AN OBSERVATIONAL STUDY OF THE
NURSE-PATIENT RELATIONSHIP
IN AN ONCOLOGY SETTING

by

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B.S.N. The University of British Columbia, 1993

A THESIS IN PARTIAL FULFILLMENT OF
THE REQUIREMENT FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES
(School of Nursing)

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
April 1996
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ABSTRACT

The purpose of this study was to describe the development of a nurse-patient relationship (NPR) in an oncology setting. Although theorists and researchers have attempted to explain the nature of the NPR, and have recognized its potential benefits, further exploration is necessary to increase our understanding of the complexities inherent in NPRs.

Using qualitative ethological research methods, videotaped recordings (VTRs) of the interactions between a nurse and patient on an active cancer treatment ward were used to investigate and delineate important features of nurse-patient interactions (NPIs) that reflect the development of a NPR. A sample of sixty videotaped NPIs that represented all the interactions between one patient and one nurse over a three-day period was selected for this study.

The data analysis of the VTRs was completed by reviewing all the interactions, identifying behavioral clusters, identifying constituents of behavioral clusters and constructing an ethogram. The findings of this study were validated and extended by using a focus group meeting with clinical nurse experts.

Several behavioral clusters were found on each day of this three-day relationship which reflected a dynamic and complex interplay between the nurse and patient. Some patterns of interaction were observed in all three days of the relationship, while others changed as the relationship developed. A dominant theme observed in most of the interaction patterns was the one of humor.

The findings of this study suggested active participation of
both the nurse and patient in relationship development. The development of this NPR was reflected in the changes observed in the behaviors of both the nurse and patient over the course of three days.

The NPR is complex. Awareness of nurse and patient behaviors that contribute to the development of effective NPRs may challenge oncology nurses to reflect on their own practice and to consciously incorporate behaviors that contribute to effective NPRs into their patient care.
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ACKNOWLEDGEMENT

I thank my committee members: Dr. Joan Bottorff, Dr. Joy Johnson, and Roberta Hewat Ph.D. (cand.) for their expertise and direction in the preparation of my thesis. I particularly thank Joan for being such a wonderful mentor to me and for making this learning experience a very positive one.

I thank my parents: Sarah and Arieh Engelberg who sewed the seed of knowledge in me at a very young age and nurtured that seed throughout my life. My parents have truly given me the gift of education, one which will undoubtedly serve me well.

Last, but certainly not least, I thank my loving husband, Gordon. His support and encouragement throughout my years in university have been very necessary and much appreciated. He too knows something about the development of an effective relationship.
CHAPTER 1: INTRODUCTION

A special kind of human caring relationship — the nurse-patient relationship (NPR) — has been discussed in the nursing literature for the past three decades. This relationship may seem simple, but is actually complex. Although the relationship cannot slow or stop a patient's pathology, it has the potential to significantly influence health care outcomes (Elder, 1965; Watson, 1985, 1988).

Statement of the Problem

Theorists have attempted to explain the nature of the link between the NPR and positive health outcomes in their conceptualizations of the NPR (Gadow, 1985; Watson, 1985, 1988). Caring NPRs have been linked to improvements in patient comfort (Gadow, 1985); increased patient participation in care delivery (Bishop & Scudder, 1990; Gadow, 1985; Peplau, 1952; Watson, 1985, 1988); promotion of growth and learning (Bishop & Scudder, 1990; Peplau, 1952, 1987); and, enabling and empowering patients to endure their illness (Bishop & Scudder, 1990). Elder (1965) reported that patients who felt relaxed and satisfied in relationships with their nurses required fewer sleeping pills and analgesics, fewer post-operative catheterizations, used the call light less frequently, and were more satisfied with their care than patients who did not have good relationships with their nurses. Subsequent investigations of NPRs completed in a variety of clinical settings lend support to these findings (Kelly & May, 1982). For example, empathic relationships have been shown to positively influence physical and emotional well-being among hospice patients (Raudonis, 1993, 1995). Furthermore, an
increase in the general satisfaction of both nurse and patient in good NPRs has been predicted by nurse theorists (Peplau, 1952; Watson, 1988) and supported by researchers (Elder, 1965; May, 1993, 1995a). Practicing nurses have also recognized the potential benefits of the NPR. Researchers report that nurses are willing to risk involvement with their patients and perceive intense levels of attachment to be most beneficial (Artinian, 1995; Raudonis, 1993, 1995).

Although theorists and researchers have attempted to explain the nature of the NPR, and have recognized its potential benefits, a gap remains in understanding this dynamic dyad. Dyad, in the present study, is defined as two persons in a continuing relationship in which they interact with each other (Guralnik, 1985). We still know very little about how effective NPRs are developed. Early theorists such as Peplau (1952) provided the first explanations of the interactive process inherent in the NPR. She based her work on observations in psychiatric settings. Since this time, researchers interested in the nature of the NPR, have based their investigations on self-reports of nurses or patients. As a result, the complexity of NPRs has not been adequately captured. Nurses and patients are not always aware of their behaviors and, as a result, important details are missed. Furthermore, self-reports based on recall focus on perceptions of events and may not accurately reflect what actually occurs in the NPR (Lowenberg, 1994).

The Context

The attention that the NPR has received in the nursing literature points to its importance and centrality in nurses'
work in a variety of settings. Although there is some consensus on the characteristics of an effective NPR, further exploration is necessary to increase our understanding of the complexities inherent in NPRs as they actually occur everyday in clinical settings. Lowenberg (1994) asserts that the only way to increase our understanding of the NPR is by learning more about the actual interactions that take place between patients and nurses.

Effective NPRs become especially important in situations where patients face life-threatening illness and endure complex technical treatments with their associated discomforts. In these situations, NPRs provide an important human dimension to experiences characterized by discomforts such as pain or nausea and sometimes disfigurement. In cancer nursing in particular, nurses are faced with the challenge of developing relationships with patients whose disease involves a number of unique physiological and psychological stresses.

Purpose and Rationale for the Study

The purpose of this study was to describe the development of a NPR in an oncology setting. Using a qualitative ethological research method, videotaped recordings of the interactions between a nurse and patient on an active cancer treatment ward were used to investigate and delineate important features of nurse-patient interactions reflecting the development of NPRs. Videotaped recordings of nurse-patient interactions make possible detailed observations of both verbal and nonverbal behaviors, including the timing and sequencing of these behaviors as they naturally emerge in the daily activities of nurses and their patients. Such observations allowed the researcher to
investigate and describe the intricacies of the NPR as it was actually enacted in this clinical setting. Lowenberg (1994) argues that examinations of videotaped recordings will enhance the study of NPRs and augment our knowledge of what actually takes place in concrete, everyday nurse-patient interactions.

The Research Question

The main aim of this study was to describe the process of developing a relationship between a nurse and a cancer patient. The research question was: What patterns of nurse-patient interaction reflect the development of an effective NPR?
CHAPTER 2: LITERATURE REVIEW

The purpose of this literature review is to present a summary of existing knowledge related to the NPR and to demonstrate a rationale for this study. Theorists such as Peplau (1952) and Orlando (1961) were among the first to conceptualize the NPR as a part of nursing practice. Since this time, the NPR has been incorporated into other nursing theories, described and attested to by expert nurse clinicians, and has been the focus of an increasing number of research endeavors. Furthermore, several authors have offered their own opinions and reviews of this topic, drawing on the literature from nursing as well as from the social sciences.

This literature review is organized into several sections. A brief historical overview is presented to describe the emergence of the NPR as a key component of nursing practice. Following this, three conceptualizations of NPRs are discussed. First, the NPR is discussed as a dichotomy based on the degree to which the relationship is therapeutic (that is, the NPR can be therapeutic or non-therapeutic, and within this dichotomy certain conditions define the relationship as therapeutic and non-therapeutic). Second, descriptions of the NPR as a typology of relationships based on levels of nurse-patient involvement is presented. Finally, conceptualizations of the NPR as an interactive process are presented. The process of developing NPRs is discussed including the factors influencing this process. This is followed by a description of the NPR in cancer nursing. Finally, the gaps in the literature on NPRs are discussed and a case is solidified for further investigation into the area of the
The Emergence of Nurse-Patient Relationships as a Component of Nursing

The NPR has not always been recognized as an important aspect of nursing practice. Prior to the 1960’s, the efficient performance of routine tasks such as, bed-making and medication administration was highly valued and clinical attention was directed toward the patients’ body care (May, 1993). Although early theorists attempted to point out problems with this impersonal approach to providing care, it was not until the 1960’s that this became a topic of debate among practicing nurses (Altschul, 1972). In part, the debate was stimulated by clinical observations that "good" relationships between nurses and patients contributed to recovery rates (Elder, 1965). However, the major stimulus for this important development came a decade earlier with the publication of Peplau’s (1952) book entitled "Interpersonal relations in nursing: A conceptual framework of reference for psychodynamic nursing." Peplau’s theory, based on her observations in psychiatric nursing, focused on the interpersonal processes inherent in the NPR. She set the stage for moving beyond advocating the NPR as simply a more personal approach, to using the NPR as a diagnostic and therapeutic tool.

This shift gave further credibility to the NPR and prompted others to explore and describe the work of nurses that extended beyond the provision of physical care from the perspective of the patient as well as the nurse. Authors noted that a lack of involvement in the patient’s subjective experience depersonalized the patient and denied the patient of human dignity, reducing the
individual to an object (Gadow, 1985; Peplau, 1952). Others noted that the caring and skill the nurse brings to the NPR appears to inspire the patient's potential for well-being. The patient is able to participate as an active subject in his/her care, rather than being a mere physical object, and is therefore able to actualize his/her inner potential (Paterson & Zderad, 1976).

Along with this shift toward viewing the patient as an active recipient of care, attention was also directed to the patient's subjective experience of the disease process and the care provided. The subjective experience of the patient could only be articulated through conversation. Thus, interpersonal relationships between nurses and patients became incorporated into approaches to nursing work such as the nursing process (Dingwall, Rafferty, & Webster, 1988) and caring theories (Bishop & Scudder, 1990; Gadow, 1985; Watson, 1988). Consequently, the approach of organizing nursing work around tasks was permanently eroded.

Today the importance of the NPR is unquestioned. It is viewed as essential content in nursing curricula and is the focus of continuing education in many clinical specialties. Nurses have also begun to explore the ethics of NPRs (Coltrin, 1992; Storch, 1992). Clinicians are recognized for their ability to develop NPRs and react to administrative changes that undermine their ability to do this. Researchers are increasingly turning their attention to understanding the dynamics involved in NPRs and their therapeutic potential.
Conceptualizations of Nurse-Patient Relationships

The NPR has been described in a number of ways: caring, supportive, therapeutic, humane and interpersonal, to name a few. However, there appears to be at least three major conceptualizations of NPRs: the NPR as a dichotomy -- the NPR can be therapeutic or non-therapeutic; the NPR as a typology of relationships based on levels of involvement; and, the NPR as an interactive process. Each of these conceptualizations will be discussed.

The Therapeutic Relationship

One conceptualization of the NPR that pervades the nursing literature is grounded in the characteristics of a therapeutic relationship. According to this conceptualization, the NPR is not viewed as unique, but rather a relationship that takes on the characteristics of similar helping relationships. The work of Carl Rogers (1961), a well known psychotherapist, is clearly reflected in the nursing literature espousing this view.

As a therapist, Rogers (1961) disliked the role of the detached expert who "figured out" the patient. He preferred a less formal approach to counselling that, in his view, was more beneficial to the patient and more comfortable for the therapist. Rogers began using "nondirective therapy," allowing patients to decide what to talk about and when. Nondirective therapy, now known as client-centered or person-centered therapy, depended on the patient's own drive toward growth or self-actualization.

The foundation of Rogers' therapy was the creation of a relationship. This therapeutic relationship consisted of three interrelated components: unconditional positive regard, empathy,
and genuineness. The therapist uses unconditional positive regard to show genuine caring about and acceptance of the client as a person and trust in the client’s ability to change. It would be non-therapeutic, according to Rogers (1961), for the therapist to give advice to the client. He claimed that advice-giving carries the subtle message that individuals are inadequate or incompetent, and as a result makes them less confidant and more dependent on help.

In using empathy as a therapeutic technique, an internal perspective is required of the therapist in order to appreciate how the world looks from the client’s point of view. Empathy is communicated verbally with statements such as, "I understand," and nonverbally by making eye contact with the patient and by nodding in recognition as the patient speaks. Reflection is also a part of empathy and is used to show the patient the therapist is actively listening and thus helps the patient to become aware of his/her thoughts and feelings. According to Rogers (1961), it is non-therapeutic to ask disruptive questions. Questions may impede the client’s confidence and motivation to try and solve his/her own problem.

Finally, the therapist is genuine with the patient. That is, there is consistency between the way the therapist feels and acts toward the client. This means that the therapist’s unconditional positive regard and empathy are real, not fabricated. The foundation of Roger’s therapeutic relationship is openness and honesty. This therapeutic relationship has the potential for positive patient outcomes such as increased self-confidence, awareness of feelings, self-acceptance and reliance
on self-evaluation rather than the judgements of others, comfort and genuineness with others, and a sense of relaxation.

Nurses embraced Roger's concept of client-centered therapy and applied it directly to the NPR. For example, Gunter (1962) substituted "patient" for "client" in Rogers' postulates to illustrate the applicability of the model to nursing. Researchers in nursing (Kemper, 1992; Shanken & Shanken, 1976) as well as nursing authors in the area of psychiatric nursing (Gelazis & Coombe-Moore, 1993; McMahon, 1992; Schwecke, 1995; Thomas, 1991; Townsend, 1993; Varcarolis, 1990) have advocated actions such as active listening, helping patients to identify their feelings and empathy as key elements of a NPR. Many nurses have contended that only a therapeutic relationship can provide the emotional environment in which nurses can assist patients to achieve goals. Influenced by the work of Rogers and other psychologists (e.g., Egan, 1982), they cautioned against non-therapeutic responses such as failing to listen, being defensive, agreeing or disagreeing and probing, and testing or challenging. Such non-therapeutic responses prevent the patient from expressing true concerns, leaves the patient feeling that his/her privacy is not being respected, and places the patient in a defensive position (Brammer, 1985).

Although less obvious in the writings of contemporary theorists, Rogers' (1961) work is still implicit in many descriptions of the NPR. For example, King (1981) described the NPR as an interactive process in which the nurse and patient mutually identify goals and the means to achieve them.

Others nurse theorists have extended our understanding of
the therapeutic relationship by incorporating the work of philosophers such as Buber (1958), as demonstrated in Bishop and Scudder’s (1990) notion of the "personal sense of nursing." These theorists have used Buber’s work to clarify the nature of a personal NPR and differentiate it from personal relationships with friends or lovers. Buber has described the pure personal relationship as I-Thou and the I-It relationship as that between a person and object.

Based on the works of Buber, Bishop and Scudder conceptualized the therapeutic NPR as an "I-It (Thou) relationship." They argued that this new conceptualization was necessary because it was impossible to incorporate Buber’s ideas about relationships to the nurse-patient dyad. The I-Thou relationship would be impractical in nursing practice and the I-It relationship demeaning to the patient and unfulfilling to the nurse. According to Bishop and Scudder, the I-It (Thou) relationship is one in which the patient is recognized as a person within the routine and demands of nurses’ work when time is often limited.

The fact that certain procedures are impersonal in their nature, such as taking a blood pressure reading or temperature, does not mean that the nurse should treat the patient in an impersonal fashion. Even when engaging in seemingly routine tasks, the nurse should always be cognizant that s/he is relating to a "Thou." Relating to the patient as a person rather than an object even during quick impersonal treatments is the basis for valuing and respecting the patient. Thus, the structured, purposeful and contextual characteristics of the I-It (Thou)
relationship and those of Rogers' (1961) person-centered therapeutic relationship parallel one another.

The notion of the therapeutic NPR has received tremendous support from psychiatric mental health nurses. In the mental health context, the therapeutic NPR is used as a basis for interacting effectively with patients in order to work collaboratively toward the goal of meeting patient needs and facilitating growth (Gelazis & Coombe-Moore, 1993; McMahon, 1992; Schwecke, 1995; Thomas, 1991; Townsend, 1993; Varcarolis, 1990). In addition, researchers have also supported the usefulness of the therapeutic NPR in the context of providing psychiatric nursing care (Heifner, 1993; Kemper, 1992; Shillinger, 1983).

The notion of the therapeutic relationship has influenced nursing beyond psychiatric mental health settings. Caring has been recognized by many nursing theorists as the "essence of nursing" (Kelly, 1990; Leininger, 1985; Morse, Solberg, Neander, Bottorff, & Johnson, 1990). The therapeutic relationship has been described as consisting of essential components such as respect, empathy, and genuineness, all of which are directly related to caring. Caring is also considered to be an essential element of the NPR by researchers (Kahn & Steeves, 1988; Morse, 1991a; Trojan & Yonge, 1993). Although the therapeutic relationship, as it is conceptualized in psychology, has extensively influenced nursing and has seemed to be effective in some settings (e.g., psychiatric settings), it is difficult to incorporate it in other nursing settings. For example, in acute care settings, patients' energies are focused on coping with impending prognoses, as well as pain or other discomforts.
Patients in such situations may not be interested in self-actualizing and promoting their personal growth. In addition, influences such as the workload on the unit, team nursing and the lack of privacy limit the time nurses can spend with individual patients to establish rapport (Morse et al., 1992).

In summary, the usefulness of the therapeutic relationship in many nursing settings remains in question. Further investigation is necessary to increase our knowledge and understanding of the NPR and the components that make it appropriate in a variety of nursing settings.

Types of Relationships Based on Levels of Involvement

The second major conceptualization of the NPR is based on the notion of involvement as an essential feature of NPRs. In contrast to the previous conceptualization of the NPR which evolved primarily from the application of knowledge of relationships developed in other disciplines to nursing, this conceptualization of the NPR has evolved primarily from inductive investigations of nurses' and patients' self-reported experiences. In sharp contrast to viewing relationships as either therapeutic or non-therapeutic, when relationships are defined by level of involvement, a wider range of relationships has been identified. In addition, increased emphasis is placed on the role of patients in influencing the nature of the relationship and the appropriateness of the different types of relationships in the range of contexts in which nurses work.

Research by May (1991), Morse (1991a), Ramos (1992) and Hagerty, Lynch-Sauer, Patusky and Bouwsema (1993) typify the qualitative studies that have led to the identification of the
different levels of involvement between nurses and patients. May and Ramos similarly collected data through informal semi-structured tape recorded interviews with nurses (May) and clinicians (Ramos) in medical-surgical settings. Morse interviewed nurses, some of whom had also been patients, from eight clinical settings. Hagerty et al. identified states of relatedness using data collected in a variety of ways, including case studies, interviews, and focus group meetings. The features found in the varying levels of involvement identified in these investigations appear to be cumulatively and qualitatively similar. Three levels of involvement seemed to encompass the findings of the above researchers.

The key features of the first type of involvement are reciprocity and exchange between the nurse and the patient. Both players are equally involved in the relationship and identify with one another on an emotional and cognitive level. In this level of involvement, the nurse is oriented toward the patient. In addition, the nurse’s personal, professional and organizational objectives are balanced. That is, the nurse maintains a professional perspective while providing the patient with a sense of personal recognition. This first level of involvement has been called a connected relationship (Morse, 1991a), primary involvement (May, 1991), a reciprocal relationship with resolved control issues (Ramos, 1992), and a state of relatedness referred to as connectedness (Hagerty et al., 1993).

In the second type of involvement the nurse overemphasizes care for a particular patient. As a result, the nurse loses
objectivity and there is role stress. Although the nurse is oriented toward the patient, her/his personal needs are given priority over patient needs. This level of involvement has been referred to as an overinvolved relationship (Morse, 1991a), a demonstrative relationship (May, 1991), a protective relationship level with an emotional component (Ramos, 1992), and as a state of relatedness called enmeshment (Hagerty et al., 1993).

The third type of involvement is characterized by an orientation to tasks. Since, organizational objectives take precedence at this level, the nurse has limited involvement with the patient. Interactions with patients are brief and superficial, although not necessarily negative. This type of involvement is appropriate with unconscious patients or when the nurse can only spend a minimal amount of time with the patient and must get the task completed. However, this type of involvement is inappropriate if the patient is feeling uncomfortable or anxious. Researchers have referred to this type of involvement as clinical and therapeutic (Morse, 1991a), associational (May, 1991), instrumental (Ramos, 1992), and as states of relatedness referred to as disconnectedness and parallelism (Hagerty et al., 1993).

The types of NPRs described in the research studies discussed above demonstrate differentiations in NPRs based primarily on nurses' self-reports. Morse (1991a) included the patient's perspective in her study to a limited extent by interviewing some nurses who had also been patients. Although it may be argued that the perspectives of nurses and patients were captured in this study, the reports of nurses who were once
hospitalized may have been influenced by their professional knowledge and experience in developing NPRs. In order to truly understand the essence of the NPR both players in the dyad must be considered.

The NPR as an Interactive Process

The third major conceptualization of the NPR is based on the NPR as an interactive process. When NPRs are defined as interactive processes, equal emphasis is placed on both the nurse and the patient in influencing the relationship. The interactive process is unlike the first conceptualization of NPRs where the relationship is viewed as either therapeutic or non-therapeutic and where the responsibility for the relationship centers on the nurse. The third conceptualization also differs from the second conceptualization of NPRs, where NPRs are defined by varying levels of involvement, that for the most part are controlled by the nurse. In contrast to the former conceptualizations of NPR, the third conceptualization is based on an interactional process that occurs between the nurse and patient.

Peplau’s (1952) theory was one of the first theoretical frameworks to describe nursing practice as occurring within a relationship with patients. Drawing from interpersonal, learning and developmental theories, Peplau considered the relationship between nurse and patient as the key to the nursing process. Peplau’s theory largely emerged from her clinical observations in psychiatric settings (Peplau, 1952, 1987, 1992). Her theoretical model of nursing as an interactive process has been tremendously influential in nursing practice and on subsequent nursing theories (eg., Orlando, 1961).
Peplau (1952) described four "overlapping" and "interlocking" phases of the interpersonal process underlying the NPR: orientation, identification, exploitation and resolution. This interactive process is used to guide the patient from dependency toward interdependent interactions. The purpose of the interaction is to "...promote a patient's health in the direction of creative, constructive, productive, personal, and community living" (p. 16). Peplau (1952) described in detail the interpersonal dynamics during each of the four phases. In some instances, these descriptions have been extended by Orlando (1961).

During the orientation phase, the nurse and patient get to know one another and each others' roles and expectations in the relationship. The nurse must be clear and consistent in order to be trustworthy in the NPR. The nurse and patient can then begin to explore and identify problems to work on in the relationship. In this phase, the patient seeks the assistance of a nurse based on "felt needs." Peplau (1952) maintains that this is the first step in a dynamic learning experience in which personal social growth can occur. Insufficient exploration of the patient's needs may delay restoration of comfort and/or could lead to exacerbation of the patient's condition. The patient experiences the concern of the nurse, feels safe, and is therefore more likely to spontaneously discuss distressful situations with the nurse (Orlando, 1961; Peplau, 1952). Orlando (1961) notes that nurses are in a unique position because they are directly and continually responsible to patients for at least eight hours at a time. As such, the nurse may capitalize on natural nursing
situations, such as bathing, medicating, and feeding, as opportunities for patients to express their needs and feelings (Orlando; Peplau).

The second phase Peplau (1952) describes is that of identification. In this phase, the patient identifies with his/her nurse and may respond to an offer of assistance. The nurse and patient become clear about their expectations and may modify preconceptions of one another. Orlando (1961) describes this process of clarity between nurse and patient as a "deliberative process." In the deliberative process, the nurse validates an activity required to meet the patient's needs before carrying it out. Thus, the nurse understands the meaning of the activity to the patient and how it will affect the patient. Conversely, if the nurse were to carry out an activity automatically, that is, without exploring it with the patient, the activity may be ineffective in helping the patient (Orlando). As a result, both the nurse and the patient use the NPR as a vehicle for respecting one another as human beings, and for examining and responding to situations (Orlando; Peplau).

In the third phase, exploitation, the patient fully uses the NPR for his/her self-interests and needs. By taking full advantage of nursing service, the patient is reassured that his/her interests and needs will continue to be met. Additionally, new goals begin to be established by the patient, such as returning to home and work life. The phase of exploitation is "an extension of the self of the patient into the future. It is characterized by an intermingling of needs and a shuttling back and forth. Rapid shifts in behavior that express
mixed needs makes observation more complex" (Peplau, 1952, p. 38).

The final and terminal phase of the NPR is resolution. The resolution phase is a psychological phenomenon and a process of freeing the patient from identifying with the nurse, and strengthening the patient's ability to stand independently (Peplau, 1952). All earlier phases of the NPR must be achieved for this outcome to be met. It is through the nurse's "unconditional acceptance in a sustaining relationship that provides fully for need-satisfaction; recognition of and responses to growth cues, however trivial... that it is possible for the patient to want to be free" (pp. 40-41).

Although Peplau's (1952) theoretical explanation about the process of developing NPRs has dominated discussions in nursing and has been supported by other theorists (e.g., Orlando, 1961), there are some gaps worthy of mention. For example, Peplau (1952) and Orlando (1961) emphasize the importance of realizing patients' felt needs and understanding patients' subjective experiences. However, neither theorist explains how the nurse proceeds in order to accomplish this task. Furthermore, because these theoretical frameworks were developed to approach psychiatric nursing situations, it may be difficult to apply them in other patient populations, such as emergency-room patients.

Building on this early work, other nurse theorists have extended our understanding of the NPR as an interactive process by focusing on the specific structures of the nurse-patient dyad (Bishop & Scudder, 1990; Gadow, 1980, 1985; Paterson & Zderad, 1976; Watson, 1988). Each has explicated important aspects of
this unique and dynamic dyad formed by the nurse and patient. For example, Bishop and Scudder describe how a personal approach in nursing practice is enhanced through an I-It (Thou) versus an I-Thou or I-It relationship; Paterson and Zderad have defined a central concept of humanistic nursing defined as a "responsible searching transactional relationship whose meaningfulness demands conceptualization founded on a nurse's existential awareness of self and other" (p. 3); Watson discusses the characteristics of a transpersonal caring relationship; and Gadow theorizes about existential advocacy as one aspect of effective NPRs. The single most compelling area of consensus among the above mentioned theorists and including Peplau (1952) and Orlando (1961) is the contributions of both nurse and patient are viewed as significant and quintessential to the NPR. Although the contribution of both parties in the relationship is seemingly obvious, it is interesting to note that some theorists, including Orem (1985, 1991) and Neuman (1982) focus only on the patient.

Contemporary theorists such as Watson (1988) attribute much importance to an understanding of the patient's experience. Watson explains that the foundation of the NPR depends upon a commitment by the nurse to maintain and enhance the patient's dignity by highly regarding the patient's own meaning of his/her condition; affirming "the subjective experience of the person (I-Thou versus I-It)" (p. 64); realizing and detecting the feelings and condition of the patient through a mutual union and by using verbal and nonverbal actions; and by using the nurse's own lived experiences to clarify, understand and be sensitive to the lived experience of the patient. The nurse, according to Watson, has
an artistic ability which goes beyond being able to receive and experience the patient's feelings. The nurse's art is in expressing the patient's experience in such a way that the patient in turn may be able to fully express and release feelings related to his/her experience or "felt needs."

The experience of felt needs was discussed by Peplau (1952) and Orlando (1961) who associated these needs with increased anxiety and tension related energy. They argued that the nurse can use this energy as a positive means for defining and understanding the illness. Furthermore, the nurse can engage the patient as an active partner in identifying and assessing his/her illness. It is only through full participation that the patient is able to fully integrate the illness experience into his/her life experience. In order to evaluate the validity of Peplau's claims and the claims of other nurse theorists, it is useful to look at research which has focused on the interactional processes of NPRs.

Forchuk and her colleagues have reviewed and tested Peplau's theory (Forchuk, Beaton, Crawford, Ide, Voorberg, & Bethune, 1989; Forchuk & Brown, 1989; Forchuk, 1991; Forchuk, 1994; Martin, Forchuk, Santopinto, & Butcher, 1992). For example, Forchuk (1994) used a variety of instruments (i.e., Relationship Form, Working Alliance Inventory) to examine the orientation phase in a prospective-panel-longitudinal study of 124 nurse-patient dyads in a psychiatric setting. The findings of this study demonstrated support for the importance of patients' preconceptions of the nurse and nurses' preconceptions of the patient as they relate to the progression or regression of the
therapeutic relationship. However, other tenets of Peplau's theory, for example, the assumption that patients' and nurses' previous interpersonal relationships affect the development of therapeutic relationships, were not supported in this investigation. Forchuk (1994) found that only patients' previous interpersonal relationships were significant in the progression of the nurse-patient relationship.

Researchers have also demonstrated how Peplau's theory can be incorporated into case management of long-term, predominantly schizophrenic patients (Forchuk et al., 1989; Forchuk & Brown, 1989; Martin et al., 1992). An instrument to assist in monitoring the relationship was developed and used by nurses to measure the phases of the NPR. The instrument consisted of a graph containing each phase of the NPR. Each phase on the graph had corresponding summary statements of each phase of the NPR. The nurses regularly used the instrument to plot where they perceived the relationship phase to be on the graph. It was argued that an accurate assessment of the NPR would allow the nurse to assess the phase in which the relationship is in and, thereby, assist nurses to select appropriate interventions (Forchuk & Brown, 1989). Although these studies provided an important beginning toward creating a valid and reliable instrument by which to measure the phases of the NPR, limitations are evident. For example, there were differences between raters in scoring phases of the relationship; the small convenience sample of patients were all community based, decreasing the generalizability of findings; and, the studies were conducted from the nurses' perspective and, as a result, only one of the
players in the dyad was considered.

Chalmers and Luker (1991) explored NPRs in community health settings using a grounded theory method of research. Their findings supported Peplau's (1952) and Orlando's (1961) conceptions of the interactional process as characteristic of NPRs. Analysis of interviews with nurses revealed that establishing a positive relationship was based on the nurse's ability to demonstrate respect and genuine concern for patients and to be perceived by the patients as helpful. The mutual "giving" and "receiving" in the NPR was found to result in achieving desired outcomes for the patient and the nurse. This study shed light on the interactive process of relationship development, yet, again only considered the reports of nurses. As a result, uncertainties remain as to why, for example, difficulties and changes in the NPR arise.

Although these investigations provide support for the conceptualization of the NPR as an interactive process, the interactive process as it actually occurs in the clinical setting has not been explored. Furthermore, most studies were based on self-reports of nurses. It is unlikely that nurses are able to accurately recall all of the dynamics of their interactions with patients. Nurses may not be aware of all of their behaviors that influence interactions. In addition, interactions are so complex that it is difficult to report on both one's own behavior as well as those of the patient. Detailed knowledge of nurse and patient behaviors that characterize the interactive process in the NPR has the potential to extend our understanding of NPRs. It is interesting to note that, whereas nursing theorists focused
equally on the nurse and the patient in their conceptualizations of the NPR as an interactive process (e.g., Peplau, 1952, 1992), most researchers only considered half of the dyad. Studies are needed to describe the contribution of both nurses and patients to the NPR.

The Developmental Process of the NPR

Although building NPRs is not separate from the interactional process, there are some qualitative researchers who have investigated the development of NPRs (Morse, 1991a; Raudonis, 1995; Thorne & Robinson, 1988; Trojan & Yonge, 1993). Morse (1991a) is the only researcher to describe the development of NPRs as a process of negotiation. Her analysis of tape-recorded interviews with nurses revealed that negotiations between the nurse and patient may be explicit or implicit, and result in the establishment of the NPR. Often, negotiation depends on the seriousness of the patient's situation. For example, if the patient feels vulnerable and dependent, s/he may assess the nurse to determine whether or not the nurse is trustworthy and willing to become involved in her/his care. The nurse also assesses the patient to determine the patient's personal needs and support system, and whether or not to make an emotional investment in the patient or simply get the work done (Morse). If, however, the patient's needs are minor and contact with the nurse is short, then hardly any negotiation is necessary. Whereas other researchers have focused on the stages of relationship development, Morse's findings reveal that a relationship only begins to develop as a result of negotiation between nurse and patient. As such, the stages in which
relationships progress are the end product of negotiation between the nurse and the patient.

Other qualitative researchers have identified stages or phases relationships progress through (Raudonis, 1995; Thorne & Robinson, 1988; Trojan & Yonge, 1993). Based on an analysis of in-depth interviews with chronically ill patients using grounded theory, Thorne and Robinson (1988) described the evolution of health care relationships in three stages: naive trust, disenchantment, and guarded alliance. The findings revealed patients entered into health care relationships with complete trust that all of their health care problems would be answered. However, this initial trust was soon lost when it became clear a remedy did not exist. Furthermore, from the perspective of chronically ill patients, health care professionals did not understand or even care about their patients' subjective experiences of chronic illness. The resulting disenchantment, along with anger and loss of trust was resolved as patients recognized that they were in need of prolonged professional health care and entered the stage of "guarded alliance." Trust was restructured to allow for an alliance that was guarded with a decreased adversarial nature. Patients developed knowledge and competence within the context of their illness management and expressed an expectation from health care professionals to accept and encourage that competence (Thorne & Robinson, 1988). According to the informants in this study, trust in the health care relationship is the most significant component, providing the basis for collaboration and cooperation on illness management. Additionally, reciprocal trust was found when
patients were trusted by their health care provider (Thorne & Robinson, 1988).

Trojan and Yonge (1993) identified four phases in the relationships between home care nurses and their elderly clients: initial trusting, connecting, negotiating and helping. The initial trusting phase described in this study is similar to the "naive trusting" described by Thorne and Robinson (1988). The elderly clients were found to exhibit a generalized trust for the nurse based on evaluations of nurses' education and work experiences. Although the respondents in Trojan and Yonge's study did not appear to go through a period of "disenchantment" and "guarded alliance," as described by Thorne and Robinson (1988), the phases of connecting, negotiating and helping share elements of mutual trusting. This aspect was found to be quintessential to health care relationships (Thorne & Robinson).

Raudonis (1995) explored the development of empathic NPRs between hospice patients and their nurses in a naturalistic study from the patients' perspective. Raudonis' study revealed that the development of the empathic relationship occurred in three sequential stages: initiating, building and sustaining. The patients' needs, nurses' functions and nurses' attributes were processes found to be present throughout all the phases of relationship development. During the initial phase of the empathic relationship, hospice patients revealed their needs to the nurse. The nurse, in turn, entered the patient's home wanting to help meet the patient's needs. The nurse's caring and gentle approach were reported to influence the establishment of the empathic relationship. The empathic relationship is
strengthened and deepened in the building phase. In this phase, there was a sense of mutual sharing, concern and commitment in that there was reciprocity and trust between nurse and patient. In addition, during this phase the nurse demonstrates competence, consistence and a willingness to spend time with the patient.

In the final phase, the sustaining phase, patients described the nurse as being available and 'going beyond the call of duty.' Patients reported feeling secure and less anxious regarding potential problems as their needs were being met. The sustained empathic relationship was a way of knowing the patient and the context in which nurses met patients' needs in a holistic and humanistic manner (Raudonis, 1995).

In reviewing the above research studies, it is interesting to note the differences in findings, particularly in light of the different perspectives from which the relationship was studied. Raudonis (1995) and Thorne and Robinson (1988) investigated the relationship from the patient's perspective, whereas Trojan and Yonge (1993) investigated the relationship from the nurse's perspective. It is interesting that themes such as trusting and mutual negotiation surfaced in all these studies. However, nurses in Trojan and Yonge's study did not report observing periods of "disenchantment" or "guarded alliance." This difference is important. It is possible that patients do not share their disenchantment openly with their health care providers. Alternatively, if nurses are not interested in patients' subjective experiences then patients' relationships with health care providers and changes in the relationship may go unnoticed. Similarly, the patients in Raudonis's (1995) study
did not report becoming "disenchanted" or having a "guarded alliance" with their nurses. Perhaps the hospice patients did not become "disenchanted" with their nurses because their nurses emphasized a caring and gentle approach, a thorough assessment during the initial phase and demonstrated a willingness to spend time with their patients.

Furthermore, patients in Thorne and Robinson’s study entered the health care relationship trusting their health care problems would be answered, and when it became clear that a cure did not exist for their chronic illness, they became "disenchanted" with their health care providers. The also felt their health care providers did not care or understand them. In contrast, the hospice patients in Raudonis’s study had already accepted that a cure did not exist for their illness, and recognized their need for prolonged health care. The contradictory findings in these studies suggest that further research is necessary to investigate the NPR in ways that include both nurses and patients. For example, it may be possible to observe differences in the way nurses and patients interact at each phase of the developmental process and how they negotiate movement to another stage.

Factors Influencing the Development of NPR

Factors that contribute to the development of the NPR have been discussed in the literature by theorists (Gadow, 1980, 1985; Peplau, 1952) and studied by researchers (Artinian, 1995; May, 1990, 1993; Morse, 1991a). The factors noted are related to the nurse, the patient or the institutional context in which nurses practice.
Factors Related to the Nurse

Factors related to the nurse that appear to be linked to the development of helpful NPRs have been conceptualized (Peplau, 1952) and investigated (Elder, 1965; May, 1993; Morse, 1991a). Nurse-related factors include the nurse's attitudes toward helping others; whether or not the nurse responds to the patient's expression of perceptions, thoughts and feelings; the nurse's commitment to the patient as well as to the good of the profession and her/himself; and whether or not the kind of help a patient requires affects the nurse's acceptance of that individual.

Another factor influencing the NPR related to the nurse is the personal/professional dichotomy. The issue of this dichotomy has been raised in relation to the nurse-patient relationship by theorists (e.g., Gadow, 1980) and researchers (e.g., May, 1990, 1993). The theoretical findings and research findings in relation to this dichotomy, however, are not in agreement. Gadow argues that being professional does not necessarily mean the exclusion of being personal. The nurse can participate in the patient's experience by synthesizing the nurse's entire self. The esthetic, physical, and intellectual dimensions of the nurse can all be used as a resource in the NPR and are conceptualized by Gadow as "existential advocacy." Entailed in Gadow's notion of existential advocacy is the experience of "fellow-feeling" (p. 91). In fellow-feeling the nurse participates in the patient's illness but is not 'infected' by the patient's suffering thus becoming clinically biased or emotionally depleted (Gadow). May (1990, 1993), conversely, noted that in order for the nurse to
have total perspective of the patient's needs, respondents in his
study found it necessary to disentangle or detach themselves from
patients so that personal interests and ward objectives do not
become confused.

Another nurse-related aspect which influences NPR
development is the difference in status between the nurse and
patient. A participant observation study conducted in an
elderly-care setting, found nurses dominated and exerted power by
controlling the content of the conversation, and by persuading
patients in order to meet their own agenda (Hewison, 1995).
Although this situation was accepted by staff and patients, it
constituted a barrier to the NPR. Others have also noted that
control affects the NPR (May, 1995a; Lawrence, 1970; Trnobranski,
1994). These authors maintain there are problems inherent in the
NPR in relation to the patient's autonomy and the nurse's
authority. On one hand, a good NPR is about the nurse assisting
the patient to make choices. On the other hand, the patient is
an individual and is an expert about her/his own needs. As a
result, it is difficult for the nurse to know how much expert
knowledge would best serve the patient. Furthermore, some
patients are not keen on participating in decisions about their
care. In such a situation it may be difficult for the nurse to
decide whether or not the patient should be encouraged to
participate in her/his own care.

Factors Related to the Patient

Factors influencing the development of the NPR that are
related to the patient have been noted by Artinian (1995) in her
study on risking involvement with cancer patients. Artinian
found nurses selectively formed relationships with certain patients based on the patient's age, vulnerability, their own similarity to the patient, and initiation of the relationship by the patient. For example, a patient possessing characteristics that reminded the nurse of a grandmother, or the patient having similar aged children as the nurse seemed to contribute to forming "special" NPRs. Others have also observed that nurses find it easier to form relationships with some patients than others (Kahn & Steeves, 1988). Liking the patient was reported by nurses as "clicking," "meshing," or "enjoying" certain patients and having their affection returned. These researchers maintained that this theme represents the "intrusion of the 'person' into the 'nurse'" (p. 207).

Increased patient needs and whether the patient is in a crisis situation have been identified by researchers (Morse, 1991a; Ramos, 1992; Reid-Ponte, 1992) as important factors influencing the development of the NPR. However, patients have been reported to actually influence the development of NPRs by using strategies to increase and decrease their involvement (Morse, 1991a). The unwillingness of some patients to 'open up' or respond to overtures by the nurse are important factors influencing the NPR. May (1993) argues, as many other nurse authors (Bishop & Scudder, 1990; Gadow, 1980, 1985; Orlando, 1961; Peplau, 1952; Watson, 1988), that interactional obstacles with patients are sometimes inevitable.

Factors Related to the Institution

Institutional factors influence the NPR primarily by regulating the length of contact between the nurse and the
patient. Factors such as rotating shifts, the nurses' workload, sets of routines, technologies and bureaucracies on the ward make contact between the nurse and patient episodic and discontinuous. As such, nurses' and patients' efforts to build and maintain relationships are often undermined. Gadow (1985) cautions that the intense network of institutional factors assert an "otherness" that often does not require human involvement and therefore the human aspects of care are potentially alienated. That is, technologies and bureaucracies can take on a life of their own leaving the patient behind.

**Nursing Cancer Patients**

Cancer, as a life threatening illness, presents patients with a series of threats that vary in intensity and duration. The patient must endure the stresses accompanied by the illness and mobilize his/her coping mechanisms and support system (Mages & Mendelsohn, 1979). Creating relationships with cancer patients that will be effective in assisting patients to endure their illnesses presents nurses with special challenges. Issues particular to cancer such as uncertainties and fears about the present and future, difficulties with accepting a terminal prognosis and the nature of suffering experienced by cancer patients, increase patients' need for support and empathy and thus the need for an effective NPR (May, 1995b; Raudonis, 1993). Health professionals, including nurses, have often found it difficult to interact with cancer patients at a meaningful level. Efforts to interact have been hampered by attitudes toward death and dying, secrecy around the diagnosis of cancer for many patients, and the need for some nurses to protect themselves from
patients' suffering (Artinian, 1995; Cohen & Sarter, 1992; Kahn & Steeves, 1994; Larson, 1992; Newlin & Wellisch, 1978; Pepper, 1985; Welch, 1981; Williams, 1982). In studying factors that influence how nurses communicate with cancer patients, researchers have focused primarily on the nurse (May, 1995b; Wilkinson, 1991). Recently, others have begun to draw attention to the role patients play in influencing the nature of nurse-patient interactions (Morse, 1991a; Raudonis, 1993, 1995).

The importance of NPRs in cancer nursing is reflected in a variety of studies. In particular, the importance and complexity of the supportive role of the nurse in caring for cancer patients has been recognized (Davies & Oberle, 1990; Heslin & Bramwell, 1989). Furthermore, from the perspective of cancer patients, effective communication has been viewed as the most important aspect of their treatment (Pepper, 1985; Thorne, 1988). Providing comfort to cancer patients was reported by nurses to be a positive and important nursing behavior (Degner, Gow, & Thompson, 1991; Fleming, Scanlon, & D'Agostino, 1987). In addition, observations of nurses and cancer patients revealed that comforting cancer patients comprised a significant part of nurses' work (Bottorff, Gogag, & Engelberg-Lotzkar, 1995).

Caring behaviors have also been identified as key elements of cancer nursing by researchers (Cohen & Sarter, 1992; Larson, 1987) and others who have written in the area of cancer nursing (Mayer, 1986; Pepper, 1985). These caring, supportive and comforting behaviors are based in and evolve from effective relationships between nurses and cancer patients.

Surprisingly, little attention has been directed
specifically to the nurse-patient relationship in oncology settings. Qualitative researchers using in-depth interviews with cancer nurses (Artinian, 1995) and hospice patients (Raudonis, 1993, 1995) have begun to provide empirical support for the importance of the NPR in oncology settings. As effective NPRs are developed, patients are reported to be empowered to deal with personal issues associated with different phases of their illness and improvements in quality of life were experienced (Raudonis, 1995). In addition, patients reported feeling accepted and acknowledged as individuals and persons of value by their nurses (Raudonis, 1993). Research also showed nurses to believe the only way to provide supportive care to cancer patients was by developing an effective NPR (Artinain, 1995). Nevertheless, these studies are limited in that researchers have focused on only one member of the dyad to explore aspects of the relationship (either the patient or the nurse), and have based their research solely on self-report. Clearly, the development of effective NPRs depends on the behaviors of both nurses and patients. This development may not be adequately captured through self-report. As a result, studying the NPR is a challenge. Although there is evidence that in the context of working with cancer patients the development of NPRs is critical, we still know little about how these relationships actually evolve in clinical practice.

Gaps in the Research on NPRs

There is a consensus in theoretical and research literature that the NPR is a key element of nursing practice. However, despite the interest and numerous studies on NPRs, gaps remain
and further research is necessary. Validation of existing theoretical frameworks are needed as well as the examination of actual interactions that reflect the professional bonds developed by nurses in clinical settings.

Most of the research concerning the NPR is based on the self-reports of nurses or patients. An assumption underlying this approach is that participants can accurately report on the dynamics underlying evolving relationships. Differences in perceptions of nurses and patients regarding the structure of the relationship and strategies considered to be helpful suggests that in addition to personal subjective accounts, it may be beneficial to conduct observational studies of naturally occurring nurse-patient interactions in order to describe the evolution of NPRs as they occur in real-life settings (Lowenberg, 1994).

Given the complexity of interactions, observational studies that use videotaped data are likely to be the most useful (Lowenberg, 1994). This has been supported in other detailed observational studies of interactions between nurses and patients (Bottorff & Morse, 1994; Pepler, 1984; Solberg & Morse, 1991) and mothers and infants (Richards & Bernal, 1972; Scaife, 1979)

**Summary and Conclusion**

The topic of the NPR was introduced with a brief account of how this concept emerged as a central component of nursing theory and practice. This brief historical account was followed by a description of three conceptualizations of the NPR: therapeutic and non-therapeutic relationships; types of relationships based on levels of involvement; and, the NPR as an interactive process.
These conceptualizations were followed by a discussion of some of the theoretical positions that have shaped our understanding of the process of developing a NPR and subsequent research. While some of the theories were supported in research studies, other theoretical aspects need further exploration. Interestingly, all of the theorists whose works were reviewed here considered the perspective of the nurse and patient equally in their descriptions of the NPR. Yet, researchers tended to investigate one perspective or the other. Most research studies were based on data that were primarily collected by interviewing nurses in a variety of settings. Furthermore, differences were found in studies that took into account the perspective of nurses and those that considered the perspective of patients. It appears that nurses and patients have different ideas regarding the constitution of a helpful relationship.

In the latter half of this literature review factors influencing the relationship were described. The factors noted were related to the nurse, the patient and the institutional context in which nurses practice.

Finally, the nursing of cancer patients was discussed. Because cancer is a disease that is accompanied by specific mental and physical stresses, it is crucial for the oncology nurse to develop a relationship with his/her patients that will be helpful and will contribute to the patient's ability to endure this illness. Although a vast amount of research has been conducted in relation to caring, comforting, and supporting cancer patients, only a few researchers focused on the NPR in cancer nursing. The impact of the relationship on the patient as
well as the nurse has been supported by theorists and researchers. The dynamic progression of cancer and its tremendous impact on the individuals enduring the illness has also been identified. Further research on the relationship between cancer nurses and their patients is needed. Such research has the potential for assisting the patient to endure the stresses of their illness and the nurse to know how to proceed in this dynamic process.
CHAPTER 3: METHODS

The main aim of this study was to describe the process of developing a relationship between a nurse and cancer patient. The research question was: What patterns of nurse-patient interaction reflect the development of an effective NPR?

Approaches used in research should be selected according to the nature of the research question and what is known about the phenomenon to be studied (Field & Morse, 1985). Quantitative research is useful in a situation where the researcher is seeking a relationship or cause between known variables. However, when the researcher is seeking new ways to "categorize, classify, or conceptualize situations [with the aim] to devise or invent labels that taken together will usefully characterize the important aspects of a given situation" (Diers, 1979, p.100), a qualitative design is more conducive to the research. In order to investigate the developmental process of the NPR as it occurs in clinical practice, a case study using a qualitative ethological approach in an active treatment cancer unit was used.

Presented in this chapter is a description of the research design, setting, sample selection, and ethical considerations. The process of data collection and data analysis will be delineated.

Research Design

The nature of this study lent itself to a descriptive research approach. In descriptive research, the investigator's aim is to describe phenomena rather than explain them (Polit & Hungler, 1991). Qualitative ethological methods were used in this study to provide an in-depth description of the development
of a NPR as it occurred in a single nurse-patient dyad.

The study of NPRs to date has been dominated by the use of self-report methods (i.e., open-ended interviews). The limitations of using self-report in describing and understanding complex interactions has been recognized (Bottorff, 1994; Morse & Bottorff, 1990). For example, nurses and patients are unlikely to be able to recall behaviors in sufficient detail to reconstruct all aspects of their interactions. Qualitative ethological methods have the potential to capture complex behavior patterns through detailed observations of behaviors as they occur in natural settings (Bottorff & Morse, 1994).

Ethology involves the microanalysis of observed behaviors. It has been used to systematically observe, analyze, and describe animal and human behaviors in natural contexts. For example, anthropologists have used ethology to study human facial expressions cross-culturally (Morse & Bottorff, 1990). Ethological research characteristically has two phases: an inductive phase and a deductive phase. The present study will involve the first inductive phase, referred to as qualitative ethology. An ethogram, a detailed recording of the behavioral patterns observed, is developed in qualitative ethology.

The aim of qualitative ethology is to specify and describe patterns of behavior within the context in which they occur (Erickson, 1992; Bottorff & Morse, 1994). By using this research method, the investigator is able to document these patterns in greater detail and with more precision than is possible with other descriptive approaches such as interviewing or participant observation (Erickson, 1992).
Observational methods such as qualitative ethology can be enhanced through the use of videotaped recordings (VTRs) of naturally occurring behavior. The use of VTRs makes it possible to study events that may be rare or of such short duration they may be missed in participant observations. Furthermore, precise information about verbal and nonverbal behaviors as they unfold moment-by-moment is available for intense and repeated analysis. As such, subtle nuances which may otherwise go unnoticed can be verified and described. Behavior is complex: in any given situation many complex events may happen simultaneously. As a result, the use of participant observation is limited because one is unable to capture the complexity. When situations are complex, the participant observer tends to favor frequently occurring events, potentially overlooking other important aspects that may confirm or disconfirm a theory (Erickson, 1992).

In contrast, VTRs present an unlimited opportunity to revisit events as they occurred in real time. The advantage of replaying events allows for a richer description of observations than those taken in the field by the observer. VTRs allow the investigator time to deliberate on interpretative judgments so that faulty inferences can be prevented (Erickson, 1992). The observer of VTRs also has the opportunity to thoroughly study rare events as well as frequent events (Erickson).

The study of NPRs could be extended through a detailed analysis of VTRs using qualitative ethological methods. Researchers who have used interviews to explore NPRs have often based their descriptions of reports of only one of the players in the interaction. As a result, important information that may be
critical to the development of the relationship is missed. In addition, self-reports, particularly in stressful situations, may be confounded by fatigue, pain, or shock. Even in the best situations, it may not be possible for the participants in an interaction to accurately report on all verbal and nonverbal behaviors that were important to the development of a relationship. In sharp contrast, the use of VTRs lends itself to equal observation of both participants.

The use of VTRs as a method of data collection has other advantages for the study of complex interactions. A wide range of behaviors, including subtle verbal and nonverbal nuances that may not have been obvious to participants, are captured and available for detailed analysis and description. Reviewing VTRs is possible as many times as necessary so attention can be directed to different features with each viewing. In addition, the review of VTRs at various playback speeds, in slow motion or frame-by-frame, may disclose new behavioral patterns not immediately apparent in observations under normal speed. These features of VTRs make a thorough and complete analysis possible (Bottorff, 1994). Furthermore, VTRs provide an opportunity to study unconscious behaviors that are generally difficult if not impossible to explicate or recall in an interview (Morse & Bottorff, 1990).

In qualitative ethology, an inductive approach is used to describe interactions. This method, particularly with videotaped data, offers an opportunity to gain a rich and complex understanding of the dynamics involved in the development of a NPR (Bottorff & Varcoe, 1995). The present study involved a
secondary analysis of videotaped data collected as part of a larger study to investigate nurse-patient interactions (NPIs) (Bottorff, 1992). NPIs are the processes of personal and mutual influence that unfold according to the characteristics of each participant and include the interactive processes related to how each individual adapts his/her verbal and nonverbal communication to one another. Other variables such as the context, the purpose of the interaction, and previous interaction history also influence the interactive process (Bottorff & Varcoe, 1995).

Sample

The primary source of data used in this study was taken from an existing data set of videotaped NPIs (Bottorff, 1992). A sample of 60 videotaped NPIs (a total of two hours, nineteen minutes and three seconds of VTRs) representing all the interactions between one patient and one nurse over a three day period was selected for this study. Each interaction began when the nurse entered the patient’s room and ended when the nurse left the room.

Stake (1994) maintains that in selecting a case for study, the investigator should choose a case that seems to offer an opportunity to learn the most. Often this means choosing a case with which the investigator can spend the most time. This particular dyad was selected because it had the most frequent number of interactions over the longest period of time compared to all other nurse-patient dyads in the data set.

Cynthia (a fictitious name), the nurse in the dyad, was an experienced full-time registered staff nurse on the cancer ward. Bob (a fictitious name), the patient in the dyad, was a 45 year
old married gentleman who had squamous cell carcinoma of the tongue and right sided lymphadenopathy. Nursing priorities for Bob were mainly symptom control related to his radiotherapy treatments, including medications for nausea and vomiting and several mouth rinses (i.e., Tantum oral rinse and sodium bicarbonate). Bob also had a gastrostomy tube and experienced gas pains, nausea and hiccoughs when feeds were infused too quickly. Along with his gastrostomy tube, oral fluids were encouraged. However, during the data collection period, he did not take oral fluids because they seemed to increase his sensation of phlegm production and he was afraid of swallowing.

A focus group meeting with five expert nurses was used to validate and extend the analysis. The nurses were selected based on the following criteria: A minimum of a baccalaureate degree in nursing, at least five years of clinical experience in working with cancer patients, and who gave informed consent (see Appendix 1).

Data Collection

Videotaped Data

The data were collected as part of a previous study of nurse-patient interaction by videotaping a convenience sample of eight cancer patients (three females and five males) and 32 nurses that were their caregivers (Bottorff, 1992). To collect data, two cameras were mounted on the wall of the patient’s room and were remotely controlled and monitored from an adjacent area. The purpose of these strategies was to decrease interference with patient care and decrease the influence of the researcher. Furthermore, participant reactivity to being videotaped was
reduced by installing cameras four weeks before actual data collection began. These strategies were found to minimize the problem of distortion of behaviors related to the use of VTR in this clinical setting (Bottorff, 1992, Bottorff, 1994). In the original study, videotaping of each patient was continuous for 72 hours (Bottorff, 1992). Videotaping was discontinued only for brief periods and at the request of the patient or staff members in order to complete private or invasive procedures. A remote controlled pan-tilt and zoom lens were used to ensure the nurse and patient were in full view as much as possible. Furthermore, a log was kept of all activities as well as field notes of comments and/or questions of staff members and patients, and any activities out of camera range. To ensure maximum quality of videotapes, Super VHS equipment was used for recording. The time in hours, minutes and seconds was recorded on the VTRs for the purpose of analysis. Demographic and clinical data were collected on each patient. For the present study, all of the videotaped interactions of one of the nurse-patient dyads were extensively studied.

**Focus Group**

Data analysis for this study was validated by using a focus group meeting with clinical nurse experts. Krueger (1994) maintains that the purpose of a focus group is to foster different points of view and perceptions on a defined area of interest without pressuring the participants to reach consensus. The researcher leading the focus group creates a nontthreatening, comfortable environment where participants can enjoy sharing their ideas. The purpose of the meeting was to discuss the
findings of this study. The meeting entailed a brief presentation of the preliminary findings. The group was then asked to discuss the findings in relation to their own experience. Participants were encouraged to provide examples from their own personal experiences that may be useful in augmenting or refining the findings of the study. The meeting was audiotaped for subsequent analysis (Krueger, 1994). An observer was also present to take notes during the focus group meeting.

Data Analysis

The focus of data analysis in qualitative ethology is to consider whole events occurring in the data, analyze these whole events by breaking them down into smaller clusters, and then conclude by rebuilding the smaller clusters into sequences or wholes. The purpose of this kind of analysis is to reconstruct highly detailed phenomena into a narrative understanding of the events that occurred. It is important that this understanding is analogous to that held by the players in the events themselves (Erickson, 1992).

The data analysis of the VTRs was completed in the following way:

1. Reviewing All the Interactions

   All of the videotaped interactions between Cynthia and Bob were systematically reviewed in an unstructured fashion. As the VTRs were reviewed, the equivalent of field notes were taken that described the recorded activity. The notes identified approximate times of activity shifts and verbal and nonverbal behaviors of special interest.
2. **Identifying Behavioral Clusters**

The next step was to identify the patterns or clusters of behaviors pertaining to the development of the NPR. Tapes were played and replayed at this stage observing the nurse’s and the patient’s behaviors. While observing behaviors, the researcher asked questions such as, "What is going on here?", "How does this behavioral response or interaction differ from another?, "What are the characteristics of this type of response or interaction?" (Bottorff, 1994, p. 256).

3. **Identifying Constituents of Behavioral Clusters**

In this stage, the boundaries of each behavioral cluster was checked in a second viewing. That is, the beginning and ending of each cluster was clearly defined. Opening and closing phrases in each cluster, for example, were used to determine when each cluster starts and stops. These behavioral clusters were then dubbed onto another tape to ease the process of analysis.

Having identified the main behavioral clusters, particular constituents of the clusters were then studied. Each cluster was viewed and reviewed several times. Each time a different aspect of the cluster was watched, listened to, and recorded in the form of field notes. For example, in the first viewing attention was only directed to the content of verbal conversation. The second viewing was directed toward nonverbal behaviors. The third viewing payed attention to who initiates the conversation, and so forth. Recording included how long each behavioral aspect lasted to the nearest second and included the time for quick reference. All relevant verbal and nonverbal behaviors were noted, such as who initiated a conversation, the content of the conversation,
how and why the conversation ended, the use of eye contact, the proximity of nurse to patient, and other verbal and nonverbal behaviors.

Behavioral clusters were compared to one another. For example, it was noted whether the nurse used the same verbal and nonverbal techniques every time the patient was distressed.

4. Constructing the Ethogram

From the above data analyses, behavioral descriptions included an interpretation of the cause or functions of observed behaviors, and the consequences and conditions under which behaviors occurred (Bottorff, 1994).

Data analysis of the focus group was completed in two ways. First, notes taken by the observer of the focus group were reviewed. Second, the audiotape recorded during the focus group was reviewed several times, paying attention to emerging themes in the discussion. The themes that emerged from the focus group were then used to refine and augment the findings of the study.

Rigor

Several measures were taken to ensure rigor in this study. Auditability was achieved by leaving a clear decision trail in every stage of the study (Sandelowski, 1986). A journal was kept detailing and justifying all decisions made during the processes of conducting the study. In the interest of neutrality, the journal also included reflective notes about what was happening in terms of the researcher's own values and interests and for speculation about emerging insights. Applicability and credibility of the analysis was ensured by detailed and repeated analysis of the VTRs to identify essential characteristics of the
developing relationship. A focus group meeting was also held to evaluate the extent to which the findings were meaningful and applicable to the experiences of cancer nurses who have worked in similar settings.

**Ethical Consideration**

Participants in Bottorff's (1992) study provided informed consent that included permission to use the data in future research, subject to the approval of an ethics committee. The ethical review committee of the University of British Columbia was sought for approval of this study. Each participant of the focus group was given an explanation of the project, told that their participation is voluntary, and that they could withdraw from the study, refuse to answer any questions, or leave the discussion at any time. All data used and collected in this project was kept confidential and anonymity of participants was maintained at all times. To provide anonymity, each participant was assigned a study number. The names of participants were not revealed in any final report.

**Summary**

Discussed in this chapter is the research method that was used in the present study. A description of the research design, setting, sample selection, data collection and data analysis procedures, and ethical considerations was provided.
CHAPTER 4: FINDINGS

In this chapter, the findings of the study which reflect patterns of behavior and behavior clusters between a nurse and a patient observed over the course of three days, are presented. Background information relevant to each day is highlighted to provide a context for these observations. Some clusters of behaviors were observed across all three days of the relationship, while others changed as the relationship developed. Several behaviors reflected in the clusters appeared often and remained consistent through the three-day relationship. For example, the humor and cordiality with which both the patient and the nurse undertook the beginning of interactions and the leave-takings were consistent. Behaviors observed to be consistent throughout the relationship are described in detail in the section called Day One and alluded to briefly in descriptions of subsequent days.

The development of the NPR in this particular nurse-patient dyad is reflected in the changes observed in the behaviors of both the nurse and patient. This conclusion is supported in several ways. First, given the number and continuity of interactions over a three day period, an opportunity for the development of a NPR existed. Second, interview data with both the nurse and patient following the period of observation indicated that both independently acknowledged similar aspects of the relationship that evolved between them. The patient, Bob, expressed great appreciation of the nurse's, Cynthia's, efforts to decrease his discomfort. He indicated he felt more comfortable with her than the other nurses, who did not know him
as well, and praised her for "being great." Cynthia stated that they had developed a "good relationship" and she enjoyed nursing Bob. She commented she was "really involved" in what was happening to him. Finally, particular observations of this nurse-patient dyad also point to the development of an important relationship. In particular, a gift exchange and sentiments expressed at the end of the nurse's assignment reflect the depth of the relationship.

One notable characteristic of this set of interactions was the predominant use of humor on the part of both the nurse and the patient. Humor was noted in the form of jocularity and lightheartedness as well as in nonverbal behaviors such as hand gestures, smiles and laughter, and facial gestures like eye rolling. Humor seemed to be a mutual process between the nurse and patient with the patient usually taking the initiative. In this relationship, humor seemed to be a means of communication that contributed to a positive and relaxed atmosphere.

Humor was also very much context bound. The nurse appeared to use it appropriately; for example, humor was never used while the patient was in acute physical distress. However, once the initial distress subsided, a humorous gesture was made by the nurse. Furthermore, humor was never used at the expense of the patient or the nurse; that is, it was not used in an attempt to embarrass or be sarcastic. The content of the humor was usually related to the patient, to his G-tube flushes or to making light of his reluctance to use his mouth therapies. The use of humor appeared to be an important basis for each of the behavioral clusters identified in this study.
For the nurse, the use of humor was based on a conscious decision: She indicated that Bob needed some fun in his days because he was at a stage where he was "sick of being sick" and needed a "lift." Nevertheless, she was sensitive in the way she used humor. During the interview, she indicated that getting to know Bob and his moods was important in determining when it was appropriate to "joke around" and when it was not. Bob's response to her humor, in addition to his own use of humor in their interactions, indicated that he was comfortable with this approach.

The extent to which the use of humor influences the development of NPRs is difficult to determine from the observation of a single dyad. However, the use of humor in this series of interactions appeared to serve an important purpose in the development of the relationship between Bob and Cynthia. It introduced a sense of informality into their interactions that stimulated conversations about Bob's care and issues that arose throughout each day as well as diverted his attention, albeit briefly, from his discomforts.

**Day One**

The first day of this three-day relationship between the nurse and the patient, consisted of a total of 22 interactions. The 22 interactions made up a total of 53 minutes and 21 seconds that the nurse and patient spent in each other's presence, with an average of 2 minutes and 42 seconds per interaction. Day one of this relationship was Cynthia's first day with Bob. During the previous week, she had nursed him for two nights and this week she would be caring for Bob for three days—two twelve hour
shifts, from seven in the morning to seven in the evening, and one eight hour shift, from seven in the morning to three in the afternoon.

During the day prior to being nursed by Cynthia, Bob was experiencing pain related to his gastrostomy tube (G-tube). For the pain, he was given Codeine which resulted in him becoming constipated. Furthermore, he was having large amounts of phlegm build up in his mouth which was very sore. He found it too painful to clean his mouth effectively with either a toothbrush or prescribed mouthwashes.

Bob's first day with Cynthia was preceded by a sleepless night. Throughout the previous night, Bob was awake at every hour. He had been given Codeine and Ativan, neither of which helped to settle him.

Four clusters of behaviors were observed to occur in the first day of interactions, including: getting to know the nurse • getting to know the patient; wooing the nurse • creating a foundation for connecting; being vigilant • demonstrating competence; and cautious consideration • making therapeutic suggestions (see Table 1). Each behavior cluster is described and is followed by examples that illustrate the cluster.
Table 1

Behavioral Clusters and Their Constituents Observed on the First Day of the NPR

<table>
<thead>
<tr>
<th>Patient Behaviors</th>
<th>Nurse Behaviors</th>
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<tbody>
<tr>
<td>Getting the Know the Nurse</td>
<td>Getting to Know the Patient</td>
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<td>- Responding to introductions</td>
<td>- Introductions</td>
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<tr>
<td>- Assessing the nurse</td>
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<tr>
<td>- Acknowledging leave-taking</td>
<td>- Leave-taking</td>
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<tr>
<td>Wooing the Nurse</td>
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<tr>
<td>- Accepting the nurse</td>
<td>- Accepting the patient</td>
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<tr>
<td>- Complementing the nurse</td>
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<tr>
<td>- Being friendly</td>
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<td>- Asking the nurse for help</td>
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<td>- Helping the nurse</td>
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<tr>
<td>Being Vigilant</td>
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</tr>
<tr>
<td>- Keeping a watchful eye</td>
<td>- Talking through her actions</td>
</tr>
<tr>
<td>- Checking the nurse's actions</td>
<td>- Carrying out nursing tasks expertly</td>
</tr>
<tr>
<td>- Establishing the nurse's</td>
<td>- Telling the patient her whereabouts</td>
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<td>whereabouts</td>
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<tr>
<td>Cautious Consideration</td>
<td>Making Therapeutic Suggestions</td>
</tr>
<tr>
<td>- Listening and cautiously</td>
<td>- Gently guiding the patient</td>
</tr>
<tr>
<td>responding to the nurse's</td>
<td>by explaining suggestions</td>
</tr>
<tr>
<td>suggestions</td>
<td>- Gentle confrontation</td>
</tr>
<tr>
<td>- Justifying actions</td>
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</tbody>
</table>

Getting to Know the Nurse «» Getting to Know the Patient

Behaviors that reflected the nurse and patient getting to know one another occurred throughout the first day of the relationship. Behaviors related to getting to know one another were embedded in introductions at the beginning of the day and
the interactions that occurred each time the nurse entered the room. These interactions focused on patient needs, social conversation (including humor), and leave-taking.

Responding to Introductions

Introductions throughout the first day were lead by the nurse. The first introduction, in particular, was characterized by personal references. For example, rather than stating her name and status, the nurse said to the patient "You have me today", a gesture which set a personalized tone for continuing interactions. The nurse often smiled as she entered the room, focusing directly on the patient as she spoke. She acknowledged the patient verbally and nonverbally by announcing her entrances and telling the patient what she would be doing. Furthermore, these introductions served to establish the time frame the nurse would be with the patient during each interaction. In the first introduction the notion of length of stay was defined by the length of the shift the nurse worked; in subsequent interactions, it was defined by the tasks to be completed. The introductions were often accompanied by humor and social conversation. These behaviors are reflected in the following segment that occurred in the nurse's first encounter of the day with Bob. Interestingly, despite their limited contact before this interaction, the nurse helps the patient make a connection to their previous encounter albeit indirectly.

N: Good morning. How are you?
P: Alright, I didn’t hear you. How are you doing?
N: You have me today. [She smiles at the patient, has direct eye contact.]
P: I’m so fortunate. [He looks at the nurse, in a joking voice.]
N: [She smiles at his humorous comment.] Ohhh.
Subsequent behavior clusters that occurred at the beginning of interactions, were often missing typical social preludes; rather, they focused on introducing or preparing the patient for the task to be performed. In the following example the nurse enters the room with the blood pressure cuff and thermometer.

N: ...Just gonna take your temperature and your blood pressure. [She gestures for the patient to take out his ear phones so she can take a tympanic temperature.] Two seconds.

Initiation of and responding to introductions and leave-takings were an important part of acknowledging and getting to know one another.

Assessing the Nurse as a Person  Assessing the Patient as a Patient

Behaviors that reflected getting to know the patient and getting to know the nurse were observed in the nurse’s assessment of the patient and the patient’s assessment of the nurse. The nurse’s ongoing assessment throughout the day consisted of a mix of questions about the patient’s care and interactions that were lighthearted and humorous. The latter appeared to break up the monotony of routine questions. The nurse usually made eye contact with the patient when asking him questions and her voice would inflect toward the end of the question, inviting more than a yes/no response from the patient. While assessing the patient’s equipment such as his feeding pump or subcutaneous injection site the nurse would talk through her assessment and glance over at the patient to make eye contact, telling the patient what she was looking at. For example, while assessing the patient’s subcutaneous injection site on his abdomen, the nurse assessed the area with her fingertips. As she did this,
she periodically glanced at the patient, told him she thought it looked a bit inflamed, and indicated she would keep an eye on it throughout the day.

During these interactions, the patient also assessed the nurse. In contrast to the nurse, who assessed the patient as a patient, the patient assessed the nurse as a person. Although the nurse had the opportunity to ask the patient assessment questions at any time, the patient had to be strategic in finding out information about the nurse. This patient took advantage of the time the nurse spent with him during relatively lengthy routine tasks, such as, flushing his G-tube, which took about seven to ten minutes to complete. At these times, he would ask the nurse questions about her personal life such as what her husband does for a living, where she lives, and whether she has a family. The nurse willingly answered his questions and, in doing so, disclosed aspects of her personal life. In these instances, the patient also shared some of his own personal life with the nurse; for example, he told her that he is a builder. He also nodded his head while she was talking and verbalized utterances such as "Uh, huh," "Oh, yeah," and "Really?" signifying that he was listening and interested.

Their questions to one another at the beginning of the day were general and reflected the newness of their relationship. For example, after the patient rinsed out his mouth in the morning, the nurse asked him, "That feel better?" The patient also began by asking the nurse general questions such as, "How's things in St. Albert today?"

As the day progressed, questions became more specific on the
part of the nurse and personal on the part of the patient. The following is an example of an interaction in mid-morning. In this example, the nurse is working with the patient’s G-tube.

N: Do you miss the taste of food?
P: Right now?
N: Yeah.
P: Not really.
N: No.
P: I’ve succumbed to um, to the fact right now. But you see, you don’t get the full story.
N: [She nods her head as she is working, and glances up at him periodically as he is speaking.] Mmm Hmm.
P: I might get out of the hospital on IV because I wouldn’t be able to really eat anything.
N: Mmm Hmm. And you’ve got this now. [She gestures to the G-tube.]
P: Yeah. In a few weeks it turned into this...Now, um, I know that nurses make some reasonable money, what does your husband do? [looking at the nurse]
N: He’s dead.
P: Is he?
N: Yeah. He used to be a... he used to run his own business.
P: Yes. [The nurse continues to flush the patient’s G-tube with a syringe.]
P: So then why do you still have Mrs. in front of your name?
N: This is my old Irish badge.
P: Yes.
N: I just didn’t get ‘round to changin’ it.
P: Yeah, good old Irish. You’re kind of particular aren’t you?
N: ...In the Irish hospital where I was born, you know, you wouldn’t be called nurse, I’d be called Miss or Mrs.
P: Yeah, really?
[interaction continues]
she had to leave the room to get something, such as an additional piece of equipment required to complete a task, or when she was leaving for the day. The nurse never exited the room without announcing that she was leaving. Often, the nurse would tell the patient that he could call if he needed anything or that she would return shortly. In the following example the nurse had just finished working with the patient's G-tube feed.

N: [She unplugs the patient from his G-tube feed.] That's it. You're free for a little while.
P: Yeah. Till around ten o'clock.
N: Yeah. Till I get back from coffee anyway I suppose. [She places the call bell next to the patient.]
N: ...Alright. Just give a call if you want anything; there's someone around.
P: I will.
N: Alright.
P: Thanks.
N: See you later, Luv.

The patient often responded to the nurse's gesture upon her leave-taking by saying "good-bye" or "thank you" or alluding to the next time they would interact, for example, by stating the time he would receive his next bolus or flush.

Wooing the Nurse ↔ Creating a Foundation for Connecting

The nurse and the patient were observed to be engaging in behaviors that reflected their individual attempts to establish a relationship. The nurse worked at creating a foundation for connecting with the patient by engaging in such behaviors as accepting the patient, involving the patient in his care, responding to his friendly gestures, passively accepting his compliments and responding to his requests for help. At the same time the patient attempted to woo the nurse by demonstrating his acceptance of the nurse by complimenting the nurse; by being friendly; and, by helping the nurse and asking her for help.
Attempts to achieve synchrony in the relationship was implicit in the tone of the interactions between the nurse and the patient. The nurse and the patient dialogued in a way that represented acceptance of one another. For example, the nurse was found to repeat the patient’s terminology. When he called his mouthwash "the mixture," the nurse would subsequently refer to the mouthwash by the same name. In another instance, when he asked if he could apply Vaseline to his lips like lipstick, the nurse responded by using his same terminology, "That's right just like lipstick." The nurse was observed to accept the patient's concerns and discomforts and put him at ease with accepting statements. For example, when he seemed concerned about being behind on his G-tube flushes, she reassured him by saying, "We’ll get there." In another situation when he was explaining to the nurse that he needed help to apply powder to his neck because he could not see where to apply it himself, she quickly responded, "I believe you." Using the same terminology as the patient and reassuring him about his care seemed to affirm the patient's worth as a person.

The patient demonstrated his acceptance of the nurse implicitly through his positive tone. For example, he would smile at the nurse as she entered the room. The patient also demonstrated his acceptance of the nurse by offering his assistance to her, and by making appreciative comments when she completed tasks by simply thanking her or giving her a compliment.

The following segments of interactions illustrate the nurse
and patient accepting one another. In the first example, the nurse enters the room after looking for new suction tubing.

N: There's just some days when I can never find anything.
P: Is that right?
N: Yeah.
P: Is this one of them?
N: Huh?
P: Is this one of them?
N: Well, I managed to find it anyway. [She proceeds to unwrap new suction equipment.] It's just that sometimes it takes longer than others.
P: One thing about it, it brings you back to me.
N: [joking] Of course. I don't know why you're complaining about your suction or your bolus taking so long, when it really means that I can stay here talkin' with you.
P: Yeah.
N: There we go.

In the second example, the nurse is checking his feeding pump.

P: If you wait a few months now you know, I can build you a house.
N: [laughs] Can you?
P: That's my business.
N: Building houses?
P: Yeah.
[The nurse continues to work with the feed pump as the patient suctions his mouth.]

In both these examples, acceptance is based on the positive tone and synchrony created by the nurse and patient. This positive tone is explicit in their dialogue and implicit in the atmosphere created in their interaction.

Complimenting the Nurse • Carrying on in a Usual Manner

The patient was observed to compliment the nurse for bringing him what he needed and respecting his personal preferences using phrases such as "lovely, lovely lady," "you betcha," "A-Okay," and "Ahhh, good stuff." The nurse was observed to passively accept the patient's compliments by continuing to do her work in her usual manner. It is possible that the nurse's response was her way of being humble when
receiving a compliment. Nevertheless, she did not negate these compliments. 

**Being Friendly » Responding to Friendliness**

The patient was observed to be friendly to the nurse by engaging in social conversation with the nurse and by using humor. For example, if the patient was watching a hockey game on TV, he would ask the nurse if she was interested in hockey. The nurse responded to the patient in an equally friendly manner, engaging in lighthearted conversation with the patient. These short pieces of social conversation and innuendos of friendship seemed to help in lightening the atmosphere and breaking up the routines of the day. Furthermore, friendliness, compliments, and social conversation helped to create a foundation for the nurse and patient to connect with one another on a more personal level. 

**Asking the Nurse for Help » Responding to Requests for Help**

The nurse frequently provided openings for the patient to make requests or express concerns, by saying, "Is there anything else I can get for you?" or "Do you need anything?" In several instances the patient took the nurse up on her offer, and asked for help. When the nurse responded to the request, he would compliment her and thank her. The patient also communicated his needs to the nurse. For example, when the patient told the nurse that he had a sleepless night, the nurse responded by sitting on his bedside and asking him what happened during the night. She looked at him directly and would nod her head as he was speaking with her. The following illustrates the patient's communication of a need as well as the nurse's response:

P: It's tough to make a positive decision after last night.
N: Oh, what's wrong? What happened last night? [She sits on the patient's bedside.]
P: Not much sleep.
N: Hmm?
P: Sure didn't sleep.
N: Didn't sleep? Why is that? Your nerves?
[interaction continues]

Through his expression of a need, the patient created a context for the nurse to "legitimately" pay attention to him. In turn, the nurse's demonstration of concern appears to assist in connecting with the patient.

**Helping the Nurse • Involving the Patient in Care**

The dynamic interplay between the nurse and patient as nursing care was being given and received also contributed to wooing the nurse (on the part of the patient) and creating a foundation for connecting (on the part of the nurse). As Cynthia carried out routine tasks, she provided opportunities for Bob to participate in his care. In concert with this, Bob actively "joined in" in what appeared to be efforts to help the nurse. For example, while the nurse was flushing his G-tube, the patient was observed to be holding the syringe for the nurse. In another interaction, the patient held one part of the suction catheter while the nurse reattached the other adjoining part to it. She placed her hand on the patient's and they applied pressure together to get a tight seal on the suction catheter. The patient also independently shut off his pump when his feed or flush had finished or flushed his G-tube:

P: See I got so independent yesterday, I did it all by myself.
N: Did what?
P: All that.
N: All your boluses?
P: Yeah.
N: You can do that yourself if you wanted to. You don't
need me to do it.

In this segment, through a somewhat boastful demonstration of competence, the patient appears to try to get the nurse onside by assisting her with his care routines. The nurse's response indicates her approval and serves to reinforce the connection she is establishing.

Being Vigilant ↔ Demonstrating Competence

A recurring behavioral cluster during the first day of this relationship was characterized by vigilance on the part of the patient and the demonstration of competence on the part of the nurse. The patient's vigilance was manifested in his closely observing the nurse as she carried out routine tasks, in checking the nurse's actions, and in establishing the whereabouts of the nurse throughout the day. The nurse was observed to demonstrate her competence by talking through her actions, by carrying out nursing tasks expertly, and by informing the patient about her whereabouts, such as when she was taking a coffee break.

Keeping a Watchful Eye on the Nurse ↔ Talking Through her Actions

Throughout their first day together, the patient continuously watched the nurse while she was working. His eyes would follow her carefully as she proceeded with routine tasks such as administering medications and working with his G-tube feeds and suction equipment. The patient's vigilance was sometimes verbalized, using humor to avoid upsetting the nurse. For example, when she was late in coming to unhook his G-tube feed, he waved his fist at her to tease her about being late. In other instances, as the patient watched every move the nurse made during procedures, he carried on a lighthearted or humorous
conversation with her that was unrelated to her task.

The nurse usually responded to the patient's watchfulness by explaining what she was going to do and by talking through her actions. For example, if she was looking at the feed pump she would "think out loud" about how much more fluid needed to be infused and how long it would take. The nurse usually spoke in a confident and clear voice, demonstrating her knowledge and expertise.

**Checking the Nurse's Actions • Carrying out Nursing Tasks Expertly**

The patient also checked to see if the nurse could be relied on. For example, he asked her if she primed the tubing or checked to see if she knew the time for his next bolus. In carrying out tasks, such as flushing the patient's G-tube or programming the feed pump, the nurse demonstrated her competence. Her actions were deliberate, sequenced, and coordinated. The nurse was also efficient in carrying out her tasks in that she managed to complete several tasks in a relatively short period of time. Often, the nurse would make humorous comments in response to the patient's vigilance. For example, when she was late in unhooking the patient's G-tube feed, she responded to the patient's fist gesture by saying, "A whole ten. Isn't that terrible? Oh dear. Tut, tut. It really will make a big difference." Her humorous comments often put the patient at ease, and as in this instance, clearly demonstrated her confidence in what she was doing. The following segment represents a typical example of this behavioral cluster. The nurse came in with a bag of fluid and prepared to run it into the
patient's G-tube.

N: How fast do you want this to run?
P: [He looks at the nurse as she is working.] Oh whatever. Did you drain it out to here? [checking whether she primed the tubing]
N: Hmm? Oh Yeah. I drained it already.
P: Oh I see [He looks at the primed tubing].
N: In fact, I got it all over my uniform there as you can see.
P: Oh you did, eh, yeah. [He looks at the nurse's uniform.] [The nurse works with the pump.]
P: [He watches the nurse working.] You got it running?
N: Yeah, it is 'cause it's up to fifteen hundred now.
P: Yeah.
[interaction continues]

In this example, the patient's vigilance was demonstrated in checking whether the nurse had primed his tubing. The nurse responded by demonstrating her competence in having primed the tubing. Furthermore, she was able to laugh at her own clumsiness.

Establishing the Nurse's Whereabouts ⇒ Telling the Patient her Whereabouts

Vigilance was observed in the patient's questions to establish the whereabouts of the nurse. That is, the patient seemed to need to know where the nurse was. However, he did not appear comfortable in asking the nurse direct questions regarding her whereabouts, such as the length of her shift or when she is going on a break. To get this information, the patient often posed indirect questions while the nurse completed routine tasks. The nurse usually answered the patient's questions directly, often giving more information than requested. Frequently, her answers were accompanied by lightheartedness and humor. In the following example the nurse prepares to run some fluid through the patient's G-tube. She talks about how much fluid is going to run through as the patient watches her prepare the equipment,
until the patient changes the topic by introducing a question.

P: So... you're off at three?
N: No, I'm on 'til seven.
P: Oh, yeah.
N: Twelve hour shift today and twelve hour shift tomorrow, and an eight hour shift on Monday.
P: Oh, yeah.
N: Either way, you're stuck with me all weekend [laughs].
P: No doubt [jokingly].
N: It could be worse I suppose [jokingly].
P: Yeah, probably, I don't mind.
[The nurse continues to watch the pump, the patient also watches the process.]

In this segment, the patient demonstrated his vigilance by attempting to determine the length of the nurse's shift in a casual and offhand manner. The nurse was sensitive to his need for information and responded to his question with a direct and informative answer as well as with lightheartedness and humor.

**Cautious Consideration → Making Therapeutic Suggestions**

The fourth behavioral cluster observed on the first day is characterized by offers of therapeutic suggestions by the nurse and a patient response of cautious consideration. The nurse made several therapeutic suggestions for improving aspects of the patient's care that were problematic. She accomplished this by gently guiding the patient, explaining her suggestions to the patient, and gently confronting the patient about aspects of his care. The patient cautiously considered the nurse's suggestions. He attended to her suggestions but was reluctant to actually try them. Additionally, the patient would justify his actions to the nurse.
Listening and Cautiously Responding to the Nurse’s Suggestions
Gently Guiding the Patient by Explaining Suggestions

Throughout the day, the nurse gently guided the patient by suggesting possibilities for improving his care, making him more comfortable, and encouraging him to try her suggestions. The nurse usually began the process of gentle guidance by finding out the patient’s need. For example, she would assess his mouth care status or his activity level. Her questions were usually clear and direct. Her voice often inflected toward the end of the question, indicating her genuine interest and involvement in the patient’s care. Once the nurse identified a problem, she would respond by suggesting ways his situation could be improved including a rationale for each suggestion. Using eye contact and other nonverbal behaviors (i.e., nodding her head), she reinforced her interest in the patient and improving the problem at hand. Furthermore, the nurse did not pressure the patient to try her suggestions or reprimand him if he did not try her suggestions.

The patient was usually willing to listen to the nurse. However, he was for the most part reluctant to try the nurse’s suggestions, particularly those related to his mouth care because this was a source of great pain for him. The patient never openly rejected the nurse’s suggestions nor indicated that he would give her suggestions a try. He simply politely listened to the suggestions. In some instances, he would tentatively agree to give her suggestions a try, although this did not necessarily lead to actually trying her suggestions. In the following example, the nurse suggests that the patient try taking ice chips
to keep his mouth clean. Although his response seems to indicate his willingness to try ice chips, he never actually gives them a try.

N: Are you eating at all?
P: No.
N: Not even trying sips? Tried chips of ice?
P: I've got so much junk coming into my mouth.
N: [She nods her head.] Mmm hmm. Nothing there would help?
P: No I don't think so.
N: Oh. [She nods her head as if to say she understands.]
P: What will it [ice chips] help?
N: Hmm? Just [to] give your mouth a clean wash rather than sipping on it.
P: Maybe.
N: I'll get you some to try [voice inflects].
P: I can just try it.

In this example, the nurse explained to the patient the potential benefit to cleaning his mouth with ice chips, yet, she did not push or try to persuade the patient to take up her suggestion. The patient cautiously considered the suggestion and reluctantly responded to the nurse.

**Justifying Actions ≫ Gentle Confrontation**

The nurse also made therapeutic suggestions by gently confronting the patient about aspects of his care, such as, not using the prescribed medications for his mouth. Her confrontations were softened by her lightheartedness and humor. The patient responded to the nurse by justifying his actions, or by 'making excuses' for why he was not using a certain product. For example, when she confronted him about not using his mouthwash he responded by saying, "I don't use that stuff, it's not strong enough." In the following example, the nurse uses gentle confrontation and the patient responds by justifying his actions. The nurse enters the room with some mouthwash for the patient, he has not taken any of the medications for his mouth
she has brought him, and they are all sitting on his bedside
table. She begins by teasing him about the number of medications
for his mouth he has on his table.

N: Bob, are these all going to be lined up? [She smiles
while looking at his collection of medications for his
mouth.]
P: Mmm.
N: It might just help your mouth if you give it a bit of a
[try]... Maybe [it would] clear it. [It] wouldn't be
quite as thick, eh?
P: Yeah, I just had a little rest, so...

This segment demonstrated the nurse gently confronting the
patient about a care issue. Her teasing about the medications
seemed to reflect her sympathy and compassion for the patient.
The patient responded by attempting to justify his actions to the
nurse, a typical response to the nurse's suggestions related to
his mouth treatments at this stage of their relationship.

Day Two

The second day of this three day relationship consisted of
27 interactions between the nurse and the patient. That is, they
spent a total of 54 minutes and 10 seconds of interaction time
together, averaging two minutes and 38 seconds per interaction
throughout this twelve hour day. Day two was Cynthia's second
twelve hour day with Bob. As in the first day, she worked from
seven in the morning until seven in the evening. Bob's second
day with Cynthia followed a reasonably good night's sleep. He
was only up twice during the night to go to the bathroom and to
get pain medication. His wife visited during the mid-morning of
the second day.

During the second day of the relationship, incidents
occurred in which the patient was observed to experience acute
physical distress related to his fear of swallowing anything. In addition, he complained of pain and discomfort during the previous night, which appeared to be associated with his G-tube feedings.

Four behavior clusters observed during the second day of the relationship included: comfortable with being known by the nurse ↔ deepening understanding of the patient; sustaining involvement with the nurse ↔ sustaining a connection with the patient; cautious responsiveness ↔ making therapeutic suggestions; and, communicating physical distress ↔ being there for the patient (see Table 2). Some behaviors reflected in these clusters such as humor, introductions throughout the day, and leave-takings were used in the same way on this day as they were on the first day.
Table 2

Behavioral Clusters and Their Constituents Observed on the Second Day of the NPR

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<th>Patient Behaviors</th>
<th>Nurse Behaviors</th>
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During the second day of the relationship, interactions reflected and evolved from the familiarity established in Day One. Once the nurse re-introduced herself to the patient, she immediately began to "zero-in" on patient problems. The
patient’s behaviors validated the continuity of the relationship and he began to discuss problems with the nurse more openly. These behaviors reflected his comfort with being known by the nurse.

**Validating Continuity → Re-introduction**

The nurse’s first introduction on the second day provided a connection to a problem they had discussed on the previous day (i.e., his problem sleeping). In this very brief exchange, the nurse effectively re-connects with the patient where they left off the previous day. The re-introduction is illustrated in the following segment:

```plaintext
N: Oh you’re awake. I didn’t want to be wakin’ you up. How are you?
P: Fine.
N: Better night last night?
P: [Puts his thumb up, giving the nurse the okay sign.]
N: Sleeping pill helped?
P: Yeah. Something helped, yeah.
N: Good.
[interaction continues]
```

The nurse re-introduced a topic they had discussed during the previous day—the patient’s lack of sleep. The patient’s response of putting his thumb up and response to the nurse’s brief question about a sleeping pill indicated that both knew the nature of the subject discussed. As such, continuity of the relationship was validated by the patient as well as by the nurse.

**Discussing Problems → Zeroing-in on Patient Problems**

On the second day, the nurse "zeroed-in" on problems that had not changed from the first day. Using her knowledge of the patient’s issues from their first day together, the nurse’s questions were specific and focused. Nevertheless, the manner in
which she assessed the patient remained similar to that in the previous day. The nurse remained lighthearted and used humor in combination with assessment questions. Her voice inflected at the end of her questions, and she stood in close proximity to the patient, making eye contact while talking with him.

Interestingly, on this day, the patient did not ask personal questions of the nurse as he did on the previous day. He continued to use humor and jocularity with the nurse and seemed very comfortable in being informal, open, and talkative. It is possible that during the first day he learned all he needed to know about the nurse and, therefore, did not need to pursue further personal questions. He willingly responded to the nurse’s assessment questions and comfortably discussed issues surrounding his care with her. In the following example, the nurse focuses her assessment on the patient’s use of different mouth care products.

N: Have you tried swallowing anything at all?
P: No.
N: Why?
P: Heaven knows, it just gets in the way. [He gestures to suction tubing.]
N: It does, eh?
P: It’s all broke up inside, eh?
N: Does it feel that way?
P: Yeah.
N: [The nurse nods.] So you’ve [inaudible]...
P: It’s too thick. [The medications for the mouth] just adds to saliva and ah, it’s terrible. Terrible.
N: Have you found any of the mouthwashes help? Just this sort of thing.
P: This works the best I think, I don’t know. [He refers to the soda bicarbonate.]
N: Mmm hmm.
P: My tongue is still bad.
N: Let me have a look. [The patient shows the nurse his tongue.] It looks sore too. You just cleaning it off?
P: Oh, yeah. And the other one, the yellow stuff, it burns.
N: Does it?
In this segment, the nurse was deepening her understanding of the patient in that she zeroed-in on a specific problem. The patient seemed comfortable with discussing his problem in detail with the nurse. In this dialogue, the increased depth of problem solving is demonstrated by the nurse's as well as the patient's focus on a problem.

**Sustaining Involvement with the Nurse » Sustaining a Connection with the Patient**

On this day, a second major cluster of behaviors reflected efforts by the nurse and patient to sustain the connection they began on the previous day. Behaviors reflecting sustaining involvement with one another included taking the time for social conversation and giving one another gifts. In addition, the nurse encouraged the patient's independence and responded to the patient's determination of her whereabouts. The patient displayed his independence to the nurse and determined the nurse's whereabouts.

**Engaging in Social Conversation » Engaging in Social Conversation**

Social conversation usually occurred in the midst of completing tasks and was initiated by either the nurse or the patient. For example, while working with the patient's G-tube,
the nurse asked the patient about a hockey game he was watching on TV. Although the social conversations were brief, they seemed to break up the monotony of repetitive tasks. Furthermore, they seemed to divert the patient's attention away from his illness to the outside world, even if only momentarily. Because the nurse was usually engaged in a task while engaging in social conversation, she would glance at the patient periodically while speaking with him and nod her head at his answers, indicating to the patient that she is paying attention. In the following segment of interaction, the nurse enters the patient's room and checks on the feeding pump.

N: ...Oh, yeah. It's a gorgeous day.
P: Nice day out?
N: Oh, yeah. It's suppose to get up to, I think plus eight today.
P: Oh, is that right?
N: Mmm hmm.  
P: [He sits up in bed so he can see outside.] Beautiful. 
N: And minus eight tonight.  
[interaction continues]

Although the nurse engaged in the routine task of checking the feeding pump, she managed to break the monotony of this task by talking about the weather. The patient's attention was directed away from the feeding pump in his response to the nurse's comments about the weather, as well as by his gesture of sitting up in bed to look outside at the gorgeous day the nurse referred to.

Humor appeared to be a prevalent theme in social conversations as well as conversations about patient care. As during their first day together, both the nurse and patient appeared to contribute equally to the lighthearted nature of their interaction. This was reflected in their dialogue and
their nonverbal behaviors (i.e., gestures, smiles). The patient's wife was visiting during the second day of the NPR. The nurse incorporated the patient's wife in the humorous moments as illustrated in the following segment. The nurse entered the room to check on the patient's feeding pump.

N: Well?
P: [The patient waves to the nurse as she comes in.] Well what?
N: Well haven't you packed up your bolus?
P: It's finished already.
N: Hmm?
P: I said it's finished already. Quit bothering me [jokingly].
N: Oh, I see. You're getting too independent now [in a joking voice]. When you put it in and out and all. I see, and I see you've got your neck talced as well.
P: Mmm hmm.
N: So between you, you've solved the problem.
P: Mmm hmm.
N: Fine, Okay, I'll pretend I'm doin' my stuff.
Wife: And then when you go for lunch he complains. You can't win.
N: No you can't win. You get patients like that, you know, you just stop trying. You just grit your teeth and say nothing.
P: [smiles] Yeah, yeah, yeah.
Wife: [laughs]

This was a typical example of the lightheartedness and jocularity in which the nurse and patient regularly engaged throughout their relationship. Through this type of interaction they affirm that they have developed a relationship and that they remain connected.

**Determining the Nurse's Whereabouts » Telling the Patient her Whereabouts**

As in the first day, the patient attempted to establish the nurse's whereabouts. Although, he was humorous and lighthearted about the nurse's comings and goings, he still seemed to need to know her whereabouts. So much so, that he even resorted to asking others about the nurse's whereabouts. The nurse usually
responded to the questions with humorous comments and by telling him when she would be back as illustrated in the following segment. The nurse is working with the patient’s feeding pump when she is called over the intercom to help a patient in another room.

P: Why don’t you go down and I’ll watch it? You can do it when you get back.
N: No, when I go I’ll be gone for half an hour or so.
P: [jokingly] Half an hour? What about me?
N: What about you? Do you think you’re the only patient here? [laughs] I’ll only be next door.
P: Hey?
N: I’ll only [inaudible]...
P: [jokingly] I’m the only one that’s on TV. [interaction continues]

In this segment, the patient reveals his desire to have his care completed by this particular nurse and therefore his need to know the nurse’s whereabouts. In response, the nurse indirectly acknowledges and encourages the connection they have established, using the lighthearted and humorous style that typifies her approach with this patient.

Displaying Independence to the Nurse » Encouraging Independence

During the second day, the patient displayed his ability to complete some tasks independently, in what appeared to be gestures to please the nurse. In response, the nurse encouraged and reinforced these efforts.

The patient took pride in ‘being good’ at looking after his G-tube and flushes; he seemed pleased when the nurse entered his room only to find that he had already completed the tasks related to his G-tube. Although the nurse played an important role in hanging up the feeds, and engaged in routine tasks such as changing his dressing and taking vital signs, she was very
positive about the patient's independence and complemented him about it. In some instances it became a source of humor in this relationship. The following segment demonstrates the patient's independence with his G-tube and the nurse's response to his independence. The nurse enters the room to check the feeding pump:

N: Nearly through yet? You've had the lot. Did you flush it?
P: Yes, m'dear.
N: Oh, great. You're getting really good at this aren't ya?
P: Yeah.
N: [jokingly] Good. You can do it yourself then the rest of the day.
[interaction continues]

In this example, the patient displayed his independence to the nurse in a way that reflects his willingness to be cooperative. This behavior, along with the nurse's positive attitude toward the patient's independence, seemed to sustain the relationship they established.

Giving to Demonstrate Gratitude • Giving to Demonstrate Caring

Giving gifts to one another on this day clearly reflected the progression of the relationship between this nurse and patient, given the personal significance of each gift. The patient's gift to the nurse, green shamrock cookies for St. Patrick's Day, was personal and thoughtful. The nurse had mentioned St. Patrick's Day during their previous day together. Giving her the green cookies acknowledged her excitement about the holiday, her Irish heritage, and may have been an act of reciprocity for the care she was giving him. The nurse's gift to the patient was a crock of gold from a rainbow ornament off a cake she shared with the staff she worked with. When she
presented the patient with this gift, she described the different decorations on the cake. Of all the ornaments she could have given him, she chose one that was symbolically significant. In a later interview, the nurse stated that she gave the patient the crock of gold for "luck," which is significant given her concern about his prognosis. The following interaction segments represent the giving of gifts. In the first segment, the patient rings for the nurse and she enters the room:

P: Do you like cookies?
N: Yeah.
P: These are yours. [He hands the nurse a tray of cookies he got for her.]
N: [laughing] Oh thank you.
P: Happy St. Patrick's Day.
N: Is this for St. Patrick's Day? Thank you very much. Thank you. They're very good. That's three symbols I have now.
P: That's right.
N: The earrings, the makeup, and the cookies.
P: And the cookies.
N: Thank you. You're very kind. Thank you.

In the second example, the nurse enters the patient's room to give him a gift from her.

P: Now what have you got?
N: I brought this down for you. [She holds up a little gold object.]
P: Isn't that something.
N: It's a crock of gold. One of the girls bought me a cake, brought me a cake in.
P: Yeah.
N: It's got two little Irishmen on it with a big shamrock. I mean it looks disgustin', all greens and yellows and a big rainbow...
P: Yeah.
N: And this is the crock of gold at the end.
P: Quite a thing to do. Isn't that nice.
N: So I brought it back for you.
P: Thank you.
N: Okay, talk to you later.

The personal nature of the gifts the patient and nurse gave one another demonstrated one of the ways in which the patient
sustained his connection to the nurse and the nurse sustained her involvement with the patient.

Cautious Responsiveness • Making Therapeutic Suggestions

As in their first day together, the nurse continued to suggest possibilities for improving the patient's care and rationalized these suggestions to the patient. The nurse also continued to gently confront the patient about problematic aspects of his care. On this day, the patient acknowledged the nurse's therapeutic suggestions by responding to them cautiously. The patient was observed to not only listen to the nurse's ideas but to go along with some of her suggestions.

Listening to the Nurse's Suggestions • Suggesting Possibilities

The nurse gently guided and confronted the patient more often than in the first day and she was more persistent in working with the patient on behaviors that had not changed. Her strategy in gently guiding and confronting the patient remained lighthearted and often humorous. The patient responded to the nurse by listening to her explanations and discussing them with her. Although the patient remained tentative about trying the nurse's suggestions, he reluctantly 'went along' with them. It is possible that the patient finally decided to try the nurse's suggestions because of her persistence or because he realized that, if he was going to improve at all, he might have to follow her advice. In the following segment, the nurse suggests a new mouth care product for the patient.

N: Cause it's [the Mycostatin] quite good.
P: It is? Better than this stuff?
N: Yeah. That's sort of a local anesthetic, whereas the, the Mycostatin is an antibacterial as well. We use it for ulcers and things like that too in the mouth.
P: Mmm. That's maybe what I should be havin' instead, eh?
N: Yeah, you might want to give it a try [inaudible]...
P: I can always, like I can rinse with it?
N: Yup, yup. You don't have to swallow it. You can just rinse with it. Just get to it on your tongue.
P: No, yeah, and then I could, then I could just rinse with water after it.
N: Rinse with water and spit it out. Yeah, you don't have to swallow it.
P: I'm going [inaudible]...
N: I know you're on it for, for rinse and rinse and swallow something like that. But, you don't have to.
P: I tried swallowing it once, aahhhhh.
N: Not good, eh?
P: Really terrible.
N: If I get you some now will you just try, just wash your mouth out with it and you can spit it out again? I find that it works very good and I find that it works for a lot of our patients with sore mouths.
P: Yeah. I want something that's going to clear it up, not just, not just freeze it.
N: Yeah. Well, you'll have more chance of that with the Mycostatin than you would with the Tantum.
P: Yeah.
N: You know that? Okay, some Mycostatin coming up.
P: You bet.

Demonstrated in this segment was the nurse's strategy for suggesting possibilities to the patient. Throughout her discussion with the patient, she remained compassionate to his soar mouth and did not insist that he try her suggestion. The patient responded cautiously by politely listening to the nurse's explanations and avoiding any kind of direct endorsement of the nurse's suggestion.

Going Along with the Nurse's Suggestions → Gentle Confrontation

The following segment of interaction illustrates the nurse gently confronting the patient about his mouth care and the patient 'going along' with the nurse's suggestion. The lighthearted tone of the interaction helps to maintain the nurse's sympathetic manner with the patient. One typical interaction begins when the nurse enters the room to check on the
feed pump and starts to talk with the patient about his mouth care.

N: Did you try some ice chips again?
P: No. You took 'em away, remember?
N: Yeah. But will you try some if I get you some more?
P: Yeah [mumbles].
N: Is that a no or a yes? It was a yes, wasn't it?
P: No [joking tone].
N: It's not a yes? [joking tone]
P: No [jokes].
N: [She points to the medications for his mouth and jokes.] What do you want to do with these? Gonna play dominos or make bales with them or something like that?
P: [smiles, nods] Well, I'll use them again here, maybe.
N: Is there any point in me going to get some Mycostatin?
P: No. [He points to the jug of soda bicarbonate.]
N: No, I didn't think so. Just that [referring to the soda bicarbonate]. Are you using these at all? [gestures to the mouth swabs]
P: [This] works the best [referring to the soda bicarbonate mixture].
N: Not very many by the look of it [referring to the mouth swabs].
P: [He holds up three fingers to gesture that he had used three mouth swabs.]
N: Pardon?
P: [Again, he hold up three fingers.]
N: Three, Okay [smiles].
P: Mmm [He sighs jokingly at her interrogation].
N: I know where I'm not wanted. [laughs] See you later.
P: Yeah.
[interaction continues]

In this gentle confrontation, the nurse attempts to make therapeutic suggestions to the patient. Her positive and lighthearted tone remained prominent through the interaction and softened her confrontation. Furthermore, the nurse seemed to know when to stop confronting the patient. The patient's response demonstrates his typically cautious manner in taking up therapeutic suggestions on his terms and to a limited extent.

Communicating Physical Distress • Being There for the Patient

During their first day together, the patient was not observed to be in any acute physical distress. However, during
their second day together, there were two instances when the patient experienced acute physical distress and communicated his distress to the nurse. The nurse responded to the patient's distress by being there for him.

These interactions stimulated by the patient's distress seemed to form important behavior clusters that reflected the nature of the relationship they had developed and provided the basis for continuing and deepening the relationship. In both instances the patient appeared to feel comfortable enough with the nurse to openly share the magnitude of his distress, something he rarely did with others. Each time the nurse's response effectively decreased his distress.

**Showing Distress ↔ Creating an Atmosphere of Calm Reassurance**

The first experience of distress related to copious amounts of phlegm formation in the patient's mouth and throat. He began to cough and choke on the phlegm. Using a suction in an attempt to clear the phlegm, he eventually obtained some relief. The nurse entered the room just as the patient was recovering from this episode. He made no attempt to hide his distress from the nurse, as he held his head and tried to catch his breath again. The nurse responded to the patient's distress by creating an atmosphere of calm reassurance. She rested her hand on his to comfort him, stayed close to the patient and asked him quietly if he was alright. She continued to observe the patient and in a soft, calm voice talked with him about clearing his mouth. The following segment illustrates this interaction.

N: You okay?
P: [He nods his head.] Mmm.
N: [She places her hand over his and looks directly at him,
then looks at feeding pump.] Alright. You’re nearly through with this, about half an hour in fact.
P: [The patient suctions his mouth.] Yeah.
N: You having problems swallowing?
P: [He shakes his head.]
N: No? [inaudible]...
P: [He suctions his mouth.] There’s so much, you know.
N: Hmm?
P: There so much more in there first thing in the morning, eh?
N: Yeah. [She removes her hand from patient’s hand.]
[interaction continues]

Interestingly, in the context of distress, neither the nurse or patient resorted to the kind of humor that was so characteristic of most of their other interactions. The intimacy created in response to his distress generated a more serious and perhaps more honest dialogue and brought them closer together on a different level. Once the initial distress subsided, however, the nurse made a humorous comment. Her humor at this point seemed appropriate and may have helped to relieve the patient’s anxiety.

Voicing Distress « Demonstrating Genuine Concern, Applying Comfort Measures

The patient experienced distress a second time when he began to have cold sweats and a bloated feeling in his stomach as a result of his G-tube feeding. This time, he rang for the nurse and explained how he felt. The nurse demonstrated genuine concern by standing in close proximity to the patient, observing and listening carefully to the patient as he described how he felt, and by responding immediately to his concerns. She brought him a hot pack for his abdomen and took his vital signs. All the while she remained calm and spoke softly to the patient. Her actions were fluid and sequenced, projecting her confidence and skill. Additionally, humor was incorporated into the situation
once the patient's initial distress had subsided. After the
distress had dissipated the nurse reviewed the distressful
situation with the patient and, with him, tried to figure out the
reason for its occurrence.

Day Three

Day three was the final day of this relationship. On the
third day the nurse was on duty from seven in the morning until
three in the afternoon. In addition, there was a nursing student
with the nurse. As a result, the student nurse took over some of
the routine tasks which would have otherwise been carried out by
the nurse. Some of the behaviors observed during the second day
of the relationship were also observed on the third day of the
relationship, such as, zeroing-in on patient problems and
determining the nurse's whereabouts. Changes were noted in some
of the behaviors; for example, the nurse's gentle confrontations
from the previous two days took a more assertive tone on the
third day of the relationship. Also, being their final day
together, the nurse and patient concluded their relationship.

One behavior that was not observed during the final day of
this relationship was that of the making therapeutic suggestions.
During their last day together the nurse did not suggest any new
possibilities for the patient to improve his care; rather, the
nurse focused on reinforcing and encouraging the patient to act
on her suggestions from the past two days. This occurred
particularly when the nurse confronted the patient about his
care.

The number of interactions between the nurse and the patient
on the third day was smaller due to the shorter shift the nurse
was working and the presence of the student nurse. A total of eleven interactions were observed between the nurse and the patient on their third day together, which amounted to 24 minutes and 11 seconds. Each interaction averaged 2 minutes and 16 seconds in length of time.

Bob's final day with Cynthia followed a night that had several interruptions. Bob took a sleeping pill at bedtime as suggested by Cynthia during their first day together. Unfortunately, the alarm on his feeding pump was set off during the night interrupting his sleep.

The clusters of behaviors observed during the final day of this relationship included: being comfortable with the nurse • being comfortable with the patient; tempered movement toward problem resolution • pushing toward problem resolution; making the most of the time left • preparing for concluding the connection; and saying good-bye to the nurse • saying good-bye to the patient (see Table 3).
Table 3

Behavioral Clusters and Their Constituents Observed on the Third Day of the NPR

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<tr>
<th>Patient Behaviors</th>
<th>Nurse Behaviors</th>
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<tr>
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<td>-Maintaining a positive atmosphere</td>
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<td>Saying Good-Bye to the Patient</td>
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<tr>
<td>-Acknowledging the relationship</td>
<td>-Acknowledging the relationship</td>
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Being Comfortable with the Nurse ↔ Being Comfortable with the Patient

The final day of this relationship began with a personalized greeting between the nurse and the patient. As in the second day of this NPR, the nurse continued to zero-in on patient problems and the patient continued to discuss his problems comfortably with the nurse.
Offering Personalized Greeting

The introduction to their third day together took the form of a personalized greeting. On this day, the nurse entered the room along with the student nurse. Unlike the first introduction between the nurse and patient, this introduction, had a very personal tone and was accompanied by humor and laughter. In the following segment, the nurse and student nurse have come to greet the patient for the first time in the morning.

N: Good morning.
P: [The patient waves.]
SN: Good morning.
N: Do you know Shelley?
P: Oh.
SN: Oh yeah.
N: Do you know me? [smiles]
P: [jokingly] It's been a long time, babe.
N: [laughs] Yeah, a whole, oh, must be twelve hours since I last saw you.
P: Yeah.
[interaction continues]

Discussing Problems

Assessments on this day continued to be focused on the patient's issues from the previous two days. The nurse knew specific details regarding the patient's care that she needed to assess and focused on what the patient may still need to accomplish, for example, increasing his activity level. The nurse maintained her lightheartedness and sense of humor when assessing the patient. The patient responded to the nurse's questions directly and in an informal fashion, incorporating humor into his answers. The following example illustrates an assessment on the third day of the relationship. Throughout this assessment there is humor and gentle confrontations. The patient eventually admits that the nurse was right about the
effectiveness of a new mouth product he tried.

N: What's happenin' to this? [checking the feed pump] How come you're only at 81?
P: I don't know.
SN: Oh, your bottle's squashed again. Look at that.
P: It fell.
N & SN: It fell?
N: Oh. Who dropped it?
P: Some nurse.
N: Some nurse [working with feed bottle], there.
P: They've been doin' that all night.
N: Have they? That's why, cause it fell. [She puts the feed bottle back up and fixes the feed pump.] Okay, any problems?
P: No.
N: Any pain?
P: Nope.
N: When'd you last get analgesic, about three wasn't it?
P: I don't know.
SN: Two, I think somebody said.
P: I had something.
N: [The nurse checks a paper in her pocket.] Two, yeah.
P: And what was that?
N: You had your Codeine at two o'clock this morning.
P: Yeah.
N: You need any now?
P: No. When's my RT? [radiation therapy]
N: Two. Okay.
P: [shrugs] Yeah.
N: You going to get up and walk about a bit more today?
P: What do you mean more?
N: It's just, every time I look at you, you're in bed.
P: I was given 'er yesterday.
N: Given what?
P: It's a saying, you know, to give... [The patient makes a motion with his arm.]
N: Oh, yeah. Okay, I don't know that expression. Must be one of those Canadian things.
P: Yeah, yup.
N: Okay.
P: I put on a lotta miles yesterday.
N: You walked three times around the station floor. Once, not even three times.
P: At a time?
N: Yeah, you did that twice. [The patient and nurse laugh.] It's all you know I have to go check.
P: Yeah. I did it at least four times, five times.
N: That might help though, to get that feeling of fullness out of your stomach.
P: Mmm, oh, yeah. [The nurse and patient continue to talk.]
N: Did you use the Mycostatin?
P: Yeah.
N: And?
P: And what?
N: And?
P: And baking soda.
N: And?
P: And, and, and.
N: What did you think of the right stuff?
P: Ah, I think it might work alright.
N: You think so? I was right [smiles].
P: Of course you were.
N: [laughs] I’ll see you later.
P: Yeah.
N: Are you using these? [She hold up the mouth swabs.]
P: This is only the second morning.
N: There’s exactly the same number there now as there were yesterday.
P: As a matter of fact I didn’t have time to brush my teeth this morning.
N: It’s not only for morning, it’s for during the day as well. Keep your mouth as clean as you can.
P: Yeah.
N: Yeah.
P: [joking] You better go see how your other patients are.
N: [The nurse and patient laugh.] Will I go see how my other patients are doing and get off your case for a while? Okay, I’ll be back.
P: Take it easy [smiles].

In this segment, the comfort level between the nurse and patient is evident in the humorous and lighthearted manner in which they are able to zero-in on and discuss problems together. Unlike the beginning of the relationship, where the nurse and patient were getting to know one another, the ease with which issues are discussed at this point in the relationship, is a demonstration of the positive connection developed by the nurse and patient.

Tempered Movement Toward Problem Resolution → Pushing Toward Problem Resolution

The nurse attempted to push toward problem resolution in the final day of this NPR by assertively confronting the patient about problems with his care that had not yet been resolved. Furthermore, the nurse encouraged the patient and attempted to provide him with direction for the future. The patient responded to the nurse’s push toward problem resolution in a tempered
manner. Although reluctantly, he agreed to take the nurse's direction for the future. It is unknown whether he followed through on his agreement.

**Reluctant Progression + Assertive Confrontation**

On the final day of the relationship, the gentle confrontation that was observed during the first two days of the relationship became more assertive. That is, the nurse was at times lighthearted and humorous about different care issues but was also quite stern about getting issues resolved and pushing the patient toward problem resolution. It is possible that because this was their final day together, the nurse was determined to resolve the issues. When the nurse assertively confronted the patient she raised her voice and was very blunt in her questioning. The lighthearted or humorous tone characteristic of previous gentle confrontations was absent. She looked directly at the patient when speaking with him and would not leave a topic until she got a straightforward answer from the patient. The patient began responding to the nurse's assertive confrontation with indirect answers and attempted to use humor, in an effort to avoid responding to her suggestions. However, when he realized the nurse was getting irritated with him, he became more direct and honest in his responses. The nurse's assertive confrontation with the patient did not seem to negatively impact on the relationship. Once the confrontation ended, the nurse and patient carried on in their usual positive and lighthearted manner.

The following example demonstrates the nurse assertively confronting the patient about his mouth care and about his pain.
Although the nurse’s assertiveness in this segment may appear harsh, it is important to understand the context in which this interaction occurred. Over the course of their three-day relationship, the nurse and patient had through their interactions and work together, come to know each other quite well. As such, it appeared that the nurse could confront the patient in this assertive manner, without upsetting him. Had the nurse assertively confronted the patient during the first day or even second day together, this action may have eroded the development of the relationship. However, at this point in the relationship, her assertive confrontation seemed appropriate. Furthermore, it did not appear to deteriorate the relationship in any way.

In this interaction, the nurse was sitting on the patient’s bed and the patient was sitting in an arm chair while they were talking.

N: That’s okay, yeah this looks, it’s less red now, there’s more of a pink coating on it. It’s not painful? [The nurse looks at the patient’s tongue.]
P: Well, yeah.
N: No?
P: Mmm mmm.
N: It is? Then why do you keep on saying you’ve no pain when I ask you? [irritated tone of voice]
P: It’s immaterial.
N: It’s not immaterial.
P: Mmm hmm.
N: Why?
P: It’s no big deal.
N: Your such a strong lad, you can put up with the pain, eh?
P: Yeah.
N: There’s no need to.
P: That’s for wimps [He gets up to suction his mouth.]
N: Oh. It’s got nothing to do with being a wimp or not being a wimp [irritated tone of voice].
P: [The patient is suctioning his mouth.]
N: It’s got nothing to do with being a wimp or not.
P: [He puts his suction catheter down.] Umhmm. Sure it
does.
N: [inaudible]
P: Yeah.
N: You need to get a stand for that.
P: It’s not a severe pain.
N: How bad is it?
P: It’s not that bad.
N: It’s just a pain, is it?
P: Ah, it’s there, eh?
N: A sting or an ache or...
[interaction continues]
N: Are you using these? [She points to the mouth swabs.]
P: No.
N: I want to know.
P: Yeah [patient shrugs].
N: Don’t just keep on shrugging [irritated tone of voice].
P: What?
N: I asked you a question.
P: What did you say?
N: I said, are you using these toothettes?
P: No.
N: Why not?
P: They hurt too much.
N: Do they?
[interaction continues]

The assertive confrontation illustrated in this segment demonstrated the nurse’s push toward problem resolution by her absence of humor, raised voice, blunt questions and persistence with issues. Despite this, the patient continues to be reluctant to take up some of the nurse’s suggestions as demonstrated by his initial indirect answers to the nurse’s questions and his attempt at using humor to circumvent the issues needing resolution.

Agreeing to Take the Nurse’s Direction in the Future «
Encouraging Continuance of Self-Care in the Future

Right up to the end of the relationship, the nurse was pushing the patient to continue working on progressing with his mouth care. She was providing direction for the future, as if to let the patient know that although she would no longer be there to work with him, he could continue to work toward problem resolution independently. The patient responded by agreeing to
take the nurse's direction. The following, is a segment of the final interaction between the nurse and the patient.

N: Sorry you didn't get swallowing better.
P: Yeah.
N: Keep up the Mycostatin, it's really good.
P: Yeah, yeah, yeah.
N: Okay?
P: Yeah, will do, thanks.
[interaction continues]

Right to this final conversation, the nurse continued to encourage the patient to persist with the mouth care regimen he started. The nurse was attuned to the patient's difficulty in developing new behaviors with respect to his mouth care. As such, she encouraged the continuance of the behaviors he started toward caring for his mouth.

Making the Most of the Time Left • Preparing for Concluding the Connection

In the final day of the relationship the nurse and patient were observed to prepare for the ending of their three-day relationship. Bob made the most of his time left with Cynthia by engaging in such behaviors as maintaining a positive atmosphere; determining the nurse's whereabouts; forecasting the conclusion; working toward independence; and making use of the nurse's service. Cynthia responded to Bob's behaviors by also maintaining a positive atmosphere; by telling the patient her whereabouts; and by responding to his forecast of the conclusion to their relationship. She also continued to encourage his independence and to provide him with nursing care.

Maintaining a Positive Atmosphere • Maintaining a Positive Atmosphere

A positive atmosphere seemed to be present throughout the third day of the relationship as in the first two days. There
was always a sense of comfort and genuineness between the nurse and the patient. The positive atmosphere seemed to be enhanced by their social conversations and use of humor with one another. This positive tone seemed to keep the nurse and patient in high spirits through the day and helped to maintain their connection. The following segment of social conversation is a small part of a long talk the nurse and patient were having about a variety of topics such as his mouth care, pain, and G-tube feeds.

N: ...Aren't these lovely.
P: Mmm hmm.
N: Are those from the spring?
P: Yeah.
N: Mmm, gorgeous. At home we call these pussy willows.
P: Here too.
N: You call them pussy willows here too?
P: Mmm hmm.
N: Aren't they gorgeous. Oh, these are [like] silk.
P: Yeah.
N: Wow.
P: Yeah, that one isn't going to waste away.
N: No, I guess not. Oh, there's a little bird in there as well.
P: Yeah.
[interaction continues]

By continuing to combine lighthearted social conversations with clinical work, a positive atmosphere was maintained in this relationship.

**Determining the Nurse's Whereabouts + Telling the Patient Her Whereabouts**

The patient continued his efforts to establish the nurse's whereabouts. As on the second day, the patient seemed to be sensitive to the nurse's comings and goings and would comment about them in a humorous way. On this day, however, the patient seemed to ask the nurse about her whereabouts more frequently than during the first two days. The nurse responded to the patient in the manner she previously used, lightheartedly and
with humor. In the following segment the nurse had just come in for the first time in the morning to greet the patient.

N: Okay, I'll see you in a little.
P: Where are you going?
N: I just came in to say "good mornin'" to you.
P: [jokingly] Oh, is that what it was?
N: Yeah, that's what it was.
[interaction continues]

Illustrated in this segment was the patient's continued need to determine the whereabouts of the nurse. Although the nurse used a humorous response to answer the patient's question, she provided him with the information he needed.

**Forecasting the Conclusion • Responding to the Patient's Forecast of Conclusion**

Ending the relationship began early on the third day of the relationship when the nurse and patient talked about this being their final day together and not seeing each other again. This interaction was important as it may have made the closure of their relationship easier. The following is a segment of this interaction.

P: You'll soon be off this shift.
N: Yeah. I'm only working until three today and then I'm off until the weekend.
P: So I won't see you.
N: Oh, that's right. You'll be gone. Are you going Wednesday? Have they been in here to show you how to use all this?
P: No. This afternoon or tomorrow.
[interaction continues]

By forecasting when the relationship will end, the patient could make the most of his time left with the nurse. The nurse responded to the patient's forecast by preparing him for the conclusion of the relationship in telling him the length of time they have left together.
Working Toward Independence • Encouraging Independence

During the third day of the relationship, the patient was becoming increasingly independent with the care of his G-tube and feeds. The nurse continued to encourage and support the patient's independence by telling him how well he is doing with the care of his G-tube and by encouraging him to be as independent as possible as he will have to carry out his own care when he is at home. The following segment illustrates the patient's independence and the nurse's support for his independence.

N: Have you had the water hooked up?
P: Yeah.
N: Doin' it yourself?
P: Yes.
N: Independent Joe.
P: Yeah.

[The nurse and patient go on to talk about the medications for his mouth.]

The patient made the most of his time left with the nurse by continuing to demonstrate to her that he is working toward becoming independent with the care of his G-tube. The nurse prepared to conclude her connection with the patient by continuing to check-in with the patient about the care of his G-tube and by continuing to encourage his independence.

Making Use of the Nurse's Service • Providing Nursing Service

Although the patient was able to carry out a large portion of his care independently, he was observed to ask the nurse to help him with some aspects of his care on the third day, such as, applying powder to his neck. It is possible that he was aware of the limited amount of time he has left with the nurse and was not quite ready to let go of all of her help or that he was making
sure that the nurse would be there to help him right until the end. The nurse responded to his request for help by carrying out the task the patient asked for. While carrying out the task, the nurse explained to the patient how he may have carried out the task independently. The patient responded to the nurse with a humorous comment. His humor seemed to indicate that he knew how to carry out the task on his own but still wanted the nurse to help him.

P: Put a bit of powder on me, would you?
N: Sure.
P: Gotta make the best use of you I can.
N: [The nurse applies powder to patient's neck.] Oh, that's right [jokingly].
P: It's been a little dry from last night.
N: [She rubs powder into his neck.] Hmm, been puttin' this on?
P: It's suppose to be put on three or four times a day.
N: So? Why aren't you doin' it?
P: Well, it's too hard for me to do.
N: Oh [inaudible]...
P: I can't see to get it in the right places.
N: Look in a mirror. Learn to do as much as you can for yourself for when you're not in hospital.
P: When I've got all these beautiful women around me?
N: Oh, yes. That's your attitude is it?
P: Oh, no, it isn't.
[interaction continues]

Although the patient was becoming increasingly independent with some aspects of his care, it seemed that one of the ways he was making the most of his time left with the nurse was by using her nursing service. By carrying out the patient's request the nurse demonstrated that although the conclusion to their connection is nearing, she is still involved in his care and is available to help him.

Saying Good-Bye to the Nurse » Saying Good-Bye to the Patient

Their final good-bye to one another was accompanied by compliments, humor and well-wishing. Furthermore, both the
patient and the nurse acknowledged that something special had happened between them. This last interaction between the nurse and patient was important in that they sought a definite closure to their relationship. The ending to this relationship was direct and obvious.

Acknowledging the Relationship

In their final interaction, the patient and nurse stated that they would miss one another as they parted. Albeit indirectly, they both acknowledged that something special happened in their relationship. The following is a segment of the final interaction between the nurse and patient. The nurse was sitting at the patient's bedside and they had become involved in a humorous conversation that led up to their final good-bye.

N: [She touches the patient's hand and holds it.] Okay, anyway, I'm goin' off.  
P: I'm goin' to miss you.  
N: Yeah, I'm going to miss you too. Anyway...[inaudible]  
P: Thanks very much. You, you're excellent.  
N: Oh, thank-you.  
P: I appreciate everything you've done.  
N: Yeah. Take care of yourself.  
P: Will do, yup.  
[interaction continues]  
N: I won't be back till Friday and you'll be gone by then.  
P: Yeah, I'll be gone by Wednesday, Thursday.  
N: [inaudible]  
P: Yes, very much so.  
N: Yup, take care.  
P: I look forward to it.  
N: Bye, bye. [The nurse gives patient's hand a couple of taps.]  
P: Bye now.

Two important things happened in this final good-bye between Cynthia and Bob. First, they individually acknowledged the close relationship they developed by telling one another they will be missed. Second, they said a conclusive fairwell by wishing each other well and by briefly noting that Bob will be discharged by
the time Cynthia will return to work after her days off. As a result, neither would have been left with ambiguous thoughts regarding whether they would see one another again.

Findings from the Focus Group

A ninety-minute focus group discussion was used to validate and augment the findings. Five participants contributed to the focus group discussion including three nurses with extensive background in oncology and palliative care, a clinical nurse specialist in palliative care, and a nurse who had recently been an oncology patient.

The focus group participants discussed the NPR as an interactive process that develops over time, much like that observed in the present study. They talked about the relationship in terms of beginning the relationship, maintaining the relationship, and ending the relationship. The group then discussed behaviors reflected in each of the stages of this interactive process.

Beginning the Relationship

Getting to know the patient and getting to know the nurse was agreed to be a necessary part of beginning the relationship. Participants of the focus group added that this process was accomplished through social conversation and self-disclosure. They also cautioned that although self-disclosure is a necessary part of the NPR, there is a fine distinction between revealing to the patient what they want to know about the nurse and self-disclosing too much to the patient.

One participant, who had been a patient, talked about feeling powerless and being dependent on the nurse for clinical
expertise and guidance. As such, in order to ensure getting the
care she needed, she tried to be friendly with the nurse and
asked the nurse personal questions. This participant felt it was
easier to connect with the nurse on a personal level rather than
a professional level. Other nurses in the group agreed that
patients are dependent on the nurse and thought that patients
wanted their nurses to like them.

Focus group participants validated that demonstrating
competence is an important part of nursing patients. The
participants who had been patients recounted that they quickly
knew which nurses did and did not feel comfortable with their
abilities. As patients, they were particularly vigilant when
certain nurses worked with them. Furthermore, when a nurse that
demonstrated competence worked with them, they felt relieved and
relaxed about their care while that nurse was on shift. Other
focus group members extended the notion of demonstrating
competence beyond performing an action to talking about the
action. As observed in the present study, focus group
participants validated that an important behavior in
demonstrating competence is talking through actions. That is,
explaining to the patient what their medications are for or what
their treatments do.

Furthermore, a nurse's competence must be combined with
her/his ability to care. Participants discussed how a nurse must
be competent to complete a task and must also be competent to
care. Incorporating humor and social conversation were some of
the ways a personal sense can be brought into the technology of
routine tasks. That is, the nurse needs to be able to care for
the patient in a humane manner, rather than focusing on the patient's machines.

Humor was seen by the group as a strategy to be used with sensitivity. One participant explained that different people have different senses of humor, and for humor to be used in a relationship, the nurse and patient should have the same ideas about what is humorous. One participant explained that, as a patient, she experienced both positive and negative affects of humor. In some instances, she felt the nurse used humor to avoid connecting with her. The participant stated that this use of humor made her feel uncared for and increased her distress level. In sharp contrast, there were instances when others realizing that she needed a lift, made her laugh at herself and what was happening. In these instances, she felt connected with the nurse and the humor helped her relax.

In discussing making therapeutic suggestions and the patient's cautious response to the suggestions, participants felt that making therapeutic suggestions is a "dance" or a process of negotiation. Suggestions need to be "opened up", especially when the patient does not take up these suggestions. This process was seen to help uncover reasons for patient's reluctance to try the suggestions without being judgmental. Additionally, participants talked about dealing with their own emotions while watching a patient in pain who had refused any analgesic. Measures such as holding a patient's hand or staying with the patient through their suffering were viewed as difficult for the nurse but effective for helping a patient through a distressful period.
Maintaining the Relationship

Drawing on past clinical experiences, participants emphasized the importance of re-connecting with the patient at the beginning of the next shift to maintain and build on the relationship already established. This was often simply done by referring to something that was relevant to the patient that had occurred during the previous day. Re-connection or re-introduction with the patient was seen as very important, particularly if a strong connection was established during their first day together. One participant emphasized that re-connecting made her feel that the nurse remembered her, and she felt relieved to be cared for again by that nurse. When this did not happen, the development of the relationship was threatened.

The participants agreed that it was courteous and respectful to let patients know how long their shifts were and when they were leaving for coffee breaks. When patients felt safe with a particular nurse, they made an effort to find out how long s/he would be working with them.

The nurses' response to physical or emotional distress, while important in enhancing patient comfort, was also described as a key factor in developing the NPR. For patients, it is critical that the nurse acknowledge their distress without diminishing or negating it in any way. One participant recounted her experience as a patient when one nurse diminished her distress by not acknowledging a sleepless night that had left her feeling distressed. The end result, from the patient's perspective, was that the connection they had previously established was instantly lost.
Ending the Relationship

Participants expressed that ending a relationship starts earlier than the final contact between the nurse and patient. In practice, they often started to say good-bye at the beginning of the relationship by letting the patient know how many days they would be working with a patient. For patients, this seemed important so that they could make the most of their time together with the nurse. Stories of final good-byes between nurses and patients included "well-wishing," encouragement, and gratitude. Gratitude was expressed by both the nurse and the patient. Patients often expressed appreciation of the nurse’s good care, while nurses appreciated having learned something from the patient. The group agreed that a clear and definite closure to any NPR was important.

Participants also validated the importance of ending interactions throughout the relationship, that is, telling the patient that they are going on a break, going home for the day, or even going off for several days. The group reported that neglecting this kind of "checking-in" with the patient can be a source of uncertainty and distress for patients.

In summary, the focus group discussion validated many of the behavior clusters identified to be important in the development of a relationship between Bob and Cynthia. In some instances, the possible consequences of not engaging in these behaviors to the developing relationship were described. On the basis of their experiences, it appears that the development of NPRs may be hindered or undermined when nurses and patients do not engage in these behaviors.
Summary

In this chapter, the findings of the study which reflected patterns of behavior and behavior clusters between a nurse and patient over their three-day relationship were presented. Background information relevant to each day of the relationship was highlighted to contextualize these observations. Some of the behavior clusters were observed in all three days of the relationship, while others changed as the relationship developed. The development of this NPR was reflected in the changes observed in the behaviors of both the nurse and patient over the course of three days.

Additionally, findings from the focus group discussion were presented. Focus group participants discussed the NPR as an interactive process that develops over time. The NPR was discussed in terms of beginning the relationship, maintaining the relationship, and ending the relationship.
Although every nurse-patient relationship (NPR) is unique, all relationships have some common features that can be observed and studied. The purpose of this study was to describe the development of a NPR in an oncology setting. Using a qualitative ethological research method, videotaped recordings (VTRs) of the interactions between a nurse and a patient on an active cancer treatment ward were used to investigate and delineate important features of nurse-patient interactions that reflected the development of a NPR. Although there is some consensus on the characteristics of an effective NPR in the literature, further exploration is necessary to increase our understanding of the complexities inherent in NPRs as they actually occur everyday in clinical settings. The findings of this study revealed patterns of behavior reflecting the development of an effective NPR.

The set of NPIs used in this investigation involved approximately two hours and twenty minutes of interactions between one nurse and one patient over a three-day period. The sixty interactions occurred during two twelve-hour shifts and one eight-hour shift. Despite the limited amount of time the nurse and patient spent together over this three-day period, they were able to develop an effective relationship.

Analysis of their interactions revealed patterns of behavior that appeared to contribute to the development of this relationship. These patterns of behavior included both verbal and nonverbal behaviors on the part of the nurse as well as the patient. These behavior patterns were referred to as behavioral clusters.
Specific clusters were identified on each day of this three-day relationship. Some of the behavioral clusters and constituent behaviors were identified in all three days of the relationship, while other behaviors changed as the relationship developed. Each cluster reflected the dynamic interplay of patient and nurse behaviors.

Behavioral clusters on the first day included: the nurse and patient getting to know one another; the patient wooing the nurse and the nurse responding by creating a foundation for connecting; the patient being vigilant of the nurse and the nurse responding by demonstrating her competence; and, the nurse making therapeutic suggestions with a patient response of cautious consideration. On the second day of this NPR, behavioral clusters were reflective of the patient’s comfort with being known by the nurse and the nurse deepening her understanding of the patient; the nurse and patient sustaining their involvement and connection with one another; the nurse making therapeutic suggestions to the patient and the patient cautiously responding to the suggestions; and, the patient communicating physical distress and a nurse response of being there for the patient. On the third and final day of this three-day relationship, the nurse and patient were observed to be comfortable with one another; the nurse was pushing toward problem resolution while the patient responded with tempered movement toward problem resolution; the patient was making the most of the time left as the nurse prepared for concluding the connection; and, the patient and nurse said good-bye to one another.

The development of this relationship was characterized by
the mutual participation of both the nurse and patient in all interactions. In addition, the extensive use of humor by this dyad appeared to be an important factor in this relationship. The depth of the relationship developed between this nurse and patient was reflected in demonstrations of respect for the other and in expressions of sentiment to each other.

**Discussion of the Findings**

Presented in this chapter is a discussion of the study findings. This discussion will be organized along several key findings including: mutual participation in relationship building; ways of knowing in a relationship; fostering achievement of therapeutic goals; humor in relationship building; reciprocity; and closure of NPRs. Questions or issues nurses need to consider in relation to developing NPRs as well as research needs will be incorporated into this discussion. Additionally, the research method used for this study will be discussed and limitations of the study considered. Finally, conclusions of the study will be presented.

**Mutual Participation in Relationship Building**

The over-riding boundaries and agenda for encounters between nurses and patients are to some extent determined by the organizational context in which nurse-patient dyads are located (May & Purkis, 1995). In this sense, both the nurse and patient in this study began the relationship within a set of constraints and expectations about nurse and patient roles. Nevertheless, within these parameters, there appeared to be space for mutual participation in building a relationship.

This mutual participation was most vividly demonstrated in
the dynamic interplay between the nurse and patient, reflected in behavior patterns of relating. For example, on their first day together when the nurse made therapeutic suggestions, and the patient responded by cautiously considering her ideas. In turn, the nurse offered explanations for her suggestions in what appeared to be an attempt to gently guide the patient to take up these suggestions. This precipitated a patient response characterized by listening and cautiously responding to the suggestions. This dynamic interplay was characteristic of all interactions, clearly demonstrating that the relationship was controlled and directed by both the nurse and patient. Neither was a passive recipient of this process.

This finding is unlike some descriptions of NPRs in which the development of the relationship is based on the behaviors of the nurse. Comprehensive nursing texts, particularly those in the area of psychiatry and mental-health maintain that the nurse has the primary responsibility of focusing, directing, continuing, and terminating the NPR (Brady, 1993; Gelazis & Coombe-Moore, 1993; McMahon, 1992; Schwecke, 1995; Thomas, 1991).

The active participation of both the nurse and patient in relationship building is supported by some researchers (Morse, 1991a) as well as theorists (Peplau, 1952). For example, Morse's analysis of in-depth interviews with nurses revealed that nurses and patients negotiate relationships. Morse's findings are congruent with those of the present study because they point to more active and equal roles on the part of both the nurse and patient in building relationships.

Morse (1991a) points out that the outcome of the negotiation
between the nurse and patient is different levels of involvement. Based on Morse’s typology, the nurse and patient in this study seemed to negotiate a mutual relationship referred to as a connected relationship. In the connected relationship, the nurse maintains a professional perspective while viewing the patient as a patient as well as a person. In turn, the patient trusts, respects, and feels grateful to the nurse. In this relationship the patient believes the nurse has 'gone the extra mile.'

In the connected relationship, Morse (1991a) maintains that there is active participation on the part of the nurse and patient in relationship building. The findings of this study suggest this process of active participation continues throughout the NPR, including closure. Other researchers (Roberts, Krouse, & Michaud, 1995) have found negotiation in the NPR is a process that encourages patient self-care behaviors resulting in patients becoming more responsible and feeling satisfied with treatment decisions and outcomes. However, these researchers did not describe what this process of negotiation entails, and how negotiation is linked to building the relationship.

Researchers have described a level of involvement based on reciprocity and exchange between the nurse and patient to provide the patient with a sense of personal recognition (May, 1991a; Morse, 1991a; Ramos, 1992; Hagerty et al., 1993). These researchers described a deep involvement between the nurse and patient. However, it was unclear what specific behaviors contribute to this level of involvement. Although the relationship observed in this study appeared to reflect a certain degree of involvement between the nurse and patient, the nurse's
primary focus was on the patient as a patient not on the patient as a person. Behavior clusters reflecting her focus on the patient included: making therapeutic suggestions, deepening understanding of the patient, and being there for the patient.

Two important issues must be considered in relation to mutual participation in relationship building. First, it is evident that there is a discrepancy between nursing texts, particularly those in the area of psychiatry and mental-health (Brady, 1993; Gelazis & Coombe-Moore, 1993; McMahon, 1992; Schwecke, 1995; Thomas, 1991), and research on the NPR (May, 1991; Morse, 1991a; Ramos, 1992; Hagerty et al., 1993). Authors of nursing texts maintain that the NPR is primarily directed by the nurse, whereas the present study as well as other research studies on NPRs have found that building the NPR is a mutual and reciprocal process between the nurse and patient. Such a discrepancy could confuse nursing students and neophyte nurses.

Second, the research that has been conducted on the reciprocal nature of the NPR has been conducted mainly from the perspective of the nurse. Furthermore, specific behaviors contributing to the mutuality of the relationship have not been previously described. The observational method used in this study to investigate the behaviors of both the nurse and the patient contributed to a rich description of these behaviors. Researchers need to give equal attention to nurses and patients to gain a deeper understanding of the development of the NPR in the clinical setting.

Additionally, the mutual participation in relationship building found in this investigation shed light on behaviors that
contribute to the development of an effective NPR. Awareness of nurse and patient behaviors that contribute to the development of effective NPRs may challenge oncology nurses to reflect on their own practice, and to consciously incorporate behaviors that contribute to effective NPRs into their patient care.

Ways of Knowing in a Relationship

Getting to know one another seemed to be an important piece in building a relationship. In this dyad, social conversations, self-revelations, and the use of humor contributed to getting acquainted on a personal level. Getting acquainted on a professional level was noted in both verbal and nonverbal behaviors. For example, the nurse used assessment strategies to become familiar with the patient's needs for nursing care. To get to know him on a personal level, she used social conversations and lighthearted humor. In a similar way, the patient intently watched the nurse, in what appeared to be attempts to learn about and perhaps assess her professional abilities. The patient used direct personal questions about the nurse and humor to get to know the nurse as a person. As such, getting acquainted with one another was played out in observations of verbal and nonverbal behaviors and incorporated the recognition of the nurse and patient beyond their roles in the hospital setting. The findings of this investigation lend support to conceptualizations of the NPR in which the patient is recognized as a person within the routine and demands of nurse's work (Bishop & Scudder, 1990; Watson, 1988; Gadow, 1985).

The nurse in this study closely matched the description of an expert nurse (Benner, 1984, 1985; Benner, Tanner, & Chelsa,
1992; Tanner, Benner, Chelsa, & Gordon, 1993). She knew the patient's patterns and responses, for example his mouth care routines and response to trying new mouth care products. As the nurse completed her work, she also came to know the patient as a person. She knew his occupation, interest in sports, and sense of humor. She also knew his moods, fears, and stoic behavior at times. Her practice was skillful and she managed complex situations, such as when the patient was in physical distress, in a calm and comforting manner. Additionally, as the relationship progressed, she helped the patient make some progress with his mouth care, an accomplishment other nurses did not manage to achieve. This nurse's expertise enabled her to understand the patient and to offer the patient realistic possibilities.

Researchers have found that knowing the patient as a patient as well as knowing the patient as a person are central to skilled clinical judgement and to patients feeling cared for and cared about (Tanner et al.).

Less recognition has been given to the patient's need to know the nurse on a professional as well as personal level. Some researchers, however, have identified this need (Morse, 1991a; Raudonis, 1993, 1995; Thorne, 1993). Thorne describes how chronically ill patients look for health care providers they can trust and demonstrate respect for their expertise. This suggests that patients need to get to know their health-care providers. It is possible that patients are not able to feel "safe" in the hands of nurses until they determine that their nurse is a competent and caring practitioner.

Morse (1991a) notes that patients assess nurses on a
personal as well as a professional level. On a personal level patients assess nurses by asking them personal questions. Asking personal questions helps patients evaluate whether the nurse is a 'good person,' whether the nurse is 'nice,' and whether they can 'get along.' Patients also observe the nurse to see whether the nurse is dependable. On a professional level, patients determine if the nurse is experienced, confident, and gentle. Morse's findings suggest that if the nurse's behaviors satisfy patients, then patients are willing to trust the nurse and place themselves in the nurse's care.

Morse's (1991a) findings lend support to several of the behavioral clusters observed in the present study. For example, the behavioral cluster of the nurse and patient getting to know one another with constituent behaviors such as the nurse assessing the patient as a patient and the patient assessing the nurse as a person was similar to Morse's finding. Similarly, the behavioral cluster of the patient being vigilant and the nurse demonstrating her competence, was reflected in Morse's study.

Raudonis (1993, 1995) investigated empathic relationships between terminally ill patients and their nurses. These patients reported that their relationship depended on the nurse's competent interventions and responses to their needs, sharing of the nurse's personhood and humanity, and the patient's reciprocity. The sharing of personhoods facilitated the development of empathic relationships. Raudonis's studies suggest that there is a need for personal knowing in order for the nurse to relate to another human being. In the present study, the patient demonstrated his need to know personal
information about the nurse. The nurse willingly shared some intimate details of her life with the patient. Self-disclosing personal information may have contributed to balancing the relationship.

Investigators and theorists in nursing have pointed to the importance of the establishment of a strong personal relationship with patients to facilitate clinical decision-making and to permit the individualization of care (Benner & Wrubel, 1989; Carper, 1978; Jenks, 1993; Jenny & Logar, 1992; Meleis, 1991; Watson, 1988). Failure to do so can result in less effective or inappropriate nursing care, patients' lack of trust in their nurses, and failure to achieve desired therapeutic outcomes (Jenks, 1993; Jenny & Logar, 1992).

In this study, knowing the patient and knowing the nurse on both a professional and personal level appeared to serve two important purposes. First, their knowledge of one another enhanced therapeutic interventions. The nurse was able to individualize her approach to the patient based on her knowledge of his needs, moods, insecurities, and personal preferences. At the same time, by knowing the nurse, the patient was able to feel comfortable enough to discuss problems, and show as well as voice his distress to the nurse. Second, their knowledge of one another seemed to decrease the power differential between them.

Porter's (1994) study of NPRs revealed that reducing the power differentials between nurses and patients resulted in more relaxed and friendly relationships. As a result, patients felt more at ease to discuss their concerns with their nurses and find out about their condition and treatments. This increased
communication gave patients more control over their care rather than conforming to the authority of the nurse. Furthermore, a less authoritarian environment was also a benefit to nurses, who felt happier with more open relationships.

These findings may challenge nurses to reflect on their sources of knowledge in clinical practice. By becoming conscious of their own knowledge, nurses may become aware of sources of knowledge which they have not used that could contribute to their relationship with patients. Observations from the present study pointed to the importance and centrality of the patient's need to know the nurse personally as well as professionally.

Fostering the Achievement of Therapeutic Goals

In the nursing literature, authors such as Newman (1990, 1994), Parse (1992), Watson (1988), and others have embraced the notion of nursing as a human science. In human science, the individual is referred to as a whole and is thus the obvious source of knowledge of her/his lived experience (Mitchell & Cody, 1992). Human science, therefore, focuses on this lived experience, that is, the meaning, values and relationships within the humanly lived experience. In this paradigm, the human being is referred to as a subjective whole who is situated in-the-world, who is intentional and free-willed (Mitchell & Cody). Incorporating this belief into nursing practice means that "the nurse would seek no more fundamental reference than the lived experience of the person" (Mitchell & Cody, p. 57). For the nurse, the notion of human science emphasizes the importance of "being there" and suggests that the nurse should not impose her/his views on the patient.
Contrary to the nursing role depicted in the human science paradigm, in the present study, the nurse was observed to be involved in making therapeutic suggestions to the patient and pushing the patient toward problem resolution. Within these behavior clusters the nurse engaged in behaviors such as gently guiding the patient by explaining suggestions, gently and assertively confronting the patient about care issues, and encouraging the patient's continuance with self-care. The nurse was observed to engage in these behaviors despite the patient's cautious consideration of her suggestions and reluctant progression toward problem resolution. These observations are interesting because they indicate that the nurse in this study actively directed care and thus acted in a manner contrary to the human science approach.

It is difficult to infer what may have happened had the nurse acted within the human science framework. It is possible that the patient may not have tried any of the prescribed mouth treatments and his discomforts may have escalated. Although the nurse guided the patient, and suggested and explained therapeutic options to him, she never coerced the patient into trying her suggestions or reprimanded him for not taking up her ideas. As such, the nurse did maintain the patient's free-will to the extent that she provided him with the opportunity to choose. As a result, the patient had knowledge of his options and was empowered to act upon that knowledge.

This nurse's actions were not unlike those observed in most clinical settings. In nursing education programs, nurses are taught to use the nursing process in the context of a theoretical
framework to guide their practice. Using this approach, nurses take an active role in planning and implementing nursing care with patients as well as enhancing patients' knowledge and skill to improve self-care and health status.

The findings of this study indicated that the nurse fostered the achievement of therapeutic goals in a manner unlike that suggested by some nursing theorists. The observed patient outcomes would suggest that her actions were appropriate and appreciated and demonstrated her caring and concern for the patient. As such, this finding implies the lived experience in the clinical setting conflicts with the beliefs in this theoretical conceptualization. Questions arise about the limits of the human science perspective in nursing practice.

Humor in Relationship Building

In this particular nurse-patient dyad humor was a prevalent behavior in many of the behavioral clusters. From the start of the relationship, both the nurse and patient incorporated humor into their conversations. At the beginning of the relationship, humor took the form of lighthearted conversations. As the relationship progressed, humor became more spontaneous and was directed at particular situations. Humor was used to soften discussions of unresolved issues surrounding the patient’s care or was simply used to "lighten" the patient’s mood or break up the monotony of routine tasks.

The claim that humor can be an essential aspect of the NPR is supported in the literature. Humor has been described to have communicative and social functions by demonstrating kindness, affection, caring, and humanity (Hulatt, 1993; Robinson, 1970,
1977). In addition to these communicative functions, humor and laughter have been reported to improve ventilation and to increase blood oxygen as well as circulation (Carlisle, 1990). It is also believed to have the ability to release endorphins, a body chemical which acts as a natural anesthetic (Gruner, 1990). In relation to the NPR, humor is thought to provide consolation, diversion, and reinforcement of empathic understanding (Hulatt, 1993; Simon, 1988). Researchers have found that a nurse who shows a sense of humor is viewed as approachable to the patient. Being approachable, makes for an easy and sincere relationship and facilitates the development of dialogue between the nurse and patient (Åstedt-Kurki & Liukkonen, 1994; Sumners, 1990).

In the present investigation the nurse seemed to know the appropriate times to use humor. For example, humor was never used while the patient was in apparent physical distress. However, once the initial distress subsided the nurse used humor in what appeared to be an attempt to decrease the patient's tension. In a study of the use of humor by psychiatric nurses, findings suggested that nurses intuitively knew when it was appropriate to use humor with their patients (Dunn, 1993). Elements such as knowing the patient, intuition, and caring helped nurses determine how, when, and where humor should be used in the NPR (Dunn).

Sumners (1990) identified that humor enhances problem solving and is needed for creating innovative solutions. By allowing humor to enter the relationship, other perspectives and flexibility of thinking may lead to creative solutions. The enhancement of problem solving with the use of humor was
supported in this investigation. The nurse made therapeutic suggestions to the patient, gently confronted the patient about his care issues and encouraged the patient's independence. The patient cautiously considered the nurse's therapeutic suggestions and displayed his independence to the nurse. It is clear from the description of these behaviors that the nurse and patient did not always agree on therapeutic ideas and the patient did not easily take up the nurse's suggestions. The patient never outwardly refused to try the nurse's suggestions and the nurse never reprimanded or judged the patient for not agreeing with her ideas. Any tensions that may have arisen on the basis of these differences appeared to be dissolved by using humor and engaging in social conversations. The use of humor in situations where the nurse and patient were not in synchrony was also supported by Robinson (1983) who maintained that humor is an indirect form of communication that can be used to relay ideas or suggestions that may be otherwise unaccepted if they were conveyed directly.

Although humor appeared to serve this relationship positively it is arguable that it was also used negatively. The nurse and patient in this study never discussed serious issues around the patient's illness. Issues such as the patient's prognosis, and the impact of his illness on his wife and business were never addressed. It is possible that the extensive use of humor prevented the nurse and patient from addressing these difficult issues. There was at least one situation where the nurse used humor to cope with her own feelings and by doing so avoided a potentially difficult topic. In an interview with the nurse, the nurse reported feeling uneasy and awkward when the
patient offered to build her a house. She stated being saddened by the thought that the patient would not live long enough to build her house. She handled her uneasiness with the topic by laughing it off and quickly changing the subject.

The findings of this study point to the importance of nurses questioning the motives behind their humor. Nurses who choose to use humor in their practice need to ask themselves whether their use of humor is to cope with difficult issues; whether they use humor at appropriate times; whether the patient shares in the humor; and most importantly, whether the humor diminishes the patient's worth and importance.

Reciprocity

Social exchange was an important aspect in this investigation. In addition to statements of gratitude, the patient gave the nurse a gift. In return, the nurse gave the patient a small gift in what appeared to be a demonstration of her caring. Furthermore, the gifts they gave one another were personal and symbolically significant.

Social exchange in relationships is a process in which we provide others with something, and expect to receive something in return (Baron & Byrne, 1987). Morse (1989, 1991b) maintains that although the nurse works for the hospital, s/he 'gives' the patient care. As a result, this situation creates an imbalance in the NPR. The act of giving a gift to the nurse is the patient's way to reciprocate for the nurse's care and pay a debt of gratitude to the nurse. Morse (1991b) argues that the patient may feel passive and in a dependent role unless s/he has the opportunity to reciprocate. Morse (1989) suggests that
hospitals with policies prohibiting gift-giving to nurses inhibit patient recovery and place the nurse in an awkward situation.

Morse (1991b) found that gifts presented by patients were symbolic of the NPR. The timing of giving a gift was considered by nurses to be most important, whereas the nature and value of gifts were less important. If the gift was given too early, it was perceived by nurses as manipulative—as a bribe. Gifts that were given to the individual nurse, as opposed to the unit for all the nurses to share, signified that particular nurse's care "made a difference." Morse delineated several categories of gifts, for example, gifts to reciprocate for the care given and gifts intended to manipulate or to change the quality of care, were two categories identified. Morse reported that in general, nurses reported feeling uneasy about receiving gifts from patients as they were taught to not accept gifts.

Morse's (1991b) category of gift giving called, "gifts to reciprocate" closely resembled the type of gift-giving observed in the present study. The gift of green shamrock cookies was given to the nurse at the mid-point of this NPR. This gift was significant given the nurse was Irish and the cookies were presented to her on St. Patrick's day. Throughout the relationship, the patient complemented and thanked the nurse for her care. Morse classified copious thanks as manipulative gifts. The patient in the present study did not thank the nurse copiously and his verbal gratitude to the nurse seemed genuine and sincere.

In this study, the nurse also presented the patient with a symbolic gift. Perhaps this gift was in reciprocation for the
cookies the patient had given her earlier. It is unknown whether the nurse's gift to the patient left the patient feeling indebted again to the nurse. Interestingly, during the final interaction between the nurse and patient, the patient initiated warm sentiments and compliments to the nurse. Perhaps by expressing his feelings about the nurse and saying to her that she was "really excellent," he repaid the nurse for her earlier gift.

Current understandings of reciprocity suggest that nurses should be encouraged to examine the meaning, role, and function a patient's gift may have in their NPR. Furthermore, the complex phenomenon of gift-giving should be considered by hospitals' administrators. It has been suggested that policies inhibiting gift-giving impede patient recovery as well as place nurses in the awkward position of refusing the gift (Morse, 1989).

Closure of NPRs

In this study, the opportunity to observe the closure of a relationship revealed some important behaviors on the part of both the nurse and patient that may be important to satisfactory closures. During interactions, patient behavioral clusters reflected tempered movement toward problem resolution; making the most of the time left; and, saying good-bye to the nurse. On the part of the nurse, behavior clusters pointing to the closure of the relationship included: pushing toward problem resolution; preparing for concluding the connection; and, saying good-bye to the patient.

Interestingly, some researchers who focused on describing the phases of the NPR have not discussed ending the relationship (Raudonis, 1995; Thorne & Robinson, 1988) or discussed the ending
of the relationship in a superficial manner (Trojan & Yonge, 1993). The termination phase of the relationship has been discussed by theorists (Peplau, 1952) and clinical experts (Brady, 1993; Gelazis & Coombe-Moore, 1993; McMahon, 1992; Schwecke, 1995; Thomas, 1991). Peplau referred to ending the relationship as the stage of resolution. She contended that this final stage needs close attention to avoid destroying the advances made throughout the relationship. Furthermore, focus is on the patient's accomplishments throughout the relationship and on setting future goals.

Comprehensive nursing texts, particularly those with a focus in psychiatry and mental-health have addressed ending the NPR as the phase of termination (Brady, 1993; Gelazis & Coombe-Moore, 1993; McMahon, 1992; Schwecke, 1995; Thomas, 1991). The termination phase is described to begin during the start of the relationship and to continue throughout the NPR. The goal of terminating the relationship is to bring a therapeutic end to the relationship. The therapeutic end is accomplished by the nurse and patient reviewing feelings about the relationship, evaluating the progress made toward goals, and establishing ways for the patient to meet future care needs. Although letting go of close, satisfying, and mutually accepting relationships can be difficult, failure to terminate the relationship is believed to violate the boundaries of therapeutic NPRs. Experts suggest strategies nurses should use for terminating the relationship, including exploration of feelings about termination, discussing the future, and anticipating possible situations the patient may face (Brady; Gelazis & Coombe-Moore; McMahon; Schwecke; Thomas).
There is no mention in these texts of the patient's role in the termination phase.

The conclusion of the relationship in this study contained some of the elements discussed by nursing experts. For example, the nurse and patient in this study shared their feelings about one another and the nurse gave the patient encouragement to maintain newly established behaviors related to his mouth care. Nevertheless, it is interesting that some of these behaviors were initiated by the patient. For example, it was the patient who was first to share his feelings for the nurse at the closure of their relationship. It is impossible to speculate what would have happened if the patient would have not taken this initiative. This example provides additional support for the active role patients are able to take in all phases of the relationship, including the termination phase. These behaviors were unlike those observed in the beginning or middle of the relationship providing support for defining this part of the relationship as a separate phase.

Additionally, in preparing for concluding the connection, the nurse in this investigation did not make any new therapeutic suggestions and began encouraging continuance of self-care for the patient. The patient responded to the nurse by agreeing to take her direction for the future and continue to work on the therapeutic suggestions she had previously made. Similarly, authors have noted that in the termination phase of the NPR, the nurse indeed focuses on the future and does not explore new areas with the patient (Brady, 1993; Gelazis & Coombe-Moore, 1993).

Focus group participants discussed the importance of closure
in a relationship. They agreed that an ambiguous ending to the relationship can leave both the nurse and patient feeling uneasy and may contribute to patient distress.

Closure in this nurse-patient dyad was marked with final good-byes, compliments to one another, by telling one another that they will be missed, and by wishing each other well. These findings were important because ending a relationship has not been given adequate attention in much of the literature on the NPR or in cancer nursing.

Discussion of the Research Method

The nature of this study lent itself to a descriptive research approach. Using a qualitative ethological method, the complex behavior patterns of the NPR were captured through detailed observations of behaviors as they occurred in a natural setting. By using this research method, the investigator was able to document patterns of behavior in greater detail and with more precision than is possible with other approaches such as interviewing or participant observation.

The use of videotaped recordings (VTRs) made it possible to study events in the NPR that may have been rare or of short duration. Additionally, precise information about verbal and nonverbal behaviors as they unfolded moment-by-moment was available for intense and repeated analysis. The use of VTRs presented an unlimited opportunity to revisit events as they occurred in real time, allowing for a rich description of the events. Furthermore, the use of VTRs lent itself to equal observation of both the nurse and the patient.

This study involved a secondary analysis of videotaped data
collected as part of a larger study to investigate nurse-patient interactions (NPIs) (Bottorff, 1992). A sample of sixty NPIs that represented all the interactions between one patient and one nurse over a three day period was studied.

The VTRs of this relationship were analyzed by reviewing all the interactions, identifying the behavioral clusters, identifying constituents of the behavior clusters, and constructing an ethogram. The investigator found the task of viewing VTRs arduous. In order to remain focused when viewing VTRs repeatedly, it was important to take short breaks often. Additionally, VTRs were revisited on a regular basis to ensure that frequently occurring events were not favored over other aspects that may be important.

To validate the findings, a focus group of five expert nurses was used to validate and extend the analysis. Furthermore, participants of the focus group suggested different perspectives on some of the behaviors found in the study which prompted the investigator to recheck segments of interactions for important aspects that may have been overlooked.

A limitation of the focus group was that patients were not included in the discussion. Because the findings of the study highlighted the active participation of both nurses and patients in building relationships, it would have been beneficial to have patients' insights about the validity of the study findings. Although two of the focus group participants also had the experience of being patients, their nursing background did not allow them to speak exclusively from a patient's perspective. The addition of patients to the focus group discussion may have
revealed important patient behaviors that were overlooked in the present study. Furthermore, these insights could have potentially extended the findings and knowledge about NPRs.

One major limitation of the use of VTRs in qualitative ethology is that information is limited to what can be observed. Bottorff (1992) interviewed the nurse and patient asking each questions related to her study. The nurse and patient alluded to their relationship in their interviews, and provided some valuable information about their relationship which helped to extend the findings of the present study. However, the nurse and patient did not speak about their relationship specifically. As a result, it was not possible to determine if the understanding of the events that occurred in the NPR is analogous to that held by the nurse and patient.

There were advantages as well as disadvantages of using a case study to learn about the development of a NPR. The rigorous exploration of a single NPR can be extremely useful in the production of hypotheses on NPR development which can then be tested in subsequent research. The intensive analysis that took place in this study has provided insights into previously unnoticed behaviors in NPRs. Additionally, this case study captured the depth and richness of the NPR as it occurred in a clinical setting in a way that is not possible using larger samples. The limitation of using a case study is that one cannot make predictions or generalizations to other settings based on the findings of this single case. It would be impossible to argue that the same relationship would manifest itself in other nurse-patient dyads.
Several steps were taken to ensure rigor in this study. A clear decision trail was left at every stage of this study (Sandelowski, 1986). The investigator kept a journal detailing and justifying the decisions made during the process of this study. The journal also included reflective notes about the investigator's own values and interests as well as for speculation about emerging insights. Furthermore, detailed and repeated analysis of the VTRs to identify essential characteristics of the developing relationship was carried out to ensure applicability and credibility of the study. A ninety minute focus group meeting was also held to evaluate the extent to which the findings were meaningful and applicable to the experience of nurses who have worked in similar settings. The focus group discussion validated many of the behavior clusters identified to be important in the development of a NPR. In some instances, the possible consequences of not engaging in certain behaviors were described.

Future research on the NPR in other nursing contexts could further our understanding of relationships between patients and nurses. Furthermore, the use of additional research methods such as open-ended interviews in combination with detailed observation and analysis of nurse and patient behaviors as they occur in a natural setting, would strengthen the validity of future research and further add to our understanding of NPRs.

Conclusions

Although the importance of the NPR has been recognized, little is known about the development of the NPR as it unfolds in clinical settings. The purpose of this study was to investigate
and delineate important features of NPIs reflecting the development of a NPR. On the basis of the findings of this study, four main conclusions can be drawn. First, the development of the NPR is based on a dynamic, complex interplay between the nurse and patient. Furthermore, it is possible to identify interaction patterns that contribute to the development of NPRs. Second, effective relationships can develop between nurses and patients over a short period of time. Third, the use of humor and social conversation appear to facilitate the development of NPRs. Finally, in-depth analysis of observational data of both nurse and patient behaviors can make an important contribution to understanding NPRs.

Summary

Presented in this chapter was a discussion of the study findings. The discussion focused on six key findings including: mutual participation in relationship building; ways of knowing in a relationship; fostering achievement of therapeutic goals; humor in relationship building; reciprocity; and, closure of NPRs. Each of these key findings was discussed in light of existing literature and was followed by a discussion of implications for practice and research. Finally, a discussion of the research method as well as conclusions were presented.

The NPR is a complex relationship. It involves personal elements such as mutuality and caring and at the same time, the NPR is clinical and therapeutic. Since the NPR is at the heart of nursing, it is essential that we come to understand the complexities of this dynamic relationship as well as how to foster it in order to serve therapeutic ends. The NPR is an
interactive process and as such, to understand it and research it both the role of the patient and the nurse must be equally considered.

Learning more about the actual process of interactions involved in the development of the NPR has important implications for patient outcomes, patient satisfaction with nursing care and nurses’ work. This study took advantage of a unique opportunity to gain a rich and complex understanding of the dynamics involved in the development of a NPR by completing a secondary analysis of VTRs of 60 consecutive interactions between one nurse and patient. As such, this study made an important contribution to our understanding of NPRs through the detailed observation and analysis of nurse and patient behaviors as they occur in a natural setting. To date, such a study of NPRs has not been undertaken. Therefore, this study was valuable in contributing to existing theories on the process of developing a NPR and providing a foundation for further investigations. Finally, extending our understanding of relationships between cancer nurses and their patients will enable nurses to enhance health care outcomes for cancer patients.
REFERENCES


_Nursing Science Quarterly, 3_(1), 37-41.


Pepler, C.J. (1984). Congruence in relational messages communicated to nursing home residents through nurse aid touch behaviors. _Dissertation Abstracts International, 45_, 2106b. (University Microfilms No. 84-22312)


APPENDIX 1:
CONSENT FORM FOR FOCUS GROUP PARTICIPANTS

An Observational Study of the Nurse-Patient Relationship in an Oncology Setting

Investigator: Michelle Lotzkar (xxx-xxxx)
Faculty Advisor: Dr. J.L. Bottorff (xxx-xxxx)

The purpose of this study is to describe the development of nurse-patient relationships as they occur in cancer nursing. This research has involved a detailed analysis of videotaped recordings of the interactions between one nurse and one patient. Important patterns of behavior have been identified from this case study. It is now important to check these findings with experienced cancer nurses. As such, you are being invited to participate in a focus group meeting to hear about the preliminary findings of this study and respond to them.

Several things will take place during the focus group meeting. You will be asked to:

1) Listen to the preliminary findings of the study.
2) Discuss your perceptions and thoughts about the preliminary findings.
3) Share some of your own experiences in developing relationships with patients.
The entire discussion will take about 90 minutes, and will be audiotaped. An observer will also be taking notes during the discussion. The audiotapes and notes taken during the discussion will be reviewed and the information obtained will be used to augment the findings of this study.

To maintain confidentiality and anonymity, audiotapes and notes taken during the focus group meeting will contain no names or identifying characteristics. No one will have access to this material except myself and three research advisors. Participation in this focus group meeting is voluntary and you may choose to not participate if you wish. If you wish to not participate or withdraw from the focus group, your employment will not be affected. If you do agree to participate, you may withdraw from the study, refuse to answer questions, or leave the discussion at any time.

By signing this consent form I indicate that I have received and read the information provided here and have a copy of this consent form. I agree to participate in the focus group meeting.

Date: __________  Participant: __________
Date: __________  Investigator: __________