This was mainly observed to occur in extended care wards. It was interesting to observe that in the same wards some other nurses did not allow self-medication. These nurses directly removed the medications from the dossette boxes and administered the medications to the patient without any involvement from them. When asked to explain, some nurses claimed that it was too time consuming to wait for the patient to self-administer and that it was outside of the general hospital policy. One nurse who allowed patients to self-administer explained.

*I just think that nurses have been doing that for so long and it is the way it is and it terrifies them ... like what if patients overdose ... to these nurses it is easier to dish the pills out than to supervise and check that patients have taken the right medications which doesn't say much about patient independence ... some nurses hide behind policy because they don't want to take the responsibility (nurse 29).*

### Type of practice paradigm

Data analysis revealed that the type of practice paradigm that was sanctioned by the nursing hierarchy was responsible for some nurses enacting their beliefs about patient participation differently to that which was intended. Some nurses claimed that they were not able to involve patients in their own care because they did not have the time to work with patients and at the same time complete all the tasks that they were expected to do. The nurses stated that some shift coordinators' *modus operandi* was task-oriented care. This had resulted in pressure being put on some nurses to complete tasks as quickly as possible with little consideration being given to patients participating in their own care.

*You are expected to do so much tasks within your shift ... like all the washes and showers must be done on morning shift as well as dressings and things ... if you are working with a coordinator who expects all this, then it leaves little time to spend with patients and involve them in their own care ... you feel like a bad nurse if you haven't done the work (nurse 19).*

Another nurse explained that even though she knew that she could leave some patient care for the afternoon staff, she nevertheless felt pressured to complete tasks rather than to spend time working with patients.

*It has been a nursing attitude that you get in there and finish all your work by 1'clock or whatever and this has been going on for years ... you must finish your work before you go and never pass it on to the next shift which is a load of crap because you can ... but you still go along with it because the coordinator expects it and you succumb to it (nurse 8).*

The above nurse further expressed concern that any attempt by nurses to deviate from the expected provision of task-oriented care was like fighting a losing battle. The nurse stated that some senior nurses were only interested in what the nurse had not completed, in terms of tasks, within a given shift. They were not interested in the type of interaction and pro-participatory care that was provided by the nurse. For instance:

*At handover, the nurse may handover and state what she had done with the patient but the other nurses may say, "what are we looking at here ... what haven't you done?" ... sometimes you wonder if being a good nurse is doing all your tasks on time ... somehow patients are not considered to be*

*important which is sad ... it is a far cry from pushing for customer focus (nurse 17).*

## **Presence of Technology**

Data from this study revealed that the presence of technology, in some instances, had affected the manner in which nurses provided care, irrespective of their understandings of patient participation or their philosophy about care. The presence of technology also appeared to inhibit some patients from complete participation, even though they believed that they should have input into all aspects of their care. Field observations showed that technology was increasingly used in the hospitals for the duration of this study. For example, nurses had to work frequently with technology in the way of handling machinery in order to provide direct patient care. Some nurses agreed that technology enhanced the delivery of accurate and precise care. However, they stated that its use was sometimes problematic for nurses. The nurses claimed that they had to learn how to use the equipment which took up their time and caused them stress. This further reduced the time available to spend with patients and to involve them in their own care, thus inhibiting patient participation. These nurses explained:

*It is the hospital environment, there are so many gadgets that you have to be familiar with like special pumps and monitors which take up the time ... they are things that require a lot of time to make sure they [pumps, machinery, monitors] are running properly ... doesn't leave much time to be with patients and involve them in their care ... pretty stressful too (nurse 13).*

*Sometimes, the turnover of new stuff [equipment] is so great that you can hardly keep up and staff development is low priority so you have to learn from the other nurses or learn through the manual which is time consuming and frustrating ... like last week, I spent the whole morning trying to figure this bloody machine out, kept beeping all the time ... I hadn't done anything with the patient and it was already morning tea time (informal nurse interview).*

The above nurses' concern about being stressed when working with unfamiliar equipment was supported by McConnell and Fletcher (1995). The authors found, in their study into 142 nurses use of medical equipment, that the majority had to learn the equipment using the manual or through other nurses, and that a third of the nurses had experienced stress. Together with other authors (McConnell, Fletcher & Nissan,

1993; McConnell & Nissan, 1993), the above authors also stated that nurses viewed the use of medical equipment as a double-edged sword which either enhanced or inhibited patient-centred or holistic care. The main factor, as identified by the authors, was the level of proficiency, knowledge, and understanding that nurses had of the equipment. This supported the above nurses' concern about not having enough time to provide care that involved patients' input because their time was taken up in learning unfamiliar equipment.

In this study, it was inferred that attending to technology took up nurses' time. Some nurses explained that looking after machines sometimes took precedence over caring for patients in a manner that promoted patient participation. The nurses were of the view that machines took up so much of their time that they did not have enough time left in the shift to work with patients. Furthermore, the nurses claimed that, because they had insufficient time with patients, they had no option but to revert to task-oriented care. This, according to some nurses, was in direct conflict with their beliefs that patients should participate in all aspects of their care.

*Really, I would like to get patients involved in their care but I find I don't have the time ... getting patients to participate takes time ... patients can be quite slow ... I know I have a responsibility to make sure the machine is working correctly so I find myself working with the machine more, instead of the patient (informal nurse interview).*

Whilst some nurses expressed concern about not having the time to work with patients because of machinery, other nurses were observed to only have regular contact with patients who had machinery attached to them. It was interesting to observe these nurses going immediately to the patient's bedside whenever the machine's alarm sounded. However, when patients with machines rang the call bell, these nurses did not respond as quickly, as demonstrated by these field notes.

*The patient had a PCA [patient controlled analgesia] machine attached. The patient had two drains and an ordinary hydration line. He had an oxygen mask on. Suddenly, the alarm on the PCA machine went and within minutes the nurse was in. She fiddled with the machine without looking at the patient or saying anything to him. When the alarm stopped, the nurse left the room. A few minutes later, the patient rang the bell and waited. Ten minutes passed before the patient rang again. Five minutes later, the nurse came into the*



*room, "what do you want Mr X?" asked the nurse. "I want the bowl, I feel sick" to which the nurse said, "hang on, I will go and get you one" and left the room. A few minutes later, she came back with the bowl but the patient had already starting to vomit (field notes).*

Some patients who had the view that patients should have input into all aspects of their care stated that machines had become the interface between patients and nurses instead of the nurse being the interface between machines and patients. The patients expressed concern that some nurses had become over-reliant on machines to the detriment of maintaining patient contact and finding out what patients can and cannot do in terms of participating in their own care. Moreover, these patients claimed that some nurses depended on the machines to assess patients' progress rather than to physically assess patients or take note of what patients were saying about their well being. The following field notes and patient comment highlights this point.

*The patient turned to the nurse whilst she was sorting out the machine's alarm and said, "I don't feel so good" to which the nurse replied, "after I have fixed the knob, you will be ok" and continued to fiddle with the machine instead of listening to the patient. The patient collapsed and needed emergency fluid replacement (field notes).*

*Sometimes, I am sure nurses must think machines keep patients alive ... there is this attitude that if the machine is working then the patient is cared for (informal patient interview).*

Data analysis showed that the presence of technology did not deter a few patients from voicing their opinions or initiating participation in their own care. Adequate knowledge about the equipment and patients feeling well enough were found to be the reason for this occurrence. These patients were observed to be cared for by nurses who were pro-participatory in their attitude and who had explained everything about the equipment to the patients.

*Even though I had all this drips and drains and the rest of it, I was happy to have the shower by myself ... the nurse had explained everything to me and all I had to do was to press the bell if I needed help ... she [nurse] did offer to assist but I said I could manage (informal patient interview).*

Contrary to the above, some patients claimed that they were hindered from participating in their own care because they were concerned about doing harm to the

equipment. These patients stated that they lacked sufficient information because no one had explained about the equipment to them. Hence, they were frightened to do anything, in case they caused problems for themselves through mishandling the equipment. The following patient comment is indicative of this view:

*You have all these tubes and things and you are scared to move or do anything in case you do yourself an injury ... might pull something out and end up in hospital longer ... so it is best to wait for the nurse to come and take you to the shower ... she [nurse] will know what to do (patient 10).*

It was found that some nurses also perceived that unless patients were fully informed about the equipment, they would not, or they would hesitate to participate in their own care. For example:

*We are aware that patients are worried about doing something to the equipment and are hesitant to move with them ... we need to explain not only the risks and consequences of mishap to equipment but also how to handle the equipment without risks (informal nurse interview).*

In summary, it was evident that the presence of technology had sometimes resulted in nurses having insufficient time to spend with patients and to involve them in their own care. This had led to some nurses not being able to provide care based on their understandings and philosophical beliefs. As for patients, the lack of information about equipment had resulted in some patients being inhibited from participating in their own care. As well, the physical presence of equipment appeared to have also inhibited some patients from participating in their own care.

## **Culture of Medical Dominance**

It was revealed in the data that nurses worked in an environment that supported the culture of medical dominance. Even though this dominance was not noticeable, it nevertheless was perceived to be present by some nurses. The area of care where this dominance was perceived to occur particularly was in patient advocacy. Some nurses voiced concern that they did not feel comfortable in encouraging patients to seek, or ask about, alternative modes of treatment because it meant that they were going

against the doctor's planned treatment for the patient. More specifically, these nurses claimed that they felt powerless with regard to going against the doctor's decision. For example, some nurses stated:

*It is hard when the doctor wants to send the patient for a procedure but the patient does not want to have it done, for example, chemotherapy... they'd rather have palliative care and die with dignity ... you can't interfere because you feel you are overstepping the line and you could be hauled over the coals by administration ... sometimes I think we are only able to give lip service to our role as patient advocates (informal nurse interview).*

Some nurses stated that patients had a right to make their own decisions and that they should be able to make informed decisions through having access to all relevant information. These nurses had no problems in stating that it was the doctors' responsibility to give patients information about their medical condition. However, they felt strongly that the doctors needed to provide comprehensive information to patients and not just inform patients about the procedures that they had scheduled for them. Furthermore, the nurses expressed concern that some doctors were not providing patients with all the information to enable them to participate in their own care by making their own decisions. The nurses claimed that they were unable to speak to the doctor about not giving adequate information to patients because they perceived that they would not be taken seriously by the doctor, for instance:

*We are supposed to be patient advocates and you know, we have the right to say to the doctor, "you have just walked in here and you have said this and this and the patient is very anxious and upset, I would like you to sit down and discuss what exactly you are going to do to him [patient] ... he is absolutely terrified and you haven't helped matters by going in there and walking out as if he is just a piece of meat that you are going to cut open and go home and have a nice big turkey for Christmas because you have made your dollar" ... But we can't say that because a lot of the time doctors have an attitude towards nurses that we are the scum of the earth and what do we know anyway! (nurse 8).*

Contrary to the above situation where some nurses perceived that they were not taken seriously by doctors, other nurses were of the view that, except for a few doctors, most doctors were approachable and that the doctors would listen to them. These nurses explained that there were a few doctors who were of the "old school" in that they treated nurses as though they were hand-maidens and thus expected them to

follow orders. However, the nurses stated that the younger generation of doctors were more open to suggestions and would go and discuss treatments with patients if they were requested to do so by the nurses.

*We had a patient who had undergone haemorrhoidectomy and the doctor had gone in and told the patient that she could go home that day but the patient was of the view that she was not ready to go home ... the patient explained to us that she had experienced a lot of pain and had problems with her bowels when she was sent home early in the past for the same operation ... so we went and explained to the doctor what the patient had said and he [doctor] was ok about it ... the patient ended up staying in until she had her bowels opened ... most doctors will listen to you (nurse 30).*

It was also found in the data that some nurses perceived that nurses overall should be more pro-active in fulfilling their advocacy role if they were to enhance patient participation. These nurses explained that sometimes it was much easier for some nurses to blame the doctors rather than to advocate for patients. This was because advocating for patients was perceived by some nurses as taking on more responsibility. The above nurses claimed that some nurses were of the view that they should follow doctors' orders, and provide the treatment that was ordered for them, without allowing patients any say in that ordered treatment. These nurses were not perceived to be concerned about empowering patients. Instead they were concerned about pleasing the doctors and encouraging patients about doing as they were told by the doctors. For example:

*I think a lot of nurses don't even think about the empowering aspect of care ... it's a term that they never ever have learned or it has never been in their minds ... like I said earlier, some people should never have become nurses ... I think they come into nursing to meet nice young doctors ... you can tell the way these young girls [nurses] flutter their eyelashes at the doctor and hang on every word he says without thinking about the patient's needs (informal nurse interview).*

The nurses who had the view that nurses should be pro-active in their advocacy role also explained to the researcher that being an advocate involved taking risks. The nurses stated that the advocacy role could sometimes involve going against the medical profession and that could have detrimental effects on the nurses. This opinion was observed to be prevalent in ward areas where the nurses perceived that they

would not receive adequate support from nursing administration should they be challenged by the doctors whilst advocating for patients.

*Sometimes you see things happen to patients that you feel you should say something to the doctor about but that will be putting your neck in a noose ... undermine a doctor?, no way, especially one who makes money for the hospital ... I realise of course that I should have the right to say it but I might as well not ... to be a realist, I realise that if I did say anything my arse will be grass and I will be out the door that fast (nurse 28).*

This nurse's concern was supported by Becker (1986) who stated that being an advocate was sometimes risky for nurses. The author claimed that nurses may lose their jobs if they were perceived to be trouble makers by the nursing hierarchy because they went against doctors decisions and advocated for patients. This, according to the author, was especially true for situations where nurses had supported patients to seek alternative modes of treatment in their zest to promote self-determination in patients. The author further stated that the fear of losing their positions had sometimes rendered nurses to be passive advocates, which involved supporting patients only within the boundaries of the norms and rules as set out by those in authority, namely the medical staff (Becker, 1986). Kubsch (1996) concurred with Becker (1986), stating that in reality the hospital culture was very much dominated by the medical staff and that nurses' responsibilities inherently involved following medical orders.

## Summary

In summary, it was found that certain hospital contextual conditions had either exacerbated the problem of *incongruence* in the understandings of participation and in the philosophy about care for nurses and patients and/ or modified the process that nurses and patients used to deal with the problem. Economic constraints, management structures, the presence of technology, and the culture of medical dominance were identified in the data as the above-mentioned contextual conditions. Reference will be made to these conditions in the next chapter when the basic social process is described.

## CHAPTER FIVE

### BASIC SOCIAL PROCESS

#### *Accommodating the Incongruence*

#### Overview of the Chapter

The overall aim of this study was to explore, describe, and analyse nurses' and patients' perspectives of the phenomenon of patient participation within the context of hospital nursing practice in Western Australia. Data analysis revealed that nurses and patients were dealing with the basic social problem of *incongruence* in the conceptual understanding of the meaning of patient participation and in the philosophy about nursing care. In this study, the nurses and patients used a basic social process labelled by the researcher as: *Accommodating the incongruence* to deal with this problem. Accommodating, in this study, has been defined as adapting to the differences in the understandings and philosophy and achieving balance in nurse and patient input into care as much as possible. It was evident from the analysis that the nurses were the dominant actors in this dynamic and reciprocal nurse-patient interactive process. This was considered to be due to the nurses being at their optimum physical level of functioning and in their own socio-cultural work environment as opposed to patients who were ill and therefore vulnerable. They were also in an unfamiliar environment, which added to their vulnerability. Hence, the process of accommodating was predominantly nurse-driven. The patients, nevertheless, did play their part but it was to a much lesser extent. This chapter will give a detailed description of the basic social process and provide excerpts from the data to support the analysis.

Whilst the problem of *incongruence* was observed to occur frequently and during the majority of the time in this study, there were a few rare occasions when both nurses and patients were observed to come together with similar understandings and

philosophy. This chapter will also describe what happened when both parties were matched in their understandings and beliefs about care.

## Accommodating

Accommodating, as previously stated, has been defined as adapting to the differences in the understandings and philosophy and achieving some balance in nurse-patient interaction and input into care. For example:

*I really needed to take the drain out but the patient did not want it done until after the visitors had gone ... I was frustrated because I was knocking off soon and felt that I had to do the drain before going off duty and should go ahead anyway ... the patient told me that she would appreciate it if I left her alone until the visitors went ... I could have forced the issue but decided that I needed to go along, just to let her decide and avoid conflict (nurse 25).*

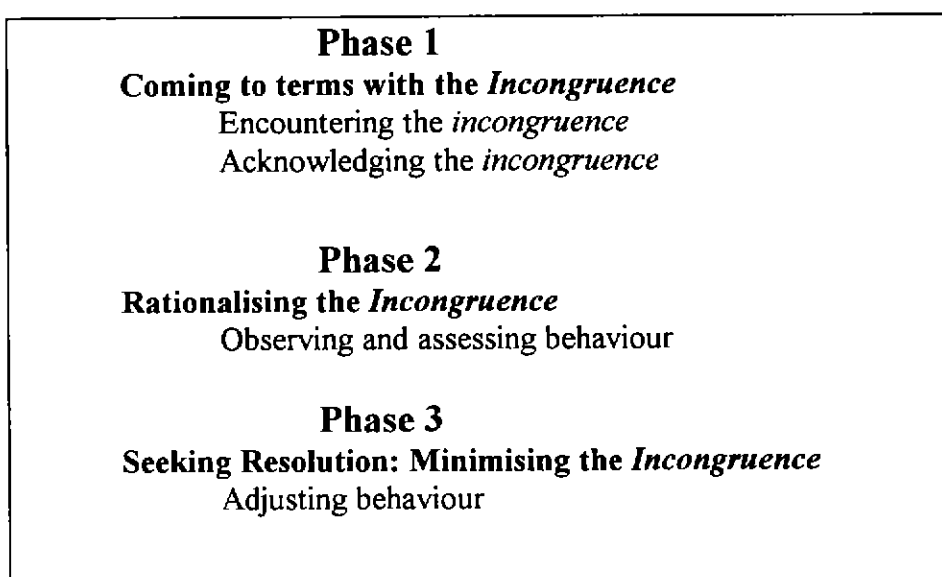
*I have been asking the nurses for a clean sheepskin but nothing seemed to be done .... In the end I got jacked off at not being listened to so I demanded to see the charge nurse or I was going to sign myself out ... this nurse came and said that they were short of sheepskins and that I did not need one now and left ... I didn't feel that was the case because I had a sore bottom and thought that the nurse was purposely not giving me the sheepskin ... the nurse came back and told me that she could order me one but I told her not to worry ... you see, I had thought about it and decided that the nurse may be right and went along with her decision ... it is give and take isn't it? (patient 30).*

Accommodating will be described from the nurses' and patients' perspective. This will include actions/interactions or strategies taken by both parties with reference to the hospital contextual conditions and varying intervening conditions that modified the process, which, as already explained, was nurse-driven. As previously alluded to in chapter four, certain hospital contextual conditions, such as economic constraints, management structures, presence of technology, and the culture of medical dominance were found to modify the process of *accommodating the incongruence*. Furthermore, varying intervening conditions that affected the patient, the nurse, or both, and the day-to-day ward environment also modified the basic social process. In instances where both nurses and patients came together with similar understandings and philosophy, the above mentioned basic social process of accommodating was not employed. Instead the status quo was maintained. The exception to this was

participation inclusion where the hospital contextual conditions and the varying intervening conditions, at times, were observed to prevent the maintenance of the status quo. This will be described later in the chapter.

### **Phases of the Basic Social Process of Accommodating**

The basic social process of accommodating was dynamic and reciprocal between the dyad. It involved three phases which were: (1) Coming to terms with the *incongruence*; (2) Rationalising the *incongruence*; and (3) Seeking resolution: Minimising the *incongruence* (refer to figure 5.1). The first phase, termed coming to terms with the *incongruence* involved encountering the *incongruence* and acknowledging that there was an *incongruence*. The second phase which was termed rationalising the *incongruence*, involved observing and assessing behaviour. The third phase, termed seeking resolution: minimising the *incongruence*, involved adjusting behaviour to minimise the *incongruence*. In this phase of adjusting behaviour, the nurses were observed to either increase patients' control and level of participation as well as increase their own level of control, or decrease patients' control and level of participation and decrease their own level of control, or alternatively converge patients' control and level of participation to meet their own level or style of participation, without them increasing or decreasing their own control.



**Figure 5.1 The phases of the Basic Social Process of Accommodating the “*Incongruence*”**



## **Coming to Terms with the *Incongruence***

As previously stated, during the duration of this study, both nurses and patients were observed to come to the bedside with their own conceptual understandings of the meaning of patient participation and philosophy about how care should be delivered. Therefore, during any given shift, an individual nurse had the likelihood of meeting up with patients who subscribed to either participation inclusion, participation marginalisation, or participation preclusion. Similarly, an individual patient had the likelihood of meeting a nurse who subscribed to any one of the above mentioned participation styles. Nurses and patients were also observed to come together, for the majority of the time, with their own ideas about how care should be delivered at the bedside. This *incongruence* occurred, as explained in chapter four, against the backdrop of the hospital context of economic constraints, management structures, the presence of technology, and the culture of medical dominance. Coming to terms with the *incongruence*, thus, was the first phase of the basic social process used to overcome this problem. This first phase involved encountering the *incongruence* and acknowledging the existence of the *incongruence*, which appeared to occur in a linear fashion.

### **Encountering the *incongruence***

The *incongruence* firstly needed to be encountered by both parties before any action and/or interaction could be taken. According to the Oxford English dictionary, the word “encounter” means to meet unexpectedly or by chance. Data analysis revealed that it usually took about 24 hours before the nurse and the patient perceived that they had encountered the *incongruence* in their understandings of patient participation and in their philosophy about nursing care. This appeared to occur because, in the initial nurse-patient encounter, the nurse was mainly observed to be preoccupied with the patient’s physical condition and the patient was still getting used to the unfamiliar ward environment or was too sick to be concerned. Examples are in these nurse and patient comments:

*When I first come on and I don't know the patients, rather than find out who they [patients] are and what they are in for, I think, well, I'll start with the*

*temperatures and then I'll go and do the obs [observations] and if I have them again, I will get to know them a bit better and I will soon know where they are coming from (nurse 20).*

*I mean the first few hours, you are still in shock of being in hospital ... you don't know what to expect so you wait and see what the nurse does before you say anything ... also in the beginning, you might not feel that well to initiate even a conversation with the nurse (patient 4).*

However, after the first 24 hours, it was observed that nurses and patients showed evidence that they had perceived that they had encountered differences in viewpoints about what patient participation meant and how the care should be delivered by the nurse and received by the patient. Data analysis revealed that nurses and patients found that they had encountered the *incongruence* when expected behaviours from each party did not match with the performed behaviours of both. For instance, patients were beginning to either question or challenge the nurses' actions when the nurses were not expecting it, or the patients were not questioning or initiating input when the nurses were expecting it. Patients were also seeking consultation with the nurses without being invited to do so by the nurses or declining to consult with the nurses when encouraged to do so by them. Another example included patients refusing to comply with the nurses' instructions or conforming with the nurses' instructions when the nurses were not expecting it. The extent to which the above occurred was observed to be dependant upon the patients' degree of wellness, their mental status, and level of knowledge. The following nurse and patient statements highlight this point.

*The other evening, I went to give an enema to the patient and he said, "well, you are not going to give me any enema" ... I was taken aback because they [patients] usually don't refuse ... so I suddenly realised that patients can be different ... I always thought nurses have the power, they can manipulate the patients ... nurses can walk up to a patient and do something to them so fast that the patient doesn't get the chance to say "no" (nurse 26).*

*I know, I should do as much as I can but there are some things they [nurses] want you to do but you cannot do ... like yesterday after the clearing medicine, I needed to go to the toilet often and I needed to be taken on the commode chair as I have difficulty walking ... and this young nurse pulled a face and seemed reluctant to do it, which took me back a bit. So I said, "well, you better go and tell the head sister to come and see me and I'll tell her that you don't want to do your work" and she looked at me as though I*

*had said something dreadful ... she ended up taking me and she was quite nice with me afterwards (patient 24).*

Some nurses who subscribed to participation marginalisation, that is, they perceived that patients should make decisions about their activities of daily living and sometimes make decisions, if able, about pain control but not other aspects of their care, stated that they had discovered that there was a discrepancy in opinion when some patients started to question their actions and wanted to be consulted about their own treatments. The nurses explained that this had occurred after they had instructed and guided the patients in their care without inviting the patients to have a say in how care and treatments were to be given. For instance:

*We don't see patients as partners in care, we see us [nurses] more as carers ... I think we have our knowledge and routine and tend to instruct our patients in what we want them to do unless they [patients] say "I would like to have this done this way, this is what I prefer, I want to discuss my treatment with the doctor" ... I guess, we realise then that they want to have a say and we should give them [patients] options so they will feel comfortable about being involved but they don't have the knowledge to make decisions or know what is best for them (nurse 10).*

Similarly, some patients explained that they had discovered that there were differences in opinions about nursing care between them and some nurses when they were asked to do something that they were not expecting to do. These patients stated that they had not expected the nurses to ask them for their opinions or to be given a choice by the nurses. The patients further stated that they were of the view that they should do as they were asked by the nurses as they did not have the medical knowledge or expertise. These patients had subscribed to participation preclusion. The following field notes demonstrate this point.

*The nurse completed doing the observations on the patient and said "Mr X, have you done your blood sugar level this evening?", to which the patient responded, "no, I haven't done that and I haven't had my insulin either ... I thought you would be doing that ... the nurse did it this morning". The nurse turned to the patient and replied, "Mr X, you have been doing them [blood sugar level and insulin] at home, haven't you? and the patient said "well yes, but in hospital, I thought you will be taking care of that". ... "Mr X, I would like you to go and have the blood test and can you do your insulin please, unless you want me to do it ... tea will be here soon ... your insulin has not been changed ... you know how much you have and I will get*

*the insulin for you from the fridge', to which the patient looked puzzled (field notes).*

In the above instance, the patient was not expecting to administer his own insulin in hospital. The patient stated that he had thought that the nurses were in charge and was therefore expecting the nurses to instruct him regarding what he should be doing. Moreover, the patient explained that since the morning nurse had done his blood sugar and had given him the insulin, he had perceived that it was the nurses' role to do the blood sugar level and administer the insulin. When the nurse had asked the patient to administer his own insulin, the patient found that his view was different from that of the nurse. As the patient stated:

*It is not as if I am lazy or anything ... I really thought that the nurses told you what to do in hospital ... I didn't want to say anything in case I offended the nurses ... they do such a good job ... frankly, I was astonished when the nurse asked me to give my own insulin, which I didn't mind (patient 13).*

The above situation was contrary to some patients who subscribed to participation inclusion, that is, they perceived that patients should have input, if able, in all aspects of their care, including making decisions about their treatments. These patients claimed that they first found that there were differences in opinion between them and some nurses when the nurses had not allowed them to take the initiative in their own care. The patients stated that, even though they had directly informed the nurses about what needed to be done with regards to their care, the nurses had not responded to them. Furthermore, they claimed that the nurses had endeavoured to continue to guide and direct them. For example:

*I knew that my stockings [Ted, anti-embolic stockings] needed to be put on after the shower so I asked the nurse to do it and she said she would do it when she was ready ... I could see the nurse standing and chatting with another nurse ... finally, I had to ask again because it was lunchtime and she still hadn't done it ... in the end, she came and did it and said nothing would happen because the stocking wasn't on earlier ... but I said to her that complications can occur as I had ended up with phlebitis at the other hospital because the stocking wasn't put on straight away and I could see the nurse wasn't pleased (patient 28).*

A few nurses who subscribed to participation marginalisation stated that when patients voiced an interest in participating in all aspects of their care, they were surprised. The nurses explained that they were surprised because they felt that patients were in hospital to be cared for and that apart from making decisions about their hygiene care and pain control, if able, they should leave all other decisions to the nurses and doctors. It was interesting to note that these nurses were surprised when they had encountered the *incongruence* in viewpoints between them and the patients, clearly indicating that they had not expected patients to completely participate in all aspects of their care.

On the other hand, some nurses who subscribed to participation preclusion, that is, they perceived that patients should listen to the nurses and do as they were told in all aspects of their care, were confronted with differences in viewpoints when some patients, who subscribed to participation inclusion or marginalisation, had challenged their orders to do something. These nurses stated that they were taken aback that some patients, especially the ones who subscribed to participation inclusion, had been assertive and had stood up to their orders. The nurses claimed that at this point they had become aware that they had come across patients who thought differently to them, as demonstrated by these comments:

*I went to give the patient some panadol for the leg ulcer pain and she refused, telling me that she would be better off with panadeine forte, claiming that she was used to taking that [panadeine forte] at home. The patient went on to tell me that she had specifically asked her doctor to write her up for panadeine forte and what was I thinking giving her panadol .... I must admit I felt put out and told her that in my opinion, I thought that panadol would do as she didn't seem to be in that much pain ... but the patient insisted ... I was taken aback by her assertiveness (nurse 21).*

*I went to do the patient's dressing and half way through the dressing, the patient started to demand that I do the dressing in a very exact way, in a very particular way, which annoyed me ... It was the first time a patient had told me what to do ... it was as if he had inside knowledge sort of thing (nurse 18).*

Similarly, some patients who subscribed to participation preclusion, that is, they perceived that they should do as they were told by the nurses, explained that they had realised that some nurses did not want them to do as they were told. These

patients further stated that some nurses had given them choices about how they would like something done regarding their care, or had asked them for their opinions. Some of these patients claimed that they were surprised that their views about care were sought by some nurses and stated that they were at a loss for words because they had not experienced this situation with the nurses in the past. These patients pointed out to the researcher that it was then that they had become aware that there were differences of opinion between them and some nurses.

*I was all set to follow their [nurses] orders because that is how I think it should be in hospital and it throws you sometimes when a nurse comes in and asks you your opinion about whatever they need to do with you ... frankly, it floored me to think that my opinion counted ... in hospital, you somehow don't see yourself as someone who should have a say (patient 24).*

*I wasn't sure about having the pain injection but felt that I had to go along with the procedure as the nurse in the morning shift had explained to me that I should have the needle every 4 hours so I had the needle ... I must have looked worried or something because this nurse on afternoon shift said to me, "Mrs X, what's wrong?" and I told her that I wasn't sure about the injections but felt I had to do as the nurse had asked me to do in the morning ... the nurse told me, "you know, you don't have to have the injections if you don't want it ... I can ask the doctor to write you up for something else" and I thought, goodness, I've never been given an option before and I realised that this nurse had her own ideas (patient 7).*

It was clear from the data that nurses and patients first must have encountered the *incongruence* before they could acknowledge and come to terms with it.

Encountering the *incongruence* therefore, was found to be the first step in coming to terms with the *incongruence*.

### **Acknowledging the *incongruence***

The Oxford English dictionary defines the word "acknowledging" as admitting that something is true. Data analysis showed that after encountering the *incongruence* in the understandings of patient participation and in the philosophical beliefs about nursing care, both nurses, to a greater extent, and patients, to a lesser extent, went through the next step of acknowledging the *incongruence* before they could come to terms with it. It was observed that the extent of acknowledgment varied between nurses and patients and amongst nurses and patients. This was found to be

dependent upon the styles of participation to which both parties subscribed. For example, nurses who subscribed to participation inclusion were more acknowledging of the *incongruence* and came to terms with it more readily than nurses who subscribed to participation marginalisation or preclusion. Similarly, patients who subscribed to participation inclusion readily acknowledged that there were differences in opinion between them and the nurses and came to terms with this, more so than patients who subscribed to participation marginalisation or preclusion.

The nurses who subscribed to participation inclusion, that is, that patients should have input in all aspects of their care, stated that they had acknowledged that there were differences in viewpoints between them and the patients when some patients had not accepted their offer to work with them. These nurses claimed that the patients were reluctant to make their own decisions about their care, when able, and had wanted the nurses to give them directions and guidance. As explained in chapter three, some patients perceived that they lacked medical and technical knowledge, and thus, had believed that the nurses should guide and direct them. These patients were of the view that nurses and doctors “knew best”. This was explained by some of these nurses as:

*Some patients are articulate and you give them the information but even then they are reluctant to initiate anything on their own volition ... They'd [patients] prefer for you to make the decisions ... I don't know if they are anxious about their medical condition or what but they sure seem to be happy for you to give them instructions in what they should do and how they should do it ... it is then that you accept that they [patients] are not on the same wavelength, and that you know you need to educate them more about their right to be consulted ... this is of course if they are well enough and willing (nurse 30).*

These nurses also stated that, in some instance, they had come across some patients who were reluctant to perform even their activities of daily living, which they were capable of doing, without being first told to do so by the nurses. The nurses stated that the patients' behaviours had indicated that they had wanted to do as they were told by the nurses. The nurses further commented that initially they had perceived these patients to be lazy and had been annoyed with them. However, the nurses explained that, when they found out that some patients had had bad experiences

during previous hospitalisations because they had voiced their opinions, they had acknowledged the differences in viewpoints between them and the patients and had come to terms with it. Hence, these nurses had set out to assist patients at least to participate in undertaking their activities of daily living, even though the patients had wanted to do as they were told.

*Some patients do by themselves take a subservient and passive role and wait to have cues from us [nursing staff] ... they may have had a hard time with nurses if they had not done as they were told in past hospitalisations ... I don't know why but some patients seem to come into hospital believing that if they are not compliant and do as they are told then their care will be compromised ... it is up to us to acknowledge this and make them [patients] feel comfortable in our cultural environment and help them if we can (nurse 17).*

*At times, we come across patients who are so timid and they will ask your permission to even go to the toilet or to go and have their shower ... they are capable and can go unassisted but they [patients] will wait for you to tell them to go ... you really need to be aware of this and do a lot of reassuring and you don't have the time sometimes (informal nurse interview).*

The above nurses who subscribed to participation inclusion also commented that they were pleased to work with patients who were pro-active about participating in their own care. These nurses claimed that, on rare occasions, they had come across patients who knew exactly what was happening to them and had voiced their opinion about being consulted in how their care should be delivered.

*Some patients have been to the library before they come into hospital and they know quite a bit, which I think is good ... like this patient was to have oxygen and he told me that he was claustrophobic and asked if he could have the nasal prongs and I thought that it was good that he was able to ask us for alternatives ... patients are much more informed these days and that is how it should be (nurse 19).*

Similarly, patients who subscribed to participation inclusion supported the above nurses' views. These patients explained that they had appreciated the nurses who had understood and acknowledged where they were coming from and who seemed to accept their input into their own care.



*I tried not to take too many pain killers ... I might take them in the morning and at night before bedtime ... the nurse was pretty good about it ... she let me decide when I wanted them and I felt she was ok about it ... sometimes, in the shower, the nurse wanted to assist me but I told her "look, I can manage myself so you can leave me" and the nurse left me alone ... we got on really well (patient 2).*

On the other hand, some of these patients who subscribed to participation inclusion claimed that they had encountered nurses who had different views about care to them and had to acknowledge that there were differences in viewpoints between them and some nurses. The patients stated that they had recognised that some nurses were only interested in guiding them what to do or directing them. They explained that in instances where the nurses had wanted to instruct them they had tended to go along with the nurses because they were unwell and had given the nurses the benefit of the doubt that they were only doing their job.

*This was the second day after my operation and I assumed that if I have pain, I would ask the nurses for some pain relief and that they would give it to me ... but that wasn't the case, the nurse explained to me that she would give the pain tablets when I was due them ... she [the nurse] said that I should have enough pain cover for another hour ... I told her that I needed the tablets for the pain but she didn't seem to listen ... so I thought perhaps she was right and that I should wait (patient 1).*

However, the above situation was not observed to be evident when some nurses had told patients what to do. For example, some patients who subscribed to participation inclusion had encountered nurses who had expected them to do as they were told, but were observed to be resistant to the nurses' commands. These patients stated that, whilst they had acknowledged that there were differences in opinion, they were not prepared to go along with the nurses' demands. Accordingly, they said:

*The nurse came in at lunchtime and said "I am in charge, bla, bla, bla and was dishing out the antibiotics and not listening to what I was saying that I had already had my antibiotics. So I told her that I had had it at 11 o' clock before lunch and still she insisted, saying "look, it is not signed off, you probably are mistaken" and I was annoyed and told her that I was no blooming fool and for her to check with the morning nurse ... after a while, she calmed down and went to check (patient 26).*

Moreover, some patients who subscribed to participation inclusion further explained that, whilst they acknowledged that some nurses had their own way of doing things and that they had not minded going along with their instructions or directions, they were not prepared to be treated as fools or to do as they were told without proper reasoning.

The nurses who subscribed to participation preclusion, on the other hand, claimed that they had recognised and acknowledged that there were differences in viewpoints between them and some patients when the patients had refused to follow their orders and had questioned their intent. These nurses explained that such patients had slowed them down in their work routine and had forced them to acknowledge the differences. The nurses further commented that some patients were articulate and were well informed about their medical condition and were aware of their rights, and that they had no option but to come to terms with the differences in opinion and placate the patients' concerns before they could do anything with them. For example:

*I go in expecting them [patients] to comply and follow doctors' and nurses' orders ... if they don't, why come into hospital? ... but you come across some patients who shut themselves off by not listening to our advice and are forever questioning you ... it is as if you are on trial or something and you know you have to work with these people so you have to do something about it ... it is hard to understand why they are like that with you ... personality clash, I suppose (nurse 23).*

The above nurses' viewpoints were supported by some patients who stated that they were not prepared to take orders from the nurses. These patients stated that they perceived that they had a right to participate or have a say in their own care, despite the nurses' opinions that they should do as they were told. One patient who had been in hospital several times had this to comment:

*Years ago, I wasn't hospital wise and doctor wise and nurse wise and I used to get upset when the nurse ordered me to do something, but I can speak up for myself now and I take it in my stride and tell them [nurses] exactly what I think, even if it means being labelled, especially if I'm not happy about doing something that the nurse wants me to do ... I realise nurses have their ways but I am a person, not a lump of wood (patient 12).*

In the above scenario, the patient was prepared to accept the consequences of being labelled by the nurses and had been assertive in how the care should be provided, even though the patient appreciated that nurses had their own views about care.

At other times, the nurses who subscribed to participation preclusion claimed that they had encountered patients who had voiced their opinion about making decisions about their activities of daily living and pain management. The nurses expressed concern that they did not consider that patients were in a position to make any kind of decisions whilst they were sick and in hospital. The nurses were adamant that patients should do as they were told and were observed to convince some patients to do as they were told. The following field notes demonstrate this.

*The nurse said to the patient "here is your panadeine forte, to which the patient replied "I am out of it and feel very dazed, I would like to see the doctor" and the nurse answered " well, you should take them for the pain in the legs [leg ulcer] ... otherwise it is hard for us to do the dressing . . you can refuse but I would like you to take them". The patient turned to the nurse and said " I don't believe I need them [panadeine forte] ... I feel dazed and get constipated ... I will take them since you want me to take them but I would still like to see the doctor". The nurse replied "ok, I'll catch the doctor if I see him" and left after giving the medication to the patient (field notes).*

Patients who subscribed to participation marginalisation, that is, that they should have input into undertaking their activities of daily living and make decisions, if able, about pain control, stated that they had sometimes come across nurses who had extended an invitation for them to have a say in the care of their treatment and had even suggested that they seek a second opinion about the treatment. Some of these patients explained that, whilst they had acknowledged that some nurses' views were different to theirs in that they had wanted them to be fully involved in their own care, they were not comfortable about being fully involved. The reason they gave was that they were concerned about making the wrong decision about their treatment and were not prepared to take the consequences of delaying recovery. These patients further explained that they had appreciated the nurses' considerations for their input, and whilst they had come to terms with it, they were not prepared to

go beyond making decisions about their activities of daily living or pain management, if able. They said:

*I accept that some nurses want you to have a say in what's been happening to you in hospital and even encourage you to ask the doctor questions about your treatment ... but somehow, I'd prefer to be guided and leave the treatment decisions to the doctor ... the nurses mean well but at the end of the day what if you make the wrong decision and then where will I be (patient 10).*

Whilst the above patients were cautious, other patients who subscribed to participation marginalisation claimed that they had acknowledged that some nurses' views were different to theirs in that they had wanted them to have input into all aspects of their care and that they were prepared to go along with the nurses' suggestions. The patients qualified this statement by explaining that they needed to have all available information from the nurses before they would make a commitment to being fully involved in their own care. The patients further stated that they needed to be well enough to do so.

*It was great when the nurse asked me what I thought about my treatment and was I happy with it ... I wasn't expecting that from the nurse but then I realised that maybe I should have a say ... it was good to see the nurse pointing out to you that it's your body and you have a right ... she [nurse] showed me the hospital information booklet that tells you that you do indeed have a right ... nobody tells you these things ... only thing I told her was that I needed to get more info [information] from her and the doctor ... it was great to see this (patient 29).*

On the other hand, some nurses who subscribed to participation marginalisation stated that they felt comfortable when they had encountered patients who were similar to them in their views about how care should be delivered and were pleased to acknowledge this. The nurses claimed that when patients had sought guidance and directions from them they had perceived that their work would be made easier because the patients were prepared to go along with them. Some of these nurses further explained that these patients were aware of their limitations with regards to their knowledge base and thus supported their own views that nurses and doctors "knew best".

*When you work with patients who meet our expectation to carry out instructions because they are sick and don't fully know what to expect in hospital, it certainly helps us in our job ... after all we are the experts and it is good when patients appreciate this fact (nurse 20).*

However, when these nurses had encountered patients who subscribed to participation preclusion, they had also acknowledged the differences in viewpoints between them and the patients. Under these conditions, the nurses explained that they did not feel comfortable with patients wanting to do as they were told, even though they had come to terms with the differences in opinions. The nurses commented that they believed that patients, if able, should have input into their activities of daily living and pain control and were observed to try and get these patients to be guided rather than for them to do as they were told. These nurses stated:

*I don't mind it if patients are happy to be guided by us, after all, we know best but when they [patients] are so subservient and tell you that they will do as you tell them to do, it is not right ... all these consumer focused bit, we need to encourage some input from them, it is their right, don't you think ... so I try to do this (nurse 32).*

In summary, it was found that nurses and patients initially needed to encounter the *incongruence* in their understandings of patient participation and in their philosophical beliefs about care before they were able to acknowledge it and come to terms with it. Data showed that both nurses and patients had become aware that they had encountered the *incongruence* and had acknowledged that there were differences in viewpoints when expected behaviours from each party had differed from the performed behaviours of both. Furthermore, nurses and patients began to acknowledge the *incongruence* and come to terms with it when actions/interactions between them were perceived by both parties to be in direct conflict with each other.

## Rationalising the *Incongruence*

The second phase of the basic social process, used by nurses and patients to deal with the basic social problem of *incongruence* in the understandings of the meaning of patient participation and in the philosophy about nursing care, was termed: Rationalising the *incongruence*. Rationalising was defined from the data as both nurses and patients convincing themselves that there was a logical reason for the differences in viewpoints. In other words, both parties tried to make sense of the differences in opinions about what patient participation meant and how nursing care ought to be delivered. It was evident from the data that both nurses and patients needed to rationalise the *incongruence* before they could consider taking any action, for example:

*When I say something suits me better re [regarding] my care, contrary to what the nurses want me to do, and the nurses are surprised that I have my own views, I give this due consideration ... there is a point for both the nurse and the patient to sort something out and to work together ... the nurse needs to listen to the patient and the patient can also gain by working in with the nurse (patient 11).*

*When you are dealing with patients who you know are going to question you about everything that you are doing to them, you begin to see that they [patients] are within their rights to do so ... after all it is their body and you slowly begin to accept that patients make sense when they question you and you tend to go along with it ... I put myself in their shoes and it is fair that they want to know (nurse 5).*

The phase of rationalising the *incongruence* involved observing and assessing behaviour. Data revealed that both nurses and patients went about observing and assessing each other's behaviours before they were able to rationalise the *incongruence*. The period of observation and assessment was generally found to occur forty eight to seventy two hours after the initial nurse-patient encounter. It was evident that both nurses and patients had to undergo the first phase of coming to terms with the *incongruence* before they were able to move into this second phase of rationalising. These nurse and patient statements reflect this:

*You have been caring for them [patients] for a few days and more and more you realise and know that they have their own minds ... sometimes, they are going home the next day so you tend not to worry too much about fitting in*

*with the patient ... but if they [patients] are going to be in hospital for a while, then you need to do something about it ... so you start watching what they [patients] are doing and saying and try to assess where they are coming from and take it from there (nurse 14).*

*Initially, I don't know where I stand with some nurses, especially in the first couple of days, but after that I watch and see what the nurses' behaviours are with me ... I am a person who likes to be independent and I tend to watch what the nurse does first before I would say anything ... I don't want to upset them [nurses] but I won't be bullied either ... we are all different and I realise that ... I was happy to speak to the nurses about this because I know the nurses have their responsibility to their patients (informal patient interview).*

### **Observing and assessing behaviour**

The Oxford English dictionary defines “observing” as seeing, noticing, and watching carefully and defines “assessing” as deciding on the value or worth of something. In this study, it was found that nurses, to a greater extent, and patients, to a lesser extent, seemed to watch each others behaviours and to evaluate the perceived degree of incongruence between them, regarding the understanding of the meaning of patient participation, and the philosophy about nursing care. It was also found in the data that nurses who subscribed to participation inclusion were found to be observing and assessing patients, who subscribed to a different participation style than themselves, more arduously than nurses who subscribed to participation marginalisation or participation preclusion. The reason for this occurrence appeared to be that nurses who subscribed to participation inclusion believed that patients should have input into all aspects of their care and were therefore seeking information about patients through observation and assessment. Whilst these nurses stated that there may be reasons why patients had not wanted to get involved in their own care, they nevertheless wanted to assist patients to be pro-active in their care. They explained:

*When I get someone [patient] who just lies there and waits for you to tell them what to do, I tend to talk to them more and find out why they won't initiate anything ... when I am with them, I try to observe their behaviour like if they were scared or worried and get them to realise that they can have a say and that is quite all right with me ... it is sometimes obvious to see that they [patients] go to say something but stop halfway and it is up to us to encourage them (nurse 13).*

*Some patients, especially the ones who have never been in hospital ... you can see that they are nervous, not knowing what to expect from different nurses and you notice that they [patients] are not asking questions about their care or treatments that they should be asking ... it is interesting to see how quickly some patients will respond to you if only you take the trouble of telling them that they can voice an opinion (nurse 30).*

Additionally, patients who subscribed to participation inclusion stated that when they had encountered, acknowledged, and come to terms with differences in opinions between them and some nurses, they first needed to make sense of this differences. They stated that they had done this by resorting to observing and assessing the nurses' behaviours. These patients commented that they initially needed to know how some nurses, who had different viewpoints to themselves, would react to them. They further added that they needed to be careful that they did not overly upset some nurses, especially the ones who subscribed to participation marginalisation or participation preclusion. This was because they had perceived that their care may be compromised if they upset the nurses. Moreover, the patients explained that on a few rare occasions, they had come across some nurses who had similar views about care to themselves. During these instances, the patients stated that they had been able to tell the nurses how they would like their care to be delivered. However, when they had encountered nurses who did not subscribe to views similar to their own, they had to rationalise through observing and assessing these nurses behaviours and act accordingly.

*When I see that the nurses don't mind you speaking up and asking questions, you know that you will be ok with them [nurses] but when I notice that the nurses are not listening to you and insist that you do as they direct you, I get annoyed ... still I try and talk to them and try and get them to see my point of view ... I let them know, I am a human and not a piece of wood ... some of the nurses will then let you decide on some things at least which I can live with (patient 18).*

*I think patients have a right to make decisions ... it is good for patients to make decisions ... when I was in hospital, this nurse wanted me to take some pain killers and I wasn't in pain ... I told her that I wouldn't take it because I would be putting into my body something that I really didn't want ... when she [nurse] insisted, I told her where to go and she backed off ... I don't mind cooperating with them but I won't be pushed ... it's a job to try and get the doctors and nurses to listen to you (informal patient interview).*



Some nurses who subscribed to participation marginalisation were also engaged in observing and assessing patients behaviour after they had come to terms with the *incongruence* in viewpoints between them and some patients. However, this was found to occur to a lesser extent than nurses who subscribed to participation inclusion. Data revealed that these nurses were not observed to rationalise the differences in viewpoints as readily. They stated that they would try and understand where patients were coming from, especially those that subscribed to participation inclusion, but that they found it difficult to allow patients to make decisions about treatments. These nurses further explained that patients generally were not knowledgeable enough to make such decisions and that they would try and get the patients to see reason and accept their treatments without question. For example:

*Sometimes you notice by the way patients behave, you can tell that they want to know exactly what is happening to them and I can understand their point of view but I think it is actually the nurse who has the governing role really in how much patients can do for themselves ... mind you, I am only too happy for them to participate in their daily care and pain management ... I can't say I am thrilled about them [patients] making decisions about their treatments and I tend to talk them around ... what would they know about infection control for example (nurse 10).*

On the other hand, the above nurses claimed that when they had observed and had assessed patients' behaviours to be one where patients had wanted to be passive recipients of care and do as they were told, they had experienced concern. These nurses further commented that whilst they can accept the reasons why patients would be passive, they nevertheless perceived that they should encourage patients to be involved in their own activities of daily living and hygiene care, if able, if not in managing their pain control. At the same time, the nurses stated that they would not push this issue with some patients if the patients were reluctant to take advice from them about being involved in their activities of daily living care.

*After a couple of days when patients are stable, you become aware, through observation, that some patients are scared and won't initiate anything ... they wait for you to instruct them ... some of my colleagues will welcome this but I don't think it is right ... If patients want to do as they are told it is their prerogative but it still doesn't make it right ... we need to encourage some basic input from them (nurse 19).*

*If I notice that patients are well enough but don't want to do anything for whatever reason, I tend not to push them too much but I will try and encourage them ... I think it is for their own good and you can see that some of the "oldies" [elderly patients] will let you do everything for the attention ... I can understand why they are like that ... even so we need to do something to get them to help themselves (nurse 1).*

Additionally, patients who subscribed to participation marginalisation claimed that, through observation and assessment of nurses' behaviours, they were able to rationalise the differences in opinions between them and some nurses. These patients espoused that when some nurses had wanted them to make decisions in all aspects of their care, they were surprised initially but had realised why these nurses had wanted them to be involved. The patients, moreover, stated that after listening to these nurses who had wanted them to be fully involved in their own care, they could see the reasoning behind these nurses' intentions and had decided to go along with the nurses. They explained:

*I was quite happy for the nurses to give me guidance and help because I know this is how it should be in hospital ... when the nurse asked me if I would like this, this and this, done, I was pleasantly taken aback and had no trouble telling her [nurse] what I would like (patient 6).*

Patients who subscribed to participation preclusion, that is, they perceived that they should do as they were told by the nurses, claimed that they too could accept and come to terms with the differences in opinions between them and some nurses. Some of these patients stated that they had had no problems in rationalising the differences in opinions and had been inclined to go along with the nurses who had wanted them to have input into their activities of daily living and hygiene care. There were some patients, however, who explained that they had great difficulties in rationalising some nurses' behaviours that had indicated to them that these nurses had wanted them to have input into all aspects of their care, including treatment decisions. Furthermore, the patients commented that they had found it difficult to understand the amount of input that some nurses were asking them to have. The reason given for this was that these patients perceived that it was not their place to make any kind of decisions about their treatments. They clearly believed that such decisions had to be made by the doctors and the nurses and not by them. This was

because they perceived that the doctors and nurses knew what they were doing and had the skills and knowledge to help them to recover. The following comments reflect this point.

*I am lying there waiting for the nurses to tell me what to do and this nurse comes along and asks me when I would like to have my wash and when I would like my dressing done ... you go into hospital thinking that the nurses have their ways and are in charge but when you see a nurse asking for your opinion, it is kind of nice and you realise that maybe you should give this due consideration and think about what the nurse is asking (informal patient interview).*

*I am prepared to do as the nurses want me to do, which the nurses expect of you ... I know some nurses are different in their thinking and you realise this when they [nurses] give you choice about your daily care like toileting, bathing, etcetera ... I think, maybe this is fair enough given the nurse should know what she is doing ... my place in hospital is to do as they [nurses] tell me, like making a decision about my wash but when they [nurses] want you to ask questions of the doctor and want you to decide about medical issues [treatments], I am afraid, I can't think of going along with this because I am no expert and they shouldn't be asking me to do this ... they are entitled to their views but I can't find a good reason to go along with them (patient 4).*

Nurses who subscribed to participation preclusion, on the other hand, stated that whilst they could come to terms with some patients' differences in opinion to themselves, they had found it difficult to rationalise this differences in viewpoints. The nurses explained that they were of the firm belief that patients should comply with what they were told to do in hospital because they were not experts in nursing and medical knowledge. Moreover, these nurses stated that patients needed to conform in order to recover as quickly as possible. Thus, these nurses found it hard to rationalise the *incongruence* in opinions between them and some patients. They further explained that because they could not see the logic in succumbing to patients' opinions, they tended to talk the patients around to their way of thinking about how the care should be delivered. They further qualified this statement by claiming that they had found it easier to do this with patients who subscribed to participation marginalisation than patients who subscribed to participation inclusion. They said:

*Sometimes some patients will ask why you they have to do something like having to sit out of bed post-op [post operation] and will be reluctant to do as you tell them to do, saying that they feel unwell and prefer to stay in bed for a bit longer ... they don't realise that the sooner they get up and move, the better it is for their recovery ... we tend to push them to get up and mostly they can't say no ... I guess we say it in such a way that they [patients] are made to feel that they are not conforming for their own good, so they give in and do as we ask (nurse 11).*

*When you have a patient whose behaviour indicates to you that they know a lot of things and they have enough confidence, it makes you feel intimidated ... I believe that's when they have their power when they say "I don't want you to do this or help to take me to the shower" after you have told them to go by themselves and then you have no choice but to go along with the patient if you want the work done ... some patients can be difficult and you have to work around them (nurse 21).*

In summary, it may be inferred that nurses and patients were observed to rationalise the *incongruence* between them in their understandings of the meaning of patient participation and in their philosophy about nursing care, after they had come to terms with it. Nurses and patients rationalised this *incongruence* at varying levels. For example, nurses and patients who subscribed to participation inclusion appeared to rationalise the *incongruence* more readily than those who subscribed to participation marginalisation or preclusion. It was evident that nurses and patients utilised observation and assessment of each others behaviours to rationalise the *incongruence*.

It was also found that as nurses were the dominant actors in the process of *accommodating the incongruence* which was dynamic and reciprocal, the degree to which the nurses came to terms and rationalised the *incongruence* appeared to influence the manner and extent to which nurses acted to seek resolution and minimise the *incongruence*. As indicated in chapter one, there seemed to be a power imbalance between nurses and patients, with nurses holding on to the power. As Lawler (1991) argued, nurses continued to practise in a somological manner, where they were mainly concerned about physical care for patients rather than to consider patients' individual needs and viewpoints and to facilitate empowerment of them. In support Foucault (1975, 1980, 1991), as already alluded to in chapter one, had claimed that health professionals tendered to objectify patients in their engagement

in the “clinical gaze”. This had resulted in health professionals treating patients as bodies that needed surveillance and monitoring rather than as individuals who needed empowering. In this study, nurses were also observed to have power over patients because patients lacked medical knowledge and information to make decisions about their own care. Hence, patients were observed to take on a more passive role in acting to seek resolution and minimise the *incongruence*, even though they appeared to have come to terms with and rationalised the *incongruence*.

### **Seeking Resolution: Minimising the *Incongruence***

The third and final phase of the basic social process used by nurses and patients to deal with the basic social problem of *incongruence* in the understandings of the meaning of patient participation and in the philosophy about nursing care was labelled: Seeking resolution: minimising the *incongruence*. This phase involved adjustment of behaviour by both nurses and patients. As nurses were the dominant actors, this last phase was observed to be predominantly nurse-driven with patients playing a subsidiary role. Therefore, nurses adjusted patients’ behaviours mostly and then their own. Patients did most of their adjusting in response to the nurses. Thus, this phase was dynamic and reciprocal. Hence, in this phase the nurses were observed to resort to either increasing patients’ control and level of participation as well as increasing their own level of control, converging patients’ control and level of participation to meet their own level or style of participation, without them increasing or decreasing their own level of control, or decreasing patients’ control and level of participation and decreasing their own level of control. Seeking resolution: minimising the *incongruence* has been defined from the data as nurses and patients deciding to take action so as to mitigate the problem of *incongruence* and to achieve some balance in each other’s input into care. To this end, both nurses and patients were observed to adjust their behaviours at varying levels. For example:

*Some patients take on the sick role as soon as they become patients and they will be reluctant to do anything that you ask of them ... even things that they can do for themselves, they will expect you to do it ... I like patients to assume responsibility for their own care so I try to work out ways of getting them [patients] to be independent again ... I might use different tactics to what I normally do to encourage this independence (nurse 22).*

*I was trying to sleep and this nurse came and started on me and told me to go and have my shower ... I had been to [operating] theatre the day before and I really didn't feel capable of getting up and doing too much for myself ... I always feel I have got to be in control of myself and asked the nurse if I could stop in bed ... the nurse had her views and insisted that I should go and shower ... in the end I gave in but told her that she has to help me get to the shower which she did ... I felt vulnerable and really you are in their hands (patient 3).*

### **Adjusting Behaviour**

Adjusting behaviour has been defined from the data as nurses and patients altering their behaviour so as to fit in with each others' differences in viewpoints about patient participation and nursing care and moving harmoniously in the care environment. For instance:

*I think patients are frightened sometimes to ask any questions or question you and I guess nurses expect patients to accept whatever they are being offered so that they can get well and be discharged ... we do things automatically that we sometimes don't give a second thought to patients ... we really need to rationalise and stop and invite input from patients ... we need to change somewhat and not expect patients to make the first move because they won't as they are frightened and sick (nurse 14).*

*If you don't do as you are told you are not going to get well quickly and go home so I tend to wait for the nurses to tell me what to do ... you feel helpless in hospital and don't want to do anything wrong ... but when nurses explain things to you and encourage you to have a say in what happens to you in hospital, you feel ok to go ahead and act more independently ... mind you, not all nurses are like that ... I generally try and fit in with the nurses (informal patient interview).*

The number of adjustments made by nurses and patients varied between nurses and patients and amongst nurses and patients. Hence, this phase of adjustment was considered to be dynamic and reciprocal. The manner in which nurses and patients interacted with each other therefore varied. This was observed to be dependent upon the style of participation either parties subscribed to and their philosophical beliefs about nursing care. For patients, their level of wellness and the degree of vulnerability they experienced also affected the amount of adjustments they made to fit in with the nurses' viewpoints. As already stated, nurses were observed to adjust their behaviours by either increasing patients' control and level of participation as

well as increasing their own level of control, converging patients' control and level of participation to meet their own level or style of participation, without them increasing or decreasing their own control, or decreasing patients' control and level of participation and decreasing their own level of control. Patients appeared to fit in with the nurses' degree of adjustment. As already explained, this final phase was predominantly nurse-driven.

Data analysis showed that it was only through adjusting behaviour that nurses predominantly, and patients to some extent, were able to minimise the *incongruence* and seek resolution. In the following section, the various strategies that both nurses and patients used to adjust behaviour to minimise the *incongruence* and seek resolution will be described. As previously explained, nurses and patients were found to subscribe to different styles of participation, that is, participation inclusion, participation marginalisation, or participation preclusion. Hence, both parties had a high likelihood of working with another with different viewpoints. The adjustment of behaviours by nurses predominantly, and patients to some extent, will be described against the backdrop of the hospital contextual conditions, as described in chapter four. The various intervening conditions pertaining to the nurses, the patients, and the ward environment, that modified this adjustment will be addressed. As well, the conditions that facilitated the nurses to increase or decrease patients' level of participation and increase or decrease patients' and their own level of control will be included. This section will also explain what happened when, on the rare occasion, both nurses' and patients' views about the meaning of patient participation and beliefs about nursing care were matched. As the nurses were dominant in this phase, the nurses' behaviours and the strategies that they used will be described, together with patients' responses to the nurses' behaviours. As already explained, patients in most instances appeared to take the cues from the nurses in terms of how they adjusted their behaviours, and adjusted their own behaviours to fit in with the nurses' behaviours.

### **Adjustment Patterns**

As already alluded to, the nurses in this study were observed to adjust their behaviours in various ways so as to minimise the *incongruence* and seek resolution.

Three patterns of adjustments were utilised by the nurses when patients' and nurses' preferred participation styles were not matched. These included: (1) increasing patients' level of participation and control as well as increasing their own level of control; (2) converging patients' level of participation and level of control to that of their own without increasing or decreasing their own level of control; and (3) decreasing the patients' level of participation and control and decreasing their own level of control. Patients, as already stated, appeared to fit in with the nurses' patterns of adjustment. It was found that pattern (1) was mainly utilised by nurses who subscribed to participation inclusion, pattern (2) was used by nurses who subscribed to participation marginalisation, and pattern (3) was utilised by nurses who subscribed to participation preclusion. The following section will describe all these three patterns of adjustments.

#### **Adjustment Pattern (1): Increasing patients' level of participation/control and increasing nurses' control**

Data showed that the nurses who subscribed to participation inclusion were observed to adjust their behaviours to increase patients' control and level of participation as much as they could. However, if patients were unable or were unwilling to accept this increased control and level of participation, the nurses were observed to increase their own level of control, in order to work with patients. It was found that the nurses who subscribed to participation inclusion were observed to engage in a behaviour termed from the data as "partnering" with patients, whenever possible. Through partnering, the nurses were able to increase patients' control and level of participation. Partnering has been defined from the data as an activity where the nurses made every effort to work closely with patients, provided the patients were well enough, were receptive to the nurses' suggestions, and the hospital contextual and varying intervening conditions allowed this to occur. The following highlights this point:

*I don't feel that because I have the uniform, I am better than patients ... I am proud to wear the uniform but to me we are both experts in our own right ... I see patients just as important as we are to them ... to me the care should be mutually initiated and shared and I don't see why we can't be*



*partners in care, as long as patients are capable and want to work with us (nurse 6).*

*To me patients should be able to ask questions, be self-motivated and feel comfortable about using their initiative to tell you how they would like to be cared for ... it is a joint thing ... gone are the days when you [nurses] did things to patients ... I know that is not always easy in every case but certainly for the ones who are compus mentus, they should be encouraged to work with us for a common goal (nurse 14).*

## **Partnering**

Partnering involved the active consultation of the nurses with patients so that mutually agreed on plans about nursing care could be achieved and patients could participate in all aspects of their care. As previously mentioned, nurses who subscribed to participation inclusion had a high likelihood of working with patients who either subscribed to participation marginalisation or preclusion. When this occurred, it was observed that the nurses did their best to upgrade the patients' participation behaviour to correspond with that of their own, as much as possible. For example, in instances where the nurses found themselves working with patients who subscribed to participation marginalisation, the nurses were observed to bring the patients up to their own level of behaviour, that is, one that involved partnering. This was observed to occur in most occasions. It was found that when this occurred, patients were observed to respond by partnering with the nurses provided they were well enough and the hospital contextual and varying intervening conditions allowed this to occur, such as, if the nurses had enough time or had a reasonable workload. In a few instances, however, patients who subscribed to participation marginalisation were observed to simply want the nurses to take the lead by guiding and directing them. They wanted the nurses to take responsibility for making decisions about their treatments and were not willing to partner with the nurses. When this occurred, the nurses were observed to respect the patients' requests and increased their own level of control in order to guide and direct these patients.

On the other hand, in situations where the nurses found themselves working with patients who subscribed to participation preclusion, the nurses were still able to upgrade the patients' participation behaviours but only to the level where they could guide them, instead of partnering with them. Under these circumstances, the nurses

increased their own level of control or involvement so that they could work with these patients. This was observed to be due to the nurses' inability to change patients' entrenched views that they should do as they were told or toe the line in hospital. The reason for this appeared to be that, due to the early discharge program, the nurses found themselves with inadequate time to work with patients and to help them change their attitudes, that is to convince them that they have a right to be involved in all aspects of their own care. On the rare occasion that these nurses found themselves working with patients who subscribed to participation inclusion, they were observed to engage in partnering with them, again, provided hospital contextual and intervening conditions were conducive to such behaviour. It was interesting to note that the nurses who subscribed to participation inclusion were able to upgrade patients' participation behaviours, either to that of partnering, where they increased the patients' level of control and participation, or to being guided, where they increased their own level of control with patients participating to some extent. This was dependant upon the style of participation to which the patients subscribed.

The above nurses were predominantly observed to use strategies such as advocating, negotiating, and explaining and discussing with patients where possible, to work with them as partners or to guide them. They also used encouragement, especially with patients who subscribed to participation preclusion, to try and upgrade their input into their own care. As encouragement was a strategy predominantly used by nurses who subscribed to participation marginalisation, it will be described in detail when discussing the second pattern of adjustment. By utilising the above strategies, the nurses were able to increase patients' levels of participation and control. Patients were observed to respond to these strategies in varying degrees, depending on the style of participation to which they subscribed. The nurses, however, claimed that before they could engage in the above stated strategies, there needed to be certain facilitating conditions. The nurses stated that they needed to have sustained contact with patients, in order to spend quality time with them and to get to know them as individuals with their own opinions about nursing care, and to learn about their capabilities. They also needed to share and give information to patients so that they could make informed decisions. The nurses were of the view that this would reduce

patients' vulnerability and promote them to work with nurses as partners or to allow nurses to guide them. They explained:

*I think it benefits both you and the patient when you spend quality time, chatting with them [patients] and getting to know them as individuals ... this way you develop trust and rapport which helps the patient to work with you in a collaborative manner as much as possible (informal nurse interview). We need to fully inform patients about what's going on without them even asking ... some patients are too scared to ask you anything ... if they know, then, they are in a position to make decisions ... patients lose the control in hospital and you need to give it back to them ... they [patients] need to be custodians of their own body and health care and work with you (nurse 3).*

The nurses also commented that for patients to be engaged in partnering or to be guided, they needed to be well enough and be receptive to the nurses' encouragement, in order to be involved in their own care as much as possible. They further added that nurses needed to be friendly, helpful, be accepting of patients' medical conditions, have a sense of humour, and actively listen to patients so that they could develop positive nurse-patient relationships with them. The nurses perceived that a positive nurse-patient relationship was the precursor to patients participating in all aspects of their care or at least in making decisions about their activities of daily living and pain control. For example:

*Well, we go on a first name basis which I think goes a long way to knocking down the barriers, we try to be friendly and we joke with them and generally show them [patients] that we care and patients will feel comfortable with you and will be prepared to work with you at whatever level ... there needs to be trusting nurse-patient relationship first and foremost (nurse 13).*

Some patients concurred with the above nurses, stating that friendliness on the nurses' part went a long way in promoting trusting nurse-patient relationships and a more consultative approach to care, as reflected in these patient comments:

*The nurses' method of approaching patients, the care, the explanation and the education given to us ... and whether the nurses show friendliness towards you ... some nurses are efficient but not friendly with you ... they come in and do what they have to do and leave without so much as saying "hello, how are you to-day?" ... a smile, a gentle touch goes a long way in increasing communications and openness from patients (patient 10).*

*There needs to be a balance between patients and nurses ... nurses need to be more friendly, helpful and flexible in how they work with you ... we need to be educated and informed and nurses should be less routinised ... by us being involved, can only assist the nurses in lessening their workload (patient 11).*

Additionally, the nurses stated that patients have to perceive that nurses were accepting of their medical condition and were prepared to work with them accordingly. Furthermore, they explained that nurses needed to be cognisant of the patients' capabilities in relation to their medical conditions and not push patients into complete participation when they were not capable.

*We need to know what their [patients] needs are as well as their abilities in what they can and can't do ... for example, if they have had surgery, you should know what that entails and assess patients' capabilities ... you ask them how they feel about having something done and you offer assistance ... this way they will feel reassured and will be encouraged to be involved in their care because they know you are there to help (nurse 4).*

The nurses further explained that a few patients had requested that the nurses take responsibility for making decisions about their medical treatments. According to these nurses, the patients were able to partner with them but opted not to engage in such behaviour. The patients had explained to the nurses that, by deciding not to make treatment decisions, they were participating in their own care. When this happened, the nurses were observed to go along with the patients' choice and increased their own level of control, in order to guide these patients. They said:

*Sometimes, you have the odd patients who are not interested in working with you as partners ... it is not that they are bloody minded or anything ... it is just that they want to abdicate the responsibility of making decisions about their treatments to you ... it is nothing to do with knowledge level or anything because these patients are very knowledgeable ... it is simply their choice and I respect that and would go along with them (nurse 30).*

*As nurses we should be mindful that some patients do not want to work with us as partners even though they are capable and we invite them to work with us ... we should not be pushing our values on to them (nurse 16).*

In agreement with the above nurses, some patients stated that when they were in hospital they were fully prepared to do everything they could in terms of meeting

their activities of daily living needs. However, they stated that they wanted the nurses to make decisions about their treatments. This was because they did not feel like making the decisions and claimed that this had nothing to do with their ability to make the decisions. For example:

*Look, when I am in hospital, I don't want the responsibility of making decisions about my treatments ... I know the nurses want me to be part of the decision making process but I don't want it ... I will do all the hygiene care and help myself as much as I can ... it is just me and some nurses are good ... they appreciate my feelings ... in a way these nurses are allowing me to make decisions about what I want to do in hospital (patient 2).*

The nurses also stated that they should have a sense of humour to break the ice between them and patients in order to develop trusting nurse-patient relationships. As already alluded to, nurses who engaged in partnering perceived that a positive relationship with patients was a pre-requisite for patients working with them, either as partners or for patients to allow them to guide them. They said:

*I think during the course of your shift, you should be able to know which patients need a bit more of your time talking with them and understanding them and even joking with them ... that brings them out and they become more relaxed with you and will feel comfortable about telling you anything ... joking also lightens the tension that patients feel when they are in hospital and reduces their vulnerability... you can use humour to get through difficult situations (nurse 29).*

Field observations indicated that patients also appreciated nurses who joked with them. The patients stated that, when nurses had a sense of humour and were able to share a laugh with them, they were able to relate to the nurses better. Moreover, the patients explained that joking and laughter lessened their anxieties and made them feel that they could communicate on a par with the nurses. It was interesting to observe that, on occasions, some patients would wait for certain nurses to come on duty before they would discuss certain care issues. The following field notes highlight this point.

*The nurse had just come on duty and was looking at the patient's charts when the patient commented, "hey, Julie, my pain is not that bad so I was wondering if this morphine drip could be turned down ... I am sure I can cope with less ... as you know, I haven't needed any bolus for a while" to*

*which the nurse replied, "ok, John, I take your point, I'll talk to the doc [doctor] about it and let you know the outcome, the doctor should be around" ... "that's good, Jules, I knew you would fix it for me", said the patient and continued, "have I told you about the joke about this bloke who went to the doctor to sort out his waterworks... (field notes).*

Nurses who subscribed to participation inclusion and partnering also perceived that they needed to actively listen to patients and ask them open questions as opposed to closed questions. The nurses stated that it was only through listening and asking open questions that they would be able to find out what patients' needs were and their preferences about how care could be shared with patients. Furthermore, they claimed that some nurses had a tendency to ask patients closed questions. This, according to these nurses, had prevented some nurses from getting to know patients and their views about how they would like to be involved in their care. Whilst the above nurses agreed that, at times, asking closed questions was appropriate because of the lack of time, they were of the view that nurses should ask patients open questions and listen to what they were saying, whenever possible. They commented:

*Quite often the nurses go in and open-ended questions aren't always asked ... the nurses just want a "yes" or "no" answer ... they are not prepared to listen to patients ... I have noticed how some nurses have a high pain tolerance for patients' pain [laughing] ... the nurses don't listen to patients when they try and tell them that they are still in pain, ... nurses must listen to the patients so that they will feel that they are part of the team (nurse 24).*

*I think, what would I like in their situation and think how I would like to be cared for ... so I listen to patients and try and fit in with them ... they have to feel ok with you before they will work with you ... it's up to us, if they are able, to get them to make as many decisions as possible (nurse 10).*

Similarly, some patients claimed that they needed to be listened to by the nurses, if they were to have input into their care and give suggestions to nurses:

*Nurses should listen to patients more ... just take note of what you are saying ... it doesn't take much for a nurse to say "how is the pain to-day?, what would you like for it?" and try and fulfil your request ... some nurses are attentive and will listen but others don't ... (patient 7).*

As already mentioned, the nurses who were engaged in partnering were observed to use such strategies as advocating, negotiating, and explaining and discussing in order

to increase patients' level of participation and control. Patients were observed to respond to the nurses' use of the above strategies in varying degrees, as stated earlier. The nurses explained, however, that hospital contextual conditions pertaining to economic constraints, management structures, presence of technology, and medical dominance sometimes inhibited them from enacting the partnering role. Moreover, varying intervening conditions including the busyness of the ward on any given shift, fluctuating patients' medical conditions, unexpected crises such as cardiac arrests or staff going off sick, also inhibited the nurses from working as partners with patients. In the following section, the strategies or actions/interactions in which these nurses were engaged whilst upgrading patients to the partnering or guiding level will be described. Figure 5.2.1 depicts Adjustment Pattern (1). Increasing patients' level of participation/ control and increasing nurses' control. The colour green has been used to highlight the nurse's behaviour of partnering.

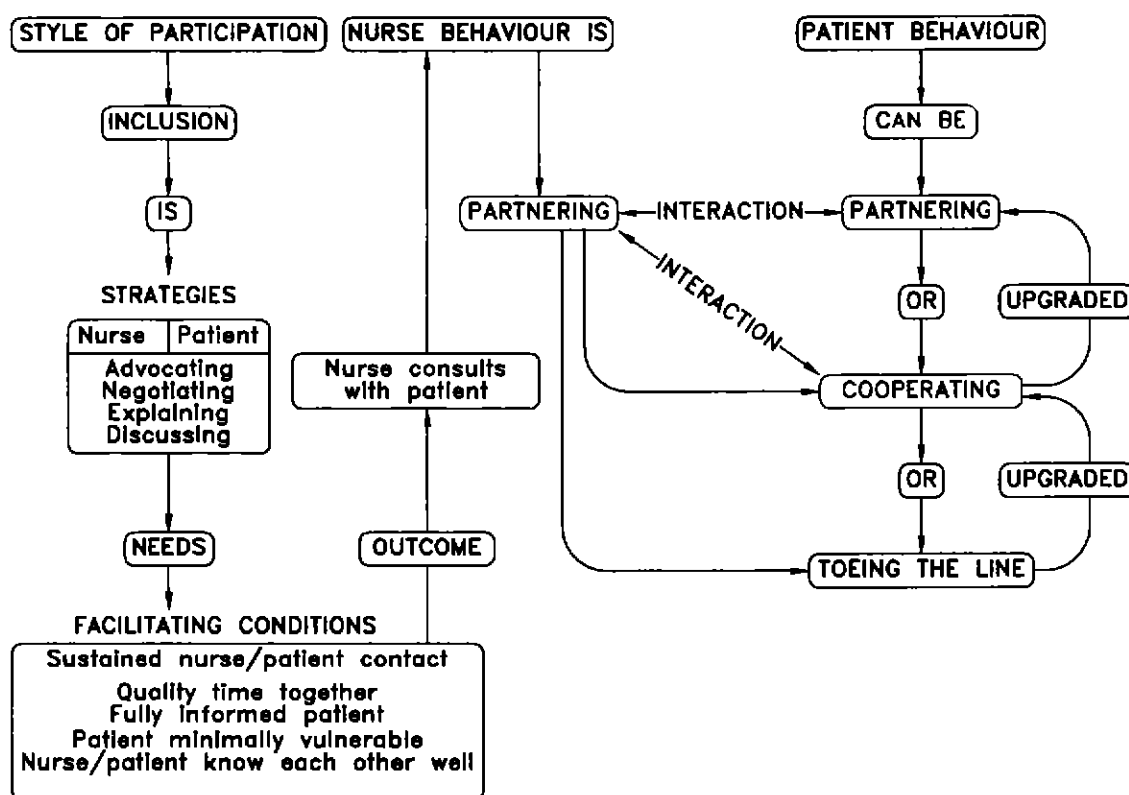


Figure 5.2.1 Adjustment Pattern (1): Increasing patients' level of participation/control and increasing nurses' control.

## Strategies used by Nurses to Upgrade Patients' Input

In order to upgrade patients to work as partners or to be able to get patients to be guided rather than to toe the line, the nurses who subscribed to participation inclusion were observed to predominantly use strategies such as: a) advocating, b) negotiating, and c) explaining and discussing. As previously stated, the nurses also used encouragement, especially with patients who subscribed to participation preclusion. However, this will be described in the second pattern of adjustment as it was predominantly used by nurses who subscribed to participation marginalisation. The above strategies were perceived by the nurses to assist in increasing patients' level of participation and control. As previously alluded to, patients were observed to respond to the nurses' use of the strategies and subsequently increased their control and level of participation, either to the partnering level or being guided.

### a) Advocating

Nurses who engaged in partnering stated that they advocated for patients, especially with regards to patients seeking alternative methods of treatment. These nurses defined advocating as primarily giving patients information so that they could make informed decisions about their care. The nurses expressed concern, however, that sometimes patients were not given enough information by the doctors about their medical conditions or treatments. They were also of the opinion that it was up to them to act as patient advocates, so that patients could make informed decisions about their treatments. They explained:

*Sometimes the consultant comes to the ward and tells the patient about having radiotherapy or chemotherapy and leaves and you find the patient upset ... you need to push patients to say to the doctor, "look, you need to ask him [the doctor] what is really happening ... ask if you need to have those treatments done, it is imperative that you ask and if you would like me to be with you when you ask him I'll stay ... you need to be fully informed about what you want to know" (nurse 30).*

*In hospital treatments are not really explained to patients by doctors ... it is up to us to be advocates and spend time with patients explaining about the treatments and encouraging them to ask questions of the doctors so that they can gain some control and say, "yes" or "no" to a particular*



*treatment that has been proposed ... we need to tell patients that what has been said is not gospel (nurse 13).*

It was supported in the data that some patients appreciated nurses who advocated for them. These patients commented that when nurses volunteered information about their treatments to them and encouraged them to further investigate with the doctors about what treatments were being proposed, they felt empowered. Additionally, they explained that they needed to have the nurses as a “backstop” before they were able to make decisions about their treatments. The patients also stated that they felt comfortable with working with nurses who were prepared to talk to the doctors on their behalf as indicated by these patient statements:

*I had this haemorrhoid operation and the doctor came and said that I could go home ... I was terrified as the last time I had this surgery, I had so much trouble with my bowels ... so I said to the nurse that I would like to stay in until I have had my bowels opened and she said she would ask the doctor ... she came back and said “I have explained to the doctor that because of your last experience, it might be better if you stayed until you have been to the toilet”, which I thought was really good of the nurse (patient 4).*

*In hospital you don't usually have control of the knowledge so it is good when nurses give you as much information as they can give and you feel you can use them [nurses] as sounding boards ... one nurse even wrote down the questions I should ask the doctor ... that was helpful when you know you can rely on the nurses ... they are your “backstop”, aren't they? It is easier to make decisions when you know the nurses are on your side (informal patient interview).*

It was also found that when nurses advocated for patients who subscribed to participation preclusion, these patients were observed to take an interest in becoming more involved in their own care, that is, they were willing to be guided rather than to toe the line. The patients stated that they felt that they had been given permission by the nurses to have a say in what happened to them with regards to their own care, contrary to what they believed should happen in hospital. The patients added that they wanted to do as they were asked by the nurses but only as far as making decisions about their activities of daily living and pain control. They were adamant that they would not feel comfortable about making decisions about their treatments. The patients stated that only doctors and nurses were qualified to make such decisions.

*When the nurses come and tell me that I should decide about what has to be done and they encourage you to do so, I feel I have been given the permission to voice my opinion ... it is kind of nice to make up your own mind about when to have a wash or what sort of pain tablets to take ... you can make such decisions because you know the nurse is behind you ... but I don't feel comfortable about voicing my opinion about my dressing or treatment ... this is the professional's job (patient 4).*

*When the nurses treat you as an equal and give you information and encourage you to have a say, you tend to have the courage to be able to speak to them on an equal footing ... you know that the nurses are not going to ostracise you or think that you are a bad patient for asking ... It is a new experience for me but I still would not take them up on deciding about the medical things (patient 30).*

When the nurses were asked why they had not been able to convince the above patients to go beyond making decisions about their activities of daily living and pain management, the nurses explained that lack of time with the patients was a problem. They added that most patients were discharged early, which left little time for patient education about their role and responsibilities in hospital. Furthermore, the nurses stated that in the initial period of hospitalisation, patients were usually too sick to receive education and that by the time they were well enough they were ready for discharge. The following comments reflects this point:

*Initially, the patients are quite sick and you tend to concentrate on their physical needs but as they get better, you want them to be involved in their own care ... but some patients are not receptive to that ... they insist on waiting for you to tell them what to do ... that is when a lot of patient education comes in which is very well if you have them [patients] for that long ... they are going out the door no sooner do they come in ... it is like a conveyer belt at times ... so the best you can hope for is for them to make a few decisions (nurse 14).*

The other problem that nurses had was the lack of continuity of care of the patients, which had resulted in further reducing the time they had with patients. The nurses stated that the care was often fragmented because they were not always assigned to the same patients. This had effectively prevented them from getting to know the patients and gaining knowledge about their capabilities and information levels. The nurses explained that this was necessary if they were to provide the relevant patient

education for involvement and be advocates for patients. The nurses blamed the permanent staff reductions on the wards, by management, as the cause for this fragmented care. To add to this problem were the changes to the manner in which handovers were conducted. As explained in chapter four, most hospitals had opted for the tape recorded handover or handover at the bedside. The nurses complained that, in the absence of the traditional verbal sit down hour long handover, they were unable to pass information about patients' abilities and knowledge levels to other nurses. The new form of handovers was perceived by the nurses to limit the content of what they could report to the other nurses. They stated:

*As we don't have the sit down handovers these days, we don't get the chance to talk about patients as a whole ... all the other aspects of care like what their [patients] views are and what sort of teaching and education they need to improve their care does not get reported ... it seems almost an expectation that you only report the physical aspects (informal nurse interview).*

Other inhibiting factors that appeared to prevent nurses who subscribed to participation inclusion from advocating was medical dominance and the lack of peer support for the nurses when they advocated for their patients. As explained in chapter four, nurses sometimes found that they could face medical reprimand if they over stepped the doctors' orders and advised patients to seek alternative modes of treatments or even to seek a second opinion. Some of these nurses also perceived that they would come under criticism from their peers if they advocated for patients. The reason given was that some nurses did not believe that patients were in a position to make any kind of medical decisions. This was because of the perception held by some nurses that patients lacked medical knowledge and that "doctors and nurses knew best". The nurses who were engaged in partnering also explained that advocating for patients carried with it certain risk-taking behaviours, which were not always sanctioned by nursing administration. This was alluded to in chapter four.

Despite the above mentioned factors that inhibited the nurses from advocating for patients, some nurses who were partnering were observed to persevere and advocate for their patients. These nurses explained that they considered their advocacy role to be paramount if patients were to work with them. They added that they had

sometimes resorted to “rule breaking” in order to fulfil their advocacy role. They said:

*I am often called into question by the doctors ... to be an advocate takes energy and commitment and my patients come first ... I refuse to fit into a mould ... I often break rules so I can help my patients, like if they don't want surgery at the last minute, then I get the doctor instead of talking patients into it ... they are entitled to change their minds (nurse 30).*

*Doctors would come and tell the patients about a particular course of action ... the patients have thought about it and decide that they were not going to go for it ... I would be the first person they would tell because they know that I would support them all the way and give them all the information and encouragement they would need to discuss the issue further with the doctors which some doctors won't like (nurse 22).*

In summary, it would seem that nurses who were engaged in partnering were observed to advocate for their patients but only under certain conditions. It was apparent from the data that these nurses needed time to develop trusting nurse-patient relationships with patients and to get to know them before they could advocate for them. Advocating for patients required the nurses to speak up on behalf of their patients and to educate them, where necessary, so that patients could make decisions in all aspects of their care or even, at least, to make decisions about their activities of daily living and pain control.

### **b) Negotiating**

Negotiating has been defined from the data as nurses and patients talking with each other and reaching agreement about how they were going to proceed regarding the care. It was observed that, through negotiations, nurses and patients were able to come to some consensus about how a particular aspect of care was to be carried out. For example, nurses and patients would voice their views and together they would agree on the mode of care which suited both parties. The following nurse and patient statements highlight this point.

*Sometimes, when you are working with patients, what they want done at a particular time, for example, for you to help them shower might not suit your work so you negotiate with them, like I would say, “I have to do this, this and this first and then I can assist you” and mostly the patients will*

*accept that or sometimes they will tell you that they still would like to have a wash and could you bring the bowl for them which is fine ... they [patients] would be prepared to have a wash by themselves which is how it should be (nurse 4).*

*The nurse came in and asked me to go and have my shower so that she could do my dressing. I told her that I have had a long walk and I was tired and didn't feel like it just then but will have the shower in half an hour ... she thought for a while and said that she could perhaps do something else for another patient and said, "would it be all right then if I leave the dressing until just before I go off duty, I know you like the dressing done before lunch but I am pushed for time this morning" ... I had no problems with that ... I thought it was fair enough so I said ok (patient 18).*

In most instances, nurses who were partnering were able to negotiate successfully with patients, provided they were well enough and were responsive to the nurses' behaviours. This was dependent upon the style of participation the patients subscribed to. For example, patients who subscribed to participation inclusion or marginalisation were more receptive to the nurses' negotiations to participate in all aspects of care than patients who subscribed to participation preclusion. This latter group of patients needed a lot more patient education before they were able to fully negotiate with the nurses and to work as partners with them. Hence, these patients were observed to want the nurses to guide them. As previously explained, the nurses needed time to spend with patients in order to give them support and to build their confidence so as to change their attitudes about being more involved in their own care.

However, the nurses were unable to negotiate when they were short-staffed and were busy with caring for other high acuity patients. As explained in chapter four, hospital contextual conditions of economic constraints had resulted in wards being left with less than satisfactory numbers of permanent staff. As a consequence, the nurses who were engaged in partnering found themselves with inadequate time to spend in talking and negotiating with patients. Therefore, they were observed to guide patients to what they wanted them to do, rather than to negotiate a mutually agreed plan of care. At other times, again due to the staff shortages, these nurses found themselves caring for patients in a speciality ward with which they were

unfamiliar. This effectively meant that they did not know the patients well enough to feel comfortable about negotiating with them.

*I like to sit down and talk through things with my patients but there can be time constraint ... if you are busy and you don't have the time to talk and discuss how and what needs to be done, you have no choice but to basically ask the patient if they would go along with you and mostly patients do understand us (nurse 32).*

*When you don't know the patients because you have been sent from another ward or you are flat out with theatre cases, unfortunately, care suffers ... there is no time for niceties like asking for patient input and negotiating care with them ... you go on to survival mode and direct patients in what has to be done (informal nurse interview).*

Varying intervening conditions such as crises on the ward, for example, cardiac arrests, patients absconding, or emergency admissions, were also perceived by some nurses as preventing them from spending the time negotiating the care with patients. The nurses stated that during a crisis all their energies went into sorting out the crisis, which effectively left little time for anything else. For instance:

*One minute, the wards can be quiet and the next all hell can break loose ... you only need to have a cardiac arrest or a patient go flat ... when this happens you might as well forget about talking with patients and asking for their input ... like the other day, my patient went down with multiple-organ failure and the whole shift was spent in assisting the doctors in stabilising him before we sent him up to ICU ... my other patients did not see me, other nurses did their obs and things (nurse 14).*

The nurses also explained that sometimes patients' mental status had prevented them from successfully negotiating with the nurses, regardless of the style of participation to which they subscribed. In such situations, the nurses stated that they would either negotiate with the patients' relatives about the care, or simply guide the patients in what needed to be done for them, until such time when the patients were mentally cognisant. The following nurse comment highlights this point:

*With all good intentions, you can only negotiate with patients if they are mentally alert ... sometimes patients become confused for whatever reason and when that happens you have no choice but to take the lead and guide*

*them [patients] ... I would negotiate with the relies [relatives] if they are there but otherwise I will direct the patients (informal nurse interview).*

*We need to negotiate with patients where possible because it is only then can we be able to include the patients in their own care ... unfortunately, after theatre or when they are doped up with narcotics they are not able or won't be bothered to negotiate with you ... I won't want to negotiate with them either ... no, you take over temporarily (nurse 30).*

Additionally, the nurses stated that staff shortages had sometimes resulted in them having to carry high patient loads, as explained in chapter four. This, according to the nurses, had left them with little time to negotiate with patients. Furthermore, the nurses added that when they had a lot of patients to care for, they had little choice but to revert to guiding patients rather than negotiating with them. For example:

*I like to have the time to negotiate with my patients about the day's care but when you are busy with six patients and your back is to the wall, you are under pressure ... I mean it is much easier and quicker to direct the patients rather than to wait for them to decide about how they would like their care ... I can bed bath someone in five minutes flat and go to the next patient ... unfortunately, you cannot spend the time negotiating and encouraging all the time (nurse 14).*

In summary, it was inferred from the data that nurses who subscribed to participation inclusion and partnering were engaged in negotiating with their patients. This was conditional upon patients being physically and mentally able and receptive to the nurses' behaviour to negotiate. Data also revealed that nurses needed time with patients in order to successfully negotiate and provide care that was mutually agreeable. Staff shortages, high patient loads, and unexpected crises on the wards, for example, had sometimes prevented the nurses from negotiating.

### **c) Explaining and discussing**

Nurses who subscribed to participation inclusion and were engaged in partnering were observed to spend time with patients explaining and discussing various aspects of care with them. The purpose of this was to increase patients' knowledge and understanding of their care, so as to increase their control and upgrade patients to their own level of partnering, where possible. The nurses were of the view that it was only through such interactions that patients were able to understand what has

been proposed and to gain information about their care and possible outcomes. Moreover, the nurses stated that explanations and discussions were necessary if patients were to make informed decisions. They added that patients could work as partners in their care or allow the nurses to guide them, only when they were able to make informed decisions. Explaining has been defined in the data as a one way interaction that the nurses had with patients. The nurses claimed that since patients often lacked medical and technical knowledge, they needed to explain to patients in order to fully inform them. According to these nurses, explaining was interaction that was initiated and conducted by the nurses. On the other hand, discussion was defined in the data as a two way interaction between nurses and patients to debate or iron out nursing care issues. Discussions were also perceived by the nurses to a greater extent and patients to a lesser extent as being essential if some kind of consensus about care was to be reached. As for explanations, some nurses had this to say:

*A lot of the times we have to explain to patients about what has been proposed about their care so that they will have the information to ask for clarification or to make informed decisions ... some patients will ask for you to explain but a lot of them [patients] don't ... I believe nurses have to provide the explanation ... it is up to us to explain first (informal nurse interview).*

*There's no two ways about it ... you have to explain before any sort of discussion can take place between you and patients about what has to be done regarding care ... when patients have the explanation they are in a position to take part in discussing with you their preferences and you tell them about your schedules and between us we can come to some kind of arrangement (nurse 13).*

Some patients concurred with the above nurses, claiming that they needed explanations from nurses before they could discuss care issues with them. To this end, the patients stated that they would ask the nurses to explain when they felt that they needed information to make decisions about their care. For example:

*Often you don't know whether the wound is going to hurt or not when they [nurse] do the dressing ... so I always ask the nurses to explain ... this way I can decide whether I need to have a pain killer or not before the nurse does the dressing ... some nurses will take the time to explain which makes it*



*easier to work out with the nurses the type of medication to have, I mean a needle or tablets (patient 11).*

Whilst some patients stated that they were prepared to ask the nurses for explanations, others stated that they would wait for the nurses to explain. This was because they either did not know what they wanted the nurses to explain and were of the view that nurses knew best or perceived that they should do as they were told and, therefore, not ask the nurses to explain. Despite these views, the patients claimed that when nurses did offer the explanations, they were able to make some decisions about their care. This had allowed them to work as partners with the nurses or allow the nurses to guide them, depending on the style of participation to which they subscribed. For example:

*I believe that nurses know best and wait for them to explain ... some nurses will explain and encourage you to be more involved in what's happening to you which is helpful because then you feel you have the information to be part of the decision making process and work with them (patient 14).*

*I have always felt that you should do as they [nurses] ask you to do in hospital but when the nurses take the time to explain and show you things and ask for your opinion, you get the courage to tell them how you feel and maybe be able to make simple decisions about the care (patient 5).*

Data showed that nurses who subscribed to participation inclusion and partnering were observed to explain and discuss care issues with patients, where possible. The nurses commented that explaining was a lot easier to achieve than discussions with patients. They added that since explaining was a one way interaction, they were able to do this even if they were short of time. Field notes indicated that these nurses were observed to explain about treatment and care issues whilst they were conducting procedures with patients, so that patients could be involved in their own care. For example, the nurses would talk to the patients and explain about care whilst they were taking patients' vital signs, doing their dressings, or sponging them.

*Whilst the nurse was doing the patient's dressing she explained "now see this tubing that is coming from the wound, well, it is a vacuum drain ... we need to make sure that the vacuum is maintained for it to work properly ... now, you see these two ears [nurse pointing to the two rubber prongs on top of the redivac bottle] ... if you see them flop together, can you please ring*

*the bell or let us know so we can re-vacuum it” and the patient nodded and said “no problems, I’ll keep an eye out for it when I am walking about” (field notes).*

The nurses were also observed to use explanations when they were trying to get patients who subscribed to participation marginalisation to the level of partnering with them. The nurses stated that they would explain about all aspects of treatments so that patients would feel that they could work as partners with them. The nurses were of the firm belief that it was only through explanations that they would be able to increase patients’ knowledge base, and be able to work with them on a consultative manner. The following field notes highlight this point:

*The nurse asked the patient to administer his own Becotide, using a spacer to which the patient replied “I don’t know how to use the spacer ... the nurses always did it for me”. The nurse turned to the patient and said “let me explain how this thing works and then you can decide if you want to do it yourself” and started to de-assemble the equipment ... “now these are the parts and you need to assemble it this way” ... the nurse took his time to show the patient how to de-assemble and assemble the equipment ... the nurse then asked the patient if she understood about how to work the equipment and the patient replied “I think so, you have explained it so well for me” ... “that’s good, now I will explain how to attach the aerosol spray and release the medication” ... the nurse repeated this procedure twice and then asked the patient to repeat the actions ... the patient did the procedure and said “I am glad that you explained because now I feel that I can do my own (field notes).*

On the other hand, the nurses stated that lack of time was a problem where discussions with patients were concerned. They claimed that, as discussions were two way interactions, they needed more quality time with patients to effectively conduct the discussions. Furthermore, they explained that whilst they did their best to prioritise their workloads and make time for nurse-patient discussions, this was not always possible. The nurses blamed increased technology, staff shortages, and short shifts as some of the factors that were responsible for this occurrence. For example, they commented that hospitals had increased their use of technology and that meant that more time was now required by nurses to learn about this technology, as alluded to in chapter four. This, according to the nurses, had sometimes resulted in them not having enough time to conduct discussions with

patients so that they could fully participate and work as partners with the nurses. For instance:

*Whilst machines can be helpful, they are time consuming, especially when you have to learn about how they work ... you come on in the morning and there is a new machine attached to the patient and you have no choice but to spend some time, mastering it . this and other chores that needs to be done leaves little time to spend, talking and discussing care with patients (nurse 13).*

Similarly, the nurses stated that when they were short staffed or working short shifts, as explained in chapter four, they found themselves with insufficient time to discuss care issues effectively with patients. In such instances, the nurses were observed to engage in explanation and not discussions with patients. As well, the nurses stated that when they were rostered to work short six hour shifts, there was no time to do anything else but to complete tasks. As indicated in chapter four, the nurses appeared to have the perception that they needed to complete eight hours of work in six hours. They were of the assumption that nursing administration expected this. This meant that the nurses had to rush through their essential work pertaining to physical care rather than to spend quality time discussing care issues with patients. Thus, nurses who subscribed to participation inclusion and partnering were observed to direct and guide patients when they were unable to conduct discussions with them.

*I am sometimes rostered to work a short six hour shift which doesn't leave you much time for patient teaching or discussions with them [patients] ... I am still expected, by management, to do everything that we would do in the eight hours and I find that hard (informal nurse interview).*

The nurses, however, reaffirmed that when they did have the time they would sit and discuss treatments and care issues with patients so that they could be upgraded to work at their level of partnering. They claimed that they also used discussions with patients who subscribed to participation preclusion to upgrade them so that they would allow the nurses to guide them rather than toeing the line. As already explained, the nurses only had a short time with patients because of the early discharge program. The following is an example of how the nurses used discussions

to upgrade patients' input to either the partnering level or get patients to allow them to guide them.

*The other day, I went to do the patient's dressing and asked him what he thought of its progress [it was an ulcer dressing] and he looked at me as if I was out of line ... so I said "Mr X, you have been admitted to hospital before with a leg ulcer, can you remember what was used before to help with the healing? ... different creams and ointments work best for different people, what do you think?" and he said, "I wasn't going to say anything but since you ask me, I think elase is what she [Silver Chain Nurse] was using and it worked well ... it seems to remove the slough better and perhaps I could have that again here" and I said, "sure, the doctor has left it to us to put something on it ... yes, we can give it a try" and the patient said "that's good, why re-invent the wheel ... if something works, why not use it" (informal nurse interview).*

In the above scenario, the nurse clearly wanted the patient to discuss with her the types of ointment that he thought would best suit the ulcer. It was evident from the nurse's statement that, initially, the patient was given information about how different creams and ointments worked differently on people, and by doing this the nurse was able to draw the patient into discussions about what cream to use and the reason for its use. Through discussion, the nurse was able to work as a partner in care with the patient. In another situation, the nurse had this to say:

*I was trying to get this patient to decide what he wanted to do for tea ... the patient kept telling me to do whatever I wanted, that is, whether he should sit up in bed or sit out in the chair ... in the end, I said "it is better to sit out but it is not a question of what I want Mr X, let's talk about what your preferences are and how you felt this morning when you sat out of bed" and the patient replied "I would like to sit out of bed to have my tea but only if you would help me back to bed after tea ... otherwise, I would rather stay in bed because yesterday, the nurse sat me out and didn't put me back to bed till late" and I said "it's good for you to sit out and I agree with you that you shouldn't be left sitting out for long so I will be back to help you" (nurse 14).*

The patient in the above scenario, on the other hand, was prepared to let the nurse decide whether he sat out of bed or stayed in bed. However, when the nurse initiated discussions with him, the nurse was able to guide the patient into making his own decision.

In summary, data analysis showed that nurses who subscribed to participation inclusion and partnering engaged in explaining and discussions with patients, where possible, in order to increase their control and level of participation. It was revealed that nurses found explaining easier to achieve than discussions. The reason, as perceived by the nurses, was that nurses defined explaining as a one way interaction as opposed to discussions being a two way interaction. This was interpreted by the nurses as explanations needing less time with patients than discussions. Due to the economic constraints such as staff shortages and short shifts, the nurses sometimes found that they had less time with patients to sit down and explain and discuss care issues with them.

**Adjustment Pattern (2): Converging patients' level of participation/control to nurse' level without nurses increasing or decreasing own level of control**

It was found that nurses who subscribed to participation marginalisation were observed to bring about convergence of patients' level of control and participation to their own level, without increasing or decreasing their own level of control. In this way the nurses were able to upgrade the input of patients who subscribed to participation preclusion or downgrade that of patients who subscribed to participation inclusion. It was observed that these nurses were able to bring about behaviour adjustments for patients to correlate with their own style, that is, participation marginalisation where patients were perceived to cooperate with the nurses. By converging patients' level of participation and control to their style of participation, the nurses were able to minimise the *incongruence* and seek resolution, without losing any control themselves. However, patients who subscribed to participation inclusion lost some of their control and degree of participation and patients who subscribed to participation preclusion gained some control and increased their level of participation. Accordingly, the patients were observed to adjust their behaviours to fit in with the nurses. From the above perspective, the nurses were observed to be engaged in a behaviour termed from the data as "guiding the patients". As patients played a subsidiary role in this third phase of *accommodating the incongruence*, they were observed to respond by "cooperating with the nurses". From the data, guiding the patients has been defined

as an activity where the nurses showed or directed the patients about what to do regarding their care. Cooperating with the nurses, on the other hand, was defined from the data as patients fitting in with the nurses' directions and requests about their care. This was provided patients were well enough to follow nurses' directions. For example:

*I feel my job is to give patients guidance and instructions about what to do about their care ... how else are they [patients] going to get better and go home ... we are not doing our job if we let patients flounder without any kind of directions from us (nurse 10).*

*I believe that nurses know what they are doing and I will try my best to follow their [nurses] instructions, if I can ... I want to fit in with them ... if you don't cooperate with them, you won't get better (patient 15).*

### **Nurses' Guiding- Patients' Cooperating**

Nurses who subscribed to participation marginalisation resorted to guiding patients with regards to their own care. These nurses were not observed to make any attempts to partner with patients. This was because, as previously mentioned, they were of the view that patients could make decisions about their activities of daily living and sometimes pain control, but could not and should not make any decisions about their treatments. As with nurses who subscribed to participation inclusion, these nurses were often observed to work with patients who either subscribed to participation inclusion, marginalisation, or preclusion. When the nurses found themselves working with patients who subscribed to participation inclusion, they were observed to downgrade the patients' participation behaviours to that of cooperating with them. It seemed that nurses who subscribed to participation marginalisation were unable to work with patients at the partnering level. These nurses' perceptions that they had professional power over patients and their reluctance to share control with patients may have been the cause of this. They stated:

*Even if patients want to make their own decisions about their treatments, you need to discourage this because they [patients] don't know better ... I don't have problems about them taking control of their activities of daily*

*living and pain control but I don't feel right about letting them decide about their treatments ... they don't have the knowledge ... doctors and nurses do and decide (nurse 5).*

Interestingly, patients who subscribed to participation inclusion were observed to allow the nurses to downgrade them to the cooperating level. When asked to explain, these patients claimed that as they were in hospital they felt vulnerable, and unless nurses thought the same way as they did about working in consultation with them, they had found it hard to get the nurses who subscribed to participation marginalisation to work with them as partners. The other point raised by these patients was that the short length of stay in hospital did not allow the time to get to know the nurses and to get them to see their point of view. Furthermore, the patients stressed that whilst they were prepared to cooperate with the nurses, they would resist doing as they were told by the nurses. They said:

*When the nurse took the dressing off, she cleaned the area and left it open ... I wanted something over the wound, so I tried to tell the nurse that I would prefer to have a dressing over it as I didn't want my clothes rubbing on it ... the nurse went on this speel about keeping it dry and she wasn't seeing my point about the rubbing ... in the end, I let it go as I wasn't going to be in hospital that long anyway and I got my wife to bring in my shortie pyjamas (patient 18).*

The other problem the above patients faced was that they seldom had the same nurses looking after them. This was due to the staff shortages, as explained in chapter four. This effectively meant that they had more nurses looking after them that did not have the same views about care as themselves. This had resulted in patients having difficulty in trying to get the nurses to change their minds towards their own way of thinking and allowing them more control in their own care

*There is no consistency of the same nurses looking after you ... sometimes, you have the ward nurses and sometimes nurses who are brought in who don't know you ... nurses are coming and going all the time ... this doesn't give you much chance for any sort of decent conversation with them to sort things out with them (patient 13).*

It was also interesting to note that when nurses who subscribed to participation marginalisation worked with patients who subscribed to participation preclusion,

they were observed to upgrade their input to the level of cooperating with them, whenever possible. The nurses commented that they felt uncomfortable when the patients wanted to do as they were told or toe the line. Thus, when this situation occurred, it was observed that the nurses did their best to convince the patients to cease being totally subservient and to take some control and work with them on a cooperating level. For instance:

*I can't stand it when patients say "yes sir, no sir, and three bags full" ... They [patients] cannot just lie there like a log and wait for you to give them orders ... they must take some responsibility and have some control of their care and I certainly try and get them to think differently (nurse 6).*

Additionally, patients who subscribed to participation preclusion stated that, when the above nurses had encouraged them to have a say in the care of their activities of daily living and pain management, they had listened to the nurses' requests and had gone along with the nurses' directions. Moreover, the patients explained that by encouraging them, the nurses were able to remove any fears that they may have had about having a say in their own care. This is reflected in the following field notes.

*"When would you like to have a wash Mrs X" asked the nurse ... "whatever, you want dear, whatever suits you" replied the patient ... "you know, Mrs X, you can have a choice, how about telling me when you want that wash, I am happy to fit in with you" and the patient responded by saying, "since you put it this way, yes, I would like to wait for my visitors first before the wash ... they [visitors] are due in any minute now and thanks for asking me (patient 30).*

On the rare occasion, however, the nurses who subscribed to participation marginalisation were observed to work with patients who subscribed to a style of participation which was similar to their own. During these situations, the nurses were observed to work in tandem, with them guiding and the patients cooperating. It was of some significance to note that the nurses who subscribed to participation marginalisation were observed to only interact and work with patients at the cooperating level. They were only interested in bringing patients to fit in with their own style of participation. This was unlike the nurses who subscribed to participation inclusion, who were observed to interact and work with patients either at the partnering level or get patients to be guided by them.



Nurses who subscribed to participation marginalisation were found to use such strategies as directing, encouraging, and persuading in order to downgrade or upgrade patients and to converge patients' level of control and participation to that of their own. The patients, on the other hand, when working with the above nurses were observed to use strategies such as listening and bargaining in order to work with the nurses at the cooperating level. It was found that in order for nurses to guide patients and for patients to cooperate, there needed to be certain facilitating conditions. These included essential nurse/patient contact for nurses and patients to get to know each other, at least partially if not fully, patients to be informed about their care to some degree by the nurses, and their vulnerability needed to be reduced at least to a moderate level. These conditions were especially important for patients who subscribed to participation preclusion. Patients who subscribed to participation inclusion were often knowledgeable about their treatments and care and were observed to persevere and ask questions of the doctors and nurses until they had the information. Contrary to these patients, the patients who subscribed to participation preclusion were observed to be subservient to the nurses and rarely asked questions or sought information from them. With regards to the facilitating conditions, the nurses stated:

*Before you can get them [patients] to participate in some of their care, you need to spend a bit of time with them [patients] to know where they are coming from ... you also need to make sure that they are not terrified about being in hospital and reassure them so that they don't feel intimidated and vulnerable ... otherwise they won't do a thing for themselves (informal nurse interview).*

The nurses who subscribed to participation marginalisation were observed to initiate conversations with patients when they were performing tasks or procedures with them. The nurses stated that they would engage in small talk with patients in order to make them feel comfortable with them and reduce their vulnerability to some extent. These nurses, however, were not observed to go and talk with patients outside of when they were performing tasks or procedures with patients. The following nurse comments reflect this point:

*I try and initiate some sort of small talk with patients when I am in there with them doing their obs [observations] or dressing ... this way you at least get to know them a bit and this opens the door for you to encourage them to do their own hygiene needs or to tell you when they have pain and to ask for analgesia ... you have to allay their fears and make them feel comfortable with you before they would ask you ... you don't need extra time, just talk when you are there (nurse 19).*

*I don't make a special trip to talk with patients ... I just try and talk with them when I am in with them doing something for them ... at least you get to know them a little and you can get them to cooperate with you (nurse 6).*

Some patients agreed with the above nurses. The patients stated that when nurses spent a bit of time talking with them whilst doing their routine, they felt that the nurses were trying to get to know them a little. Moreover, the patients claimed that small talk with the nurses had relaxed them and had made them feel comfortable with the nurses.

*When they [nurses] talk to you when they are doing things to you, it makes you feel like a person and you feel that you can talk to them ... a little bit of small talk is all you need to feel that the nurses are there for you ... you don't feel that they [nurses] are up there and you are down here (patient 10).*

The nurses who wanted to guide patients were of the view that patients needed to have some information about their care so that they could work with them at the cooperating level. They perceived that a totally uninformed patient would not be able to have any input into their own care. Accordingly, the nurses were noted to provide procedural information to patients without being asked. They were observed to give simple explanations about why certain tasks and procedures needed to be done and the reasons why patients should cooperate with them. They were, however, not observed to give or share treatment information with patients. This, as previously stated, was because these nurses did not believe that patients should make decisions about their treatments. It was of interest to note that when patients who subscribed to participation inclusion asked these nurses for treatment information, they were observed to provide it. However, the nurses did not

encourage or advocate for these patients so that they could make decisions about their treatments.

*I always tell them what I am doing and why certain procedures had to be done ... if patients understand the reason, they will more than likely cooperate with you and it makes your life easier ... you have to inform them that just because they have a drip, doesn't mean that they can't shower themselves, if they are able (nurse 5).*

*I don't volunteer medical or treatment information to patients unless they ask and some patients do ... in that case I will give them the information they want and even get the doctor sometimes but I try and explain to them that they should cooperate and do as the doctor has ordered if they are to recover quickly (informal nurse interview).*

Data also revealed that nurses who subscribed to participation marginalisation perceived that, in order for patients to cooperate with them, they needed to give patients some degree of control regarding their own care, even though they did not perceive that patients should have full control. Furthermore, they stated that it was up to them to let patients know that they should and could take control of their activities of daily living and pain management, if able. Thus, the nurses were observed to actively encourage patients to make decisions in the above mentioned areas. The following is an example of the sorts of things these nurses would say to patients.

*The nurse said to the patient "I have a few things to do before I come back to you ... by the time I return, you should have decided when you want the wash done ... also whether you need a needle before the dressing, it's up to you ok?" ... the patient looked at the nurse and said, "I don't mind, whatever you think ... do you think I need something for the pain?" and the nurse replied, "Mr X, you think about it and tell me when I come back ... you can decide you know" and left the room (field notes).*

The above nurses, however, were not observed to give patients total control of their care. This situation was especially noticeable with patients who subscribed to participation inclusion. The nurses stated that they would withhold treatment information from patients so that they could not have full control. As some of these nurses explained:

*I don't care what anybody says ... patients cooperate in hospital ... we give them the information they [patients] need and that is all that they need ... why bother coming into hospital if they want to make treatment and medical decisions ... they still get to make other basic decisions anyway ... I always explain to them the rationale of why we do things (nurse 12).*

Patients who subscribed to participation inclusion confirmed the above nurses' views. They stated that they had found it difficult to obtain medical information or information about their treatments from some nurses. They added that the doctors were not always available to give them these sorts of information, which they needed to make informed decisions. The patients qualified their statements by stating that, even though they appreciated the fact that nurses may not always be able to give them the information, they nevertheless expected them to be advocates and provide them with the information that they had requested. For example:

*I like to know exactly what is happening to me and what the doctors intend to do with me ... I would want to be consulted regarding my treatment, what it entails, any side-effects and so on ... I am not an idiot ... the doctors usually tell me if I ask but some nurses ... it is like getting blood out of a stone ... mum's the word I think with some ... I know that nurses are restricted in what they can disclose but surely, they can get the doctor if they are worried ... they are supposed to be caring (patient 18).*

*I was booked in for back surgery and I wanted to know about any complications that might occur ... I asked the nurses if I could have more information and nothing was forthcoming ... some of the nurses kept telling me to ask the doctor ... surely, the nurses know something about it ... I think, it's like going somewhere and you can't find your way ... you don't know the street and you know you have been lost ... that's the sort of feeling I got when they wouldn't tell me anything ... that was frustrating because you can't make up your mind without the knowledge (informal patient interview).*

As already mentioned, nurses who subscribed to participation marginalisation and were engaged in guiding were observed to engage in such behaviours as directing, encouraging, and persuading, so as to get patients to cooperate with them. Patients, on the other hand, were observed to be engaged in listening and bargaining with nurses in order to work at the cooperating level with them. It was noted, however, that intervening conditions, such as patients being too sick to cooperate or mentally incoherent, prevented nurses from guiding patients. Under such circumstances, the nurses took over and did everything for patients. In the following section, the

strategies used by the nurses and the patients will be described. Figure 5.2.2 depicts Adjustment Pattern (2): Converging patients' level of participation/control to nurse' level without nurses increasing or decreasing their own level of control. The colour blue has been used to highlight the nurse's behaviour of guiding.

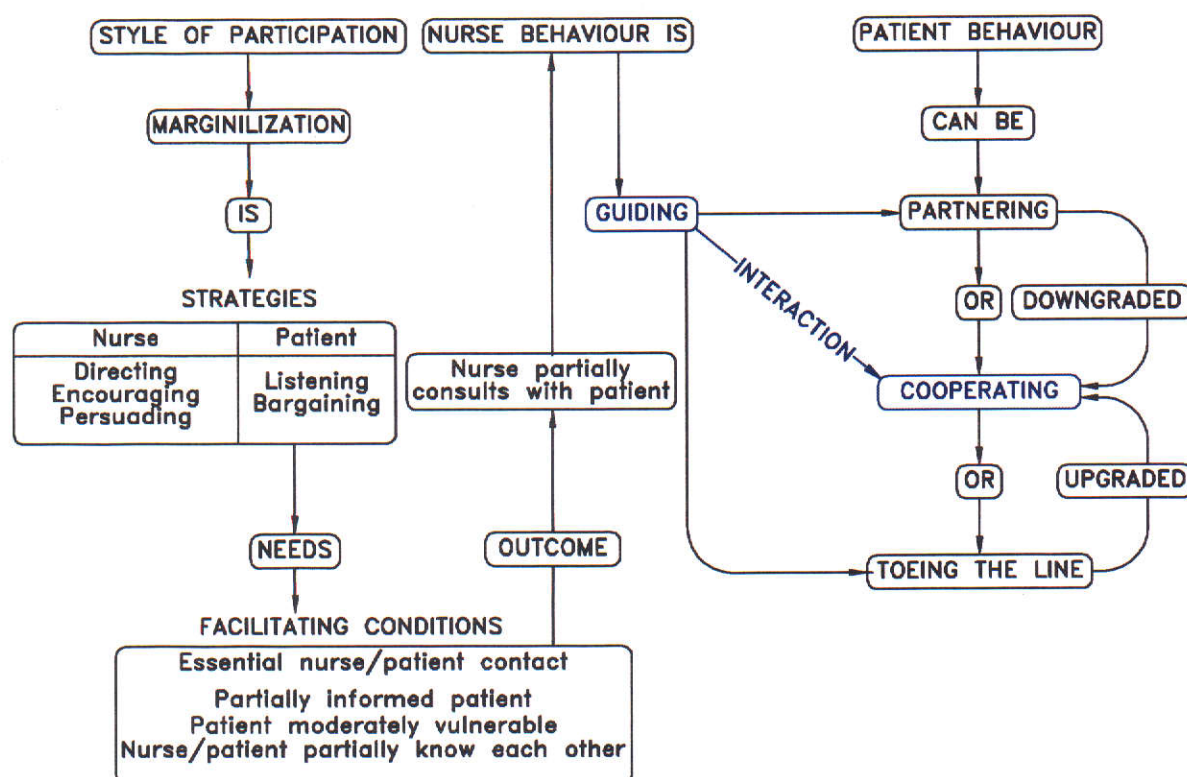


Figure 5.2.2 Adjustment Pattern (2): Converging patients' level of participation/control to nurses' level without increasing or decreasing own level.

### Strategies used by Nurses to Downgrade and Upgrade Patients' Input

In order to converge patients' level of participation and control to their own level without losing any of their own control, nurses who subscribed to participation marginalisation were observed to use such strategies as, a) directing, b) encouraging, and c) persuading. These strategies were perceived by the nurses to decrease control for patients who subscribed to participation inclusion and to downgrade their input.

Similarly, the nurses used these same strategies to increase control for patients who subscribed to participation preclusion and to upgrade their input. Patients were observed to respond to these nurses' strategies. For instance, patients who subscribed to participation inclusion used the strategy of bargaining with the nurses so as to hold on to some control and patients who subscribed to participation preclusion responded by listening to the nurses so that they could attempt to work at the cooperating level with them.

#### **a) Directing**

Nurses who were engaged in guiding patients were observed to direct patients with regards to what they wanted them to do. Directing has been defined from the data as nurses showing patients what to do or how to do something. The nurses explained that since patients lacked medical and technical knowledge, they needed directions from nurses so that they could cooperate with them. Furthermore, the nurses explained that, initially, they would wait for the patients to cooperate with them before they would direct them. However, if the nurses found the patients to be reticent about cooperating with them, they stated that they would direct them. They said:

*I usually wait for them to be cooperative and get involved in their basic care but if I find that they are hesitant, I will tell them to do things for themselves like I would say "come on, you can wash yourself, give it try ... I'll be here to assist if you need help, ok?" and the patients usually respond (nurse 10).*

*I try and tell them [patients] what I am doing and why I am not showering them completely and I say "this is why you are here and I am trying to get you back to your previous state ... that is why I want you to do as much as possible without having to rely on us [nurses] because when you go home, we are not going to be there (nurse 6).*

In the above situation, the nurses were dealing with patients who subscribed to participation preclusion and who were reluctant to do anything without being told to do so by the nurses. In these instances, the patients were observed to respond to the nurses' directions with ease and subsequently cooperated with them. Contrary to this, patients who subscribed to participation inclusion were observed to have some difficulty in responding to the nurses' directions. These patients expressed

frustration that the nurses were not allowing them to participate in all aspects of their care and had expected them to follow their directions. The main concern was in the area of making decisions about their treatments. It was observed that patients who subscribed to participation inclusion performed their own activities of daily living and managed their pain control, if they were able. They did not wait for the nurses to direct them. Whilst the nurses went along with these patients making decisions about their activities of daily living and pain control, they were observed to direct these patients with regards to treatment issues. The following is a nurse and patient comment, highlighting this point.

*Like to-night, I went in and this patient who was still on clear fluids after bowel surgery told me that he had been having tea with milk and that the doctor had said that he could ... I wasn't happy with this and I told him that no one had told us and as far as we [nurses] were concerned, he should only drink black tea and would he refrain from adding milk to his drinks ... the patient started to argue with me but I insisted and pointed to the sign above his bed, explaining to him that he would get a stomach upset if he continued to drink milk ... in the end he reluctantly accepted to follow my directions (nurse 20).*

*I didn't think I needed to have the ventolin nebulisations every four hours ... so I refused it when the nurse came to give it to me ... I usually administered my own nebs as I am an asthmatic and I do it at home all the time ... but the nurse directed me to have the neb, saying that I should have it whether I needed it or not ... I tried to speak to her about spacing the neb but she insisted I have it ... I ended up having the neb but told the nurse to ask the doctor to see me when he was on the ward next (patient 16).*

On the other hand, when the nurses who subscribed to participation marginalisation and guiding were working with patients who had similar views to themselves, the nurses were observed to have no problems with patients following their directions. It was observed that these patients expected to take directions from the nurses. For example:

*I am happy for the nurses to give me instructions or directions so that I will know what I should be doing ... my place is to listen to the nurses and follow their instructions because they are the experts and I want to get better (patient 10).*

In summary, it was found that nurses who believed in participation marginalisation and were engaged in guiding patients directed them in all aspects of their care. Patients who subscribed to participation marginalisation and preclusion were observed to respond to the nurses' directions with ease. However, patients who subscribed to participation inclusion had some difficulty in following the nurses' directions.

### **b) Encouraging**

Encouraging was defined from the data as nurses increasing patients' self-confidence so that they would feel comfortable about participating in their own activities of daily living and pain control. The nurses were observed to encourage patients by using certain words that had the potential for increasing patients' input towards self-care. Additionally, the nurses also praised patients' efforts so that they would be more inclined to take some initiative in their own care. The nurses claimed that encouragement was most useful when working with patients who subscribed to participation preclusion. This was because it facilitated the nurses to upgrade these patients from toeing the line to the cooperating level. They explained:

*I use encouragement to get them [patients] to do as much as possible, provided they are able ... for example, in the shower, I stand back and sort of encourage them. I would say like, "how about washing your legs or whatever ... just a bit of verbal praise and it does work. I will, for example, direct them to pop the cream on or their Ted stockings ... you know I just encourage them to go for a walk and they do cooperate and I tell them that I appreciated them going for the walk (nurse 1).*

The nurses further stated that some patients who perceived that they should do as they were told and patients who had machinery attached to them would sometimes be hesitant to initiate any sort of self-care. In such instances, the nurses claimed that they needed to actively encourage these patients. For example, the nurses would encourage patients to go to the shower by themselves but tell patients that they would be there to assist, as soon as possible. Once the patients were in the shower, the nurses explained that they would take their time in getting to the patients and when they did get there, they would hover around the patients without doing too



much for them. The nurses, however, commented that they would be observing the patients during the shower, in case any harm came to them.

*I help patients out of bed and from that I can assess that they are ok to go and shower themselves ... I encourage them to get their things and to walk to the shower and that I would be there shortly ... I tell them to get started and that I would assist if needed ... once they are in the shower, they feel confident that they are able to do it, especially the ones who are scared to do anything without being told ... when I eventually get there, I praise them for what they have done but watch rather than jump in and help (informal nurse interview).*

Some patients concurred with the above nurses' views, stating that when nurses encouraged them, they felt better about their capabilities and were prepared to cooperate with the nurses and do as much as possible for themselves. Furthermore, the patients, especially those that subscribed to participation preclusion, stated that they needed to be encouraged by the nurses before they felt that they could participate in some aspects of their care.

*I was in with a stroke and the nurses encouraged me to help myself as much as I could ... they [nurses] would say things like, "come on Mrs X, you can sit up, you can dress yourself, try and undo your buttons" and things like that which was really great ... it gives you the confidence to go forward because I was scared about doing anything (patient 4).*

Whilst the nurses who wanted to guide patients were able to get patients who subscribed to participation marginalisation and preclusion to cooperate by encouraging them, the nurses were not always successful with patients who subscribed to participation inclusion. With these patients, the nurses were not always able to encourage the patients to change their minds and cooperate with them. The nurses explained that some patients had stood their ground and were not prepared to listen to the nurses' encouragement and follow their directions, as reflected by this comment:

*I expect a certain degree of cooperation from them [patients] when I encourage them ... I know what is good for them so I generally talk them around by encouraging to do whatever but you do get those who are adamant and you just have to persevere, it's like hitting your head against a brick wall (nurse 6).*

Similarly, patients who subscribed to participation inclusion stated that nurses' encouragement had not made any difference to them about changing their minds and going along with the nurses. They explained that they had succumbed to cooperating with the nurses because they could not be bothered arguing with the nurses. Moreover, they stated that they would wait for certain other nurses to come on duty before they would attempt to discuss treatment issues.

*I wanted the pethedine needle for the pain but the nurse felt that I should stop the pethedine and have the panadeine ... she [nurse] said that I did not need strong pain killers and that it would be better for my health if I went on to the tablets ... she said we should try this and if it didn't work, then, she would give me the needle ... I reluctantly agreed and cooperated with the nurse but was going to ask the afternoon nurse to give me the pethedine which the doctor had written up for me (informal patient interview).*

In summary, it was evident that the nurses who subscribed to participation marginalisation and guiding were successful in using encouragement to upgrade patients who subscribed to participation preclusion and to get them to work at their level. The nurses, however, were observed to experience difficulty in achieving full cooperation with patients who subscribed to participation inclusion because these patients were reluctant to give up their control totally.

### **c) Persuading**

Another strategy used by nurses who were engaged in guiding patients was persuading them so as to facilitate cooperation from them. Persuasion was defined from the data as nurses reasoning with patients so that they would follow their directions. The nurses were noted to engage in this behaviour whilst they were performing tasks or procedures with patients. A common situation where nurses were observed to use persuasion was when they were dealing with perceived "difficult" patients. As covered in chapter three, some nurses had perceived difficult patients as those who did not do as they were instructed by the nurses or those who actively sought to participate in all aspects of their care, including making decisions about their treatments. The nurses claimed that it was much easier to persuade patients who subscribed to participation marginalisation or preclusion than patients who subscribed to participation inclusion. For example:

*Some patients are so subservient that you need to use persuasion before you can get them to do anything ... you know that they can perform the task [activities of daily living] but they won't do it ... so I persuade them by saying, "I know you don't want to do it but can you try for me ... I know you are afraid but I am here to help and you let me know what you want me to help you with" (nurse 10).*

The nurses were also observed to use persuasion when their actions, such as directing and encouraging, did not facilitate cooperation from some patients. This was particularly true with patients who subscribed to participation inclusion. Furthermore, the nurses explained that it was only through persuasion that they were able to get these patients to agree to the type of treatments that they were being administered. The nurses stated that patients who subscribed to participation inclusion did not always accept that doctors and nurses knew best, and that they were difficult to work with at the cooperating level. For instance:

*It is frustrating to get some patients to cooperate with you ... persuading them to see eye-to-eye with you is time consuming, especially when you are trying to do it amongst other things ... a few patients I know, have been very knowledgeable and they told me what to do about the dressing ... even though I felt intimidated, I had to persuade the patient to let me do the dressing as I thought best (nurse 19).*

Some patients who subscribed to participation inclusion concurred with the above nurses. They stated that some nurses would go to any length, such as persistent persuasion, to get them to cooperate with them. They added that they found this behaviour from the nurses to be patronising and expressed concern that some of the nurses were not prepared to listen to them and see their point of view. Furthermore, they explained that, after a while, the nurses had worn them down, and as they were unwell, they had resorted to giving in and cooperating with the nurses. As these patients had stated previously, they were of the view that they were in hospital for only a short time and it had not bothered them that much to cooperate with the nurses, even though they believed that they should be consulted in all aspects of their care. They said:

*They [nurse] are like a dog with a bone, they will persist and persuade you that what they are doing is the best thing for you ... it is hard to keep up because you are sick and vulnerable ... I sometimes wish that they would stop for once and at least listen to what you have to say ... in the end, you give up and go along with them ... as long as it is not going against my views too much, that's ok, I guess (informal patient interview).*

In summary, it was found that nurses who subscribed to participation marginalisation and were engaged in guiding patients, sometimes resorted to using persuasion in order to enhance patients' cooperation. As with directing and encouraging, these nurses seemed to have no problems with getting patients who subscribed to participation marginalisation and preclusion to cooperate, using persuasion. It was found that patients who subscribed to participation inclusion had allowed the nurses to persuade them because of the reasons they had mentioned.

### **Strategies/ Responses by Patients**

Data showed that when nurses upgraded or downgraded patients' input by using such strategies as directing, encouraging, and persuading, they received different responses from patients. For instance, patients who subscribed to participation inclusion used the strategy of bargaining with the nurses so as to hold on to some control whereas patients who subscribed to participation preclusion responded by listening to the nurses and cooperating with them.

### **Listening and bargaining**

It was found that patients responded to nurses who guided them by either listening or bargaining with them. Listening has been defined from the data as patients paying attention to what the nurses were asking them to do and fulfilling the nurses' directions and requests. They did not question the nurses' directions. Bargaining, on the other hand, was explained from the data as patients agreeing to do as they were asked by the nurses but with nurses having to fulfil certain obligations for them in return. It was observed that patients who subscribed to participation marginalisation and preclusion listened to nurses' directions, encouragement, and persuasions, and appeared to work with them at the cooperating level. The patients who subscribed to participation marginalisation claimed that nurses knew what was best for them and consequently they were prepared to listen to the nurses. These patients took control of their activities of daily living and pain control, if able, on their own

initiative. They were, however, observed to wait for the nurses to direct them with regards to their treatments. They explained:

*I don't wait for the nurses to decide about my showers and when I want to go to bed ... if I have pain, I know I can ask the nurse for some pain killers or even if I need a sleeping tablet ... I am more than happy to listen to them [nurses] when they explain to me what they are going to do about the treatment, how or when they are going to do it ... I trust their judgement totally to get me better (patient 29).*

Similarly, patients who subscribed to participation preclusion were also prepared to listen to the nurses and be guided by them. As these patients were of the view that they should do as they were told, they were observed to allow the nurses to guide them because this was what they perceived the nurses wanted. As previously explained, these patients needed a lot of encouragement and persuasion from the nurses to let them know that it was all right for them to take some initiative for their activities of daily living and pain management. It appeared that these patients needed this endorsement from the nurses so that they did not think that they would be labelled by the nurses as “difficult” and subsequently receive less than satisfactory care. The following field notes reflects this concern:

*The nurses said to the patient, “Mrs X, I would like you to go for at least two walks this morning ... I notice you have been in bed a lot, it's good for you to get moving, so can you do that for me?” ... the patient turned to the nurse and replied, “it hurts when I move so I was waiting for you to tell me when I should be walking, I didn't want to do anything that you didn't want me to do” ... to which the nurse stated, “look Mrs X, things like walking will help you get better and it would please me if you do walk, don't wait for me to tell you” and the patient replied, “as long as you say it's ok sister, I would walk, I don't want to be trouble for you” ... that's ok Mrs X, you are no trouble and the afternoon nurses will be pleased that you are walking (field notes).*

In the above scenario, the patient was prepared to listen to the nurse and follow directions, despite the patient being in pain. It was observed that the nurse did not ask the patient to explain about the pain nor did the patient ask the nurse for pain relief before going for the walk. From this, it may be extrapolated that this patient was only concerned about listening to the nurse and following directions. When the

researcher asked the patient why she did not ask for pain relief, this is what the patient had to say:

*I always felt that you must do as they [nurses] ask you to do regardless of what you feel, they are the boss here [in hospital] and if you don't want to get into their bad books, you do as told, even if you are not totally sold on doing something ... if you don't do as they tell you, they will not look after you, they will not come near you and then where will you be ... so I always play safe and do as asked (patient 1).*

Contrary to the above situation, patients who subscribed to participation inclusion were observed to engage in bargaining with the nurses when they directed, encouraged, or persuaded them to do something. This was these patients' way of attempting to hold on to some control. As already alluded to, the above patients were often knowledgeable about their care and treatments, they actively sought information from the doctors about what was happening to them, and were noted to be assertive, whenever possible, when working with nurses at the cooperating level. It was interesting to note that even though these patients succumbed to having their input downgraded and to work at the cooperating level with the nurses, they were observed to make sure that the nurses agreed to do something for them in return. For example, the patients would tell the nurses that they would cooperate with them if, in return, the nurses would be prepared to get the doctor to change the treatment orders or ask the doctor to come and explain to them why a certain treatment needed to be adhered to.

*This night, the nurse came and said that as the ward was going to be noisy because of this sick patient who had just come back from surgery, I should take some sleeping tablets ... I told her that the pills made me hallucinate and that I didn't want any sleepers ... she [the nurse] kept insisting that it was for my own good as I needed the sleep and there was no single rooms available to move the sick patient ... so I told the nurse that I would take the sleepers as long as she can get the doctor to write me up for something different and the nurse seemed ok about this (patient 22).*

Another common example of patients bargaining was when the nurses were performing dressings on patients' wounds. It was noted that nurses often decided to do patients' dressings without asking them if they required any pain relief prior to doing the dressing. It was observed that when the nurses went to do the dressings,

some patients would bargain with the nurses to give them pain relief first before they would let them do the dressing. For example:

*The nurse did not ask the patient if she was in any pain before commencing the dressing on the abdominal wound site ... as the nurse was about to take the previous dressing down, the patient turned to him [the nurse] and said, "are you going to give me some pain tablets first, it has been throbbing for a while ... the nurse replied, "it is only a simple dressing Mrs X, it shouldn't be that painful" ... and the patient replied, "do you have to do the dressing now?" and the nurse said, "not really" to which the patient said, "in that case, how about giving me two panadeines and coming back in half an hour to do the dressing" ... the nurse replied, "ok, I'll get you the pills and do the dressing later" (field notes).*

Nurses who subscribed to participation marginalisation and guiding confirmed that some patients would bargain with them before they would cooperate with them. These nurses stated that they often took things for granted and worked on the assumption that, as long as they explained to patients what they were going to do to them and the rationale for doing it, patients would cooperate with them. When asked why the nurses did not offer pain relief prior to dressings, they commented that they did not think of offering analgesia, for instance:

*I don't know why we don't ask them about pain relief ... we assume that they [patients] will ask if they need it so we don't bother ... when they ask for it, you have to listen to them and do something about it, even if it means you getting behind in your work ... I know, we are taught at uni [university] to ask about toilet and pain but we don't ... patients will bargain with you which I don't mind and I am quite happy to appease them (nurse 6).*

In summary, it was found that patients responded to nurses' directing, encouraging, and persuading by either listening to nurses or bargaining with them. Patients who subscribed to participation marginalisation and preclusion were observed to respond by listening to the nurses whilst patients who subscribed to participation inclusion were observed to bargain with the nurses whilst working with them at the cooperating level.

### **Adjustment Pattern (3): Decreasing patients' level of participation/control and decreasing nurses' control**

Data analysis showed that the nurses who subscribed to participation preclusion were observed to adjust their behaviours to decrease patients' control and level of participation, whenever possible, in order to minimise the incongruence and seek resolution. However, if patients who subscribed to participation inclusion refused to accept the decrease in their control and level of participation and to toe the line, the nurses had no option but to decrease their own control and allow these patients to work at the cooperating level with them. As explained in chapter three, the above nurses were of the view that patients should not have any input into their care and that they should do as they were told. The nurses stated that they were in charge and that patients should obey their orders, even when the orders were observed to be inappropriate at times. Accordingly, the nurses were observed to engage in a behaviour termed from the data as "overbearing" with patients. The patients, on the other hand, being the more passive actors in the process of *accommodating the incongruence*, were observed to engage in a behaviour identified from the data as "toeing the line", except for those that subscribed to participation inclusion. Overbearing has been defined from the data as nurses treating patients as though they were powerless and dominating them. From the patients' perspective, toeing the line has been defined from the data as patients conforming to what the nurses wanted them to do without voicing concern or question. The following reflects nurses' and patients' behaviours of overbearing and toeing the line respectively.

*When patients come to hospital, they are giving us consent and so they should do as we tell them ... patients should conform and not be assertive and question everything we are doing ... I am in charge here [hospital] and this is my territory and patients need to obey us if they know what is good for them ... I hate working with patients that challenge you (nurse 21).*

*I consider the nurses to be in control and when you are sick, you have no choice but to obey their [nurses] orders if you want care from them ... the patient opposite me complained and no one came near her unless they had to ... pretty scary when you think about this ... best thing is to keep your mouth shut and do as you are told (patient 5).*



### Nurses Overbearing- Patients Toeing the Line

Nurses who subscribed to participation preclusion were observed to engage in overbearing behaviour with patients, whenever possible, in order to decrease patients' control and level of participation. As with nurses who subscribed to participation inclusion and marginalisation, these nurses were noted to work with patients who either subscribed to participation inclusion or marginalisation, thus, creating incongruence, although on a few occasions, they worked with patients who subscribed to similar views to themselves. During these instances, the above nurses stated that they felt comfortable, as patients who subscribed to participation preclusion were prepared to obey them and allow the nurses to dominate them. However, when the nurses found themselves working with patients who subscribed to participation inclusion, they were observed to be only able to downgrade the patients' participatory behaviours to that of cooperating with them. Similar to the nurses who subscribed to participation marginalisation, these nurses were unable to work with patients at the partnering level. The above nurses were, however, unable to downgrade the input of patients who subscribed to participation inclusion to the toeing the line level, even though the nurses appeared to possess apparent power. Patients who subscribed to participation inclusion were observed to be too assertive for the nurses who wanted to dominate them, as indicated by this nurse comment:

*With most patients, you can get them to conform or do as you ask but there are a few [patients] who will resist you and because they know so much and are articulate, you have no choice but to give them some control ... you have to, even though you don't like it because they will stop you from doing your routine ... you can't always label them because other nurses think that the patients are ok (nurse 27).*

As previously stated, patients who subscribed to participation inclusion claimed that they would not allow the nurses who subscribed to participation preclusion to order them around. They emphasised that, whilst they were prepared to cooperate with the nurses, they did not feel comfortable about doing as they were told. These patients stated that by cooperating, they at least were able to hold on to some control and participate in their own care to some extent. Furthermore, the patients explained that

as long as they were well enough, they would resist the nurses' orders as much as possible. For example:

*I like to know exactly what is being done and be part of the decision-making process ... if nurses want to push me around as if I don't exist and some try, I will not stand for it ... as long as I am able, I'll say something to them and if I don't get anywhere, I'll sort it out with the doctor ... I want the nurses to at least meet me halfway ... we have rights ... fortunately not all nurses are like that (patient 22).*

Some patients who subscribed to participation inclusion stated that they would resort to being stand-offish with the nurses who ordered them around. Moreover, they commented that they had rights and that they deserved to be consulted about their care. These patients were also critical of the nurses' behaviours, stating that if nurses could not work in a collegial manner with them, they should not be working as nurses.

*The nurse fixed my ileostomy bag but it was leaking, so I pressed the bell and the nurse came back and she sort of bit my head off and said, "look, what's the matter this time? rah, rah, rah" ... so I turned to her and told her [the nurse] that she was most gruff and rough and not caring ... I told her that if I was well enough, I would do it [bag change] myself and that she could get another nurse and that she should not be a nurse with that sort of attitude ... the nurse kind of apologised and helped me with the bag ... after that incident, this particular nurse was sort of ok with me (informal patient interview).*

Furthermore, the above patients explained that if they could not work as partners with the nurses, they were prepared to compromise their views and work with these nurses who subscribed to participation preclusion at the cooperating level, as highlighted by this patient comment:

*I wanted to stay up and read but this nurse ordered me to turn the lights out and go to sleep ... I told her that if she can't discuss with me about whether or not I would be affecting the other patients, I wasn't going to do as she told me ... the nurse was taken aback and asked if it would be too much trouble to go and read in the patients' lounge ... as she [nurse] appeared to be human and ask, I didn't mind cooperating with the nurse and going to the lounge (patient 13).*

As voiced earlier by the patients who subscribed to participation inclusion, the fact that they were in hospital for only a short period of time meant that they did not mind working at the cooperating level, provided the nurses were prepared to go along with them.

It was of significance though to note that when nurses who subscribed to participation preclusion worked with patients who subscribed to participation marginalisation, they downgraded their input to the level of toeing the line with them. The nurses stated that, unlike patients who subscribed to participation inclusion who were knowledgeable, these patients were not knowledgeable. They added that this factor, together with these patients' views that nurses knew best, had facilitated the nurses to get the patients to toe the line or do as they were told.

*Some patients look up to you to make the decisions for them, especially about treatments ... they literally leave you to decide ... so it is not hard to get them [patients] to obey your orders ... if you are firm with these people, they will give in usually (nurse 11).*

Patients who subscribed to participation marginalisation concurred with the nurses above. They explained that, in hospital, they felt vulnerable and did not have sufficient information to go against the nurses. They emphasised that they did not want to be labelled as "difficult" or "bad" patients because that meant that they would not receive quality care from the nurses. Consequently, these patients were prepared to give up their control and not participate in their care and allow their input to be downgraded by the nurses to the toeing the line level. It seemed that, even though these patients were not happy to toe the line, they still went along with the nurses because of this fear of less than satisfactory care. They said:

*I like the nurses to think that I am cooperating with them but when you get nurses who are bossy and expect you to do as they tell you, you don't have the power to over-ride them ... I want to get proper care from them [nurses] so I can recover ... I guess, I tend to go along with the nurses, even though I am not that keen because I don't want anything jeopardising my recovery (patient 10).*

Contrary to the above situation, patients who subscribed to participation preclusion were observed to readily toe the line with the nurses. The patients stated that, in hospital, they were quite prepared to obey the nurses' orders as they had perceived this to be their role. Additionally, the patients claimed that they felt extremely vulnerable and believed that they had no control over the nurses. Some of these patients stated that they perceived themselves to be disenfranchised in hospital, which subsequently had led them to believe that they had no say in whatever happened to them.

*Some of the nurses tend to give you orders and I am sure, to them, [nurses] you are just a body on the bed ... there doesn't seem to be any communication between us and the nurses ... when you are afraid and alone and sick, your best bet is to do as you are told and let them get on ... patients don't have power in hospital ... you feel disenfranchised (patient 5).*

It was noted that the following facilitating conditions prevailed when the nurses were overbearing with patients and patients toed the line. It was apparent from the data that nurses and patients had minimal contact with each other. The nurses who subscribed to participation preclusion and who were overbearing were observed to approach patients only when they had to. For instance, the nurses would go near patients if they needed to complete tasks on them. It was also of interest to note that when these nurses were with patients, they were observed to refrain from talking with patients on a personal level, except to give orders. This effectively resulted in nurses and patients having no time together for information sharing, information giving, patient education, or even to get to know each other. It was observed that patients, especially those who subscribed to participation preclusion, did not ask the nurses any questions. The patients who subscribed to participation marginalisation would sometimes ask the nurses questions. In such cases, the nurses were observed to rarely respond to the patients. However, when patients who subscribed to participation inclusion asked questions, the nurses were observed to reluctantly provide some answers.

*We are in control ... we call the shots and that includes telling patients what we want to tell them ... I don't encourage questions from them [patients] ...*

*it slows us down with our work ... I tend to fob patients off when they ask questions, if they are that keen, they will ask the doctors, although with some patients you have to give them information if you want any cooperation from them (nurse 27).*

The above nurses' behaviours of not wanting to give patients information was observed to result in patients being uninformed. Except for patients who actively pursued these nurses for answers, the majority of patients who met up with nurses who were overbearing with them were left in the dark about what was happening to them. It appeared that the nurses deliberately did not give patients information. This may have been because the nurses had wanted to hold on to their power and control over patients, as described by Beck (1997) in chapter one.

It was evident that patients who toed the line were highly vulnerable. One explanation for this seemed to be that since nurses and patients had no time together, there was no opportunity for either party to get to know each other as individuals who had their own opinions about care. As previously explained, nurses and patients needed time together so that they could develop trusting nurse-patient relationships, which were crucial to patients' well being and for a reduction of their vulnerability. The following field notes depict this point:

*Ten minutes into the dressing, the patient began to cry ... the nurse appeared to ignore this and continued to do the dressing ... the nurse said "can you lift your boobies up so I can put the tape on properly" ... the patient did as she was told. When the nurse had finished, she said, "why the tears, are you sore or what?" to which the patient replied, "yes" and the nurse continued, "well, I'll give you some panadeine tablets, if you are due ok? (field notes).*

Later when the above patient was asked by the researcher why she had not said something to the nurse about the pain before the procedure, she explained that on the previous day the same nurse had done the dressing. She stated that she had complained about the pain but the nurse had ignored her. The patient further explained that the nurse had told her that it was normal to have a bit of discomfort during the procedure and that she was not to worry about it. The patient stated that she had finally got the pain tablets when the afternoon nurse came on duty. When the patient was asked why she had not asked for the analgesia earlier, she replied

that after the dressing she did not see the morning nurse even once. The patient also stated that the nurse had kept away from her because she had complained. It was extrapolated from this that the patient had perceived that she did not have any say in her own care. On the other hand, when the nurse was asked why she had not given the panadeine tablets before the procedure, she claimed that the operation was only minor and that the patient should not feel much pain anyway.

Nurses who subscribed to participation preclusion and who were overbearing with patients were observed to engage in such behaviours as ordering patients, using standover tactics, and bullying patients. Patients, on the other hand, were observed to respond by either resisting the nurses' orders, tolerating the orders, or conforming to the nurses' orders. These patient behaviours appeared to be contingent upon the style of participation to which they subscribed. For example, patients who subscribed to participation inclusion were observed to resist whilst patients who subscribed to participation marginalisation were observed to be tolerant. On the other hand, patients who subscribed to participation preclusion were noted to readily conform. The following section will describe the strategies that the nurses used to downgrade patients' input and to get them to toe the line as well as describe patients' responses. The strategies that nurses used to decrease their own control so that they could work with patients who refused to toe the line will also be described. Figure 5.2.3 depicts Adjustment Pattern (3): Decreasing patients' level of participation/control and decreasing nurses' control. The colour red has been used to highlight the nurse's behaviour of being overbearing.

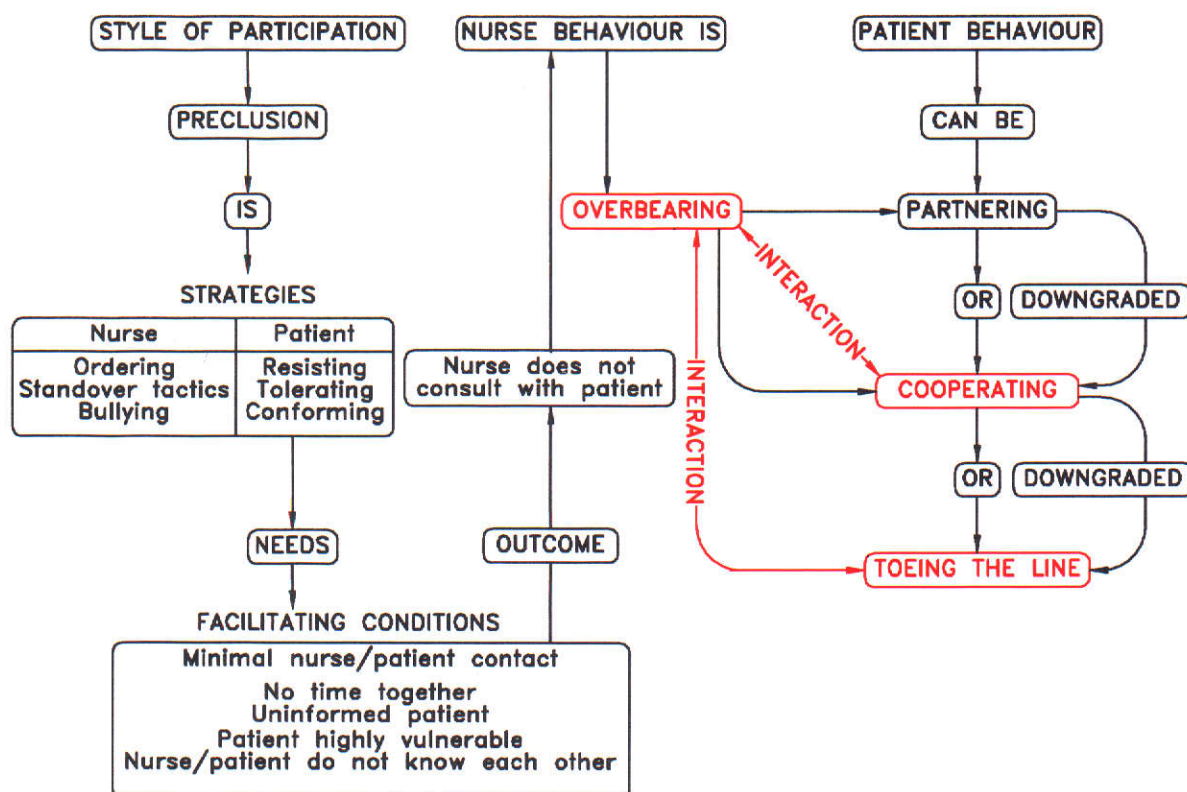


Figure 5.2.3 Adjustment Pattern (3): Decreasing patients' level of participation/control and decreasing nurses' control.

### Strategies used by Nurses to Downgrade Patients' Input

In order to decrease patients' control and level of participation and to downgrade their input to the toeing the line level, the nurses who subscribed to participation-preclusion were observed to use strategies such as, ordering, using standover tactics, and bullying. It was found that the nurses were not always successful in downgrading patients' input by using the stated strategies. In some instances, the nurses had to use strategies to decrease their own control so that they could work with patients.

#### Nurses ordering

The nurses who were overbearing with patients were observed to give patients orders. Ordering was defined from the data as nurses issuing commands to patients to do something exactly as they wanted them done. It was apparent from these nurses' statements that patients' input or feelings were not considered by the nurses. It almost seemed as though the nurses were not concerned about patients being

individuals with their own views about how nursing care was to be delivered. The nurses stated that they considered the patients' role as obeying their orders and doing as they were told. In some instances, it was disconcerting to hear these nurses state that they did not see anything wrong with ordering patients to do things. They commented.

*You need to give patients orders so that they will know what to do ... a lot of patients who come in [into hospital] don't have a clue anyway ... I don't necessarily see giving orders as negative ... patients need to be told what to do and with some patients you have to give a direct order before they will budge (nurse 21).*

Some patients supported the above nurses' attitudes. The patients claimed that they had come across nurses who ordered them around. Furthermore, they explained that to some nurses this behaviour was normal. They expanded by stating that these nurses appeared to be oblivious to the notion that patients might want to say something about their own care. This view was particularly true for patients who subscribed to participation inclusion. For example:

*Some nurses don't tell you anything ... they just walk in and give you an order to do something ... never mind that you might want to suggest something about what is to happen ... they say, "this is what I want you to do and this is how I want it done, it's like I'm the nurse and you are the patient, I'm giving you the orders and that's that" ... sometimes, I felt like walking out (patient 18).*

*I am sure some nurses think that they are way above you and strut around giving you orders ... they don't seem to care about your feelings ... they are abrupt too and don't give you a chance to voice an opinion (patient 14).*

On questioning the nurses about giving orders to patients, they explained that they were being assertive and only doing their jobs. Moreover, they were of the view that ordering was appropriate if they were to complete all the tasks on time. They explained that allowing patients to have their say was a time waster and that most patients would respond to a direct order, especially the elderly. They further stated that ordering was an effective strategy to use when they wanted patients to conform and do as they were told. They stated:

*Some of the oldies, especially, will not do a thing for themselves ... by giving them orders in what you want them to do certainly helps us ... you*



*can do your back in if you are not careful, trying to lift them [patients] ... no, I tell them what to do ... with the younger patients, you push them to do things, otherwise you will not get your work done (nurse 11).*

To this end, the above nurses were sometimes observed to inappropriately involve patients in their daily living activities. Patients who were not capable of showering themselves, for example, were taken to the shower by the nurses and left to wash themselves. The nurses were observed to tell the patients that they would return and assist them but this seldom eventuated. The consequence of this situation was that patients either did not wash and dry themselves effectively or enlisted help through the researcher to give them a hand. When this occurred, the researcher sought the assistance of other nurses who were available to help the patients. When the nurses who came to assist asked the patients why they had not rung the bell, they stated that they had not wanted to bother the nurses by ringing. When the researcher questioned the nurses about leaving patients in the showers unattended, they shrugged their shoulders and stated as matter of fact that they believed that, in their opinion, the patients were capable. Furthermore, they commented that they had expected patients to ring the bell and since they had not rung, they had assumed that the patients were all right.

*With some patients, you just have to literally take them to the shower and order them to get started ... sure, some patients have arthritis and discomfort but they need to realise that they have to get a move on if they are to get out of hospital ... I think, some patients like the attention in hospital and are not bothered to get home ... they should ring the bell if they are not coping, shouldn't they ... we are not mind readers you know (nurse 21).*

In summary, it was found that the nurses who were overbearing with patients used strategies of ordering patients to decrease their control and to get them to toe the line. The need to do this was perceived by these nurses as essential if they were to get patients to obey them and to complete their routine work. It appeared that the concept of promoting patient input was not important to these nurses. Even though they were observed to order patients to undertake their own activities of daily living, it was mainly through default and not a genuine interest on the nurses' part.

### **Nurses using standover tactics/bullying**

It was found that nurses who were overbearing with patients used standover tactics and bullied patients into obeying their orders, whenever possible. Standover tactics was defined from the data as nurses using coercion or pressure patients to obey their orders and toe the line. Bullying was defined as nurses intimidating patients to the point that they felt that they had no options but to follow nurses' orders. These two behaviours by the nurses were particularly observed when interacting with patients who subscribed to participation marginalisation and preclusion. As previously explained, as these two groups of patients were experiencing moderate to extreme vulnerability, they had feared that if they upset the nurses by not doing as they were told their care may be compromised. The following field notes reflect nurses' use of standover tactics and bullying behaviours.

*The nurse walked into the 4 bed ward, pulled the blinds up, and stated in a loud voice, "now, you lot, I want you all to sit out for breakfast ... this way, I can make the beds and get this job out of the way, now, come on, I haven't the whole morning and I am on my own to-day" ... three of the patients immediately hopped out of bed, the fourth patients remained in bed and the nurse went to this patient and said, "why aren't you getting out, didn't you hear me" to which the patient said, "I am all stiff this morning and my arthritis is bad, I will get out if you please help me" to which the nurse replied, "use the monkey bar over your bed, that's what that is for, how about trying, eh" and the patient slowly grabbed the bar and managed to pull himself up and sit at the edge of the bed ... his facial expression indicated that he was experiencing some pain ... finally he was able to sit on the chair ... during this time, the nurse stood with her hands on the hips and looked (field notes).*

Field observations showed that the nurses who subscribed to participation preclusion consistently used standover tactics and bullied patients as they went about doing physical tasks. As already alluded to in chapter three, these nurses were only concerned about completing tasks and did not appear to be interested in encouraging patients to participate in their own care. It was apparent that these nurses were determined to adhere to routine and to get tasks done.

Some patients' comments were also suggestive of nurses using standover tactics and bullying them. These patients explained that the nurses who wanted them to obey

their orders would intimidate them, whenever possible. They further stated that the nurses often let the patients know that they were in charge and that patients' well-being and comfort were dependent upon the nurses attending to their needs.

Common examples given by some patients were in the area of pain control and comfort measures in bed. They stated that if they did not obey the nurses their pain cover was conveniently neglected or they were left lying longer than necessary in wet beds. Another strategy used by nurses to bully patients, according to a few patients, was that the nurses would inflict unnecessary discomfort on them if they disobeyed orders. An example is this patient comment:

*This particular nurse had been at me for doing something for her ... I know they [nurses] need to have some routine, but we are adults and I told her that I didn't feel like doing whatever she was after at that very moment ... she left without saying anything ... later she came in but no conversation ... just said, "it is time for your heparin" and pulled the bedclothes down and literally jabbed me ... it started to bleed when she pulled the needle out to which the nurse said "there, you can say ouch for that" and left me feeling upset, in discomfort and extremely vulnerable (informal patient interview).*

The notion of some nurses inflicting unnecessary discomfort on patients and patients being left in wet beds was supported by the nurse manager. The manager claimed that letters of complaint had been received from some patients and relatives following discharge from hospital. For example:

*Most complaints are about basic nursing care ... soiled beds not changed, drains being pulled out without cutting the suture, nurses not communicating with patients, etc (nurse manager).*

Some patients also stated that some nurses would deliberately use standover tactics to get their own way with patients. These patients claimed that some nurses did not consider them as having a brain and being capable of having a say in their own care. This attitude, according to these patients, had resulted in some nurses blatantly using standover tactics with them as indicated by this patient comment:

*They [nurses] just stand over you and bully you into doing something ... like one evening, this nurse came and said, "take this" and before I could say anything, she was practically pushing the capsule into my mouth ... I asked her what it was and she muttered something about it being an antibiotic ... I*

*told her that I was only supposed to have four a day and not six ... she ignored me and said if I knew what was good for me I would take it ... I asked her to get the doctor but she said the doctor was not on till the morning ... she literally stood there until I took the capsule, I didn't think she even thought that I may be right (patient 12).*

In summary, it was found that nurses who were overbearing with patients were observed to use standover tactics and bully patients into doing as they were told. This was especially true with patients who subscribed to participation marginalisation and preclusion. However, patients who subscribed to participation inclusion were observed to resist these behaviour from the nurses.

### **Strategies/ Responses by Patients**

Data revealed that patients responded in various ways to the nurses use of ordering, standover tactics and bullying. Patients were observed to resist, tolerate, or conform in responding to the nurses. Patients responsive behaviours were dependent upon the style of participation to which they subscribed.

#### **Patients resisting**

Patients who subscribed to participation inclusion were observed to resist nurses who ordered, bullied, or used standover tactics with them. As already described, these patients were articulate and actively sought as much information as possible so that they could make informed decisions about all aspects of their care. This was conditional upon the patients being well enough. It was found that if these patients were well enough they would engage in stand-offish behaviour with nurses who bullied or ordered them. They stated that they would ignore the nurses' orders and try and get the nurses to at least see their point of view. Additionally, they explained that they would persist in questioning the nurses' motives for ordering them around or bullying them until the nurses were prepared to cooperate with them. For example:

*I rang the bell to ask the nurse when I would be able to go home ... the previous day, the doctor told me that I could ... this nurse marched in and demanded what the problem was ... I asked her when I could go and she started to give me a lecture about the doctor having done his rounds whilst I was in the shower and won't be back till the next day ... I told her that it*

*was not good enough and to get the doctor back because I had made arrangements for my friend to pick me up ... in the end, the nurse gave in and went to ring the doctor ... I won't have them bully me like that ... I am sure some nurses and doctors think that they are gods (patient 18).*

The nurses who were engaged in ordering and bullying patients qualified the above patients' statements. They commented that with some patients, especially those that subscribed to participation inclusion, the strategy of ordering patients was ineffective. They added that these patients would ignore their orders and tell the nurses what they would be prepared to do. When this occurred, the nurses claimed that they had no choice but to decrease their own control and listen to the patients and come to some arrangements with them. For instance:

*I told the patient to go and have his shower but the patient just looked at me and said he wasn't going to and wanted to know what the hurry was about him having the shower at 8.30 in the morning ... he said that unless, I could give him a reason, he was going to wait till after the doctors have been before going for the shower ... I was so annoyed at him for refusing me ... really some people don't realise that it puts the routine out ... I had to agree and go along with the patient (nurse 27).*

### **Patients tolerating**

Unlike patients who subscribed to participation inclusion, patients who subscribed to participation marginalisation were observed to tolerate nurses ordering, bullying and using standover tactics with them. It was found that these patients ended up toeing the line, even though they were only able to tolerate such behaviours from the nurses. Interestingly, even though these patients were observed to toe the line, they commented that they were not convinced that this was the correct thing to do. They explained that their views that nurses and doctors knew best had been an over riding influence in them allowing the nurses to use standover tactics or even bully them into doing as they were ordered. Moreover, these patients stated that, as they did not have all the information about their care from the nurses, they felt that their hands were tied and that they had to succumb to the nurses' orders. They said:

*I know it is wrong for the nurses to order us around as though we are second class citizens ... I have always thought that nurses were the experts and they should know better than to intimidate you into submission ... you don't know enough so you are kind of stuck between a hard place and a*

*rock ... you give in reluctantly ... thank god, some nurse are nice and will include you in the care (informal patient interview).*

These patients, as already alluded to, were also afraid of being labelled as “difficult” by the nurses if they did not give in to them. It was disturbing to hear these patients equate being labelled as “difficult” with receiving poor quality or even unsafe care. This, together with their entrenched views that doctors and nurses knew best, may have been responsible for them being tolerant of the nurses’ behaviours of ordering and bullying, and them toeing the line. They explained:

*My paramount concern is to get well and for that you need care from the nurses, you need their attention ... so you have to put up with some awful nurses who boss you around, I don't agree with what they [nurses] are doing but do I really have any option ... you are in their hand for care and safety (patient 5).*

### **Patients conforming**

Patients who subscribed to participation preclusion were observed to conform to the nurses by allowing them to order them around, bully them, or to use standover tactics with them. It was of concern to note that these patients were not too disturbed about taking orders from the nurses or toeing the line. It was as if these patients fully accepted the above mentioned negative nurses’ behaviours and were prepared to do as they were told. One explanation for this could be that these patients perceived that their role was to do as they were told and that their care was essentially nurse-driven, with no input from them. They also believed that the nurses expected them to be “good” patients. Furthermore, they stated that to be perceived as “good” patients by the nurses, they needed to do as they were told. They said:

*The nurses are in control and they expect you to do as they tell you ... I have no problems with that although I wish that they are a bit friendlier sometimes ... you want to be good for them [nurses], don't you because then they be all right with you (patient 1).*

*I go into hospital all ready to do as they tell me to do ... their job is to get me well and my job is to obey their rules and regulations and conform ... if you don't expect to comply with their orders, why go into hospital ... you must keep in good terms with the nurses if you want to get better (patient 5).*

Data also showed that the above patients would make light of the nurse's negative behaviours. They appeared to do this so as to convince themselves that it was acceptable for the nurses to behave in such manner, as indicated by these field notes.

*Two nurses assisted the patient who had had a stroke from the chair to the bed ... after they [nurses] had positioned the patient, the nurses pulled the bed clothes up and proceeded to leave ... at this point, the patient turned to the nurses and said, "I have this rash on my back, can you please put some cream on it, it is so uncomfortable" to which one of the nurses replied, "no, not after all this getting you into bed and sorting you out ... I will see about it the next time you are out of bed" and left the room ... the patient turned to me [the researcher] and said "that's telling me, isn't it but fair enough I suppose, it's their prerogative, I will wait" (field notes).*

The nurses who subscribed to participation preclusion and who were overbearing with patients confirmed the above patients' views that they were quite content to toe the line. Moreover, they explained that some patients would let them do anything with them without question and that they had found these patients easy to work with. Furthermore, the nurses stated that such patients affirmed their views that patients should do as they were told, unlike some patients who would resist and challenge them. For example:

*I like working with patients who put their care totally in your hands ... you can do anything with them ... I tell them to do something and they do it ... I can be myself, after all I am in charge here although you do get some [patients] that will buck the system (nurse 11).*

In summary, it appeared that the patients who subscribed to participation preclusion were prepared to conform to the nurses' orders or to their use of standover tactics. These patients had perceived such behaviours from some nurses as normal. It was apparent that nurses who subscribed to participation preclusion and who were overbearing with patients were successful in using this behaviour with patients who subscribed to participation marginalisation and preclusion, in order to decrease their control and prevent them from participating in their care. However, they were not so successful with patients who wanted to work as partners with them. Although the nurses were not prepared to work at the partnering level with these patients, they, nevertheless, had to decrease their own control and settle for working at the cooperating level with them.

## Summary

In this chapter, the basic social process of *accommodating the incongruence* was described. Three phases were identified. Phase one included coming to terms with the incongruence. This phase encompassed encountering and acknowledging the incongruence. Phase two involved rationalising the incongruence and this included observing and assessing behaviour by both nurses and patients. The third phase consisted of seeking resolution and minimising the incongruence through adjusting behaviour. In this phase, the nurses were observed to increase patients' control and level of participation as well as increase their own level of control, decrease patients' control and level of participation and decrease their own level of control, or converge patients' control and level of participation to meet their own level or style of participation, without them increasing or decreasing their own control.

It was found that the process of *accommodating the incongruence* was nurse-driven with patients taking a subsidiary role. To this end, patients mostly adjusted their behaviours in response to nurses' adjustment of behaviour. Nurses who subscribed to participation inclusion engaged in partnering with patients. Patients responded by either partnering with nurses or allowing them to guide them, depending on the style of participation to which they subscribed. Nurses who subscribed to participation inclusion consistently upgraded the patients' input to either the partnering or guiding level, provided the patients were well enough and hospital contextual conditions and intervening conditions were conducive. With patients who subscribed to participation preclusion, the nurses increased their own level of control in order to guide them. The strategies used by nurses included advocating, negotiating, and explaining and discussing, as well as encouraging. Patients responded to these strategies and were observed to work with nurses at the partnering or cooperating level. The facilitating conditions for partnering to occur were sustained nurse/patient contact, quality time between nurses and patients, patients being fully informed, patients and nurses knowing each other well, and patients being minimally vulnerable.



Nurses who subscribed to participation marginalisation were engaged in guiding patients and patients responded by cooperating with them. In this instance, the nurses converged patients' level of control and participation to that of their own so that they could downgrade the input of patients who subscribed to participation inclusion and upgraded that of patients who subscribed to participation preclusion to the cooperating level. The strategies used by nurses included directing, encouraging, and persuading, in order to guide patients. The patients listened or bargained with the nurses, depending on their style of participation. The facilitating conditions for guiding and cooperation to occur included essential nurse/patient contact, nurses partially informing patients, patients being moderately vulnerable, and both nurses and patients knowing each other at least partially.

Nurses who subscribed to participation preclusion were found to be overbearing with patients and patients responded by toeing the line. In this instance, the nurses consistently decreased patients' level of control and prevented participation in order to downgrade the patients to either the cooperating level or to the toeing the line level again depending on their style of participation. With patients who subscribed to participation inclusion, the nurses had to decrease their own control in order to downgrade the patients' input to the cooperating level, even though they would not toe the line. The input of patients who subscribed to participation marginalisation was downgraded to the toeing the line level. The strategies the nurses used were ordering, using standover tactics, and bullying patients. The patients who subscribed to participation inclusion resisted the nurses' behaviours, the patients who subscribed to participation marginalisation tolerated the nurses' behaviours, and the patients who subscribed to participation preclusion conformed and accepted the nurses' behaviours. The conditions that were found to prevail in this situation were minimal nurse/patient contact, patients being totally uninformed by the nurses, patients experiencing high vulnerability, and nurses and patients not knowing each other.

## **CHAPTER SIX**

### **DISCUSSION**

#### **Overview of the Chapter**

The purpose of this study was to explore, describe, and analyse nurses' and patients' perceptions of the phenomenon of patient participation within the context of hospital nursing in Western Australia. More specifically, using grounded theory methodology, the study sought to examine and describe the manner in which patient participation occurred or did not occur in the practice setting, from the perspectives of both nurses and patients. In addition, it focused on uncovering the factors that enhanced or hindered the enactment of patient participation. It also aimed to discover and describe the extent to which nurses and patients incorporated patient participation within the constraints of the bureaucracy of the hospital setting and within the scope of their own beliefs, values, and understandings of the meaning of participation. This chapter will discuss the findings of this study in the context of current theories and literature and will explicate the implications of the findings for nursing practice, theory, research, and education. It will also include recommendations and limitations of the study.

#### **Patient Participation**

In Australia's current climate of economic constraints with the health dollar rapidly shrinking, the concept of patient participation has become a focal point of attention, amongst health care providers and administrators (Speedy, 1996). As Cahill (1996) stated, patients taking an active role in their own care has to be the contemporary nurse's mandate if patients are to care for themselves effectively following early discharge from hospital. The philosophy of professional nursing practice also alludes to patients being the centre of care with as much input into their own care as possible. To enhance patient-centred care, the nursing process, in its entirety or in the modified form, has been put into place in many Australian hospitals (Cooney & Watts, 1992; McMurray, 1989; O'Connell, 1996). The nursing process encompasses assessment,

diagnosing, implementing, and evaluating care based on patients' individual needs, as perceived by both nurses and patients (Bayntun-Lees, 1992; Salvage, 1992).

Studies, as described in chapter one, have also demonstrated that when patients participate in their own care, they experienced less stress of hospitalisation and greater satisfaction in care as well as being better prepared for discharge (Avis, 1994; Beisecker, 1988; Brearley, 1990; Dennis, 1990; Meyer, 1993). On the other the hand, some studies have shown that not all patients want to participate and they questioned the rights of nurses to push patients into participating, if able, in their own care (Cox, 1996; Teasdale, 1987; Waterworth & Luker, 1990; Wilson, 1987). Wilson (1987) suggested that health professionals could perhaps be promoting patient participation in a bid to cut costs and that patients were being used as pawns in this game. There is also literature which states that, even though nurses espouse pro-participatory values, there is evidence that nurses do not always allow or encourage patients to participate in their own care (Biley, 1992; McMahon, 1989; Wright, 1986). The available literature and research in the area of patient participation was inconclusive, especially in the Australian context, and indicated that further research needed to be conducted. The purpose of this study was, therefore, to gain further insight into the phenomenon of patient participation, within the context of contemporary hospital practice.

### ***Accommodating Incongruity: A Theory of Patient Participation***

The findings from this study led to the development of a substantive theory of patient participation from the nurses' and patients' perspective. This theory, which was labelled: *Accommodating Incongruity*, emerged from the basic social process that nurses and patients used to deal with the basic social problem of incongruence in their understandings of the meaning of patient participation and in their philosophy about nursing care. *Accommodating incongruity* was a dynamic and reciprocal nurse-patient interactive process. This was because nurses predominantly and patients to a lesser extent adjusted their behaviours at varying levels, depending on their styles of participation. From the problem perspective, in this study, the concept of patient participation was generally acknowledged as a value by both nurses and patients.

However, the conceptual understandings of the meaning of patient participation differed amongst nurses and patients and between nurses and patients. It was particularly interesting to find that, even though the nurses in the study were formally schooled, through the use of the nursing process, that they should involve patients in all aspects of their care, they stated different meanings of patient participation. This concurred with Ashworth et al.'s (1992) view that understandings of participation differed amongst nurses and that some nurses had inadequate understandings of its meaning. Factors, such as the theory/practice gap and exposure to utilitarian nursing, were identified as contributing to the incongruence in the understandings of the meaning of patient participation held by nurses. This incongruence in the meaning of patient participation effectively resulted in nurses promoting the concept of patient participation differently amongst themselves. Patients coming into hospital with their own varied understandings of participation added to the problem in that both nurses and patients used different approaches with regards to the degree to which participation was enacted. Factors, such as attitudes to self-care, level of information, previous hospital experience, and knowledge of their medical condition, were identified as contributing to patients' having different understandings of the meaning of participation.

The other problem was the incongruence in nurses' and patients' philosophy about nursing care, which juxtaposed into the way they promoted or did not promote participation. For nurses, their attitudes to caring and the influence of role models in the practice setting shaped their philosophy of how care should be delivered. As well, nurses' philosophy about care was found to influence the manner in which they internalised and enacted their understandings of the meaning of patient participation. For example, even though some nurses stated that they understood patient participation to be all encompassing, they were not observed to involve patients in all aspects of their care. The patients' philosophy of care was derived from their culture, their age, their home life, and their desire to be "good" patients. The patients' understandings of the meaning of participation were also to some extent, shaped by their philosophy.

For nurses and patients, the incongruence in the philosophy about care, together with the variations in the understandings of the meaning of patient participation, posed a problem in the enactment of the ideal of patient participation, that is, patients participating in all aspects of their care. To exacerbate this situation, the hospital contextual and the various intervening conditions were not always conducive to the promotion of this participation ideal. Nurses' and patients' incongruence in the understandings of the meaning of participation and in their beliefs about care resulted in nurses and patients adopting three styles of participation. These were: participant inclusion, which encompassed patients participating in all aspect of their care, including treatment decisions; participation marginalisation, which encompassed patients participating in their activities of daily living and having control over their pain management, if able; and participation preclusion, which encompassed patients having no input into their care.

In order to deal with the problem of incongruence in the understandings of the meaning of patient participation and in the philosophy about care, nurses and patients employed a basic social process labelled, *accommodating the incongruence*. As discussed in chapter five, nurses were clearly the dominant actors in this process, with patients playing a subsidiary role. This process, which was dynamic and reciprocal, had three phases, namely (1) coming to terms with the incongruence, (2) rationalising the incongruence, and (3) seeking resolution: minimising the incongruence. This process was also dependent upon contextual factors, such as, economic constraints, management structures, the presence of technology, and the culture of medical dominance. Phase one involved nurses and patients encountering and acknowledging the incongruence, phase two involved nurses and patients observing and assessing each others' behaviours, and phase three involved nurses adjusting their behaviours to minimise the incongruence with patients responding to these behaviour adjustments by the nurses. In the third phase, the nurses were observed to either increase patients' control and level of participation as well as increase their own control, converge patients' control and level of participation to meet their own style of participation without increasing or decreasing their own level of control, or decreasing patients' control and level of participation as well as decreasing their own level of control. This was dependent upon the style of participation favoured by the patients concerned.

Through the above adjustments, the nurses were able to either upgrade patients' input to the partnering or cooperating level of behaviour, or downgrade patients' input to the cooperating or toeing the line level of behaviour and minimise the incongruence. It was evident, however, that on a day-to-day basis, the styles of participation constantly varied between different nurse-patient dyads and under varying contextual conditions which were described in chapter four. Figure 6.1 (on page 265) depicts a theory of patient participation labelled: *Accommodating Incongruity*, as derived from the findings. In the diagram, colours have been used mainly to highlight the various complex aspects of the theory. It should be noted, however, that the colours themselves have no particular meaning. In the following section, the theory of *accommodating incongruity* will be discussed within the context of other theories and literature.

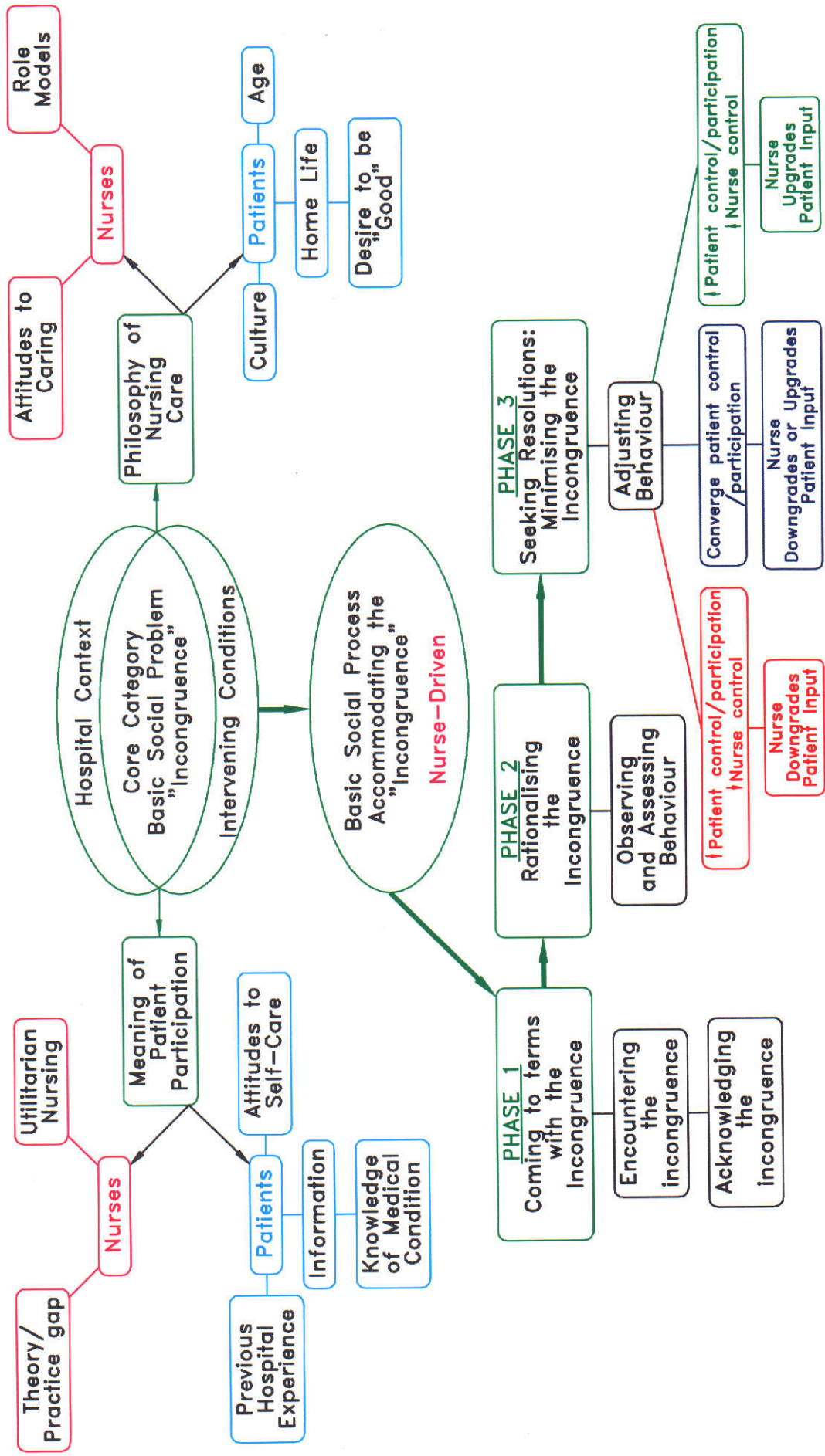


Figure 6.1 A Grounded Theory of Patient Participation: Accommodating Incongruity

## **The Theory of *Accommodating Incongruity* within the Context of Literature**

The literature search revealed that there was no theory that was totally similar to the theory of *accommodating incongruity*. However, several theories reflect various aspects of it. Among existing theories, conflict theory could be considered to be the main theory which appeared to be most relevant. Robbins and Mukerji (1990) defined conflict as the perceived incompatible differences between people, which could result in some kind of opposition or interference with the status quo. The incongruence in nurses' and patients' understandings of the meaning of patient participation and in their philosophical beliefs about care certainly constituted the incompatibility that Robbins and Mukerji alluded to and created conflict for both parties. In conflict theory, there is suggestion that when people are involved in conflict, they generally attempt to address it by way of resolving the conflict (Robbins & Mukerji, 1990). This was the case with the nurses and patients in this study, when they faced conflict by way of incongruity in their understandings of the meaning of patient participation and in their philosophical beliefs about care. The nurses, to a greater extent, and patients, to a lesser extent, sought resolution by means of adjusting the behaviour of the other party and their own and minimising the incongruence. As explained in chapter five, the nurses adjusted patients' behaviours mostly and then their own. Patients did most of the adjusting in response to the nurses because the nurses were the dominant actors in the process of accommodation. The theory of *accommodating incongruity* will be expanded later in this chapter, within the context of conflict theory.

The theory of *accommodating incongruity* could also be compared to role theory with particular reference to role conflict and ambiguity, as espoused by Biddle (1979) and Hardy and Conway (1988). Aspects of theories about caring, especially those explicated by Benner and Wrubel (1989), Leininger (1985), Roach (1985), and Watson (1989) could also be related to the theory of *accommodating incongruity*. Differences and similarities will be explicated between the caring theories and this theory. As well, components of Orem's (1985) nursing model of Self-Care showed



some similarities and differences to the theory of *accommodating incongruity*. This theory also shares some similarities with Foucault's (1980) views about the relationship between power and knowledge. Irurita's (1996a) nursing theory of Preserving Integrity and Parse's (1987) theory of Human Becoming also demonstrate some resemblance to the theory of *accommodating incongruity*. As for existing literature, components of the findings within the theory of *accommodating incongruity* concur as well as differ with previous literature. All the above mentioned issues will be discussed in more detail in the following sections of this chapter.

### **Conflict Theory**

Conflict theory evolved from the work of Karl Marx who espoused that conflict or antagonism invariably existed between different classes of people and that this conflict defined people's existence and brought them into reality (Waters & Crook, 1993, p. 188). In the 1950s, Dahrendorf, a German scientist, criticised Marx's theory claiming that his theory overemphasised economy as linked to class structure and that ownership of things did not necessarily bring about the power to control (Waters & Crook, 1993). Furthermore, Dahrendorf argued that the complexities of modern society often resulted in two groups of people, that is, those who told people what to do and those who were told. These two groups, according to Dahrendorf, had the potential to create class structures. Moreover, Dahrendorf claimed that any one person had the potential to have control in one organisation but could be subjected to it in another organisation (Waters & Crook, 1993, p. 188). However, Waters and Crook (1993) challenged Dahendorf, stating that in to-day's modern society, it was a known assumption that some people within organisations continued to remain more powerful than others, regardless of class structure. In this study, the nurses clearly had power and control over patients and were even observed to force patients into adjusting their behaviours, contrary to what the patients wanted to do. This was particularly demonstrated in the manner in which the nurses were able to upgrade or downgrade patients' input to fit in with their own style of participation. This occurred even when patients, at times, shared the same class structure as the nurses. Consequently, conflict was created between nurses and patients about their ideologies of care and related to the power imbalance between nurses and patients in hospital.

The literature alluded to different views of conflict in organisations. Robbins and Mukerji (1990) espoused three views of conflict, which can be compared to the conflict faced by nurses and patients in the theory of *accommodating incongruity*. Firstly, there is the traditional view of conflict that states that any sort of conflict or disagreement is detrimental and that it must be avoided at all costs. Secondly, there is the human relations view of conflict that supports the notion that it is normal for people in any organisation to have conflict of ideas and that conflict is not necessarily bad, and that conflict often leads to improvement in performance by those in the organisation. Finally, there is the interactionist view that some conflict is essential if those in the organisation are to perform effectively (Robbin & Mukerji, 1990, p. 340). According to these authors, the interactionist view proposes that not all conflict is beneficial. They further espoused that within the interactionist view, there existed both functional and dysfunctional conflicts. Functional conflict was viewed as constructive and therefore good, in the sense that it brought about improvement for both parties experiencing the conflict. Dysfunctional conflict was destructive and therefore was considered to be bad, in the sense that it made the situation worse for one or both parties (Robbins & Mukerji, 1990).

Within the *accommodating incongruity* theory, it may be extrapolated that the interactionist view of conflict is the most applicable with some qualifiers. Whilst the interactionist view of conflict was similar in some ways to the *accommodating incongruity* theory, it was also different. For example, the nurses who subscribed to the participation marginalisation style were observed to experience both functional and dysfunctional conflict at the same time. For instance, when these nurses met up with patients who subscribed to participation inclusion, they faced dysfunctional conflict which subsequently resulted in them downgrading the patients' input to their own level and to cooperate with them. As explained in the previous chapter, the nurses achieved this by decreasing the patients' control and level of participation. In this case, the nurses were able to resolve the conflict to benefit themselves but not to the benefit of the patients, who wanted to have full control and participate in all aspects of their care. However, when these same nurses worked with patients who subscribed to participation preclusion, they faced constructive conflict which resulted in them upgrading the patients' input so that they would cooperate with them. Only in

this case, the nurses increased the patients' level of control and participation so that they would allow the nurses to guide them rather than to be subservient and toe the line. This resulted in both nurses and patients benefiting, following resolution of the conflict. The interactionist view of conflict being either functional or dysfunctional, furthermore, was demonstrated in this study with nurses who subscribed to participation inclusion or preclusion. For example, when nurses who subscribed to participation inclusion met up with patients who subscribed to participation marginalisation or preclusion, they found their views to be in functional conflict with that of these patients. By enhancing certain facilitating conditions, as described in chapter five, these nurses were sometimes able to upgrade patients' input to the partnering or to the cooperating level, which was beneficial to both parties. On the other hand, when nurses who subscribed to participation preclusion met up with patients who subscribed to participation inclusion or marginalisation, they too recognised the conflict in views between themselves and the patients. Instead of recognising this conflict as constructive and doing something positive about changing their own approach, these nurses downgraded the patients' input to the cooperating or toeing the line level. Thus, this conflict was destructive as it was observed to cause concern and stress for the patients.

In a bureaucratic organisation such as the hospital, the cause of conflict could be multifaceted. Gillies (1989) identified that conflict in organisations could be related to goal incompatibility where people and departments within the organisation did not share the same goals. This was evident, in this study, when some nurses' goals of patient care, especially those that subscribed to participation inclusion, were incompatible with the overall goals of the hospital management structure. In the study, the management of the hospital was said to be only interested in cost cutting and at times was prepared to sacrifice quality patient care in the name of economic rationalisation. Hospitals cutting costs, as found in this study, concurs with existing literature. For example, Davis and George (1993) claimed that the need to cut costs in Australian hospitals had resulted in administrators being more interested in input costs rather than in patient outcomes. O'Connell (1997) found in her study, that cost cutting in Western Australian hospitals was perceived by nursing staff to have resulted in the reduction in the numbers of permanent nursing staff being employed. Waddell

and Petersen (1994) argued that economic rationalisation by hospitals may have contributed to conflict between bureaucratic demands and nurses' occupational priorities. Williams (1996) in her study, found that nurses were unable to provide quality care because of increased workloads due to staff shortages. Lack of time, as a consequence of the increased workloads, had prevented some nurses from providing quality care. In this current study, some nurses faced conflict between their professional values and goals and that which were sanctioned by hospital administrators. This goal incompatibility sometimes prevented the nurses, especially those who subscribed to participation inclusion, from *accommodating* the *incongruity* successfully. For example, these nurses would resort to working with patients at the cooperating level because they were left short staffed or had such high workloads that they did not have the time to spend with patients and educate them so that they could participate in all aspects of their care. In other words, the conflict in goals affected the process of its resolution.

Another source of conflict, as described in the literature, included conflict arising from individual differences in terms of attitudes, expectations, personalities, and perceptions (Gillies, 1989; Hardy & Conway, 1988; Robbins & Mukerji, 1990). These authors claimed that such conflict between individuals had the potential to lead to feelings of anger, hostility, and a sense of helplessness. Furthermore, they added that people facing conflict will either directly express hostility towards the other party, temporarily withdraw, give in to the other party, or develop suspicious feelings towards the other party and become cautious. The authors also stated that, as bureaucratic institutions usually discouraged open expression of feelings, the above mentioned outcomes of conflict were more likely to be expressed indirectly (Gillies, 1989; Hardy & Conway, 1988; Robbins & Mukerji, 1990). This was not always observed in this study. As nurses had power over their patients, some nurses, especially those that subscribed to participation preclusion, clearly were observed to show overt hostility towards some patients, even though they worked in a bureaucratic environment. Although patients did not express overt hostility towards the nurses, there were nevertheless subtle indications of some negative feeling being expressed towards some nurses, similar to that described in the literature. This was especially true for patients who subscribed to participation inclusion.

In this study, as already explained, individual differences in attitudes and understandings of patient participation and in the philosophical beliefs about nursing care had created conflict or incongruity between nurses and patients. As for the nurses, some were observed to be assertive towards their patients, rather than showing hostility, during the process of *accommodating the incongruity*. This was observed with nurses who subscribed to participation inclusion and marginalisation. However, the nurses who subscribed to participation preclusion were observed to be aggressive towards their patients in trying to *accommodate the incongruity*. For example, these nurses were observed to bully patients or use standover tactics with them. Patients, on the other hand, were observed to display various behaviours when they were confronted with conflict with the nurses. For example, patients who subscribed to participation inclusion were observed to withdraw from the nurses by being stand offish; patients who subscribed to participation marginalisation tended to give in; and patients who subscribed to participation preclusion were often left helpless and scared. The finding of patients giving in to the nurses and experiencing helplessness because of negative behaviours of some nurses is similar to Irurita's study (1996a). Irurita's explication of patients' vulnerability caused by some nurses' non-caring behaviours such as, bullying and threatening had also left patients feeling upset, devalued, and not in control. This notion of not being in control could be matched with patients feeling helpless in this study. From this, it may be stated that nurses were able to demonstrate more overt responses to conflict than patients could, further reinforcing the stance that the nurses were the dominant actors in this theory of *accommodating incongruity*.

Some literature suggested that whenever conflict was encountered, the individuals facing the conflict would usually try and resolve the conflict (Cuthbert et al. 1992; Gillies, 1989; Hardy & Conway, 1988; Porritt, 1990; Robbins & Mukerji, 1990; Waters & Crook, 1993). Conflict resolution had been defined by Fisher and Ury (1985) as incumbents in a conflict situation sorting out their differences. Robbins and Mukerji (1990, p. 344) defined conflict resolution as a way of problem solving. These authors put forward several techniques of conflict resolution. These included: avoidance, where individuals withdrew from the arena of confrontation; smoothing, where individuals down played the differences but focused on the similarities;

compromising, where individuals in conflict forfeited some of their values so as to reach consensus; and forcing, where some individuals in conflict used their authority whilst the others accepted this authority, even though they did not agree with it. Porritt (1990) espoused that conflict in itself was acceptable, although the author expressed concern regarding the manner in which conflict was resolved. Moreover, the author alluded to conflict being resolved in either a constructive or destructive way. As previously mentioned, the theory of *accommodating incongruity* involved nurses, to a great extent, and patients, to a small extent, seeking some sort of resolution to their differences in viewpoints about patient participation and philosophical beliefs about care.

In reviewing the techniques of resolutions put forth by Robbins and Mukerji (1990), smoothing and forcing appear to be the common techniques utilised by the nurses who were the dominant actors in this theory of *accommodating incongruity*. Compromising was observed to take place sometimes with nurses and patients who subscribed to participation inclusion. Avoidance did not appear to be used. Nurses who subscribed to participation marginalisation were noted to smooth the differences they had with patients who subscribed to participation inclusion and preclusion. These nurses were observed to use gentle persuasion and encouragement, for example, to placate the patients and minimise the incongruence between them and the patients. This resulted in these nurses working with patients at the cooperating level, which suited their style of participation. On the other hand, nurses who subscribed to participation preclusion used the technique of forcing with their patients to minimise the incongruence. These nurses used their authority by way of ordering, using standover tactics, and bullying to downgrade patients' input to the cooperating or toeing the line level. The patients who subscribed to participation preclusion were observed to totally accept the nurses' authority and did as they were told, although some patients stated that they did not agree with the nurses' orders. This concurs with Porritt's (1990) destructive form of conflict resolution. Nurses and patients who subscribed to participation inclusion could be said to employ compromise at times. For example, these nurses had to forfeit their values about patients participating in all aspects of their care and accept working at the cooperating level with patients who subscribed to participation preclusion, for reasons already explicated in chapter five.

Similarly, patients who subscribed to participation inclusion had to forfeit their values and work at the cooperating level with nurses who subscribed to participation marginalisation and preclusion. This matches Porritt's (1990) constructive form of conflict resolution.

### **Role Theory: Role Conflict and Ambiguity**

One of the consequences of the incongruence in the understandings of the meaning of patient participation and in the philosophical beliefs about care, appeared to be the creation of role conflict and ambiguity in some nurses and patients. This role conflict and ambiguity was, therefore, a salient component of the theory of *accommodating incongruity*. As role conflict and ambiguity stem from role theory, a brief description of this theory is warranted. Hardy and Conway (1988) identified two theoretical perspectives on role theory. The first one was the structural-functional perspective, which emphasised the division of labour within a social structure for individuals. The second was the symbolic interaction perspective which focused on the interaction between individuals in a given social system. In the second perspective, specific actions and behaviours of individuals within the system were sanctioned and learnt, and certain roles were constructed. Creasia and Parker (1991) claimed that in nursing, although both perspectives may be applicable, the structural-functional perspective could be viewed as more relevant, in relation to the role of the nurse in the practice setting. These authors justified their views by stating that, as nurses worked in hospitals which were highly structured, it was appropriate to consider the nurses' role in terms of the structural-functional perspective (Creasia & Parker, 1991). Hardy and Conway (1988) disagreed, arguing that both perspectives of role theory were equally important. They espoused that the professional socialisation of nurses especially occurred through the symbolic interaction perspective. Furthermore, they stated that whatever nurses learnt, through this socialisation, was reflected in their perceived role (Hardy & Conway, 1988).

This study supports the above views of Hardy and Conway (1988), especially where the nurses were concerned. It was apparent that both the structural-functional and symbolic interaction perspectives were influential in the manner in which the nurses

conceptualised their roles and operationalised their various styles of participation. The nurses' individual styles of participation were observed to affect the manner in which they tried to resolve the conflict in viewpoints between them and their patients, with regards to patient participation. This was evident in the theory of *accommodating incongruity*. For example, some nurses, especially those who subscribed to participation inclusion, were unable to enact their perceived roles which encompassed involving patients in all aspects of their care. This was because of the constraints of the bureaucratic nature of the hospital, as explained in chapter four. It was also clear that nurses, especially new graduates and junior nurses, internalised their understanding about how nursing care should be provided through professional socialisation in the practice setting. This concurs with existing literature on the topic of professional socialisation of nurses. Greenwood (1996) claimed that graduates soon learnt that their role was to get their work done as quickly as possible, which invariably consisted of performing tasks with little consideration given to patient-centred care. The author further stated that the graduates were so adamant about being accepted by the other nurses that they would be prepared to sacrifice their own values and provide care that may not be in the repertoire of their perceived role, as care givers. Here, Greenwood (1996) alluded to the presence of the theory-practice gap, which was also confirmed in this study. For example, some nurses in this study found themselves working in an environment that subscribed to utilitarian nursing as opposed to the provision of holistic care. This had resulted in some nurses finding that their expected role was predominantly one of being a technician rather than a care-giver. Greenwood's (1996) view was supported by Hart, (1991), McCaugherty, (1991), Melia, (1981), Moorhouse, (1992), Quill, (1983), Seed, (1991), and Street, (1991). All these authors stated that graduate nurses would emulate the behaviours of senior nurses, even to the detriment of their own views about care, so that they could be accepted within the ward culture, once again confirming the findings of this study.

As for patients, the structural-functional perspective (Creasia & Parker, 1991) of role theory could be said to be more applicable than the symbolic interaction perspective. In this study, patients came into hospital with their own views about their perceived role, that is, whether they should share the responsibility of their care with the nurses, allow the nurses to take most of the responsibility for their care with them playing a



minor role, or giving total responsibility of their care to the nurses. It was found that, even though the patients were not directly affected by the bureaucratic structure of the hospital, they nevertheless were indirectly affected. For instance, the patients were cared for by nurses who were directly affected by the bureaucratic functioning of the hospital and who were subjected to professional socialisation. As a result, it was apparent that the nurses' perceived roles were subjected to change. As patients played a subsidiary role in the theory of *accommodating incongruity*, they were subjected to fitting in with the operationalisable role of the nurses, contrary to that of the perceived role of the nurses. This role change for some nurses, and patients having to fit in with the nurses, led to a situation of role conflict and ambiguity for both parties in this study.

According to Hardy and Conway (1988) and Nunnally (1978) roles encompassed subjective components, such as values, attitudes, and opinions, which were internalised and enacted in behaviours by individuals. The authors argued that in any given organisation, it was likely that individuals' values and attitudes, which were operationalised in their behaviours, may not be congruent with those of others in that organisation. When this occurred, the individuals may be subjected to role conflict and ambiguity as their expected roles would be perceived to be in conflict with those which were expected of them by others in the organisation. Role conflict was defined by Biddle (1979) as the demands of the role being incompatible or contradictory to those which were expected. Role ambiguity, on the other hand, was defined by the above author as the existence of uncertainty or lack of clarity with regards to role expectations (p. 323). In this study, role conflict and ambiguity were predominantly found to be linked to nurses' and patients' philosophies about care. Some nurses and patients, especially those who subscribed to participation inclusion, were unable to enact their perceived roles, as defined by their philosophies, in the care setting. This was found to affect the manner in which they worked through the process of minimising the incongruence in the *accommodating incongruity* theory. For nurses, the hospital contextual conditions, such as economic constraints, management structures including changes in the staffing and rostering systems, and the culture of medical dominance, sometimes prevented them from enacting their perceived roles. Kahne, Wolfe, Quinn, Snoek, and Rosenthal (1964) supported the notion that changes

in bureaucratic organisations that adhered to conformity had the potential to lead to role conflict and ambiguity amongst those that were in it.

In this study, the hospital proved to be a bureaucratic environment that also demanded conformity from the nurses. For example, the nurses who subscribed to participation inclusion stated that at times they were unable to engage in partnering because of staff shortages. These nurses perceived that, as they were short staffed, they could not allow patients time to fully participate in their care. There was a perception in these nurses that they had to complete certain tasks within a given time frame. At other times, the nurses could not fulfil their advocacy role for patients because they did not have their superiors' support or back up. This is in agreement with the views of Pyne (1994), who claimed that nurses did not have a good track record in supporting their colleagues in relation to them fulfilling their advocacy role. For nurses, the role conflict and ambiguity affected their management of minimising the incongruence. For patients, their lack of knowledge and support from the nurses, the lack of consistent care by the same nurses, and their perceived vulnerability stopped them from enacting their perceived role and created conflict and ambiguity. For example, patients claimed that they often had to work with many different nurses during their short hospital stay, all giving them various directions about their care. This had caused some patients stress and had brought about uncertainty regarding their role and what they were supposed to be doing in hospital. Findings of O'Connell (1997) and Irurita (1993) concur with the above patient situation. In both these Western Australian studies, it was found that patients usually experienced several different nurses, often with different approaches, looking after them during their short hospital stay, which also had caused confusion and uncertainty in patients about their own role. For both nurses and patients the role conflict and ambiguity, which stemmed from the problem of incongruence in their understandings of participation and in the philosophical beliefs about nursing care, therefore, became a salient component in the theory of *accommodating incongruity*.

The findings showed that there were differences between some of the nurses' views of quality care versus what constituted quality care with some Nurse Managers. This had created role conflict in some nurses. The nurses, especially those that subscribed to

participation inclusion, perceived quality care as all encompassing. They perceived that the psychosocial aspects of care were just as important as the physical aspects of care. These nurses, therefore, placed a high value on their role being one where they spent time with patients, got to know them, shared information, and were able to engage in patient education. Moreover, they believed that a positive nurse-patient relationship was the precursor to patients participating in all aspects of their care. The notion of nurses placing value in the provision of the psychosocial aspects of care is similar to several other studies (Lapsley, 1991; Larson, 1984; Larson, 1987; Smit & Spoelstra, 1991; Williams, 1996). However, for some of the Nurse Managers, the provision of quality care was synonymous with only the provision of physical care. This was reflected in the way the managers staffed the wards. As it was described in chapter three, if the nurses were to request more staff because they wanted to provide the psychosocial aspects of care and have enough staff to facilitate patient participation, they stood the risk of being labelled by some Nurse Managers as not being able to “cope”. The fear of being labelled resulted in some nurses not requesting the “extra” staff and being forced to provide only physical care. Consequently, these nurses experienced role conflict and ambiguity. This was because they were unable to fulfil their perceived role to provide quality care for their patients, which included inviting patients to participate in their own care. The role conflict in relation to quality care is similar to the findings in Williams’s (1996) West Australian study. In William’s study, nurses sometimes found themselves working under conditions of staff shortages which had prevented them from providing quality care, as perceived by them. This had resulted in the nurses being engaged in selective focusing, where they provided the psychosocial aspects of care only if they had enough time.

Patients experienced role conflict and ambiguity when they were unable to enact their perceived role because their views about care differed from those of the nurses who were looking after them. This was especially evident when patients’ input was downgraded from the partnering level to the cooperating level or from the cooperating level to the toeing the line level by some nurses. Interestingly, patients did not appear to be too affected when their input was upgraded to the partnering or cooperating level by the nurses who subscribed to participation inclusion. One explanation for this could be that, since the patients’ input was upgraded by nurses

who subscribed to participation inclusion, the nurses were observed to spend time with patients and to provide the information and education. Consequently, patients were observed to experience an easy transition from their perceived role to the expected role. Similar to some nurses, some patients also equated the provision of the psychosocial aspects of care as pertaining to quality care which incorporated patients being allowed to participate in their own care. This finding concurs with the findings of Irurita's (1993) study that showed that patients perceived that they should receive both physical and psychosocial care from the nurses. However, in Irurita's study, the term used by patients was "soft-hand" care for such care. In this study, patients' perceptions of what constituted quality care, which encompassed patients participating in all aspects of their care, was not always congruent with some nurses' views. This created role conflict and ambiguity for some patients.

### **Caring Theories**

The theory of *accommodating incongruity* can be compared to aspects of some of the contemporary caring theories. The findings of this study revealed that nurses' attitudes to caring was one of the factors that shaped their philosophical beliefs about nursing care. As explained previously, the style of participation that nurses adopted, that is participation inclusion, marginalisation, or preclusion, was clearly the outcome of their philosophical beliefs, regardless of their understandings of the meaning of patient participation. As nurses' philosophical beliefs influenced their concept of caring, it was considered appropriate to examine some of the caring theories in relation to the theory of *accommodating incongruity* and patient participation.

The literature contained various caring theories such as those espoused by Benner and Wrubel (1989), Boykin and Schoenhofer (1990), Forrest (1989), Gaut (1983), Leininger (1985), Morse, Solberg, Neander, Bortoff, and Johnson (1990), Roach (1985), Smith (1990), Watson (1989), and Wolf (1986). These authors defined caring as a process that offered both the carers and the cared for opportunities for personal growth. More particularly, caring in the nursing context had been defined as an interpersonal process between nurses and patients where the nurses were expected to engage in activities in a manner that conveyed to patients the explication of certain

affective behaviours such as liking and compassion (Griffin, 1983). Street (1995) claimed that caring was evident in nursing when nurses showed verbal and non-verbal caring, were technically competent, and were engaged in the attainment and maintenance of health (p. 28). Morse et al. (1990) further added that the literature on caring included both the actions performed as in “taking care of” as well as concerns demonstrated such as “caring about” (p.2). Griffin (1983) also claimed that the concept of caring constituted activities and attitudinal aspects, which were explained in chapter three. Griffin stated that the activities aspect involved nurses completing tasks whilst the affective aspect involved nurses respecting the autonomy and dignity of patients. Morrison and Burnard (1997) argued that nurses needed to care because of their contractual and ethical responsibilities. Moreover, the authors added that nurses were contracted to care because of the mere fact that they were nurses and that their code of practice encompassed such behaviours as showing empathy, support, compassion, and protection for their patients (p. 14). Whilst there were several definitions and viewpoints on caring, available literature revealed that there was no definitive definition of caring in the nursing context (Dunlop, 1986; Morrison & Burnard, 1997). In the following section, some of the above mentioned definitions and viewpoints on caring, as put forward by some of the authors, will be examined for similarities and differences in relation to the theory of *accommodating incongruity*.

According to Leddy and Pepper (1993), a meta-analysis of caring showed that there was a range of perspectives on caring. These included Benner and Wrubel’s, (1989) and Leininger’s (1985) perspective on caring being a human trait, Watson’s (1989) being a moral ideal, and Roach’s (1985, p. 176) perspective on caring as encompassing such attributes as, compassion, competence, confidence, conscience, and commitment. Conscience, as a component of caring given by Roach (1985), is similar to that of Watson’s view of caring being a moral ideal (1989). In comparing the various perspectives on caring with the theory of *accommodating incongruity* and in particular to the styles of participation adopted by the nurses, it was apparent that only aspects of some of these caring perspectives were considered by nurses in this study.

Some nurses in this study espoused that caring to them was treating patients as individuals, taking into account patients' feelings and opinions, building rapport and trusting relationships with patients, and giving patients control, hence, reflecting some of the components of Benner and Wrubel, (1989) and Leininger's (1985) perspective on caring being a human trait. Benner and Wrubel (1989) identified caring as being explicated when nurses valued human relationship and showed commitment to their patients. Leininger (1985), on the other hand, claimed that caring was the essence of nursing and that nurses needed to take into account patients' cultural beliefs so as to provide holistic care. Holistic care, as described by Daly and Watson (1996), encompassed care that took into account patients' biological, psychosocial, and spiritual needs, and nurses facilitating empowerment through encouraging patient involvement. However, in this study, the nurse's actions showed that not all nurses were able to actualise the above-mentioned perspectives provided by Benner and Wrubel and Leininger on caring at the patient's bedside. This was clearly borne out when some nurses were only concerned about the performance of tasks on patients, especially those who subscribed to participation preclusion. Some nurses were clearly not committed to their patients and to these nurses providing care appeared to be just a job. This was evident regardless of whether the nurses were busy or not. Some nurses stated that caring involved respecting and operationalising the view that patients had rights and that they should have significant input into their own care, highlighting certain aspects of Roach's (1985) and Watson's (1989) perspective on caring as a moral ideal. Both Watson and Roach claimed that caring represented the soul in nursing and that without incorporating components, such as protection, enhancement, and preservation of dignity, nursing was nothing more than a conglomeration of tasks (cited in Brykczynska, 1997, p. 4). Contrary to these statements, not all nurses in this study were able to uphold the espoused idealistic perspectives on caring, for one reason or another as explained in chapter three.

In the theory of *accommodating incongruity* various levels of caring, as described in the literature, were shown by the nurses as they went about minimising the incongruence and achieving some balance. Underlying the perspectives of caring, as espoused by some of the caring theorists, was the notion of providing care that was holistic or patient-centred. The concept of patient-centred care could be translated as

patients being allowed to participate in their own care or to be consulted about their care, so as to preserve their dignity and self-worth. It may be interpreted that only nurses who subscribed to participation inclusion were able to or attempted to demonstrate all the elements of caring, as identified in the literature, and endeavoured to promote patients participating in all aspects of their care. Nurses who subscribed to participation marginalisation, on the other hand, were only able to fulfil certain aspects of the elements of caring, as described in the literature, and those nurses who subscribed to participation preclusion demonstrated very little, if any, caring. As explained in chapter three, some nurses in this study perceived caring as only providing technical and task-oriented care because they believed that such care was vital to the patient's recovery. Other nurses had stated that if they were not attending to technical care, they were not doing anything for the patients and, therefore, had felt redundant and uncaring. It would seem that these nurses' views on caring could be matched with only one aspect of Morse et al.'s (1990) definition of caring, that is, the "taking care of" aspect. The "caring about" aspect which encompassed such issues as liking and compassion, as also supported by Griffin (1983), was found to be absent in these nurses.

Stevens and Crouch (1998) provide further explanations as to why this might have occurred to some of the nurses in this study. These authors argued that even though nurses had always espoused "care" as being the tenet of their philosophy, there appeared to be a new meaning ascribed to it for political reasons (p. 159). This new meaning involved juxtaposing care with the term "cure". The politicisation of care, according to Stevens and Crouch (1998), was an attempt by nurse academics to gain autonomy for both the practical and intellectual aspects of their domain. Additionally, through this new meaning, nurses were able to lay claim to being the exclusive experts in caring for the total person, especially with regards to patient autonomy and giving patients an active voice in their care (p. 160). This was perceived by nurse leaders to separate "care" as being specific to nursing, which in turn was considered to increase the self-image of nursing (Stevens & Crouch, 1998, p. 160). The only problem with this, as postulated by Lawler (1991) and McFarlane (1976), was that there were already two recognised areas of nursing work. These were basic care, which involved meeting patients' needs irrespective of their illness, and technical care, which was

determined by medical treatments, hence paralleling the care versus the cure dichotomy for nurses. Stevens and Crouch (1998) stated that if caring had been adopted as the core of nursing's ideology, then basic care could be expected to be given higher status by nurses than technical care, but this was not the case. Nurses were observed to give higher status to technical care and cure than basic care because they continued to perceive the latter as lacking in special skills and importance (Lawler, 1991, p. 62). Technical care was perceived by nurses to be aligned to doctors' work and, thus, considered to be important (Stevens & Crouch, 1998). According to Seymour (1989), nurses assigning higher status to technical care and preferring to work in highly specialised areas may be an attempt by nurses to move upward in the established hierarchy of the hospital.

This concurs with the findings of this study. Some nurses stated that they preferred to work with technology and disliked working with medical patients who only needed basic care. These nurses perceived basic care as providing the psychosocial aspects of care such as being with patients, listening to them, comforting, and supporting them. The reason given for not preferring basic care was that such care was considered to be boring and unimportant. Taylor's (1994) account of basic care representing the ordinariness in nursing, meaning care that anyone could perform, supports this statement and offers another explanation as to why basic care was not taken seriously by some nurses. Smith (1992, p. 2) gave similar explanations to Taylor (1994). Smith argued that basic care in nursing was aligned with "women's natural work". This had resulted in basic care being perceived by nurses as invisible and undervalued and pushed to the background against the technology of medical work. Smith (1992) also claimed that basic care was considered to be the emotional labour of nursing because it involved feelings, emotions, and personal commitment. The problem with this was that with rising health costs and economic rationalisation, nurses were expected to show patient outputs, which were technical and measurable, rather than to concentrate on basic care which was non-measurable. This was evidenced in this current study when examination of nurses' notes showed that the majority of nurses only recorded the tasks that they had completed for patients with little or no reference to the psychosocial aspects of care. This was also found in O'Connell's (1997) study



into the use of the nursing process by nurses and in particular with the nature of documentation.

Additionally, the above aspect of this study's findings is supported by Stevens (1997), whose earlier longitudinal study of 156 nursing students in New South Wales revealed that throughout their education student nurses preferred to work in high technology areas where technical care was paramount. Hence, in this current study, some nurses' attitudes to caring could have been very much influenced by this dichotomy of care versus cure. Therefore, a lot of the affective aspects of caring, as espoused by the caring theorists, were not enacted by the nurses, especially those who subscribed to participation marginalisation and preclusion. The nurses who subscribed to participation inclusion, however, were able to overcome the dichotomy between care versus cure and were observed to incorporate both the technical and affective components of care, as defined by the caring theorists. The levels of caring, within the various participation styles adopted by the nurses in this study, may be interpreted as being similar to Irurita's (1996a) theory of Preserving Integrity. Irurita described the highest quality of care as "soft-hand care" (similar to participation inclusion), mediocre, technically competent care as "firm-hand care" (equating with participation marginalisation), and omissions of care or impersonal, bullying type of care by the nurses as "rough-hand care" (also found in participation preclusion).

A salient point, as identified in the literature on caring, was that caring was demonstrated in the interpersonal relationship between the nurse and the patient. This could be related to the type of nurse-patient relationship that existed within the dyad. In this study, one of the facilitating conditions for complete patient participation to occur was the presence of a positive and trusting nurse-patient relationship. Within this milieu, nurses and patients knowing each other well was found to be an important condition for patients and nurses to work as partners in their care. This finding concurs with emerging literature on knowing the patient as an important tenet of individualised care (Evans, 1996; Henderson, 1997; Irurita, 1993; Jenny & Logan, 1992; Radwin, 1996; Williams, 1996). Additionally, May (1992) in his study with Scottish nurses found that knowing patients was considered by nurses to be pivotal to patient involvement in their care. May (1992) further stated that the nurses viewed

knowing the patient as one of the dimensions of caring. Whilst most nurses in this study espoused the value of getting to know patients as individuals and finding out their capabilities, not all nurses knew their patients well. In some instances, nurses genuinely were not able to get to know their patients because of the lack of time due to the shortened length of hospital stay for patients. There were situations, however, when nurses could have got to know their patients but chose not to do so.

Nurses who subscribed to participation inclusion made every effort to get to know their patients well, so as to engender trust and rapport with them. As previously explained, these nurses perceived that getting to know patients was part of developing a positive nurse-patient relationship, which they perceived to be crucial if they were to work with them as partners. This concurs with the work of Morse (1991) whose research into nurse-patient relationships identified the connected relationship as the nurse and patient trusting each other and working together. Morse (1991) also alluded to the notion of the nurse acting as an advocate for the patient and bending rules to meet the patient's needs. The nurses who subscribed to participation inclusion, in this study, were also observed to act as advocates for their patients and sometimes bent the rules. On the other hand, nurses who subscribed to participation marginalisation were only prepared to get to know their patients partially, and nurses who subscribed to participation preclusion usually did not know their patients at all. Clearly, these nurses were only able to work with patients at the cooperating and toeing the line levels, respectively. Nurses getting to know patients partially and not knowing patients in this study, could again be compared to Morse's (1991) research into nurse-patient relationships. Morse's identification of the therapeutic relationship, where the nurse was efficient and met the patient's physical needs and sometimes the psychological needs, for example, prior to surgery or when the patient was overtly upset, could be aligned with the nurses in this study who partially got to know their patients and allowed patients to participate in some aspects of their care. As for the nurses who did not encourage any participation from patients and had made no attempt to get to know their patients, Morse's (1991) identification of a clinical relationship could be applied. In this instance, the interaction between the nurse and the patient was superficial with no personal involvement within the dyad.

Some patients, in this study, also identified that they needed to have positive relationships with the nurses if they were to initiate and actively participate in their own care. These patients interpreted nurses spending time with them, getting to know them as individuals, and allowing them to express their own opinions, as caring behaviours on the part of the nurses. A phenomenological study conducted by Riemen (1986b) into patients' experiences of caring and non-caring behaviours showed that patients perceived caring as nurses treating them as individuals, giving them a feeling that they were valued, and listening to them. The patients in Riemen's study viewed positive nurse-patient relationship as essential if they were to feel that they were being cared for by the nurses. The above study supports the views of some patients in this current study. Riemen's study (1986, p. 32) also highlighted non-caring behaviours by nurses, such as being in a hurry and being efficient, just doing a job, being rough and belittling patients, being unresponsive to patients' questions, and treating patients as objects. Some patients in this current study also experienced the above-mentioned non-caring behaviours, especially from those nurses who subscribed to participation marginalisation and preclusion. As already described in previous chapters, some of these patients had experienced increased vulnerability and fear as a consequence of nurses not listening to them, treating them as objects, bullying them, or using standover tactics with them. As a result, they were unable to voice their opinions or concerns and were unable to participate in their own care as they had wanted to.

Moreover, in this study, the manner in which nurses or new graduates, learned to provide care was found to relate to the influence of role models in the practice setting. Most nurses in the study were familiar with their role as being to provide holistic or patient-centred care. Despite this knowledge, not all nurses were observed to engage in such care. The example set by other nurses in the provision of holistic care seemed to be a predisposing factor in whether the nurses internalised holistic care as part of their philosophy of care or not. The study also highlighted that new graduates often emulated the behaviours of senior nurses so as to be accepted into the nursing culture of the ward, as already explained. In the study, some nurses were observed to provide patient-centred or holistic care. This was said to be because they had worked with senior nurses who believed that caring encompassed taking individual patient needs into account and actively involving them in their own care. In other words, these

nurses were fortunate to work in an environment that supported patient-centred care. It may be appropriate, therefore, to state that junior and graduate nurses learned the culture of caring through professional socialisation. This finding is similar to the work of Wolf (1988) who emphasised the importance of role modelling and mentoring by senior nurses. The author claimed that learning to care was tacit knowledge and that it was only through working closely with a nurse who demonstrated overt caring behaviours that student nurses learned to internalise the concept of caring and incorporated it into their philosophy of care. The findings of this current study also matches the findings of another Western Australian study by Chapman (1997) who found that student nurses often faced conflict between what they perceived as care as opposed to what was sanctioned on the wards. Kramer's (1975; 1985) work on graduates facing culture shock between the ideal of what they had learned about caring and what was expected of them in the real world also concurs with the findings of this study.

### **Nursing Models/Theories**

Aspects of the theory of *accommodating incongruity* can be aligned with Orem's Self-Care model (1985) and Parse's (1987) theory of Human Becoming. The essence of Orem's model of Self-Care focused on the patient's need for self-care. The author suggested that, as people experienced illness during their life-time, they were likely to experience various degrees of loss of self-care ability. Moreover, for some individuals their illness could result in them being unable to care for themselves and needing another, such as nurses, to care for them. Orem (1985) in her model particularly highlighted the usefulness of nursing for such individuals. With respect to nursing, Orem wrote that, as illness had the potential to incapacitate people, they could benefit from the care provided by nurses. Orem further explained that some people may only need some care from the nurses whilst others may need total care, depending on their disability. To this end, Orem articulated nursing systems of caring which she explained directed the nurses to attend to individual patient needs in different ways. Orem was careful in explicating her model in such a way that patients could actively participate in their own care, if they were able. To quote, Orem (1985) stated, "nurses and patients act together to allocate the roles of each other in the production of patients'

self-care and in the regulation of patients' self-care capabilities" (p. 38). Thus, in essence, Orem considered nursing as assisting patients to meet their needs if they were incapable of providing for their own self-care. This may be interpreted as the need for nurses to encourage patients to participate in all aspects of their care, if able.

In the theory of *accommodating incongruity*, some nurses were able to relate patient care and participation to Orem's (1985) model of self-care. A few nurses even mentioned that they had been exposed to this model during their education and that some of the wards that they had worked had utilised Orem's model in a modified form. Some nurses also stated that Orem's model was a template upon which they based the provision of care and level of participation. This was because they perceived Orem's model to facilitate the promotion of self-care and patient participation.

However, the findings demonstrated that nurses internalised the self-care concept of the model only to mean patients participating in their activities of daily living and pain control, if able. This was particularly true for nurses who subscribed to participation marginalisation. These nurses, for example, were observed to actively promote more patient involvement with patients who subscribed to participation preclusion and they did this by upgrading their input to the cooperating level. The nurses did not appear to equate decision making about treatments as being inherent in the concept of self-care, as espoused by Orem (1985). This was evident when the above nurses prevented patients who subscribed to participation inclusion from making decisions about their treatments.

The above situations showed that the nurses in the study did not fully understand Orem's model. It appeared that the nurses who subscribed to participation inclusion involved patients in all aspects of their care because of their beliefs that patients had rights and that they should participate, if able, and not because they were operationalising Orem's model. Nurses' lack of understanding of the model confirms Greenwood's (1996) statement that most nursing models, which were generated from the British and the North American culture, were often not viewed as suitable or applicable to the Australian context. Furthermore, Greenwood stated that, although student nurses were taught various nursing models and theories in the classroom, many did not see these models and theories being utilised in the practice setting by

nurses. Thus, to these students, models and theories were not considered to be important or relevant. Greenwood (1996) also questioned the applicability of some nursing models and theories because they had not been fully tested in the practice setting. Additionally, Greenwood argued that some theories were grand theories and, as such, were problematic to test and apply successfully. In support, Jolley and Brykczynska (1995) stated that some nursing models and theories lacked the level of specificity which was required to formulate principles from them so that they could be applied and tested. For this reason, they had not been used by clinical nurses.

The other problem with models like Orem's (1985) was that they were predicated on the assumption that all patients, if able, would like to be engaged in self-care (Smith & Draper, 1994). These authors, together with Waterworth and Luker (1990), argued that not all patients would want to participate in their own care, even if they were capable. This was evident in the findings of this study. Some patients who subscribed to participation marginalisation, for example, were not prepared to be upgraded and work at the partnering level with the nurses who subscribed to participation inclusion. These patients had claimed that they were grateful to the nurses who had wanted them to work as partners with them. However, it was their choice that they had preferred the nurses to make treatment decisions for them, clearly supporting the views of Smith and Draper (1994) and Waterworth and Luker (1990). Some patients were also reluctant to make decisions because of the fear of making the wrong decisions, as indicated by Biley (1992). Biley was of the view that some patients clearly preferred health professionals to decide for them because of this fear of making incorrect decisions and not because patients wanted to be passive recipients of care.

Aspects of Parse's theory of Human Becoming (1987) are also reflected in the theory of *accommodating incongruity*. Parse developed her theory from her earlier work on "Man Living Health" in 1981. The goals of Parse's theory included nurses enhancing the quality of life from the patients' perspective and preserving their dignity (Daly & Watson, 1996). Central to the theory of Human Becoming was the notion that nurses should not consider patients as objects to be manipulated or controlled. Instead, nurses needed to work as co-participants with patients and consider decisions and care for patients from their perspective (Parse, 1992). In essence, Parse's (1987)

theory highlighted the view that nursing practice occurred when nurses and patients engaged in a subject-to-subject relationship with patients so as to promote quality of life. Parse also alluded to nurses being in true presence with patients when they focused on patients' needs in a non-routinised and non-technical manner (Parse, 1987). In the theory of *accommodating incongruity*, nurses who subscribed to participation inclusion and who upgraded patients to the partnering or cooperating level appeared to engage in true presence with patients, as articulated by Parse (1987). This was demonstrated in their actions when they spent quality time with patients, getting to know them, and encouraging patients to work with them as partners or at least to have some input into their care. This partnering could be compared to Parse's notion of nurses working in co-participation with patients. However, the nurses who subscribed to participation marginalisation and preclusion did not appear to work in true presence with their patients. On the contrary, these nurses' contact with patients was one of routine and task-oriented care with little consideration given to the inter-subjective nature of the nurse-patient relationship, especially for participation preclusion.

### **Power Imbalance**

In this study, it was found that there were power differentials between nurses and patients. In the theory of *accommodating incongruity*, nurses, as previously explained, clearly decided on the amount of control and level of participation that patients could undertake. For example, nurses adjusted their behaviours to increase or decrease patients' level of control in the care situation and dictated to what extent patients could participate in their own care. Nurses' perception that patients lacked medical knowledge and that they knew best was highlighted as one reason for some nurses being reluctant to give patients control. This concurs with the views of McCormack (1993) who claimed that nurses often fell into the rhetoric of thinking and believing that they knew best, which had the potential for nurses not meeting patients' real needs. Even though some nurses in this study equated information as the precursor to control and participation, not all nurses were willing to give or share information with their patients. This suggested that some nurses wanted to hold on to their own control and power by withholding information from patients.

This was supported by Johnson (1997) who espoused that nurses determined the rate and amount of information they disclosed to patients. Furthermore, the author stated that nurses maintained their power by creating and perpetuating uncertainty in patients about their illness status (p. 119). This was demonstrated in this study when nurses who subscribed to participation marginalisation and preclusion consciously withheld information from patients so that they could downgrade patients' input to the cooperating or toeing the line level. As described in chapter five, patients, especially those that subscribed to participation marginalisation, allowed the above nurses to downgrade their input because of their perception that they did not have adequate information to go against the nurses. Furthermore, they claimed that they did not know what questions to ask the nurses, which had left them feeling uncertain about what was happening to them and "in the dark". Additionally, the patients had stated that they were in an unfamiliar environment that had added to their vulnerability. In support of the above patient situation, Rawls (1972), Reeder (1982), and Willard (1996) claimed that knowledge and expertise clearly rested in the hands of health professionals. As a consequence of this, the authors stated that patients often had no option but to become dependent upon health professionals to guide them. Furthermore, they added that health professionals had the upper hand because of their knowledge of the complex hospital system to which patients were not privy. This lack of knowledge of the system further increased patients' vulnerability and dependence on the health professional. Some patients found this to be the case in this study. This also concurs with the views of patients in Avis's (1994) study. In Avis's study the patients had stated that they were self-conscious about their lack of medical knowledge and hospital routine. Hence, they had forfeited the responsibility to make decisions about their care to the doctors and nurses.

Foucault's (1980) views about power and knowledge can be applied to the theory of *accommodating incongruity*. Foucault claimed that health professionals clearly objectified patients as bodies that needed surveillance and monitoring. This Foucault (1980) termed the "clinical gaze", where doctors and nurses were only interested in doing things to the body, with little or no consideration given to the psychosocial aspects of care. The psychosocial aspects of care, as explained in earlier chapters, included nurses considering patients' feelings and concerns and allowing them to have



a say in what happened to them in hospital. According to Grbich (1998), Foucault used the metaphor of the Panopticon to explain the kinds of disciplinary power that nurses and doctors held over patients. The Panopticon, as Foucault (1980) described it, represented a circular prison with a watchtower in the middle so that the warders could keep constant surveillance on the prisoners. Similarly, Grbich (1998, p. 38) stated that the hospital was like a prison where the medical and nursing staff acted as medical surveillance agents. This, according to Grbich (1998) and Parker and Gardner (1992) explained the pre-occupation that some nurses in this study had with exclusively seeing the patients as objects of nursing interventions rather than as people who required caring. In this study most nurses were observed to be mainly engaged in performing physical tasks on patients. The nurses only went near patients if they had to monitor the machinery, do a set of observations on them, administer medication, or check the wound dressing. Except for the nurses who subscribed to participation inclusion, the nurses who subscribed to participation marginalisation and preclusion were not observed to spend quality time with patients to get to know them as people and to fully consider their points of view.

Grbich (1998) further explained that the disciplinary actions taken by the warders in Foucault's (1980) Panopticon could also parallel the disciplinary actions taken by doctors and nurses if patients did not fit into patterns of behaviour, as determined by them. This power that Foucault termed "bio-power" was used as a control mechanism by health professionals. In interpreting Foucault's concept of bio-power, Grbich (1998) stated that patients were categorised into normality or deviance, depending on their condition. For example, if patients were perceived to be deviant, that is, whether they were physically ill, mentally ill, or not complying, doctors had the power to constrain them by prescribing medication or by institutionalisation, such as putting mentally ill patients into mental institutions. In this study, the behaviour of the nurses who subscribed to participation preclusion could be aligned with the bio-power to which Foucault alluded. For instance, patients especially those that subscribed to participation inclusion, were sometimes labelled as "difficult" by these nurses because they had stood up to them and had refused to comply. As a consequence, their call bells were not answered on time or they had to wait longer than necessary for pain medication. This concurs with the findings of another Western Australian study

(Irurita, 1993), where patients had perceived that if they were labelled as “difficult”, the nurses had limited their contact with them and had not answered call bells readily.

The findings of May’s (1992) study of Scottish nurses and their reluctance to democratise the unequal power relations that existed between them and patients could be matched with the findings of this study. In May’s study, the nurses were observed to hold on to the control by manipulating the form of interaction they had with patients and the amount of information they gave them. This resulted in patients lacking the necessary information to participate in all aspects of their care, which included making decisions about their treatments. In this current study, most of the patients stated that they needed to be fully informed if they were to make informed decisions about their care, especially those that subscribed to participation inclusion and marginalisation. Contrary to this, most nurses in this study did not perceive that patients needed to be fully informed, except for those that subscribed to participation inclusion. For example, the nurses who subscribed to participation marginalisation and preclusion could have volunteered information to patients, but they chose not to. Instead, some nurses only gave procedural information, as supported by Macleod-Clark (1981), whilst others gave no information at all. This resulted in patients being placed in a disadvantaged position for participating in all aspects of their care. This is also supported by Irvine (1996) who claimed that, unless patients had knowledge and information, they could not apply critical judgement and be true consumers of health care, that is, participate in all aspects of their care.

Using grounded theory, Payle (1998) studied allied health professionals’ views on patient participation in England. This involved interviewing forty one participants which included nurses, physiotherapist, occupational therapist, dietitians, and speech therapist. Payle’s findings revealed that health professionals espoused avoidance of inequality and misuse of power with patients, which they perceived to mirror medical encounters. To this end, Payle’s informants espoused such concepts as, “working together”, “information sharing” and “building a relationship” with patients as mediums through which power and control could be equalised between them and patients (Payle, 1998, p. 2). Despite this, the author stated that health professionals’ need for respect had “in itself” put limitations on their conceptualisation of patient

participation. Thus, health professionals in Payle's study were prepared to delegate only certain amount of control to their patients and had rationalised this stance as them knowing what was best for patients. Furthermore, the health professionals were observed to replace terms such as "compliance" with "cooperation" so as to avoid the negative connotation of "compliance" meaning patients having little or no control in their own care. This was supported by Fawcett (1995) and Moore (1995) who argued that even though health professionals had changed terms to appear less judgemental, they still implied that patients had a responsibility to defer to the so called expert knowledge of health professionals. Arnstein (1969) described the above stance as paying tokenism to patient participation and Geiger (1969) called it a rhetoric with health professionals using it as a means to an end.

The findings in Payle's (1998) study reflect the findings in this study. The nurses who subscribed to participation marginalisation and preclusion were particularly adamant that they knew best and were observed to decrease patients' level of control and participation by downgrading these to the cooperating or toeing the line level. For example, the nurses who subscribed to participation marginalisation were observed to minimise the incongruence by converging patients' level of control and participation to their own style of participation. Some of these nurses also stated that they had felt intimidated when patients who subscribed to participation inclusion had been articulate and knowledgeable about their medical condition and had challenged them. As the nurses were not prepared to lose any of their own control, they had used persuasion to decrease the patients' level of control and participation.

In this study, the nurses who subscribed to participation marginalisation, to some extent, and the nurses who subscribed to participation preclusion, to a greater extent, were observed to use closed questions to control the type of interaction they had with patients and to prevent disclosing information to them. Furthermore, the nurses claimed that they had purposefully asked closed questions to avoid lengthy conversations with patients, which they had perceived to possibly lead to the loss of control for them. Asking closed questions was also perceived by the nurses to shorten the time spent with patients. This concurs with the findings of an earlier Australian study by Gibb and O'Brian (1990) whose investigations into nurse-patient

conversation styles in nursing homes found that nurses repeatedly used closed questions that required a “yes” or “no” answer. The authors stated that the obvious lack of negotiations, via the use of open-ended questions, was a ploy by nurses to make patients acquiescent (p. 1398). This matches the views of Lanceley (1985) who in discussing the use of language by nurses with the elderly, stated that nurses deliberately limited the depth and quantity of conversation with patients, so as to maintain control over them. The author added that phrases such as “you must” “you should” and “you have to” were often used by nurses to maintain their own control. In this current study, the nurses who subscribed to participation preclusion tended to use belittling language with some patients, especially the elderly. For example, the nurses were observed to use language such as “be a good girl”, “yes, love” and “no, love” to intimidate patients and to ensure compliance. The patients had found this type of language use demeaning and a lack of respect for them by the nurses.

The findings in this study indicated that, even though most nurses perceived that it was their responsibility to advocate for patients in order to empower and give them control, not all nurses were observed to advocate and empower patients. As explained in chapter three, advocacy involved nurses promoting and safeguarding the well being and interests of patients. Gibson (1991) described empowerment as giving power to or enabling patients to exercise their rights. More specifically, Hegar and Hunzeker (1988) explained that empowerment in nursing involved nurses and patients sharing the power, not so much in terms of patients having more power but for them to feel more powerful to have a say in all aspects of their care. This indicated that nurses needed to give patients control and empower them through being an advocate. Gadow (1989) asserted that advocacy was about assisting patients to become clear about what they wanted, whilst Salvage (1987) implied that advocacy involved nurses sharing an alliance with patients and supporting them, over and above those that were in authority, such as hospital administrators. Several authors also claimed that the giving of sufficient information to patients by nurses, in a language that they could understand, and allowing patients time to make voluntary decisions were central to the advocacy role (Dworkin, 1988; Gillon, 1985; Willard, 1996).

As alluded to earlier, the nurses in this study were not always able to, or were not prepared to, advocate for their patients. Some reasons given were lack of support from superiors, fear of reprimand from the doctors, fear of litigation, or unwillingness to take risks. To this end, only nurses who subscribed to participation inclusion were observed to advocate for their patients in all aspects of their care, including treatment decisions, such as whether they should have chemotherapy or radiotherapy. These nurses were prepared to give sufficient information to patients, take risks, and stand up to the doctors in support of patients. Nurses who subscribed to participation marginalisation only advocated in areas of pain control and activities of daily living because they did not want to encroach into the doctor's domain for fear of reprimand or litigation. On the other hand, the nurses who subscribed to participation preclusion were not observed to advocate at all in any areas of care. To these nurses, patients were in hospital to do as they were told and, hence, there was no need to advocate. The above levels of advocacy, as enacted by the nurses in this study, can be aligned with Snowball's (1996) explanation of advocacy.

Snowball (1996) alluded to the notion of nurses being either active or passive advocates. The author claimed that nurses tended to be reactive rather than to be proactive in their enactment of the advocacy role. Moreover, the author stated that nurses mainly saw themselves as building patients' trust in doctors and only supported patients if they perceived their decisions to be congruent with those of the doctors. This, according to Snowball (1996), showed that nurses were more loyal to doctors than to their patients, clearly indicating that nurses were ignoring their moral obligations. This concurs with Orb (1993) who stated that some nurses were ignoring ethical principles and seeking rewards such as power and control over their patients rather than empowering them. This is supported in this current study. The nurses who subscribed to participation marginalisation were observed to advocate only if they perceived that their patients' queries and concerns were acceptable to them and which they perceived to be within the constraints of the hospital policy and outside of the doctor's domain. This matches with Snowball's (1996) reactive or passive advocacy. Contrary to this, the nurses who subscribed to participation inclusion were observed to advocate for patients and empower them as much as possible and to give them control of their care. As such, these nurses were prepared to take risks and put

themselves out to help patients, thus, demonstrating the pro-active approach to their role as patient advocates or active advocacy, as espoused by Snowball (1996). The nurses who subscribed to participation preclusion were not observed to advocate for patients or to empower them. These nurses appeared not to consider advocacy and subsequent empowerment of patients as part of their role, regardless of it being explicated in their code of practice. Hence, these nurses were neither engaged in passive nor active patient advocacy as stipulated by Snowball (1996).

The issue of power imbalance between nurses and patients especially at the level of participation preclusion is disconcerting. The nurses who subscribed to participation preclusion used such behaviours as ostracising, not answering call bells, not listening, and bullying to get patients to comply and to disempower them. These nurses clearly were not prepared to share the control with their patients. This was in direct conflict with the various definitions of advocacy, as explicated in the literature. This can be equated to what Irurita (1996a) described as nurses' abuse of power in her theory of Preserving Integrity, and in particular "rough-hand care". As patients did not want to be labelled as "difficult" and miss out on care, they simply went along with nurses instructions or "toed the line". This presents concern because it is not in keeping with society's value in empowering patients and enhancing social equality, as highlighted by Waddell and Petersen (1994). This situation also calls into question the nursing profession's philosophy of holistic care and patient involvement.

## Summary

The findings of the current study revealed that nurses and patients faced incongruence in their understandings of the meaning of patient participation and in their philosophical beliefs about care. This had resulted in nurses and patients adopting three different styles of participation, that is, participation inclusion, participation marginalisation, and participation preclusion. Therefore, the enactment of the phenomenon of patient participation differed amongst nurses and patients and between nurses and patients. This created conflict and ambiguity with regards to their perceived roles. In an effort to resolve the conflict and achieve some balance, nurses

and patients engaged in a basic social process labelled as *accommodating the incongruence*. As nurses were in their own socio-cultural environment, as opposed to patients, and were at their optimum physical level of functioning, they assumed the dominant role in this process of *accommodating*, with patients playing a subsidiary role.

The nurses accommodated and minimised the incongruence by adjusting their behaviours and the patients fitted in with the nurses, as much as possible. The adjustments made by the nurses varied and depended upon the style of participation they adopted. The nurses who subscribed to participation inclusion engaged in partnering with patients, if possible. This involved the nurses increasing the patients' level of control and participation. However, the nurses increased their own control with patients who subscribed to participation preclusion, in order to guide them and prevent them from toeing the line. The nurses who subscribed to participation marginalisation guided patients, with patients cooperating regardless of whether they subscribed to participation inclusion or preclusion. This involved the nurses converging patients' level of control and participation to that of their own style of participation marginalisation, without relinquishing any control themselves. The nurses who subscribed to participation preclusion were overbearing, with patients toeing the line or doing as they were told. This involved the nurses decreasing the input of patients who subscribed to participation marginalisation, that is, decreasing the level of control and participation to get them to toe the line. It also involved the nurses decreasing their own level of control with patients who subscribed to participation inclusion so that they could work with them at the level of participation marginalisation.

The above adjustments were made against the backdrop of the hospital context of economic constraints, management structures, presence of technology, and the culture of medical dominance. Furthermore the intervening conditions that affected the nurses, patients, or both on a day-to-day basis also modified the process of accommodation and led to the development of a substantive theory of patient participation labelled: *Accommodating Incongruity*. As this theory was supported by a number of theories, literature, and opinions of scholars, it is worthy of being

considered as making an important contribution to the understanding of the phenomenon of patient participation in acute care hospital settings. Through this theory, the issues of patient participation can be expanded and incorporated more effectively into the practice setting. As well, this theory provides a forum upon which the nursing profession may consider approaches through which patient participation may be enhanced as well as form a basis for further research.

### **Limitations of the Study**

This study was designed to be exploratory, descriptive and to result in the development of a substantive theory of patient participation in acute care settings in Western Australia. Measures to ensure trustworthiness of the data have been discussed in Chapter two. Although the proposed theory of *Accommodating Incongruity* reflects the experiences of the study population, it cannot be claimed to be generalisable. This is because the study only explored and described the perspectives of a specific group of nurses and patients, purposefully selected, within a specific context in keeping with the principles of the grounded theory method. Moreover, as with all qualitative designs, the researcher was the tool and as such, much of the analysis was the outcome of the researcher's own mental input in naming and developing categories, through the use of the researcher's own words and language. Even though dictionary definitions have been used and transcripts were used to illustrate meaning and the derivation of this meaning, the human element of the analysis process highlights another limitation to this study. However, these limitations were minimised as the developed substantive theory was presented to a number of practising nurses and scholars in seminars and conferences, both nationally and internationally. This enhanced the theory's credibility. Furthermore, the theory of *Accommodating Incongruity* was presented locally, in a seminar, to practising nurses at a major teaching hospital who recognised and acknowledged the process that nurses and patients used to deal with the problem of incongruence in the understandings of the meaning of patient participation and in the philosophical beliefs about nursing care. The other limitation is that the scope of this research did not extend beyond exploring the views of English speaking patients even though several



informants came from non-English speaking backgrounds. This limitation needs to be examined in future research using non-English as well as English speaking patients in order to obtain a broader perspective on patients' views on participation.

## **Implications and Recommendations**

The findings of this current study, considered together with the review of the literature, have implications for nursing practice, management, theory/education, research, and consumerism. In the study, it was found that even though patients were integral to the phenomenon of patient participation, it was clear that the nurses were the ones in a position to influence its process. Therefore, it was considered to be appropriate to make recommendations predominantly with regards to how nurses can improve patients' participation in their own care. Nevertheless, recommendations about how patients can be better placed to be effective consumers of health care will be put forward under the heading of consumerism. The implications, based on the findings, will be presented under the above headings, although it is recognised that some overlap may occur between the areas.

### **Nursing Practice**

The findings from this study led to the development of a substantive theory of patient participation. This theory, which was labelled *Accommodating Incongruity*, emerged from the basic social process that nurses and patients used to deal with the problem of incongruence in their understandings of the meaning of patient participation and in their philosophical beliefs about nursing care. In order to accommodate the incongruence, nurses adjusted their behaviours so that they could minimise the incongruence and achieve some balance. Patients, being in a position of vulnerability, adjusted their own behaviours in response to the nurses' behaviour adjustments. It was found, however, that even though the nurses made adjustments to their behaviours to minimise the incongruence, not all adjustments made by the nurses could be considered to be positive in relation to patients participating in their own care as much as possible.

The nurses who subscribed to participation marginalisation, for example, were observed to converge patients' level of control and participation in order to upgrade or downgrade patients' input to that of their own style of participation. This had resulted in patients being only able to participate in their daily living activities and pain management, if able, thus, effectively limiting their scope of participation. These nurses were observed to hold on to their control over patients by only giving procedural information to them. This had resulted in patients not having sufficient information to make informed decisions about their treatments. On the other hand, the nurses who subscribed to participation preclusion were observed not to give patients any information and they adjusted their behaviours to decrease patients' level of control and participation. By doing this, such nurses were able to downgrade patients' input into their own care. Hence, these nurses' behaviour adjustments could be considered to be negative in terms of nursing's ideology to promote patient centred-or holistic care. Some patients had also stated that the nurses should give them the necessary information without them having to ask for it, as they did not always know what questions to ask the nurses. The above two groups of nurses were also found to adhere to strict routine which, in itself, seemed to limit the extent to which patients could participate in their own care. This appeared to be a problem for patients in that the nurses were not as flexible in the way they provided the care. Some patients had stated that they needed the nurses to be flexible so that they would be able to voice their opinions about their own care and participate.

The findings also revealed that the nurses who subscribed to participation inclusion were observed to adjust their behaviours to increase patients' level of control and participation in order to upgrade their input into their own care. These nurses were observed to give and share information with patients and advocated for them, whenever, possible. The nurses were of the view that, unless patients had comprehensive information, they would not be able to participate in all aspects of their care. To this end, the nurses endeavoured to spend time with patients to get to know them, and to inform and educate them. Other strategies that the nurses used, which were positive, were to engage in negotiating, and explaining and discussing care issues with patients so as to promote the ideal of patient participation, that is, participation inclusion. Unfortunately, as the findings showed, the above nurses were

not always able to enact the ideal of patient participation because of the contextual conditions of lack of time, being short staffed, and the culture of task-oriented care in the practice setting. The nurses also found themselves frequently working with agency and casual nurses who were usually unfamiliar with the technology and the ward routine. This had resulted in the nurses spending time instructing and teaching other nurses, rather than working with patients to enhance patient participation. The nurses also raised concern about being assigned to different patients on a regular basis, which had resulted in care being fragmented and which had effectively reduced nurses' opportunities to get to know patients and to build trusting nurse-patient relationships. They perceived this latter to be crucial to patients participating in their own care. Furthermore, the nurses who consciously tried to advocate for their patients were not always able to or were reluctant to do so because of the fear of reprimand from medical staff and the lack of support from nursing management.

The above findings have implications for nursing practice in that not all nurses were able to promote the ideal of patient participation, that is, patients being able to participate in all aspects of their care, if able. As nurses were found to be in a position to affect patients' behaviours, it could be implied that nurses could make it easier for patients to be more involved in their own care. In order to achieve this, it is suggested that nurses could be more flexible in their care, especially in the area of routine care. By prioritising and careful planning, nurses should be able to accommodate patients' requests regarding their own care, thus enhancing their participation. Nurses need to change their attitudes and mind set to reflect the views that they do not have to adhere to routine and task-oriented care, and plan care that is individualised, rather than follow routine standards of care that may not always be appropriate for all patients. It is suggested that nurses re-visit the hospitals' preferred practice paradigm of task-oriented care and find ways to enhance holistic or patient-centred care, which is more in line with the concept of patient participation.

Some nurses had stated that, due to staff shortages, they did not always have the time to sit and talk with patients so as to build trusting nurse-patient relationships, which they had identified to be pivotal to patients participating in their care. Based on these findings, if nurses are short staffed and busy, they could optimise the contact time they

do have with patients by talking to patients whilst doing the necessary procedures. By doing this, nurses should be able to get to know their patients with regards to their capabilities and views about care, without having to set a specific time to go and sit and talk with patients. Nurses could also explain and discuss care issues with patients at the same time as was the case with some of the participants of this study. Nurses could also manage their time better and learn to work “smarter rather than harder”. For example, nurses could write their progress patient notes at the bedside as they provide care rather than to put aside an hour towards the end of their shifts to write the notes. This saving in time should allow nurses to have more contact with patients, which has the potential to facilitate patients getting to know them. It was found to be more likely that patients would ask the nurses questions about their care and feel comfortable about voicing their opinions if they got to know the nurses and if the nurses were in their presence more. An additional benefit of writing progress notes at the bedside is that they are likely to be more accurate as nurses do not have to rely on memory when they write the notes towards the end of their shifts. (In a coroner’s court accurate documentation is paramount).

As patients had identified the need to be given information, nurses need to practise giving information to patients rather than waiting for patients to ask them for information. As patients had indicated that they did not always know what questions to ask, it is up to the nurses to volunteer information so that patients can make informed decisions about their own treatment and care. This should increase patients’ level of control and participation in their own care. In order to provide information nurses need to communicate more with their patients and other members of the health care team.

### **Management**

Some nurses had stated that they were not always assigned to the same patients which had effectively reduced the time they had with patients and fragmented the care. The nurses were also of the view that, in the initial period of hospitalisation, some patients were too ill to participate in their own care. Therefore, the nurses had stated that they needed to work with the same patients for a time so that they could get to know them and to promote patient involvement. Nurses and patients knowing each other well

was found to enhance patients feeling comfortable and being able to work with nurses as partners rather than to be passive recipients of care. Therefore, the introduction of staffing strategies with the potential of enhancing continuity of contact between nurses and patients could be beneficial. This in turn should allow nurses and patients to get to know each other and build trusting nurse-patient relationships. As indicated in the study, patients needed to know that they could trust the nurses before they would feel comfortable about taking the initiative to participate in their own care.

In the study, some nurses had claimed that they were often faced with working with agency and casual nurses who did not know the equipment or ward routine. Furthermore, they had stated that having to work with agency and casual nurses had reduced their time with patients. This was because the hospitals were short staffed and were engaged in the practice of bringing in outside nurses to cover the wards. A suggestion put forward to increase the contact time between nurses and patients and to also reduce the fragmentation of care is the introduction of permanent pool staff by hospitals to cover the wards that are short staffed. This should enable the wards to have staff who are familiar with the equipment and ward routine. In turn, this should prevent the usual ward staff from spending time teaching and instructing the agency and casual nurses, thus, freeing them to spend time with patients and to educate them so that they could participate in their own care. Having permanent pool staff should also allow the wards to be sufficiently staffed with an appropriate skill mix of staff to cope with the demands of the wards.

It was apparent in this study that some nurses had perceived that there was a lack of staff development available to them to assist them to learn about new procedures and equipment. The nurses had claimed that they had to learn new equipment, for example, at the same time as they were caring for their patients. This had resulted in them spending considerable time learning about the equipment when they should have been using the time to work with patients as partners in the care. It is suggested, therefore, that sufficient funds need to be allocated for staff development purposes.

Nurses and patients in this study were of the view that nurses needed to advocate for patients so that they would feel comfortable about making decisions about their

treatments. Some patients were particularly keen to know that the nurses would be prepared to be their backstop and support them in whatever decisions they made, regardless of what the doctors wanted. However, not all nurses were able to advocate for their patients due to the reasons previously stated. One implication for this is that Nurse Managers need to be encouraged to be more supportive of nurses when they advocate for their patients. This should result in more nurses feeling comfortable about exercising their advocacy role. More specifically, nurses need support when they are advocating for patients in areas which may be considered to be in the doctors' domain. This could have staff development implications in that nurses need to be taught the clear boundaries between nursing, medical, and legal aspects with regards to their advocacy role. Nurses also need to be shown how to use their boundaries of the advocacy role within their code of practice without feeling that they are encroaching into the doctors' domain.

From the findings of this study, it was clear that some nurses had felt that they would be perceived negatively by Nurse Managers if they were to ask for more staff. These nurses were of the opinion that if their workloads were appropriate, they should be able to provide care that involved both the physical and psychosocial aspects of care, as well as incorporating patients' input into their own care. Based on this, Nurse Managers need to be encouraged to listen to the nurses on the ward when they request for more staff to cope with the patient load.

### **Theory/Education**

Nurses' philosophy of care was found to influence the manner in which they operationalised the meaning of patient participation and adopted the style of participation they preferred to be engaged in, whilst caring for patients. The findings indicated that the causal factors for the incongruence in the understanding of patient participation for nurses was inadequate transference of learned knowledge into the practice setting and the influence of role models. Therefore, some consideration should be given to the manner in which student nurses are taught holistic or patient-centred care. If the concept of holistic care, which involves patient participation, is taught to students at universities, why then are nurses not able to successfully promote this in clinical practice? Perhaps nursing curricula are only concerned with

outcome measures in learning. The process of how to actually involve patients may need to be given more emphasis when teaching nursing students. Certainly this issue should be investigated further.

As indicated in the study, exposure to nurses who practised holistic or patient-centred care was found to shape student nurses' philosophy of how nursing care should be delivered. In view of this, where possible, nurse academics should ensure that students in clinical experience units are placed with nurses who would be good role models in the practice setting. As well, nurses should be taught effective strategies for improving patient input into their own care. To achieve this, nurses need to be taught how to communicate effectively with patients such as how to ask open questions and actively listen to patients. More specifically, the communication process needs to be emphasised rather than informing nurses about the importance of communication.

The findings of this study indicated that nurses' attitudes to caring were influential in shaping their philosophy of care. A key element of caring, as espoused by some nurses in the study, was the notion of taking into account patients' feelings and opinions and giving patients control of their own care. However, in this study not all nurses were able to achieve this. The nurses who subscribed to participation marginalisation and preclusion were not able to give patients control of their own care, nor were they completely prepared to listen to patients' viewpoints about care. Thus, even though these nurses adjusted their behaviours to accommodate the incongruence and achieved some balance between their viewpoints and the patients', it was negative in the sense that patients' level of control was effectively reduced. It was apparent from the patients' perspective that they needed to feel that they had control over their care, if they were to initiate participation in their own care. Some nurses in the study had also perceived that caring only constituted performing physical tasks on patients.

Given the above situation, it is suggested that the caring aspect of nursing needs to be emphasised to nurses as being just as important as the cure or technical aspect. More importantly, the unique function of the nurse as a care-giver, first and foremost, needs to be explicated in the classroom as well as demonstrated by good role models or mentors in the practice setting. Nurses need to be encouraged to give control to

patients so that they can participate in all or some aspects of their care, if able. Nurse academics could also place more emphasis on the affective aspects of caring so that student nurses would place equal importance to both the affective as well as the technical domains of caring.

### **Research**

Further research at other sites or with similar groups is recommended in order to test and further develop the proposed theory of *Accommodating Incongruity*.

Additionally, research needs to be conducted with non-English as well as English speaking patients to explore and discover how these patients perceive the phenomenon of patient participation. This should be valuable as Australia is a multi-cultural society.

### **Consumerism**

Patients' philosophy of care and understandings of participation was found to be related to their previous hospital experiences, knowledge about their medical condition, information, attitudes to self-care, culture, age home life, and desire to be "good patients". Overall for patients, however, their vulnerability and the lack of information about their medical condition and the proposed treatment were found to be the major deterrents to them participating in all aspects of their care. Based on this, it is suggested that patients be given information at the first line of contact with their General Practitioner. In this way, patients should be able to absorb the information more effectively than when they are given the information in hospital when they are likely to be highly stressed and vulnerable.

Some patients had stated that their stress levels were increased because they were not familiar with the ward routine or layout and were not given sufficient information by the nurses about what to expect in hospital. Some patients were also of the view that they were unprepared for discharge, again with regards to being fully informed. In light of this, it is suggested that nurses need to be encouraged to make sure that they orientate patients to the ward routine and lay out as soon as they are admitted, if possible. Furthermore, nurses should be encouraged to ensure that patients are given



the appropriate information prior to discharge so that they will be able to care for themselves more effectively following discharge. Nurses should also direct patients to the hospital's information booklet and available leaflets on various medical conditions so that they are aware of their rights and become informed about their medical condition. This should reduce patients' stress levels and enable them to participate more in their own care.

### **Concluding Remarks**

In conclusion, this study explicated a substantive theory of the manner in which the phenomenon of patient participation was understood and enacted in the hospital practice setting by nurses and patients in Western Australia. The participation of patients in their own care has been espoused as a value in nursing practice as it represents nursing's philosophy to provide patient-centred care, which involves patients being consulted in all aspects of their care, if they are able. To date, the process of how the phenomenon of patient participation was operationalised when nurses and patients came together at the bedside had not been clear. Through this study, some light has been shed on this phenomenon. It also highlighted various obstacles for both nurses and patients that prevented patients from fully participating in their own care. From a personal point of view, I saw the ideal of patient participation being enacted in the busiest of wards and the worst approach, that is, participation preclusion being enacted when time and other intervening conditions were not a hindrance. This gives hope that it is not too late for nurses to see patients as true partners in care with them and, in the process, to raise their own professional standing and respect in the eyes of the public. This remark from a patient reflects this:

*After a grain of sand gets inside an oyster it causes an irritation, so the oyster gets rid of the irritator by covering it up. In the same way the irritation of the incongruence between nurses, patients and the medical profession is covered up to stop the irritation. But if we look inside the oyster we see a pearl, not the grain of sand. Similarly, if we look inside the problem we see a pearl of an answer, not the discomfort of the incongruence. That pearl is the opportunity to improve the job satisfaction of the nurses, the comfort of the patients and a more user friendly medical system.*

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## Appendix A

### Information sheet and nurse consent form

**Study Title:** The phenomenon of patients participating in their nursing care in hospital

**Investigator:** Saras Henderson

**Phone:** (08) 92471419

The purpose of my study is to increase understanding of the way in which patients participate in their own care through patient-nurse interaction. The knowledge gained from this study will be of major significance to nursing practice and education and will facilitate efforts of the nursing profession to develop practice models that enhances nursing care.

The study will involve nurses working at the bedside and patients ready to be discharged from the same hospital. Information for the study will be collected by a tape-recorded interview that will be approximately 50-60 minutes in duration. If you agree to participate in the study, you will be interviewed at a place and time suitable to you. A follow up interview may be required to clarify issues identified from the first interview. It would be appreciated if you could remain available for this subsequent interview. The second interview is envisaged to take less time than the first interview.

During the interview, you may decline to answer any question and request that the tape recorder be turned off. No names will appear on the transcribed interview which will be available to you if you wish. Extracts of the interview may be used in the research report, however you will not be identified in any way. Anonymity and confidentiality will be observed at all times. Participation is entirely voluntary and you may withdraw at any time without penalty. There are no risks associated with your participation. The Ethics Committee of this hospital has given approval for this study

### PARTICIPANT STATEMENT

I \_\_\_\_\_,

(print full name)

have read the above information on the study relating to patients participating in their own care. I understand the nature and intent of the study and that I have the opportunity to ask questions. I know where to direct any future questions that I may have. I agree to the interview being tape-recorded. I have received a copy of the consent form. I understand that my participation in the study is voluntary and that I may withdraw at any time without disadvantage to me.

Signed \_\_\_\_\_ Participant.      Contact Tel: \_\_\_\_\_

Signed \_\_\_\_\_ Researcher

Date    \_\_\_\_ / \_\_\_\_ /199\_\_

## **Appendix B**

### **Interview Guide (Nurses)**

I wish to ask you a number of questions to explore your views on patients participating in their own care.

The following questions will form the broad outline for the formal interviews. The responses to these questions will be explored indepth with cues being followed and issues thoroughly explored. The participants will be requested to give examples where required.

1. What do you understand to be the meaning of holistic care?
2. How is this best achieved?
3. What do you see your role in this to be?
4. What do you see the patient's role to be?
5. In what way do your patients participate in their care?
6. How important do you consider it is for patients to participate in all phases of their own care? What measures can be used to enhance this? What detracts from this or prevents it?
7. How do you incorporate patient's opinions and choices about activities of daily living?
8. How do you incorporate patient's opinions and choices about aspects of their treatment and care?
9. Who do believe to be responsible for keeping patients informed about their care whilst in hospital?
10. How do you see the role of the nurse when it comes to keeping patients informed about their nursing care and ongoing developments like discharge?

## Appendix C

### Demographic Information: Nurses

**Please tick the space that most accurately describes your background/situation and enter details as requested.**

Interview code number \_\_\_\_\_ (researcher's use only)

Ward code number \_\_\_\_\_ (researcher's use only)

**Gender**                  1) Male \_\_\_\_\_                  2) Female: \_\_\_\_\_

Age \_\_\_\_\_

Type of Organisation: 1) ----- Teaching Hospital  
2)----- Private Hospital  
3)----- Other

Years of practice \_\_\_\_\_

Level of employment \_\_\_\_\_

Present area of work \_\_\_\_\_

Length of time worked in the present area \_\_\_\_\_

Shifts worked \_\_\_\_\_

### Qualifications

\_\_\_\_\_

\_\_\_\_\_

Basic nurse education                      1) ----- Hospital Based nursing course

## 2) -----Tertiary Institution

Post-basic nursing courses completed: \_\_\_\_\_

\_\_\_\_\_

This section will be completed by the informant at the end of the interview

**Appendix D**  
**Information sheet and patient consent form**

**Study Title:** The phenomenon of patients participating in their nursing care in hospital

**Investigator:** Saras Henderson

**Phone:** (08) 92471419

The purpose of my study is to look at the way in which patients participate in their own care in hospital. The knowledge gained from this study will be of major importance in helping nurses improve the care they give to their patients. It will also have implications for what nurses are taught during their training.

The study will involve interviewing patients who are ready to be discharged about their experience in hospital. The interview will take about 50-60 minutes and permission will be sought from you to tape-record the interview. If you agree to take part in my study, you will be asked to sign a consent form, a copy of which will be given to you. You may wish to be interviewed at the hospital or after you have returned home. If you wish to be interviewed in the hospital, it would be at a time suited to you. Similarly, if you wish to be interviewed at home I will contact you by telephone to set a suitable time for the interview. A follow up interview may be needed to clarify issues raised in the first interview. This second interview should not take more than half an hour at the most.

During the interview, you may refuse to answer any question and ask that the tape-recorder be turned off. No names will appear on the transcribed interview which will be available to you if you wish. Parts of the interview may be used in the research report; however, you will not be identified in any way. Anonymity and confidentiality will be observed at all times. Participation in the study is entirely voluntary and you may withdraw from it at any time without penalty. There are no risks associated with your participation. The Ethics Committee of this hospital has given approval for this study.

**PARTICIPANT STATEMENT**

I \_\_\_\_\_,  
 (print full name)

have read the above information on the study relating to patients participating in their own care. I understand the nature and intent of the study and that I have the opportunity to ask questions. I know where to direct any future questions that I may have. I agree to the interview being tape-recorded. I have received a copy of the consent form. I understand that my participation in the study is voluntary and that I may withdraw at any time without disadvantage to me.

Signed \_\_\_\_\_ Participant.      Contact Tel: \_\_\_\_\_

Signed \_\_\_\_\_ Researcher

Date \_\_\_\_ / \_\_\_\_ /199\_\_

## **Appendix E**

### **Interview Guide (Patients)**

Tell me about your recent experience with nursing staff whilst in hospital?

From this general opening 'ice-breaker' the following topics will be explored according to the cues presented by the patient.

- a) The perceived importance of the patient's participation in their care
- b) Factors that enhance and/or prevented patient participation (patients will be asked to describe this in relation to their recent hospital experience)
- c) Patient's input regarding their nursing care
- d) Patient's choices regarding their nursing care
- e) Ability to make informed decisions about the care that they received
- f) The manner in which they were able to/ allowed to participate in their care (patients will be asked to describe this at all phases of their care ie. on admission, during hospital stay and at discharge)
- g) The person responsible for initiating patient participation in their care and the manner in which this was done
- h) Factors that helped them make decisions and to play an active role in their own care
- i) The perceived importance of being informed about all aspects of care in hospital
- j) The person/s responsible for providing information on all aspects of patient care
- k) The amount/ adequacy of information they received in order to meet their needs in hospital
- l) The manner in which they were given explanations and information in hospital (the level of understanding from the patient's perspective)
- m) The comfort with which they were able to ask nurses questions about the care that they were receiving

## Appendix F

### Demographic Information: Patients

Interview code number \_\_\_\_\_ (researcher's use only)

Ward code number \_\_\_\_\_ (researcher's use only)

Please tick the space that most accurately describes your background/ situation and enter details as requested.

Gender:                      1) Male:-----                      2) Female:-----

Age:                      \_\_\_\_\_

How often have you been in hospital :

\_\_\_\_\_

Length of hospital stay during this hospitalisation:

\_\_\_\_\_

Type of hospitalisation:

- 1) -----      Emergency
- 2) -----      Booked/ Surgical
- 3) -----      Booked/ Non-surgical
- 4) -----      Other

Diagnosis:

\_\_\_\_\_

What other conditions/ health problems (ongoing) do you have?

\_\_\_\_\_

What wards/ units were you nursed on during this hospitalisation?

\_\_\_\_\_

When did you come home from hospital?

\_\_\_\_\_

This section will be completed by the informant with the researcher's assistance at the conclusion of the interview.