

School of Nursing

Impeded Nursing Care: Nurses' Lived Experiences

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Abstract

This phenomenological study describes the lived experience of ten registered nurses who provided a standard of nursing care that they perceived to be impeded because of their negative reactions to their patient's condition. Purposeful sampling was used to recruit participants via an advertisement in a local nursing organisation's newsletter. In-depth interviews generated data about the nurses' personal and professional experiences. Data analysis incorporated the qualitative methods of Huserrlian (descriptive) phenomenology and Colaizzi's method of data analysis. Findings revealed that during some stage of the nurses' careers they had reacted negatively to a patient's condition. These negative reactions included frustration, annoyance, nurses fearing for their own safety, revulsion, sadness and feelings of guilt that impeded care had been provided.

These reactions translated into behaviours that were associated with providing nursing care to the patient that the nurses themselves perceived to be of impeded quality. Behaviours included not being there or spending less time with the patient, not communicating well and having less rapport with the patient, not meeting the patient's psychological and social needs and not meeting the patient's spiritual needs. The nurses found their awareness that this had occurred disturbing and they devised strategies to cope personally and also to ensure that a better quality of care was provided in subsequent situations. Strategies included discussions with colleagues, arranging for colleagues to provide care for the patient, mental preparation, and using individual coping strategies.

There was a pattern of contextual factors impeding the provision of good care. These factors included an existing poor rapport with the patient, a bad experience with a patient with similar characteristics, time pressures and a lack of autonomy, chronic work stress, low staffing levels, a lack of clinical experience, negative reactions to the patient's condition by other staff members, a lack of visits by the patient's significant others and disagreement with the patient's medical treatment.

CHAPTER 1

1. **Introduction**

Little is known about the concept of providing care for a patient with a condition that stimulates a negative reaction in the nurses delivering that care. In the course of their careers nurses may encounter a patient whose condition evokes, in the nurses themselves, a negative reaction. This reaction has the potential to negatively influence the quality of care given, in that some or all of the patient's needs are not met.

The phenomenological research methodology used in this study provides a rich description of the lived experience of nurses who have, in their own assessment, provided impeded care because of their personal reactions to the patient's condition. The descriptive findings of this thesis should be interpreted as unique to the research participants and the social context within which their experiences were lived (Morse, 1991). Nevertheless, a negative reaction to a patient's condition can be experienced by anyone, regardless of the relationship to the patient or the person's field of employment. Anyone who cares for, or interacts with a person whose medical condition may be disturbing, can benefit from this thesis by learning from the experiences of others. This has the potential to be of benefit to the patient as the feelings of others with whom the patient interacts influences the quality of their relationship, and a lack of understanding can compromise this quality (Byrne, 1998).

1.1 **Background to the Study**

The seed for this study was planted in 1987 when I assumed coordination of an educational programme that was designed to encourage caring behaviours in neophyte baccalaureate pre-registration nursing students. The text on which the unit was based was written by Watson (1985) and contained the theory that for holistic nursing care to be provided, 10 carative (as opposed to curative) factors must be used by the practising nurse.

The carative factors are as follows:

1. The formation of an humanistic-altruistic system of values.
2. The instillation of faith-hope.
3. The cultivation of sensitivity to one's self and others.
4. The development of a helping trust relationship.
5. The promotion and acceptance of the expression of positive and negative feelings.
6. The systematic use of the scientific problem-solving method for decision making.
7. The promotion of interpersonal teaching/learning.
8. The provision of a supportive, protective, and (or) corrective mental, physical, sociocultural, and spiritual environment.
9. Assistance with the gratification of human needs.
10. The allowance for existential-phenomenological forces.

One of the educational strategies used in the course was workshops. These were based on the students' analysis of the quality of nursing care in student selected nursing care studies, described by registered nurse authors, using Watson's 10 carative factors as the basis for the analysis. The students analysed:

- a) Whether the care study included a particular carative factor in the delivery of nursing care.
- b) If holistic care had been provided by considering the patient's biological, psychological, sociological and spiritual needs.
- c) The effect that the presence or absence of the carative factor and holistic care had on the client's outcome (Maltby, Drury & Fischer-Rasmussen, 1995).

This analysis encouraged the students to orientate their provision of nursing care from an holistic perspective (Greenwood, 1996; Kozier, Erb, Blais & Wilkinson, 1995). The analysis of care studies also provided the students with insight and knowledge that would be useful in future clinical situations and helped to refine skills in analysis and planning (Johnson & Purvis, 1987; Wood, 1984).

1.2 **Statement of the Problem**

Other literature indicated that this educational unit should also consider the “underside” of providing care, where the quality of care provided is impeded. Whilst searching the literature for information relevant to the course, I came across the work of Preston (1979), who wrote that the provision of nursing care was often impeded because of nurses' reactions to the patient's condition. He called this the Gregor Effect, a term based on Kafka's (1936) monograph about the fictitious character Gregor Samsa, who awoke as a human sized cockroach but had retained his human intellect and feelings. The cockroach was symbolic of any major abnormality suffered by humans and Kafka's tragic tale described how Gregor's previously loving family experienced feelings of ambiguity toward Gregor. They still loved their son but were repulsed and embarrassed by Gregor's presence and appearance. As time passed, hope for a recovery faded and the family began to see Gregor less as their son and more as a cockroach. Later, the family experienced profound relief when Gregor died.

Preston (1979) argued that nurses can experience the Gregor Effect in that they can react negatively to the patient's abnormality or incapacity, and that this reaction can result in the provision of nursing care that is impeded. He supported his view with earlier work by Freud (1936) and Becker (1973). These theorists argued that humans strive to suppress their awareness of their own mortality, and that to witness a person with incapacity or abnormality was disturbing, as it was a reminder of one's own mortality.

Preston's attempt to test this theory was unconvincing. He wrote that his research was not intended “to prove the existence of the Gregor Effect” (Preston, 1979, p.87), yet used statistical analysis of the responses of his “114 nurse subjects” (Preston, 1979, p.

90), to conclude “that the Gregor Effect exists” (Preston, 1979, p.92). Also, he used methods of sample selection that are associated with qualitative research by using “convenience” (purposeful) sampling and an open-ended questionnaire, but then analysed his data with statistics, which is usually associated with quantitative research. A further indication of a lack of rigour is his acknowledgment that when he did not get the results that he expected, he “pressed some research subjects until they admitted that despite appearances (i.e. responses to his questionnaires) they were bothered by the conditions of many patients” (Preston, 1979, p.92).

Although his study’s design was flawed, the logic of his argument as to why the Gregor Effect exists was convincing. He convincingly argued, acknowledging others with expertise in the area, that to witness a person with incapacity may be disturbing as it is a reminder of one’s mortality. It was his empirical testing of the concept that was unconvincing. He explained that the return rate of his questionnaires was “certainly too few for any statistical ‘virtuosity ’” (Preston, 1979, p. 91). He omits to quantify how many questionnaires were returned and despite his previous comments regarding lack of statistical “virtuosity”, provided statistical analysis of his data as support for the existence of the Gregor Effect, based on the percentages of nurse respondents who reported experiencing disturbing reactions to aspects of patient incapacity (Preston, 1979, pp 91-94).

My own experience on a cancer ward provided support for Preston’s theory. I had reacted negatively to a patient’s condition when holding a teaching position at a Sydney hospital. However there was nothing in the literature that measured the existence, prevalence or impact of the Gregor Effect on the provision of nursing care. I shared Preston's work with my students and devoted one of the lecture sessions to providing an overview of his work. One of the students, intrigued by the concept and cognisant of the lack of supportive empirical evidence, conducted a small informal survey to identify the existence of the Gregor Effect amongst nurses working in two Perth teaching hospitals. Her unpublished work (Collett, 1992) reported that 88% of the nurse respondents indicated that they had experienced the Gregor Effect and that it had impeded their provision of patient care.

On the basis of these preliminary results, several colleagues and I (Drury, Blackmore & Bailey, 1999) conducted a study that sought to determine the extent to which registered nurses perceived the Gregor Effect was operating in the provision of care, and the extent to which these negative responses impeded that care. Of the 69 registered nurse respondents involved in the study, only one respondent questioned the existence of the Gregor Effect. Respondents reported perceiving that the Gregor Effect had occurred, and that it was significantly more likely to impede the meeting of a patient's psychological, social, and spiritual needs, rather than physical needs. A recommendation of the study was that qualitative methodology be used to further investigate the phenomenon. This study which explores the experiences of those who have provided the impeded care is the outcome of that recommendation.

1.3 Related literature

The literature contains considerable discussion of the psychological effects of incapacity or abnormality from the standpoint of those who have an incapacity or abnormality, and how such people feel about the way others react to them (Coward, 1990; Goffman, 1984; Lawler, 1991; Price, 2000). However, research has only touched on the provision of care to patients with conditions that evoke a disturbing reaction in the caregivers (Forrest, 1989; Larson, 1987; Sontag, 1989).

Goffman (1984) argued that throughout history people with incapacity or abnormality have felt stigmatised and marginalised. However, his work was not specific to the nurse - patient relationship. It was centred on society in general. Although some of his observations could be extrapolated to the context of the nurse - patient environment, he did not examine the perspectives of the people interacting with, observing or providing care for those with the incapacity or abnormality. Instead, his work was concerned with the impact of incapacity or abnormality on the people with the incapacity or abnormality. Similarly, Coward's (1990) well conducted phenomenological study of five women living with metastatic disease provides a rich insight into the lived experience of women diagnosed with stage four breast cancer, who had reported that the quality of their lives had improved since their diagnosis. Using Colaizzi's (1978) method of data analysis, themes emerged that provided an understanding of the

terminally ill women's perspectives of the impact of their conditions upon the nurses and significant others caring for them. However, as in Goffman's (1984) study, the themes that emerged were derived from the patients' perspectives, rather than from the perspectives of those providing the care.

Work by Lawler (1991) is relevant to this study in that she argued that there are certain aspects of dealing with patients' wounds and body secretions that nurses find psychologically disturbing. Lawler's view is that essential coping skills which are necessary for nurses to comfortably deal with patients' wounds and body fluids have been, and are still, informally taught by role modelling in the clinical area. Her work indicates a gap in the knowledge base that should be addressed. However, the central theme of her work is not the lived experience of registered nurses providing impeded care for a patient with a condition that the nurses themselves find disturbing. Its relevance to this study is that it acknowledges that nurses can react negatively to the patient's condition.

Studies by Larson (1987) and Gooding, Sloan and Gagnon (1993), provide a comparison between the perceptions of nurses and patients as to which behaviours are seen as caring and non-caring. These studies centred on comparing the different perspectives of patients and of the nurses caring for them, regarding which nurse behaviours were indicative of caring. Interestingly, the two perspectives were often incongruent. Their work is relevant to this study as the nurses in it acknowledged that some nurse behaviours are non-caring. However, it was not specific to the lived experience of registered nurses providing care for a patient with a condition that evoked a negative reaction in the nurses providing the care.

Forrest (1989) used a phenomenological research method to investigate the meaning of caring for Canadian nurses. The results of the study were that two broad categories emerged: 'What is caring?' and 'What affects caring?' It is significant for this study that in Forrest's category of 'What affects caring?', a theme of the "hard to care for patient" (Forrest, 1989, p.820) emerged. This theme was not explored in any detail, but the study did find that some of the nurses expressed feelings of negativity toward some

patients, avoided some patients and arranged for other nurses to care for their patients. It is not clear from the report of the results if the same or different patients evoked these responses. The report implies that these responses may have been due to the impact of the patient's condition upon the nurses caring for them. This possibility requires investigating, as the nursing care the patients were receiving may have been impaired because of a poor rapport between the patients and the nurses providing care for them, associated with the nurses' negative feelings. There may also have been poor monitoring of the patient's response to medical and nursing interventions associated with the nurses' avoidance behaviour.

Recent studies have found that some health care workers have negative perceptions towards patients who have A.I.D.S., partly due to fear of contamination and partly due to underlying attitudes of homophobia (Hodgson, 1997; Leasure, Hawkins & Merrill, 1996; Mosier, 1994; Wamstead, 1993). Some health care workers have been found to stigmatise elderly patients who are mentally ill (Herrick, Pearcey & Ross, 1997), and Malone (1996) found that there was stigmatisation by some nurses of patients whose conditions were associated with heavy usage of emergency departments.

These studies are relevant to this current study in that they have established that certain patient characteristics evoke negative reactions in the health care workers providing care for them. Hodgson (1997) argued that there is a broad reluctance amongst health care workers to care for patients with A.I.D.S. and Mosier (1994) expressed the view that to improve the quality of care provided, negative feelings amongst health care workers toward people with A.I.D.S. must change. Herrick et al (1997) found that health care workers' stigmatisation of mentally ill patients reduced their quality of patient assessment. They argued that health care workers should be assisted with strategies to change their negative perceptions so as to improve the accuracy of their patient assessments and ultimately the quality of their health care. This current study will further investigate the phenomenon of providing impeded care because of a negative reaction to the patient's condition. It will describe the lived experiences of ten registered nurses who provided a standard of nursing care that they perceived to be impeded, because of their negative reactions to the patient's condition.

1.4 **Purpose of the Study**

This study will use phenomenological methodology to describe the lived experience of registered nurses who perceived that their reactions to a patient's condition adversely affected their provision of care. Factors that inhibit the provision of care will be identified. Strategies that registered nurses use to deal with their negative responses will also be explored. Contextual factors conducive to the nurses' negative reactions will be identified and described.

1.5 **Objectives of the Study**

1. To explore and describe the lived experience of registered nurses who perceive that their quality of nursing care has been adversely affected by their reactions to the patient's condition.
2. To identify a standard benchmark of what they individually describe as good care.
3. To describe the factors that are perceived to decrease the quality of care in the situation described.
4. To identify the strategies used by registered nurses to deal with their negative reactions to the patient's condition.
5. To describe which areas of patient need (biological, psychological, sociological and spiritual) are perceived to be affected by the nurses' negative reactions to the patient's condition.
6. To identify and describe contextual factors that are conducive to the nurses' negative reactions to the patient's condition.

1.6 **Significance of the Study**

There is a lot of information from patients' perspectives of their experiences of receiving impeded care, but little from the perspective of nurses. This study will contribute to redressing that imbalance by focusing on the experiences of nurses. This study

identifies and describes factors that have contributed to the registered nurse participants' negative reactions to the patient's condition. It is hoped this will encourage the reassessment of factors in the environment within which the nurse-patient interaction occurs. This study will also fill a need to understand the feelings and experiences of nurses who are aware that their delivery of care was impeded because of their reactions to a patient's condition. Little is known of how nurses react to such self-awareness. It can be expected that there is a distressing professional self-remonstration that accompanies the realisation that impeded care has been provided.

By understanding the lived experience of nurses who are aware that they have provided care that was impeded, there may be benefits to the nurses personally and to the community. Nurses will benefit from the study as it will increase their awareness of the possibility of the Gregor Effect in themselves. This in itself is salutary as the increased awareness per se can be expected to lessen the incidence of the Gregor Effect. Findings of this study will be integrated into nursing curricula, which will be conducive to nursing graduates providing improved levels of care.

There is potential for patients to benefit from this knowledge via the nursing profession's increased awareness of which areas of patient need were compromised, the factors that decreased the quality of care described and the identification of strategies used by the nurses to deal with their negative reactions.

This study is also significant as there is within society an increasing recognition of the rights of the disabled. This is occurring at a time when the health policies of both major political parties reflect the growing trend of de-institutionalisation. Large numbers of people with disabilities are being moved from the relative obscurity of hospitals and hostels to the more visible community environment. Accordingly, there is an increase in the provision of community nursing support services to provide care in a more visible family and public environment. Health professionals need to be aware of how their reactions to a patient's disability are perceived by the families and the public. The findings of this study will provide an understanding of factors within the nurse – patient relationship that are conducive to a therapeutic reaction to a patient's condition and to

providing a quality of care that meets best practice goals.

1.7 Assumptions Underlying the Study

Objectivity in phenomenology means faithfulness to the phenomenon, which in this case is the research informants' lived experience of providing impeded care for a patient because of the research informants' negative responses to a patient's condition. To achieve this faithfulness, the researcher has identified his assumptions or preconceived ideas related this phenomenon. By identifying these assumptions and preconceptions the researcher aimed to decrease the chance of his ideas influencing the interview process and the data analysis. These assumptions and preconceptions are derived from the author's own experience; literary works by Kafka (1936), Preston (1979) and Lawler (1991); the informal study mentioned previously by Collett and the study by the author and his colleagues (Drury et al 1999). The assumptions and preconceptions are listed below:

1. Most registered nurses experience the Gregor Effect.
2. Most find the experience distressing.
3. Most don't cope well initially with the particular situation - some learn to cope over a few days/shifts - some never do.
4. Some directly acknowledge the Gregor Effect's occurrence as it happens - others only acknowledge the Gregor Effect in retrospect.
5. Most registered nurses feel unprepared for the experience of the Gregor Effect.

1.8 Thesis overview

Chapter One of this thesis provides a background for the study and a statement of the problem. This includes literature that is relevant to this study of the lived experience of nurses who are aware that they have delivered care that was impeded because of their reactions to the patient's condition. The purpose, objectives, significance and underlying assumptions of the thesis are discussed.

Chapter Two outlines the methodology used and includes the reason for choosing phenomenology as the research method, steps taken to ensure scientific rigour, ethical issues and the methods of collecting, managing and analysing data. Chapter Three presents the findings of the study. Chapter Four discusses these findings with reference to existing literature, the study's limitations and presents the recommendations arising from the study.

CHAPTER 2

2. Methodology

This chapter places the study within the descriptive phenomenological field of research. Reasons for the use of Husserlian phenomenology are discussed and why this approach to phenomenology is best suited to the phenomenon investigated. This is followed by a description of the sampling method utilised and of the means of data collection. An overview of Collaizi's method of data analysis and discussion of its appropriateness for this study is provided. The chapter concludes with an explanation of the steps taken to ensure rigour and ethical considerations.

2.1 Phenomenology

Phenomenology has been increasingly used as a methodology in social science research (Morse, 1994). It is an inductive descriptive research approach and with its focus on human phenomena is suitable to study a humanistic discipline such as nursing (Ray, 1985). The focus of study in phenomenology is lived experience which aims to understand a phenomenon from the perspective of the study's informants. There are two reasons why phenomenology is suited to this study. It is particularly useful for describing the lived experiences of research participants through "sense perceptions - seeing, hearing, touching, tasting and smelling, and other phenomena such as remembering, believing, and judging" (Ray, 1985, p. 127). It is anticipated that the nurse participants in this study will report such perceptions when describing their lived experiences of providing care that was impeded because of their negative reactions to the patient's condition. Phenomenology also fits well with this study because this is the first time that this phenomenon has been examined, and therefore, a descriptive methodology is most suitable (Koch, 1995).

There is no one theory or approach that is subscribed to by all phenomenologists, but there are common features among the various groupings of phenomenologists. The two broad fields of phenomenology are Heideggarian hermeneutic (interpretive) phenomenology and Husserlian transcendental (descriptive) phenomenology. The

methodology utilised by each field differs. Heidegger and Husserl were both philosophers and they are key influences in phenomenological research (Cohen & Omery, 1994). The major difference between the two is that while Husserl's philosophy concentrated on epistemology (the theory and validity of knowledge), Heidegger's philosophy focused on ontology (the nature and relations of being). Husserl's philosophy emphasises description of a person's lived experience.

The central recommendation of the article by Koch (1995) comparing the two fields, is that the researcher appraises the philosophical underpinnings of both methodologies when choosing one as a research methodology. The following is an appraisal of Heideggarian hermeneutic (interpretive) phenomenology and Husserlian transcendental (descriptive) phenomenology.

2.2 **Husserlian phenomenology**

Spielberg (1982) wrote that there are four constants through Husserl's philosophy:

1. Ideal of rigorous science: Husserl believed that phenomenology would enable objective scientists to clarify and critique their fundamental concepts and assumptions. He felt that this would restore contact with the deeper concerns of people and science.
2. Philosophic radicalism: Central to Husserl's belief was that human experience contains a meaningful structure. Philosophy consists of ontology and epistemology. Ontology is concerned with the nature of relations of being. Epistemology is the theory of the nature of knowledge, especially its validity. His epistemology involved the study of essential (a priori) structures. His descriptive (eidetic) phenomenology sought universal essences, their structure and relations, based on descriptive reduction. The phenomenology of essences seeks insight into what is experienced.

3. Ethos of radical autonomy: A central focus of this constant was that people are responsible for themselves and their culture.
4. Respect for wonders: The central focus of this constant was the being that is aware of its own being and of other beings.

Husserl believed in phenomenological reduction; that reflection on existing beliefs served to allow obtaining unadulterated phenomena that were otherwise unobtainable. His phenomenological studies “uncovered and described the fundamental structure of our life world” (Cohen & Omery, 1994, p. 139). His phenomenology emphasised description of a person’s lived experience.

2.3 **Heideggerian phenomenology**

Like Husserl, Heidegger sought to redefine and center the mission of philosophy. He brought together thoughts from metaphysics (ontology and epistemology) and hermeneutics. Heidegger defined philosophy as the universal phenomenological ontology based on the hermeneutics of human being (Spielberg, 1982). His ontological phenomenology reveals that truth is to be found in the world interpreted hermeneutically.

According to Cohen & Omery (1994), a unique feature of Heidegger’s philosophy is that he saw the task of phenomenology as destruction. This involved looking past the everyday, normal meanings of life to see the larger meaning. Heidegger’s phenomenology centered on the method of approaching philosophical research. In his view, it is an approach that allows the researcher to see what is otherwise concealed and of finding truth.

Heidegger was critical of the aspect of Husserl’s phenomenology that emphasised description of a person’s lived experience. Heidegger believed that merely describing a person’s lived experience “was at best useless, at worst spurious” (Cohen & Omery, p. 141, 1994). His view was that phenomenology is primarily a method of approaching research. Part of his belief was that phenomenology is a methodological approach that should go beyond description of the lived experience of the person and that it “makes us

see what is otherwise concealed, of taking the hidden out of its hiding ... and detecting it as the truth” (Cohen & Omery, p. 141, 1994). For this to happen, Heidegger’s phenomenology requires explicit ontological self-interpretation. Hermeneutics as a research methodology is a way of dealing with these interpretations (Bolton, 1987).

2.4 Choice of Husserlian (descriptive) research methodology

Based on this review of the two methodologies and the descriptive, rather than interpretive, purpose of the study, the methodology chosen was that of Husserl. Whereas descriptive (Husserlian) phenomenology aims to identify the structure of experiences as described by research informants, Heideggerian (interpretive) phenomenology takes the process further by analysing what the participants' descriptions of their lived experiences ‘really’ mean. This is a descriptive study investigating the lived experience of registered nurses who provided impeded nursing care because of their negative reactions to the patient’s condition. Husserlian phenomenology, because of its descriptive orientation, is best suited for this purpose. This choice is supported by the descriptive phenomenological studies conducted by Coward (1990) and Forrest (1989). Both these researchers investigated phenomena similar to that explored in this study using Husserlian research methodology. Forrest specifically refers to the Duquesne (Husserlian) school in her work and used its approach effectively as a phenomenological research tool (Cohen & Omery, 1994). This current research study, like the studies of Coward and Forrest is descriptive and not interpretive .

2.5 Sample

Purposeful sampling was used for the recruitment of registered nurse participants for this study. Purposeful sampling is commonly used in qualitative research. It involves selecting research participants according to the needs of the study (Glaser & Strauss, 1967; Morse, 1991) in that researchers choose participants who have undergone the experience they are investigating. It provides informants who give a richness of information that is suitable for detailed research (Patton, 1980).

The selection criteria for inclusion were registered nurses who could articulate their experiences of the phenomenon being investigated - providing impeded care because of

their responses to the patient's condition, during any stage of their careers. There was preclusion from the study of any registered nurses who were currently students of the researcher, so as to prevent the informants feeling at risk from disclosure, and to avoid participants providing misleading data from feelings of coercion.

An advertisement was placed in a local nursing organisation's newsletter (Appendix 1). The advertisement was repeated once with only three nurses in total responding and these respondents were included in the study. Given the limited response, another method of recruiting participants needed to be found. Registered nurses who had participated in the earlier study by the researcher and his colleagues (Drury et al 1999), had expressed a willingness to participate in further research. Three of these former participants were contacted and agreed to participate in the study. Nominated or snowball sampling technique (Morse, 1991) was then used with the three former participants agreeing to contact other registered nurse participants on the researcher's behalf. They asked colleagues if they were interested in being interviewed to describe an experience when they had, in their own assessment, provided impeded care because of their personal reactions to the patient's condition. The names and telephone numbers of those who expressed a possible interest to participate were given to the researcher who then contacted them to explain the background to the study and the criteria for inclusion in the study.

The researcher advised the potential participants that the interview would be approximately one hour in length and tape-recorded. He then explained that to maintain rigour he would require a second contact with them to allow their examination of his analysis of their experiences. The researcher provided the potential participants with a choice of venue for the interviews, at either his or their places of work, his home or the participants' homes.

All eight nurses contacted by the researcher agreed to join the study and most expressed the view that research of this nature was important and timely. This gave a sample size of eleven participants. The researcher was prepared to use a similar method of participant recruitment to boost the sample size if new information was provided during

the interviews of the last participants. This was unnecessary as the later interviews provided information that had been elicited in the earlier interviews indicating that saturation in terms of completeness of data had been reached (Morse, 1991).

2.6 **Ethical Considerations**

Formal ethical approval of this study was obtained from the Human Research Ethics Committee, Curtin University of Technology.

The purpose of the study was explained to participants and they were encouraged to ask questions or seek clarification. Participants were advised of the voluntary nature of their participation and that they could withdraw from the study at any time without penalty. Informants were also advised that at any time during the interview they could decline to answer any question, request that the tape recorder be turned off or terminate the interview. Written consent was obtained from the participants to tape the interviews (Appendix 2).

The researcher explained that to ensure confidentiality he would be the only person who would be able to link names with interviews and that the tapes would be kept in a separate locked filing cabinet and destroyed on completion of the study. Participants were informed that the interview transcripts would be kept in a separate locked cupboard and would be destroyed five years after the completion of the study. Quotes from the interviews are included in this report. However, informants will not be identifiable because the researcher has ensured that informants' names or any other potentially identifying information are not contained in the report. Participants identifying details have been disguised and are held in a separate computer and will be destroyed at the completion of the study.

The researcher was aware of the possibility that participants may describe experiences that were at odds with his own code of professional standards, that it was appropriate for him to remain non-judgmental and that his body language should not convey disapproval during interviews.

It was anticipated that respondents might have found reliving their experiences

distressing. Prior to the first interview, the researcher contacted two professional counselling services and ascertained that interviewees could be referred if necessary. In the event that respondents had indicated distress, the researcher would offer to terminate the interview and offer to provide the contact details of the counselling services. There was no distress indicated by or observed in the respondents and the counselling services were not required.

2.7 Data Collection

Collection of data was via audio taped in-depth interviews. Each interview lasted for approximately one hour. Interviews ranged in length from 45 minutes to one hour and fifteen minutes. Once written consent was obtained, the interviews proceeded with the aim of obtaining a description of the research participants' lived experiences of providing impeded care, in their own assessment, because of their reaction to the patient's condition. A follow up contact enabled clarification and validation. The researcher used a non-directive style of questioning (Kozier, Erb, Blais & Wilkinson, 1995; Porritt, 1990) which became more directive as appropriate.

A non-directive style of interviewing involved the researcher using open-ended questions that allowed the participants freedom to control the pacing and subject matter of the interview. Participants were encouraged to express their feelings. With the use of empathetic responses and congruent body language the researcher established a rapport with the participants that encouraged them to describe their experiences of providing care that they perceived to be impeded. A more directive style of questioning was used at times during the interviews when the researcher required clarification of information that the participants were providing. This involved the use of a more closed and structured questioning style that elicited specific information from the participants.

Prepared questions were used to guide the researcher in the interview (Appendix 3). Aspects covered in each interview included the participant's reaction to the patient's condition, factors that impeded the provision of care, strategies that were utilised to minimise the impact of the negative response and aspects of the patient's needs that were affected by the negative response. In the course of the review of these questions, it was

decided to include another question. The research participants were asked, during the initial stage of the interview, to describe a situation when they had provided care that they would describe as good care. This was included for two reasons. It was thought that research participants would feel more comfortable describing the provision of impeded care if first given the opportunity to describe giving good care, and also to establish a benchmark of the participants' perspectives of the components of good nursing care.

Another refinement of the prepared questions occurred after the second, unsatisfactory interview during which the participant seemed unsure as to whether she had in fact provided care that was impeded because of her reaction to the patient's condition. The interview was politely terminated and the data discarded. In subsequent interviews, after the researcher had provided a background to the study, he asked directly if the participants had provided care that they perceived to be impeded because of their reactions to the patient's condition. All subsequent participants responded that this was the case and all interviews were continued. Responses in the negative would have indicated that discontinuation of the interview was appropriate as the participants would have been unable to describe their experiences of the phenomenon being studied.

A last modification of the prepared questions used by the researcher to guide the interview, was to ask at the conclusion of each interview if there was anything the participants would like to add, before he turned off the tape recorder. This modification was made after interview three when the participant gave additional information of her experience of providing impeded care after the interview had been concluded and the tape recorder was turned off. This information was not used, as the participant seemed to be of the view that these later comments would not be included in the data and were made outside of the boundaries of her consent.

2.8 Data Analysis

2.8.1 Colaizzi's method

The method of analysis described by Colaizzi (1978) was utilised to provide a rich description of the essential structure of the phenomenon. Colaizzi (1978) developed his

approach from the Duquesne (Husserlian) School (Cohen & Omery, 1994) and his method is frequently utilised in phenomenological research (Forest, 1989). It is well suited to Husserlian phenomenology as Husserlian descriptive principles underpin his method of analysis (Koch, 1995).

Colaizzi's (1978) method comprises seven steps:

1. Each research informant's verbatim transcript is read to acquire a sense of the whole.
2. Significant statements and phrases pertaining to the phenomenon being studied are extracted from each transcript.
3. Meanings are formulated from the significant statements.
4. Meanings are organized into themes, and these themes evolve into theme clusters, and eventually into theme categories.
5. These results are integrated into a rich and exhaustive description of the lived experience.
6. The essential structure of the phenomenon is formulated.
7. Validation is sought from the research informants to compare the researcher's descriptive results with their lived experiences. If necessary, the researcher's description is modified to achieve congruence with the lived experience of the research informants.

Interviews were transcribed verbatim from the audiotapes by a typist who was experienced in transcribing interviews conducted for qualitative research. A hard copy and a copy on computer floppy disk of each interview were returned to the researcher with its accompanying audio taped recording. The data were copied directly to a word processing package that was compliant with the researcher's home computer. Analysis of data proceeded through the stages outlined in Figure 1 below:

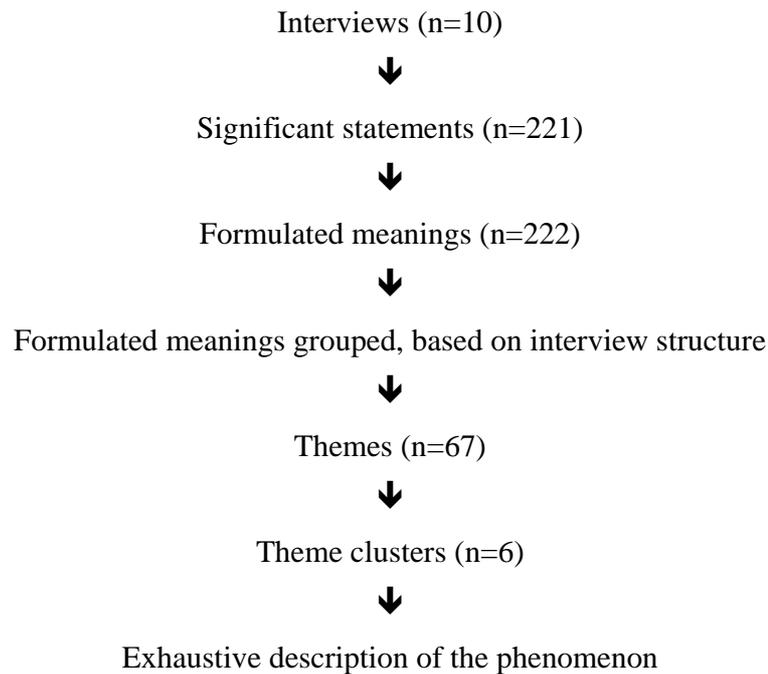


Figure 1 Summary of data analysis

Each transcription, called a “protocol” (Colaizzi, 1978, p. 59), was read several times, as the audiotape of the interview was replayed, to gain a sense of the total content. An extract of a protocol of the first interview conducted is in Appendix 4.

2.8.2 Extracting significant statements from the protocols:

Significant statements and phrases pertaining to the phenomenon being studied, the provision of impeded care because of a negative reaction to the patient’s condition, were extracted from each protocol and coded (Appendix 5).

2.8.3 Formulating meanings from the significant statements:

Next, the underlying meaning of each statement was written. This step “moves from what the participants said to what they meant” (Forrest, 1989; p.817). It involves the researcher being cognisant of contextual factors that modify the meanings of verbatim transcription of the interviews. The research participants' use of sarcasm, jargon, economy of phrase and the expression of strong emotion can alter the meanings of the verbatim transcriptions.

This step is a "precarious leap" (Colaizzi, 1978, p.59), and the researcher undertook the

following check to ensure that he remained true to the data: The underlining meaning of each significant statement, called a formulated meaning, was coded with the same symbol as the significant statement from which it was derived. A colleague who is experienced in phenomenological analysis then independently read each significant statement while listening to a copy of the audiotape and, referring to a hard copy of the transcribed interview protocol, wrote the formulated meaning for each significant statement. The researcher and his colleague then compared notes, discussed any discrepancies and made adjustments where necessary. The only significant change made was to rectify a degree of blandness that the researcher had introduced into the formulated meanings by using language that was less descriptive than that used by the participants. A total of 222 formulated meanings from all interviews were written. An example of coded significant statements and formulated meanings from the interviews is provided in Appendix 6, and an extract is below:

Significant statement one with its coded formulated meaning:

He was hard to handle as he knew the (psychiatric) system and was manic and was trained in martial arts.

Formulated meaning: The patient's knowledge of the hospital system, his mania and his potential to physically harm him (nurse) made him difficult to provide care for.¹

Significant statement two with its coded formulated meaning:

He was unpleasant to physically restrain, as his skin would literally peel off on your hands, he was oozing due to severe psoriasis.

Formulated meaning: The patient was unpleasant to physically restrain as his skin was oozing and would come off due to severe psoriasis.2

Significant statement three with its coded formulated meaning:

It impeded a lot of people's quality of care; he was not a priority.

Formulated meaning: His reaction to the patient's condition and other staffs' reactions to the patient's condition impeded the quality of care provided, as he was not a priority.3

Next, the coded formulated meanings from all of the interviews were combined.

2.8.4 Organising formulated meanings into themes:

"The next step in the data analysis was to form clusters of themes that were common to the protocols. The formulated meanings were sorted into groups that represent specific themes" (Coward ,1989, p. 164). Each theme was coded and each formulated meaning that formed part of a particular theme was listed beneath it. For example, below are themes 20 and 21 with their associated coded formulated meanings:

Theme 20 Experienced feelings of sadness, regret, guilt after experience of providing impeded care

- Experienced feelings of sadness and regret at her response to the patient's condition after he died.(formulated meaning 81)
- Feels that it is sad that there are occasional patients with whom none of the nurses can relate.(formulated meaning 124)
- Feels that his rejection of this child is what he (child) doesn't need.(formulated meaning 126)
- Feels that it is unfortunate that she can describe an experience in which her quality of care was impeded because of her reaction to a patient's

condition.(formulated meaning 133)

- Feels that because of the patient's manipulative behaviour she ignored her complaints about a sore tongue which was indicative of a real cancerous growth. (tone of voice conveyed guilt)(formulated meaning 139)
- Feels remiss at missing the patient's symptoms of cancer.(formulated meaning 140)
- Feels guilty because she and other nursing staff feel sufficiently intolerant to remove the patient's call bell.(formulated meaning 145)
- Feels guilty and annoyed that her care is compromised.(formulated meaning 150)
- Is distressed that his perceptions of the patient are interfering with the way he is relating to the patient and delivering his nursing care.(formulated meaning 106)
- Feels that it is implicit that he is supposed to be caring and doing the best for these kids.(formulated meaning 110)

Theme 21 Upon reflection of experience, would act more therapeutically next time, has resulted in improved care

- With the benefit of hindsight, she perceives that now she would have a more therapeutic response and would have given the patient counselling.(formulated meaning 83)
- Thinks that experiencing a negative reaction to the patient's condition helps her to cope with subsequent similar situations.(formulated meaning 95)
- Has learnt from the experience and can now speak to people without the anger she had then.(formulated meaning 104)
- Feels that she is a better nurse because of her experience of providing

impeded care.(formulated meaning 220)

- Reflecting on what happened (reacting angrily to the patient whose baby couldn't attach to the nipple) she now knows with her knowledge and experience that the situation will never happen again.(formulated meaning 221)
- Has since developed strategies to deal with her negative reactions to the patient's condition.(formulated meaning 87)
- Feels that by working in the area longer you become more understanding.(formulated meaning 96)
- Feels the negative incident with the patient was a good learning experience and is not sorry that it happened.(formulated meaning 102)
- Has learnt from the experience and can now speak to people with out the anger she had then.(formulated meaning 104)

2.8.5 Organising coded themes into theme clusters:

The next step in the analysis of data was to organise similar coded themes into theme clusters. For example, theme cluster three is “the nurse-patient environment in which impeded care was provided” and its coded cluster of themes are listed below:

Theme cluster three: The nurse-patient environment in which impeded care was provided:

- theme8 Impeded care exacerbated by chronic work stress, burnout, short staff levels, time pressure, lack of autonomy.
- theme23 Other staff similarly reacted negatively.
- theme26 Feels unable to use usual management strategies.
- theme30 Reaction exacerbated by other staff having, telling of similar reactions.

- theme31 Perceived a need for assistance - wished had learnt better to cope at university - wished for assistance in the clinical area.
- theme27 Patient's diagnosis contributes to reaction - past experience.
- theme34 Conflict with doctor over patient's treatment exacerbated negative reaction.
- theme35 Reaction exacerbated by absence of visits from significant others.
- theme36 Response exacerbated by existing poor rapport.

At this point the researcher and his supervisors decided that no further collapsing of the data was appropriate, as to do so would lose richness that is contained in the data. Six theme clusters had been extracted from the data and these provided a rich picture of the phenomenon being analysed: the provision of impeded care because of a negative reaction to the patient's condition.

2.8.6 Writing an exhaustive description of the phenomenon being studied:

The next step in the analysis of data was to produce an exhaustive description of the phenomenon being studied from the theme categories. According to Patton (1990, p.3), an exhaustive description goes beyond mere fact or surface appearances, but stops short of becoming "trivial and mundane". An exhaustive description should communicate the "voices, feelings, actions, and meanings" of the interacting individuals. This enabled an exhaustive description of the lived experience of the respondents of this study, who perceived that they had provided nursing care that was impeded because of their reactions' to the patient's condition.

A final validation was undertaken by returning to the research informants and asking them if the researcher's description validated their own experiences. Three of the informants were uncontactable. All seven of the remaining informants contacted expressed the view that the researcher's description of providing good care, and of providing care that was impeded

because of a negative reaction to the patient's condition, had congruence with their own experiences and was an accurate description of the essential structure.

2.9 **Rigour**

Care was taken to ensure that the analysis was not biased by the researcher's acknowledged preconceptions. The most common technique used by Husserlian researchers to ensure that rigour is not compromised due to researcher bias is to "identify and articulate assumptions prior to data collection and analysis" (Morse, 1994, p. 148). The researcher listed and reflected upon his own beliefs about the provision of impeded nursing because of a negative reaction to the patient's condition. These assumptions are listed in Chapter One.

The steps of extracting significant statements and creating formulated meanings from the interview protocols were done independently by the researcher and a colleague experienced in phenomenological methodology and approved by the researcher's supervisors as being suitable for the task. The analyses were compared and found to be congruent except for the researcher's tendency to lose some richness of data by using a blandness of language when formulating meanings that did not reflect the depth of feeling of some of the significant statements. These formulated meanings were modified to accurately reflect the participants' lived experiences. The same colleague scrutinised and validated the researcher's organisation of formulated meanings into themes and their evolution to theme clusters.

Data collection and analysis were documented to provide an audit trail. Examples are included in Appendices 4 -6. Field notes were kept summarising date, time, location and the subject matter of all meetings between the researcher and his supervisors, the research informants, and the colleague who validated the data analysis.

2.10 **Limitations of study**

When considering the findings, the limitations of purposive sampling should be kept in mind. The results of this study need to be treated with caution as they can not be generalized to a wider population of nurses. However the findings do provide a basis

for the design of further studies using qualitative or quantitative designs.

CHAPTER 3

3. **Findings**

The purpose of this study was to provide a rich description of the lived experience of nurses who have, in their own assessment, provided impeded care because of their personal reactions to the patient's condition. The main objectives of the study were to: describe the factors that are perceived to decrease the quality of care in the situations described, identify the strategies used by registered nurses to deal with their negative reactions to the patient's condition, and to describe which areas of patient need were affected by the nurses' negative reactions.

Initially, research participants described situations in which they had provided nursing care that they perceived to be good care. This was done for two reasons. It was thought that research participants would feel more comfortable describing the provision of impeded care if first given the opportunity to describe giving good care, and also to establish a benchmark of the participants' perspectives of the components of good nursing care.

Research participants then described situations in which they had provided nursing care that they perceived to be impeded because they had reacted negatively to the patient's condition. These reactions varied in intensity from mild to extreme and included frustration, annoyance, fear, revulsion, sadness, helplessness and guilt. These reactions translated into behaviours that included poor communication with the patient and spending less time with the patient. These behaviours impeded the participants' ability to meet the patient's psychological and sociological needs. There was also an awareness by the participants that they had provided care that fell below their own criteria of good care. In some cases this experience subsequently resulted in the provision of higher quality care. This was a result of strategies that the participants used to cope with providing impeded care. These coping strategies are described, as are the contextual factors within the environment in which the impeded care was provided.

The clinical settings in which participants of this research project described their own experience of giving impeded care varied, as did the conditions of patients which generated the negative reactions in the participants. The clinical settings included a locked ward at a psychiatric hospital, a surgical ward, a coronary care unit, a renal ward, a child psychiatric unit, a nursing home, a medical ward, an intensive care unit, a long term stay medical unit and a maternity ward. Patients' conditions included severe psoriasis and mania, narcotic addiction, physical trauma associated with domestic violence, myocardial infarction and a psychiatric history of violence, wound infection associated with diabetes mellitus, encopresis, diabetes mellitus, a progressively degenerative musculoskeletal disorder, confusion and aggression associated with a neurological impairment, cystic fibrosis and problems with breast-feeding.

3.1 Participants' criteria for good patient care

Participants were asked to describe examples of when they, or another nurse, had provided care that the participants classified as good care. The themes that emerged from the data are as follows:

Providing good patient care involves meeting the patient's and family's bio/psycho/ sociological needs

One participant felt that the provision of good care involved staying with the patient, using touch and providing reassurance to decrease the patient's anxiety.

She described her actions:

... when I was doing a complex procedure when the patient was very scared I just stayed there with him to give reassurance, I just held the patient's hand and stayed with him. That decreases their anxiety and they feel more comfortable. Participant 4

As an example, another participant recounted seeing another nurse provide good care:

Well, all the clinical aspects were taken care of. The competence. But I think it was basically the other side of the care

there... the emotional support and the caring aspect, that was what made it stand out. Participant 10

Treating the patient holistically was central to this participant's provision of good patient care: She described her feelings:

Well I think it would be providing the nursing care that's required by the patient, but then you've got to cover all the other factors. Their psychological frame, their relatives, sociologically if they've got other problems. So it compasses everything... holistic care. Holistic. So it's not just actually nursing them and their condition, other things are occurring at the same time that might have impact on that care you're giving them, or the condition that they're in for. So you've got to take everything into consideration. Participant 2

Another participant described providing good care for a comatose intensive care patient by keeping the patient alive, meeting his physical needs and building a relationship with the patient's family:

Well I guess the bottom line is that they're still alive for the end of the shift. Like I guess that's the... you know, the first criteria you know would be to provide basic nursing care, so you're keeping them alive and you're supporting the health care professionals around you to make sure... to you know, to ensure that the patient's alive and in the best health situation they can be at the end of the shift when you're passing on to someone else. And then the next thing is to support the family, to help them through their coping process. This is like Intensive Care I'd say, so you want to build a relationship with the significant others, whoever that may be. And I think it's helping them in the continuum of their grieving process because they're going through a grieving process, at some sort of level. Whether it be just the shock of coming to Intensive Care, because even our

stable patients that you know were leaving... you know that they will leave in 48 hours, 24 hours, it's a real shock to the family. But if you can help them to overcome that and to be able to relate to the patient, that's really your aim. Like I believe good care is supporting the family enough so that they've then got the strength to relate to their significant person in their lives that's the patient you're looking after. And then once you've got beyond that, and those two are basic things, then it's actually providing for your patient's care. So you've got the third, you know, then you've got the third factor of keeping them clean, keeping their lungs clear, keeping their eyes and their mouth good, their bed clean, made, all those things are fairly minor down the line, and in through that if you can build a relationship with your patient that's there within the room, unconscious, then that's really the fourth step. Participant 3

A participant described her provision of good care by involving a patient's wife in the care:

Where I'm working now we have an eighty... he's about eighty... year old man who... a dementia, and progressing like really rapidly... dementia. And his wife is the problem at work because... "why isn't he getting this and he's really gone down hill, we want the priest in, we want the last rights, we want doctor in". And the husband is saying, "you embarrass me", to the wife, and then he will not talk, he won't swallow, he won't do anything because the wife is embarrassing him. So he finds it easier to sit in his little shell. So I find good care is going back to the wife and telling her that his condition... he's a dementia but he's still aware of what she's doing. He is embarrassed by her, and I realise that she's grieving a lot for her husband, but she has to first of all cope with that away, like behind the scenes and then come back and be able to tell her husband that he is

doing well and putting up a... I know it's a bit of a front, even though this man's demented he can still say she is embarrassing. And it's a vicious circle. So I think the good care is realising that the relative is the problem. But it takes ages and it's really involved, ... I think she should be allowed to come here because it's her husband, she's looked after him for 60 years or whatever they've been together, and it's something that has to be done. Participant 6

Providing good patient care involves establishing a rapport and communicating well

In addition to meeting the patient's bio/psycho/sociological needs, another theme that emerged from the data, was that participants felt that providing good patient care involved establishing a good rapport with the patient and communicating well. This is congruent with work by Porritt (1990) who stated that patients rate nurses' communication skills as the most important factor in good patient care. One participant expressed her feelings this way:

And then, when the patient arrives the first thing that you do is you build up a rapport with the person so that you can then truly care for them and then provide for their needs after that point. Participant 10

Another participant described her observation of a colleague providing what she considered to be good care:

I first started as a midwifery student at (hospital name withheld for confidentiality), and I remember this nurse mentor ... I was with her, and she was so calm and patient and took a lot of time to explain to the actual postnatal patient what was going on after her delivery and she was checking the vaginal blood loss and she just took her time to just gently explain to her what to look for, to the mother, and to alert her if there was any problems or any

changes. I was just impressed with just how well she explained the care to this mum. Participant 9

Providing good care is staying with the patient and doing more than is required

Participants felt that providing good care also involved staying with the patient and doing more for the patient than was required. One participant said of nurses working on his ward:

We see this sort of phenomenon all the time, where particular nurses because of the working relationships, once they engage the child or the family you take what's expected of far beyond what you could really ask. It's not only extra hours but the things that you actually do for either the child or the parents, or the family as a whole. ... They just do it spontaneously. With certain nurses I know once they latch on the kids don't have a chance mate, they're going to get better by hook or by crook. Participant 5

A description of an incident of providing good care by staying with the patient and providing continuity of care was provided by another participant:

I stayed with her through the whole of her shift. I walked her outside until she got into established labour, I stayed with her... I let people in and out of the room, I delivered the baby and the placenta, and then I packed her up in my car and took her home. Participant 7

Another participant felt that good care involved doing extra things than were necessary for the patient. She said:

I think doing simple things that the patient appreciates that wouldn't matter whether they were done or not, like an extra hair wash or do their nails, or just do their hair in a different way, you know, simple little things like that are really appreciated by

patients. But even in Intensive Care Unit doing something like that makes you feel better, even though the patient's totally oblivious, you just go that extra... Little things that you don't always have time for, you're so busy doing... well, saving their lives so to speak in ICU. It's nice to sort of be able to do those little basic care, a few little personal touches. Participant 8

In summary, participants felt that providing patient care that they classified as good, involves meeting the patients bio/psycho/sociological needs, establishing a rapport with the patient and communicating well, and staying with the patient and doing more than is required.

3.2 Personal reactions that nurses associate with providing care that was impeded

Having established the research participants' descriptions of the provision of good patient care, participants of this study then described their experiences of providing nursing care that they perceived to be impeded, because they had reacted negatively to the patient's condition. The reactions that they described include frustration, annoyance, fear, repulsion, sadness and guilt.

Frustration, Annoyance

Participants reacted with feelings of frustration and annoyance. In some cases, the annoyance was directed towards the patient. In other cases, participants felt annoyed with themselves. One participant who was attempting to help a new mother breast feed described her reaction:

And of course at that stage I was feeling quite frustrated and felt that ... all I wanted to do was put that baby on the bottle and run away, ... she couldn't feed it and then there was a huge problem ... pissed off that she couldn't manage the feeding herself, that it wasn't working, that no matter what she did and we did it just didn't happen at all. It wasn't happening. It only happened on two shifts where we (nurse and patient) were almost doing battle and she got, the mother, I mean she was tired

and exhausted anyway, she got fed up and I was just so frustrated. Participant 9

Another participant reported feeling annoyance toward herself for providing impeded care:

But it's not really her fault. I mean, she's been like it... her family say she's been like it ever since they can remember, she's a hypochondriac and this and that. Yeah. But it still really... it annoys me that I treat her that way. Participant 6

This participant described his annoyance with himself for providing impeded care:

They (encopresis patients) don't use the toilet properly and the colon actually enlarges and then they have this large rock, it just sits there, because it's been stagnant for so long the patient feels the sensation that they need to go to the toilet, because it's a concrete block the body needs to get rid of it somehow and so it doesn't withdraw as much fluid from the faeces and it just flows around this concrete block and so they are constantly dribbling. ... This is where I get really cross with myself because I can accept the .. It's quite, when you sit down and actually analyse it, it's actually quite distressing (for the nurse). Participant 5

Another participant was critical of herself and her colleagues when impeded patient care was provided. She said of a patient with diabetes mellitus and a severe wound infection:

...I didn't attend to any of his psychological needs. I'm critical of other people when they do that and I was very critical of myself. Participant 4

Fear for own safety

Another theme which emerged from the data was participants fearing for their own safety. The data revealed that there were several factors which contributed to the participants reacting this way. One of these factors was the patient's knowledge of the system and his ability to manipulate it. One participant had been so disturbed by the experience that he changed his career. As he said of a patient in the manic phase of bipolar disorder:

And he was also so very... he was knowledgeable, which sounds bad, but he knew the system so he could manipulate because he knew the system. And because he was manic he was a challenger... I mean he was always challenging the authority of the staff. You need a certain amount of control in those areas, otherwise they don't work. And if you get somebody who knows the system and who's manic, and aggressive, then they're a threat. So it's a fear, a threat, and when they're a threat it makes it difficult to deal with. He was one of the main reasons why I got out of psych (mental health nursing) and went to do general (nursing). Participant 1

Another participant reacted with fear because of the patient's past history and his physical appearance:

..in the CCU (coronary care unit) where we had a psychiatric patient that came in. I mean he was a man in about his forties, he was very large, big and strong and slightly overweight, but mainly just big and strong. He was about 6 foot 6, a very solidly built man, probably slightly overweight as well, dark skinned. I mean he'd come from the forensic unit with a history of rape and murder with a psychotic type of personality, so he had two psych specials (mental health nurses) and caring for him was just incredibly scary.... The first thing I felt was fear when I walked into the room, before I got close to the chappie. He'd actually follow you around the room with his eyes, so if you walked... as soon as you walked into the room his eyes would follow you but

his head wouldn't move, so he'd just follow you the whole way around the room. But his actual look was particularly intense, which would've been heightened by the dark skin and dark eyes I think. Participant 3

Revulsion

A reaction of revulsion to the patient's condition was another theme that emerged from the data of this study. The data reveal that severe patient abnormality provoked a strong reaction in some participants. As one participant reported of a patient with severe psoriasis:

*...his skin would literally peel off on your hands. When you grabbed him... you'd grab him and he was oozing... his whole body was just covered. So yeah that affected my...phew!...and it just used to turn my stomach, nausea, queasiness... that's a good one! I was never sick but there's something about washing somebody's... skin off your hands and it's on your clothing.*Participant 1

Another participant described her reaction:

*I walked into the patient's room. The smell was so bad there was gangrene, poorly controlled diabetic, he was also a dialysis patient. So I walked into the room, took off his dressing; the smell was terrible. I took off the dressing and there were maggots everywhere and I started heaving... I was disgusted that he'd let himself get this bad, disgusted really.*Participant 4

Another participant was physically repelled by the patient's mannerisms and appearance:

He's got unfortunate features, he has very annoying mannerisms. I can't relate to this kid.....He's not the sort of kid that one reallytouch, that I would be willing to touch. I don't want to have physical contact with him. You keep away ... I don't want to

touch him, he's difficult to work with because of it... it's just his mannerisms and the way he looks and I just don't want to touch him, sometimes. Participant 5

Interestingly, another participant reported that she had never provided impeded care because of her reaction to a patient's physical condition, but instead, that she had reacted negatively to psychosocial aspects of the patient's condition:

*... physically nothing's upset me to the fact (sic) that it's affected my nursing care. It's mainly personalities and psychological problems, or emotional problems. One instance would be a woman who continuously gets admitted after she's been bashed up by her defacto, and we've all spent heaps of time talking to her, discussing options. She wants to get out of the situation. But you get to the stage where she's admitted, you know darn well she's going to straight back to him and you feel you've wasted all your time. It just turns me off, and you think, well, what's the point of talking to her ...*Participant 2

Sadness, Helplessness, Guilt

Participants experienced sadness when reflecting on their awareness that they had provided impeded care. One participant said at the time of interview that she still felt sadness many years after the death of her patient. She expressed her reaction as follows:

*Not at all, I didn't even think about that (meeting the patient's spiritual needs), but a short time afterwards he passed away and I still find that very hard, he knew me.*Participant 4

In the words of another participant:

... sad and helpless that there's nothing that I can do to help her, but then I think to myself does she want to be helped? So I've two minds. Does she want to be helped, or is there anything else I can do? So you feel helpless in the end and you don't feel

as though you're doing the best you could. ... So the emotion you have is feeling of helplessness, and also wondering if she really wants to be helped ... it's mainly helplessness, that's... I've found with a lot of situations. Participant 10

Another participant had feelings of sadness and guilt associated with giving care that she perceived to be impeded:

...and the whole situation (of the patient receiving impeded care) makes me feel sad ... and it makes me feel guilty because I shouldn't be feeling this way about her (the patient) Participant 8.

3.3 Personal behaviours that nurses associate with providing care that was impeded

After participants described their negative reactions to the patient's condition, they then identified specific behaviours that translated from their reactions, which they perceived to be of significance when providing care that was impeded. These behaviours included not being with or avoiding the patient, not communicating well with the patient and having a poor rapport. For most participants, physical care was unimpeded, but not meeting the patient's psychological and sociological needs were major factors in participants providing impeded care.

Not being there, spending less time with the patient

For one participant, who was treating a patient who was acutely ill with a myocardial infarction and who also had a psychiatric history with associated violence, fear for her own safety led her to avoid the patient. Normally, patients admitted under her care received immediate and urgent treatment. As she explained, she positioned the patient further away from the nursing station than was usual. This resulted in the patient's unstable condition being less closely monitored. She also delayed initiating treatment:

He'd come to us with a heart attack (and) our routine care would be immediate. ... so the first phone call that we had was the fact that we had a patient that had had a heart attack downstairs, but

he had a psych (iatric) history and came from the forensic unit. So even before he arrived we actually set aside a room down the corridor, where routinely we'd actually place him up close to the desk. And then the second thing is, is that if we heard that a chappie of his age was having a heart attack we'd probably be quite quick in getting them up, but because we had to move patients to get the room down the end set aside for him, it meant that that was delayed by probably about 15 or 20 minutes, which is relatively significant in terms of someone having an M.I. (myocardial infarction) at the time. Participant 3

After the participant began treatment, she described how she avoided being with the patient and in doing so, provided a compromised quality of nursing care:

But I guess we came up with a... the situation and the fact that the bulk of these patients would be sighted all the time, whereas we weren't really prepared to stay in there all the time with him. So his care was very, very compromised. We actually didn't do general nursing care on this chappie, the psych. nurses did that, whereas I'm sure that if he didn't have a psych. history, there hadn't been rape and he hadn't come from the forensic unit that it wouldn't have been a big deal to wash this chappie. But because of the situation and his sheer height, and size, that was deemed to not be a priority in his care. So really all he received from us was us sitting out there, about 100 metres away, just watching his heart rate. Participant 3

Another participant felt that her care of a patient with confusion was impeded because of her avoiding the patient:

... but I still don't feel good about it because she's not getting good care ... she's being left in her room because no one... I don't have to listen to her prattling on. Whereas anyone else, I'll go up and talk to them and I'll put my hand on their arm or

whatever, and have you enjoyed your meal? So I just avoid her and I and they (other staff) never ask her that. Participant 6

Avoiding the patient was also a factor in this participant's description of when she provided care that she perceived to be impeded:

The third thing was I avoided her like hell. The times that I did have to spend with her, I did, but as soon as I could (leave), I was out of there. Participant 7

Another participant described how his care for a patient was impeded by him avoiding the patient and giving the patient a lower priority than other patients:

Umm, right. It impeded a lot of people's quality of care, I mean, so of course he was... I wouldn't say that he was purposely avoided as such, but he was always avoided ... considered low down in the priority, which made it worse of course. That would explain his behaviour because he was after the attention and it was just a vicious circle. Participant 1

Another participant described how she avoided spending time with patients who had taken drug overdoses:

And the patient that's just overdosed, sometimes they can be very aggressive. I think most of the situations that I've been in where I haven't given care they've been aggressive and I just avoid them and give them or do for them what you really have to. Participant 8

Not communicating well, having less rapport

Participants perceived that another significant factor in providing impeded care was their use of poor communication skills with their patients, and a failure to establish a good rapport with their patients. One participant described her behaviour as follows:

...but I wasn't nice to him, I didn't spend that extra bit of time, I

was brisk and efficient. And normally I wouldn't answer back because I know that when patients snap they don't mean it, or they've got a good reason for being upset. But because I couldn't cope with the way he was, I left the room ... I got all the equipment I needed but then when I went back in I was brisk and efficient. Participant 4

Another participant described how she stopped listening to her patient and adopted a very directive style of communication:

I'm annoyed with her. And I just don't have any time to listen to her. And I close off. I just stop listening to what she's telling me. I don't communicate at all. I say, I've got your tablets here for pain, you must take them. Or for your bowel or whatever they're for, and you must take them Participant 6.

Another gave this example:

Well I couldn't get close enough to him because I mean it's part of your job as a psych nurse but I couldn't get close to him because of... and as I said, it's not just his psoriasis, that sounds terrible, it's the combination of everything because if he had just had the psoriasis it would've been OK. And if it was just the mania it would've been OK. It was just the combination of the two and that was the difference. But I couldn't get close enough to him... plus I think he had a bit of a dislike for me Participant 1

The use of poor communication skills had impeded the quality of care that this participant provided:

But you get to the stage where she's admitted, you know darn well she's going to straight back to him and you feel you've wasted all your time. And you think, well, what's the point of talking to her, so you really don't talk to her as much as what you feel you should do. You're just doing your basic care: handing

out the pills, how are you? ... have a good night, ring me if you want anything. I do night shift obviously. But I don't give her the opening to talk to me like I should do. Participant 2

Giving the patient good physical care

A major theme that emerged was that most participants perceived that their abilities to meet their patient's physical needs were unimpeded by their negative reactions to the patient's condition. There were, however, three participants whose physical care was influenced by their reactions. One participant described his experience:

Well I was lucky in so far as I was in charge (of the ward) so his physical needs in relation to his psoriasis and that, I gave that job to somebody else! ... Yes, I would've done anything to try and get out of it (giving the patient physical care) anyway. ... I would've had to do a deal with somebody if I was treatment nurse or whatever, I would've done a deal with somebody to do that. Participant 1

Another participant said:

So really all he received from us was us sitting out there, about 100 metres away, just watching his heart rate. Participant 3

A reluctance to touch the patient, which no doubt would impede his ability to provide physical care, was experienced by this participant:

He's not the sort of kid that one really wants totouch, that I would be willing to touch. I don't want to have physical contact with him. .. I don't want to touch him, he's difficult to work with. You can't sit down and do the classical management strategies, because he hasn't got the capacity, he can't turn around the words, which I don't have a problem with. That's a nursing thing. It's just his mannerisms and the way he looks and I just don't want to touch him, sometimes. Participant 5

However, other participants recorded that although they had provided impeded care, it was not their provision of physical care that was impeded. They were very clear on this aspect of providing care, and typically gave statements to the effect that their physical care was unimpeded, in concise and specific statements. One participant described how her physical care was unimpeded:

*Well physical nursing care wasn't affected but emotionally I don't feel I gave her full emotional care I could've given her.*Participant 2

Another participant expressed, in a similarly forthright manner, that her physical care was unimpeded:

*I didn't give him (the patient) any less physical care but I wasn't as friendly and understanding.*Participant 4

Another participant stated that her physical care was unimpeded in this similarly succinct manner:

*It (nurse's negative reaction) didn't influence my ability to meet her physical needs.*Participant 10

Another participant described her physical care for a new mother with difficulties breast-feeding, this way:

*..Well, making her comfortable and...Yeah, I suppose in that respect I... yeah, I think probably just sort of setting her up and seeing if she wanted a drink and yeah, just making it as comfortable as possible for her feeding ... that physical care wasn't any different.*Participant 9

Not meeting the patient's psychological and sociological needs

Although most participants said that their provision of nursing care relating to

the patient's physical care was unimpeded, participants felt that their negative reactions impeded their abilities to address the patient's psychological and sociological needs. This was a significant part of the phenomenon of providing impeded care.

One participant described how her care was impeded by her not addressing the emotional needs of a patient with a narcotic addiction:

...emotionally I don't feel I gave him full emotional care I could've given him ... I don't think I gave him the opportunity to discuss with me any emotional problems he might have had. I carried out the care that I was ordered to do. Although I was still casual, I would talk to him, discuss... you know, what book are you reading, that looks interesting, but it would be very impersonal. The conversation would never get into a personal level or emotional problems. Participant 2

Another participant described how her care was impeded by her failing to address the patient's psychological needs:

... psychologically he probably didn't gain a lot from us either. The only thing we actually cared for was the fact that this chappie was sedated and we did everything in our power to sedate him as much as possible to keep him quiet down the end of the corridor. ... non-violent Yeah. Quiet and safe basically. But I'm sure that if we'd had some great aim or incentive, you know, and we thought we could cure this guy's psychiatric condition, that we might have virtually worked towards that, but we certainly didn't help any psychiatric condition. And I don't really believe that the psych nurses did either really. You know, we certainly didn't have an active plan of care for his psych treatment, which probably was his greatest need. Participant 3

This participant was sure that her reaction to the diabetic patient's severe wound

infection affected her ability to address his psychological needs:

That was definitely affected, I didn't attend to any of his psychological needs. I'm critical of other people when they do that and I was very critical of myself. Participant 4

Similarly, another participant described how his reaction to the patient with encopresis compromised his ability meet the patient's psychological needs:

I can look at the child's psychological needs and identify what those needs are, but then the compromise comes in. Participant 5

This response was echoed by another participant who, because she did not consider her patient's psychological needs, provided impeded care:

Well I don't think I had given her psychological needs any thought at all prior to that situation. ... Oh I don't think... I didn't care. I don't think I cared at all. I couldn't care... I couldn't give adequate care without considering their psychological needs, and to do that I had to be able to care from within rather than just cruise on through life. Participant 7

Frustration impeded this participant's ability to meet her patient's psychological needs:

Let me think. I don't really think that ... probably, I was getting as frustrated as she was mainly because she was finding it so difficult. So I don't think I met her psychological needs one bit. Participant 9

Not meeting the patient's spiritual needs

Earlier, participants had described their criteria for behaviours associated with the provision of good care. In doing so, several indicated that meeting the patient's spiritual needs was not a part of their usual nursing practice, or a factor in the provision of care that the participants classified as good nursing care.

Similarly, when describing their experiences of giving impeded care, participants also revealed that they did not address the patient's spiritual needs. However, this was perceived by the participants as not a major factor in providing impeded patient care, as the patient's spiritual needs were not considered in their usual nursing practice.

It is unclear whether this participant considered patients' spiritual needs in the usual course of his nursing practice. It is clear though, that when describing his experience of providing patient care that was impeded, spiritual needs were not considered:

No, I can't say that I was that concerned about his spiritual needs, and I don't think he was that concerned about his spiritual needs to tell you the truth. He was only concerned with his immediate needs. Instant gratification or whatever he wants! But you could see that he was in a vicious circle, I mean his psoriasis may have been... well, it was... the more manic he became the worse his psoriasis became. Vicious circle. Participant 1

Another participant also neglected the patient's spiritual needs, but did not see this as a factor in providing care that was impeded:

No, I don't think that it (considering spiritual needs) was applicable in this case. It's mainly ones that are ... seriously ill, dying..., or sometimes they've got a problem that surfaces in the middle of the night. They might... because night time's really good for talking to people. They can't sleep and everything's quiet and you're not busy, so you tend to sit down and they talk to you about things. Sometimes it is spiritual things that come out of it. Participant 2

This participant explained that the spiritual needs of her patient were not considered when she provided impeded care. Again, it is unclear whether the

participant considered patients' spiritual needs as part of her usual nursing practice.

We didn't even think about his spiritual needs. One thing is that I'm not sure that you'd actually get a chaplain in to that environment (fear for the chaplain's safety). So the other thing is that you'd have to think, would it be safe enough, you know, to bring some extra person in to the environment, but does it (the chaplain) really need to be there when we've decreased the sedation because it's not a particularly safe environment to come into. So our philosophy was to decrease to whatever level we could the amount of people that had contact with him. Participant 3

Another participant described how his negative reaction influenced his ability to consider the patient's spiritual needs. Again, it is interesting that spiritual needs were not considered with other patients, as a part of the usual care process:

Of course it (the participant's negative reaction to the patient's condition) has (influenced his ability to meet the patient's spiritual needs) ... that's a very interesting question because in the treatment process itself, spiritual needs are not formally addressed. Basically no. Participant 5

3.4 Awareness that impeded care had been provided

After providing patient care that was impeded because of their negative reactions to the patient's condition, participants had a spontaneous self-awareness that they had provided impeded care. There was a realisation in every case that impeded care had been provided and that this in itself was unacceptable to the individual participant's code of professional ethics and standards of nursing practice. It is significant that this awareness was not prompted by reactions or comments from their colleagues, patients or the patient's significant others. For some participants, this awareness translated into them being able to provide a better quality of care.

Awareness

One participant described her awareness that impeded care had been provided as follows:

...you walk out (of the patient's room after providing good care) and you know you've done a good job there, and you feel good yourself. But if you haven't covered all areas you don't feel comfortable. You walk out thinking now there's something I've missed. Sometimes you can't pick up what it is you've missed, but there is something going on: you do acquire it. As you get older you tend to be more alert to it... I think it would've taken me about 10 years. Participant 2

Another participant described his awareness of giving impeded care as follows:

It's implicit in that you're supposed to be caring and doing the best for the these kids and you are aware that you're not. Participant 5

Another participant said:

OK, the first strategy probably was to recognise the fact that I had done something that was outside of the Nurses Code of Practice, and probably... well, most definitely... outside the Nurses Code of Ethics. So to recognise that you had done what was not in the best interest of the patient ... Participant 7

Understanding, Improved patient care

Some participants found that the experience of providing care that they perceived to be impeded because of their reactions to the patient's condition, resulted in them subsequently being able to provide a better quality of patient care. One participant described her reaction as follows:

Now, I would just sit down and talk to the patient and tell him that this is because of this, then I'd go ahead and do the dressing. I think that once you've experienced one thing like that (reacting with repulsion to the diabetic patient's severe wound infection),

you can then go back in and cope differently. It's the shock of it though. Having spoken to you now, I would cope with it a lot better than if I hadn't spoken with you ... Yes I'd (be) much less critical (of the patient), ... you become more understanding. ... It was a good learning experience and I'm not sorry that it actually happened ... Because it made me look at things differently and how to deal with things and I think in hindsight I would have done it differently, but that's because I've learnt from it. I just wish I'd learnt to deal with it earlier at university and now I can speak to people face to face without the anger that I had then. Participant 4

Another participant described how she reacted to a patient's behaviour that was associated with a neurological condition, by slapping the patient's face. Her subsequent reflection on her unethical and illegal behaviour improved the quality of care she provided to that patient:

The first thing I did was I actually took the time, because I didn't care about her. When I slapped her I didn't care about her at all, and that was probably one of the reasons why I did it (slapped the patient's face) because I had no feelings for her. So I took the time to actually learn and to try and create some sympathy, if not empathy, for her in her situation. So I actually got to know her better. It was a specific point that I made myself go and do, was to spend time with her, not as a carer but as getting to know her from a personality so that I understood her more. ... I made an effort to know her better. I still didn't care for her, but I made an effort to try and understand a little more deeply where she was coming from. ... Ahh... I think I probably was closer to her than a lot of people in the long run, but I think if I hadn't slapped her I wouldn't have been. So I took the time to get to know her and to put myself in her place a little bit... However, once I had got to know her a little bit better I felt as though I could then provide

better support.

Another participant described how her experience of providing impeded care had improved her quality of patient care:

But the only thing that I can think about is knowing that with the experience that I've got now, that I've had, and looking back in hindsight at that situation, I'm a far better nurse now and I'm sure that... even from experiencing that and remembering what I went through with that, and thinking that you know I have to make it better for the next time. I never want to go through that again. Not in a pink fit. So, yeah, just reflecting on that and I suppose ... not wanting to experience ...just with what I know now and with my knowledge and experience I'm sure that I ... that situation will never occur again. I wouldn't allow it. Participant 10

3.5 Strategies used to cope with providing impeded care

Participants utilised specific strategies to cope with providing care that was impeded. They found providing impeded care an unpleasant experience and, as detailed earlier, reacted with feelings of frustration, fear, repulsion, sadness, helplessness and guilt. The data show that some of the strategies were employed to help the participants minimise the personal distress associated with experiencing these feelings. Other strategies were aimed at improving the quality of the care that they provided. In some cases, the distinction between the two types of strategies is clear, while in other cases the distinction is less obvious. Overall, the strategies that were employed were discussions with colleagues, arranging for colleagues to provide patient care, mental preparation, and the use of individual strategies.

Discussions with colleagues

Participants communicated with colleagues to cope with the experience of providing care that was impeded. As this participant graphically described, confiding in a resident doctor helped her to cope with her reaction to her diabetic

patient's severe wound infection:

But because I couldn't cope with the way he (patient) was, I left the room. The doctor came out at the same time and he said 'fuck I've never seen this, what are we going to do? I said 'We're going to have to go back in and kill those maggots' ... communicating with him (resident doctor) helped ... because we'd seen it together, but it was horrendous. The doctor was standing there stamping on the maggots: the only thing that helped was peroxide. Participant 4

In order to discuss his negative reaction to a patient with a trusted nursing colleague, one participant used the privacy of the nurses' station:

What we found over the years, we go in the nurses' office and discuss the issue, we sit and talk about it. I talk with colleagues in privacy yeah, but it's selective, it's selective who you talk and react with, just a few long standing colleagues basically, I don't tend to do it with new chums. I think I'm perpetuating this myth that all nurses can give every client good care ... It is, we've got to perpetuating that sort of myth. Again you're not comfortable talking with a new colleague. Participant 5

Another participant described her way of coping with her negative reaction to a patient with a neurological deficit:

I'd say step back and take time out and go and talk to other people always helps, you know, the tea room, it does help. Talking to colleagues. Because we've all been through it, and if you're really not coping you can get hopefully someone else to step in. Participant 8

Arranging for colleagues to provide patient care

Sometimes, participants' discussions with colleagues would result in the colleague providing nursing care for the patient. One participant described

arranging for a colleague to provide care for her patient:

*... there's only one nurse allocated to that patient, but you do have a coordinator who's hanging around. And I can remember getting her at the end of the shift to go in and take over (the patient's care) ... I can go in with you and so I let her manage it and I got to the stage really where I didn't really want to see her. I didn't want to see her again. It was just getting too much. I mean I was lucky that you know that there was somebody else around to take over at the time,*Participant 9

Swapping patients was also a strategy used to cope with providing impeded care by another participant:

*... sometimes you just can't stand them (patients), so you'll say to your friend that you're working with, can you look after his care and I'll look after so and so. You work it in so you don't look after that patient, someone else does. That would only have been on a few occasions with someone with senile dementia or Alzheimers who's climbing over the cot sides and trying to hit you with the walking stick and being absolutely revolting. And you find you get to the end of your patience, and that would be the only reason I'd ask somebody, look, can you just go and see what he's up to this time, I looked last time and he's just driving me around the bend. (laugh)*Participant 2

A female participant described swapping patients with a male colleague as a strategy to cope with her patient's inappropriate sexual behaviour:

*Sometimes you change patients if it gets too much of a problem, so you've actually refused to care for them and you swap with a male nurse.*Participant 3

Mental preparation

Participants used mental preparation as a strategy to minimise providing impeded care. A participant who reacted negatively to a patient's narcotic

addiction described her mental preparation:

I try and sort of psych myself up. If I go, I'll go in there without making a conscious effort, I'm going to say he's a waste of time, he's taking up my time, I could be spending it with another patient. So I say to myself, now, he is a patient, now you've got to do certain things so let's just get on and do them. Participant 2

Another participant described how she used communication skills that she learnt at university to cope with a psychiatric patient's aggressive behaviour as follows:

That's when you actually use like (sic) your assertiveness I guess. So you actually have to communicate your way out of the situation. Sometimes you negotiate a deal. So I've had... so hopefully you'll be able to relate... you know gain their respect basically by using assertiveness. ... that TA (transactional analysis) and assertiveness stuff, that actually helped heaps. Yeah, particularly aware of what I did, and to a certain extent TA is like second... you know, basically second nature when it comes to patients. Participant 3

Another participant had reacted so angrily to the behaviour of a patient that she had slapped the patient's face. She described her subsequent mental preparation to improve the quality of care that she provided:

The second thing I did was I sat down and I gave myself some time to work out what I was going to do, how I was going to do it, and what I expected to happen. So I took the time to actually learn and to try and create some sympathy, if not empathy, for her in her situation.

A coping strategy of this participant was described:

I suppose the only other thing I can remember doing is you know,

I was talking to myself, I was trying to talk myself into the... this is going to get better, trying to be positive about it. Participant 10

Individual coping strategies

Participants described individual strategies that they had used to cope with unpleasant patient behaviour. One participant described how she withheld pain relief from a patient to modify his inappropriate sexual behaviour toward her:

... and in one situation I had to just refuse pain relief basically, so you use what you've got and I had one chappie that made very, very strong sexual moves the whole way through the night, and then would buzz for pain relief, and one time he actually made all these lunges and sexual moves and then asked for pain relief, and I said well you can't be in pain if you've just moved that much in the bed, you may as well wait for rounds, I'm not going to answer your bell, and I just walked out of the room. And then he was fine after that, he was screaming in agony by the time I got back four hours later with pain relief, and we never had a problem after that point. So... but that was after quite a few attempts at finding some sort of ... some different way, and basically every other nurse had a problem with this chappie except for me, and I was the one that had withheld pain relief for four hours. So you actually learn some techniques to survive with I guess, and so whatever you've got to help you then you end up using basically, whether that be pain relief or providing for comfort needs, keeping them clean and turned or whatever, you've got fairly good negotiating power really. And in conversation you should be able to bring that to their attention without actually changing things, so often if I have a real problem I'll say, look, well I'm the one providing your pain relief, I'm the one turning you at night, if you make it uncomfortable I'm not going to be in here very often (The nurse has done this) on multiple occasions. (And the effect is) usually

successful ... usually... oh, very, very much so. You know they'll..... Yeah. They'll always respond... you know, respond in some way and say look, you can't do that, and I'll say, well, it's only me and you tonight, we're here for 10 hours, I can do whatever I want to do. Participant 3

Another participant described how she cognitively minimised guilt after she provided care that she perceived to be impeded:

Well I think don't feel bad about not giving 100% patient care. The patient either is loopy and doesn't know, and so what if someone doesn't get you know... sure they ... they'll survive. You just give them what you really have to and leave them to it. And people... the patients that are with us and it's their choice, or it's their personality towards you, then don't feel bad about giving them ... if their sheets haven't been changed that day, so what? If they haven't been washed for a day or two, so what? You know, it doesn't matter. Participant 8

One participant was repulsed by male patients who exhibited sexually inappropriate behaviour toward her. Her strategy for modifying the patient's inappropriate behaviour was to adopt a more formal demeanor. She described her behaviour as follows:

Well sometimes you get patients who are a bit slimy (laugh). A touch. Sexually. What I'd call being sexually abusive but in a very sneaky way, and the hands going up ... onto the backside. Or they talk dirty. And I just don't have time. ... it happens quite often, and it's a lot of older men that do it. Because they think they can get away with it because of their age. They don't know what they're doing. The slimy old fellow I had no time for at all. I also try and... I act more as a lady. I'll put on more airs and graces as though I'm a proper lady when I'm with him. So I bring myself up a level. And I find that approach does help at

times. But we do, we're human. Well if you act more like a lady I feel that you're not quite as reachful (sic). Is that a word? (laugh) I'm usually fairly relaxed and very informal with my patients because they're the sort of patients I've got. But I have looked after patients in private hospitals with titles and I find I've got to be a bit more.... More formal. So that's how I act when I've got a slimy gentleman. (laugh) Oh you didn't touch me. Participant 2

A strategy used by another participant was what she described as “sick” humour, as a means of coping with the behaviour of a demented elderly patient:

Yeah. But it still really... it annoys me that I treat her that way. Humour. Just by saying, oh come on, you're OK. You know, like sort of it's alright, it's not that bad. I remember one time she was on the floor and I called the ambulance and set her off to ... I think we sent her to (hospital A) ... and they said no, we want to send her to hospital B). I said no, (hospital A) is further away it'll take longer for her to come back. And just before I was leaving I said, well, have a good Christmas, and she said, oh, I won't be alive at Christmas time. And I said, ah well, then all your presents can be opened by someone else. And the ambulance people just looked at me like I was the worst person in the world, but when they brought her back they understood. They were just... but it's sick humour really that gets me through with her. Participant 6

One participant had trouble coping psychologically with a patient. He undertook activities away from work as a way of coping:

Outside of work, well, just relaxation things really. Fishing, diving, that sort of stuff. It was a conscious thing. To cope with him outside of work, doing leisure, relaxing leisure type activities, you're sort of taught certain techniques and that through your training for relaxation and reducing stress. A lot of

psych nurses do that. You have to when you're working in those areas otherwise you just don't cope. He was one of the... I mean there was a lot of other instances as well but he was one of the main reasons why I took off from (name of hospital deleted for confidentiality) and being a psych nurse. Participant 1

3.6 **Contextual factors impeding care**

The data from this research project describe the contextual factors within the environment in which the participants provided care that they perceived to be impeded, because of their negative reactions to the patient's condition. Factors included participants having an existing poor rapport with the patient, having had a bad experience previously with a patient who had similar characteristics and an absence of visits by the patient's significant others. Other contextual factors were participants experiencing chronic work stress, burnout, low staffing levels, time pressure, a lack of autonomy and a lack of clinical expertise. Other nursing staff reacting negatively to the patient was also an important contextual factor in the provision of impeded patient care. One participant felt that her disagreement with the patient's medical treatment exacerbated her negative reaction to the patient's condition.

Existing poor rapport

A theme that emerged from data of this research project was that participants' negative reactions to the patient's condition were exacerbated by an existing poor rapport with the patient. One participant had provided an impeded quality of care because of her negative reaction to a severe wound infection in her diabetic patient. As she described:

His rudeness, that's what made it (the participant's negative reaction) worse. He was rude over a preceding period and at the time itself. Participant 4

Another participant had provided care that she perceived to be impeded, because she reacted badly to her patient's degenerative musculoskeletal disorder. The participant described how her feelings of dislike for the patient contributed to her

negative reaction to the patient's condition as follows:

I think her borderline personality disorder was probably the underlying thing, she was a very unlikable person. She was a very demanding and yet dependent personality. Participant 6

An existing poor rapport with the patient was described as a contributing factor to another participant's negative reaction to a patient's condition:

And she didn't quite endear you to her which is one of those things that you shouldn't really react to, should you? Participant 9

Bad experience with a patient with similar characteristics

Participants were more likely to provide care that was impeded when they had previously had an unpleasant experience with a patient with a similar condition. This participant describes how she reacted negatively before even meeting her patient:

So, I guess if I hadn't had past experiences that have been bad, and if we had like sufficient backup, if we'd had some male staff on the ward at all times...It was a female staffed ward. No, it didn't help. The past experiences that I'd had with forensic patients had been bad. Oh they had been and that made the situation worse. Which meant that even before he arrived the first thoughts were the past experiences that I've had with forensic patients which had been bad experiences. And those bad experiences stopped providing the usual standard of care for them too obviously. The experiences that we had... one day we had a forensic patient that was also quite large and we'd decreased his sedation because he was going to theatre that day ... it was on the Orthopaedic Ward, and he'd... I think broken one of his shin bones, I'm not sure what he had done, but anyway he was going to theatre which meant that we had to decrease his medications so that we could wake him up and then sedate him properly for theatre. I mean he actually had two psych specials

*as well but he actually knocked the two psych specials out so he broke an arm and broke a nose of his two psych nurses and then proceeding to just throw things down the corridor. I wasn't there. But we actually had to call in for extra staff so I was called that day to come and provide backup as well just in terms of staff because the other staff had gone home in shock basically.*Participant 3

This participant felt that a factor in her negative reaction to the patient's behaviour was the patient's ethnicity. The participant had unpleasant experiences with other patients of similar ethnicity, who had exhibited what the participant considered to be similarly demanding and manipulative behaviour:

*It (the reason the participant acted negatively) might be that she's Anglo-Indian. Their cultural differences are really there, and we've had other Anglo-Indians (patients) who are exactly the same, demanding, manipulative, ... ah well she's Anglo-Indian.*Participant 6

Absence of visits by the patient's significant others

Patients to whom the participants reacted negatively often had few visits or an absence of visits from friends or family. As this participant described a patient who had received impeded care, because of the participant's negative reaction to the patient's condition:

*He was written off by his family, he'd given them so much trouble in the past that he didn't have any support network. The hospital was his support network.*Participant 1

This participant said of her patient:

*And we certainly didn't communicate well with him. And apart from that, he was there without family or friends, which is different.*Participant 3

A patient's lack of visits from significant others was also a contextual factor in this participant providing care that she perceived to be impeded:

She didn't really have any significant others, she didn't have family or friends that visited her. Her hairdresser visited her. Her husband used to visit on the odd occasion, she had no children. Participant 7

This participant usually included the mothers' partners when providing advice. However she noted that in the situation when she had reacted negatively to the patient's condition, that the patient was not visited by significant others:

No, in fact I can remember there wasn't anyone (visitors) around. There wasn't anyone there. The only thing... I mean that I was probably conscious of was just sort of making sure that you know that she talked with her husband about whether she wanted to continue breast feeding, but there was no-one there, not even visitors.

Participant 9

Chronic work stress, burnout, low staffing levels, time pressure, lack of autonomy

This participant described how his negative behaviour toward the patient was exacerbated by inflexible ward policy, shortage of staff and a lack of autonomy:

... the control ... places like the secure unit ... secure units, especially in (hospitals name deleted for confidentiality), they're hammered with policy ... in fact then it was (ward name deleted for confidentiality). It was routine and policy and procedure and so you were trapped with this guy as well because you couldn't allow him any rope. So you help treat his mania maybe, or get him off to one side, you didn't have the staff, you didn't have the ability to be able to say well OK (patient's name deleted for confidentiality), come into the gym with us now, you can stay back with such and such and we'll do something that may be

*beneficial for you. You couldn't do it. Because of policy he had to go. All for one and one for all. They all had to go. A lack of autonomy... So, there's my own physical nausea it's (the negative reaction) made worse by inflexibility nursing and hospital policy. Because you're on the line. This guy could put you on the carpet. If you refused him a telephone call because you've another 20 patients to move and he's saying well I need to make it now... and you're saying well you can't and he's saying but I have to. You know... or I'm not taking that medication.. So if we had more autonomy to make decisions, it would have been easier Underneath it all I don't think that he was that unreasonable, but the situation at he was in, and his condition, and the way we treated him because of his physical condition, made it worse. It created a vicious circle and his behaviour became worse because we weren't paying enough attention to him. It was the attention that he wanted, so you were forever in conflict with him. So he would then play up and you would have to restrain him.*Participant 1

The same participant described how his negative reaction was intensified by chronic work stress:

*I was left in the security unit for a long time because I was a bit bigger than most and ... so they left me there. And I got to the stage where I was just feeling like I was forever dealing with aggression, and that every day is stressful, wears you down. And it's aggression, it's continual abuse and in those areas, because I mean they're secure areas and the people in them don't want to be there and on top of it they've got psychiatric problems. So you get really a bad outlook.*Participant 1

Another participant described how her angry reaction was intensified by a lack of staff support and the lack of time to give individualised care:

I suppose really only that I didn't have a resource person handy

*at the time when ... When I needed it, and if I had someone there who was able to you know mentor me closely, but that's what you find, in some of these postnatal wards you know it was just flat out and you didn't time for the one to one.*Participant 9

Lack of clinical expertise, lack of preparation

Participants felt that a contributing factor to their reacting negatively to the patient's condition, was a lack of knowledge and skills to cope with the situation. As one participant commented:

*... so we go in there and we're going bang bang this is what you're getting, we're giving you your tablets, we don't want to know anything, and we're out of there. Whereas we should be learning to cope or discuss way that we can go in there and be pleasant to this lady.*Participant 6

Another participant expressed that she wished she had been taught during her pre-registration nursing course at university, to cope with her negative reaction to her diabetic patient's wound infection:

*Because it made me look at things differently and how to deal with things and I think in hindsight I would have done it differently, but that's because I've learnt from it. I just wish I'd learnt to deal with it earlier at university and now I can speak to people face to face without the anger that I had then.*Participant 4

Coping would have been easier, in this participant's view, if more information had been given on the Gregor Effect at university in subsequent semesters (beyond semester one) of the pre-registration nursing programme:

*I remember in semester one, the information you (researcher) gave us on the Gregor Effect stuck in my mind, If that had been extended on in subsequent semesters and substantiated ... then we'd be better prepared to cope with a situation like that.*Participant 3

Despite theoretical preparation, a lack of clinical practice contributed to this participant's provision of impeded patient care:

And you know thinking about the little bit of the theory that I did know behind it at the time and using it slowly ... the little that I knew. But then I hadn't experienced... you know, that was the theory, I hadn't really experienced the practice. Participant 9

The participant continued by saying that better preparation during her midwifery course would have improved her quality of care for the patient as follows:

I suppose I would've been much better off, in hindsight, if we had more preparation ... you know in the course. Right from the beginning. Whereas you know it was going in cold and dealing with it at the time while it was going on. I mean there were cases where I was actually helping (patients) ... and it worked, but there was no doubt that ... (when impeded care was provided) it was very difficult... Participant 9

Negative reactions toward the patient by other nursing staff

Participants felt that negative comments made by other nurses about the patient had resulted in the participants themselves providing care that was impeded.

This participant described her experience as follows:

And it's not listening to other staff's opinions until you've actually nursed the patient and have got your own opinion. Because that happens a lot. If you have a handover and they'll give you their opinion of this patient... oh he's a real bastard to look after. And you go in there expecting this real bastard and find that you get on fine with the patient. But it can influence you if you're not aware of it. ... so you say to yourself, well I'm not going to have an opinion about that patient until I've actually looked after him, or he's rubbed me up the wrong way, then I'll call him a bastard ... it happens an awful lot, especially with

verbal handovers, the staff actually... you don't discuss patients on the dictaphone when you do a recorded handover. You don't discuss them like you do verbally. So I find with verbal handovers they pre-judge patients, or discuss patients and what their opinion of that patient is, and you find you're forming the same opinion before you've actually looked after the patient. Participant 2

Another participant described how her negative reaction to the patient's condition was intensified by other nurses reacting similarly:

Every one had had the same willingness to do... to respond the same way, however, they probably were a little more experienced, and a little more tolerant, and maybe a little less assertive than what I was. Participant 7

A negative reaction by this participant to a patient was exacerbated by other nursing staff criticising the patient's behaviour at handover:

Other staff telling me what she's been like previous to me going in (contributes to the nurse's negative reaction) Some of the staff are saying, oh she's a real pain, she wants this done, she wants that done, and she knows I haven't got time to do it, but she'll go on and she'll ring the bell. And now she doesn't have a bell because she's ringing it all the time. And I feel guilty because I'm not the only one who feels this way ... Participant 10

Disagreement with the patient's medical treatment

Another participant described how her angry reaction to her patient's narcotic addiction was exacerbated by her disagreement with the doctor over the patient's medical treatment:

Yes, and I think it's the doctors that are to blame. The patients want it (narcotic drugs) more but the doctors do not stand up to the patient or try to find out why. They just admit them. And if you try and speak to the doctor the doctor says, look, I don't

care, you just give him what he wants, when he's had enough he'll go home. And you think, why am I doing this? And a lot of the staff feel that they're contributing to the patient's addiction by giving the injection. But then again it's an ordered drug, and being of the old school, you don't fight the doctor. ... I'm more angry at the way patients are being treated ...more or less at the doctor admitting that patient when I know there are other options available. There are pain clinics, I don't know the full range, but I'm sure there must be drug clinics available to help these patients if they have an addiction problem, or if they have a pain problem. But putting them into hospital and getting the nurses to give regular IM injections is not going to kill the problem. It's going to keep coming back, so I feel angry. Participant 2

3.7 The exhaustive description of nurses providing care that they perceive to be good care

When providing care that is good, nurses are physically close to their patients. As they perform nursing procedures with them there is time to do what is needed for basic care to be provided, and also time to provide care that is beyond the essential. In doing those extra things, such as helping patients with their hair, nurses have a physical presence that conveys that they will be there to provide care when patients need them.

Nurses use touch which they perceive provides reassurance to their patients and helps alleviate anxiety and fear. There is an inclusion of the patient's family in the provision of care and an especially strong and therapeutic rapport exists between nurses and patients. The lines of communication are open, and as nurses attend to physical needs of patients, they also intuitively acknowledge them as holistic beings and respect the importance of their psychological and social needs. There is also a recognition of patients' requirements for differing levels of autonomy when nurses provide care that they perceive to be good care.

3.8 The exhaustive description of nurses providing care that they perceive to be impeded because of their negative reactions to the patient's condition

Nurses provide impeded care when they react negatively to patients' conditions that they find frightening, disgusting or to which they have reacted negatively in the past. These negative reactions are manifest in varying ways. Some nurses are physically repulsed by their patients' conditions and are reluctant to touch them. This translates into delaying initiating interaction with the patients and in doing so reduces the effectiveness of the patients' care. When these nurses perform nursing procedures they convey the impression there is only time to deal with basic physical needs. This indicates to the patients that their nurses will not be there to care for them and in doing so further damages the poor rapport that exists between them. Others, despite their negative reaction to the patient's condition, provide a good standard of physical care but there is no provision of care beyond the essential, in that patients' social and psychological needs are unrecognised, considered to be unimportant or considered a waste of the nurses' available time. This also results in a deterioration in the existing poor communication between them, and as this occurs the needs of other patients are assigned a higher priority.

Often a vicious circle develops in which negative comments are made about patients by nurses' colleagues. This influences other nurses, some of whom are not even acquainted with the patients, to form negative perspectives of them. Absence of visits by patients' significant others contributes to the impression that the patient is an isolated figure without emotional or social links with the world beyond the clinical area. It seems that nobody cares.

As time passes nurses become aware that their provision of care is compromised because of their negative reactions to the patient's condition. They find this to be unsatisfactory and at odds with their personal and professional standards. The awareness does not come about from criticism or comments made by others. It occurs spontaneously. Sometimes it occurs while they are still providing care for the patient to whom they reacted negatively. However the awareness usually happens after the patient

has died or been discharged. Some nurses clearly recall decades later the events that occurred, usually with feelings of sadness at what has transpired. The nurses often perceive that they were poorly prepared to cope with the situation and that the work environment exacerbated their negative reactions. These negative reactions often occur in a setting in which the nurses perceive that they have a lack of flexibility in providing individualised care for their patient because of restrictive hospital policy, time pressures or disagreement with the patient's medical treatment.

With the awareness that impeded care was provided comes a determination that the situation will not be repeated. Often the awareness per se is sufficient to enable nurses to provide good care to other patients with similar conditions. Other nurses cope by discussing their difficulties with colleagues and by arranging for colleagues to provide care for other patients with similar conditions. Some nurses are so disturbed by the situation that they choose a career change and leave nursing, sometimes for good.

CHAPTER 4

4. Discussion

4.1 Introduction

The findings of this phenomenological study demonstrate that some registered nurses, at some point in their careers, provided patient care that they perceived to be impeded, because of their negative reactions to a patient's condition. The research informants' descriptions of their lived experiences of providing impeded care because of their negative reactions to the patient's condition, are sufficiently graphic and detailed that they will provide a significant contribution to the nursing profession's body of knowledge. The findings of this study have important implications for nursing education, nursing research, nursing practice, and nursing management and resourcing.

Despite an ethos within the nursing profession that nurses should not and do not react negatively to their patient's condition, the data from this study show this to be a fallacy. Frustration, annoyance, fear for own safety, revulsion, sadness and guilt were experienced by nurses who reacted negatively to the patient's condition. These negative reactions translated into negative behaviours impeding the provision of care. These behaviours included not being with the patient, not communicating well, and not considering the patient's psychological, sociological and spiritual needs. Three of the research participants also provided impeded physical care, but the other seven participants' lived experiences were that the patient's physical care was unimpeded.

The registered nurses were aware that they had provided impeded care. This awareness led to an understanding of the situation, the development of strategies to cope with providing impeded care and improved care in subsequent nurse-patient interactions. Coping strategies included discussions with colleagues, arranging for colleagues to provide care for the patient, and mental rehearsal for subsequent interaction with the patient.

A pattern of contextual factors influenced the situation in which the nurses found themselves. These factors were an existing poor rapport with the patient, a prior

negative experience with a patient with similar characteristics, an absence of visits by the patient's significant others, chronic work stress and burnout, time pressures, a lack of flexibility, a lack of clinical expertise with the patient's medical condition, negative reactions and comments by other staff toward the patient, and disagreement with the patient's medical treatment.

The findings of the study will be discussed in relation to pertinent literature. As no literature directly related to this phenomenon, studies with findings linked to the nurses' reactions and behaviours will be drawn upon.

4.2 Negative reactions experienced by participants

Annoyance, Anger and Guilt

Registered nurse participants in this study experienced reactions of annoyance and guilt when providing care that they perceived to be impeded. Often they experienced the reactions simultaneously. Other participants reacted first with annoyance and later with guilt when reflecting on their reactions of annoyance which they felt were inappropriate and incongruent with their personal standards of professional nursing practice. In some cases they were annoyed with themselves. More often the annoyance was directed at the patient or sometimes at colleagues, whom they also perceived to be providing care that was impeded because of their similar negative reactions to the patient's condition. Amongst some informants of this study there were retained feelings of guilt about reactions and behaviours that had taken place 20 and 30 years earlier.

These findings have congruence with work by Kushner, Rabin and Azulai (1997) who reported that anger was a recurrent theme in clinical practice amongst paediatric oncology nurses. Their study found that efforts to conceal and/or suppress this anger was a major source of stress amongst research participants, and that suppression of anger was linked to burnout. Often the guilt remained with them for years after the event. In both Kushner et al and this study nurses experienced anger toward themselves and in some cases toward colleagues because of their involvement in aspects of patient care that they considered to be wrong. These feelings impacted upon their personal and professional lives.

Fear for own safety

Another reaction that two participants of this study described was fear for their own safety. They freely described how the patient's condition threatened their own physical well being which impeded the participants' provision of good care. This fits with the model by Maslow (1962) which describes a taxonomy of human needs with physical survival needs at the base of the taxonomy. Participants of this study who experienced fear for their own safety could not provide good care for the patient while they felt physically threatened. Both participants felt that they were given inadequate protection by the hospital system from the threat of violence by the patient. In both instances later events showed their fears to be well founded. One patient who suffered from severe psoriasis and mania later seriously injured a member of the nursing staff before committing suicide. The other patient broke the arm of a nurse providing care for him.

Lobell (1999), in studying registered nurses' responses to sexual harassment by patients, described responses that are similar to the findings of this study. One of the emotional response themes that emerged from the data was that registered nurses experienced fear for their own safety, as well as shock, disgust, embarrassment, hurt and discomfort. The nurses also acknowledged that in several of the incidents their reactions to the patient's sexual harassment affected the quality of care provided to the harassing patient.

In a related study Bennett (1998) found that a significant proportion of nurses react with fear for their own safety when providing care to patients with AIDS, due to possible contamination of themselves, and that this fear is rational and appropriate. This, she argues, is because there is a real risk of contamination if universal precautions are not followed by the nurses, and the fear motivates adherence to the universal precautions. The reactions of fear by the participants of this study were also rational and appropriate as there was a very real risk that their patients would physically assault them. However, the appropriateness of the avoidance behaviours adopted by the participants of this study is harder to judge. No-one should be subject to physical assault as part of their nursing practice, yet their avoidance behaviours in two instances put the patients' lives at risk.

Revulsion

Reactions of revulsion to the patient's condition were experienced by four of the research participants. Two of the participants' reactions were as a response to their patient's physical conditions of psoriasis and an infected gangrenous wound infection. One patient was suffering from severe psoriasis with skin that peeled off when touched, and fluid that oozed on to the chair on which the patient had been sitting, and then flowed down on to the floor. The research participant described feeling nauseated when interacting with this patient. Another patient with poorly controlled diabetes mellitus had a severe lower limb wound infection that had a very offensive odour and was infected by maggots. The nurse was so repulsed by her patient's condition that she experienced dry-retching. Another participant expressed revulsion to the patient's recurring self destructive behaviour and another was repulsed by a combination of physical, behavioural and social circumstances associated with his patient's condition of oncopresis.

All four participants described how their reactions severely impeded the quality of care that they were able to provide. These reactions translated into behaviours of being unwilling to touch the patient, avoiding spending time with the patient and ignoring the patient's social and psychological needs.

A search failed to identify any literature echoing the finding that nurses are sometimes repulsed by their patient's medical condition. However, a paper by Richmond and McKenna (1998) claimed that some nurses experience disgust at homosexual patients' life-styles and that this reaction compromises the quality of nursing care that these patients receive. They argued that despite an holistic and unprejudiced approach to clients being widely endorsed within the nursing literature, the degree to which this approach has been integrated into nursing practice remains subject to nurses' attitudes towards certain individuals or groups. A conclusion of the Richmond and McKenna (1998) study is that homosexual patients are often subjected to bias from nurses and, as a result, receive impeded health care.

Although not using the term “revulsion” Lawler (1991) argued that there are certain aspects of dealing with patients' wounds and body secretions that nurses find emotionally disturbing. She expressed the view that because nursing literature and theory did not tackle this issue, nurses are taught to cope with distasteful or repugnant aspects of the patient's condition informally, in the clinical setting, by role modelling from more experienced nurses, who earlier in their careers were taught to cope by the similar means. This supports a finding of this study that one of the participants expressed the view that her university education, with less clinical exposure than the previous hospital apprenticeship model, had her unprepared for a distasteful aspect of a diabetic patient's care.

de Paula, Moreira and Silva (1999) found that nurse education is not adequately preparing students emotionally for aspects of clinical practice. Their study obtained descriptions of respondents' feelings when providing care for their patients. Respondents described the seemingly contradictory feelings of sadness and satisfaction in the clinical area and frequently emphasised not feeling prepared either technically or emotionally. The authors suggest there is a need to reconsider professional nurse preparation, both technically and psychologically, in the light of their findings.

Sadness, Helplessness and Guilt

Three participants of this research project experienced reactions of sadness, helplessness and guilt which accompanied the awareness that they were reacting negatively to the patient's condition. One participant felt both saddened by her reactions and helpless that there was nothing she could do to rectify the situation. Another expressed feelings of helplessness at her inability to control her negative reaction, and also felt guilty that she was providing a standard of care that fell below her own personal and professional standards.

Palsson & Norberg (1995) conducted a study which described the lived experiences of 23 Swedish district nurses who narrated 147 difficult care situations. Among the themes that emerged in the analysis of the stories are a number that are congruent with the findings of this study: conflicting opinions over patient's treatment; feeling powerless;

feeling disgust, shame and guilt; relationships with patients' families; and communication gaps. The findings strongly emphasise that district nurses experienced problems in the home care of seriously ill patients. The authors of the study state that it is important to form support groups to help district nurses deal with demanding care situations and to relieve them of negative feelings and thoughts aroused in the provision of care. The authors conclude that support in the form of clinical supervision may impact on the quality of care in a positive manner.

4.3 Personal behaviours that nurses associate with providing care that was impeded

The negative reactions of participants in this study to the patient's condition translated into behaviours that impeded the quality of care they provided.

Not being there, spending less time with the patient:

A theme that emerged from the findings is that research participants provided impeded care for their patients by avoiding them. All ten participants described how they spent less time with their patients than they felt was appropriate for the patient's situation. Participants also readily related how their avoidance behaviours compromised their patient's well being. As noted in the previous section, for some participants the avoidance behaviour was motivated by a fear of being physically hurt by the patient. One participant graphically described how she gave impeded care to an acutely ill patient with an unstable and potentially life-threatening cardiac condition, poorly controlled psychosis and a history of violence toward nursing staff. When admitting the patient to the ward, she positioned him further away from the nurses' station than was usual which compromised her ability to monitor his condition. She also assigned a lower priority to his needs compared to the needs of other patients and thus delayed his treatment. It is clear when considering that her patient had a serious and unstable cardiac condition that the participant's actions endangered his life and were a dereliction of her duty of care. Another participant of this study who also feared for his safety from the possibility of patient violence, said that on reflection he later realised that he had avoided the patient and had at the time provided impeded care for the patient. He had inappropriately justified his avoidance behaviour to himself by considering his patient's needs to be of a lower priority than those of other patients.

Other participants of this study described how they avoided their patient because they found the patient's condition repulsive. For two participants the revulsion stemmed from their reactions to the patient's physical condition. Both participants who were providing care for these two patients described avoiding their patients for periods of time that they considered significant and detrimental to their patient's well being. Similarly, other participants of this study recalled how they had avoided the patient despite knowing that their presence was in the patient's best interest. One of these participants described how, because of her negative reaction to the patient's degenerative neuromuscular and mental condition, her patient was left alone in her room even though the participant felt that the patient would benefit from the nurse being with her.

Another participant avoided the patient for a different reason entirely. She had been so angry at her patient's confused mental state and unco-operative behaviour that she had once slapped the patient's face. This was an unpremeditated and spontaneous act. The participant was immediately shocked at what she had done and her initial response was to avoid the patient as it seemed to be in both parties' best interest. Interestingly, when she later collected her thoughts and realised the legal and professional implications of her behaviour, and that her previous action was personally and professionally unacceptable to her, she purposefully made efforts to establish a better rapport with the patient and was able to provide her with what the participant considered to be an improved quality of care.

A disturbing qualitative study involving 103 in-depth interviews of South African maternity patients by Jewkes and Abrahams (1998) found that many of the patients reported verbal and physical abuse from nursing staff. While acknowledging this study examined the provision of poor care from the perspective of the patient rather than the nurse, the abuse described in the Jewkes and Abrahams study was sometimes a nurse's reaction to a patient's unco-operative or abusive behaviour. However, their study also found that at other times, the abuse of patients by nurses was ritualised in nature and had become a part of the nursing ethos within the health care systems of developing third world countries in the region.

Patistea and Siamanta (1999) conducted a literature review of what constitutes caring and non-caring behaviours from nurses' and patients' perspectives. Their review showed that whereas nurse clinicians focus on the psychosocial aspects of caring, which are centred on nurses spending time with their patients, patients assign the highest value to technical skills and professional competence. Similar to the findings of this study, a non-caring behavior described by both nurses and patients was physical and emotional absence from the patient. Coulon, Mok, Krause and Anderson (1996) explored the meaning held by nurses of excellence in nursing care. In their study, in which qualitative data were collected from 156 undergraduate and postgraduate nursing students by means of an open-ended questionnaire, respondents were asked to reflect on practice which enabled a clear understanding of the meanings given to excellence in nursing care. A theme that emerged from the Coulon et al study that is relevant to this study is that the provision of good nursing care requires the nurse to consider the patient to be the central focus of care delivery and that adequate time spent with the patient is essential in developing a therapeutic nurse-patient relationship.

Not communicating well, having less rapport

Another theme to emerge from the data was poor communication. All ten research participants reported communicating less therapeutically with their patients than they did with other patients. This led to a quality of rapport between the participants and their patients that was poor relative to that which was usually established. One participant reported that in addition to spending less time with her patient, she was less understanding of his needs, less friendly and "brisk" in her behaviour. Impeded listening skills were described by all participants and two participants reported that they prematurely terminated conversations that were initiated by their patients. The participants used words such as "I close off", "I stop listening", "I say you must take this". It was clear when reviewing the interview transcripts of participants that central to their impaired communication with their patients was the participants' move away from open-ended and non-directive styles of interaction, and a move toward more closed and directive communication styles. In doing so, the participants determined the "agenda" of the conversations that occurred with their patients and simultaneously

discouraged patients from expressing their needs and feelings (Porritt, 1990).

The finding of this study that participants used poor communication skills and established a poor rapport with their patients, which they perceived diminished the quality of their nursing care, has congruence with a literature review by Caris-Verhallen, Kerkstra and Bensing (1997). With regard to the role of communication in nursing care for elderly people, they argued strongly that nurse-patient communication is central to the provision of good nursing care. An important finding in their review was that providing good nursing care involved the nurse establishing a rapport with the patient that is characterised by intensive meaningful dialogue. Their review also acknowledged that at times, nurses excluded the patient and were concerned only with doing tasks. In these cases, nurse initiated verbal communication with the patient was absent or restricted to that necessary to get the job done. This is congruent with the findings of this study in which most participants reported that when providing care that they perceived to be impeded, physical care was unimpeded, yet the provision of care to address the patient's psycho/socio/spiritual needs, all of which require meaningful nurse-patient dialogue (Porritt 1990) was absent. Rundqvist and Severinsson's (1999) findings that patients who nurses find less attractive receive a diminished standard of care, as nurses adopt a position within the nurse-patient relationship that results in increased social distance, has links with the findings of this study, where participants have avoided their patients.

Giving the patient good physical care

Participants of this study discussed whether the physical care that they had provided to their patients had been impeded because of their negative reactions to the patient's condition. Seven of the ten participants were clear that their physical care was unimpeded and that it was other aspects of the patient's care that were compromised. Three participants however, described how their provision of physical care to their patient was impeded because of their negative reactions.

Those who described giving the patient good physical care, despite their negative reactions to the patient's condition, had met the patient's biological needs as well as

they would for a patient to whom they had not experienced the negative reaction. Most participants used terminology such as “physical nursing care was not affected” and “physical needs were taken care of”. They expressed themselves very clearly and unambiguously when making these comments. In fact, two participants manifested surprise when asked by the researcher if their ability to meet the patient’s biological needs were impeded by their negative reactions to the patient’s condition. They succinctly explained that it was the patient’s “other” needs that were not met. When asked to elaborate the participants clarified that the “other” needs were the patient’s psychological and social needs.

However, there were three participants of this study who were equally clear that their provision of physical care for the patient was impeded by their negative reactions to the patient’s condition. They were reluctant to touch the patient. In two instances although physical care was needed, none was given. The third participant held a position of seniority and was able to arrange for a junior colleague to attend to the patient’s physical care.

An important philosophical stance embraced by the nursing literature is holism. The general consensus of the nursing profession is that when good care is provided, the whole patient, including his/her physical, spiritual, emotional and cultural needs are cared for (Coulon et al, 1996). It is clear from this study that holistic nursing care is not always provided.

Not meeting the patient’s social and psychological needs

As mentioned above, not meeting the patient’s social and psychological needs was a theme in providing care that was impeded. All ten participants failed to address these needs of the patient when giving care. Their negative reactions to the patient’s condition caused them to forget that the patient had social and psychological needs. Although they were usually aware of other patients’ needs to be in a social setting within the ward environment that was appropriate for them, participants found that when providing care that was impeded, they omitted to see the patient as a social being with a need to socialise within the hospital setting and to interact therapeutically with

visiting friends and family.

Many of the patients who received impeded care from the participants in this study were seriously ill with medical conditions that had poor prognoses and shortened life expectancies. Whereas the participants would normally be sensitive to other patients' psychological needs, they found that when providing impeded care their patient's psychological needs became invisible. The patient's expression of feelings of fear, anxiety, frustration and helplessness were unnoticed by the nurses or went unheeded. Other patients' expressions of these feelings would usually be identified and nursing measures would be implemented to lessen the patients' feelings of distress. These measures include providing reassurance to the patient and encouraging the verbalisation of these feelings (Porritt, 1990).

Whereas good nursing care involves nurses empathising with the patient and having genuine concern for the patient's well being (Watson, 1985), impeded care lacks this element. As a result the patient's psychological needs were ignored by nurses or the needs were considered unimportant. Eight of the ten participants of this current study experienced significant feelings of guilt for reacting in this manner to the patient's condition as it conflicted with their personal and professional code of ethics and was contrary to the nursing ethos. This finding has implications for nursing education programs.

Not meeting the patient's spiritual needs

The participants in this study said that they did not feel that it was a part of their role in providing good patient care to address the patient's spiritual needs. It was described by the participants as not usually considered in their plan of care. Unlike addressing the patient's biological, psychological and social needs, which participants viewed as central to their role in providing good care, addressing spiritual needs was not considered to be a part of providing good care.

This conflicts with informal observations in the clinical setting made by the researcher who has often witnessed nurses addressing patients' spiritual needs. He has seen nurses arrange for patients to be visited by members of religious orders and when doing so,

ensure that the minister contacted is appropriate to the patient's usual religious practices. He has also observed nurses using communication skills that encouraged patients to express their religious or spiritual views and to express the relevance that these views have for them. The genuine respect that the researcher has observed nurses give to a religious minister attending children and their families at a Perth paediatric oncology unit demonstrates to him that nurses do consider that patients' spiritual needs are of importance, and that these spiritual needs are considered by nurses when providing good nursing care. This view is supported by Ross (1997) who argued that the spiritual dimension is becoming increasingly prominent in the provision of nursing care.

This incongruence between the descriptions of the research participants and the observations of the researcher has a number of possible explanations. One is that the term "spiritual needs" is not part of usual hospital vernacular. It is, however, a term that is widely used in the literature. Nursing schools also describe holistic nursing care as meeting the patient's biological, psychological, sociological and spiritual needs, and similar nomenclature is used in popular foundation nursing texts (Kozier et al, 1995). For these reasons this term was used in the interview guide. It is probable that the phrase "meeting the patient's spiritual or religious needs" is preferable and if it had been used in the interview guide it may have elicited responses from the participants that are more in keeping with what the researcher has informally observed in the clinical setting

4.4 Awareness that impeded care had been provided and providing better care

Two themes that emerged from this study were a spontaneous awareness amongst research participants that impeded care had been provided by them, and that they subsequently provided improved patient care. The improvement in care resulted from participants' self reflection and by them then taking measures to exercise more control of their own nursing practice.

Awareness

Participants freely discussed a spontaneous awareness that they had provided impeded care. None of the participants became aware of the matter as a result of comments made

to them by other staff, the patient or the patient's significant others. Participants realised that the impeded care was unacceptable to their own individual code of professional ethics and standards of nursing practice.

Usually, the spontaneous awareness occurred as they left the patient's room. For other participants, the awareness happened after they had ceased contact with the patient, usually because the patient had died or been discharged, and when the participants were reflecting on the unsatisfactory interaction that had occurred between them and the patient.

Understanding, improved patient care

Participants found that their awareness of providing poor care resulted in them subsequently being able to provide a better quality of patient care. They found that by reflecting on their negative responses to the patient's condition and the impeded nursing care that they had subsequently provided, their provision of care improved. For some participants the quality of care improved for the particular patient to whom they had reacted negatively. Self reflection enabled them to empathise with the patient's situation, to be more understanding and compassionate, and to take a more holistic approach. A better rapport between the patient and the participant was a key element of the improved provision of care. Other participants were able to reflect on their responses after their contact with the patient was over. As time passed, self reflection led them to be better prepared when subsequently providing care for a patient with a condition similar to that to which they had reacted negatively. Participants reported that subsequently their negative reactions were less intense, and that the standard of care they provided was better.

This use of reflection is supported by Rashotte, Fothergill-Bourbonnais and Chamberlain (1997). Their study of the grief experiences of paediatric intensive care nurses found that participants identified that there had been certain deaths that continued to haunt them. Self-reflection helped them to come to terms with a child's death and to cope with their exposure to deaths in the future. Through a process of reflection they had learned to understand how they had reacted inappropriately to the death of a child

and to identify what factors of the death affected their grief response. Self reflection also helped the participants to understand which coping strategies helped them manage their grief. These findings support the data of this study which show that self reflection enabled participants to provide improved care in situations where care had previously been poor.

4.5 Strategies used to cope with providing impeded care

Discussions with colleagues

A number of participants of this study used informal discussions with colleagues as a means of coping with the realization that they had provided care that they perceived to be impeded. One participant used the privacy of his office to discuss his negative reactions with a trusted colleague. He made the point when being interviewed that he never discussed, and therefore never admitted to new staff, that he was providing care that was impeded. In saying so, he spontaneously acknowledged that he was “perpetuating the myth that all nurses can give every client good care.” Another research participant used informal discussions with nursing colleagues in the staff tea room as a means of coping. In the situation where both the resident doctor and the nurse had to leave the room to deal with the diabetic patient’s maggot infested wound, the nurse’s coping strategy before returning to the room and resuming treatment for the patient, was to express her revulsion to the resident doctor. He was similarly repulsed by the maggot-infested wound and they both found that confiding was made easier because they had both experienced the same situation. They quickly formulated a plan and resumed their treatment of the patient.

Arranging for colleagues to provide patient care

An outcome of the participants of this study discussing their negative reactions to the patient’s condition with colleagues, was that the colleagues would sometimes offer to assume the care for that patient. Interestingly, patient conditions that individual participants found repulsive or annoying often did not have a similar effect on their colleagues. The colleagues would offer to take the patient as part of their caseload because they were unperturbed by the patient’s condition. Swapping patients was a related coping strategy that was used by participants. Sometimes the participants had

been providing care for the patient for a number of shifts and felt the need for a break from the patient.

Barton (1999) supports these findings in a study which found that a crucial factor in the successful treatment of TB patients is flexibility in case (patient) assignment to staff. When difficulties were experienced or anticipated with patient compliance with the anti-TB drug regimen, interdisciplinary staff meetings were held and the registered nurses who were visiting the patient would decide who was best suited to continue visiting the patient. This fits with the findings of Gibbon (1999) who wrote that the effective delivery of health care to stroke patients requires the use of team work and that this is facilitated via the use of team conferences which discuss among other things, the allocation of a specific team member to a particular patient's care. Although the participants of this current study did not use formal meetings to achieve this result, they did informally initiate collegial conversations to discuss the possibility of swapping patients with colleagues.

Mental preparation

Some participants used mental preparation as a strategy to minimise providing impeded care. They described "psyching themselves up" and "trying to be positive". They exercised self-control over their negative reactions so as to lessen the degree to which their care was impeded. One participant was providing care for a patient whose psychiatric condition caused the patient to exhibit aggressive and sometimes violent behaviour. She responded to his behaviour by avoiding him and ignoring his psychological and social needs. To improve her standard of care for the patient, she mentally prepared herself for their next interaction by recalling transactional analysis and assertiveness techniques that she had learnt during her nursing education at university. Her experience was that using these techniques lessened her negative reaction to the patient's condition and consequently improved her nursing care for that patient. It is of interest to note that, in contrast to earlier comments about education programs not preparing graduates for these situations, this was an example of relevant knowledge and skills from such a program being used.

Individual coping strategies

Other coping strategies were specific to individual participants. One participant used what she described as “sick” humour as a means of coping with the behaviour of a demented elderly patient. The use of humour helped the research participant in two ways. It helped her personally to cope with her negative reactions to the patient’s demented behaviour and it also was a vehicle for light hearted communication with the patient. The study by Rashotte et al (1997) found that several of the participants spoke of using humor, especially “black or gallows” humor as a means of coping with their emotions. They also found that humour served two purposes for the research participants of their study. It served as a means of enabling them to retain control of their emotions and also permitted them to release some of their emotions in a manner that was more personally acceptable to them in this environment.

Unlike the individual in this study however, the participants in the study by Roshette et al, because of the terminal nature of the patient’s condition, used the humour only privately with colleagues so as not to offend or upset the patient or significant others. In agreement with these findings is the research by Struthers (1999) who found that the spontaneous use of humour by nurses, although potentially damaging to the nurse-patient relationship if the patient perceived the humour to be inappropriate, was an effective therapeutic means of enhancing the quality of nursing care. As this study did not include the patient's perspective there are no data on how the participant’s use of humour was perceived by the patient although the participant viewed it as helpful to their relationship.

4.6 Contextual factors impeding care

A number of common contextual factors influencing the provision of impeded care emerged from analysis of the data. There was a wide range of clinical areas in which the participants were working, and in their years of experience. Also, there was a variety of medical diagnoses and the conditions from which their patients were suffering. Despite these variations, impeded care was provided within work environments that had many similarities. Participants freely described work-place situations which had comparable features. This suggests that the contextual factors within the work environments

contributed to the nurses providing impeded care and that the environmental milieu strongly influences nurses' reactions to their patients' conditions.

Existing poor rapport

An existing poor rapport between the nurse participants of this study and the patient was an important contextual factor in the nurses' negative reactions and subsequent impeded care. This is because their negative reactions were exacerbated by poor rapport. One participant had been offended by a patient's rude behaviour over a period of time prior to the experience that she described, when she reacted negatively to his severe diabetic wound infection. She volunteered that she was sure the patient's rudeness had made her reaction to his physical condition worse. Another participant described how her dislike of her patient's personality had contributed to her negative reaction to the patient's physical deformities, which were caused by a progressively degenerative musculoskeletal disease.

Previous negative experience with a patient with similar characteristics

Another interesting finding of this study was that participants were more likely to provide care that was impeded when they had previously had a less intense but nonetheless unpleasant experience with a patient with a similar condition. One of the participants of this study reacted negatively when she read of the patient's medical diagnosis before she had even seen or met the patient. Her negative reaction translated into behaviours that included delaying admitting the patient which she would normally have done immediately and regarded as urgent. Another participant felt that a factor in her negative reaction to the patient's abnormal behaviour was the patient's ethnicity. The participant had previous unpleasant experiences with other patients of similar ethnicity, who had exhibited what the participant considered to be difficult to manage behaviour.

This finding could be regarded as incongruent with a previously discussed finding of this study which is that an awareness by the participants that impeded care had been provided led to a subsequent improvement in the care provided, either to the patient who was receiving care at the time, or to subsequent patients with the same condition. An explanation of this seeming incongruity is that participants' previous negative reactions

were less intense and not sufficient to cause them to provide impeded care at the time. However the nurse had been disturbed by the experience and then provided impeded care to subsequent patients with the same condition.

A study by Lobell (1999) found that an event that damaged rapport between the patient and the nurse providing care formed the basis for subsequent negative reactions and behaviours by the nurse toward the patient and in some cases to other patients as well. Participants who had been sexually harassed by patients reported that they experienced feelings of disgust, fear, embarrassment, hurt and discomfort and that their subsequent provision of nursing care was reduced in quality and quantity. In the Lobell study, three of the fifteen registered nurse participants reported avoiding contact with the patient, two nurses reported having only minimal contact with the patient after the sexual harassment event and two other nurses refused to care for the patient after the event occurred. All seven reported that their subsequent provision of care to other patients of the same gender and ethnicity as those who had harassed them, was of a lesser quality.

Absence of visits by the patient's significant others

In this study a contextual factor which was conducive to research participants reacting negatively to the patient's condition, and subsequently providing impeded care, was an apparent lack of concern for the patient's welfare by significant others. This was demonstrated by behaviour that the research participants perceived to be non-caring. For two of the participants this was manifested by negative comments about the patient by significant others when visiting the patient. A more frequently recurring theme was that the patient had very few visitors or a complete absence of visits from significant others. The patients appeared to have no one outside the hospital who cared for them or were advocates for their well being. It was as though the significant others' seeming disinterest in the patient's well being exacerbated the participants' negative reactions to the patient's condition.

Chronic work stress, burnout, low staff levels, time pressures, lack of flexibility

Another influencing factor within the context in which nurses provided patient care that was impeded, was inflexible ward policy and a lack of flexibility for registered nurses in

planning and delivering patient care. There was incongruity between the way the participants felt that care should be provided, and the way that the hospital policy directed that care should be provided. This led to a restriction of the nurses' ability to provide patient care that they felt was suitably individualised, which in turn led to feelings of frustration and contributed to the research respondents' negative reactions to the patient's condition.

An example is the research participant who was providing care for a patient with severe psoriasis, poorly controlled mania and a history of violence toward nursing staff. In the participant's clinical judgement, it was appropriate to allow the patient telephone contact with his significant others, as the patient had repeatedly requested. Otherwise, severe patient distress and violence toward himself, other patients and nursing staff was considered an imminent probability. Unfortunately, ward policy did not allow the telephone call to be made and the patient responded with violence toward the participant and other colleagues. This exacerbated an existing poor rapport between the patient and staff, and increased negative staff reactions to the patient. In another instance in this study, a participant felt resentment toward her patient's inability to breast feed when obliged to continue with unsuccessful attempts which distressed the mother and baby. There was incongruity between her clinical assessment that attempts were unlikely to succeed and ward policy which indicated that attempts at breast feeding should continue.

Rochette et al (1997) found that a significant contextual factor in their study of nurses' grief response to babies who die, was a dissonance between policies and procedures of the organisation and beliefs of the research participants regarding the care of the deceased. For example, in coroners' cases many of the required procedures interfered with how they wanted to care for the child after the death. Nurses were not able to remove tubes so that the family could hold the child or touch the child in the same manner as they would have without all the equipment. Another example related to the shrouding and preparing of the body for transportation to the morgue. The practice of wrapping of the bodies in plastic, the tying of the limbs together, and the placing of infants in a suitcase-like structure for transportation were all considered disrespectful,

inhumane, and dehumanising activities. Unlike this study in which the nurses' negative reactions were to the patient's condition, the nurses in the Rochette et al's study reacted negatively to hospital procedures. There is a link between the two however, in that participants' negative reactions were exacerbated by a lack of flexibility in delivering individualised care which contributed to the participants providing care that they perceived was not in the patients', or parents' best interests.

Lack of clinical experience and/or lack of preparation

A lack of clinical experience related to the patient's condition was a contextual factor identified by five participants of this study. This lack of experience contributed to the participants' negative reactions and to the provision of patient care that was impeded. They lacked the clinical knowledge and skills that they felt they required to cope with the situation. Interestingly, participants described how they were able to better cope when providing care for subsequent patients with the same condition. They had gained insight and learned to cope while providing impeded care for their previous patient.

Two participants of this study expressed regret that they had not been better taught to cope with these types of situations during their pre-registration university courses. Another participant felt that despite having gained sound theoretical knowledge of how to cope with the patient's condition, her negative reaction to it was enhanced by a lack of clinical experience. Other participants felt time pressures contributed to their negative reactions to the patient's condition. Two participants felt a lack of time for them to prepare and plan the provision of care for the patient. They felt that time pressures denied them the opportunity to discuss with colleagues aspects and strategies for providing care, and that their poor preparation contributed to their negative reactions to the patient's condition.

Congruence exists between the findings of this study and those of the qualitative study by de Paula, Moreira and Silva (1999) who examined the feelings of nurses toward the handicapped. A major theme to emerge from their data was that registered nurse respondents described feeling that a lack of adequate preparation either technically or emotionally had hindered their provision of good quality nursing care.

Negative reactions toward the patient by other nursing staff

The participants considered that hearing nursing colleagues make negative comments about the patient had contributed to the participants' own negative reactions to the patient's condition. One participant expressed an awareness that judgmental comments made about a patient by colleagues at handover could influence her to react negatively to the patient's condition before she had even met the patient. She described how she talked to herself prior to her initial meeting with the patient, to avoid adopting the same negative opinions as those of her colleagues. Another participant expressed feeling of "sadness" when she found herself echoing the negative reactions of her colleagues to the patient's condition.

Several other studies have found that people have a tendency to stigmatise patients who have certain conditions and that this stigmatisation impacts negatively on the quality of treatment that the patients receive. For example, Peters, den Boer, Kok and Schaalma (1994) addressed the issue of stigmatisation and discrimination against patients with a variety of medical conditions. Their study found that although there was a tendency for research subjects to react negatively to patients with conditions that were perceived by the research subjects to be the result of patient behaviour, such as non-medically acquired AIDS, other variables such as the incurability of the disease, the risk of infection and associations with homosexuality, may be more useful in explaining the research participants' negative reactions.

Disagreement with the patient's medical treatment

For two of the participants of this study, a clashing of their beliefs of how the patient should be treated, and of their perceptions of how the patient was being treated, emerged as important contextual factors influencing the impeded care they provided. One research participant was providing care for a patient who was being treated medically for a narcotic addiction by the administration of regular, four-hourly intramuscular injections of the narcotic drug Pethidine. She experienced anger, which was simultaneously directed towards herself, the doctor and the patient, because of a clash of two co-existing and contrary values. On the one hand, she felt a professional and legal

obligation to administer the drug as it was prescribed. This was incompatible with her view that the regular administration of Pethidine was doing nothing to help the patient with his addiction, and was in fact exacerbating his problem. Subsequently, her negative reaction worsened her rapport with the patient, which in turn impeded the quality of care that she provided.

Another participant also experienced a co-existence of contradictory views which he perceived to impede the quality of nursing care that he provided. His patient's medical diagnosis was encopresis, a condition in which children purposefully soil themselves with faeces. A theory among mental health professionals at the time, and one shared by the participant, was that in many cases children with this disorder exhibited this bizarre behaviour so as to make themselves physically unattractive to adults, as a defense against repeated sexual abuse. The participant felt a professional obligation to treat the child holistically, and to provide him with the same high standard of care that he felt he and his colleagues gave to other patients. Clashing with this perceived obligation was his cognisance that he was unlikely to do so, because he was repulsed by the patient's physical condition. Also, he found disgusting the concept of providing care for a child who was being sexually abused, without taking measures to eliminate the abuse, which he felt was occurring in this case. These conflicting thoughts generated feelings of anger within him that he perceived impeded the quality of care he provided for the patient.

4.7 Summary

When registered nurse participants in this study reacted negatively to the patient's condition, it adversely affected the quality of nursing care that they provided. Reactions of frustration, annoyance, fear for their own safety, revulsion, sadness, helplessness and guilt were experienced. These negative reactions translated into negative behaviours which included avoiding the patient and delaying treatment, not communicating well with the patient, and not addressing the patient's psychological and sociological needs. However, in only a minority of cases did the participants believe that their negative reactions resulted in provision of sub-standard physical care.

There was a pattern of common contextual factors within which the research participants provided impeded care. These factors included an existing poor rapport with the patient, a previous negative experience with a patient with similar characteristics, an absence of visits by the patient's significant others, chronic work stress, time pressures and a lack of permitted flexibility in planning individualised patient care. Other contextual factors were a lack of clinical experience or expertise with the patient's medical condition, negative reactions to and comments by other staff about the patient, and disagreement with the patient's medical treatment.

All ten participants were conscious that they had provided impeded care as a result of their negative reactions to the patient's condition. This awareness led the participants to reflect on their negative reactions and behaviours, and consequently develop a better understanding of the situation. Strategies were devised to provide improved care in subsequent nurse-patient interactions. These strategies included discussions with colleagues, arranging for colleagues to provide care for the patient, and mental preparation including self control to lessen their negative reactions.

4.8 Recommendations

4.8.1 Education

This study supports the work by Preston (1979) that at some stage of their careers, nurses may provide care that is impeded, because of their negative reactions to the patient's condition. He coined this phenomenon the "Gregor Effect" which is a term based on earlier work by Kafka (1936). It is therefore appropriate that this concept becomes a component of nursing knowledge. It is clear from the findings of this study that accompanying nurses' spontaneous awareness that they are providing impeded care because of their reactions to the patient's condition, are feelings of sadness and guilt, as their reactions are incongruent with their professional self concept and the broader nursing ethos. There is a need for the nursing profession to acknowledge that the Gregor Effect can occur in some nurses at some stage of their careers, and that, although this response is undesirable, it is a component of normal human response to illness or incapacity. To this end the first recommendation is:

1. That the study's findings be shared with the broader nursing population through the various means of publication.

Nurse education also needs to better prepare its graduates that they may, at some stage of their careers, experience a negative reaction to the patient's condition and that it may impede the quality of their care. Aspects such as the ethical issues raised by such responses, anger management and confidence to deal with these types of patients need to be addressed in curricula.

2. If substantiated by future research that the Gregor Effect is a common phenomenon amongst nurses then a component of the undergraduate pre-registration curricula should be devoted to the concept of the Gregor Effect, and that this component should identify patient characteristics and contextual factors that are likely to evoke its occurrence, and also provide strategies to minimise its negative impact on the provision of care.

4.8.2 Research

This study has not established the frequency with which nurses experience the Gregor Effect. This was not one of the study's objectives but does need to be established.

3. That further research be conducted, using quantitative methodology, to identify the frequency with which nurses experience the Gregor Effect.

Participants of this study reported that they do not usually consider the patient's spiritual needs when providing nursing care that they perceive to be good care. This is not the case in the wider nursing population, as the researcher has observed many instances of nurses respecting and addressing the patient's spiritual needs when it is appropriate, most frequently when the patient has been diagnosed as terminally ill, has suffered a significant loss or expressed a need for spiritual guidance. As indicated in the Discussion section, the cause of this incongruence is probably the researcher's use of the inappropriate term "spirituality" in the interview guide. Although used frequently in the university setting, this term is not a part of the language of nursing culture in the clinical setting.

4. That in order to obtain more conclusive data in regard to meeting patients' spiritual needs in situations where the Gregor Effect is operating, the relevant component of this study be included in future studies, using the same methodology, but with the term "spiritual or religious needs" in place of the term "spirituality" in the interview guide.

The choice of nurses as participants in this current study was because of the researcher's long involvement in nurse education. It is common sense to assume that other health professionals, during some stage of their careers, also may experience similarly negative reactions to the patient's condition, with a subsequent impediment to the quality of the service that they provide to the patient.

5. That a similar study be conducted among medical doctors and other allied health professionals.

4.8.3 Resourcing

The findings of this study indicate that low staffing levels, time pressures and the unavailability of more experienced senior nurses with expertise in providing care for the patient, are factors contributing to less experienced nurses reacting negatively to the patient's condition and subsequently providing care that is impeded.

6. That clinical areas be adequately staffed with experienced registered nurses.

4.9 Conclusion

This study has provided a rich description of the lived experience of 10 registered nurses who provided a standard of nursing care that they perceived to be impeded, because of their negative reactions to the patient's condition. Although these reactions are undesirable, they are a component of normal human responses to illness or incapacity. By providing an understanding of these reactions and the pattern of contextual factors within which they occurred, this study has the potential to benefit patients, nurses, other health care professionals and the community.

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APPENDIX 1

ADVERTISEMENT FOR PARTICIPANT RECRUITMENT

CURTIN UNIVERSITY OF TECHNOLOGY
SCHOOL OF NURSING

NURSES AND THE PROVISION OF PATIENT CARE

Are you a registered nurse who perceives that during some stage of your career, you have delivered an impeded quality of care, because of your reaction to a patient's condition?

A study is being undertaken by a nurse researcher as part of a Master of Science Degree in Nursing, to further understand this experience.

If you are willing to share your experiences by participating in an interview, please contact John Drury on (09) 2738618.

Information gained at interview may be published, but the researcher will ensure that no interview participants are identifiable. The researcher gives a guarantee that all research participants will remain anonymous.

APPENDIX 2**INFORMED CONSENT FORM**

Informed consent form

Curtin University of Technology

School of Nursing

Project Title: *Nurses' strategies for coping when their personal reactions to the patient's condition has impeded the delivery of care.*

My name is John Drury and I am employed as a Professor by the School of Nursing at a Perth university and am currently enrolled in Master of Science studies at the School of Nursing at Curtin University of Technology. The purpose of my study is to describe the lived experience of the Registered Nurse who has provided care that was impeded because of the Registered Nurse's reaction to the patient's condition. The knowledge gained from the study will contribute to nursing's existing body of knowledge and will modify existing educational curricula with benefits to patients and practising nurses.

The study will involve Registered Nurses with experience in any clinical setting. Initial interviews will last approximately one hour and will be conducted at a time and place suitable to you and me. A follow up interview or interviews will be requested at a later date to expand on details in the first interview, and to verify my interpretation of the data.

During the interview you may decline to answer any question, request that the tape recorder be turned off or terminate the interview. Your participation is completely

voluntary and I will be the only person who can link your name with the interview. Your name will not be identified in any way in the research report. Nobody other than myself will have access to information that links your name to the transcribed interview. The audio tape and transcribed information will be kept in my locked office at Edith Cowan University and will be destroyed after five years. You may withdraw from the study at any time without penalty.

If you have any questions or concerns about this study please contact me on 09 2738618 or my supervisor, Dr Chris Birdsall, on 09 3512750.

PARTICIPANT'S STATEMENT

I, _____

(print full name)

have read the above information on the study relating to the Registered Nurse's lived experience of providing impeded care because of the Registered Nurse's reaction to the patient's condition. I understand that my participation in this study is voluntary and that I may withdraw from the study at any time without penalty.

Signed _____ (participant)

Participant's telephone number: _____

Date: _____

Signed _____ (researcher)

Date: _____

APPENDIX 3

INTERVIEW GUIDE

Hello,

So as to ensure that you can't be identified I'll not be addressing you by name during the interview.

This started by work with Kafka in 1916 in a classic paper called the Metamorphosis in which a young man called Gregor awoke to find that he'd turned into a cockroach. What was unusual about the work is that instead of describing the feelings of Gregor, Kafka described how Gregor affected the rest of his family and friends and how his appearance and presence adversely affected them.

This work was followed by Goffman in the 1960's with a book called Stigma, and then by an author called Ronald Preston and lately by this book (display book) by Lawler which says that nurses are taught to cope with unpleasant aspects of patient care by informal role modeling. I've taken it a step further and done some research with a grant from the university with about 100 RN's, most of whom said that at some stage in their careers they have provided an impeded standard of care because they were adversely affected by a patient's condition.

I am now exploring this situation so that I can include in the curriculum strategies that which will help students to deal with the situation, should it happen to them.

As you know I'm researching a phenomenon that influences patient care. It's a thing called the Gregor Effect and is a situation in which an RN is unable to give the usual standard of nursing care because of her or his reaction to a patient's condition.

Have you experienced this phenomenon?

You've indicated that you've experienced this reaction and I'd like to explore this experience or experiences with you. Before we get onto that though, I thought I'd start by asking you to describe to me an example of when either you or someone else provided what you would class as good nursing care."

and as a prompt if needed

"What was it about this care that lead you to class it as good?"

OK now let's explore the other side of the picture, where care can be impeded! Can you describe an experience you've had in which your quality of nursing care was impeded because of your reaction to the patient's condition?

Can you describe, as fully as possible, your reaction to the patient's condition?

Can you describe any other factors that impeded the quality of care or contributed to the way that you reacted?

Can you describe any strategies, if there were any, that you used to help you cope with the situation?

Finally, I'm going to ask you which area or areas of patient need or needs were affected by your response.

Can you describe how your reaction influenced your ability to consider or meet the patient's physical needs?

And how did your reaction influence your ability to consider the patient's psychological needs?

And how did your reaction influence your ability to help the patient meet his/her needs with regards to significant others?

And how did your reaction influence your ability to consider the patient's spiritual needs?

Well that's all of the questions that I have. I'd like to express to you how helpful and beneficial the information's been. Before we close, is there anything that you would like to add that would further help my understanding of your experience?

Thank you very much for your help in this research project.

END

APPENDIX 4**AN EXTRACT OF A PROTOCOL FROM AN INTERVIEW**

*I As you know I'm researching a phenomenon that influences patient care.

It's a thing called the Gregor Effect and is a situation in which a Registered Nurse is unable to give the usual standard of nursing care because of her or his reaction to a patient's condition. Earlier research has shown that this happens at some stage in the career of about 85% of Registered Nurses. You've indicated that you've experienced this reaction, and I'd like to explore this experience or experiences with you. Before we get onto that though, I thought I'd start by asking you to describe to me an example of when either you or someone else provided what you would class as good nursing care.

*P Oh, yeah, I thought it was going to be (UNCLEAR).

*I You can turn it off any time you want.

*P Goodness, I see it all the time, every day I suppose at work. There was one particular incidence where a guy... there was a little old lady, a psychogeriatric with Alzhiemers who'd had a fall and I'm not sure whether she had a fractured (UNCLEAR) or not, and the two nurses on really did look after her as though I suppose she was their mother. We ended up getting her off to (name of hospital, and in a way, as it turned out, the lady died shortly after... she had a fracture and she developed pneumonia and she died, but not at our hospital, at another hospital. And the relatives got nasty about it.

*I Did they?

*P Yeah. But, I as a manager had actually written to the two staff members on saying how well they'd treated the lady and it should go on their record as... and that actually worked for the hospital in the end because the family had recourse. But that was one instance.

*I What was it about this care that lead you to class it as good care?

*P Well, all the clinical aspects were taken care of. The competence. But I think it was basically the other side of the care there... the emotional support and the caring aspect, that was what made it stand out.

*I OK. Now let's explore the other side of the picture where care can be impeded. Can you tell me of an experience you've had in which your quality of nursing care was impeded because of your reaction to the patient's condition?

*P I was working in the ---- Hospital and I was the late shift in charge of the security ward, and we had a patient with manic depression and he was a long term patient, had been in and out of hospital for years and years and years. In fact my father had nursed him. And he'd actually been a psychiatric nurse, so he knew the system. He trained with my father but eventually was unable to work at all. And he developed Cirrhosis and the combination of his mania, he was a (UNCLEAR) as well in his younger days, his Cirrhosis and his aggression made him a real handful. That was alright, the psych side of things was OK, you could handle his behaviour, that was alright but when he was aggressive and we had to restrain him his skin would literally peel off on your hands. When you grabbed him... you'd grab him and he was oozing... his whole body was just covered. So yeah that affected my...phew!

*I So your reaction to his condition impeded the quality of care that you were able to give?

*P Umm, right. It impeded a lot of people's quality of care, I mean, so of course he was... I wouldn't say that he was avoided as such, but he was always (UNCLEAR) in the priority, which made it worse of course. That would explain his behaviour because he was after the attention and it was just a vicious circle.

*I Can you describe as fully as possible, your reaction to the patient's condition?

*P Well his mental condition was OK. And his physical condition would've been OK had he not had the mental condition! With that sort of combination....! And it just used to turn my stomach, I couldn't...

*I So what was the actual reaction of your experience? Or a number of

reactions?

*P There was a number. The words... should be coming out of my mouth...
disgust...

*I You see this is the key to what...

*P Yeah.

*I If we can get this then I can start designing a curriculum to help, because 85% of people have this experience, and we've done nothing, nothing to help our students prepare themselves for it. So if we can actually put our finger on the actual reactions that you had, the feelings that you've had, then we can start to develop it.

*P Nausea, queazia... that's a good one!

*I So you felt physical sick in the stomach?

*P Oh yeah.

*I Were you ever sick?

*P No, no, I was never sick but there's something about washing somebody's... skin off your hands and it's on your clothing and...

*I Right. It sounds awful.

*P It was. I mean I feel sorry... at the same time I felt sorry for the man, but on the balance I didn't feel that sorry.

APPENDIX 5**EXAMPLES OF CODED SIGNIFICANT STATEMENTS**Code:

Letters indicate significant statements related to giving care that was good.

Numerals indicate significant statements related to giving care that was good.

Interview 3

C You've got to cover all the other factors - their psychological frame, their relatives, sociologically.

D It's not just actually nursing them and their condition.

19 Intuition or the patient's body signals tell her that holistic care is not being provided.

20 Sometimes you just can't stand them and you'll ask a friend you are working with to look after his care and you'll look after so and so.

21 It takes ten years experience before you intuitively know that your care has not been holistic.

22 Physically nothing's upset me that it's affected my nursing care.

23 It's mainly personalities or psychological problems or emotional problems.

24 If the patient is going back to the same violent de facto relationship, she thinks "what is the point of talking to her?"

25 You just do the basic care and don't give her the opening to talk.

26 You feel helpless when the patient doesn't want to be helped.

27 It (the Gregor Effect) doesn't affect her physically, only emotionally.

28 She feels angry that she's contributing to the patient's addiction by giving the Pethidine injection.

29 A touch or they talk dirty - she just doesn't have time.

30 Older men think they can get away with sexually abusive talking or touching because of their age.

31 A lot of nurses make the junkie wait for his prescribed narcotic injection but she doesn't, because the doctor has ordered it.

32 She puts on airs and graces as though she is a proper lady when she is with the slimy (sexually abusive) old fellow.

33 She finds this approach (putting on airs and graces and acting like a lady) does help at times.

34 The doctor's attitude (in prescribing narcotics for the addict) contributes to the way she feels.

35 The ruder and nastier patients are to her, the nicer she is to them - she feels that it's hard for patients to remain angry and hostile toward someone who is being so nice.

36 When a demented patient is being revolting and she is at the end of her patience, she asks somebody else to look after him.

37 She psychs herself up by saying he is a patient and she's got certain things she has got to do with him in providing nursing care.

38 If she doesn't psych herself up she thinks she's wasting her time with this useless piece of rubbish (Pethidine addict) when she could be looking after the lady dying of cancer.

39 Nursing care wasn't affected but she doesn't feel she gave the bashed patient returning to the violent de facto husband the full emotional care she could have given her.

40 She thinks "what's the point, why waste my time?" with the patient who will return to the violent de facto husband.

41 She does not think she gave the addict the opportunity to discuss any emotional problems he might have had.

42 She (only) carried out the care for the addict that she was ordered to do.

43 She wouldn't have spent the time with the addict that she would have spent with someone with a different problem.

44 The conversation with the addict would never get personal about emotional problems.

45 Meeting spiritual needs was not applicable in the addicted and bashed patients she discussed - only those who are seriously ill or dying.

46 Negative reports about a patient at hand-over can encourage pre - judgement of a patient before she actually has met the patient, if she is not aware of it.

47 Despite a negative report about a patient at hand-over she reserves her opinion until she's actually looked after him.

Interview four:

E Feels that the best you can care for them in intensive care is to keep them alive and care for their family.

F On the (general) wards the first thing she does is to build a rapport with the patient so she can truly care for them and provide for their needs.

48 The patient was big strong and a full blood Aboriginal.

49 He came from the forensic unit and had a history of rape, murder and a psychotic personality.

50 He was admitted with two nurse "specials" because of his psychiatric condition.

51 Usually she put heart attack patients near the nurses' station but

she placed him further down the corridor.

52 Even before she saw him she had given impeded care by taking 20 minutes longer to admit him for his heart condition.

53 The nursing staff's first strategy was to defend themselves.

54 His care was very compromised by having less emergency equipment and by her spending less time with him.

55 She didn't wash him because he had a history of rape and came from the forensic unit.

56 Nursing staff assigned him a nurse who wasn't frightened of him.

57 She reacted with fear when going in to his room.

58 She spent as little time as possible with him.

59 She felt surprise and then fear.

60 After experiencing surprise, she felt fear and defensiveness.

61 His Aboriginal appearance made him more frightening.

62 Security staff or male staff would have reduced her fear of the patient.

63 Before he arrived her first thoughts were bad experiences in the past with forensic patients.

65 Gives a lesser guilty of care to patients who make sexual remarks to her.

66 Uses assertiveness skills as a strategy to cope with a patient who has made sexual remarks.

67 Includes a male nurse in the patient's care to deal with patients' sexual comments.

68 Has refused to care for patients who make sexual comments.

69 Uses transactional analysis and assertiveness to cope with patients' sexual comments.

70 Has withheld pain relief to a patient who was making sexual moves.

71 Has explained to patients that making sexual advances will cause her to spend less time with them for turns or pain relief.

72 The coronary patient's physical care was impeded.

73 Psychologically he didn't gain much from us either even though it was probably his greatest need.

74 The psych nurses didn't communicate well with him and neither did she.

75 She and her nursing colleagues didn't even think about his spiritual needs.

76 TA didn't work because he failed to communicate verbally.

77 Feels a need to show male patients that she's the one with the power.

78 It's harder to deal with suggestive behaviour when you're providing care for the person.

APPENDIX 6

EXAMPLES OF CODED FORMULATED MEANINGS THAT WERE EXTRACTED FROM CODED SIGNIFICANT STATEMENTS

Code:

Single letters indicate significant statements related to giving care that was good.

Numerals indicate significant statements related to giving care that was good.

Fm indicates formulated meanings with their codings indicating the numbers of the significant statements from which they were extracted

C You've got to cover all the other factors - their psychological frame, their relatives, sociologically.

fm Good care involves meeting patients' physical needs and also their psychological and sociological needs.C

D It's not just actually nursing them and their condition.

fm The provision of good nursing care involves more than just meeting the patient's physical needs.D

19 Intuition or the patient's body signals tell her that holistic care is not being provided.

fm Intuition or the patient's body signals tell her that holistic care is not being provided.19

20 Sometimes you just can't stand them and you'll ask a friend you are working with to look after his care and you'll look after so and so.

When she doesn't like a patient she discusses it with her colleagues and they swap patients.20

21 It takes ten years experience before you intuitively know that your care has not been holistic.

fm It takes ten years experience before you intuitively know that your care has not been holistic.21

22 Physically nothing's upset me that it's affected my nursing care.
fm A patient's physical condition has not caused her to react by
providing a lesser quality of nursing care.22

23 It's mainly personalities or psychological problems or emotional
problems.
fm It is a patient's personality, psychological problems or emotional
problems that cause her to provide an impeded quality of care.23

24 If the patient is going back to the same violent de facto
relationship, she thinks "what is the point of talking to her?"
fm If the patient is going back to the same violent de facto
relationship, she thinks "what is the point of talking to her?"

25 You just do the basic care and don't give her the opening to talk.
fm She meets the patient's physical needs but communication with the
patient is impeded.

26 You feel helpless when the patient doesn't want to be helped.
fm You feel helpless when the patient doesn't want to be helped.26

27 It (the Gregor Effect) doesn't affect her physically, only
emotionally.
fm It (the Gregor Effect) doesn't affect her physically, only
emotionally.27

28 She feels angry that she's contributing to the patient's addiction
by giving the Pethidine injection.
fm She feels angry that she's contributing to the patient's addiction
by giving the Pethidine injection (as opposed to feeling helpless in
the case of the bashed woman who will return to the violent de facto
husband)28.

29 A touch or they talk dirty - she just doesn't have time.
She hasn't got time for patients who are sexually abusive toward her.29

30 Older men think they can get away with sexually abusive talking or
touching because of their age.
fm Older men think they can get away with sexually abusive talking or
touching because of their age.30

31 A lot of nurses make the junkie wait for his prescribed narcotic

injection but she doesn't, because the doctor has ordered it.
 fm A lot of nurses make the junkie wait for his prescribed narcotic injection but she doesn't, because the doctor has ordered it.31

32 She puts on airs and graces as though she is a proper lady when she is with the slimy (sexually abusive) old fellow.
 fm She puts on airs and graces as though she is a proper lady when she is with the slimy (sexually abusive) old fellow.32

33 She finds this approach (putting on airs and graces and acting like a lady) does help at times.
 fm An effective way of coping with sexually abusive male patients is to put on airs and graces.33

34 The doctor's attitude (in prescribing narcotics for the addict) contributes to the way she feels.
 fm Disagreement with the doctor over the patient's medical treatment contributes to her angry reaction.34

35 The ruder and nastier patients are to her, the nicer she is to them - she feels that it's hard for patients to remain angry and hostile toward someone who is being so nice.
 fm A strategy for coping with patients' angry or hostile behaviour is to adopt a caring and kind demeanour.35

36 When a demented patient is being revolting and she is at the end of her patience, she asks somebody else to look after him.
 fm When a demented patient is being revolting and she is at the end of her patience, she asks somebody else to look after him.36

37 She psychs herself up by saying he is a patient and she's got certain things she has got to do with him in providing nursing care.
 fm She psychs herself up by saying he is a patient and she's got certain things she has got to do with him in providing nursing care.37

38 If she doesn't psych herself up she thinks she's wasting her time with this useless piece of rubbish (Pethidine addict) when she could be looking after the lady dying of cancer.
 fm If she doesn't psych herself up she thinks she's wasting her time with this useless piece of rubbish (Pethidine addict) when she could be looking after the lady dying of cancer.38

39 Nursing care wasn't affected but she doesn't feel she gave the bashed patient returning to the violent de facto husband the full emotional care she could have given her.

fm Nursing care (meeting physical needs) wasn't affected but she doesn't feel she gave the bashed patient returning to the violent de facto husband the full emotional care she could have given her.39

40 She thinks "what's the point, why waste my time?" with the patient who will return to the violent de facto husband.

fm She thinks "what's the point, why waste my time?" with the patient who will return to the violent de facto husband.40

41 She does not think she gave the addict the opportunity to discuss any emotional problems he might have had.

fm Her reaction to the addict impeded the provision of emotional care.41

42 She (only) carried out the care for the addict that she was ordered to do.

fm She only provided care for the addict that involved following the doctor's orders.42

43 She wouldn't have spent the time with the addict that she would have spent with someone with a different problem.

fm She wouldn't have spent the time with the addict that she would have spent with someone with a different problem.43

44 The conversation with the addict would never get personal about emotional problems.

fm The conversation with the addict would never get personal about emotional problems.44

45 Meeting spiritual needs was not applicable in the addicted and bashed patients she discussed - only those who are seriously ill or dying.

fm She feels that meeting spiritual needs was not applicable in the addicted and bashed patients she discussed - only those who are seriously ill or dying.45

46 Negative reports about a patient at hand-over can encourage pre -

judgement of a patient before she actually has met the patient, if she is not aware of it.

fm Critical comments about a patient at handover can cause a negative reaction in her toward the patient before she has met him, if she is not aware of this occurring. 46

47 Despite a negative report about a patient at hand-over she reserves her opinion until she's actually looked after him.

fm Despite a negative report about a patient at hand-over she reserves her opinion until she's actually looked after him.47

Interview four: John's analysis before validation from Jenny's independent analysis.

E Feels that the best you can care for them in intensive care is to keep them alive and care for their family.

fm The provision of a good quality of nursing care with intensive care patients is to keep patients alive and care for their families.E

F On the (general) wards the first thing she does is to build a rapport with the patient so she can truly care for them and provide for their needs.

fm When providing good care on the general wards the first thing she does is to build a rapport with the patient so she can truly care for them and provide for their needs.F

48 The patient was big strong and a full blood Aboriginal.

fm The patient was big strong and a full blood Aboriginal.48

49 He came from the forensic unit and had a history of rape, murder and a psychotic personality.

fm He came from the forensic unit and had a history of rape, murder and a psychotic personality.49

50 He was admitted with two nurse "specials" because of his psychiatric condition.

fm He was admitted with two nurse "specials" because of his psychiatric condition.50

51 Usually she put heart attack patients near the nurses' station but she placed him further down the corridor.

fm Usually she put heart attack patients near the nurses' station but she placed him further down the corridor.51

52 Even before she saw him she had given impeded care by taking 20 minutes longer to admit him for his heart condition.

fm Even before she saw him she had given impeded care by taking 20 minutes longer to admit him for his heart condition.52

53 The nursing staff's first strategy was to defend themselves.

fm The nursing staff's first strategy was to defend themselves.53

54 His care was very compromised by having less emergency equipment and by her spending less time with him.

fm His care was very compromised by having less emergency equipment and by her spending less time with him.54

55 She didn't wash him because he had a history of rape and came from the forensic unit.

fm She reacted with fear and didn't wash him because he had a history of rape and came from the forensic unit.55

56 Nursing staff assigned him a nurse who wasn't frightened of him.

fm Nursing staff assigned him a nurse who wasn't frightened of him.56

57 She reacted with fear when going in to his room.

fm She reacted with fear when going in to his room.57

58 She spent as little time as possible with him.

fm She spent as little time as possible with him.58

59 She felt surprise and then fear.

fm She felt surprise at his large size and Aboriginal appearance and then felt fear.59

60 After experiencing surprise, she felt fear and defensiveness.

fm After experiencing surprise, she felt fear and defensiveness.60

61 His Aboriginal appearance made him more frightening.

fm His Aboriginal appearance made him more frightening.61

62 Security staff or male staff would have reduced her fear of the

patient.

fm Security staff or male staff would have reduced her fear of the patient.62

63 Before he arrived her first thoughts were bad experiences in the past with forensic patients.

fm Bad experiences in the past with forensic patients had reduced the quality of care she was able to give this patient.63

65 Gives a lesser guilty of care to patients who make sexual remarks to her.

fm Gives a lesser guilty of care to patients who make sexual remarks to her.65

66 Uses assertiveness skills as a strategy to cope with a patient who has made sexual remarks.

fm Uses assertiveness skills as a strategy to cope with a patient who has made sexual remarks.66

67 Includes a male nurse in the patient's care to deal with patients' sexual comments.

fm Includes a male nurse colleague in the patient's care to deal with patients' inappropriate sexual behaviour.67

68 Has refused to care for patients who make sexual comments.

fm Has refused to care for patients who make sexual comments.68

69 Uses transactional analysis and assertiveness to cope with patients' sexual comments.

Uses transactional analysis and assertiveness to cope with patients' inappropriate sexual behaviour.69

70 Has withheld pain relief to a patient who was making sexual moves.

fm Has withheld pain relief to a patient who was making sexual moves.70

71 Has explained to patients that making sexual advances will cause her to spend less time with them for turns or pain relief.

fm Has explained to patients that making sexual advances will cause her to spend less time with them for turns or pain relief.71

72 The coronary patient's physical care was impeded.

fm The coronary patient's physical care was impeded.72

73 Psychologically he didn't gain much from us either even though it was probably his greatest need.

fm Did not address the patient's psychological needs even though this was his biggest need.73

74 The psych nurses didn't communicate well with him and neither did she.

fm The psych nurses didn't communicate well with him and neither did she.74

75 She and her nursing colleagues didn't even think about his spiritual needs.

fm She and her nursing colleagues didn't even think about his spiritual needs.75

76 TA didn't work because he failed to communicate verbally.

fm Transactional analysis didn't work because he failed to communicate verbally.76

77 Feels a need to show male patients that she's the one with the power.

fm Feels a need to show male patients that she's the one with the power.77

78 It's harder to deal with suggestive behaviour when you're providing care for the person.

fm It's harder to deal with sexually suggestive behaviour when you're providing care for the person.78
