THE ESSENTIAL STRUCTURE OF A CARING AND AN UNCARING ENCOUNTER WITH A NURSE -- FROM THE CLIENT'S PERSPECTIVE

By

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B.Sc.N., University of Iceland, 1978

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

in

FACULTY OF GRADUATE STUDIES

The School of Nursing

We accept this thesis as conforming to the required standard.

THE UNIVERSITY OF BRITISH COLUMBIA

April 1988

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Abstract

This phenomenological study was designed to explore the essential structure of caring and uncaring encounters, as perceived by recipients of nursing care in their interactions with nurses, with the aim of adding to the knowledge and understanding of these phenomena.

Data were collected through 18 in-depth interviews with nine former recipients of nursing care. The interviews were tape-recorded and transcribed verbatim for each participant. The researcher saw the participants in the study as coresearchers and through inter-subjective interaction, or dialogue, the essential description of a caring and an uncaring encounter was constructed.

The essential structures of both caring and uncaring encounters are composed of three basic components: the approach by the nurse, the presence or absence of relationship formation, and finally, the patient responses to the encounter. The first component in the essential structure of a caring encounter with a nurse -- from the client's perspective, is the professional caring nurse approach. The nurse is perceived to be competent, administering her care with genuine concern for the patient as a person, giving him full attention when with him, and constituting a cheerful presence for the patient. The coresearchers reported that these characteristics, which were perceived by them as evidence of caring, had promoted in them a feeling of trust, which had facilitated a development of a nurse-patient relationship. The development of a nurse-patient relationship, or professional attachment, comprises the second essential component of a caring encounter.
Developing a nurse-patient relationship was conceptualized in this study as a process involving five phases: initiating attachment, consisting of reaching out and responding by both nurse and patient; mutual acknowledgement of personhood, where nurse and patient recognize each others as persons; acknowledgement of attachment, involving confirmation of attachment; professional intimacy, when the patient feels safe enough in the relationship to reveal to the nurse particulars about his present condition and how he feels about them; and finally negotiation of care, when the nurse works collaboratively with the patient and truely takes his perspective into account when giving nursing care. Throughout the attachment development the professional nurse keeps a distance, an important dimension of professional attachment which the coresearchers clearly articulated had to be present in order to keep the nurse-patient relationship within the professional domain. This combination of intimacy and distance is referred to as nurse-patient attachment with professional distance.

The professional caring nurse approach and the resulting nurse-patient attachment with professional distance form the essential structure of professional caring. The patient responses to professional caring comprise the last component in the structure of a caring encounter with a nurse. Five themes were identified in the coresearchers' accounts: sense of acceptance and self-worth; sense of encouragement and support; sense of confidence and control; sense of well-being and healing; and finally sense of gratitude and liking.

The essential structure of an uncaring encounter with a nurse -- from the client's perspective is also comprised of three basic components: the nurse's approach to the patient, which is perceived by the patient as
indifference to him as a person; the resulting nurse-patient detachment with total distance between the nurse and the patient; and finally patient responses to uncaring.

Four dimensions of an uncaring nurse approach were identified in the data, characterized by increased indifference, inattentiveness, and insensitivity to the patient and his needs: apathetic inattention, unconcerned insensitivity, unkind coldness, and harsh inhumanity. Perceived nurse indifference to the patient as a person makes the patient distrustful of the nurse. The patient often perceives the nurse as an authoritarian person with a need to control, and the patient's encounter with her is characterized by a lack of professional attachment, limited verbal communication, negative nonverbal communication by the nurse, and a lack of collaboration and negotiation of care. This is referred to as nurse-patient detachment with total distance.

It was the coresearchers' unanimous perception that uncaring encounters with nurses were very discouraging and distressing experiences for them as patients. The coresearchers responses to the uncaring encounters were many-sided. Seven major themes were identified in their accounts: puzzlement and disbelief; anger and resentment; despair and helplessness; feelings of alienation and identity-loss; feelings of vulnerability; perceived effects on healing; and finally long-term effects of uncaring encounters. It was the coresearchers' unanimous perception that the uncaring encounters made an indelible impression on them, had a longer lasting effect than caring encounters, and tended to be both acid edged and memorable unresolved experiences.
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I would like to thank the members of my thesis committee, Dr. Joan Anderson and Donelda Ellis, for their professional guidance and inspiration. To my friends, Ling Lai and Marjorie McIntyre, who shared with me the process of doing phenomenology, I offer my sincere gratitude for being friends in need indeed. I am also deeply indebted to my nine coresearchers who so readily shared with me their experiences of caring and uncaring. Moreover, a sincere acknowledgement goes to my friends Lara Thordarson, Olgeir and Shirley Arnason, Joan and Sigrun Isberg, Mary Ann Bibby and Cora Lavoie, for memorable time during recreation and for making my stay in Canada so special. Last but not least I would like to acknowledge and thank my family for it’s support and caring. Without them this thesis would never have been done.
CHAPTER 1: INTRODUCTION

Background to the Problem

Historical belief in nursing as a caring profession (Sample, 1987) and traditional values of caring and compassion embodied in the word "nursing" are worth preserving for future generations of nurses and patients (Beyers, 1987). An awareness of, and sensitivity to caring and uncaring, backed by systematic investigation of care phenomena, offer one of the greatest hopes for improving health care services to advance the discipline of nursing (Leininger, 1984).

It has been suggested that care is the essence and the central, unifying, and dominant domain that characterizes nursing (Leininger, 1984). Caring has been seen as a nursing term, representing all the facets used to deliver nursing care to clients (Watson, 1985). It has even been suggested that caring means the same as nursing, which is derived from 'to nourish' (Griffin, 1983). Given our space-age technology, the need for caring in nursing today is paramount (Carper, 1979; Henderson, 1985; Kelly, 1984; Leininger, 1984).

Although 'care' and 'caring' have been used in the nursing literature for more than 100 years, it is only recently that nurses have undertaken systematic philosophic and scientific investigation into this construct (Ray, 1984). Weiss (1984) claims that investigation of care and caring behaviors relative to nursing is imperative for nurses as well as for nursing. She points out that the concept of caring is widely used yet lacks specific definition of behaviors, and asks, "What do nurses know about client perceptions in nurse-patient relationships?" (p. 162). This is an important
question since the limited research available regarding caring and uncaring nursing interactions has mainly been that seen from the nurse's perspective (Goldsborough, 1969; Amacher, 1973; Hyde, 1977; Wallston et al., 1978; Ford, 1981).

The public's image of nursing could become markedly and positively changed if nurses focused on being exquisite care providers, because the public seems to want sensitive and knowledgeable caregivers (Leininger, 1984; Mayeroff, 1971; Sarason, 1985). It is up to nursing as a profession to decide what kind of concept of caring it will work to support, for the benefit of the giver as well as the receiver of care (Griffin, 1983).

If nurses want to become known as care providers and advocates, however, they must become knowledgeable about caring and uncaring from the client's point of view, since it is logical to assume that the best source of information about the client is the client. It is primarily when caring is studied from the client's perspective that progress can be made in providing clients with the quality of nursing care that can be identified and labelled by the public as caring (Swanson-Kauffman, 1987).

**Conceptualization of the Problem.**

Within some of the medical anthropology and nursing literature a central notion is the idea that what people say and do needs to be understood in terms of their "explanatory models" (Kleinman, 1978; Anderson 1985). The discrepancy between lay and professional interpretations has been addressed by Kleinman's cultural system model (Kleinman, 1978). Kleinman proposes that within the cultural system of health care, three distinct but interacting domains of interpretation and
experience are in operation. These are the professional, popular and folk sectors (Kleinman et al., 1978).

![Venn diagram](image)

**Figure 1. Kleinman's Conceptualization of the Structure of the Health Care System** (Adaptation from Kleinman, 1978, p. 86).

Kleinman (1978) explains that the popular sector comprises principally the family context of sickness and care, and also includes social network and community activities. He points out that in both Western and non-Western societies, somewhere between 70 and 90% of sickness is managed solely within this domain. The folk sector, Kleinman (1978) explains, consists of non-professional healing specialists, sometimes classified by ethnographers into sacred and secular groups, while the professional sector consists of professional scientific ("Western" or "cosmopolitan") medicine and professionalized indigenous healing traditions (e.g. Chinese, Ayurvedic, Yunani, and chiropractic).

Kleinman (1978) claims that "these arenas contain and help construct distinct forms of social reality. That is, they organize particular subsystems of socially legitimated beliefs, expectations, roles, relationships,
transaction settings, and the like." (p. 87). Kleinman, Eisenberg, and Good (1978) point out that each sector possesses its own explanatory systems, social roles, interaction settings and institutions. Kleinman (1978) further asserts that the explanatory model concept illuminates how problems in clinical communication frequently represent conflicts in the way clinical reality is conceived in the popular, folk, and professional arenas of the health care system, and therefore it points to the systematic entailment of these problems within that cultural system.

Kleinman's explanatory model focuses on actual transactions between patients (and their families) and practitioners. He argues that merely eliciting the ideas of the one or the other, without studying how those ideas interact is insufficient. He states, "It is the process of interaction which discloses the real structures of knowledge, logic, and relevance that operate in different health care sectors and systems, and which reveals how they are used in the healing process." (Kleinman, 1978, p. 89).

Kleinman (1978) emphasizes that health professionals need to recognize differences in clinical realities and explanatory models, and need to attempt to negotiate between discrepant explanatory models of patients and practitioners. He suggests that such recognition and negotiation might prevent major conflicts in health care transactions and might "exert a positive influence upon patient adherence to the medical regimen, satisfaction, and appropriate use of health facilities, and potentially might speed ejection from the sick role and return to normal social role and function" (Kleinman, 1978, p. 90).

Health professionals are coming to realize that an understanding of the client's explanatory model is necessary to the negotiation of mutually satisfying and efficacious care (Leininger, 1978; Anderson & Chung 1982;
Anderson, 1985). Anderson (1985) has pointed out that the process of negotiation between sociocultural systems is a key feature in the nurse-client interaction if culturally acceptable, effective and economical care is to be provided. The process of negotiation, critical to providing effective care, can take place, however, only if the nurse understands the patient's perspective.

Anderson (1985) argues that it is nursing's prerogative to understand the client's perspective, and to help the client to acquire knowledge and skills to cope with his or her situation in a way that is culturally acceptable to the client. She points out that within the context of the explanatory model framework the goal of the nurse is to comprehend the complex network of symbols and meanings within which health and illness experiences are constructed. Anderson states,

The encounter between nurse and client becomes one of sharing the explanatory models of the situation; the nurse deliberately elicits from the client how the client understands the situation, including the goals of the encounter with the nurse. (1985, p. 238).

Kleinman's model provides an excellent framework for studying clients' perceptions of caring and uncaring encounters with nurses. Research studies have shown that there is a discrepancy between nurses' and clients' perceptions of caring and uncaring encounters with nurses (Larson, 1981; Mayer, 1987), and there is reason to believe that this discrepancy is due to a difference in explanatory models nurses and clients have. Leininger (1978) has pointed out that discrepancies between expectations held by health professionals and clients have resulted in dissatisfaction with care. The differences in perception have caused
"serious difficulties not only in communication with patients but in establishing therapeutic relationships with them" (Leininger, 1978, p. 76).

Kleinman's conceptual framework directed the researcher to design a phenomenological study which explored clients' perceptions of caring and uncaring encounters with nurses, in order to gain a better understanding of explanatory models associated with these experiences. Studying the client's perspective provides nurses and other health professionals with a valuable insight, because it gives them an inside view of what it is like to experience caring and uncaring. The specific research problem addressed in this study developed from the previously stated concerns regarding nurses' and other health professionals' ability to appropriately meet the needs of patients in hospitals in a way that they feel cared for.

**Problem Statement**

The limited research available on caring and uncaring nursing interactions has mainly been from the nurse's perspective. However, only when uncaring and caring are studied from the client's perspective can progress be made in providing clients with the quality of nursing care that can be identified and labelled by the public as caring. This is especially important since studies seem to indicate disagreement between professional nurses' perceptions of caring and patients' perceptions of caring. This may be due to variations in sample, design etc., or may indicate that caregivers' and care recipients' perceptions of caring are indeed not congruent. That would mean that nurses who care for patients cannot assume that intended caring is always perceived by the clients as caring. Further research in this area is needed to fully illuminate the
client's perspective of what constitutes a caring and an uncaring encounter with a nurse.

**Purpose of the Study**

The purpose of this phenomenological study is to explore the essential structure of caring and uncaring encounters, as perceived by recipients of nursing care, in their interactions with nurses, with the aim of adding to the knowledge and understanding of these phenomena.

**Research Question**

The research question for the study is: "What is the essential structure of a caring and an uncaring encounter with a nurse, from the perspective of the recipient of nursing care"?

**Theoretical and Methodological Perspectives of the Study**

**Introduction of the Methodology.**

The conceptual framework directed the researcher to design a study which explored clients' perceptions of their experiences of caring and uncaring encounters with nurses, in order to elicit their explanatory models regarding these experiences. Since the phenomenological research approach exists for this expressed purpose (Colaizzi, 1978; Giorgi, 1970, 1975), it was the design chosen for this study. As Bruyn (1966) stated, "phenomenology serves as the rationale behind efforts to understand individuals by entering into their field of perception in order to see life as these individuals see it" (p. 90).
Phenomenology is a philosophy, an approach, and a method (Oiler, 1982). The phenomenological method is an inductive, descriptive research method (Omery, 1983). The task of the method is to investigate and describe all phenomena, including the human experience, in the way these phenomena appear "in their fullest breadth and depth" (Spiegelberg, 1965, p. 2). Watson (1985) points out that although there are different views regarding the course that phenomenological research should pursue and the principal objectives of such research, what unites the different views is an acceptance of the general principle that priority should be given to an analysis of experiences from the point of view of those who have the experience or are able to have them.

Duffy (1985) contends that nursing as a scientific discipline is really a neophyte. She points out that nursing research has not evolved with immunity from the qualitative-quantitative debate which has surrounded the behavioral and social sciences. In a chapter called "New lens for seeing nursing", Watson (1985) states,

It is appropriate that nurses question the impersonal, objective model of science for the personal unique and gestalt experiences. The science paradigm for nursing must allow human phenomena to emerge and still be investigated. The method must be such that the humanness of a relationship between two beings is neither diminished nor lost." (p. 9).

Omery (1983) points this out more strongly when she states, "For too long the quantitative methods have been the only methods of scientific research legitimized in the scientific community" (1983, p. 61). She asserts that even when these methods have failed to be as valid and reliable in nursing and other human sciences as they have been in the natural
sciences, "researchers in nursing have clung to them, feeling that their only claim to the title of scientist lay in the quantitative methods" (1983, p. 62). Omery concludes that other nurse scientists have realized, however, that they can no longer ignore the fact that the view of humans developed by the quantitative methods is not comprehensive, but, rather, "a simplistic reduction and abstraction of a part of this phenomenon." (p. 62).

Smith (1983) points out that quantitative and qualitative or interpretive perspectives sponsor different procedures and have different epistemological implications. The quantitative approach takes a subject-object position on the relationship to subject matter; the interpretive approach takes a subject-subject position. The former separates facts and values, while the latter perceives them as inextricably mixed. One searches for laws, and the other seeks understanding. Smith states, "these positions do not seem to be compatible given our present states of thinking," (p. 12), and he concludes, "this is not to say that the two approaches can never be reconciled, only that at the present time the actual divisions are more notable than the possibilities for unification" (1983, p. 12).

Watson (1985) points out that the traditional science approach takes concepts, viewpoints, and techniques of natural science and medicine and applies them to nursing and the lived-in world of human health-illness experiences. She asserts that such an approach is marred by medical values, goals, and interventions laden with paternalistic notions that are inconsistent with the human caring and the notion of a person as an end in and of him- or herself. As a human rather than a natural science, however, nursing can choose methods that "allow for the subjective, inner
world of personal meanings of the nurse and the other person" (Watson, 1985, p. 17).

Phenomenology represents the effort to describe human experience as it is lived (Merleau - Ponty, 1964). Van Kaam (1966) states that human experiences, "cannot be measured or experimented with -- they are simply there and can only be explicated in their givenness" (p. 187). Human science, the antithesis of natural science, is a paradigm well suited for nursing, since "nursing, as a science, has a goal to understand those individuals being cared for." (Lynch - Sauer, 1985, p. 94). Oiler (1982) points out, however, that phenomenology cannot replace other methods of inquiry in nursing, serve all nursing interests, or account for all its aims. She states, "The phenomenological approach is an alternative research method, one which most effectively can serve nursing's goal to understand experience." (p. 178).

Watson (1985) emphasizes, however, that as nurses we can choose to study the inner world of experiences rather than the outer world of observation. We can choose to be a part of our method and involved in the clinical research process rather than be distant, objectively remote, and primarily concerned with the product of science. She contends that this different path can expand our limited thinking and allow us, as professionals and scholars, to develop new pictures of what it means to be human, to be a nurse, to be ill, to be healed, and to give and receive human care.

Under the leadership of Leininger (1978, 1981, 1984), important strides have been made in the research on caring that involve both quantitative and qualitative research methods. Leininger (1984) points out, however, that care research generally necessitates knowledge and
skills related to qualitative methods since it involves searching for the meaning of care and identifying its attributes. While one may wish to measure care, there are other features that are nonmeasurable or not reducible to numbers. As Riemen (1986a) points out, "quantitative data can provide information, but cannot provide what it feels like to be in a caring or an uncaring interaction" (p. 104).

To conclude, phenomenology was chosen as a research approach since the purpose of phenomenology is to assist the investigator to understand a human experience and "offers a methodology that can lead to systematic explication of human experiences and human science paradigms" (Lynch-Sauer, 1985, p. 94). At its most basic level, nursing is a relational profession that exists by virtue of its commitment to provide care to others. Tinkle and Beaton (1983) point out that if the concerns and perceptions of the recipients of nursing services are considered unimportant factors in nursing research, "then nurses may indeed be providing nursing care that is more meaningful to themselves than to patients" (p. 31). Similarly, if research studies regarding patient behavior fail to ascertain the patients' perceptions of the rationale for their own actions, "interpretation of research results will reflect only a one-sided bias in favor of what the nurse thinks the patient thinks" (Tinkle & Beaton, 1983, p. 31). The phenomenological research approach reduces this risk by truly introducing the patient's perspective, and the researcher is encouraged to strive to understand the total meaning that the experience has had for the patient (Omery, 1983).
**Definition of Terms:**

**Client:** A non-hospitalized Anglo-Canadian over twenty years of age, who has had previous experiences both of caring and uncaring encounters with nurses during a previous hospitalization and who is able to communicate his/her perceptions regarding these experiences.

**Caring and Uncaring:** Uncaring and caring are not defined by the researcher but by the participants in their verbal descriptions.

**Encounter:** Any mutual or reciprocal action or influence between the client and the nurse.

**Nurse:** A registered nurse. It is presumed, however, that some of the descriptions may refer to a nurse who is not a registered nurse. Nonetheless, it is a person whom the client has identified as being a member of the nurse category.

(Adopted in part from Riemen, 1986 a)

**Assumptions.**

1. Human caring and uncaring are universal phenomena, but the expressions, processes, and patterns vary among cultures.

2. Identifiable differences in caring and uncaring values and behaviors between and among cultures lead to differences in the nursing care expectations of care-seekers.

3. Uncaring is demonstrated and practiced interpersonally just as caring can be effectively demonstrated and practiced only interpersonally.

Limitations.

The reality constructed within the research encounter is that of participants and is culturally and socially located. This means that the generalizability of findings is limited to the cultural and social groups represented in the study sample. The informants in the study will be considered cultural representatives (or "the experts") of the population of Anglo-Canadians who have experienced caring and uncaring encounters with nurses.

Summary

In this chapter the background to the problem, the conceptual framework guiding the study, as well as theoretical and methodological perspectives of the study have been introduced. Studying caring and uncaring from the client's perspective is of great importance to nursing since an understanding of the client's explanatory model is necessary to the negotiation of mutually satisfying and efficacious care. Kleinman's explanatory model provides an excellent framework for studying the client's perceptions and directed the researcher to choose the phenomenological research approach. The methodology will be explained in more detail in Chapter Three. The following chapter will discuss caring and uncaring and describe the different perspectives offered in the nursing literature.
CHAPTER 2: REVIEW OF SELECTED LITERATURE

The concept of caring has a very special place in nursing discourse. There is an abundance of literature in nursing addressing the importance of, and the need for caring in the nurse-patient relationship. Nursing traditionally has been concerned with not only the care needs of people, but also with caring as a value or principle for nursing action (Gaut, 1983). The interest of nurse researchers in caring phenomena has grown slowly over the last ten years, and although there appears to be an increased use of the term care/caring in nursing, few nurse researchers have really explored caring and the implications of the construct (Wolf, 1986). Little is known about how clients of nursing view the notion of caring and less still how clients experience uncaring and what caring/uncaring means to the client.

Models of Caring

Caring has been approached from various perspectives. Larson (1984) points out that four major models for examining the phenomenon of caring exist: those of Bevis, Watson, Leininger, and Gaut. These models will now be reviewed in order to examine their contribution to the discussion and understanding of caring.

Bevis' Conceptualization of Caring

Em Olivia Bevis' (1982) conceptualization of caring proposes four sequential stages of a caring process applicable to the nurse-patient relationship. In her interpretation, Bevis (1982) asserts that the process of caring is as central to nursing as problem-solving or communication. She
sorts the process of caring into four levels, or stages, of development, each comprising several sequential tasks. Bevis emphasizes that each stage must be successfully completed, since each successive stage includes the behaviors of the previous ones. The four stages and sequential tasks of the caring process according to Bevis are:

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**Figure 2. Bevis' Conceptualization of Caring as a Process.**
(Bevis, 1982, p. 129).

**Attachment.** Bevis (1982) explains that attachment, the first stage in the caring process, describes the behaviors or tasks in the initial stage of caring. This attachment is accomplished by successfully completing the four successive tasks of: recognition, self-revelation (step 1), validation, and potency. Bevis (1982) explains that being aware of another's presence is the beginning of getting to know another. This recognition may be made operational in several ways. Ritualistic behaviors that are safe and predictable are generally employed first. Examples are handshaking, smiling, eye contact, firm touching, and typical questions such as "How are
you?". Bevis states, "through these behaviors one indicates recognition, notice, and initial awareness of another" (1982, p. 129).

The next task is self-revelation, step 1 - data gathering. Self-revelation has three steps, one step in each of the first three stages of caring. The desire to know more about another individual leads to data gathering and self-revelation. During data gathering and self-revelation, each person begins to identify, examine, and validate positive and possibly negative aspects of the other individual, that is a task that Bevis calls validation. The final task in Stage I is potency which, according to Bevis, indicates the will and power to begin moving forward, including the willingness of the individuals to put forth the energy to bring about the desired caring relationship.

**Assiduity.** Bevis (1982) explains that this phase is marked by solicitous, persistent, personal attention. It involves sitting beside, being with, and concern for the welfare of the other person. It engages the constant energetic application of self to the enterprise of caring. Assiduity, close attention to the building of the relationship, includes the tasks of respect, potentiality, attentiveness, honesty, self-revelation (step 2), responsibility, confidence, and courage. Thus, the first behavior in the assiduity phase of caring is respect. The behaviors of respect are; being reverent, being accepted, and being nonjudgmental. According to Bevis (1982) respect is inherent in caring and begins early in the relationship, but it is not until Stage II that it hallmarks the relationship.

The next task, potentiality, is an awareness of the possibilities for persons individually and together in the relationship. Attentiveness is the third task, and comprises heeding, attending, and listening in a discerning
manner. Honesty is the fourth task and is present in the behaviors of being open, genuine, and truthful. It includes actively confronting oneself and the other person.

Self-revelation in the stage of 'Assiduity' goes beyond the data gathering phase of Stage I, into material that is closely aligned with who the person really is. The sixth task is responsibility. According to Bevis (1982) responsibility in caring is dual: responsibility for oneself and accountability for one's own behavior, thought, feelings, and words; and responsibility to respect the vulnerability of the one cared about. The seventh task in phase II is confidence. Bevis states that, "dependent relationships, those in which confidence does not exist, stagnate at this point and progress no further" (1982, p. 133). Courage, the last task in Stage II, provides the temerity to venture into the unknown of the third stage, intimacy.

**Intimacy.** Intimacy is the stage of caring in which the caring parties move into a level of closeness in which they share each other's innermost being and come to understand and know the other's essential nature. It is marked by close physical, mental, and/or social association and unreserved, easy confidential expression of self. In this stage there is a deep commitment to the relationship, and the relationship takes on feelings of permanence. Bevis states, "even if the caring relationship does not successfully attain all the tasks of this stage, each friend makes an indelible imprint and is never forgotten" (1982, p. 134). The stage of intimacy is marked by five tasks, probity, self-revelation (step 3), perspicacity, sexuality, and inclusiveness.
**Confirmation.** Bevis (1982) claims that qualities and feelings developed through successful caring relationships provide one with the ability and desire to share the richness and positive feelings of those relationships. She maintains that successful attainment of the third stage enables one to feel sufficiently comfortable and safe to expand caring on a wider basis. She states, "attaining stage IV in a caring relationship also has positive benefits for maturing the individuals concerned. One seems to feel secure, willing to be vulnerable, to grow, expand, and be the best possible self" (1982, p. 136).

Bevis (1982) explains that the stage of confirmation is that in which one verifies oneself, one's own sense of being good, worthwhile, able, strong, capable, and unafraid of intimacy in relationships. The behaviors of caring are deeply ingrained and are consistently practiced. Confirmation means to validate, assure, strengthen, and authenticate. Bevis claims that in caring this is a confirmation of oneself and of the relationship with others about whom one cares. She asserts that because of the personal validation that takes place in the fourth level, relationships with others are sustained and expanded. There are four tasks in this stage: personal validation, augmentation, sustainment, and expansiveness.

Bevis (1982) proposes that knowledge about the caring process, its purpose, organization, and outcome, enables nurses to understand and interact with clients more wisely and with greater caring because they make choices based on knowledge. She offers the proposition that those who enter into personal caring relationships with others, and who reach the fourth stage, more readily expand their caring to the impersonal generalized caring about people.
**Watson's Philosophy and Science of Caring.**

Jean Watson (1979, 1985) views caring as the science of nursing derived from the integration of concepts from the humanities and the biophysical and behavioral sciences. She uses ten carative factors that blend the philosophy of caring as an art into a science that can be enacted in practice. Watson uses the term carative in contrast to the more common term curative to differentiate nursing and medicine. She claims that the carative factors are those that the nurse uses in the delivery of health care to the patient/client. She states, "whereas curative factors aim at curing the patient of disease, carative factors aim at the caring process that helps the person attain (or maintain) health or die a peaceful death." (1979, p. 7)

The carative factors are a combination of caring interventions that are both expressive and instrumental in nature. *Expressive activities* include: establishing relationships that are characterized by trust, hope, sensitivity, compassion, warmth, genuineness; and offering support, which may include nurturance, surveillance, comfort, protection, and respecting and accommodating privacy and territorial needs. *Instrumental activities* include: physical action-oriented helping behaviors, such as assistance with gratification of human needs, administering procedures and medications, specific stress alleviation through various modalities, and maintenance of physical environment; and cognitively-oriented helping behaviors, such as conducting specific teaching regimens, instructing, advising, and problem solving.

Watson (1985) emphasizes that all of this is presupposed by a knowledge base and clinical competence, and that all of these carative factors become actualized in the moment-to-moment human care process. Watson points out that the degree of caring is influenced by multiple,
complex forces. She asserts that the more human caring is actualized as an inter-subjective moral ideal, the more potential it holds for human health goals to be met through finding meaning in one's own existence, discovering one's own inner power and control, and potentiating instances of transcendence and self-healing.

Watson (1985) states that interventions in her theory are "related to the human care process with full participation of the nurse/person with the patient/person." (p. 74). She points out that human care requires knowledge of human behavior and human responses to actual or potential health problems; knowledge and understanding of individual needs; knowledge of how to respond to others' needs; knowledge of our strengths and limitations; knowledge of who the other person is, his or her strengths and limitations, the meaning of the situation for him or her; and knowledge of how to comfort, offer compassion and empathy.

The primary subject matter of Watson's theory includes:
1. Nursing within a human science and art context.
2. Mutuality of person/self of both nurse and patient with a mind-body-soul gestalt, within a context of inter-subjectivity.
3. Human care relationship in nursing as a moral ideal that includes concepts such as phenomenal field, actual caring occasion, and transpersonal caring. (Watson, 1985, p. 73).

According to Watson (1985) the totality of experience at any given moment constitutes a phenomenal field. The phenomenal field is the individual's frame of reference and comprises the subjective internal relations and the meanings of objects, subjects, past, present, and future as perceived and experienced. The phenomenal field can be known only to
the person and can never be known to another except through empathetic inference and then can never be perfectly known. Watson recognizes that her ideas are influenced by writings on gestalt psychology and existential psychology by Carl Rogers, Kurt Goldstein, and Kurt Lewin, as well as by Eastern psychology.

Watson (1985) asserts that "transpersonal human care and caring transactions are those scientific, professional, ethical, yet esthetic, creative and personalized giving-receiving behaviors and responses between two people... that allow for contact between the subjective world of the experiencing persons" (p. 58). By using the word transpersonal, Watson is referring to an inter-subjective human-to-human relationship in which the person of the nurse affects and is affected by the person of the other. Both are fully present in the moment and feel union with the other. They share a phenomenal field which becomes part of the life history of both and are coparticipants in becoming in the now and the future. Watson contends that such an ideal of caring entails an ideal of inter-subjectivity, in which both persons are involved.

The value system set forth by Watson (1979, 1985) regarding her theory of human care, consists of values associated with deep respect for the wonders and mysteries of life; acknowledgment of a spiritual dimension to life and internal power of the human care process; growth and change. Watson asserts that human care requires high regard and reverence for a person and human life, nonpaternalistic values that are related to human autonomy, and freedom of choice.

In Watson's theory (1979, 1985), there is a high value on the subjective-internal world of the experiencing person and how the person (both patient and nurse) is perceiving and experiencing health-illness
conditions. An emphasis is placed upon helping a person gain more self-knowledge, self-control, and readiness for self-healing, regardless of the external health condition. The nurse is viewed as a coparticipant in the human care process. Watson therefore places a high value on the relationship between the nurse and the person. This value system is blended with Watson's ten carative factors, for example humanistic altruism, sensitivity to oneself and others, along with love for and trust of life and other humans.

**Leininger's Transcultural Care Theory**

Madeleine M. Leininger is one of the first professional nurse anthropologists and founder of transcultural nursing as well as pioneer of transcultural nursing care theory (Alexander et al., 1986). For several decades she has taken the philosophic, theoretic, and research posture that "care is the essence and the central, unifying, and dominant domain to characterize nursing" (1984, p. 3). She has also postulated that care is an essential human need for the full development, health maintenance, and survival of human beings in all world cultures (Leininger, 1978).

Leininger (1981) states that in pursuit of knowing the nature of humanistic and scientific caring, and based upon her research findings, she has "identified several assumptions to guide nurses' deliberations about caring". (p. 10). She contends that the following assumptions may challenge nurses to discover in depth the phenomenon of caring:

1. Human caring is a universal phenomenon, but the expressions, processes, and patterns vary among cultures.

2. Every nursing care situation has transcultural caring behaviors, needs, and implications.
3. Caring acts and processes are essential for human development, growth, and survival.

4. Caring should be considered the essence and unifying intellectual and practice dimension of professional nursing.

5. Caring has biophysical, psychological, cultural, social, and environmental dimensions which can be studied.

6. Transcultural caring behaviors, forms, and processes have yet to be verified from diverse cultures. When this body of knowledge is procured, it has the potential to revolutionize present-day nursing practices.

7. To provide therapeutic nursing care, the nurse should have knowledge of caring values, beliefs, and practices of the client(s).

8. Caring behaviors and functions vary with social structure features of any designated culture.

9. The identification of universal and non-universal folk and professional caring behaviors, beliefs, and practices will be important to advance the body of nursing knowledge.

10. Differences exist between the essence and essential features of caring and curing behaviors and processes.

11. There can be no curing without caring, but there can be caring without curing.

   (Leininger, 1981, p. 11).

Leininger (1981) concludes after studying nearly 30 world cultures through interviews, structured questionnaire guides, literature sources, and direct observations, that there are many concepts associated with care or caring (varying in cultural usage with respect to which terms are used in different cultures). She theorizes that the following constructs are the major taxonomic caring constructs: comfort, compassion, concern, coping behaviors, empathy, enabling, facilitating, interest in, involvement, health consultative acts, health instruction acts, health maintenance acts, helping behaviors, love, need fulfillment, nurturance, presence, protective
behaviors, restorative behaviors, sharing, stimulating behaviors, stress alleviation, succorance, support, surveillance, tenderness, touching and trust. Leininger states that "with each of these constructs, there are many embedded ideas associated with the concepts of care or caring. And there are some constructs that may not be found in designated cultures" (1981, p. 10).

Leininger offers the following definitions of care and caring:

**Care** in a generic sense refers to those assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway.

**Caring** refers to the direct (or indirect) nurturant and skillful activities, processes, and decisions related to assisting people in such a manner that reflects behavioral attributes which are empathetic, supportive, compassionate, protective, succorant, educational, and others dependent upon the needs, problems, values, and goals of the individual or group being assisted.

(1984, p. 4).

Leininger (1984) emphasizes that care is the essence of nursing. She states, "it is the unique, major, boundary feature of nursing, and one of its most promising areas of study" (p. 14). She points out that qualitative research provides data on the meanings, attributes, essences, and other understandable features of care to make it a meaningful concept for nurses and the public. She stresses that such knowledge is greatly needed today to establish nursing as a discipline and profession, and to improve or maintain health care services. Leininger states, "once care is examined in its fullest breadth and depth, then the author predicts that nursing's public image, economic worth, political posture, academic value, and other desired values and goals will become clearer" (1984, p. 14). Leininger concludes by stating her belief that "nursing as a discipline will find its place in
society and in academic institutions through the explication and use of care" (1984, p. 14).

**Gaut’s Philosophical Analysis of Caring.**

Delores Ann Gaut (1983) uses a philosophical analysis in her development of a "theoretical adequate description of the concept of caring" (p. 313). She points out that philosophical analysis is a fairly new approach to thinking about ideas and phenomena. Whereas the empirical researcher asks questions that require the explanation of events and causes, the philosopher asks questions that invite conceptual clarification or justification.

According to Gaut (1983) "caring" as a word comes from the Old English and Gothic words, *carián* and *kara* or *karon*. She points out that used as a verb, "cared, caring, cares" (*carián*) means having concern for, or to feel interest in; to provide for or look after; to have an inclination or liking or regard and thus be inclined or disposed to; and to have regard for in the sense of fondness or attachment for. Gaut points out that in the negative sense, "not to care" gives the notion of disregard, inattention, or indifference. She contends that it might even imply apathy or lack of motivation as in "He doesn’t care enough to do that". In another sense, "she doesn’t care for you", carries with it a lack of regard or affection, Gaut points out.

When used as a noun, the word "care" has a number of referents. Gaut (1983) points out, for example that "care is love, care is concern, care is understanding" (p. 315). When used in the grammatical form as a participle, caring denotes doing or action. Gaut states that caring, whether used in common word usage or scholarly literature, seems to involve at
least three senses: 1) disposition or feeling within the carer; 2) the doing of certain activities regarded as caring activities; or 3) a combination of both attitude and action in which the caring about the other disposes the person to care for another through the doing of certain activities (1983, p. 316).

Gaut (1983) makes an interesting distinction between 'caring for' and 'caring about'. She points out that 'caring for' in the sense of providing for, or being responsible for, can be discussed apart from any sense of 'caring about'. 'Caring about' the other (in the sense of a valued other) brings a quality to the relationship between the carer and the cared for. Gaut states that 'caring about' "eliminates the apathy, indifference, obligation, withdrawal, isolation, manipulation, and possession in one-way relationships of 'caring for' in the limited sense of 'providing for' " (1983, p. 316).

Gaut (1983) sees the task of her philosophical analysis to be the consideration of caring as a practical activity and the identification of conditions both necessary and sufficient for the employment of the term 'caring'. In an attempt to answer the question, "what must be true to say that S is caring for X ?," Gaut specifies five conditions: awareness, knowledge, intention, means for positive change, and the welfare-of-X criterion (1983, p. 318-322). She then collapses these five conditions into three:

Condition 1: S must have knowledge about X to identify a need for care, and must know that certain things could be done to improve the situation.

Condition 2: S must choose and implement an action based on that knowledge, and intend the action as a means for bringing about a positive change in X.
Condition 3: The positive change condition must be judged solely on the basis of a "welfare-of-X" criterion.


To state these requirements in another way, Gaut (1983) explains that any action may be described as caring, if and only if, S has identified a need for care and knows what to do for X; S chooses and implements an action intended to serve as a means for positive change in X; and the welfare-of-X criterion has been used as a nonarbitrary principle in justifying the choice and implementation of the activities as caring actions. Gaut points out that there is a set of necessary relationships among the conditions. The intention or purpose of the chosen activity first must be related to the need for care, and second, must be a means for bringing about a positive change directly related to the need for care. The justification of the action is then based on the nonarbitrary criterion: welfare-of-X.

"Welfare-of-X criterion", is an interesting concept introduced by Gaut, and deserves a more detailed description since it is a key concept in her model. Gaut (1983) explains that while the identification of a needful state in X is a necessary condition for caring, the possibility of the identification of the need for care implies that some standards or criteria exist that permit S to observe, "X needs something". The notion of change as positive or negative also suggests criteria or norms by which one might say, "that is good for X", or "what I intend to do will bring about a positive change in X". To determine what would count as a positive change for X, one must be generally informed about criteria according to which something would be accepted as good for all X's distinguished from Y's or Z's.
Gaut makes one other distinction, however, which is the distinction of what is good for this particular $X$, in this specific situation. Thus, the judgment of the intended action as a means for bringing about a positive change must be based on not only what is good for $X$ rather than $Y$ or $Z$, but also what is good for $X$ in a particular situation. The welfare-of-$X$ consideration then becomes a nonarbitrary criterion which serves as a norm, standard, or principle for any intended or implemented activity as "means for positive change in $X". Gaut concludes, "the positive change would be judged solely on the criteria identified as good for the welfare-of-$X$, thus excluding actions based on the whim, or wishes of $S$ or some other agent." (1983, p. 322).

Gaut (1983) points out that the usefulness of such a description of caring evolves from the necessary conceptualization process of refining abstract ideas for scientific research, and specifically for nursing into caring. She contends that further development of this caring description entails utilizing the identified caring conditions as the action categories. Gaut states, "the purpose of such activity would be the formulation of a systematic theoretical construction to which one can appeal in order to answer questions about how one improves research and the teaching of a practical activity such as caring" (1983, p. 323).

Larson (1984) contends that although these four models provide an arena for a dialogue about caring, they are limited in that none define caring at the behavioral level. Leininger (1981) asserts that until the professional dimensions of caring, the cognitive goals, processes and acts are adequately researched and refined, caring will remain a nebulous term, open to various interpretation. Researchers' interest in caring has been growing for the past ten years and some of the resulting studies will
now be reviewed, concentrating on nurses' versus clients' perceptions of caring and caring versus uncaring.

**Nurses' versus Clients' Perceptions of Caring.**

Nurses, when asked to identify the important aspects of caring, have consistently ranked the affective aspects, such as listening, touching and talking, as the most important ones. Kleinman's explanatory model encourages us to ask ourselves, whether patients hold similar perceptions. Larson (1984) tells of a woman hospitalized for a second induction of therapy for leukemia who was asked, "What makes you feel cared for?". She said, "Without a doubt, it is what the nurse says to me. However, the nurse must first prove to me that she knows how to manage my meds and treatments. Until then, I'm not too interested in what she has to say." It appears that a critical first step in addressing the concept of caring, as it relates to nursing, is to understand patients' perceptions of the most important nurse caring behaviors.

One of the few studies of clients' perceptions of caring before 1980 was done by Henry (1975), who identified major care categories of technical, communication, and interpersonal nurse behavior that indicate how caring is perceived by patients. Henry interviewed 50 home care patients about their perceptions of caring; responses included descriptions of what the nurse does, how the nurse does it, and how much the nurse does as the three major caring categories.

Brown (1981) interviewed 80 hospitalized medical-surgical patients to identify, describe, and classify behaviors that were indicators of care but also to examine the task and affective dimensions of these behaviors. Specific categories and behaviors were identified from responses to "what
the nurse does," and "what the nurse is like". Brown's data support the
concept that caring is based on the attributes of the caregiver as well as
both expressive and instrumental behaviors. These two studies evaluated
both the caring attributes and behaviors of nurses from only the patient's
perspective.

Larson (1981) analyzed the perceptions of nurse caring behaviors
from both the patients' and nurses' perspectives. This study was unique
because both nurses' and patients' perceptions were evaluated, and
because of the instrument used to measure these perceptions, the Caring
Assessment Report Evaluation -Q sort (CARE-Q). Utilizing the Q-sort
methodology, the CARE-Q was developed to measure, by ranked
importance, the differences and similarities of perceptions that nurses and
patients have regarding caring behaviors. Fifty caring behaviors were
classified under the following six themes: anticipates, comforts, explains
and facilitates, develops and sustains trusting relationships, monitors and
follows through, and is accessible. The behaviors and themes are similar to
those identified by Brown and are both expressive and instrumental in
nature. When administered to 57 medical-surgical nurses and 57 cancer
patients, Larson found significant differences between nurses and patients
(t-test, p < .05) in the ranked importance of 19 of the 50 caring behaviors.
Patients ranked instrumental behaviors higher whereas nurses ranked
expressive behaviors as more important.

A replication of Larson's study was done by Mayer (1987) which
further validated the perceptions of important nurse caring behaviors
reported by Larson. The overall agreement between the patients and
nurses in both samples may contribute to, or enhance the caring
relationship, but categorical and individual differences exist. Patients
appear to value the instrumental, technical caring skills more than nurses do, while nurses rank the expressive behaviors higher. Nurses may be assuming a certain level of technical competence while patients may not. Patients may not be open or receptive to the expressive caring behaviors until basic physical needs have been met through instrumental activities. For example, listening to the patient may not be perceived as caring if at the same time the nurse is not skilled in starting an intravenous infusion or has not administered needed analgesics. By identifying important nurse caring behaviors, as perceived by patients, nurses will be more able to develop a repertoire of behaviors to convey caring.

Caring versus Uncaring.

Caring can also be approached by the method of contrast. Watson (1979, 1985) points out that a distinction can be found in society (and in nursing) in some form, between those persons who are caring and those who are uncaring. Watson (1985) states that the most abstract characteristic of a caring person is that he or she is somehow "responsive to a person as a unique individual, perceives the other's feelings, and sets apart one person from the ordinary" (p. 34). The uncaring person is by contrast "insensitive to another person as a unique individual, non perceptive of the other's feelings and does not necessarily distinguish one person from another in any significant way" (p. 34). Watson states,

Perceptible characteristics of caring that are revealed in actions and attitudes are some particulars, but are not a pure form of caring. Nevertheless, such views and data on caring provide us with ways to contrast caring with noncaring to get a better understanding of the phenomena (1985, p. 34).
The limited research on caring in nursing has substantiated the above view that caring indeed connotes a personal response (Brown, 1981, 1986; Gaut, 1983; Mayer, 1986). That is also in line with Griffin (1980) who has argued that there are two major aspects to caring in nursing: an activities aspect, and the attitudes and feelings underlying the activities. She takes caring to mean a more or less long term disposition to act/feel in certain ways which include emotional states (as distinct from defining it as an emotion, which is often considered to be a kind of temporary state of a person). The 'activities' aspect and the 'attitudes and feelings' aspect are complementary. The 'activities' of caring defined as assisting, helping, and serving are mediated through the nurse-patient relationship which is a particular sort of personal contact. Griffin (1983) states,

A nurse's activities in relation to a patient may be called caring only because these acts are performed in a certain way; as the expression of particular emotions. Some, though not all of these emotions have an essentially moral component... it might not be altogether too far-fetched to identify a dominant emotion in caring as a kind of love. (p. 294).

Riemen (1986, 1986a) did a phenomenological research study on clients' perceptions of caring and noncaring nursing interactions. Her study is the only study found in the nursing literature that explores noncaring. The sample in her study was ten nonhospitalized adults over 18 years of age who had prior interactions with a registered nurse and were able to verbally communicate their experiences and feelings regarding these interactions.

Riemen (1986a) describes her data analysis in the following way: "taped interviews of the ten subjects were transcribed, and the significant statements extracted from these transcriptions became the raw data for analysis" (p. 95). Then "meanings were formulated from the significant
statements...These meanings were arrived at by reading, rereading and reflecting upon the significant statements in the original transcriptions to get the meaning of the client's statement in the original context" (p. 99). Finally "the aggregate of formulated meanings was organized into clusters of themes. These clusters represent themes that have emerged from and are common to all of the subjects descriptions." (p. 99). The following are clusters of common themes from Riemen's study:

**Caring:**

1. Nurse's existential presence
   a. The nurse's physical and mental presences are available for the client's use.
   b. For the client, the nurse's presence is available not only when it is called for, but also when the nurse's presence is needed but not solicited.

2. Client's Uniqueness
   a. The nurse recognized the client's uniqueness by really listening and responding to him or her as a valued individual.
   b. The client perceives he or she is treated by the nurse as a human being of value.

3. Consequences
   a. The nurse's individualized concern for the client results in the client feeling comfortable, secure, at peace and relaxed.

**Noncaring:**

1. Nurse's presence
   a. The nurse's physical presence is to get the "job" done.
   b. For the client, the physical presence is available briefly or not at all, even when solicited.

2. Client's uniqueness
   a. The nurse does not recognize the client's uniqueness because he or she does not "really listen" and appears "too busy" to pay attention to the client as an individual.

3. Consequences
   a. The nurse's lack of concern for the client results in him feeling frustrated, scared, depressed, angry, afraid, and upset.

Riemen (1986, a) concludes about her findings:
Findings of this phenomenological study add credence to the limited research on caring. It is not only what the nurse does in the way of physical acts of assistance, but what the nurse is. Being existentially present or available, showing genuine interest in the client as a valued individual by really listening is considered by clients to be one of the most important aspects of caring (p. 103).

Summary

Caring has been approached from various perspectives. Four major models for examining the phenomena of caring exist: those of Bevis (1982), Watson (1979, 1985), Leininger (1978, 1981, 1984), and Gaut (1983). These four models of caring offer valuable but different perspectives of caring. Bevis' conceptualization of caring, proposes four sequential stages of a caring process which she contends are applicable to the nurse-patient relationship. Watson, on the other hand, views caring as the science of nursing and refers to her work as a theory. She uses ten carative factors that blend the philosophy of caring as an art into a science that can be enacted in practice. Leininger's transcultural care theory offers a valuable transcultural perspective of caring. She has identified 27 major taxonomic caring constructs, some of which, however, can not be found in designated cultures. Finally, Gaut offers still another perspective of caring by using a philosophical analysis in her development of a theoretical description of the concept of caring.

Research studies on caring are relatively few but are increasing in number every year. These studies indicate that there is a discrepancy between nurses' and clients' perceptions of caring (Larson, 1981; Mayer, 1987). Discrepancies between expectations held by health professionals and clients have resulted in dissatisfaction with care. The differences in
perception have caused "serious difficulties not only in communication with patients but in establishing therapeutic relationships with them" (Leininger, 1978, p. 76). Further research in this area is therefore needed to fully illuminate the client's perspective. There is also a need to explore the client's perspective on what constitutes an uncaring encounter with a nurse. Only one study was found in the literature that explored noncaring as well as caring nursing interaction (Riemen, 1986).

Studying the client's perspective of caring and uncaring experiences directed the researcher to choose the phenomenological research approach. The theoretical and methodological aspects of that approach were introduced in Chapter one. The following chapter will describe how this particular research approach was interpreted and implemented in the study.
CHAPTER 3: METHODOLOGY

The phenomenological perspective of qualitative research theory guided the methodological approach to this study. This chapter describes how this perspective was interpreted and implemented in the selection of participants, data collection and data analysis.

Selection of Participants.

The phenomenological research perspective directed the researcher to use nonprobability sampling, the theoretical type. Morse (1986) points out that the purpose of selecting nonprobability samples is "to facilitate understanding, for description, and to elicit meaning." (p. 184). She points out that when using nonprobability sampling techniques, the researcher cannot generalize the findings to the population, since the researcher knows nothing about the distribution of the phenomena. Morse rightly points out, however, that this is not the purpose of qualitative research, and suggests that instead of using probability and sample size as criteria for evaluating nonprobability samples, the criteria of appropriateness and adequacy would be more useful.

According to Morse (1986) "appropriateness refers to the degree in which the method of sampling "fits" the purpose of the study as determined by the research study." (1986, p. 185). She explains that if a qualitative research question is asked, then a probability method is inappropriate and a nonprobability method should be used. She stresses that in this case an appropriate sample will provide understanding and insight.
Morse states that "adequacy refers to the sufficiency and quality of the data" (1986, p. 185). She points out that in quantitative research, adequacy is evaluated in sample size. In qualitative research, however, adequacy is evaluated "by the quality, completeness, and amount of information contributed by informants rather than by the number of cases. Thus informational adequacy includes the meaning, accuracy, precision, and completeness of the data" (Morse, 1986, p. 185). Furthermore, Morse notes that adequacy is attained and sampling ceases when the researcher gains understanding of the situation or setting, obtains coherence, does not collect any new information, and cannot locate negative cases. When this occurs, the categories are considered "filled" (Morse, 1986).

Morse (1986) emphasizes that in qualitative research informants are selected according to their knowledge base and receptivity. She explains that one of the assumptions underlying nonprobability sampling is that all actors in a setting are not equally informed about the knowledge sought by the researcher. Some members of the group or culture are privy to more information than others, owing to differences in roles, status, age, past experiences, ability to recall, and so forth (Douglas, 1976). Furthermore, some members are more receptive to being interviewed and are more likely to disclose information to the researcher (Spradley, 1979).

**Criteria for Selection.**

The criteria for selecting participants included: nonhospitalized Anglo-Canadians over 20 years of age who had experienced previous caring and uncaring encounters with nurses within a context of a prior hospitalization and who were able to communicate their perception regarding these experiences. The underlying assumption when selecting
informants was that people who have experienced caring and uncaring encounters with nurses are the source of knowledge for the understanding of these phenomena.

Rationale for Criteria: Informants selected were adults over 20 years of age. Because it was important to find people who had experienced caring and uncaring encounters with nurses, the probability of finding them seemed more likely in the adult age bracket as compared to the adolescent or child groups. Aside from a higher probability of finding people who had experienced caring and uncaring encounters with nurses and who were able to reflect upon their experiences, it was also important for the individuals to be able to communicate their perceptions to the researcher in a detailed interview. For these reasons, adults were selected as informants.

Informants were required to describe their experiences. It was important that the individuals involved within the study were able to reflect upon and talk about their experiences. To understand the meaning of uncaring and caring encounters, the extent to which a person can recall and reflect upon his or her understanding of the experience is important. This is the main rationale for deciding to include in the study people who were non--hospitalized versus those who are presently receiving nursing care. It is assumed that people who are not in the midst of an experience are able to reflect more fully and are able to provide a more comprehensive picture of the phenomenon. It is furthermore assumed that the reconstitution of the experience reflects how the phenomenon is lived (Schutz, 1970).

The informants were Canadians who can be described as coming from the "western" culture. Another cultural area may be one for further
exploration, but, for this study, it was considered important to understand the meaning of caring and uncaring encounters with nurses within the boundaries of one culture. Leininger (1978, 1981) and Aamodt (1984) have pointed out that there are cultural differences in the perception of caring and uncaring, and that influenced the decision to stay within a single cultural group.

**Selection Procedure**

In order to recruit people for the study, the researcher began listing knowledgeable and receptive informants through a network of colleagues. The researcher selected participants by starting at the beginning of the list and stopping only when "saturation" had been obtained, conforming to the idea of theoretical sampling (Morse, 1986). Such saturation was obtained with eight informants but the researcher decided to add the ninth informant, who had volunteered to participate in the study, for validation purposes.

Initial contact with the participants was through a colleague and/or through a letter of information (see Appendix A). Departures from this procedure occurred in two instances, in which two people approached the researcher to request that they be considered for participation when they heard of the purpose of the study. Two people, who were approached by colleagues of the researcher, declined to participate in the study. In the former case, a woman explained that her experience of uncaring was still so emotionally laden, although many years had gone by, that she feared that she would be too strongly negative and thus embarrass herself. In the latter case another woman explained that her experience happened so
long ago that she could only remember an uncaring experience, "although I must have had some caring experiences" as she phrased it.

**Characteristics of the Participants.**

Five women and four men participated in the study. All nine participants were English-speaking Canadians who had lived in Canada for more than ten years and who were all presently living in Greater Vancouver. The participants represented a variety of professions, their socioeconomic situations were heterogeneous, and the style of living varied markedly within the sample. The ages of the participants ranged from 33 to 59 at the time of the study.

Six of the participants were currently employed, one of those was self-employed. One was a graduate student, one was on maternity-leave and one on sick-leave. Seven of the participants were married and six of those had children. The participants had encountered nurses in a variety of hospital settings e.g. medical-, surgical-, psychiatric-, maternity-, and emergency-settings. Six of the participants had experienced multiple hospitalizations but three only a single one. Those accounts were markedly shorter than those who had experienced multiple hospitalizations.

**Data Collection**

Unlike the traditional empirical researcher, the researcher using the phenomenological research approach does not believe that his or her data will be contaminated or biased by the full participation of his or her "subjects" (Claspell, 1984). Instead "subjects" are invited to become co-researchers (Friere, 1970). Together, they collaborate and try to make
sense out of the varying profiles of the phenomenon referred to (Kochelmans, 1966). Such research, therefore, takes place among persons on equal levels without divisiveness of social or professional stratifications (Colaizzi, 1978).

Claspell (1984) points out that phenomenological research is dialogal. She states, "The basis from which the dialogue can proceed is trust. The researcher brings to the co-researcher the phenomenon for investigation and the co-researcher assumes responsibility for sharing the meaning of this phenomenon through his or her life experience. Smith (1983) points out that the investigator of human affairs must always take into account the fact that meaning is socially and historically bounded, both for the investigator and the investigated. He states, "A hermeneutical approach is therefore employed to achieve an interpretive understanding of human activity, and this interpretation is expressed in the language of the situation rather than in a neutral scientific language." (p. 12).

Oiler (1982) rightly points out that it is impossible to be totally free of bias in reflection on experience, but she stresses that it is possible to control it. She states, "this is called "bracketing", which means that to see lived experience, an individual must suspend or lay aside what he thinks he already knows about it" (1982, p. 179). Bracketing is a matter of peeling away the layers of interpretation (Merleau-Ponty, 1956). Oiler (1982) states that other ways to practice bracketing are to wonder, to allow oneself to feel confused, in conflict, or uncertain, and to ask for opinions and really want to hear them. She states that nurses need to ask, "What does he mean?", "What do I mean?" In this way, a person can identify what he thinks about experience and bracket it more effectively"

Data collection in a phenomenological study necessitates such bracketing. It also necessitates seeing your coresearcher as an expert and seeing the whole data collection process as an inter-subjective interaction where meaning is mutually constructed. Data collection in this study will now be described. Included will be the procedures for data collection, the construction of accounts, as well as how ethical considerations affected the study in general and the data collection in particular.

**Procedure for Data Collection.**

Data were collected through 18 in-depth, open-ended interviews that were tape-recorded and transcribed verbatim for each subject. Sixteen interviews were transcribed by the researcher herself. Transcribing the interviews proved to be a fruitful part of the data collection and analysis process. Listening to and transcribing an interview gave in-depth impressions of the coresearchers' emphasis and feelings, and increased the level of understanding the researcher had of the coresearchers.

The study incorporated two interviews with each coresearcher. The initial interviews involved the coresearchers' descriptions of their experiences of caring and uncaring encounters with nurses. Subsequent interviews were used primarily for clarification, expansion of the descriptions, and validation of the dialogue up to that point. This involved verification with the informants that what transpired and what was written was "true" to the experience of the person. All coresearchers felt that they had exhausted the topic at the end of the second interview. The researcher felt the same way.
Each coresearcher was encouraged to describe his or her own experience of a caring and uncaring encounter with a nurse as fully as possible, including a detailed description of a personal encounter with a nurse they felt was caring and another personal encounter with a nurse they felt was uncaring and how they felt during these encounters. Questions related to the individual and his or her experience that were asked (if not addressed) in the narrative included e.g. "How do you view (think about, feel about) your experiences now?"; "How did you view yourself and the nurse during your experience and afterwards?"; What was helpful for you during the experience of uncaring?"; "What could have been helpful?" (See Sample Interview Questions, Appendix A).

The data were collected in a series of intensive interview sessions that took place over a period of three months. Of the 18 interviews, eight were conducted in the coresearchers' homes, six in their offices, three in the researcher's home, and one in a research room at UBC. The taped interviews ranged from 30 to 90 minutes in length, with the average length being around one hour. The researcher's contact time with the coresearchers was, however, often substantially longer. Most coresearchers talked freely in the presence of the tape recorder and all of them seemed to forget the presence of it after a short while. Good rapport was established between the researcher and all the coresearchers, and it was the researcher's impression that the participants enjoyed the experience of being given total attention and being listened to about experiences that some of them had not really shared with anyone before.
Construction of Accounts

Sandelowski (1986) points out that qualitative research "emphasizes the meaningfulness of findings achieved by reducing the distance between investigator and subject and by eliminating artificial lines between subjective and objective reality" (p. 34). The construction of accounts in this study reflected an evolving dialogue between the researcher and the coresearchers. The researcher approached the coresearchers with very broad questions that concentrated on the descriptions of caring and uncaring experiences and the feelings attached to them now, and at the time they occurred. During the dialogue or interaction with the coresearchers the researcher asked questions that were in direct response to the coresearchers' descriptions in order to arrive at a deeper level of understanding, to reflect and to validate. It was through this inter-subjective interaction or dialogue that the coresearchers and the researcher constructed the essential description of the experience and the meaning attached to it. This dialogue or interplay between the researcher and the coresearchers was a creative and rewarding experience for the researcher. Comments from coresearchers seemed to indicate that this enjoyment was mutual.

Ethical Considerations

Before initiating this study, the researcher obtained approval from the University of British Columbia's Screening Committee for Research Involving Human Subjects. The rights of the participants were safeguarded in the following ways:

Informed consent. The initial verbal explanation and written consent (Appendix A) gave a clear option of participation or nonparticipation
without prejudice. The written consent stated that withdrawal from the study could occur at any time and informed participants that they could refuse to answer any questions. No coresearcher exercised this right.

Confidentiality. The written consent informed participants that they could request erasure of any tape or portion of a tape at any time during the study. No coresearcher exercised that right. Confidentiality of results were maintained by the coding of the participants' names on the transcripts, with subject identity being known only to the researcher. Participants were asked not to mention names during the interviews and any names accidentally mentioned were deleted from the transcripts by the researcher. Access to the data was limited to the researcher and her advisory committee. Participants were assured that they would never be identified with their responses, participants' identities would never be revealed, and published and unpublished materials would never include names of persons or institutions.

Data Analysis

As Lofland (1971) states, "one's analytic and observational activities run concurrently. There is temporal overlapping of observational and analytic work." (p. 118). This means that the processes of data collection and data analysis occur simultaneously (constant comparative analysis), and although these processes are presented separately they did not constitute distinct phases in the research process. The final stage of analysis (occurring after observation has ceased) becomes, then, a period for bringing final order into previously developed ideas.

After each interview, the cassette tapes were transcribed verbatim. The formal analysis then began with the reading and rereading of the
transcripts. This was done in order to get some sense of the experiences of caring and uncaring as a whole. The next step of the analysis involved breaking the transcripts into meaning units (Giorgi, 1975). Meaning units were attained through reading a transcript and delineating each time a transition in meaning was perceived. Once the natural meaning units had been obtained, each unit was reflected upon and refined so that the fullest meaning within each unit was captured, using the informants' words as much as possible.

After obtaining a list of meaning units, key statements and phrases which directly addressed the phenomena of caring and uncaring were extracted from the transcripts (Colaizzi, 1978). The meaning units were then reread and collapsed to avoid redundancies. When the first set of meaning units had been obtained, it was compared to the next set (from the second coresearcher) and so on, conforming to the notion of "saturation" in theoretical sampling (Morse, 1986). The comparison of meaning units resulted in clusters of themes and patterns of the experience of caring and uncaring nursing encounters. The clusters of the final meaning units were referred back to the original transcripts to validate them. Validation is "achieved by asking whether there is anything contained in the original protocols (transcripts) that isn't accounted for in the clusters of themes and whether the clusters of themes propose anything which isn't implied in the original protocols" (Colaizzi, 1978, p. 59). The researcher then synthesized and integrated the insights achieved into a consistent description called the phenomenological description (Claspell, 1984). Subsumed within the phenomenological description is the essential structure of caring and uncaring. The essential
structure is the condensed version of the phenomenological description, or the core of the experience.

**Summary**

The phenomenological perspective of qualitative research theory guided the methodological approach for this study. This chapter has described how that perspective was interpreted and implemented in the selection of participants, data collection and data analysis. The phenomenological research approach directed the researcher to use theoretical sampling, intensive unstructured interviews, and constant comparative analysis.

The researcher saw the participants in the study as coresearchers and through inter-subjective interaction or true dialogue the essential description of a caring and an uncaring encounter was constructed. This in-depth interplay between the researcher and the coresearchers was a creative experience and the results of this process are presented in the following chapter.
CHAPTER 4: THE ESSENTIAL STRUCTURE OF A CARING AND AN UNCARING ENCOUNTER WITH A NURSE -- FROM THE CLIENT'S PERSPECTIVE

The results of the study are presented in this chapter. The intersubjective interaction between the researcher (R) and the coresearchers (C) in the process of data collection and analysis has already been described (chapter 3). This interplay is emphasized again at this point, because the description of the essential structure of a caring and an uncaring encounter with a nurse, is a result of this collaboration between researcher and coresearchers in their joint effort to make sense of these phenomena.

It is recognized that each coresearcher is a unique individual with a unique perspective. It became evident to the researcher, however, in the process of data collection and analysis, that there were common themes in the coresearchers' accounts. It was as if they were all trying to describe essentially the same phenomena, or at least some aspects of the same phenomena. Following initial interviews with seven coresearchers these common themes developed into a tentative analytic framework that was used by the researcher to guide the scope and level of exploration in the second interviews, and in the interviews with two additional coresearchers. The data that emerged in subsequent interviews shaped the final analytic framework that was used by the researcher to organize the data in a manner that would include, and be true to the essential aspects of each individual description. This final analytic framework represents the essential structure of a caring and an uncaring encounter with a nurse -- from the client's perspective, and will now be presented schematically and narratively.
CARING ENCOUNTER:

<table>
<thead>
<tr>
<th>Approach by nurse</th>
<th>Relationship formation</th>
<th>Patient responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional caring nurse approach</td>
<td>Nurse-patient attachment with professional distance</td>
<td>Patient responses to professional caring</td>
</tr>
</tbody>
</table>

- Compassionate competence
- Genuine concern
- Undivided attention
- Sober cheerfulness

Developing professional attachment:
- initiating attachment
- mutual acknowledgment of personhood
- acknowledgement of attachment
- professional intimacy
- negotiation of care

Keeping a professional distance.

UNCARING ENCOUNTER:

<table>
<thead>
<tr>
<th>Approach by nurse</th>
<th>Relationship formation</th>
<th>Patient responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse indifference to the patient as a person</td>
<td>Nurse-patient detachment with total distance</td>
<td>Patient responses to uncaring encounter</td>
</tr>
</tbody>
</table>

- Apathetic inattention
- Unconcerned insensitivity
- Unkind coldness
- Harsh inhumanity

- Puzzlement and disbelief
- Anger and resentment
- Despair and helplessness
- Alienation and helplessness
- Feelings of vulnerability
- Perceived negative effects on well-being and healing
- Long term negative feelings and memories

Figure 3. Schematic Representation of the Essential Structure of a Caring and an Uncaring Encounter with a Nurse -- From the Client's Perspective.
The Essential Structure of a Caring Encounter with a Nurse
--From the Client's Perspective

It was evident from the coresearchers' accounts that, from their perspective, the caring nurse had some personal qualifications that made her different from other nurses. These personal qualifications became apparent in her caring approach to the client, which can be described as genuine concern for the patient as a person. This caring approach promoted feelings of trust in the client which facilitated relationship formation between the nurse and the client. This relationship, they recounted, was in many ways different from other relationships they had known before, in that it involved intimacy about the client's present condition (professional intimacy), and yet it involved more distance than usual in relationships (professional distance). This complex combination of intimacy and distance is referred to as "attachment with professional distance."

When asked about their reaction to the caring encounter, the coresearchers unanimously related very positive feelings. Most of them talked, in one way or another, about how encouraging the attachment with the nurse was at the time, and how, in their perception, it facilitated their recovery and healing. Most of them stated that it gave them a sense of security and helped them to feel better about themselves and their hospital stay. The coresearchers, even as long as 19 years later, still had very positive feelings associated with the encounter with the caring nurse, and when reminiscing about it, their expression, verbal as well as nonverbal, gave evidence of that.

The professional caring nurse approach, and the resulting nurse-patient attachment with professional distance, form the essential structure of professional caring. Professional caring is a different kind of
caring than, for example, caring between friends. This professional caring, the coresearchers’ reaction to it at the time, and the consequences of this kind of caring will be described in more detail in the following section, using the coresearchers’ own words as much as possible.

**Professional Caring Nurse Approach.**

From the coresearchers’ perspective, the caring nurse is skillful, knowledgeable, and committed to the provision of personalized care, and knows how to safeguard the personal integrity and dignity of each person under her care. The professional caring nurse approach essentially includes compassionate competence, genuine concern for the patient, undivided attention when the nurse is with the patient, and an element of cheerfulness. These essential elements are perceived by the coresearchers as evidence of caring and will be described in the following sections in more detail.

**Compassionate Competence.**

The coresearchers emphasized that competence was an essential component of professional caring. They indicated that caring without competence was of little value to them as patients. For them, competence administered with caring would be the ideal situation. In fact, they argued that a nurse had to be both competent and caring to be truly professional. This combination of competence and caring, which was described by most of the coresearchers, was summed up by one coresearcher, when asked of...

* For the sake of clarity, feminine will be utilized in reference to the nurse, and masculine in reference to the coresearcher/patient/client. In the text ‘nurse’ and ‘coresearcher/patient/client’ can refer to both males and females.
his definition of caring. He stated,

C: Aahm......the definition of caring?......compassionate competence! Yeah, I think that would be it, compassionate competence, summed up.

Another coresearcher expanded upon this.

C: If one wants to put it in a bit of a nutshell, the nurse has to stand on two legs. One is the professional side, and the other is the human side and the two of them have to belong to the same person. They have to be compatible. You can't have a professional side that is out of touch with the human side. And if those two are in harmony, as it were, belong to the other, I think a lot of the other things will follow and then it doesn't matter so much whether a person is spontaneously friendly or is a little on the gruff side...They fit together and you can accept it as a package.

R: Would you call it compassionate competence?

C: Yes, mmhmm. I think that is a pretty good choice of words, yeah, yeah.

Many of the coresearchers were quite explicit about the importance of competence, while at the same time emphasizing the human aspect.

C: I think the competence is the most important thing, I mean you want to feel that whoever is looking after you knows what she or he is doing in terms of proper treatment. You don't want to get the wrong shots, you don't want too much, you don't want to be getting some oxygen where you should be getting something else, so basically that has to be taken care of, has to be taken for granted. So, the competence is number one, and if it's then administered with care then obviously you have an ideal situation.

C: I think competence is a vital issue, quite apart from the pure technical competence of knowing what medications do, what side-effects there are and when to call in help, which is a very important aspect. I think of competence.... to know where your competence ends and you have to call in people with a different competence.
C: So, competence, and not only the appearance of competence, but legitimate competence, is a very important part, and I think an acceptance, by the nurse, of the importance of that competence and of keeping it up to date, because nursing, like everything else, is changing a great deal. At the same time being professional does not mean being so professional that you become less human. I think truly professional in the health care field, or any caring field, has to have the kind of knowledge that makes up competence, the kind of skills that make up competence, and the kind of attitudes that make up professional competence.

It can be seen from the previous accounts that the coresearchers did not see caring and competence as a dichotomy, but perceived them as two elements that have to be together to be of any value in professional caring. It was explored with the coresearchers whether caring and competence could in fact be segregated. This exploration is illustrated in the following account.

R: Do you think we can differentiate between caring and competence?

C: Oh, I think you can, I mean if you talk about caring without competence it's pretty meaningless, but you would assume that the competence level is there or else the nurse would not get hired, and then the caring is an essential added ingredient. Yeah.

R: So, the prerequisite would be the competence, but you would also have to have caring to be a good nurse?

C: Absolutely!

R: So, what would be your definition of caring then?

C: Caring on its own doesn't mean much, I would imagine, I mean it has to be coupled with competence, I mean it's a profession! It's not a, you can be a caring mother and bring up terrible children, caring in itself is not good enough.
R: That's interesting. So, could we talk about professional caring? [C: mmhmm], and then one aspect of that could be competence?

C: Well the competence would be implied in the professional, I would imagine, yeah, o.k.

It is apparent that the coresearchers see limited value in caring without competence. Some coresearchers, however, pointed out that the need for compassion and/or competence depended somewhat on the patient's situation. One coresearcher explained,

C: If I was really ill, feeling miserable, feeling very bad, having very rough time physically, at that point a nurse's competence is very very important, but if I'm not feeling too bad, which has been mostly my case in the hospital, I mean I have had a lot of stays in the hospital which were a great amount of fun (laughs), at that point I think I can accept an incompetent nurse more than I can accept an unnurturing nurse.

The coresearchers' accounts have demonstrated their perception of the importance of competence in professional caring. Many coresearchers emphasized, however, that competence alone often has limited value. The following account illustrates this.

C: Well, I was thinking... the concrete things in your hospital stay are your, you got bladder problems to deal with, or bowel problems, or diet or things like that, your medication, and your sleeping pills or whatever, those sorts of things, but the other thing that a patient is doing is a psychological thing, you're groping with the fact that, you know, that this is the third attack you have had of this disease, and what does that mean to my life? and that's very very big, that's the other thing that is happening to that patient lying in that bed, and of course you don't see it. And a competent nurse who is not nurturing, or caring, whatever word we are using, is no help to me, you know...the psychological trauma...competence doesn't help, there is no competence that can, unless by competence we are including this feature of caring or nurturing.
To summarize, the data indicate that competence administered with compassion is an essential component of professional caring. It implies that a professional nurse is perceived by the patient as caring only if she is competent and administers her care with compassion. Thus compassion is perceived, by the coresearchers, as the kind of attitude that makes up true professional competence. This attitude or feeling tone is perceived, by the coresearchers as genuine concern for the patient as a person, another essential aspect of professional caring.

**Genuine Concern.**

A professional caring nurse approach includes genuine concern and respect for the individuality and well-being of the patient. The coresearchers explicitly emphasized that genuine concern for the patient as a person was one of the most important aspects of true professional caring.

C: I guess the business of caring is something more than doing duty, that is something that recognized the individuality of the patient, or just seemed to have different kind of intention, that is, where the intention seemed more genuine to comfort.

C: When we talked there was something personal for me in it, I mean the conversation was always over and above "how are you feeling", that there was something in our conversation, which indicated she cared about my family life, or my professional life, or something, that she cared about other than that I was a patient in a bed.

C: I'm not referring to the mechanics of caring, but in genuinely wishing the patient well, that is wishing the patient speedy recovery, I guess it's having those feelings, I mean it's more than just thinking "wouldn't it be nice if Mary Jones would be able to leave the hospital", it's a feeling tone, I say that because I'm suspicious that people pick up on the feeling tone, so if in fact you're indifferent and
you just say that, you know, that he or she will be able to leave soon, it’s nowhere near as effective and caring as if there really is genuine caring. So, it’s a kind of a spiritual dimension to it, it’s somehow that it matters, you know, it’s almost tangible that it matters to someone that you graduate from the hospital, that you leave.... upon your feet.

These accounts indicate that the quality and the genuineness of the nurse’s concern is perceived by the patient. This indicates that it’s not only what is said and done, that determines what is perceived as caring by the patient, but also how things are said or done. One coresearcher elaborated on this, when asked about the fundamental difference between caring and uncaring from his point of view.

C: (pauses and thinks for 11 seconds). It seems to me primarily the quality of the intention, which is a hard thing to specify, you sort of, you feel it, and intuitive, I guess, or something like that, in the transaction. So it’s not what’s done it’s the way it’s done or something like that. Or it’s not even necessarily what’s said but the way that it’s said, it... might be the tone of voice, or sometimes it’s the little extra efforts, you know, it’s the plumping of pillows or just the moment for a kind word or just popping a head in the door and saying “how are you doing? is everything o.k.?.. So, it can be little things like that, but often even just in the executing of routines, the bringing of pills and stuff like that, it would be, just a word of inquiry, or, mostly, you, the focus seemed to be on how I felt, rather than discharging the responsibility, not “the patient in room 316 is now done”, and I can go back to the next chore and so on, it was more to make sure that I really was o.k.

It is apparent from the coresearchers’ accounts that it’s difficult to fake concern, that patients, and perhaps people in general, are sensitive to the sincerity of the concern. The following accounts explicate this.

C: I know in trying to deal with students who have interest in things like salesmanship or management skills, I mean we can do a lot to teach them some of the aspects that make for good managers or make for good salesmen and things like that, but if they don’t have
the genuineness of the intention the skills never seem to quite pull it off, you know, because it always, at least for the sensitive patients or the sensitive clients, you will always be read as somewhat artificial, somewhat strange, somewhat forced, somewhat faked. I mean there is a joke among salesmen that what’s really important is sincerity, once you can fake that the rest is easy. But the reason for that being a joke is that it’s very difficult to fake sincerity, I mean people are pretty good at seeing through the person who shakes your hand but really, his mind is on the money that you represent or something like that. So, I think we are pretty sensitive for the most part, on people who really care versus people who are going through the motions.

C: It’s better to have somebody who is genuine and friendly but in a gruff sort of a way, than to have somebody who has the friendliness as part of a sort of a professional armour, a part of the professional uniform that gets turned on and off, it isn’t a genuine thing, it is an acquired behavior, rather than part of oneself, and I think a good nurse doesn’t have to put it on, it’s there because of the caring that comes from within, and that they see, I mean they wouldn’t be able to do it any other way, and if they got to a stage, a nurse got to a stage where that kind of caring that came from within, not an acquired learned behavior, but an experienced behavior, so to speak, where that dried up they wouldn’t want to be a nurse anymore, it’s more that kind of a nurse.

Genuine concern for the well-being of the patient includes accepting the patient as he is, and acknowledging his pain and suffering. The following accounts illustrates this aspect.

C: Caring experience was mainly where I felt, where the nurse was very competent and knew what she was talking about and doing, and where she didn't deny the fact that you had pain and you were suffering, so there was a level of understanding of what you were going through instead of discarding your feelings and pain, or whatever, discomfort. And the caring part came in, administering of the shots, for example, how that was done was an indication of whether the nurse cared or she didn’t care. Coming for a call, the caring ones would always be there sort of in seconds and understand that there was a genuine need instead of, "what the hell do you want now" kind of thing, which happened as well.
C: I remember going through situations of pain and there was almost as if you asked for a pain medicine, you weren't strong enough, that you really sort of ought to grin and bear it, and I remember that this particular nurse, it was never that way, if you said, "I really have pain", right away she would respond to that. And there was no judgement or any sense of criticizing you because you were doing that, that she accepted the fact that you were having pain and she better do something about it. So, there was this sense of acceptance, and non-judgement.

The nurse's genuine concern also includes respect for the individuality of the patient. One aspect of that is individualizing the nursing care, for example, by responding to the specific needs of the patient.

C: The ideal nurse, I would say is firm, to the point, full of confidence, showing confidence in his or her professional capability so there is no hesitation, and I guess an intuitive adaptation to what the patient needs, like I had back-surgery, I don't need somebody standing by my bed chatting to me, the person next to me had a brain-tumor, who was in desperate need of somebody talking to him, where the treatment obviously is meaningless because the man will be dead within two or three weeks, or however long it will take, so the treatment in that case is not important, but the emotional aspect is, there is no chance of him getting better, so it's a very different situation. So, I guess an ideal nurse knows how to distinguish between the two of them.

The importance of nurses' ability to individualize their care was emphasized by most coresearchers. Some coresearchers saw that ability not only as an evidence of genuine concern, but of professional judgment, or some sort of intelligence.

C: An intelligent person can pick up other person's...pick up who that other person is more quickly. I would rather have an intelligent
nurse than somebody that was not as intelligent. But it's not trained intelligence, it's sort of intelligence that comes from living. You know, I would rather have a twenty-five year old nurse than an eighteen year old nurse, you know. So, that's the kind of intelligence I mean, that somebody with experience, somebody who can understand things, about different people, you know, and understand different...different motivations and different values and different goals.

Individualizing the approach to the patient can also be done by calling him by name. Many coresearchers considered that a very important part of making them feel cared for, and special.

C: I guess in terms of what made me think she was a caring nurse where, on other visits, ahh, she called me by my name and asked questions..... about .... myself I guess, and seemed to.....be interested in me as a person rather than just as a patient.

C: They certainly were available a lot, and the trouble they took to always remember your name before they came to your bed, because if they saw you, and as I said I stayed only a few days, I walked alone in the corridor, a nurse would come to me and say "and how are you", and know my name! Again this sense that you are not just 'a case', another breast surgery or whatever happened to be. They took the trouble to know you and again I think that it's a form of individualizing the care.

To, summarize, it is clearly the coresearchers' perception that genuine concern and respect for the individuality and well-being of the patient is an important aspect of true professional caring. It includes genuinely wishing the patient well, really attempting to understand him, accepting him in his unique circumstances, acknowledging his pain and suffering, responding to his specific needs, and calling him by name. The following account summarizes the importance of genuine concern.
C: A caring nurse to me deals with each patient as a real individual, not as a case number or, you know, somebody occupying a bed, but a real individual, gets to know them a little bit. When she talks to them, she talks to them personally, with a lot of eye-contact. She feels for their pain and their agony, yeah that's important, something that I didn't mention maybe. Somebody who hasn't been hardened by this whole experience of being in, of working in the hospital so long that she's seen it all, "oh, one more", you know. Somebody who still feels, to see somebody else's suffering or somebody else's worry, you know. Who brings to her job many skills to alleviate suffering, who helps the patient, who helps the patient mobilize their own strength, their own inner forces, their own inner doctor. Who's not afraid to do a little bit of counseling I suppose, you know, asking questions, getting the patient thinking about the inner doctor. You know, ... who helps legitimize the experience, so you don't feel totally alien, you know, that this is a freak experience that's happening to me, you want to get rid of that feeling, and the nurse can help do that.

Related to, but separate from, genuine concern, is the nurse's undivided attention to the patient while she is with him. This requires alertness, or heightened awareness which will be described in the following section.

**Undivided Attention.**

An important part of a professional caring nurse approach is receptiveness, alertness or heightened awareness. This quality is evidenced by a nurse's undivided attention to the patient while she is with him. It seems to be the coresearchers' perception that this undivided attention appeared, for example, that the nurse was "right there" when she was with them, "really listening", and "really hearing" what they had to say.

C: The nurses who cared, you could really see that they wanted to hear what you had to tell them. No matter how many times I
repeated the story, no matter how many times I was complaining, they were just sitting there listening.

C: It's not easy to pinpoint what made her seem caring, it was the way she took a little extra time ....to be personal so that in...in providing the service, it was far more than mechanical or a matter of job requirement or something, it was... it just felt different. What she did may have been much the same but it felt like it was done for the purpose of comfort rather than for the purpose of discharging the responsibility or for the purpose of, you know, getting off the shift or something like that. So there seemed to be a focus of attention. I found out later that that's a quality this person has, that is that in all of her interactions, she's a very good listener and very responsive to people and rarely seems impatient to get on to the next item, that is when she's doing something, she seems right there!, very present in that transaction.

Patience, or not seeming impatient to get on to the next item, was a quality that was valued by many coresearchers. They emphasized that the caring nurses rarely looked in a hurry although busy. When asked what he needed from a nurse to feel cared for, one coresearcher stated,

C: Not to look in a hurry, you know, give the impression that you have all the time in the world, spend quality time, o.k. if you know that you don't have more than say two minutes to be with the patient, be really with the patient those two minutes.

When asked what it was that made the caring nurse, they had encountered, seem caring, two coresearchers stated.

C: You know, it was in her eye-contact, the aahh, all her body-language, she was never in a hurry, you know, I was the most important patient at that five minutes, I mean even though she had maybe another twenty on her schedule that day.
C: I never felt that she was too busy, although I, she never made me feel like she was too busy, but I could see that she was.

R: So, once she was with you, she was with you.

C: That's right! and there was never, "oh, I've got to hurry up, I can only spend a few minutes with you", or something like that, she was always with me. But I also knew that she was busy, and probably doing more than she could really handle.

Being truly attentive also includes being very observant. One coresearcher called it "to be dedicated to the art of observation", while another referred to undivided attention as "emotional perceptiveness". When asked about the most important aspects of caring, one coresearcher stated,

C: Listen... to the patient, identify the problems, and act on them right away, o.k.? because it's an acute situation. Patients are in the hospital not because they would like to lounge around, they are there because there are definite problems that have to be resolved. So, listen to the patient..... and listen, I mean, not just for problems, listen to the total human being, you know, yeah, I would say we are in the hospital because there are problems, right? so if the nurse pays attention to this problem, and acts in order to make the situation easier, more comfortable, then the patient would know that she is paying attention, that she cares.

In summary, is is apparent from the data that undivided attention is perceived, by the coresearchers, as a very important nurse approach, as well as an essential element of professional caring. Incorporated in undivided attention is the ability to be alert and observant. Genuine listening is a part of alertness, as well as really hearing what the other is trying to say. Undivided attention also includes patience, not being rushed and being present in the moment. To be present in the moment, in the hospital reality, is the philosophy that this moment and this patient are the most important things there are, at this moment. To be truly present,
however, is not enough. The data indicate that a cheerful presence is instrumental in the coresearchers' perception of what constitutes professional caring.

**Sober Cheerfulness.**

The last theme that emerged from the coresearchers' accounts, concerning the approach by the caring nurse, was the importance of a cheery disposition. It was the coresearchers' unanimous perception that cheerful presence of a nurse was an element of professional caring that was extremely important within the often grim reality of their hospital situation.

R: If you were in a hospital now and you couldn't move, you would just have to stay in bed, what would the ideal nurse be like? your ideal nurse?

C: (thinks for a few moments). It's hard to say,...some cheeriness of disposition, that is, you know, optimistic, up-beat, lively, having some animus themselves, just so that, nothing is an antidote to the otherwise potentially depressing and boring kind of environment. So, something that is a little lively, not false in any way, not smiling when you don't feel like smiling, or something like that, so, a cheery disposition.

This account illustrates the importance of cheerfulness that is not false in any way. Many coresearchers stressed that. They emphasized that it had to be genuine, or sober cheerfulness, that is to be cheerful without being overly so.

R: You mentioned her personality, could you elaborate more on that?

C: Ahm, I think number one, she was not, aah, haah, she was not overly vivacious and yet she was... she was cheerful without being overly so, without being forced. In other words she was a very
optimistic person, she could find joy in anything that happened with you or for you. She could also experience other emotions like your sorrows, but somehow was able to make you feel that, ahm, they were learning experiences and not to stay on them for too long, that you'd learned. So, I think she was a positivist, I think by nature she probably is somebody who is cheerful.

This account exemplifies one important aspect of sober cheerfulness, which is the joy that the caring nurse conveys to the patient. Some coresearchers contended that evident joy of working with people was a part of their perception of a caring nurse. The following accounts portray this.

C: I think a nurse has to be a people-person... and I think she has to enjoy working with others, I guess in every job you basically have to work with others, but I think in that one, you know, you have to.

C: How does she feel about being there? is she happy to be in the hospital? is she happy to be doing the kinds of things she is? is she a person who likes dealing with people, meeting strangers? likes being in a position where she can bring some assistance, some help to them? These are all important aspects of caring.

C: The caring nurse looked like a very happy woman all-over, that was my feeling, or maybe she knew how to separate herself from, if she does have any problems at home, she knows how to separate the two issues, work and home. So no matter what, where she's coming from, the caring nurse, a happy home or not, at work it looks like she really cares what she's doing, and she enjoyed it! you could really see that she's enjoying it.

C: I think another thing is, ahm, her personality, which I realize is idiosyncratic or specific to an individual but she genuinely seemed to like people, she genuinely seemed to derive her self-satisfaction
from the helping role, she genuinely seemed to feel fulfilled by the job that she was doing, and I think as such, aah, she was more positive and more able to give of herself, spend more of her energy in productive time with the patient.

These accounts clearly illustrate the coresearchers' perception of the importance of cheerfulness and joy. Many coresearchers also mentioned the importance of smiles, as an outward evidence of genuine cheerfulness, and some mentioned the benefit of a genuine warm sense of humor and laughter. The following accounts illustrate this.

C: I think another thing was, I may have mentioned it before, but was being interested in my own situation, my family, were I was coming from, learning to recognize who my wife was when she came to visit, that meant a lot, ..even just *smiles*.

C: I don't think I have mentioned that, and I should have mentioned that every time we talked about anything like that [caring], is a sense of real genuine warm sense of humor, and laughter, because hospitals can be very grim places and I think that is even more important where people are really quite ill, to introduce some genuine laughter, not manufactured, but genuine laughter and joy and humor into the situation. There is also a need for diversion of the patient from symptoms, to restore the natural balance, as it were, because in one's normal life, presumably, one has joy and laughter and humor, and one needs it there.....more.

The importance of sober cheerfulness in professional caring is evident from the data. It seems to be important for people, who are patients, to have in their presence someone who is cheerful and enjoys nursing, enjoys working with people, and manages to convey that joy clearly to the patients.
In summary, it is evident from the data, that from the coresearchers' perspective, the caring nurse has a special kind of approach to the patient. This professional caring nurse approach includes compassionate competence, genuine concern for the patient, undivided attention when the nurse is with the patient and, finally, sober cheerfulness. These themes are summed up in the two following accounts from coresearchers who where explicating what they would expect from a caring nurse.

C: I expect her to have a basic knowledge of what she's doing, that she empathizes with me, and knows what's going on inside me, at least physically, and hopefully mentally. That she is accepting of all the emotions and also the physical things that are happening, that she shows caring towards me, and also towards my family, that's important too. I remember especially with the heart-surgery, the nurse taking time to explain to my wife, who was sitting beside my bed, what she was doing, and that was important. Respect for me as a human being, and .. I like a sense of humor.

........................................................................................................................................................................

C: I'd like her to be calm, I'd like her to be confident herself, I'd like her to acknowledge me as a person. I'd like her to give the sense that we're not rushed. I'd like her to be honest with herself and with me... you know, I'd like her to be honest and not try to put up some kind of a show. I'd like her to respect me as an intelligent person, and ...I'd like her to be cheerful.

The coresearchers reported that this professional caring approach by the nurse promoted in them a feeling of trust, which facilitated the development of attachment between them and the caring nurses. This attachment development will be described in the next section.
Nurse-Patient Attachment with Professional Distance

It was the coresearchers' unanimous perception that encountering a caring nurse created in them a sense of trust, which facilitated the development of a nurse-patient attachment, or relationship. For many of the coresearchers, this attachment, or personal relationship, was the fundamental difference between caring and uncaring.

R: What would you say would be the fundamental difference between caring and uncaring?

C: I'm not sure how to put it other than 'personal relationship', the sense is somehow that your and my spirit have met in the experience. And the whole idea that there is somebody in that hospital who is with me, rather than working on me.

Another coresearcher explained it this way,

C: You know, there is that kind of bonding, that kind of feeling of ... not intimacy but at least connection, there has been a connection made with that person, a connection which I could then follow-up on, you know I would feel free to do so.

It is apparent from the coresearchers' accounts that this bonding or attachment involves a professional distance. Nurse-patient attachment with professional distance, therefore, involves two interrelated processes: developing professional attachment; and keeping a professional distance.

Developing Professional Attachment.

From the coresearchers' perspective, it is clear that professional attachment is an essential component of professional caring. Furthermore, dimensions in true professional caring depend on the depth of attachment
developed. Professional attachment development can be conceptualized as a process involving five phases: initiating attachment, or reaching out; mutual acknowledgment of personhood; acknowledgment of attachment; professional intimacy; and negotiation of care, which represents the final phase in the development of professional attachment. These phases will be described in the following sections.

**Initiating attachment.** The first phase in developing attachment is reaching out. Reaching out can be initiated by the nurse or the patient, but attachment does not develop further if the other one does not respond.

C: Emotional attachment can really, I think, only develop if the nurse has the capacity in the first instance either to reach out, as the first person reaching out, or has the capacity to respond to a patient who makes, initiates that kind of contact.

Although the attachment does not develop beyond this first phase, the reaching out by the nurse is appreciated.

C: When I was in the hospital I was certainly grateful for anything anybody said to me (laughs), so, I mean I really did appreciate it when somebody else reached out.

Reaching out is sometimes done by the nurse by asking questions that are specific to that individual patient.

C: It started with her having some knowledge of me before she talked to me, knowing questions to ask that indicated that she really knew something about me and was on top of it, you know, instead of just these vague amorphous, you know, "how are you doing" sorts of questions.
If the patient is the one who is reaching out, the nurse can respond by listening.

R: So there was a relationship, how do you think that developed?

C: I'm not sure, at least, all that comes to mind is that I felt listened to. I don't remember what she did, but it was clear to me that she took it [the patient's story] seriously and was gonna relate the information and do something with it, and I didn't care much what she did but it was gratifying just that she seemed to take it seriously, it wasn't just something, you know another complaint or you know, "this happens all the time", so she wasn't dismissive about me, I don't know what to say, just the listening skills, I mean in some ways I was just another patient, I mean in the sense that, it's not like we sat and had conversation like friends, I mean she was busy, she had lots of things on the go.

Some coresearchers found it difficult to describe how attachment was initiated, while others found it somewhat mysterious, even though they tried to describe it.

R: How do you think such a connection is established?

C: How did she establish that? Ahh, well, through her face (laughs), through her face a lot, a lot, the way she looked at me...eye to eye...smiled, the way her body-movements, I think that's very important, she did not breeze in and breeze out, which is not to say that she was slow on her feet but she just didn't give you the impression that she was, that you were just one on her list, you know, ahh.....I really liked her, ....I really liked her, ....How she did it, I don't know, that's mysterious I think even for the patient, you're happy enough to have that kind of a relationship or have that kind of help. I haven't really analyzed how she did it.

It is apparent from the coresearchers' accounts that reaching out requires communication, verbal or nonverbal. One coresearcher clearly
articulated the importance of good communication techniques in attachment development.

R: Do you have any ideas about how attachment is developed?

C: Yes, I think that comes from communication, if what you are trying to communicate is received you immediately feel good, and you feel a bond, yes! we have communicated.

R: How, how did she give you the feedback, "yes, I have received"?

C: Sometimes feedback what I was saying, in a different way, sort of normal good communication techniques.

R: Were there some other ways in which, you know, you would know, "yes, she has received"?

C: Expressions, body-language, usually response back, feedback in another way of what you've said just to clarify and, or expand upon what you've said and perhaps another leading question from your response, so that she was looking for clarification and you got this feeling that that person does again give you the feeling of caring because they're asking more things to try to specifically get the message, so that gave you the feeling that this person really cares, they want to get the right message, not just a very simple response. Asking for details, that was important.

To summarize, the first phase in the attachment development is reaching out, which can be initiated by the nurse or the patient. Initiating attachment requires effective communication, verbal or nonverbal. If there is a lack of reciprocity in this phase, the attachment does not develop any further. Successful completion of this phase, however, means that the attachment development progresses beyond the first phase towards the second phase in the attachment development, mutual acknowledgment of personhood.
**Mutual acknowledgment of personhood.** The second phase in the development of a professional nurse-patient attachment, is mutual acknowledgment of personhood, where both nurse and patient remove the masks of anonymity and recognize each other as persons. This requires the nurse to do something to indicate to the patient that she is a person, while at the same time recognizing the patient as a person. This phase involves some mutual self-disclosure, but only enough to acknowledge that both the nurse and the patient have a larger life and a larger role outside the hospital. This is explicated in the following accounts.

C: I wouldn’t expect the kind of intimacy that you would from friends, like you know bareing your soul, and heart to heart talks or anything like that, nor do I think that is required. I mean I think a little self-disclosure and a little interest in the broader dimensions of the patient’s life is enough to personalize the contact, to take off the mask of anonymity. I mean that’s really what has to be done. The role transaction that is the patient-nurse thing is potentially very sterile, especially when they are both anonymous, you know, it’s a chart and its a cap and gown, you know, I mean they are not people at that stage, so it’s putting the people back in the process, as I said before removing the masks of anonymity. But you only have to see the real face, you know, in a sense, you don’t have to learn all the secrets, not at all. In fact, if you communicate in acceptance well, it communicates that you accept the person, words and all, that is despite the fact that they are ill, and that’s directed to the patient, aahh, that they are still somehow valued, and their uniqueness acknowledged, and their future is hoped for, that someone cares if there is recovery or ease of discomfort, of pain and that someone is solicitous after their well-being.

R: What, then, would be your definition of caring?

C: (thinks for a while) The key components would be something that is personal, both ways, acknowledges my personhood and displays some of personal dimensions in the nurse, and so doing something that is truthful, in the sense that it is candid, so there is not
necessarily all good news, meaning that if someone is irritable it's o.k. to say that. Communication that is tolerant and forgiving, and again tolerant of bad news or negative feelings, or something like that, or perhaps ill-temperedness or things like that, so it's a personality that is tolerant and forgiving. I guess that's all sort of subsumed under just being caring.

It is evident from these accounts that mutual acknowledgment of personhood involves mutual communication of acceptance, feelings and all, as well as mutual acknowledgement of each other's uniqueness as persons.

In summary, the second phase in the development of a professional attachment establishes the bond between the nurse and the patient. Successful completion of this phase results in mutual acknowledgement of personhood and the professional attachment progresses to the third phase, acknowledgement of attachment.

**Acknowledgement of attachment.** The third phase in professional attachment is acknowledgment of attachment. The coresearchers indicated that they knew when attachment had developed. Some of them emphasized that it was intuitive knowing. One coresearcher stated,

C: You don't name it, you just know it. It's almost indescribable.

Others were more articulate.

R: So, when there is a caring nurse-patient attachment formed, when it is formed, how do you know, what is it that makes you know that there is now an attachment?

C: It's hard to say, I guess it's when she responds to me as a person and not a patient, that she is not only responding to the fact that I may be in pain, or I might be hungry, but she is also responding to
me. I might make a comment to her, and she responds personally, I might make a humorous reply and a smile or a laugh.

R: That's interesting, when she starts to respond to you as a person, not only as a patient. So, there is sort of a person-person exchange instead of nurse-patient exchange.

C: Right! 'cause my experience in hospitals is so often that it is dehumanizing, it is intended to make me dependent, the whole situation, and when she makes me feel important for myself. Remember the second person I talked about was a man nurse and I never got that sense of being important, or worthwhile, it was always very impersonal. So, when she makes me feel worthwhile and important.

C: It comes in little, aahh, in small indications. It's not as if she came in and said "I'm trustful, you can talk to me whenever you are in a crisis". It was in her eye-contact, the aahh, all her body-language, she was never in a hurry, you know, I was the most important patient, at that five minutes, I mean even though she had maybe another twenty on her schedule that day.

R: Can you describe what she did that made you realize that attachment had developed?

C: Well she would ask questions, you know, before she did things, she would say, you know, or just checking in "you're o.k. 'A' [name of coresearcher], or "what do you want 'A' ? or "what can I get you 'A' ?", "can I get you anything?". I mean just very off the cuff sort of things, but those were important. The off the cuff things make you feel special, because you can't imagine that she runs down the hall and says that to everybody, you know, "can I get you anything?".

It is apparent from these accounts that one of the indicators for acknowledging that an attachment has developed is that the nurse responds personally to the patient, and he starts to feel special. More detailed indicators include verbal and nonverbal expressions, such as eye-
contact, body-language, warmth in the voice and nature of questions asked. These indicators are articulated more clearly in the following account.

R: I'm so interested in this nurse-patient attachment. Can you describe how you knew there was an attachment? What was it about the nurse, how did the nurse show you, or how did you recognize that there was?

C: That's a good question. Voice, tone, nature of questions asked, willingness to do little things, no little things too much trouble, expressing concern, asking in a sincere way, the questions seemed to be very sincere, there was a sincerity about the person.... There was a difference in the nature of the conversation and I'm trying to analyze just what kind of difference it was. Somehow she seemed to hit a different level of, a different depth of question, somehow you got the feeling much more of true concern, as opposed to superficial, "how are you to day", and not listening for the answer, type of questions. In the less noncaring, not the noncaring situation but a slightly caring situation it appeared to be a matter of routine, the same old questions one after the other, and repeated daily, whereas the caring nurse seemed to be doing things in a variety of different ways and perhaps the same questions but asked in a different manner. There is one example I just thought of, relating it to yesterday, she seemed to remember how I responded yesterday, "oh, that's different than yesterday, or related things to a different period of time, whereas in another situation that didn't happen at all, and that gave you the feeling." yes, this person really does know, and does care", because they noticed that I was different from yesterday and I know they have a lot of patients and they remembered that, so, they must really care, so you got that feeling. But she could also get it from reading the chart (laughs) and asking me appropriate questions, it didn't matter, the feeling that came across was that this person remembered and cared.

One coresearcher described the acknowledgment of attachment slightly differently.
C: You have the sense that there is something between you that has a positive, kind of, electric current going, there is a connection, as it were, a kindred spirit of some kind.

In summary, there are many different ways a patient can know that an attachment has developed between him and the caring nurse. What seems to be the strongest indicator of this professional attachment, from the coresearchers' perspective, is that the nurse responds in such a personal and caring way to the patient that he starts to feel special. The result is that the attachment progresses to a deeper level, where the patient not only trusts the nurse, but feels safe enough to share with her intimate information about his present condition. This is referred to as professional intimacy.

**Professional intimacy.** Developing professional intimacy constitutes the fourth phase in the nurse-patient attachment process. When the patient has realized that an attachment has developed between him and the caring nurse, he feels safe to open up to the nurse about intimate aspects of his present condition. What makes this intimacy professional is the emphasis on keeping the intimacy to the patient's present condition, of keeping it at that moment. Professional intimacy was articulated by one coresearcher in this way.

C: It seems to me that it's an emphasis on living in the moment, and not bringing everything else into the relationship. For instance, if I'm suffering some pain and I want some encouragement in that, and that's fine, to have an intimate relationship over the suffering of that pain, but to keep it at that particular moment, and not allow it to get into other parts of our lives.
Developing professional intimacy means that the patient feels safe enough and free to talk about his feelings to the nurse. This is clearly illustrated in the following accounts.

C: The way I felt with her was that I was being treated as a human being with whom I shared some sort of intimacy about what I was going through, that I had shared with nobody else and in whom I didn't have to worry about what I said or, or what I felt. Ahm, I in no way felt as though this was an individual who could, aah, adversely affect my life so therefore I better only tell her certain things, like "oh, I shouldn't tell her that I wasn't able to sleep".

C: I would sort of expect certain intimacy with my nurse about my present physical condition. It seems to me that what would make the relationship feel different from, I mean that can be done on a very clinical level, you know, "it hurts here, it hurts there, it hurts when I do this", whatever, so that's like just communicating the data, what would make it feel intimate is if you could also communicate the feeling, that not only does it hurt but I'm frightened, you know, or "I'm worried about my family, how will they get on without me", if you have a terminal patient, or things like that. That is if you can express the feeling, not that the nurse can change the feeling, or solve the problem, or anything, but just that it is o.k. to speak the truth, whatever that may be. And going the other way I would expect the nurse to speak the truth, even if it is, "I don't feel so well this morning", you know, "I'm really tired because of this and this going on in my life", or, but, so it's sort of a quality of candidness, again not that deep dark secrets have to be told, just that it's o.k., that the relationship is accepting that, you know. I can tell you, if you ask how I am I don't have to be just polite and say, "fine thank you very much", I can speak the truth! I can say, you know, "I'm not feeling well today, I'm really depressed, or something like that, so it's more the feelings than the clinical data, it's not that it hurts in my body, it's that it hurts in my soul, if you can say that I think you have, there has more intimacy been created, and as a result more of the patient is being nursed."
Professional intimacy does not only mean that the patient feels free to speak the truth about his present condition, it also includes feeling free to ask the nurse questions pertaining to his present situation and being able to trust that she will be truthful.

C: If I had the sense that a nurse was speaking candidly and just being friendly, I mean that would be the first nurse you would ask, "now, listen, I would like to know the truth", you know, "how did those X-rays turn out?", you know, and so on, or "am I getting any better?"... Some of those questions put the nurse in a jam, because maybe it's the doctor's role to offer the diagnostics and all that, but you would ask the person you trusted to tell you the truth, and to be candid with you, perhaps especially if you expected the worst, you know, if you thought the truth might be hard to take.

C: She's somebody I would have asked questions to, now whether I did or not, I don't remember. But she's somebody I trusted. I would have asked her questions about this and that or "could you find out about...", you know, "about this medication", or "how long I'm gonna be on it", or you know, "why I'm not coming off it sooner", and things like that. Yeah, I don't...and she's somebody who would be patient with (coughs) little patient's concerns like, you know, "when am I going for that test"? you know, somebody who gives you the impression that it's o.k. to ask questions like that, you're not a bother.

C: Another feeling that I got was that I shouldn't hesitate to ask for something, there would be no problem if I did, whereas in the uncaring nurse, you felt that if you asked for something you would be really bothering this person, putting them out, and it just wasn't worth while.

R: Mmhmm, so you tended to ask the caring nurse, you tended to ask her questions that you wanted to?

C: Yes, I think so, because you felt you could and there was not too much trouble, and because you were comfortable you could talk
more about whatever was bothering you, and you didn't feel as if, I was always fairly sensitive that these people are very busy, try not to add to their workload sort of thing unnecessarily, and yet I felt with the caring nurse that I wouldn't be doing that, whereas with the uncaring nurse I felt "oh, boy, that nurse is just so busy and don't ask for anything because they're already too busy". You're not gonna get it for one thing, and for another, ahh, you just don't wanna bother them.

Intimacy about the patient's present condition also involves the nurse's willingness to be involved in embarrassing situations without making the patient feel too embarrassed about it. It is seeing the patient as he is, and accepting him that way, even when that means something unpleasant. The nurse respects the patient as a person, and calls him by name. Most coresearchers emphasized how the attachment was individualized, and intimacy created when the nurse called them by name. Just to memorize the name, however, is not enough.

C: But it's also the way she uses the name, you know, you can say a name which says look at me, isn't this smart, I know your name, I've memorized the names, right? and there is another way you can use the name, which says it, ahh, with some degree of intimacy, you know. So, even to say she knows my name isn't enough, we've got to talk about how she says that name, I mean learning somebody's name, that's something you can learn, that's cognitive, but the affective that goes with it, you know, the way you say the name. Yes, the really important things in life are not superficial or cognitive, the really important things are affective I think, in nursing too.

To summarize, developing professional intimacy is an important aspect of professional caring. It involves nurse-patient intimacy about the patient's present condition. If successfully completed, the patient feels safe enough to open up and speak the truth to the nurse, of sharing some of his explanatory model with the nurse. Furthermore, it means that the
patient feels free to ask the nurse questions concerning his present condition and trusts her to be truthful. Only when professional intimacy has been developed is there a foundation for true negotiation of care, the last phase in the development of professional attachment.

**Negotiation of care.** The last phase in the development of the nurse-patient attachment is the negotiation of care. This means that the nurse appreciates the patient as an independent individual in his own right. In helping him she does not impose her own ideas, rather she allows the patient to guide what she does, and skillfully works with the patient in negotiation of care. The following accounts illustrate this.

C: She very competently and adeptly worked with you so that you made your own decisions.

R: How did you view yourself and the nurse during your experience and afterwards?

C: I think during, as I mentioned before, as equals and as people working together to achieve a common goal. My, I felt, sincerely felt in the joy that she had out of it, my successes were her's as well, I mean, and my failures she felt too, but as opposed to just empathizing or giving me sympathy she felt it was her job, and just as an individual, to try to give you a sense of optimism and how, give you, I, try, help to generate ideas to make yourself feel better. So, I think she was a facilitator, a catalyst, I mean, aah, you know, she didn't do the work for you but she did help.

The importance of being treated as an equal is apparent in the coresearchers' accounts, and comprises the foundation of negotiating care. The following accounts illustrate the importance of being treated as an equal, from the coresearchers' perspective.
C: She was very observant and very cautious and very, aaa, professional in the way she treated you as an equal and not as a nurse to a patient or whatever else.

C: Hm, I think importantly she did not try to become my best friend, or become a parent, or a figure of authority that was giving me advice. We were *equals*, ahm, amongst whom any topic was, aah, open for conversation, but usually only at my request, in other words, she would never, ahm, think of asking me or telling me, "how are things with your husband", and what not, without me first having made a suggestion, or a gesture or given her some kind of an indication that I wanted to discuss that topic.

Treating the patient as an equal, and truly negotiating care gives the patient the feeling that the nurse is on his side.

C: I felt she was on my side during the whole thing. There were times, what I had was some heart surgery, and there are some painful times in the recovery from that. Ahh, and I appreciated her sense of confidence and caring at the same time, that is she was able to come in and encourage me to, like coughing the first few days after the surgery, it was just a painful experience, ahm, and she was one of the few nurses that I felt like she was on *my side*. She wasn't sitting over there with a whip, forcing me to do something I didn't want to do, but she was in there working *with* me, and I appreciated that. She also, you know, on occasion, not too deeply, but on occasion she shared with me a little bit about her life. And I cared about that.

Feeling that the nurse is on his side, the patient sometimes becomes dependent on the caring nurse. This aspect is illustrated in the following account.

C: Ahm, well I think she was like, aaa, somebody takes drugs to, to feel good, I took a caring nurse to feel good (laughter), you know, it was, I started to *depend* on her, but I was very much aware of it too, so.. towards the end, I guess I wasn't a normal patient really in a sense, but I know maybe if you took another person who was in my
condition, they really would develop a dependency on all of those people who showed that they cared for you.

R: Mmhmm.

C: Ahm, it would be very very difficult to, I mean, I don't know how to put it.. to become independent again.

One important aspect of, or task included in, the negotiation of care, however, is that the nurse is supportive without nurturing too much dependence. Furthermore, when the patient does become dependent on the nurse, she fosters independence as soon as possible, and up to a point where the patient doesn't need the nurse anymore. This implies that the goal of the attachment development is that the patient becomes able enough to stop being a patient. This aspect is illustrated in the following accounts.

C: She fostered a working relationship between the two of us, as I said importantly as equals and fostered a sense of independence for your own growth, your personal growth to the point were you didn't need her in that role anymore.

C: In most other relationships what you want is some sort of deepening of the ability to communicate or the commitments so that the relationship is ongoing, that is you want to perpetuate the relationship whereas in nursing and teaching the ideal thing is like parenting, what you want to do is to enable the client to graduate, that is to leave, the best thing that could happen is that the patient is able enough to stop being a patient. Well, that is a peculiar thing in a relationship, that is, you are hoping for it to stop, for it to be no reason to continue, and then to be able to say good-buy with blessings, so that makes it unusual, I think, as a relationship.

It is apparent from the data that as a result of professional intimacy the nurse is better able to understand the patient and his world. This
understanding enables the nurse to work with the patient as an equal toward their common goal, his well-being. The nurse allows dependence when necessary, but fosters independence as soon as possible. Because the patient feels the nurse is on his side he is more likely to be cooperative in the negotiation of care.

In summary, developing professional attachment is an important aspect of professional caring. It can be conceptualized as a process involving five phases. Initiating professional attachment is the first phase and requires some reaching out and responding by both nurse and patient. For professional attachment to develop further, mutual acknowledgment of personhood has to occur. This constitutes the second phase, which is crucial in developing professional attachment. It means that the nurse must, in some way, indicate to the patient that she is a person, while at the same time recognizing the patient as a person. Mutual acknowledgment of personhood occurs through some reciprocal self-disclosure, limited, but sufficient to remove the masks of anonymity, remove the stereotypes of patient and nurse, and put people in the picture instead.

Acknowledgment of attachment constitutes the third phase. The patient realizes that attachment has developed, which generates in him a sense of trust. He becomes willing to open up, and feels free to reveal to the nurse some details about his present condition, and how he feels about it. This moves the professional attachment to a deeper level, to the fourth phase of professional attachment development, professional intimacy, or intimacy about the patient’s present condition.

The last phase in the development of professional attachment is negotiation of care. As a result of the attachment that has developed, the
nurse is better able to understand the patient and his world. This understanding enables the nurse to appreciate the patient's perspective, which is a prerequisite for truly negotiating care. The nurse works with the patient as an equal toward their common goal, his well-being.

Although the professionally caring nurse is both with the patient and for him, she maintains her separateness throughout the attachment development. This separateness is what constitutes professional distance, a dimension of professional attachment which has to be present to keep caring in the professional domain. Professional distance will be described in the following section.

**Keeping a Professional Distance.**

It was the coresearchers' unanimous perception that there had to be some professional distance in the attachment between the nurse and the patient. From the coresearchers perspective, it is apparent that professional distance is one of the main differences between professional attachment and attachment with family and friends.

R: So, what would, in your opinion, be the difference between a caring relationship between a patient and a nurse, and a friendship?

C: (Pause for 12 seconds). Now that's hard to describe, I guess there is more *distance*, in the nurse-patient relationship then there is in the friendship. Ahm, most definitely more distance. But on the other hand perhaps there is a friendship that's as much friendship as one would ever expect upon such short meeting, short time conversing. So, it's similar to friendship.

C: I felt a personal relationship to her [the caring nurse].
R: You say 'personal relationship', did you feel that relationship was different from a friendship relationship in some way?

C: Well, yes and no, first of all it never occurred to me, then or after, like that she and I would ever become lifelong friends. But on the other hand it was a friendship relationship. But there was probably more distance than with a friend. As I say, when she told me, for instance, about her family she didn't really tell me about all...the personal things about it. And I probably didn't tell her a lot of personal things about my family either. So there was not a lot about delving into that. She was very caring listening when I, times when I would talk about my frustrations, for instance with the hospital system, or if the pain would get particularly bad, and she would say "well you've got to wait another couple of hours before you can have some more pain medicine", so she was very caring and sympathetic then, and I felt like she was on my side.

R: Mmhmm

C: And like she was a friend. But there is a difference, there is a difference between that and being a friend.

R: And the main difference would be?

C: I think in how much we risk...of ourselves, that is, how much I was willing to share with her, for instance, if I'd been having trouble with my wife I doubt that I'd talk about that to her or, or with the kids or something like that. And the last thing I wanted to hear were her personal problems.

It can be seen from the previous account that the patient is sometimes trying to maintain a distance from the nurse. People who are patients do not seem to want to know more about the nurse than is absolutely necessary to personalize the encounter. The patient's need for professional distance is explicated in the following accounts.

C: How caring feels like? Oh, it feels good. And it's a very secure feeling which means that I'm here because I have a problem and I get the care that I need for it, right? somebody is listening. But at the same time, it brings down all the barriers of trying to keep a
distance. The patient is sometimes trying to keep a distance from the nurse, because patients are coming from all kinds of backgrounds. I know I'm very shy and it takes me a long time, shy physically, I don't mean emotionally, but physically, and it takes me a lot of time to feel comfortable with somebody who is a stranger.

C: The distance I felt is that I didn't know her [the caring nurse] outside of the hospital, I didn't know very much about her life, she didn't know much about mine, but that was o.k., and that was, to my thinking that was the way it should have been or was the way that I wanted it, you know.

R: So, she didn't talk about herself ?

C: No, no, and I didn't ask much, I asked things to be polite, you know, but that's all, at that point really, I'm not that interested, I mean to be honest really. I'm sick!

The coresearchers not only articulated their own need for professional distance, they also explicated why they thought it was important for the nurse herself to keep a distance.

C: I mean, I still have such wonderful feelings, somebody who I felt so close to and yet I really knew nothing about her personal life, and I didn't need to, you know, so.....

R: She didn't talk about herself ?

C: No, not at all, no not at all, I mean she would talk about things, mundane things like clothes or interests, but what her last name was or what, how many kids she had, or whatever, she kept very separate, and I think that's healthy, to be honest.

R: Hmhm.

C: I think in that kind of a job you really do, I mean it's a very stressful job, you can get too involved in your work and than she wouldn't be any good for herself, her family or for the patients.

R: Hmhm.
C: So, I, that never bothered me, I thought that was quite intelligent, you know. So...

C: She was open, and she was, you had respect for her, admiration, but she always maintained, she wasn't cold, she maintained a distance that I think she had to maintain. She was very warm too, she would smile when she saw you in the morning, and she would be happy, but if she was busy with somebody else, you know, she just, you know, that was it for now and "I'll see you later". So, she was, there was genuine warmth from her, but she did maintain a distance such that you felt the advice that she was, no, she never gave advice, such that you felt the conversation she had with you were objective, you know.

R: Hmuhm

C: and I think that was very important. I didn't want somebody who sort of saw everything my way and was white-washing everything, and I was, she was objective. So, a good friend may sometimes sacrifice a bit of warmth for doing what they feel is best for you in a situation and she knew that line.

It is clear from these accounts that the coresearchers emphasize the need for professional distance. They also indicate that developing a professional attachment serves a particular purpose, for a limited time, and therefore attachment without professional distance would be inappropriate.

C: I think one has to keep in mind what the context of this relationship is and the purpose of this relationship, the purpose of this relationship is to make the patient more comfortable, to get the patient to understand what is going on and to take away a lot of the anxiety, and to create a positive environment for healing. When one talks about more intimate relationships there is always the tendency to think of carrying on after, and I think by and large that is not a helpful thing, because the patient on leaving should not be thinking about a relationship with a nurse in a hospital, he should move on.
It is apparent that the nurse-patient relationship serves not only a particular purpose, from the coresearchers' perspective, it belongs to a particular setting. The coresearchers clearly articulated that they did not want to pursue this attachment beyond that particular culture or setting.

C: My relationship to a nurse or nurses is different, it's a little bit, well, no, I was gonna say shallower, in a way it's not shallower it's just different, it's like they're two different orbs. Here is my normal life, and here is the hospital, my hospital life, they're very separate, and the nurse maybe knows me in that particular setting, you know, your relationship is built on that one particular setting.

C: It's funny, it's funny, the hospital is a unique environment, and when you go in there I think you know that you are in a unique environment and I don't expect that the nurses know me like people outside know me, and I'm not the same person either, so I don't even, I don't want to pursue it. They know the sick 'J' [name of coresearcher], you know, and they know the sick 'J' better than my friends know the sick 'J', they connect with the sick 'J', they know something about how I react to my sickness, they might not, however, know if that's normal or not normal, so....

C: And really when you leave the hospital you want to leave the hospital behind, and all the nurses, you know you don't want to continue a relationship, for example with this caring nurse we were talking about, that when I go home I'll still have a relationship.....Because they are two different worlds, it's different culture, we could speak of it that way. It's a different culture, and you go into that culture and you have experiences in that culture, and when you leave that culture than you're back home, you're living again in your primary culture.

The coresearchers not only regard professional distance appropriate and desirable for themselves and the nurse, they also seem to consider
"the right amount" of professional distance an important part of professionalism. The following account illustrates this in part.

C: I felt that the caring nurse was more professional than the uncaring one.

R: In what ways?

C: Appearance, ahm, showed more respect for the patient, just the manner in which she conducted the nursing that she did, that was just a very professional manner, like concise, very clear in her direction, ahm, provided an adequate amount. I wasn't usually confused by anything that she had said, ahm, I was quite certain of what I was supposed to do or not supposed to do, whereas sometimes I wasn't quite sure what was intended, I had to ask clarifying questions from some of the other nurses, ahm, some that were I guess mid range (laughs) between caring and noncaring. I guess professionalism is hard to describe, it's...almost a presence...of professionalism, an air to...the the professional. I don't know, I don't know what it is, just...I guess almost, to a certain extent formal, as opposed to very casual, ahh, and yet not so formal that it made you feel ill at ease, it just was........

R: A certain distance then or ?

C: A certain distance! not overly familiar and yet ahh,......

R: Comfortable?

C: Yes! comfortable! yes!, just the right distance (laughs), just the right amount, yes.

Developing attachment without keeping a distance was identified by the coresearchers as lack of professionalism, and as an evidence of caring that was not professional. The following account illustrates this.

R: I'm interested, you mentioned professional caring, in what way would that be different than say usual caring for your husband or for your wife?
C: I think it would have to do with the degree of personal risk, and the depth of which you would share the intimate details of your life. I remember many years ago, when I was in my mid twenties and I was in a hospital, falling in love with my nurse, ahh, and as I look back at it now, twenty-some years later, part of that was her! Ahm, because it wasn't a professional caring, I mean not that she certainly did anything that was out of line professionally, but, aah, maybe that happens all the time, that people fall in love with their nurses, especially if you are a young man (laughs). But anyway, I think she allowed too much of intimacy to develop, and I did, I certainly encouraged that (laughs), I mean I didn't object it, but I remember the shock getting out of the hospital and seeing her about a week later, and expecting that same sense of intimacy and caring to be there, and it was like ...a cold wall. So, I'm not sure I can describe it anymore, than that sense of intimacy and risk that you would want to develop with your close friend or a lover or somebody like that. I don't think that has a place in the hospital, so that's what I meant by professional caring......

When you begin to risk with people, and share intimate parts of your life with other people you do that very tenderly, and sometimes there is sort of opening up and than a pulling back, because you "oh, I have shared too much". I think that sense of sort of pulling back and opening up, that sense of excitement and fear, I just think that would be very destructive of the patient-nursing relationship. You see, I wouldn't want to, a sense of a long term, even a friendship developing out of it, I'd like to be able to leave the hospital and leave the hospital behind.

In summary, it is evident from the data, that keeping a professional distance is an essential aspect of professional caring. People, who are patients, do not only wish for a professional attachment, but for a professional distance as well. The coresearchers clearly articulated that from their point of view, the nurse-patient attachment belonged to a particular setting, or culture, and should be confined to that setting. Furthermore, they emphasized that keeping a professional distance was one important way of keeping the nurse-patient attachment within the professional domain.
Nurse-patient attachment with professional distance is an essential component of professional caring. Patient responses to professional caring will be considered in the following section.

**Patient Responses to Professional Caring**

The coresearchers' responses to professional caring were many-sided. Five major themes were identified in their accounts: sense of acceptance and self-worth; sense of encouragement and support; sense of confidence and control; sense of well-being and healing; and sense of gratitude and liking. These themes, that are in many ways interrelated, will be described in the following section.

**Sense of acceptance and self-worth.** Professional caring seems to give the patient a feeling of acceptance, and that he has worth in his own right. The professional nurse gets to know the patient as a unique individual, not as a stereotype, and treats him accordingly. Consequently, the patient feels accepted, feels legitimized as a person and as a patient, and he feels like a normal human being.

R: Could you describe how you felt during the interactions with these caring nurses?

C: First of all you have a greater sense of *self-worth*, particularly when you are an independent person and are suddenly in this dependent position, you are flat on your back, you are dependent on them, you are not supposed to get up and you are, even when you feel you are informed...nevertheless there is always uncertainty and a certain amount of anxiety and, and in this particular experience the nurses never sort of made it appear less...of an anxiety or "oh, don't worry about it", you know, "in 90somewhat per cent of the cases......". None of that, they accepted first of all that that was a legitimate feeling to have and I think that is really important, that it isn't put
down.....It diminished for me the anxiety quite a lot, by the way they approached, approached me.

C: Caring, I think, makes you feel accepted, it makes you feel, makes me feel accepted and makes me feel ....legitimized! ....legitimized as a patient, and legitimized as a person, both! Now those are two things that don't always go together, somebody can make you feel legitimized as a person because they react to you or interact with you on that level, who you are outside the hospital. But somebody who makes you feel legitimate as a patient makes you feel that your questions and your little concerns, your medical concerns are also legitimate, so she did both, you know, and she made me feel, she made me feel happy to be there, you know she's that kind of person you like to have around and like to be dealing with.

It is evident from these accounts that the caring nurse manages to convey to the patient that his concerns are legitimate, and that she can help the patient to feel all right about himself and about being there. This is expanded upon in the following accounts.

R: So, you think caring is important, could you expand a little bit on why you think it is important in hospitals.

C: Well, I think it's very important that you emotionally and mentally your self be .....be accentuating the health in you, you know, not being dragged down mentally and emotionally by your disease, and that whatever happens to you, ahh.....becomes alright, let's use the word legitimizes. If you shit your pants, you know, somehow that's got be legitimized so that's not something that says to you "oh, God, look who I am now, look what's happened to me now", you know, "now I'm just one step further down the ladder", you know. And a nurse can do that for you, she can help to legitimize it. Now I'm not thinking of that nurse I was talking about, but there was another nurse who really did that for me, when that happened, you know. Just her, her attitude just seemed "oh, sure, o.k.", it wasn't breezy, it wasn't, she wasn't absent from the situation, but she somehow just made it all o.k., it was o.k. and she understood my upset, she didn't brush that away, but she did still in some way give
me the message that "you don't have to be that upset", you know. So, that caring is very important to help me work on my own health.

C: Caring is one of the things that helps ....helps you to see the world as being o.k. and helps you to feel that being there is o.k., you know, it's a pleasant environment, and maybe that's the way we can say it that the caring nurses helped to make it a pleasant environment for you.

The data also indicate that the caring nurse can be instrumental in making the patient feel valued as an individual and that she can somehow acknowledge his humanity in a very special way.

R: How did you view yourself and the nurse during your experience and afterwards?

C: You see, I think one of the things about her, well one of the things about me, that she dealt with very well was that I don't like to appear weak, or sick in front of other people, like psychologically I don't think we humans like that. And so, she never, she never made me feel that way, ahm, and I liked that, I mean she sort of made me feel like I was normal anyway sitting there in bed. Ask me that question again because I think I really didn't answer it.

R: How did you view yourself?

C: O.k. so the, I was able to see myself as being a normal human being, when the tendency for me would have been to see myself as being sick, weak, sort of less than fully human, a person. And that was really important. When you ask me about the uncaring nurse, I have one in mind, not in this stay but in a previous one, that I didn't feel that way at all. And the difference between the two is just like night and day.

C: Maybe caring is carrying on almost as if the person was not a patient, it's one-to-one exchange that somehow rises above the necessities of the hospitals and the circumstances of invalid nature of
the patient or something like that. It acknowledges people's humanity or maturity or personal identity in a way that's different.

These accounts seem to indicate that being treated as a normal human being, in spite of sickness, is very important for people who are patients. Moreover, the caring nurse seems to be able to make the patient feel valued as an individual, and she can make him feel special.

C: One feels nurtured and loved and that your recovery matters somehow to somebody, ahh, so you feel valued as an individual.

In summary, the data indicate that professional caring makes the patient feel accepted, and makes him feel that he has worth in his own right. The professional nurse seems to be able to make the patient feel legitimized as a person, and as a patient. She treats him like a normal human being and makes him feel valued as an individual. This is very encouraging to the patient and he feels supported.

Sense of encouragement and support. The second theme that emerged from the coresearchers' accounts, concerning their reactions to professional caring, was their sense of encouragement and support. The professional nurse seems to be able to give the patient hope and optimism which encourages him to get better. This is illustrated in the following accounts.

R: You said that caring makes a difference, could you expand on it how it makes a difference in the hospital?

C: I guess it means.... the word that comes to mind is positive, and I felt positive about getting better when I was dealing with a caring person, and I guess it was, I felt optimistic about getting better, and how I hoped it wouldn't be too long and somehow that was the type of discussion that I often got involved with a caring person, whereas
the noncaring person, there was very little to discuss and almost no feedback, I felt like, "maybe things don't look so good, maybe my bloodpressure isn't what it should be", because I'm not getting this feedback, I'm not getting positive feedback and I'm looking for it, so that no feedback means negative. So, I would say that caring meant, that somehow it meant positive feedback, it was sort of translated as positive feedback.

R: And you felt it was encouraging?

C: Yes, very much encouraging me to get better, because it's up to me to do it, nobody can do it for me, and just encouragement to try something, "if you felt going for a walk you go for a walk and here is where you can go", sort of thing, as opposed to not saying anything, "this bed is where you're gonna lie and that's your place and you stay there until you're better", sort of thing, no encouragement to try anything new or whatever.

C: She made you feel at least optimistic, not, she .......she gave you that little voice that said "o.k. it's really bad, but I can do it," you know, "I'm going to try", that's what she did.

R: Hmuhm

C: She made you feel like it was worth it to try, to wake up and to try again in the morning.

R: Hmuhm

C: So, in that sense she did, she made you feel good. But, but I, I would like to emphasize the other emotions and things because they're internalized things, sometimes goodness is just, she just gave you a smile for a moment, or whatever,

R: Hmuhm

C: that she did too, but more importantly for me is I felt that internal sense, as I said, "yes, I'm going to try today", you know,

R: Hmuhm

C: and maybe tomorrow.
C: She never said too much, she always seemed to know what was just right, ahm, in the sense that she knew when you didn't want to talk for two hours about something and yet she would also know when you did, when it was two hours. So, I think the horsesense with people, and I'm, ahm, for lack of better words, were the main things her generosity and her cheerfulness. But her ability to give you optimism, I think was the most important thing.

It is evident from these accounts that the caring nurse communicates with the patient in a way that encourages him, gives him reassurance, and a sense that there is someone who is available to look after him. This is further expanded upon in the following accounts.

C: The individual attention I thought was really good and of course after surgery you wake up at night a lot, you are uncomfortable and both the amount of time that they spent with you if you were not sleeping and the nature of the conversation that ensued, I thought that was quite, well I think it was appropriate to start with, but it was very supportive in the way that, that was looking towards tomorrow rather than dwelling on the day before kind of thing, and I think that is a very helpful approach, and strengthens all the patient's resource, to think that tomorrow is indeed a better day, because you're healing one day more and so on, and they were available, the other thing is that if someone required assistance and the bell was on they came, there wasn't a whole lot of waiting.

R: If you analyze it, what do you need from a nurse to feel that you are being cared for?

C: I need feedback, I need information about what I should be doing to help myself get better and I need.....reassurance.....security.

C: A feeling that I got was, ahh, somewhat of a feeling of security, that someone was looking out for me and that I wasn't just another
patient, that she would be careful to make sure that....ehh...everything went right.

It is apparent from these accounts that the approach by the caring nurse and the nurse-patient attachment gives the patient a sense of reassurance and security. This is further expanded upon in the following accounts.

C: Some of the nurses disappeared, you didn't see them, you didn't know if they were coming back or not. But the caring nurse, like... there was a reassurance, "I will be back", "don't worry, I'll be there", you know. And if she had a night-shift she would tell me "you'll be sleeping, you're not going to know I'm here, but I want to let you know I'm here, so if you have a problem, you can always call me".

R: How did you feel during the experience of caring? During the experience?

C: I felt reassured

R: Mmhmm

C: and secure .......I guess ...I'm not sure how to describe it, but I would say I looked forward to, ehh, the caring nurse's visit because it was someone to talk to who seemed interesting and it's quite boring lying in a hospital bed, even if you have lots to read. People make quite a difference. And ....someone pleasant makes a big difference, so, I don't know how else to describe, ehh, the feelings.

In summary, the data indicate that professional caring is encouraging and supporting for patients. The professional nurse seems to communicate with the patient in a way that gives him hope and optimism, reassurance and a sense of security. The feeling of being cared for strengthens the patient and gives him more confidence.
Sense of confidence and control. The coresearchers unanimously emphasized that the approach by the caring nurse, especially her genuine concern and compassionate competence gave them feelings of security and confidence.

R: Could you describe how you felt during the experience of caring?

C: Oh, ahm, it relaxed me a lot. Ahm, and gave that sort of warm feeling to you, and it gave me, because she was caring, it gave me a lot more confidence and so I felt stronger.

C: Now, the caring nurse ....... It's funny, now this all happened, you know, earlier this year, so it's some time ago, but when I think about the caring nurse the first thing that comes to mind is her smile, you know. I think, a caring nurse to me, I think, is a nurse that I want to be caring for me, you know, I must have some definition to hang this on.... somebody I want to have ministering to my concerns and my needs o.k.? who is she or what is she like? She's gentle, she has a ready smile, and ....and she's confident, like, you know, I feel confident because she feels confident, so that makes me feel good.

R: How did you feel when you interacted with her?

C: I felt very confident, you know, I really did. I just felt that she knew what she was doing, and that I was in good hands. And I was really just turning all my trust to her completely, you know.

It is evident from these accounts that compassionate competence and the nurse's own confidence is important to the patient and makes him feel more confident, reduces his anxiety and, thus, relaxes him. This is expanded upon in the following accounts.

C: Competence in a nurse shows in the way a nurse conducts herself. People who feel that they are competent, and know that they are
competent, convey a sense of assurance that translates into a sense of security in the patient even if the competence is not as great as is conveyed or perceived. I think it is one of the features that diminishes anxiety and increases confidence that people around you know what they are doing, so I think competence is very important.

R: How did you feel, how did you feel when you felt that you were being cared for?

C: Well, basically you lose total control when you are in the hospital, you have no say over what happens to you, therefore you would like to be in control of somebody or under the control of somebody whom you trust and who you know is not going to abuse you in any way physically, mentally or whatever, and therefore it's sort of a matter of abandoning the desire for control, which is hard to do, but I think if you're in the care of somebody who knows, who's good, that you don't mind doing that, so it's more a total relaxation, relaxing situation rather than tensing of "what is she gonna do now" or "does she know what she's doing?" or "does he know what he's doing?"

It is apparent from the data that professional caring makes the patient feel more confident. Moreover, the professional nurse seems to be able to give the patient some feeling of control. When describing the nurse-patient attachment, one coresearcher stated,

C: This was a completely, a situation where you were in control, one of the few things you were in control of when you were in the hospital.

Sense of control can also be given to a patient through information and respect.

C: When you are in the hospital you need information, you need to know what's going on, because it's a strange environment and it's a little confusing and perhaps what you also need is to, if you are in a hospital situation that hospital is your home for a little while, you need to feel at home in that space and so, anything a nurse can do to make you feel at home, makes you feel better.
R: How can she make you feel at home?

C: I guess by allowing you to have your own space, have your privacy, to have your belongings close to you ..... respect ..... I guess somehow if she can make you feel that you are not a visitor in her hospital, but that when she comes into the room she's visiting your space, so..

To conclude, being in a strange environment, where control is limited, makes the patient vulnerable, and he needs help to overcome that feeling. A professional nurse creates in the patient feelings of confidence and control, which diminishes his anxiety and makes him feel more relaxed and stronger. This is perceived by the patient to positively affect his well-being and healing.

**Sense of well being and healing.** The coresearchers unanimously emphasized that it was their conception that caring influenced their well-being and healing. The following accounts illustrate this.

C: I think caring is extremely important.

R: Can you maybe tell me a little bit more about why you think it's important?

C: Sure. Well, when a person is in a hospital they want to, not only to be cared for and to feel that they're in safe hands, because they're out of control, they don't have control of themselves, they're trusting someone else to take care of them. If ...they are forced to trust someone that doesn't exhibit this caring relationship, it definitely would make the patient very ill at ease, and I'm sure that it makes a big difference in the person's ability to recover. They would be worried constantly if they didn't feel that their needs were being looked after. And I just think their whole attitude towards their stay in hospital would be far more positive if all nurses were caring. And I don't think it would be a situation where it would ever be so
positive that you would want to stay in a hospital for any longer (laughter). However, I think that, I think it would make for shorter hospital visits, I'm sure people would recover faster.

R: So you think that caring influences cure or healing?

C: Yes, definitely! That's a feeling I have, I don't know, I can't certainly back that up with scientific proof, but I'm, that's a feeling I have...for sure.

R: Mmmh

C: It's sort of like encouragement, ahm, a caring nurse encourages the patient to get better and the patient gets better.

R: Hmhm

C: The noncaring nurse...there is no encouragement, there is no caring...that's sort of discouraging for the patient. So, I'm sure that a discouraged patient will not heal as fast as an encouraged patient.

C: The caring allowed the strength to be built up again because you didn't have to deal with a lot of negative emotions, and that in itself is probably the best predictor for a speedy recovery, I mean all in all they made you feel that they were glad that they were able to do the things for you.

R: Do you think caring is important in nursing?

C: Oh, I think it's essential! Yeah.

R: Why?

C: Because I think that a lot of how you feel when you're in a hospital, or at anytime, depends on how you feel mentally; I mean if you are made to feel comfortable and something is being done that is gonna help you ultimately, that you recover quicker, I would imagine, or you won't feel the anxiety that you might have if you had somebody who doesn't know what she's doing. And I think that translates up the ladder, if the nurse doesn't know what she's doing,
does the surgeon know what he's doing and you question the whole system.

These accounts illustrate these coresearchers' conceptions of how caring influences the patient's ability to recover: both as a result of the nurse's encouragement and help and because the patient does not have to deal with negative emotions; presence of something positive as well as the absence of something negative. Some coresearchers articulated the relief that they sensed when they felt cared for and how that diminished anxiety and gave them time to concentrate on getting better.

C: The caring nurses managed to convey the sense that it was important to them too, that they had some investment in the patients they treated, to get better, not just, you know, there wasn't this sausage-factory kind of approach that you sometimes, sometimes see. So I felt a great relief. I also knew that if I needed anything, that they would be there, so that again diminished the anxiety. They never made you feel that you should be practically on your last breath before you called them and not only with you personally, but you knew that from what you saw around you, and heard around you, that they came, so it diminishes the anxiety, it diminishes some of the uncertainty, and I think it gives you the time to concentrate on getting better.

C: I guess my feeling was, just some relief that I was being cared for, but I think in the absence of it I would have felt very alone and very depressed, and could well have gotten sick because of that, or gotten sicker. In fact it strikes me that it wouldn't take much depression before I became indifferent to whether or not I recovered, and that could easily become a self-fulfilling prophecy, I mean if I didn't have the will to live, I mean the likelihood that drugs would force me to live might be remote, because I was very sick, and without the will, who knows? So...

The preceding account deals with the question of healing with or without drugs and conveys the conception that caring can sometimes be a
question of life or death for the patient, that is, when the patient doesn't get any encouragement he may in fact lose the will to live. Some coresearchers actually referred to caring as medicine of sorts.

The purpose of the friendliness and the caring is focused on a particular professional activity and a particular very short period in the life of the patient and designed to...it's another form of medication of sorts, it's part of the healing, part of the getting the patient better and it's creating the climate for the patient getting better.

Some coresearchers wanted to differentiate between dispensing medicine and healing, and some emphasized that caring affected healing through the psyche of the person.

C: I think there is a real difference both in nursing and medicine between dispensing medicine and, ahm, well, like I said before, healing. I mean dispensing medicine is the attitude of "we do...for you", this is what we give you, this is what we do for you. But the healing is "we have now helped to work to make yourself better and to overcome" and I think that these is really what separated those two uncaring nurses from the first, caring one.

C: I think the effect on the psyche of a person is very much a part of the healing, because I believe in treating the whole person, treating them as body, mind, and spirit not just the body alone but the three of them combined, and if their psyche is being damaged or uncared for then how can their body get well? To me, we are integrated and the three things are part of the identity and that is the person, body, mind, and spirit.

The coresearchers' conception of the relationship between caring and healing is really summed up in the following account.

R: Do you think caring in nursing is important?
C: Oh, absolutely! absolutely!, aah, an ounce of caring is worth a pound of pharmaceuticals, aah, yeah, I'm absolutely convinced of that because I think healing, I mean I would say that to doctors, healing is greatly assisted by the intentions of people and the extent to which the patient recognizes that, I mean a patient that's being treated mechanically may indeed get better but it's almost in spite of the absense of caring. So, I find in general our medical model, to treat medicine as just a science, to be very simplistic and to miss perhaps some of the more important aspects of the healing relationship, and I would say that Sigga not only of nurses but of doctors, of people in a pastoral situation, that is people who are clinicians, psychiatrists, priests, whatever, people who are trying to help others, emotionally, provide any kind of counseling and advice, helping people through their problems, be they medical, or emotional, or just coping with life changes. I think that all works better when there is genuine caring. In fact, I'm so convinced of that that I'm also convinced that people who are genuinely caring often make better counselors, even when they have very crude skills, than people who are essentially professional to a fault, to the point when they're uncaring, no matter how sophisticated their skills, you know. Being processed by a professional is not necessarily helpful because it's the humanity of the exchange, I think, that makes a big difference. I think that's even true where the healing appears to be the result of the surgical procedures, or the antibiotics, or the other medications that are provided. I'm quite convinced that the healing is more profound, probably more rapid, and certainly better internalized, that is the person ends up feeling better healed, when they've been in a caring circumstance.

To conclude, it was the coresearchers' unanimous conception that caring positively affects healing. Some coresearchers compared caring to medication and maintained that from their point of view caring created the climate for patients' getting better. Many coresearchers asserted that without caring it would have been difficult for them to get better. Some coresearchers suggested that caring affected healing through the patient's psyche and emphasized a holistic approach to the patient. It is apparent from the data that the nurse-patient attachment is a therapeutic or healing relationship. It seems that professional caring makes healing more
profound, more rapid, and better internalized if it is provided and it
definitely seems the make the patient himself feel better healed.
Apparently it also makes the patient grateful.

**Sense of gratitude and liking.** Most of the coresearchers
expressed sincere feelings of gratitude towards the professional nurse.
Even nineteen years after a caring encounter, they still had that warm,
positive feeling of gratitude.

C: Many, many times I've thought about her and smiled and been *so grateful*, and wished that I would go back and see her at a point that
I judge she would be happy to see me at, and say "look", you know,
"this is, this is what you helped...with". And so, I think, you know, I
think just *gratitude* for the dedication, for it's much more than
dedication, but that was really what I think now, you know.

C: I was also very *grateful* to her, and I've seen her since to tell her.
As a matter-of-fact, I contacted the head of the hospital later, after I
had discharged, and told that - well, I forget what his name is - but
told Mr. 'NN', I think it was, of 'NN' Hospital, how much I appreciated
that particular nurse, and how I felt that she deserved a special
commendation for her actions.

R: How do you view, ahh, think about, or feel about your experience
now?

C: I feel that I was, aah, in terms of a caring nurse and that
experience, I feel that I was ....I was extremely lucky to have
encountered an individual who had that sense of, aah, or sensibilities
that I felt very important to me, but primarily I must stress that she
seemed to be a woman who truly felt a dedication and a joy in her
work and so it was very hard not to feel that kind of joy in a
relationship with her. So, I guess gratitude is the major thing. And I
have often thought about going back to the hospital just to see her
and let her know how I'm doing, because she was, aah, she was there
during the very critical and acute times, and I think it would be nice for her to have that feedback. I'm sure it's not very often that she gets that kind of feedback.

It is evident from these accounts that the positive feelings of gratitude are longlasting, and make the patient want to go back to the nurse and let her know how valuable her caring was to them. Some coresearchers had indeed done just that. The coresearchers also clearly articulated that they really liked the caring nurse and that they appreciated having her involved in their care.

R: Do you remember how you felt during the interaction with her?

C: Oh, yeah, well I have, you know that's why I remember her, I mean she was very... very nice and I *liked* interacting with her, I *liked* her somehow being involved in my health care, you know.

C: I really feel that she was like my *guardian angel* you know. She probably saved me from what could have been a very much more traumatic incident.

R: How do you view, think about or feel about, your experience now? Your caring experience?

C: I have a very warm feeling about that, I mean I feel good. That was one of the good parts of my hospital stay.....and a good memory that I carry away.

To conclude, most of the coresearchers expressed feelings of gratitude and liking, when they related their experiences of a caring encounter with a nurse. Many coresearchers expressed a longing to go back to the nurse and thank her, while some had already done just that. It is clear from the coresearchers' accounts that the caring nurse was, and
still is, a very special person in their minds. It is evident that they have a very warm feeling about her and the caring encounter, a warm feeling that constitutes a pleasant memory.

**In summary,** the essential structure of a caring encounter with a nurse -- from the patient's perspective is composed of three basic components: the nurse's professional caring approach; the relationship that develops between the nurse and the patient, which is one of attachment with professional distance; and finally patient responses to the caring encounter, which essentially can be described as encouragement and well-being. The nurse's professional caring approach is a prerequisite for nurse-patient attachment, and together they form the essential structure of professional caring.

From the coresearchers' perspective, the caring nurse is skillful, knowledgeable, and committed to the provision of personalized care, and knows how to safeguard the personal integrity and dignity of each person under her care. The nurse's professional caring approach essentially includes compassionate competence, genuine concern for the patient, undivided attention when the nurse is with the patient, and an element of cheerfulness. These essential elements are perceived by the coresearchers as evidence of caring. The coresearchers reported that this caring approach by the nurse promoted in them a feeling of trust, which facilitated the development of a professional attachment between them and the caring nurses.

Developing professional attachment is an important aspect of professional caring. It can be conceptualized as a process involving five phases. Initiating attachment is the first phase and requires some reaching out and responding by both nurse and patient. For professional
attachment to develop further, mutual acknowledgment of personhood has to occur. This constitutes the second phase, which is crucial in developing professional attachment. It means that the nurse must, in some way, indicate to the patient that she is a person, while at the same time recognizing the patient as a person. Mutual acknowledgment of personhood occurs through some reciprocal self-disclosure, limited, but sufficient to remove the masks of anonymity, remove the stereotypes of patient and nurse, and put people in the picture instead.

Acknowledgment of attachment constitutes the third phase. The patient realizes that attachment has developed, which generates in him a sense of trust. He becomes willing to open up, and feels free to reveal to the nurse some details about his present condition, and how he feels about it. This moves the professional attachment to a deeper level, to the fourth phase of professional attachment development, professional intimacy, or intimacy about the patient’s present condition.

The last phase in the development of professional attachment consists of negotiation of care. As a result of the attachment that has developed, the nurse is better able to understand the patient and his world. This understanding enables the nurse to appreciate the patient’s perspective, which is a prerequisite for truly negotiating care. The nurse works with the patient as an equal toward their common goal, his well-being.

Although the professionally caring nurse is both with the patient and for him, she maintains her separateness throughout the attachment development. This separateness is what constitutes professional distance, a dimension of professional attachment which has to be present to keep caring in the professional domain. It is evident from the data, that keeping
a professional distance is an essential aspect of professional caring. People, who are patients, not only wish for a professional attachment, but for a professional distance as well. The coresearchers clearly articulated that from their point of view, the nurse-patient attachment belonged to a particular setting, or culture, and should be confined to that setting. Furthermore, they emphasized that keeping a professional distance was one important way of keeping the nurse-patient attachment within the professional domain.

It is evident from the data, that the patient's reactions to professional caring are very positive. The professional nurse gets to know the patient as a unique individual and treats him accordingly. She communicates to the patient in a way that makes him feel accepted as a normal human being, and legitimized as a person and as a patient. This helps the patient to feel all right about himself and his hospital stay. Professional caring also seems to give the patient a sense of hope and optimism, encouragement and reassurance. To feel cared for also seems to give him a sense of security. All this decreases the patient's anxiety, increases his confidence, and positively affects his sense of well-being and healing. It is evident from the coresearchers' accounts that they were, and still are, very grateful for their caring encounter, it is a pleasant memory they carry away from their hospital stay.
Essential Structure of an Uncaring Encounter with a Nurse -- From the Client's Perspective

The essential structure of an uncaring encounter with a nurse from the client's perspective is comprised of three basic components: the nurse's approach to the patient, which is perceived by the patients as indifference to him as a person; the resulting nurse-patient detachment with total distance between the nurse and the patient; and finally the patient responses to the uncaring encounter. These basic components are described in this section.

Nurse Indifference to the Patient as a Person

It was the coresearchers' unanimous perception that the fundamental characteristic of an uncaring approach by a nurse was an indifference to the patient as a person. They emphasized that the nurse seemed to care about the routine, the tasks she was supposed to perform, but not about the patient himself as a person. One coresearcher stated,

C: I don't know if I'm making myself very clear, but when I'm describing a noncaring nurse I think they do care about the routine that they are doing and they do that well, they just don't care about the patient (laughs).

Thus, from the coresearchers' perspective the uncaring nurse is often competent in terms of tasks to be performed, but they perceive a lack of genuine concern in the nurse for the patient as a person. This is expanded upon in the following accounts.

C: Maybe I can summarize it by saying I think when I look back now, and I sort of picture us in that room she was more involved in her task than she was in me, maybe that's a way of just summarizing
what was happening, yeah, because she wasn't confident about doing that task, right? she was nervous herself, and jittery, and you know, she had no time for me, to see me as a person and to deal with me as a person.

R: So, what would be your definition of uncaring?

C: Ahh, well, you could obviously just negate all the caring dimensions and look at the other side of the coin. There are all kinds of ways of ruining that, you know, being indifferent and rushed, or rude and irritable, or just depressed and indifferent. It's just being unresponsive, you know, I guess indifference is the word, it does keep coming back to me, as if you go through the motions, if the nurse is just doing that, you know, like punching a clock, ehh, it's just not very meaningful, it doesn't communicate caring, it communicates the dispatch of some chore, what's done is done, you know.

Four dimensions of an uncaring nurse approach were identified in the coresearchers' accounts (in order of increased indifference): apathetic insensitivity; unconcerned indifference; unkind coldness; and harsh inhumanity.

**Apathetic Inattention.**

The uncaring nurse approach is characterized by indifference to the patient as a person, and a lack of attentiveness. Apathetic inattention refers to the approach in which the nurse is inattentive or insensitive to the patient and his specific needs. It refers to the lack of a positive or caring approach rather than the presence of something destructive. The nurse is perceived by the patient as inattentive and lacking in genuine concern.

C: The nurse's approach wasn't as solicitous as it might be, that is, it wasn't asking me to express how I felt, or didn't seem to express care how I felt, except perhaps to respond to complaints, you know
if I had a problem, to be responsive to that, but it wasn't taking the *initiative* to inquire.

R: What made her uncaring, in your mind, what was it about her [the uncaring nurse]?

C: That she didn't answer specific needs, I wanted a personal.. I didn't want to be one of twenty patients.

R: Hmuhm.

C: I wanted to have that personal, aahh, that feeling that she really understood my needs, and that she would answer *specifically* on what I needed.

The perceived lack of attentiveness to the specific needs of the patient is apparent from the preceding account. This is further expanded upon in the following account.

C: The noncaring nurse, I was wondering, "she's not writing down anything, I mean how will she remember for me, all the details I'm asking from her, from the next person?". And sure enough I never got an answer from the noncaring nurse because she didn't write it down, she didn't refer to me specifically, to my specific needs, and she was kind of a little bit maybe absentminded sometimes, like her mind was in a different place.

Absentmindedness, tiredness, and exhaustion were frequently identified by the coresearchers as characteristics of, and explanations for lack of caring.

C: You know, some of the nurses, the noncaring nurses, I realized that they are doing other things, like some were studying, I mean it's great that somebody wants to study and expand their horizon, and so on, but then at night they were like corpses, they were themselves *half dead*, sometimes I wondered if I should give them an emotional support.
C: You know the caring nurses would come in the mornings smiling, they looked fresh, ready to start their work, right? and I could see that in the interaction also with other nurses. But the noncaring nurses they would come and they were droopy and mad and upset and tired and you could, you would wonder "this woman is now starting a twelve hour shift, I mean by then she's gonna be completely dead." My caring nurses always came smiling, content, maybe it has to do with how happy they are at home..... Those noncaring, I don't know, noncaring nurses maybe are coming from situations at home, where they come already drained to work so they cannot apply themselves to, to the job.

The coresearchers also linked lack of a caring approach to job dissatisfaction.

C: Unlike the nurse who was very caring, the uncaring nurse seemed to be very dissatisfied in her job, and found people, like frustration and found they're troubles and frustration. Her idea of a good day is "get my meds, give meds, do the rounds, give the meds to my patients", you know, "do whatever paperwork I have to do associated with that, then prepare for the meds at lunch", and then that was the day the way she, that's it! you know, so,...

R: Do you feel that the uncaring nurses, ahh, ahh, you said that they, you felt that one of them maybe was tired in her job, didn't like the job.

C: Yeah, I felt, now that's an unfair, it's a very difficult judgement to make, but in business I've seen people, were I've worked, and you can spot right away somebody who hates being there and is just there, goes through the motions and I, I think that that perhaps would have been the case for her. She didn't display any more warmth to her comrades, like to her other nurses than she did towards her patients. So, I suspect that might have been the case.
In some instances a personal characteristic about the nurse was perceived by the patient as an evidence of a lack of caring. For example, lack of warmth in the voice.

C: She said the right things, you know, but she said them with a tinny voice, you know what I mean? it's no good a tinny voice, it just sounds like you're selling encyclopedias or something, you know, I mean, there's got to be warmth in the voice, now that's something that we haven't mentioned, bu the warmth in the voice, that's not something you could train people to have, right? they either have warmth or not. Yeah, she appeared to me to be very, very, very young, in fact when I recall her now, like in my mind she looks to be about fifteen, now she obviously wasn't fifteen, but that's my impression, she was so young, so young, so inexperienced, so untouched by life, you know, so protected in a way I suppose, yeah, all those things. Not a rich person, you know.

To conclude, apathetic inattention refers to the approach in which the nurse is inattentive or insensitive to the patient and his specific needs. It refers to the lack of a positive or caring approach rather than the presence of something destructive. The nurse is perceived by the patient as inattentive, absentminded, tired, dissatisfied in her job, or lacking in some caring quality, e.g. warmth of voice. The next dimension of uncaring is unconcerned insensitivity which involves some transference of negative energy and is more disruptive for the patient.

**Unconcerned Insensitivity.**

When the nurse's indifference to the patient as a person becomes disruptive for the patient it is referred to as unconcerned insensitivity. The patient strongly feels that the nurse doesn't care about him and that her presence is disruptive in some way.
C: She (the uncaring nurse) didn’t care about me! Was uncaring, didn’t care, ahm, you know I had no doubt that she knew what she was doing, so in that sense she wasn’t unprofessional, in the sense of not having a technical understanding of what was going on and what had to be done. But unprofessional in the sense that I think she really delayed my doing what I was supposed to be doing.

C: There was one uncaring nurse whom I do remember very distinctly (laughs) and first of all she wouldn’t come if somebody rang the bell, she would go in the intercom, which wakes the whole room up and then if it was obvious that she did have to come, she would come into the room and turn all the lights on, which meant that six people woke up, and then she would have long conversations outside the hall-way with whoever, I don’t know who, just somebody in the hall-way, just not the right person. But she was the only one of that low, incredibly low calibre. You were just wondering "why the hell are you in this profession, you don’t seem to care about people, for their comfort or your job for that matter". But the others were all excellent.

R: I would like to hear more from you about this uncaring nurse. Could you describe in more detail what she did and how it felt?

C: Basically it felt like a continuous disruption, it wasn’t like. To me the care of a nurse should be sort of supplementary or complementary to your state of well-being, and this creature made it worse, I mean the loud noises, the clanging of bed-pans, the lights, the talking, the way of ripping back the curtains, just generally did not contribute at all to any level of comfort at all, it made it worse for anybody who was there.

Unconcerned insensitivity by the nurse is also perceived by the patient as a total blindness to his feelings, and the patient starts to feel that he is bothering the nurse when asking for help.

C: Her total blindness to my feelings at the time. She made me feel, or I felt in her presence, I felt like a big, big inadequate, incompetent nit-wit, you know, she had no understanding, and she didn’t even
seem to be trying to understand, you know, she was judgmental, there is an important word I think, *judgmental*, yeah, that she sized up the situation. I mean, in my mind .. but you see that was somebody with whom I had no relationship, and maybe that was the problem, that somebody came in to do that, with whom I had no relationship to work on, you know.

C: With the noncaring nurse, every time I called her you could see that her face is just scrunching. Why am I *bothering* her? Meanwhile I'm in agony in bed, so I'm wondering, shall I call her, every time when I thought about calling her again, and when I meant calling her, it's like "I'm trying, it's not going, I know I have to empty my bladder otherwise I will explode".. And maybe I just wanted another human being to be beside me, or, so it was like, the moment I finished to talk to her and tell her about that I feel very uncomfortable, she disappeared.

To conclude, unconcerned insensitivity involves some transference of negative energy from the nurse to the patient. The patient strongly feels that the nurse doesn't care about him and that she is totally blind to his feelings. He starts to feel that he is bothering the nurse when asking for help, and finds her presence destructive in some way. Greater indifference still is unkind coldness.

**Unkind Coldness.**

When there is a total lack of humanness in the nurse's approach to the patient, he perceives the nurse almost like a computer or a machine, as someone cold and unkind. This is referred to as unkind coldness and affects the patient profoundly in a most negative way. This nurse approach is illustrated in the following accounts.

C: Her actions towards me were so *cold*, and so obviously in *disgust* because she found out why, that, you know, I had tried to commit suicide and that I had a good husband waiting outside, and family,
and what not. She was so obviously disgusted that, ahh, it made it even worse.

C: The second one [uncaring nurse] was cold, and I can at least give her that much because I interacted with her enough. The first one, I would just say I was, .. what?, I don’t know, a piece of dust on the floor, I mean, I can’t, I was a bother. I was something that had to be, ahm, you know, "she’s still not asleep, now what am I going to do" sort of thing. So it was, we were, the people in that room were just beds, that’s all, you know, beds, she had prescriptions, she had a checklist of what she had to do, you know, your heart, etc. and that’s all it was, for everybody, not just for me, you know, so......

C: I have experiences of being in another ward for three days, and there was a tremendous high percentage of noncaring nurses. Actually, this is a nice description saying noncaring nurses, they were completely like ...cold...cold human beings, like computers, it’s like, sometimes I was worried, I was.. was wondering if they really even noticed I’m there.

Unkind coldness involves considerable negative feedback from the nurse to the patient. The nurse treats the patient as a nuisance, that is, if it weren’t for him her life would be a lot easier.

C: It’s also a sense of just being accepted as part of the hospital, not being invisible, like another piece of equipment, and even worse being treated like a nuisance, you know like I’m a headache, that is, if it weren’t for me the job would be a lot better and so on, you know, yeah, it’s just that the person isn’t put out by having to do the required nursing, that somehow the social contact is not a negative experience for the person. Even if I was the patient and I’m not in the position to offer much in the way of making the experience positive, you know, because I’m not able to be cheery or carry on conversation or anything like that. It would be additionally depressing if the nurse seemed reluctant, or in any way, or seemed like this was a negative experience, because who needs that kind of social contact which gives you that sort of feedback, that it’s a drag to be with you.
C: In terms of, in terms of someone that wasn’t caring, ahm, it was I guess the attitude was very abrupt...and short, not the least bit friendly, extremely business-like, as if "I’m here to take your blood-pressure", and "give me your arm right now", and "don’t move" (laughs) and that’s it.... and just leave, no word, no feedback as to whether things were good or bad, no smile just in as quickly as possible and out as quickly as possible. And.. definitely a huge contrast (laughs). Ahm, definitely a huge contrast to the caring nurse. I guess I observed a similar behavior towards the patient who was in the bed next to me, who was an elderly man and could not look after himself very well, and the caring nurse was exactly the same with him as she had been with me and the noncaring nurses almost, appeared to treat him as if he were a nuisance and they rather wished he wasn’t there because it was more work to look after than somebody else, and I’m sure he felt that, ahm, though I couldn’t communicate much with him, he wasn’t really talkative, so I’m just sure that’s how he felt, just watching what was going on.

C: When you as a patient are getting negative information, that is that you are a nuisance, that you are an irritation to the nurse, and I’ve experienced it a lot, I mean not just from the one episode that I recounted, but in a lots of times it’s pretty obvious that you ring the bell for the nurse, and the nurse is put out, you know, she was enjoying her break she doesn’t want to come down and have to answer your call again or, you know, if she’s harassed in general but she’s so busy with so many things going on, so you do see that, you know, where you can read that quite obviously that you are a nuisance to the nurse, that her life would be a lot better if you weren’t ringing quite so often, you know, that you’re nagging.

R: And that’s still worse than the indifference?

C: Yeah, oh yeah.

To conclude, when there is a lack of humanness in the nurse’s approach to the patient, he perceives her almost like a robot, someone cold and unkind. Even worse is the message that the patient receives, which is
that he is a nuisance to the nurse, if it weren't for him her life would be a lot easier. The most severe form of indifference, however, is harsh inhumanity, where the social contact becomes severely destructive for the patient.

**Harsh Inhumanity.**

The most severe form of indifference to the patient as a person is harsh inhumanity. It is characterized by various forms of inhumane attitudes, such as being totally ignored as a person, being mistreated, ridiculed, and treated as a pest. The following accounts illustrate this gruesome nurse approach.

C: I mean it was just as if I wasn't there, and certainly you can't be more uncaring than that. And it is, I don't know how, 'cause I've never talked about this really, I don't know how to best describe it in words, but it is really as though you had, you had become a shadow, instead of a person...it is the non-entity, the non-existence, as though you were dead, you know, and you weren't there! I think it is probably in many respect the worst... If they had been a little rude that would have been bad, but at least you would still be there! You felt that there was some contact, one person to another person, there was no one person to another person.... at all, other than doing the actual procedure of clearing up the miscarriage. And I think I'd rather have somebody who was a crabby nurse than to have somebody who is a no nurse, or a no person, so, that was the hardest.

C: And after that [a surgical procedure] is over with, they have to get you to force the use of the kidney, which is a very painful, ahh, experience. And I remember this particular nurse, and this was a male nurse, this particular nurse, ahh, used for me, used a lot of aggression and shame and guilt in trying to get me to do this.... And to force it to operate was a painful experience. And so you start up by a few minutes at a time, and this particular nurse I had no sense that he cared about, about that, and the first few times I tried, it was excruciating pain and he was just in there saying, "can't you", you
know, "can't you be a man about his, just grin and bear and do it", and he would come back an hour later and say "have you clamped that thing off again" (said very annoyingly), and if I hadn't done it he'd say, "how are you ever gonna get out of here if you don't do that?". And there was a sense like it was him against me, and I'm sure he was trying to do his job, I mean, he had to get me to do that, that thing, to clamp off that, the drain. But there was no sense that he was on my side or encouraging me or anything, and I never formed a relationship with him, I couldn't tell you this day who he was, or anything about him as a person. And he'd walk in the room and my body would just stiffen... I didn't have any idea that he wasn't technically equipped to do the job, but I sure didn't want him around me. I felt bad about myself, you know you say to yourself "why can't I grin and bear this whole thing?".

C: There was just something about her words, that seemed to me that there was, for reasons that I didn't understand, some sort of power struggle or some sort of resistance, that she was... calling the shots, she was the nurse on duty, and what she said was the rule, and once she made the decision that I was not gonna get medication, nothing I said made any difference, so that was very frustrating for me, as I said only when I became very sick did she respond. And so that seemed, I mean it felt cruel, at the time it just felt cruel because it was indifferent to my discomforts and suffering, and perverse, I mean it was no reason for it... For I was, that made me feel angry, I mean both out of the frustration, but also because I felt that I was being mistreated, it wasn't like I was just being ignored or being treated with indifference, I felt like I was being mistreated, so I felt victimized.

C: Uncaring only conveys what's not happening, the absence of something, but here I mean you are talking intentionally about the presence of something that is just negative feedback, the patient is not being ignored, the patient is in a way being acknowledged but the message the patient is getting is that "you're a pest", you know. It seems that the nurse communicates anger and that kind of stuff, you know, the attitude is "I'm glad you're sick", or "it's just as well you're sick", "you deserve to be sick", that kind of, you know, when people are angry at you, you know, it seems to me that you get more victimized by your pain and circumstances, and stuff like that, it's
almost if you're suffering some punishment because you were bad, that people are willing to see you punished.

These are four examples of harsh inhumanity. Being totally ignored as a person, being mistreated, ridiculed, and treated as a pest, constitutes a very strong negative feedback for the patient and involves a transference of considerable negative energy. The patient feels that the nurse is against him, he suffers, and feels victimized.

In summary, it is apparent from the data that perceived nurse indifference to the patient as a person is defined as uncaring by the coresearchers. Four dimensions of an uncaring nurse approach were identified in the data, characterized by increased indifference, inattentiveness, and insensitivity to the patient and his needs: apathetic insensitivity, unconcerned indifference, unkind coldness, and harsh inhumanity.

The perceived nurse indifference results in lack of trust in the nurse by the patient, and there is no attachment formed between them. The resulting nurse-patient detachment with total distance will be described in the following section.

**Nurse-Patient Detachment with Total Distance.**

It was the coresearchers' unanimous perception that they had not formed any attachment or relationship with the uncaring nurse. The perceived indifference and lack of concern by the nurse made them distrustful, and there seemed to develop some mutual avoidance; the nurse spent minimum time with the patient and the patient didn't want the nurse too much around him. There was minimum verbal communication between the nurse and the patient, and the nonverbal
feedback from the nurse made the patient feel that he was a bother, a nuisance or a pest to the nurse. As a result of the perceived uncaring nurse approach, mutual avoidance, and lack of communication, there was detachment with total distance between the nurse and the patient.

The coresearchers' perceptions of detachment came clearly through in their accounts.

C: To, to, I am sure I'm going to details again but to sum it up... it's the coldness... of the uncaring person. Aahm... the way she looks at you, aahh, like you are not a part of her world, aah, or that she doesn't want to attach, you can feel that there is no emotional attachment there.

C: There have also been a few experiences that I wouldn't describe as necessarily being negative but that were a sort of impersonal.

R: That was my next question, what about the nurses that are sort of in between, how are they, you know, what is it that makes them not very caring and not, you know

C: not uncaring but yeah, right, what makes them that way? Detachment I think, they wouldn't be humiliating to a person, on the one hand, but on the other hand they wouldn't be totally accepting either, it would be an impersonal detachment, probably doing their job very well, efficient... and you run into those people a lot, I think.

The coresearchers perceived the uncaring nurse as either unwilling, or unable, to connect with, or develop attachment to, the patient. Invariably, each coresearcher had tried to find a reason behind this nurse behavior. For example, that the nurses didn't like his personality, that they were overworked, had problems relating to people in general, or that they didn't want to take the risk of attachment in case something happened to the patient.
C: It looked like they [the uncaring nurses] were working nightshifts and during the day they were doing something else, or they looked like they didn't want to attach themselves to you and you were wondering "is it because they don't like your personality", which could be too, I mean it's chemistry between people.

C: My own experience, I have found nurses, generally, fairly agreeable and I am, by and large I think, a fairly jolly patient, and a very positive patient, and I haven't had too many problems. But I have certainly seen nurses making it very difficult for a relationship to develop, sometimes, I think, because they are overworked, but sometimes because of who they are, and they probably have the same problem in relating to other people.

C: Only one thing can I understand about an uncaring nurse or doctor, because I'm a patient and temporary problem in her life. I'm coming in her life uninvited and I'm going out uninvited o.k.? And, which means it has to do with how healthy I am, and maybe she doesn't want, how many patients like that does she have to treat? Thousands and thousands in her professional life. So, maybe she doesn't want emotional... maybe she is burnt-out what we call, she doesn't want to attach herself because if, God forbid, if something went wrong could she afford emotionally to cry? Could she afford, eeh, breaking down, so maybe she was preparing herself. But on the other hand, I don't want to accept it, because being an uncaring nurse, she's working against the principles of her job... I mean this is a,... the values of her, of her work. If you don't like it and you are not ready to come out with your emotions, which are a very important ingredient in your job, don't do it! But who is going to judge you on that? What another human being can judge an uncaring person and give let's say grades how caring she is or uncaring she is? Because those are the subtleties, right? between the caring and the noncaring nurse.... This is an element in a human being that, no other human being can judge you for that unless you are a patient.
The preceding account illustrates some common feelings identified in the coresearchers' accounts. First of all this coresearcher expresses the common view, among coresearchers, that only patients can truly recognize caring and uncaring in nurses. Furthermore, when the coresearchers were telling their stories about uncaring, they invariably were trying to find explanations for it, trying to understand it. On the other hand, however, they made it quite clear that, from their point of view, uncaring was absolutely unacceptable in hospitals. This is further illustrated in the following account.

C: If she is avoiding the patient she is avoiding work, isn't she? No, maybe it's too much for her, the emotional contact, maybe that's the reason. But she cannot carry on to do her job if she doesn't pay attention, right? So, how really do they function those nurses? I don't know. I mean that means they are not doing their job are they? So, it's like I said, "you might as well not come!". Or you have another day to fix it, like if you felt bad about it, you didn't do everything you were supposed to do one day, then the next day you fixed, right? But I'm talking about the noncaring nurse, she's consistently not caring, I'm not talking about the up and down moods, I was long enough to see the noncaring person. So, you have to make a conscious effort that you are working with people and they are human beings and you cannot forget it!

It is evident from the preceding accounts that no attachment was developed between them and the nurses perceived to be uncaring. Furthermore, it is apparent that the resulting detachment was accompanied by limited communication, and limited, if any, collaboration and negotiation of care. The following accounts clearly illustrate the total distance involved when there is lack of communication.

C: I was left to wait there, nobody came to say whether the physician was likely to come, nobody said "are you comfortable?", "do you need anything?", I was just like a package that had been delivered and nobody had come to call for it yet. There was no concern.... For me this
was a very traumatic experience... And during the entire time I was there—it was allowed as a rest—they said "you just stay here and rest", and off they went, and I lay there and nobody came, nobody said "hello", and nobody said anything. There was no communication of any kind! Nothing!

R: Could you describe how you felt during the interactions with these nurses?

C: Well, the first one, as I said, the interaction was just, ahm, a nightmare, I didn't want her anywhere near me, physically or otherwise, not because I thought she was going to do something to me, but because I was terrified of her. "What is she going to do now?", you know. She wouldn't tell me what was going on with me, let alone anything else.

R: Hmuhm.

C: So, I didn't know what she was doing, she was changing something in the I.V. or she is telling me to take medication or she was writing something down, or...so, I felt that it was just a clinical, ahm, gloved hand, that was, you know, looking after me, just what I said before, aloof, very cold. I had no feeling..., caring, the whole word caring just did not apply, that's all, you know, it was sanitized, robotized... this is a bed, this is what you get at four o'clock, six o'clock, and eight o'clock, that's all, period, that's all I can say because we really never said much to one another, you know.

C: I never received any communication other than that I was being a nuisance, that is, it's not like I knew that there was something else important happening on the ward that prevented her from attending to me, or that she clearly communicated that, you know, "it's not only eleven o'clock and your medication is not due until twelve" or anything like that, it was just essentially, although I don't doubt that she didn't use these words, it was "shut-up and don't bug me!", you know "I'll get to you in my own sweet time". So, I mean, she never asked for my understanding, or she never provided information to encourage my understanding, so I have very little, and even the passage of time [more than a decade] hasn't changed that, and so, you know, a word of explanation or something like that might have gone a long way to changing my perspective about her, but in the total
absence of that, nothing has changed in the passage of time particularly, except it just fades in memory, so the feelings get less pronounced.

These accounts clearly illustrate the importance of positive communication, and how lack of communication alone can be perceived by the patient as uncaring. Some coresearchers stated that the uncaring nurses did not relate specifically to them and that their responses where almost like standard responses. This is illustrated in the following account.

R: Do you remember having asked the uncaring nurse some questions, whether you got answers?

C: Yes, yes, I did ask, I did ask some questions, the responses I got were not satisfactory to me, they were very short and I guess almost guarded, it did not contain much information. I guess an example would be if I asked, ”how was my blood-pressure?,” "o.k." (laughs), whereas the caring nurse might have said exactly what it was and that seemed a normal range or that’s to be expected or that’s high or low or whatever but she amplified the response and told me more information than, that made me feel better.

R: Mmhm.

C: I guess I almost thought that I really couldn’t believe anything that the noncaring nurse said (laughs), because it was just such a short response, as if that’s how you respond to everybody and that’s your standard response, it’s not a response to me.

Although the coresearchers clearly identified the significance of communication in developing attachment and communicating caring, they also emphasized the importance of positive content in what is being communicated.

C: What I’m emphasizing is that I don’t think a lot of time is always necessary to convey caring. I mean sometimes it’s a casual comment, while in the process of doing something else, you know. I guess the
thing that's important is perhaps also the character of those comments, obviously they need to be comments that address the patient in a respectful way, and by that, what I have in mind is, you know, where the patient is treated as a responsible and thoughtful adult, I mean, obviously comments that are patronizing and treat the patient like a child, are not very helpful. I can remember one nurse, you know, checking bedpans or catheters and making idiotic statements, like you might make to a three year old you're toilet training, you know. That was just, it was at the best silly, at the worst insulting, and it was just inappropriate, I mean it had this kind of Kindergarten mentality, as if the patients because they were flat on their backs were somehow rendered stupid or childlike. Maybe it was too long in a geriatric ward or too long in some other circumstance, but it was inappropriate for me. So, it's more than just saying something, because if you say it in a patronizing way than it can be an insult.

It is apparent from the coresearchers' accounts that one of the difference between caring and uncaring lies in the approach to the patient and how that is communicated. This difference was identified, by one coresearcher, in the following way,

R: What would be the main difference between the caring and the uncaring nurse?

C: (thinks for a little while) The caring nurse, ahm,...looked for a response from the patient and, like sought a response from the patient. I could describe it this way, a caring nurse asked for a response and the noncaring nurse took it. I don't know if that makes sense to you.

R: That's interesting, say something more.

C: The caring nurse worked with the patient to get the response, she asked questions and made conversation to obtain the response. The noncaring nurse without conversation perhaps would take blood-pressure and say next to nothing, just go back in a flash, out she goes, absolutely minimal response, didn't give the patient an opportunity to respond, or to speak, or to express any concern. It was just very simple, "well, I'm here and you didn't tell me anything so obviously there is nothing wrong". Whereas the caring nurse would be there to ask if there was anything wrong, or if there was anything you wanted
to talk about, if there was anything you were concerned about. She looked for a response, the other one just simply did whatever she had to do.

This account also illustrates the lack of collaboration between the nurse and the patient, which was also mentioned as an important characteristic of uncaring, by most of the coresearchers. One coresearcher described this in a somewhat comical way.

C: She was not caring... maybe ignoring my existence altogether, I mean not caring is ignoring isn't it? Right! I might as well not exist, then there won't be a problem of caring or not caring. It's like, o.k. I always like to bring examples, it's like if a nurse comes into a room and two patients are there, the caring nurse would attend to them right away and see what's needed, to make them feel better. And with the not caring nurse you might as well put two puppies in the beds, and all what she has to do is just to walk in and say, "Hi" and walk out. She might as well not do anything, she can walk into this room and start to play the guitar, I mean she is not doing her job, she is not caring, she is not relating to anyone! So, when she walks into that room she is not a nurse, she can be a conductor, she can be anything she wants to be, but she's not a nurse.

This account also illustrates how the uncaring approach, which results in nurse-patient detachment with total distance makes the nurse seem more like a conductor or overlord, rather than facilitator or catalyst, as the caring nurse was perceived. This is illustrated in the following accounts.

C: She definitely was...something on the other side of the fence, we weren't working together at all! I mean there was me, and she was overlord and I think that's the best way I can describe that. Overlord is probably the right word.

C: Once in a while a caring nurse would come in and join the conversation, you know it was like an interaction with the staff. The noncaring nurse would always kind of, if she heard a lot of laughter
coming out of our room, she would just glance to see, ahh, "would she have to control us?" or you know it's like, instead of like a nice human being come in and say "what's the joke? I want to participate too, let me hear too", like the caring nurse did.

C: It was as if suddenly I was an interloper on her territory, that is that the ward was her territory and I was there on her sufferance and that I was behaving badly, that I was misbehaving in that situation, I was abusing the privilege I had of being on her ward, something like that. Whereas previously I had felt that the ward was there for the benefit of the sick people and that the nurses were part of the many people who were there to help, I mean they were staff who came in to help, but the patients were there permanently, 24 hours a day, seven days a week, and the nurses, and the orderlies, and the doctors all came and went. So, the reality very much was that it was the patients' territory, they were the permanent residences and everyone else was transient, but her attitude was quite different from that. In fact, she reminded me of, there had been a movie - this happened more than a decade ago - and there had been a movie in sort of recent circulation, "One Flew Over the Cuckoo's Nest", and there had been a book that I had read before that, and she reminded me of the big nurse in there, who is very much, I mean the ward is hers, I mean much more so than it belongs to the doctors, or certainly any of the patients. In that case it's an insane asylum, psychiatric ward, and she rules it with an iron hand, and the doctors are quite powerless in that scenario in that movie compared to her influence. I felt like this woman wanted a similar authority, although she was just, I had the feeling she had power only because of the shift circumstances, that there were so few other people around that she was left with a lot of responsibilities, that had she been working day shifts she would not be the senior person.

To conclude, perceived nurse indifference to the patient as a person makes the patient distrustful of the nurse. The patient often perceives the nurse as an authoritarian person with a need to control. The patient's encounter with the nurse is characterized by a lack of professional attachment, limited verbal communication, negative nonverbal communication by the nurse, and a lack of collaboration and negotiation of
care. This is referred to as nurse-patient detachment with total distance. Patient responses to uncaring nurse approaches and resulting nurse-patient detachment will be described in the following section.

**Patient Responses to Uncaring.**

It was the coresearchers' unanimous perception that uncaring encounters with nurses were very discouraging and distressing experiences for them as patients. Their responses were many-sided. Seven major themes were identified in their accounts: puzzlement and disbelief; anger and resentment; despair and helplessness; feelings of alienation and identity-loss; feelings of vulnerability; perceived effects on healing; and finally long-term effects. These themes, that are in many ways interrelated, will be described in this subsection.

**Puzzlement and disbelief.**

It is apparent from the coresearchers' accounts that they expected nurses to be caring. When they encountered uncaring nurses, their first reaction was puzzlement and disbelief. One coresearcher stated,

C: I felt, "my God! this isn't what I thought a nurse was going to be like".

This is characteristic of the patient's first reaction, he just can't believe, at first, that a nurse can be uncaring, it seems to be so contradictory to the image of a nurse. A friend of one coresearcher exclaimed when she heard the concept "uncaring nurse" mentioned,
F(riend of C): An uncaring nurse! How could a nurse be uncaring?!

After the initial puzzlement, the coresearchers invariably seemed to try to explain away the experience: "maybe she wasn't so uncaring, maybe it's just me", "there must be something wrong with me", or "maybe she was uncaring only for this limited amount of time". This was a phase most of the coresearchers seemed to go through. The following accounts illustrate these thoughts.

R: But you thought "there must be something wrong with me, in me or about me that makes her behave like that"?

C: Yes, yes, yes, yes, yes that's right! Because the communication that I got from her indicated that I was being a nuisance, I was like a bad child, that I was being a nuisance with unrealistic demands or requests, and she knew better and when the time was come she would take care of it and I should stop bugging her thank you very much, you know, I mean that she was irritated by my needs. That she knew best and that I was a nuisance to her.

C: We all have ups and downs and I'm wondering if I'm judging, if two weeks were enough for me to pass a judgement on people.

R: Hmuhm.

C: You know, the two weeks I was in the hospital, because maybe she was a noncaring nurse just for these couple of weeks.

R: What feelings did you have when she responded like that?

C: I guess I wondered why she was so callous. What had happened in her own life, her own experience as a nurse to make her such an uncaring person and an uncaring nurse? I guess I always believe there's a reason for things.
C: And I couldn't help but wonder, and have wondered since, what was her reason for being so uncaring that day.

R: Mmhm

C: I remember talking to her at another time, in a different situation, and remarking to her in a nice way, I thought, about her voice - because her voice was obviously different - and also she had a very big scar on her throat - which was visible to all who looked at her - and I asked her whether she herself had had surgery, and she said "oh, yes, but not here!" And I thought to myself, well, obviously her attitude has got something to do with her own personal experience in a hospital perhaps - in a different hospital she said - and I just decided that she had a real chip on her shoulder about something.

C: When I thought about it after that, I thought "ahal wait a sec., an intensive care unit is extremely stressful, maybe this is the only way that this woman can cope with that stress". And so, I thought "you're making a judgment that perhaps is not fair", I mean, you know, you just don't know. But when I did see her with other nurses there was no better interaction or no better warmth or whatever. I think she has problems, feelings, attitudes, that she is bringing to the job, that are affecting the job, I would say.

These accounts illustrate what seems to happen to the patient who experiences uncaring. Following the initial puzzlement and disbelief the patient concludes that it is indeed uncaring he is experiencing and he decides upon a conceivable reason behind the uncaring behavior. Whatever his conclusion, as to the reason behind uncaring, the patient invariably becomes angry or resents the uncaring behavior.

Anger and resentment.

Following the realization that he is indeed experiencing uncaring, the
patient goes through a stage of resentment and/or anger, depending on how serious the uncaring is.

**R:** How did you feel during the experience of uncaring?

**C:** At times I felt I was in the way, ahm, I felt as if, I seemed to be in a position "I wonder what I’ve done to cause that". I guess I also felt a little bit of *resentment* in that... I wasn’t there by choice and I would just as soon not be there, and I would like to make the visit as short as possible, much the same as she seemed to want to make that. However, ahh, she didn’t do anything to make that time pleasant in any way she performed, so I guess I resented that a little bit, and I didn’t feel any feeling of warmth whatsoever, ahh, from this person, it might not have been a person for that matter.

**R:** How did you view the nurse during the [uncaring] experience?

**C:** I had a lot of *anger*... and *guilt*, feeling very guilty about it, not being able to do what this particular nurse wanted me to do. Ahm, frustration, anger sort of at the doctors too, because I was angry that they would let this continually go on. It was clear to me that they were supporting whatever this nurse did or at least they weren’t caring.

**R:** About this uncaring experience, how did you view yourself and the nurse during your experience and afterwards?

**C:** Oh, I was *very angry* at her, very angry, and I really wanted to get rid of her, get her out of there, you know, and afterwards too...yeah, she was making a bad situation worse.

These accounts illustrate the mixed feelings of resentment, anger, guilt, and frustration. One coresearcher indicated that there was a mutual resentment between the uncaring nurse and the patients.
R: How did you feel when she answered like that?

C: Well, you feel that you shouldn't really be calling her, that you're disturbing her privacy, and even if you're the patient and you should be looked after, you had the feeling that you should take care of her needs, which you are not there for. Resentment I guess, mutual resentment obviously, she resented us calling and I resented her presence and, well it's just a whole range of annoying things, like talk right outside the door four o'clock in the morning in a loud voice, like not whispering, which is annoying enough, but in a normal day voice, well I know she's working night shift and it's like a day to her but it's not like a day to us. But she stood out as I said, all the others were good.

R: Do you feel any resentment towards her now?

C: Well, I think she shouldn't be in that job, yeah.

This account illustrates what most of the coresearchers related, that they still harbored some anger and resentment towards the uncaring nurse. This is illustrated in the following accounts.

R: How do you feel about that nurse now?

C: Well I think she should find something else, she should do something else, but I don't know what, a debt-collector or something like that (laughter).

R: What do you think we should do about these uncaring nurses?

C: Fire them. Get rid of them.

C: And... this is......not only noncaring person, this is, as far as I'm concerned, did you see the movie "One Flew Over the Cuckoo's Nest" with the nurse there?
R: Mmmh.

C: She was something like that, I mean she should be hanged.. in a public square, that nurse!

Because of the patient's circumstances the feelings of anger and resentment often develop into feelings of frustration, despair and helplessness. This is illustrated in the following account and explored further in the following subsection.

R: How did you feel during the uncaring experience?

C: I was really angry! I was, you know how the anger and sense of frustration and sense of being let down and, and the feeling of real black depression, all of this come together, and the determination not to let it show of course, and you know it takes a lot of energy, and made me more tired.

Despair and helplessness.

Many coresearchers expressed how feelings of anger and frustration developed into feelings of despair and helplessness, because of their circumstances. This is clearly illustrated in the following account.

C: I felt very frustrated and yet I also felt very powerless especially because of the circumstances, I mean it was the late night shift and she was the only one, as far as I knew, on duty, I mean maybe there was someone else covering a part of the ward, but anytime I rang my buzzer, she was the one who showed up, and I had no way of reaching anyone else......so I felt very frustrated but also very powerless, I mean it's not, but I guess, I mean part of the frustration is because you feel so powerless and, and this, this woman, who I quickly assessed was not being helpful and was, for whatever reasons, acting in a way that felt perverse, that I was, I was stuck, I mean there was, I mean I was like a prisoner, I mean there was nothing I could do to seek help from anyone else. Now, that may always feel that way, but especially in the night shift, I mean I had no way, my call-button only rang to her, I was too weak to get up, I mean
too hard-wired to get up and too sick just generally, so I was totally reliant on her, and yet she was the wrong person, I didn't want to be reliant on her, and in fact if I could have I would have fled you know, I mean just because I didn't trust her, so I felt distrusting as well, so it made me feel very angry in response to that too, I mean the frustration, the powerlessness, the sense of anger, but, I mean, in my circumstances then, I was so weak that the anger, I mean it keeps you awake but it doesn't do much more than that, it's not like you can act out your anger, it's just an emotional distress, and also I remember some fear, because I knew I was getting sicker.

This account illustrates how the negative destructive feelings of anger and frustration develop into feelings of helplessness and hopelessness because of the patient's circumstances. Furthermore it illustrates how these negative feelings are sometimes connected with fear. The following account expands on these feelings.

C: There is that feeling of impotence and a sense of loss in a way, and a sense of having been betrayed by those on whom you counted, and whether we want to or not we do count on nurses to be there and to be caring, and to be understanding, and to provide information, and to respond to one's needs, and if they don't do that then I think one has perhaps the same emotional response as one has as a child. It may in fact be more exaggerated than the situation warrants simply because it reactivates some unresolved feelings one carries with one from experiences as a child, just like fear, when you are afraid of something within the hospital context I think some of it is some very basic childhood fear that is still there, and I think that is probably true when there is a noncaring experience, whether there be nurses or anybody.

Being uncared for and helpless in an unfamiliar setting is depressing, and if the nurse's uncaring approach is severe the patient develops strong feelings of alienation. This is somewhat illustrated in the following account but described more fully in the following subsection.
C: There is nothing worse than being in a hospital where you feel alone and the people don't care about you. It's just *depressing*.

**Alienation and identity-loss.**

Being uncared for in a dependent situation eventually creates feelings of despair and helplessness. If on top of that the patient is treated by the nurse as if he were something less than a human being, the patient's feelings develop from despair and helplessness to feelings of alienation and identity-loss. This is illustrated in the following accounts.

C: I found that in this particular experience I felt not only uncared for, I really did feel as though I was not treated as a human being, ahh... I felt depressed but I also felt very *angry*, but neither anger nor depression describes the sense that you feel of being *not there!* you know, of just being a *non-entity;* I mean it's better, you can deal with anger of somebody doing something to you better, but, than the absolute indifference that was displayed by this.... (silence for a few moments).

R: How did you view yourself and the nurse during your experience and afterwards?

C: Hmm, well in the first instance the intensive nurse, ahh, I think, as I mentioned, I was just a *bed* and I was to be dominated by what her plan, schedule, and whatever, said. I'm trying, you know, I've thought about this a lot, so I'm, I don't think I'm doing any injustice, I'm trying to objectively see how this went, and and, that's all, it was just a *work, just a job,* it didn't matter if it was a side *df beef in the bed,* or whatever, it was just a job. So, I felt alienation and I felt "my God, this isn't what I thought a nurse was going to be like".

Feeling like a side of beef, an object, or a machine illustrate feelings of alienation and identity-loss. The following accounts expand on these feelings.
C: For instance in the delivery room, about eight years ago, I had about ten different people in the room when I was delivering. And it wasn't like today, it was aaah, like an operating room, and I had all kinds of nurses going in and out, in and out, you know, and I was like another piece of object, I was another object, one of the many objects in the room... I maybe talk a lot, but I'm very shy when it comes to my body, and I felt like I was exposed to the whole world.

C: I didn't feel any assistance and I just felt I was an object being inspected.

C: Ahm, he [the uncaring nurse] was a tall person, and so, very imposing, threatening almost, and there was never a smile on his face. There was always very business-like, and very business-like, well sometimes very unbusiness-like, because there was a sense of judgement-look on his face, I can remember his coming in and almost being judged by the way he looked at me. When we would work with the clamping off, I mean there is this tube sticking in your side, and not that he would be rough with it but he certainly didn't treat it with any tender, tenderness or caring. It was as if I was a machine hooked up to a machine almost, if that makes any sense. And we had to get this machine working, and if I didn't do my part, the machine wasn't going to work properly.

R: How did you view yourself? you talked a little bit about it.

C: Well I felt really diminished, I felt as though "I have no value", I was just one of those objects that one did something to and once one had done whatever one has to do, that was the end of it. It was not human experience, and I think that's very poor.

To summarize, experiencing uncaring within the hospital setting is probably contrary to most people's expectations when they enter a hospital. Initial reaction, therefore, seems to be characterized by puzzlement and disbelief. The patient finds it difficult to believe that he is indeed
experiencing uncaring, followed by a tendency to look at himself to find a reason for the nurse's behavior. If the patient doesn't find a credible reason within himself, he seems to look at the nurse's situation to come to a conceivable conclusion about the reason behind the uncaring behavior.

Following the realization that he is indeed experiencing uncaring, the patient goes through a stage of resentment and anger. In fact, many coresearchers related that they still harbored some feelings of anger and resentment towards the uncaring nurse. Because of the patient's vulnerable circumstances, however, the patient is most often unable to act out his feelings of anger and resentment, and these strong negative feelings seem to develop into feelings of despair and helplessness. The patient is reliant on the nurse, but she is the wrong person to be reliant on, and he can't do much about it. The patient, therefore, develops feelings of impotence, a sense of loss, and a sense of having been betrayed by those on whom he had counted for caring.

Being uncared for in a dependent situation, thus, eventually creates feelings of despair and helplessness. If on top of that the patient is treated by the nurse as if he were something less than a human being, the patient's feelings seem to develop into feelings of alienation and identity-loss. The patient feels he has no value as a person, that he is indeed less than a person: a side of beef, an object, or a machine. Experiencing uncaring exaggerates the patient's own feelings of vulnerability within the hospital setting.

**Feelings of Vulnerability.**

It was the coresearchers' unanimous perception that they felt vulnerable and in need of caring when they were in the hospital. Some
suggested this makes patients more sensitive to caring and uncaring.

C: I would suspect that most people who are in hospitals are very sensitive to caring or uncaring, you know. They're in the need of caring, needing to be cared for, and maybe they're just that much more sensitive to whether they feel cared for or not.

C: I would expect that people being ill makes them vulnerable, so that when they have an uncaring transaction, like someone treats them rudely, they are more deeply wounded in that circumstance than if they were healthy and walking the street and someone on the bus-corner said something stupid or insulting, I mean that they can shrug off and ignore, but here they are sick and in need, and probably feel weak in spirit, and weak in body, and so it hits home harder, any transaction may hurt them more. My own experience as a patient was that you are doing your utmost to be co-operative, I mean you are not trying to be cantancerous, and I remember some experiences where you just had the feeling that, like it was my fault, like I wasn't trying hard enough, there were people being impatient with me when I was sort of straining to do things.

C: You're a patient and you're kind of stuck there (laughs).

R: Mmhm

C: And at times you're somewhat...ahh...helpless, compared to how you normally would be, and that's an uncomfortable feeling I think for probably most people. And, they need help overcoming that feeling.

These accounts illustrate the coresearchers' own perceptions of their sensitivity and vulnerability as patients. Needing and expecting caring, being in a dependent situation, and feeling weak in spirit and body makes the patient vulnerable and insecure. To receive uncaring in such a
vulnerable situation makes the patient feel helpless because in most hospital situations the patient can't leave, he is stuck there. This aspect is illustrated in the following accounts.

C: People are more vulnerable to uncaring in the hospital than in society because they are looking for the caring, and if they don't find it, it is much more significant to them. If you're walking down the street and a neighbor walks by and doesn't say "hello", you don't get upset, but if it's the person who is responsible for your, who is caring for you who walks through your room and doesn't say anything or if you called them and they don't respond, you get upset... your needs are different.

R: So, you are more vulnerable in the hospital?

C: Definitely, I think a patient feels very vulnerable and insecure.

R: Why?

C: Because they are not in control of themselves, or their situation. The situation right now, I can get up and walk right out the room and leave, whereas in the hospital if anything was wrong with me I couldn't do that, I'm stuck there! I'm not physically in control of my destiny, and so naturally that makes me feel insecure. So, I guess you therefore feel that you need help and you look to someone who is caring for that help, because you naturally wouldn't look to somebody who didn't care, you are putting yourself in the hands of someone else, you're trusting someone else to look after you, so naturally you trust someone who appeared to care for you, much more than someone who didn't care at all.

C: And again you can't defend yourself, which is always a part of that negative experience in hospital, whether it was nurses, or lab technicians, or whoever, or the kitchen-staff for that matter, you are at their mercy, you are dependent on them. You can't pick up your bag and say, "I'm going to another place folks, I'm not staying here". You are there, whatever they do to you, someway or another you have to take it, and by the time you are through it you are so sick of it you don't really want to, I mean some people write letters of complaint, I'm not much given to letters of complaint, because I do also know
that often they are treated as "well there is another crabby patient", or whatever, so I don't do that, I didn't do that in school either when I thought a teacher was an absolute, well whatever... it's not worth it. But when you are on your back in a hospital bed you are defenseless, you are dependent, and you are much more affected by the attitudes and the actions of people than you are if you are upright and can look them straight in the eye, and I think that is something that nurses really have to always remember.

These accounts illustrate how defenseless the patient sometimes feels when he receives uncaring in the hospital setting. Only two coresearchers, however, had complained about uncaring to someone in authority. Some of the reasons for not complaining are illustrated in the following accounts.

C: I felt upset, mad, eeh, humiliated, because this is a very special situation. You are confined within the walls of the hospital, right? eehm, you... you don't have another choice, you cannot go anywhere, you know that you are gonna stay only for about three days, so who is gonna complain, I mean by the time you complain, by the time they do something about it you are out of the hospital, so you say, you might as well not say anything.

R: Mmhm

C: What for?

R: Mmhm

C: And, eeh, then you are worried that if you complain and the same nurse is anyway gonna treat you, you might make the situation worse.

R: Mmhm

C: Aah, because you are at the mercy....... of the noncaring nurse.

R: Mmhm

C: Right? So the whole situation, and you are very vulnerable when you come out of delivery, so, o.k. so I'm talking about after giving birth, but can you imagine, let's say somebody who went through a
very difficult operation and he really cannot move at all, and he is at
the mercy of a noncaring nurse. I mean I don’t wish it on my enemy!

R: Mmmhm

C: Like I said "noncaring nurse go home!" (short laughter) "this is not
your place to be in".

C: You see, once you leave the, when you are in the hospital, in the
midst of the situation, you are not gonna complain about it, that the
one who’s taking care of you is so cold, because you are at the mercy
of those people, o.k.? it’s like being a prisoner in a prison, you are not
gonna do that, because the retaliation, who knows what will be the
retaliation. You don’t want to submit yourself to more pain and agony
than you are already [receiving]. And once you leave the hospital, that
means you are cured more or less, I’m not talking about the ones who
leave and die (laughs), so, that means that the moment you leave you
are going to better times, and the tendency of people is to leave the
bad times behind them, look at me! I didn’t write or complain about
what they did, and I know I should. It’s just that I cannot get that
energy, even the desire to go back, even to the location of the building,
to deal with those people, you know, you want to forget it, and I did a
good job forgetting it. So.. but when I bring it back, and I talk about it,
it is painful, so, it’s the reality that people usually go on to other things
and keep on with their lives and life is usually quite busy, and if you
are coming out of the hospital most likely you have neglected a few
things and you have to keep up with everything and put more energy
in all kinds of areas that you have neglected (laughs), and so you want
to put it at the back of your mind. You know, if I have to go into that
building again, I think I would rather put a bomb underneath it, this is
how I feel about it, yuck/ (said with disgust). I mean I get
goosebumps when I go through that building, you know. I have even
developed allergy, I was allergic (laughs), every time I walked in I
just sniffed the air of the closed environment, you know because they
cannot open a window or anything, I would get right away tight.. in
the throat, and running nose and this is how I felt about it.

It is apparent that while still in the midst of the hospital experience the
patient is often fearful about retaliation for complaining. It might even make
the situation worse! This is probably particularly pertinent to long-term
hospitalizations, where the patient realizes that he will more than likely have the same nurse again later. In the case of short hospitalizations, the patient tries to endure the uncaring. By the time something is done about his complaint he will probably have been discharged anyway. Home again, the ex-patient seems to try to forget the uncaring encounter instead of trying to find the time and energy to complain and risk to be deemed as just "another crabby patient".

One coresearcher asserted that patients in hospitals do have some power. He pointed out, however, that a lot of that power is not active power.

C: A lot of the power the patient has is more of a negative variety; of not cooperating; of being disagreeable; of being noncompliant; and be quite negative.

The few things that the coresearchers found helpful, during the experience of uncaring, were their own personal strength, supporting family and friends, and the caring nurses.

R: What was helpful for you during the experience of uncaring?

C: What did help me?

R: Yeah

C: (laughs) my sanity I guess (hearty laugh). Because I did have other support systems. If I hadn't had that it would have been really bad. I mean I had my husband, who is the best nurse..on earth (laughs), and the best cook, and I have so many friends who are nurses and doctors.. So, if I didn't get what I needed emotionally or physically in one place, I always had an outlet... It's like, that's why I found myself quite o.k. I mean I didn't fall apart, but I don't know if somebody else didn't have all of this support system that I have, I think it would have been really tough.

R: Mmmh
C: Really tough, because my situation wasn’t easy at all.

R: What was helpful for you during the experience of uncaring?

C: Hm, what was helpful? What was really helpful was seeing other nurses who were interacting with other patients in a completely different way. You know, I knew that this was a particular case and that’s not the way, I didn’t feel in general that’s the way the nursing profession, aah, operated everywhere, I mean, sometimes you just get scared, “oh, my God, this is the way it is in a hospital”, that wasn’t the case.

To conclude, it was the coresearchers’ unanimous perception that they felt vulnerable and in need of caring when patients in the hospital setting. Needing and expecting caring in their dependent situation, they felt like defenseless prisoners, when suffering uncaring. Only two coresearchers, however, had complained about the uncaring to someone in authority. What seemed to help the coresearchers through this abuse of vulnerability, which uncaring is, according to the coresearchers, was having a strong personality, having support from family and friends, and having or seeing a caring nurse. It was the coresearchers’ perception, however, that uncaring affected their healing.

**Perceived Negative Effects on Well-being and Healing.**

Many coresearchers related that they perceived uncaring as a transference of negative energy that negatively affected their well-being and delayed or even prevented their recovery. This is illustrated in the following accounts.

C: The caring nurses were a part of the healing process. But every time I bumped into a nurse that wasn’t caring, it depends how bad she was, all that I could do was to dwell on the bad experience that I had
with her, like my mind didn’t have time to heal it was going backwards I think, you know.

C: I think there has to be, you have to have some method of recourse, because if a person is not a caring individual in the way your needs perhaps demand, you know, that can be so detrimental to your recovery, it can be so detrimental to your progress.. you don’t have a chancel you know, essentially you’re fighting something else.. not only the illness you’re fighting, you know, the system almost, and I don’t think anybody under those circumstances can get better.

C: The fact that the hospital hadn’t treated the emotional aspect of this experience, had not even given any credence to it, but just ignored it, I think had an impact on the way I dealt with that, because I was also angry at them for their absolute lack of caring or understanding or just the ordinary human compassion. I mean, every , any bystander on the street would have been more caring, and there was a lot of nurses who were in that emergency ward on that morning. So, I think it did delay my recovery from, in that sense, and it has, even though it shouldn’t I suppose, slight remnant of that I still carry, and I know a lot of very good nurses.

C: I think if the nurse is very tired or stressed out, like anybody in a job, ahm, if the job itself is too, how do you put it? taxing, then she can certainly not help with the healing process, and I’m gonna take my radical attitude as before, I hate to say this but I think that there is just some instances and some jobs where people are just not well suited to them, and I don’t think that’s a matter of failure, I think it’s perhaps a matter of how you are and who you are.

It is apparent from these accounts that the coresearchers believe that uncaring is detrimental to the healing process. Some coresearchers stated that it was enough to meet one uncaring nurse, or one uncaring physician, to come to a conclusion that hospitals were not helpful places for mental and physical well-being and healing. This is illustrated in the following account.
C: It goes back to how smart the caring nurse is, or the noncaring nurse is, because if she is not smart enough to understand all the subtleties of caring how can she... she does more damage treating the patients then, than caring about his wound or pain with a needle, because the mental damage is so traumatic. What we should do is eliminate all the uncaring nurses and tell them to go home (short laughter). This is what I feel (serious), because this is one of the reasons why I said "I'd rather die peacefully at home then be in a hospital in...". Because for me it was enough to meet one uncaring doctor or one uncaring nurse to determine that "this is not the place I'm gonna cure myself", you know. I had to go home and cure myself, and so I cured myself with my husband (short laughter). But in the hospital it was,...ehh,...it was very difficult, I mean we go there thinking that we would like to cure ourselves, in the hospital, right? I found out that every time I entered the hospital I'm sicker; I'm sicker when I go there! I come home and I'm a healthier person. So, I said "o.k. what are the risks of being at home? what are the risks of being in the hospital?". At least I knew that at home I'm getting my mental balance back and if physically something is happening there is always an ambulance that can take me for twenty-eight dollars right to the hospital and in between the crisis I can be home. So, I think I was starting to think about my will too at that time, that I want to die at home (short laughter), I don't want to die in a hospital.

The final subsection portrays the coresearchers' perceptions of the long-term effects of uncaring encounters with nurses in hospitals.

Long-Term Negative Feelings and Memories.

It was the coresearchers' unanimous perception that the uncaring encounters made an indelible impression on them, and had a longer lasting effect than did caring encounters; that they tended to be both acid edged and memorable. This is illustrated in the following accounts.

C: The uncaring experience I remember, ahm, I don't know in five years if I'll remember this [caring] nurse's name, that I really liked down here, or not, maybe, but I don't think so.
R: Because it's not bothering you?

C: Right! exactly! yeah, it was supposed to be there, and I got a lot out of it but that's no longer a part of my life. But if you go away frustrated and angry, and tense, that still is a part of your life, because it's unresolved. As I said, I still remember vividly this male nurse, and I'm sure that if I ever saw him again, it would be, I would feel that same sense of tension, although I'm sure if I saw nurses that I liked, from previous years, again, even after I forgot, there would be this sense of warmth, but I'm sure if I saw him...

C: The uncaring actually is, is sharper in my memory, because there is a, you know, I remember the feelings I had. You see, the feelings I had with the caring nurse were, just feelings of being o.k., well, they are not sharp feelings, they are just comfortable feelings. But the uncaring, that's a sharpness, and I can still, when I talk about it, feel that, you know, so it's easy to talk about it, it's easy to drum that up, to find it again.

R: Most people have talked about this, how long-lasting uncaring memories are, would you have any idea why? Why people remember them better?

C: Because you don't expect it. It's a bad experience you don't anticipate, so it's more of a, I mean the whole hospital stay is a bad experience, but at least you are anticipating it, but if there is somebody who is bad on top of that, then it's a double negative, which will reinforce more than double in your mind. Again you can compare it to a restaurant, you go to a restaurant, you get a bad meal, you'll remember that, but if you get a good meal you expected that, I mean that's what you go for. So, that's unexpected like a bad treatment it will stick to or in your mind.

C: What reoccurs in my mind all the time is the events with the noncaring nurses, because it bugs me, so... because I didn't resolve it, right? it's an unresolved experience like, I feel like going back and settle the issue with her, with the noncaring nurse, but with the caring nurse, it was satisfying, it was good, you know it's like having sex (laughs), you know, with a climax, it was done and over and that's
it, you know (laughs). I mean those are experiences that are fulfilling the same moment and you don't have to go back to it...but with the uncaring nurse, I mean *this stays with you forever*, you know.

It is apparent from these accounts that, for the patient, an uncaring encounter is often an unresolved experience. The encounter was unexpected and elicits a lot of negative feelings that often do not get to be resolved. This is further illustrated in the following accounts.

C: Let me see, that was in August '68, 19 years ago and it still has an emotional, elicits emotional response, that long ago! That tells you something about the power of nurses, for good or for not good, you know. Imagine if it has that impact on someone like myself, who's had a lot of hard times, and generally positive and sort of hearty, strong emotionally, what that does to some people who are weak, who don't have the emotional stamina, who don't have a satisfactory life, in the general sense. I think that those are, probably without exaggerating *scars*, and I think they are *unnecessary scars*.

R: So, how do you view your experience now?

C: That particular experience [an uncaring experience]?

R: Yes.

C: I still have some anger towards him. Ahm, I think it affected my, it's interesting, it affected my view of that hospital, ahm, and I know that it has one of the finest reputation in the country.... but I would not want to go back there.

R: How do you feel about the uncaring nurses now?

C: How do I feel? They are subhumans, they are not humans, you might as well have a machine to take care of you. So, when I'm in an extremely good mood, I'm trying to reason with them why they did what they did, but when I'm in a bad mood I definitely don't care what's bothering them! you know I'm saying, "do your job and that's
it! So, of course we can find a reason why everyone is doing whatever they are doing, but when you are in a situation where you need the best care, you are yourself terrified from everything, 'cause a lot of things are unknown to you; you are worried about yourself; you don’t know, the notion of dying suddenly becomes very much apparent, even though you are not dying really, but being in an environment of only sick people you get closer to the issue of dying, of death; and you are disconnected from your friends, your family, your kids; you lie there and you are at the mercy of strangers. You’re trying to assess it's like being a newborn baby, I guess, into a new world, and you didn’t choose to be there, so... a noncaring nurse, if she approaches you, it's the last thing you need, not only the last - you don’t need it! period! So, it’s amazing, very rarely do people have a good experience in the hospital, because it’s enough to have one not caring nurse or a terrible doctor who can make an unbearable situation, I mean a bad situation, because you are there for a problem, make it even worse.

C: I, this experience, I still, and I’m not trying to be melodramatic, but I still have nightmares about both of those nurses.

These accounts clearly illustrate the negative feelings still attached to the memory of the uncaring encounter. Some of the coresearchers referred to these memories as scars, and although they are trying to understand or make sense of the uncaring experience they are most often still angry, or even have nightmares about the nurses perceived to be uncaring. Some of the coresearchers identified how the uncaring experience got them thinking about ultimate realities, affected their view of the hospital, and how it even dictates their decisions today. This is further expanded upon in the following account.

C: Dealing with noncaring people really gives you;... you start thinking about ... consequences, which means 'God, what if I’m really helpless and I have to be in the hands of noncaring nurses or noncaring doctors. If this is what, what's happening if I cannot control my mind anymore? is this where I really want to be? you know, suddenly it has implications to..., were situation worse, where you are not so much
in control, maybe your mind is going a little bit, your physical health is really deteriorating, is this an environment where I really want to be?" So, this is what I'm saying, when you deal with caring nurses it's a good experience and it's finished, I mean you can go on with your life more as a complete person, but when you deal with noncaring people, which are nurses and doctors, you:.. it occupies your mind for years and years afterwards. I still have terrible experiences and memories from noncaring personnel, of, from my last delivery, which was eight years ago, and this really dictates my decisions today, I mean, I was pleasantly surprised to see that things have changed in the health system after eight years, which made my life a little bit sweeter. But all my decisions this time when I delivered my baby where based on my experiences with the noncaring personnel.

R: Mmhm

C: So.. I'm saying it's amazing to see how long lasting those memories are..

R: Mmhm

C: with the noncaring people.

R: Mmhm

C: And.. aaah.. and caring people, you have to kind of bring it back, from the back of your memory to say "wait a second, but there are some still good people who where, are doing a good job".

R: Mmhm

C: But you have to bring it back

R: Mmhm

C: Really work hard to balance the good experiences and the bad experiences.

The preceding account illustrates some of the long-term effects of uncaring experiences, and how the coresearchers really seemed to try hard to "balance the good experiences and the bad experiences". Some coresearchers even tried to see something positive out of the experience.
C: And it [the uncaring experience], was in some ways a good experience, I mean it wasn't at the time, but it was a good experience for me as a person who works with people, to be at the other end, and I think that is always very good, to see how little it would have taken, certainly wouldn't have costed the hospital any money, so it wasn't a matter of shortage of staff, or because of nurses being rushed off their feet, they had lots of time, and they just didn't give a damn, basically. "That's just another one of these wretched miscarriages", you know "what a nuisance, why doesn't she do it at home". I don't know what they thought, but it was in every respect a degrading experience, you were treated as though you were some package, and I mean they didn't even help me down from the bed, and just now thinking about it I can still get quite excited about that. I thought it was very, very poor, and I mean there is nothing much more that I can add to that, because there wasn't a nurse who was uncaring, it was just nursing period! that was uncaring.

This account illustrates that even if the ex-patient tries to see something positive about the uncaring experience the anger and the resentment is sometimes not far away. Two coresearchers, however, stated that they felt sorry now for the uncaring nurses.

C: I feel sorry for the uncaring nurses, I don't think they are enjoying their work, and that must be a very difficult position.

R: How do you feel about the [uncaring] experience now?

C: I feel sorry for me and I feel sorry for her [the uncaring nurse], you know, I think it was a bad time for both of us. But at the same time I think, I doubt if she'll make a good nurse, because she didn't have those qualities within her, you know, she didn't, she was what I would call a light-weight, you know what I mean by that? just a light-weight, you know. Could do a lot of things very well, I'm sure, but nursing is not a light-weight profession, it's a profession for heavy-weights (laughs).
Although most of the coresearchers had tried to forgive the uncaring nurse, some of them related that they probably had more of a forgetfulness than forgiveness towards her. Furthermore most of the coresearchers seemed to have pondered what would happen if they were to meet the nurse again. Some of these thoughts are shared by two coresearchers in the following accounts.

R: How do you feel about the nurse today?

C: Well... I'd like to say "I feel forgiveness", but I'm not sure I do... I mean I don't have a lot of thought, so I have a lot of forgetfulness.... I suspect if I were to encounter her again, my reaction would be ....a lot of anger.... still, and avoidance, I mean I would be fearful, not in the sense that I would, I don't know how to describe that, not that I would shirk from her, I mean I might feel very defiant, but I would definitely want to avoid her that is I would not want to be in her care, I don't feel forgiveness in that sense, so I mean if I were, if I found myself on her ward again I would want to avoid her, and would request that, I mean I would not give her a second chance as it were, I mean she's had her second and third chance already, as far as I'm concerned! But mostly it's just forgetfulness, you know, I don't ...to this day I still have not felt compassion for her position.

R: Could you describe how you felt during the interaction with the uncaring nurse?

C: Ohhm, I don't know if it was so ...painful or so ...bad at the same moment the interaction happened, it's ...once she left you , and your mind starts thinking about the interaction, then... you start saying "why didn't I do that," and "why didn't I tell her that", I call it the unresolved situation. For her it probably passed and she doesn't even know! she doesn't have the slightest idea what she did just now, but you as a patient you are left with the bitter experience or the bad experience or the uncomfortable experience because it's not always bitter and so bad, but I found out that I'm always, I'm dwelling on it later on, and ...all my desire is is to go back to that person later on and say "hey listen, why were you like that to me?" you know, "I didn't deserve that, I'm here, not because I want to be here, but you are here
because you want to be there, you are getting paid for it! so do your
damn good job to make sure I feel good about it! So... so with me it
was left for many years afterwards and, and my last experience which
just happened last month, eehh, you can see also the way I am talking
about it that I'm really starting to boil over it and in my dreams I'm
always going back to... to finish my business with her. Like take her
and shake her and say "if you don't like what you're doing, then
leave", but then we know reality, what am I gonna go back and talk to
her? that's ridiculous! Or even if I met her again, I don't even think I
would raise it because she's gonna look at me as if I'm out of, I'm just
landed from Mars. "What am I talking about?" you know, it's like "I
wasn't that bad to you", because, well she didn't slap me and she
didn't pinch me, it was very subtle, her behavior towards me. So, for
her probably it went passing by unnoticeable, but for me it left me
with lots of bad memories.

These accounts illustrate the coresearchers' negative feelings about the
uncaring encounters. Furthermore, the preceding account illustrates the
longing to go back and confront the uncaring nurse, while at the same time
realizing that the nurses, perceived to be uncaring, are probably unaware of
their influences on the patients, and would therefore not recognize the
patient's story.

To conclude, it was the coresearchers' unanimous perception that the
uncaring encounters made an indelible impression on them, and had a
longer lasting effect than caring encounters; that they tended to be both
acid edged and memorable. It is apparent from the data that, for the patient,
an uncaring encounter is often an unresolved experience. The encounter is
unexpected and elicits a lot of negative feelings that often do not get to be
resolved. Some of the coresearchers referred to the memories of the
uncaring encounters as scars, and although they seem to be trying to
understand or make sense of the uncaring experience they are most often
still angry, and even have nightmares about the nurses perceived to be
uncaring. Some of the coresearchers identified how the uncaring experience
had them thinking about ultimate realities, affected their view of the hospital, and how it even dictates their decisions today.

Although most of the coresearchers had tried to forgive the uncaring nurse, some of them related that they probably had more of a forgetfulness than forgiveness towards her. Some of the coresearchers expressed the longing to go back and confront the uncaring nurse, while at the same time realizing that the nurses, perceived to be uncaring, were probably unaware of their influences on the patients and would therefore not recognize the patient's story.

**In summary**, the essential structure of an uncaring encounter with a nurse from the client's perspective is comprised of three basic components: the nurse's approach to the patient, which is perceived by the patients as indifference to him as a person; the resulting impersonal nurse-patient detachment with total distance between the nurse and the patient; and finally the patient responses to uncaring, which include the patient's reactions to uncaring as well as his perception of the long-term negative memories of uncaring encounters.

It is apparent from the data that perceived nurse indifference to the patient as a person is defined as uncaring by the coresearchers. Four dimensions of an uncaring nurse approach were identified in the data, characterized by increased indifference, inattentiveness, and insensitivity to the patient and his needs: apathetic inattention, unconcerned insensitivity, unkind coldness, and harsh inhumanity.

Perceived nurse indifference to the patient as a person makes the patient distrustful of the nurse. The patient often perceives the nurse as an authoritarian person with a need to control. The patient's encounter with
the nurse is characterized by a lack of professional attachment, limited verbal communication, negative nonverbal communication by the nurse, and a lack of collaboration and negotiation of care. This is referred to as nurse-patient detachment with total distance.

It was the coresearchers' unanimous perception that uncaring encounters with nurses were very discouraging and distressing experiences for them as patients. The coresearchers' reactions to the uncaring encounters were many-sided. Seven major themes were identified in their accounts: puzzlement and disbelief; anger and resentment; despair and helplessness; feelings of alienation and identity-loss; feelings of vulnerability; perceived negative effects on healing; and finally long-term negative memories about the uncaring encounter. It was the coresearchers' unanimous perception that the uncaring encounters made an indelible impression on them, had a longer lasting effect than did caring encounters, and tended to be both acid edged and memorable unresolved experiences.
CHAPTER 5: DISCUSSION OF FINDINGS.

In this chapter the findings of the study, presented in the preceding chapter, will be discussed in light of related literature. The discussion will relate to the three major themes: the perceived caring and uncaring nurse approach; presence or absence of relationship formation; and, finally, patient responses to caring and uncaring.

**Perceived Caring and Uncaring Nurse Approaches.**

It was the coresearchers' unanimous perception that the fundamental characteristic of an uncaring approach by a nurse is indifference to the patient as a person. Conversely, from the coresearchers' perspective, the caring nurse is skillful, knowledgeable, and committed to the provision of personalized care, and knows how to safeguard the personal integrity and dignity of each person under her care. The fundamental difference in the caring and the uncaring nurse approach seems to be, according to the coresearchers, whether or not the nurse acknowledges the patient as a person. These findings are in accord with nursing literature. Nursing's heritage and many nursing theorists emphasize respect for persons as a fundamental principle in professional caring.

Watson (1985) contends that there are common and broad themes from nursing's heritage about the nature of nursing. One of these themes, she argues, is a view of the human as a "valued person in and of him- or herself, to be cared for, respected, nurtured, understood and assisted; in general a philosophical view of a person as a fully functional integrated self." (p. 14). Another theme, Watson states, is "an emphasis
on the human-to-human care transaction between the nurse and person and how that affects health and healing." (1985, p. 14). Watson asserts that human caring in nursing is not just an emotion, concern, attitude, or benevolent desire. She states, "caring is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity." (1985, p.29).

According to Watson (1985) the essence of the value of human care and caring may be futile unless it contributes to a philosophy of action. Gaut (1983) goes further and says the action must be judged solely on the welfare of the person being cared for. Gaut (1986) further asserts that the ability to attend to another, as similar in personhood and yet quite distinct from self as person, requires a very special regard and respect for self and all other persons. She argues that using respect for persons as a principle or norm for action requires respect for a person's actions, decisions, values, and claims. Gaut states, "to regard all human beings as persons is to grant them certain rights that can never be forfeited or retracted... if caring is intentional human action, then respect for persons will serve as the underlying principle for all caring transactions." (1986, p. 82).

According to Bevis (1982) respect is inherent in caring. She asserts that respect is first for the humanness of the individual and as such is impersonal. She claims that "without respect for one as a human, nurse caring is perfunctory and ritualistic" (1982, p. 130). Bevis asserts that with respect for humanness comes a reverence for life and acceptance of individuality, separateness, and a nonjudgmental attitude that enable support for the other person in his or her own ethnic, ethical, and behavioral mode. She states "respect means acknowledging and accepting
the wishes, preferences, differences, needs, and desires of another and feeling o.k. about them" (p.130).

Gadow (1980) argues that a fundamental premise of nursing is that a patient has the right to receive affirmation and acknowledgment as a human being. She contends that human beings are unique and so complex that each individual transcends the categories of science. She states, "the recipient of nursing care has more than a legal right to scientific and technically competent treatment - the patient has a moral right to humanistic care" (p. xvii). Gadow (1980) proposes existential advocacy as the essence of nursing and points to the nurse's participation, the give and take, the dialogue with the patient in determining the unique meaning for the patient.

Leddy and Pepper (1985) assert that effective changes in clients occur when the nurse uses a high degree of positive regard; demonstrates congruence between who she is and what she is; demonstrates congruence between verbal and nonverbal communication; and infers accurately the inner world of the client by listening well and understanding the subjective and objective world of the relationship as it changes over time. They emphasize that internalizing the principles of empathy, respect, and genuineness make it possible for the nurse to demonstrate these behaviors and experience satisfaction in nursing practice.

Hammond et al. (1977) contend that in order for the client to experience his right to exist as an other, the nurse must demonstrate a receptive attitude that values his feelings, opinion, individuality and uniqueness. They emphasize the value of respect and nonpossessive caring for, and affirmation of, another's personhood - as a separate individual, - in the nurse-client relationship. Furthermore, they indicate
that respect builds self-esteem and self image and that in the nurse-client relationship, respect is demonstrated when there are equality, mutuality, and shared thinking about strengths and problems.

The importance of acknowledging the patient as a person is evident from the literature. Nursing's heritage and many nursing theorists seem to emphasize this fundamental principle. Nurse indifference to the patient as a person is therefore contrary to nursing's images and ideals. It is, however, surprising how scarcely it is dealt with in nursing literature. The literature is considerably richer about the caring nurse approach. A professional caring nurse approach will be discussed in the following subsection.

**A Professional Caring Nurse Approach.**

Four themes were identified in the professional caring nurse approach: compassionate competence; genuine concern; undivided attention; and sober cheerfulness. The last theme, involving a cheerful nurse presence, which was identified in all co-researchers' accounts, could not be identified in the literature. The other themes will be discussed in light of related literature in the following subsections.

**Compassionate competence.** The data of the current study indicate that competence administered with compassion is an essential component of professional caring. It implies that a professional nurse is perceived by the patient as caring only if she is competent and administers her care with compassion. Thus, compassion is perceived, by the co-researchers, as the kind of attitude that makes up true professional competence. This finding is supported by literature.
Mayeroff (1971) points out that we sometimes speak as if caring did not require knowledge, as if caring for someone, for example, were simply a matter of good intentions or warm regard. He states,

To care for someone, I must know many things. I must know, for example, who the other is, what his powers and limitations are, what his needs are, and what is conductive to his growth; I must know how to respond to his needs and what my own powers and limitations are. Such knowledge is both general and specific. (1971, p. 13).

Gadow (1980) points out that the role of the modern nurse requires far more knowledge and skill concerning equipment and apparatus than ever before. She questions, however, whether the advancement of technology in nursing signifies a necessary concomitant; a decline in the customary caring that has characterized nursing. She contends that nursing seems to be faced with a decision between preserving its commitment to caring, on the one hand, or following the progress of medical science with more technically intricate curing, on the other hand.

Wilson (1974), argues that "... in a society of machines, in institutions of healing run by machines, the nurse has a vital part to play in preserving the human aspects of patient care" (p. 414). Likewise, Sward (1980) points out how technology and science dominate the health-care scene and are considered vital to quality health care. She argues that, still, with technology in place and scientific measures having proved their worth, results do not satisfy. Sward states, "the fault is not necessarily with technology or science, per se, but with the fact that these are not balanced with sensitivity and responsiveness to human need" (1980, p. 7).

Watson (1985) has stated, "a nurse may perform actions toward a patient out of a sense of duty or moral obligation, and would be an ethical nurse. Yet it may be false to say he or she cared about the patient" (p. 31).
Watson is referring to the attitude, or feeling tone underlying a nurse's actions. This attitude or feeling tone is referred to as genuine concern for the patient as a person, another essential aspect of professional caring.

**Genuine concern.** It was the coresearchers perception that genuine concern and respect for the individuality and well-being of the patient is an important aspect of true professional caring. It includes genuinely wishing the patient well, really attempting to understand him, accepting him in his unique circumstances, acknowledging his pain and suffering and responding to his specific needs.

van Kaam (1959) wrote to a nursing audience specifically regarding the patient's feelings of "really being understood". His existential phenomenologically based research revealed that patients felt that they were really understood by nurses whose "views, feelings, and behavior... manifest consistently genuine interest and care" (p. 1710). His analysis was that the nurses' interest had to be perceived as genuine and honest, not feigned because "patients in their intensified sensitivity" distinguish sharply between genuine and pretended interest and care.

According to Mayeroff (1971) honesty is present in caring as something positive, as in "being honest with oneself", where this includes actively confronting and being open to oneself. He states, "in caring I am honest in trying to see truly. To care for the other, I must see the other as it is and not as I would like it to be or feel it must be" (p. 13). Mayeroff adds, "I must be genuine in caring for the other, I must 'ring true'. There must not be a significant gap between how I act and what I really feel, between what I say and what I feel." (p. 14).
Bevis (1982) states "in caring, honesty is present in the behaviors of being open, genuine, and truthful. It includes actively confronting oneself and the other person" (1982, p. 131). She asserts that honesty in response is essential to the caring relationship. When asked a direct question, one either answers truthfully or states clearly that one does not wish to talk about the topic. "Honesty is practiced within the limits of the self-exposure that the individuals are willing to allow at each stage of the caring process." (Bevis, 1982, p. 132). According to Bevis honesty is one of the elements that comprise trust, just as trust is an element that enables honesty. The two develop together. Additionally, she contends that respect helps the caring person to recognize the limits and potentials and to assess the current status of the relationship clearly so that no more honesty is required than there is trust to support.

Watson (1979) asserts that a patient/client who feels that the nurse really cares about and really sees the person's individual needs and concerns is likely to establish trust, faith, and hope in the nursing care. She contends that the person/client is also far more likely to talk about sensitive matters with the nurse who communicates a genuine caring response. Watson (1979) states, "genuineness refers to being real, honest, and authentic" (p. 26). She adds, "genuineness and congruence are basic to a helping-trust relationship. The nurse who has congruence can move toward a productive working phase because she/he has a realness that transcends the rigidity of role expectations" (p. 28).

Travelbee (1971) states that an effective nurse is able to provide a non-threatening, safe, trusting, or secure atmosphere through acceptance, positive regard, love valuing, or nonpossessive warmth. Gazda et al., (1975) point out that although warmth alone is inadequate for an effective
helping relationship, it seems to encourage the development of the conditions of empathy and genuineness. They, furthermore, point out that warmth is communicated through a wide variety of behaviors e.g. gestures, posture, tone of voice, touch, and facial expressions, and that warmth is an important nonverbal message and attitude that has a positive impact.

Research on nonpossessive warmth, as well as on congruence and empathy, evolved from the theories of Carl Rogers (1957, 1962), who described such warmth and positive regard toward another as a feeling that is not paternalistic, nor sentimental, nor superficially social and agreeable.

It is apparent from the literature that genuine concern and respect for the individuality and well-being of the patient is an important aspect of professional caring. This is congruent with the study by Riemen (1986a), who asserts that it is not what the nurse does in the way of physical acts of assistance, but what the nurse is. She concludes about her study, "being existentially present or available, showing genuine interest in the client as a valued individual by really listening is considered by clients to be one of the most important aspects of caring" (Riemen, 1986a, p. 103). Likewise, Watson (1985) asserts that "it is not so much the what of the nursing acts, or even the caring transaction per se, it is the how (the relation between the what and the how) the transpersonal nature and presence of the union of two persons' soul(s), that allow for some unknown to emerge from the caring itself". (p. 71).

Related to, but separate from genuine concern, is the nurse's undivided attention to the patient while she is with him.

**Undivided attention.** An important part of a professional caring nurse approach, according to the coresearchers in the current study, is
attentiveness, alertness or heightened awareness. This quality is evident by a nurse's undivided attention to the patient while she is with him. Incorporated in undivided attention is the ability to be alert and observant. Genuine listening is a part of alertness, as well as really hearing what the other is trying to say. Undivided attention also includes patience, not being rushed and being present in the moment. The importance of attentiveness in professional caring is supported by literature.

Griffin (1983) emphasizes attention and attunement in caring and refers to Heidegger's (1949) concept of Gestimmtheit (translated as 'attunement'). She explains his concept by stating that in daily life knowledge may come to us, or truth present itself to us as a result of a primitive openness in our attitude. We attune ourselves to see what everyday eyes do not see, there is an intense effort to shut off the inessential, (the trivial, the self), so that we may 'receive' what has hitherto been concealed; the emerging truth, the reality of the situation. Griffin asserts that this giving of our whole attention has cognitive, moral and emotional aspects; "the reason why we look is that we care; a patient's need is perceived by the nurse, whose consequent action has several layers." (1983, p.292). Griffin explains that there is the clinical assessment of what is required, the cognitive and moral recognition of importance of the patient as a person, and the emotional element, "motivating and energizing the act, and licensing us to call it caring" (1983, p. 292).

According to Bevis (1982) attentiveness is a behavior necessary in caring, and comprises heeding, attending, and listening in a discerning manner. She claims that it is one of the most important things that a caring person can do for another. She states, "it provides a bridge for individuals to reduce aloneness...In a caring relationship one learns to listen to content."
the process (the message behind the words), and feeling tones in a conversation." (1982, p.131). Another part of attentiveness, according to Bevis, is awareness of how one responds to what is said. She asserts that allowing another to express ideas, feelings, or thoughts different from one's own requires that one neither discount nor judge the other. "Each person is not held to the exact words that are spoken, but intent and meaning are sought so that clarifying is part of the communication process" (1982, p. 131).

According to Mayeroff (1971) patience is an important ingredient in caring. In his interpretation, patience is not waiting passively for something to happen, but is a kind of participation with the other in which we give fully of ourselves. He indicates that it is misleading to understand patience simply in terms of time, for we can give the other space as well. Mayeroff emphasizes that by patiently listening to the distraught man, by being present for him, we give him space to think and feel. He contends that perhaps, instead of speaking of space and time, it would be truer to say that the patient man gives the other room to live; he enlarges the other's living room, whereas the impatient man narrows it.

Sundeen et al. (1976) assert that listening is the most important therapeutic technique in the process of effective communication in that listening transmits the message that "you are of value to me", and "I am interested in you". They emphasize that it is devastating to the formation of a helpful relationship if the nurse fails to listen. When the nurse fails to listen, the message communicated to the client is: "you are not of value to me," or "I am not interested- actually I am bored" (Sundeen et al., 1976, 89-90).
The coresearchers' perception of the importance of attentiveness seems to be consistent with current literature. The nurse's undivided attention when she is with the patient, and her genuine listening, seem to be strong indicators of caring for the patient.

The coresearchers reported that nurse indifference to them as persons, accompanied by limited verbal communication, made them distrustful and a relationship failed to develop between them and the nurses perceived to be uncaring. Conversely, they reported that the professional caring nurse approach, accompanied by nurse acknowledgement of the patient as a person, and including compassionate competence, genuine concern, undivided attention and sober cheerfulness, promoted in them a feeling of trust, which facilitated the development of attachment between them and the caring nurses. This presence or absence of relationship formation between the nurse and the patient will be discussed in light of related literature in the following section.

**Presence or Absence of Relationship Formation.**

In the current study, it was the coresearchers' unanimous perception that they had not formed any attachment or relationship with the uncaring nurse. The perceived indifference and lack of concern by the nurse made them distrustful and there was a detachment with total distance between the nurse and the patient. Conversely, the coresearchers reported that encountering a caring nurse created in them a sense of trust, which facilitated the development of a nurse-patient attachment, or relationship. For many of the coresearchers, this attachment, or personal relationship, constituted the fundamental difference between caring and uncaring. These findings seem to be consistent with current literature.
Watson (1979) states that there is a steadily growing body of empirical evidence that supports, what she claims many have been believing intuitively for centuries, that the quality of one's relationship with another person is the most significant element in determining helping effectiveness. Watson (1979) contends that a basic element of high-quality care is the development of a helping-trust relationship. She asserts that to develop such a relationship, the nurse must first get to know the other person, including the other person's self, life space, and phenomenological view of his or her world. She emphasizes that the nurse must also examine how she regards other human beings - as objects to be manipulated and treated, or as human beings to be understood.

Bevis (1982) points out that each caring relationship is unique. She claims that although the components are the same, the individual's context, variables, experiences, and circumstances are different for each caring relationship. Bevis states, "the caring pattern affects only the common denominator of feelings and behaviors, their sequence and form. The experience remains uniquely one's own" (1982, p. 137).

Watson (1979) asserts that a balanced sensitivity to one's feelings gives a foundation for empathy with others. She asserts that if nurses and other health professionals fail to be human at sensitive or painful times, they fail at helping. She states, "they succeed only in hiding behind their role and their insecurities and anxieties; and they contribute nothing to their own health or the health of others." (p. 18). Watson also contends that a nurse attains and promotes health and higher level functioning only if she or he forms person-to-person relationship as opposed to manipulative relationships.
Watson (1985) contends that personal relationships between friends have a give and take process of exchange wherein the one who needs the most receives from the other. She points out, however, that there is a reciprocal sharing and an accepted norm of mutuality where each party in the relationship helps the other. She asserts that a professional caring relationship may and does allow for the nurse to benefit and be influenced by the other. She argues however, that the nurse does not depend upon receiving from the patient to maintain the involvement.

Similarly Bevis (1982) asserts that the nurse-caring relationship tends to be a variation of the usual caring relationship in that it generally operates in one direction (clients being the prime recipients of caring). She explains that the crisis, need, and generally lowered functional capacity typically experienced by clients during their interaction with nurses facilitate a one-way flow of caring energy. On the other hand, because the relationship is of a caring nature, clients recognize that they receive more than they give and often comment about that aspect. Bevis contends that as energy returns and is available for giving to others, clients often attempt to put the caring relationship on a more lasting basis by inviting the nurse into greater participation.

Gadow (1985) contends that in a caring relationship, the subjectivity of the patient is assumed to be as whole and valid as that of the nurse, and that their intersubjectivity is a relation. She identifies that the typical objection to a relation of dialogue in health care is that it asks too much of the patient, who cannot be expected to give to the caregiver. She points out, however, that it is the same asymmetry that philanthropy assumes. Gadow asserts that, even on that model, patients are expected to offer the
professional a gift - a gift of inestimable value, without which even the most one-sided relationship collapses: the gift of trust.

Findings in the current study clearly indicate the importance of trust in developing professional attachment. In fact, it seems to be a major determinant in developing attachment, and lack of trust seems to be one of the major reasons for nurse-patient detachment. Discussion of nurse-patient detachment, or lack of relationship formation, will be followed by discussions about the development of a nurse-patient relationship.

**Absence of Relationship Formation.**

The coresearchers in the current study reported that no attachment or relationship developed between them and the nurses perceived to be uncaring. Moreover, they reported that the resulting nurse-patient detachment was accompanied by limited communication, and limited, if any, collaboration and negotiation of care. These findings are supported by literature.

Watson (1979) asserts that the sensitivity of the nurse in an interpersonal communication encounter is one of the most crucial therapeutic tools for delivering care. She contends that of all the problems that can arise in nursing care, perhaps the most common is failure to establish rapport and a helping-trust relationship with the other person. She asserts that within the context of a helping-trust relationship, general principles of communication need to be considered, and identifies that communication consists of all the cognitive, affective, and behavioral responses used to convey a message to another person. Watson (1979) points out that within such a context there is no such thing as "no
communication" or nonbehavior. She concludes that all behavior has meaning for the person, and all behavior has a message value.

The coresearchers in the current study perceived the uncaring nurse as either unwilling or unable, to connect with, or develop attachment to the patient. Watson (1979) points out that the education and practice situations in nursing often prevent or at best discourage the nurse from being too sensitive to or getting too involved with patients. Watson asserts that the nurse may overreact to protect her or his own feelings. As a result, the nurse often forms impersonal, detached professional relationships, in which she or he hides behind a so-called professional character armor (Jourard, 1964).

Contrary to the coresearchers' perceptions of the uncaring nurses' inability or unwillingness to connect with the patient, they perceived the caring nurses as both willing and able to develop an attachment or relationship with the patient.

**Developing Professional Attachment.**

From the coresearchers' perspective, it is clear that professional attachment is an essential component of professional caring. There seems to be a need in the hospitalized patient to develop a certain attachment or to connect with his caregiver. This finding is widely supported by literature.

Fromm (1956) contends that the deepest need of man is the need to overcome his separateness and "leave the prison of his aloneness" (p. 9). He argues that love, or caring, is an active power in man; a power which breaks through the walls which separate man from his fellow men, a power which unites him with others. Fromm states, "love makes him overcome
the sense of isolation and separateness, yet it permits him to be himself, to retain his integrity" (1956, p. 20-21).

Hagerman (1969) asserts that most psychologists, psychiatrists, and philosophers agree on the basic need of man to have relationships with other humans. She contends that love, or caring, is a process whereby one becomes aware of another person, respects him as an individual, understands and considers his needs, and eventually becomes able to share oneself with this person.

Riemen (1986a) cites Buber (1958) who stated that the "self", or the "I", of each person comes into being in one or another of two primary relations: the I-it or the I-thou. Buber emphasized that no man can know another simply as he knows objects, that knowledge of another person requires openness, participation, and empathy. Buber stated that I-Thou involves "a real encounter and genuine mutuality" (1958, p. 50). He asserts that what has happened is that the proper balance of I-it and I-Thou has been disturbed by an increase of I-it relations.

Riemen (1986a) asserts that a differentiation must be explicit between "caring" and "taking care of". She points out that to take care of someone physically could very easily be done in an I-it relationship. Riemen states, "nurses today are accustomed to dealing with people as nonpeople. To be involved in an existential caring relationship means the establishment of an I-Thou relationship" (1986a, p. 88).

The importance of establishing a relationship between care-giver and care-receiver is clear from the examination of the literature. In the current study, professional attachment development is conceptualized as a process involving five phases: initiating attachment; mutual acknowledgement of personhood; acknowledgement of attachment; professional intimacy; and
negotiation of care. These phases will be discussed in light of related literature in the following subsections.

**Initiating attachment.** The first phase in attachment development is reaching out. This can be initiated by the nurse or the patient. Initiating attachment requires effective communication, verbal or nonverbal. This finding is supported by literature.

Leddy and Pepper (1985) assert that the human need for relatedness binds people together and that communication serves as the exchange medium in these relationships. They contend that the verbal and nonverbal messages exchanged in human relationships determine, to a large extent it's structure and function. They further assert that the quality of the communication process between the nurse and the patient is an essential determinant of the success of the professional relationship. They point out that mutual goals cannot be defined or achieved in the relationship without effective communication.

In the current study it was concluded that if there is a lack of reciprocity in this phase, the attachment does not develop any further. Successful completion of this phase, however, means that the attachment development progresses beyond the first phase towards the second phase in the attachment development, mutual acknowledgment of personhood.

**Mutual acknowledgement of personhood.** The second phase in the development of a professional nurse-patient attachment, is mutual acknowledgement of personhood, where both nurse and patient remove the masks of anonymity, and recognize and respect each other as persons. The importance of this phase is widely supported by literature.
Watson (1979) emphasizes that developing a "helping-trust relationship", means that the variable in the process must involve the person of the nurse, not simply the nurse in general. She stresses that it is the person variables and personal qualities of the nurse that determine effective implementation of specific communication skills or techniques as well as effective implementation of other procedural technical skills and techniques. Watson (1985) considers the nurse and the patient to be coactive and codeterminant partners in the human care process. She contends that it is the interdependent, intersubjective human process that can shape conditions necessary to sustain a person and caring in instances where humanity is threatened.

Zaner (1985) contends that illness is uniquely dyadic; that it uniquely appeals for recognition by persons for persons. He states that the dyad, caring and trusting, is a profoundly moral phenomenon. He states, "the promise of this relationship is that not only may the sick person recover from the illness; more to the point, it promises the recovery of ourselves, patients and caregivers, as persons" (p. 101).

Gaut (1983) contends that the notion of "respect for persons" is crucial to the discussion of caring, because it entails an attitude necessary in the carer. She states, "awareness of 'personhood' must include not only a basic recognition of who one is, but also an awareness of other human beings as persons worthy of respect in their own right" (Gaut. 1983, p. 320). Similarly, Watson (1985) asserts that the transpersonal human-to-human caring is the essence and moral ideal of a style of nursing where human dignity and humanity are preserved and human indignity is alleviated in health-illness experiences.
Gadow (1985) contends that the image of a caring person is of one who is solicitous, tender, sympathetic and supportive (Steele & Harmon, 1983). She notes that to describe the nurse-patient relationship as essentially one of caring might then require those traits of nurses rather than others like detachment or efficiency. She emphasizes, however, that caring as a moral ideal, rather than as an interpersonal technique, entails a commitment to a particular end. That end, she proposes, is the protection and enhancement of human dignity. She states that "caring as the moral ideal of nursing is concern, above all, for the dignity of patients" (Gadow, 1985, p. 32).

It was argued in the current study that this second phase in the development of a professional attachment establishes the bond between the nurse and the patient. Successful completion of this phase results in mutual acknowledgement of personhood and the professional attachment progresses to the third phase, acknowledgement of attachment.

**Acknowledgement of attachment.** The third phase in professional attachment is acknowledgement of attachment. The coresearchers reported many ways in which they knew that an attachment had developed between them and the caring nurses. What seemed to be the strongest indicator, however, was when the nurse responded in such a personal and caring way to the he felt special.

Along similar lines, Watson (1985) states, "the art of caring in nursing begins when the nurse, with the object of joining another (or others) to oneself with a certain feeling of care and concern, expresses that feeling by certain external indications." (p. 67). She also states, "the more individual the feelings are that the nurse transmits, the more strongly does the caring
process affect the recipient." (p. 68). Watson also asserts that clarity of expression assists the nurse's caring.

The result of the acknowledgement of attachment is that the relationship progresses to a deeper level, where the patient not only trusts the nurse, but feels safe enough to share with her intimate information about his present condition. In the current study this is referred to as professional intimacy.

**Professional intimacy.** Developing professional intimacy constitutes the fourth phase in the nurse-patient attachment process. When the patient has realized that an attachment has developed between him and the caring nurse, he feels safe enough to open up to the nurse about intimate aspects of his present condition, he feels safe enough to share with the nurse relevant aspects of his explanatory model.

Kleinman, Eisenberg, and Good (1978) have argued that health professionals need to elicit the patient's explanatory model. They have suggested certain questions in order to get to know the patient's therapeutic goals and the psychosocial and cultural meaning of his illness. Among questions, suggested by Kleinman et al., are questions like "What are the most important results you hope to receive from this treatment?", "What are the chief problems your sickness has caused for you?", and "What do you fear most about your sickness?" (1978, p. 256). The findings of the current study seem to indicate that if the client is to feel safe enough to answer these and other similar questions truthfully, the health professional must be perceived as caring, by the client, and a relationship has to have developed between them to make such self-disclosure possible.
Many nursing theorists have emphasized the importance of understanding the client's perspective (e.g., Leininger, 1978; Anderson, 1985). In fact, Watson (1985) points out that nursing has always had a strong commitment to care of the whole person and a concern for the individual's own perspective. Henderson (1964), for example, defined the nurse's role as very subjective and qualitative, and contended that the nurse should "... get inside the skin of each of (her) patients in order to know what (he/she) needs" (p. 63).

Watson (1985) believes that a transpersonal caring relationship depends, for example, upon the nurse's ability to realize and accurately detect feelings and the inner condition of another. According to Watson this can occur, for example, through actions, words, behaviors, cognition, body language, feelings, thought, senses and intuition. She points out that in the teaching-learning process the nurse must learn what the patient's perceptions are before giving him or her cognitive information. She asserts that it helps the nurse to work within the patient's framework. Watson (1979) states, "the nurse seeks to understand the individual's internal reference point even though it can never be perfectly known" (p. 209).

Benner (1988) contends that nursing is the most intimate of the helping professions. She states, "expert caring requires that the "expert" not be set apart; rather, expert caring means one is approachable and available. The goal of expert caring is empowerment rather than domination and control." (p. 319). Benner further states, "in our culture, nurses are viewed as insiders. Patients expect nurses to be able to listen to and provide care for patients' intimate physical and personal concerns" (p. 319).
The coresearchers in the current study emphasized the importance of being able to share positive and negative feelings with the nurse. Watson (1979) emphasizes that therapeutic intervention and the development of a helping-trust relationship focus on a person's feelings. She asserts that "the acceptance and promotion of the expression of positive and negative feelings has been identified as a major carative factor and a part of nursing's core" (p. 46).

In a clinical study by Yalom (1975), successful patients in group therapy were asked to recall a single critical incident that seemed to be a turning point for them in therapy. The incident most often reported was a patient's sudden expression of strong negative feelings. In the same study, the critical incident reported almost as often as the former incident also involved strong emotions, but a positive one.

Watson (1979) asserts that the science of caring must allow for, promote, and accept the expression of positive and negative feelings in self and others. She claims that the nurse should allow others to express negative and positive feelings without feeling defensive and with understanding and support for the expression. She states, "the nurse should be supportive enough to permit such risk taking in self as well as in others" (1979, p. 47). Watson adds that reality testing can occur for both the nurse and the other person in relation to the appropriateness of the feelings for the situation or the inappropriateness of avoiding certain feelings. Watson concludes, "in turn the helping relationship will move to a deeper, more honest level that is necessary for the practice of the science of caring" (1979, p. 47).

In the current study it was indicated that if the task of professional intimacy was successfully completed, there developed a foundation for true
negotiation of care, the last phase in the development of professional attachment.

**Negotiation of care.** As a result of professional intimacy the nurse is better able to understand the patient and his world. This understanding enables the nurse to work with the patient as an equal toward their common goal, his well-being. The importance of negotiating care with the client is widely supported by literature.

Anderson (1985) has articulated the importance of negotiation of care in the nurse-patient relationship. She contends that both the nurse and the client must be learners as well as teachers. She states that although it would be naive to assume that each has equal power in the relationship it is not presumed that the nurse's scientific knowledge is more credible than the client's understanding of his or her situation. "What is to be taught to the client is not decided a priori but is constructed in response to the client's situation" (Anderson, 1985, p. 239).

Gadow (1985) points out that the movement toward greater patient autonomy in treatment decisions is one way in which the view of patients as objects has been countered. She asserts that disclosure of information to patients is central in most cases to their exercise of autonomy. She concludes that "assistance to patients in defining their situation and in constituting their personal truth is the approach of caring, an affirmation of the subjectivity of persons that distinguishes them from objects." (1985, p. 38).

Pellegrino (1985) points out that philosophers argue endlessly about what constitutes the distinguishing feature of being human. Without trying to settle that debate Pellegrino points out that "it would be hard to deny
that one observable feature unique to humans is the capacity to make choices, to set up a life plan, and to determine one's goals for a satisfactory life." (p. 22). He contends that the good that is proper to humans as humans is that which fulfills our potentialities as individuals of a rational nature, capable of choice. Pellegrino concludes, "to be treated as humans is to be accorded the dignity of choosing what we believe to be good and to be accountable for our wrong choices" (1985. p. 23).

Curtin and Flaherty (1982) point out the vulnerability of patients. They assert that the petitioner role of the patient creates an imbalance of power between the professional and the patient unless the professional structures a collaborative relationship. They point out that the professional who needs to exercise power and receives satisfaction from others' dependency will demonstrate more unjustifiable patronizing behavior to the patient than will the professional who is committed to an advocacy role with the client. Curtin stated, "tragic errors may occur unless patients are permitted, indeed assisted, to become full partners in the development, design, and implementation of their own care" (Curtin and Flaherty, 1982, p. 93).

The patient's right to self-determination is essential for Gadow's (1980) conceptualization of nursing as existential advocacy. This conceptualization is based on the belief that "freedom of self-determination is the most fundamental and valuable human right" (1980, p. 84). Gadow argues that nurses must assist patients in authentically exercising the freedom of self-determination, that is, in making decisions which express the full complexity of their values. She contends that the nurse is obligated to act in the patient's interest, but that she cannot define what the patient's 'best interest' is. Gadow argues that the nurse must assist patients to
determine their best interests and become clear about what they want to do. "Existential advocacy as the essence of nursing is the nurse's participation with the patient in determining the unique meaning which the experience of health, illness, suffering, or dying is to have for that individual." (1980, p. 81).

The data in the current study indicated that people, who are patients, do not wish only for a professional attachment, but for a professional distance as well.

**Keeping a Professional Distance.**

The coresearchers in the current study clearly articulated that from their point of view, the nurse-patient attachment belonged to a particular setting, or culture, and should be confined to that setting. Furthermore, the coresearchers did not only regard professional distance appropriate and desirable for themselves and the nurse, they also seemed to consider "the right amount" of professional distance an important part of professionalism. Professional distance is not dealt with in the four caring models reviewed earlier. However, the idea behind the concept is not new in the literature.

Gadow (1980b) points out that in friendship, mutuality is the accepted ideal, and departures from it, when one or the other person needs unusual attention, are understood to be temporary. She emphasizes that the basis of the professional relation, however, is the established disposition of one of the persons to attend to the other without receiving attention in return. Gadow argues that the value of mutuality in personal relations prevents the friend from maintaining a one-sided approach, except as a temporary departure from supporting the other as an ultimately indivisible unity of subject and object. She points out that the
professional, unlike the friend or the patient himself, is able to maintain for the patient the one perspective toward his experience which is the most difficult for him to develop, sustained objectivity.

Mayeroff (1971) asserts that to care for another person, we must be able to understand him and his world as if we were inside it. He emphasizes, however, that in being with the other, we do not lose ourselves. We retain our own identity and are aware of our own reactions to him and his world. He states, "seeing his world as it appears to him does not mean having his reactions to it, and thus I am able to help him in his world: something he is unable to do for himself" (p. 31).

Dunlop (1986) refers to her own nursing education and states that in a very atheoretical way, nursing sought to teach her to maintain both separation and linkage in her practice - "separation, 'you must remember that the other is a stranger', and linkage, 'you must think and act as if he were not." (p. 663). She concludes, "thus one achieves something like 'caring' in it's emergent sense as it is applied in the public world - a combination of closeness and distance, which always runs the risk of tipping either way" (Dunlop, 1986, p. 664)

Gadow (1980) argues that the issue of softening the distinction between personal and professional involvement requires a sound and new conceptual framework with the means for unifying and transcending the once contradictory relation between professional and personal. The conceptualization of professional caring - involving the nurse's professional caring approach and the resulting nurse-patient attachment with professional distance can be seen as such a framework, where the nurse is personal without being unprofessional -- develops a professional intimacy with professional distance.
To conclude, the current study, viewed in light of relevant literature, seems to indicate that professional distance is an essential component of professional caring. Conversely nurse-patient detachment with total distance is perceived as uncaring by clients. The final section in this chapter will compare patient responses to caring and uncaring encounters, and discuss the findings in light of literature.

**Patient Responses to Caring and Uncaring.**

It was found in the current study that patient responses to professional caring were very positive. The coresearchers reported that the caring nurses got to know them as persons and communicated with them in a way that made them feel accepted as normal human beings, and legitimized as persons and patients. The coresearchers claimed that this helped them to feel all right about themselves and their hospital stay. Professional caring gave them, they claimed, a sense of hope and optimism, encouragement and reassurance, as well as a sense of security and confidence. The coresearchers also reported positive effects on their sense of well-being and healing.

This is in accord with the study by Riemen (1986a). That study is the only one found in the literature that has explored this aspect of caring. Riemen concluded that patient consequences to the nurse's individualized concern for the client resulted in his feeling "comfortable, secure, at peace and relaxed" (1986a, p. 99). Conversely Riemen states that "the nurse's lack of concern for the client results in the client feeling frustrated, scared, depressed, angry, afraid, and upset" (1986a, p. 99). Riemen indicated a difference in female and male accounts of patient perceptions of caring. Such difference was not found in the current study.
Uncaring encounters with nurses were perceived to be very discouraging and distressing experiences by the coresearchers in the current study. They reported having had feelings of puzzlement and disbelief, to begin with, that developed into feelings of anger and resentment. Because of the patients' vulnerable circumstances, however, they are most often unable to act out their anger and resentment and these strong negative feelings seem to develop into feelings of despair and helplessness. Being uncared for in a dependent situation makes the patient feel very vulnerable and eventually leads to feelings of alienation and identity-loss. The patient feels he has no value as a person, that he is indeed less than a person.

The coresearchers in the current study reported their own perceptions of their vulnerability as patients and their sensitivity to caring and uncaring. Needing and expecting caring in their dependent situations seemed to amplify their responses, both to caring and uncaring.

Patient Vulnerability and Sensitivity to Caring and Uncaring.

It was the coresearchers' unanimous perception that they felt vulnerable, and sensitive to and in need of caring, when they were in the hospital. Patient vulnerability and sensitivity within today's hospital reality has been described by many theorists.

Watson (1979) asserts that the patient learns on entering a hospital to delegate as much responsibility as possible to the staff. She states, "for that reason the nurse must be especially aware of the depersonalized features of the hospital and she or he must provide the most supportive, protective, or corrective environment possible." (1979, p. 89). Watson furthermore states, "often the loss of one's identity and loss of
independence that are associated with hospitalization are compounded by the care given by a procedure oriented staff that has difficulty in achieving meaningful interpersonal relationships" (1979, p. 88).

Zaner (1985) states, "it is unquestionably essential for a physician or nurse to understand that illness or injury results in more or less damage to a person's autonomy, integrity, self-image, and relatedness to other people" (p. 83). He contends that a failure to understand this in the most practical ways could result in inappropriate medical or nursing conduct, which could be additionally damaging to the patient.

Zaner (1985) contends that to undergo hospitalization is a form of culture shock. He states, "it is to find oneself, in Alfred Schutz's idiom, a "stranger" however temporary it may be" (p.87). Zaner asserts that not only have hospitals been recognized as forbidding places sociologically but also architecturally, designed more to enhance than to ameliorate this foreignness. He contends that the people who populate hospitals - other patients and the staff- are strange. Moreover, Zaner points out that patients are stripped of familiar things (clothes and possessions) and made to put on nondescript gowns that permit ready access to their bodies; to disclose their intimate details of personal life to whoever takes their history; to expose their bodies in the most intimate and humiliating postures, for strangers to poke and prod, swab and stick, palpate and feel - in a continuous daily round. Zaner concludes that to be a patient requires remarkable patience, and that it is hardly surprising that many patients, even to themselves, seem out of place - beyond what their illnesses may have brought about.

Dossey (1982a) asserts that a patient-as-object approach to care delivery is destructive because it violates the oneness and wholeness that
are necessary for healthy, viable living systems. He suggests that the
caregiver-patient bond is real; that the flow of information between the
two is obligatory and bidirectional; and that the bond is ever functioning,
always being used to either the patient's health or harm.

Gadow (1980a) speaks of the patient's dichotomy between the body
as a private, lived reality and a public object open to inspection. She
explains that the object body is the body which the anatomist and
physiologist describe, an object fully accessible upon examination and fully
comprehensible by its examiner. It belongs, as do all objects, to the
dimensions of quantified space and time. It is an object with parts having
only functional value, not emotional, esthetic, or spiritual value. The lived
body, on the other hand, is not in objective space and time, it forms its own
space through its actions.

Gadow (1985) then describes caring as a relationship in which
patients are protected from being reduced to the moral status of objects.
She points out that in addition to the domination by apparatus and by
experts that can accompany the use of technology, patients can be reduced
to objects in a more fundamental way than by the use of machines: in the
view of the body as a machine. She states, "such reduction occurs because
regard for the body exclusively as a scientific object negates the validity of
subjective meanings of the person's experience. Those meanings are
categorically nonexistent in the scientific object" (1985, p. 36). This
constitutes a major threat within the technically oriented hospital reality of
today and will be further explored in the following subsection.
The Threat of Alienation and Identity-loss Within Today's Hospital Reality.

Many coresearchers in the current study alluded to the threat of alienation and dehumanization within today’s hospitals. This observation is supported by literature.

Benner (1988) has pointed out how alienating hospitals can be: how patients can lose their sense of connection to others, their sense of hope, the sense that they matter and that their recovery is important. She states, "patients are not persuaded to return by a world that is cold, impersonal, and technical... they are persuaded by care, and often that care must be expressed in ways that run counter to convention and hospital routine" (p. 319. She argues that this is why caring is often described in the language of making exceptions, of 'individualizing' care.

Twaddle (1979) points out that a number of people have written about the "dehumanization" of the patient (Ramsey, 1970; Malleson, 1973; Ribicoff, 1972). He suggests that the main reason people feel alienated is that they are objectively alienated. He states, "people will feel powerless when they have no power, normlessness when they are being manipulated, meaninglessness when events are unreasonable, isolation when they stand alone, and self-estrangement when what they do is disjointed from who they think they really are" (Twaddle, 1979, p. 163).

Twaddle (1979) asserts that to be identified as sick is to be alienated. He contends that this alienation has both objective and subjective dimensions that correspond to the distinctions made among disease, illness, and sickness (Twaddle & Hessler, 1977). Twaddle (1979) argues that in a special sense, disease is a form of objective alienation. He explains that the pathological process results in reduced capacities, thus depriving the individual of some degree of control over her/his own body. He indicates
that the individual thus becomes alienated from control over the most important resource of all.

Furthermore, Twaddle (1979) argues that illness, in the form of pain, weakness, and other altered feeling states, can also be treated as a form of alienation. He explains that feeling unwell, the individual loses command over physical capacities. Twaddle states, "to a degree, alienation of this type is existential. It is inherent in the process of living. The therapeutic response is one of reducing alienation." (1979, p. 172). Finally, Twaddle (1979) asserts that sickness, the social designation of people as being unhealthy and hence eligible for special treatment, is also a form of alienation. He points out that in one sense it is a recognition of the fact that the sick person is alienated by disease and/or illness. But in addition, and to the extent that the sick role is brought into play, the individual can be further alienated by removal from everyday activities and by participation in medical care.

From Twaddle's line of argument, the patient can be seen as one who needs help by virtue of being sick, but lacking both the technical skills and resources and the necessary objectivity to diagnose and prescribe, he is unable to provide that help for himself. The health professional, on the other hand, is an expert with the knowledge and resources to provide help as well as the emotional detachment necessary for good judgment. Hence, there is an irreducible competence gap that makes the patient dependent and passive in relation to an active and autonomous health professional, even when this dependence is not inherent in the disease process.

Twaddle (1979) points out that passivity of the patient is often further enforced by the disease process. Indeed, it is inherent in many diseases that the patient is physically altered so as to be unable to fend for
himself. For example, because of weakness, dizziness, limited muscular
capacity, loss of consciousness, or confusion.

To conclude, the patient's vulnerability and the threat of patient
alienation within today's technocratic hospitals seems to make the patient
more sensitive to caring and uncaring. Furthermore, it was the unanimous
perception of the coresearchers in the current study that caring and
uncaring affected their well-being and healing -- for better or worse.

Perceived Effects of Caring and Uncaring on Well-being and Healing.
The coresearchers unanimously emphasized that it was their
perception that caring influenced their well-being and healing. They
related that it influenced their recovery both as a presence of something
encouraging and positive, as well as an absence of something negative and
destructive. Some coresearchers actually referred to caring as medicine of
sorts. Conversely, it was the coresearchers perception that uncaring was a
transference of negative energy that delayed their recovery or even
prevented it.

The interrelationship of caring and curing has often been indicated in
the literature, both by former patients (e.g. Cannon, 1979; Pauley, 1985;
Zaner, 1985), and theorists (e.g. Dossey 1982a; Bishop and Scudder, 1985;
Benner, 1988). Hyde (1977) for example stated that nurses can be life-
giving by caring for others. She emphasized that caring - the human
contact, dialogue, really listening, spending time, and meeting - are all part
of healing. Dossey (1982a) asserts that nursing *is* nurse healing. He claims
that a new paradigm has risen, that nurse-patient interactions are powerful
events. He explains, "they set in motion a host of physiological responses in
patients which can be measured. Why? Because consciousness matters."
The nurse's presence or words or touch impact on the patient's consciousness, and thus on the patient's physiology." (p. 81).

Watson (1979) refers to Adler and Dreikurs, who, she claims, "considered encouragement the central mechanism in teloanalytic group counseling." She adds, "both men thought that success in group counseling depended largely on the counselor's ability to encourage and that failure was usually due to the inability to encourage" (p. 13). Watson states that, "faith-hope is so basic that it can affect the healing process and the outcome of illness" (1979, p. 14).

Benner (1988) asserts that in her study of expert practice she has repeatedly found the primacy and power of caring in making cure possible. She states, "nursing is more than mere technique. Central to effective nursing care is communicating that the nurse cares. This communication is necessarily contextual and relational. You cannot extract the action from the relationship" (p. 319).

Gadow (1980) points out that it is often maintained that optimal healing depends upon the interaction of patients and professional as whole human beings. She contends that this view is then translated into concern for the patient as a unique psychobiological whole that is self-responsible and self-healing.

Watson (1985) asserts that transpersonal human care occurs from person to person in an I-Thou relationship. She states, "It can release inner power and strength and help the person gain a sense of inner harmony within the mind, body, and soul; this contact and process in turn generates and potentiates the self-healing processes." (p. 58). Watson points out that the two individuals (the nurse and the other) in a caring transaction are both in a process of being and becoming. Both individuals bring with them
to the relationship a unique life history and phenomenal field, and both are influenced and affected by the nature of the transaction, which in turn becomes part of the life history of each person. Watson asserts that in this sense of a caring transaction, caring is a moral ideal, rather than an interpersonal technique and it entails a commitment to a particular end. The end is "the protection, enhancement, and preservation of the person's humanity, which helps to restore inner harmony and potential healing." (p. 58). Watson states, "when the natural self of the nurse and patient coparticipate in a caring transaction, it potentiates self-healing human integrity and there is greater harmony for both nurse and person" (1985, p. 66).

The perception of the coresearchers in the current study, of the interrelationship of caring and healing, seems to be consistent with views of other former patients, as well as nursing theorists. Caring and curing, therefore, do not seem to be a dichotomy but indeed closely interrelated phenomena.

In summary, the findings of the current study have been discussed in this chapter in light of literature. It is apparent that perceived nurse indifference to patients as persons, accompanied by limited verbal communication is perceived by patients to be uncaring and makes them distrustful of the nurse, which prevents any relationship formation. Conversely a professional caring approach accompanied by nurse acknowledgement of the patient as a person promotes in them a feeling of trust which facilitates the development of attachment between them. The presence or absence of relationship formation seems to be one of the major difference between caring and uncaring, from the patient's perspective.
It is apparent that uncaring experiences are discouraging and distressing experiences for hospitalized patients and are perceived to negatively affect their well-being and healing. Conversely, caring experiences are reported to be positive experiences for patients, perceived to positively affect their well-being and healing.

The final chapter of this thesis will summarize and conclude this report, as well as present implications for nursing practice, administration, education, and research.
CHAPTER 6: SUMMARY, CONCLUSIONS, AND IMPLICATIONS OF THE STUDY.

Summary and Conclusions of the Study.

This study has explored the essential structure of a caring and an uncaring encounter with a nurse -- from the client's perspective. Although 'care' and 'caring' have been used in the nursing literature for more than a century, it is only recently that nurses have undertaken systematic philosophic and scientific investigation into these constructs. Moreover, the limited research available on caring and uncaring has mainly been from the nurse's perspective. It is, however, primarily when caring and uncaring are studied from the client's perspective that progress can be made in providing clients with the quality of nursing care that can be identified and labelled by the public as caring.

The conceptual framework that guided the study was based on Kleinman's (1977, 1978; et al. 1978) conceptualization of the structural domains of the health care system. Kleinman proposes that within the cultural system of health care, three distinct but interacting domains of interpretation and experience are in operation. These are the professional, popular and folk sectors. According to Kleinman et al. (1978) each sector possesses its own explanatory systems, social roles, interaction settings and institutions. Kleinman (1978) asserts that the explanatory model concept illuminates how problems in clinical communication frequently represent conflicts in the way clinical reality is conceived in the three arenas of the health care system, and, therefore, points to the systematic entailment of these problems within that cultural system. Kleinman's model provides an excellent framework for studying clients' perceptions of caring and uncaring encounters with nurses, since research studies have shown that
there is a discrepancy between nurses' and clients' perceptions of caring and uncaring. There is reason to believe that this discrepancy is due to a difference in explanatory models nurses and clients have.

Kleinman's conceptual framework directed the researcher to design a phenomenological study which explored clients' perceptions of caring and uncaring encounters with nurses, in order to gain a better understanding of explanatory models associated with these experiences. Studying the client's perspective provides nurses and other health professionals with valuable insight, because it gives them an inside view of what it is like to experience caring and uncaring. The research problem addressed in this study developed from the previously stated concerns regarding nurses' ability to appropriately meet the needs of patients in hospitals in a way that they feel cared for.

Literature was reviewed in order to provide a background for the study. It revealed that the concept of caring has a very special place in nursing discourse and yet little is known about how clients of nursing view the notion of caring and less still how clients experience uncaring and what caring/uncaring means to them. Four major models for examining the phenomenon of caring exist: those of Bevis, Watson, Gaut and Leininger. Although these models provide an arena for a dialogue about caring, none define caring at the behavioral level. Review of literature revealed that research studies on caring are relatively few but are increasing in number every year. These studies indicate that there is a discrepancy between nurses' and clients' perceptions of caring, and that discrepancies between expectations held by health professionals and clients have resulted in dissatisfaction with care. Further research in this area if therefore needed
to fully illuminate the client's perspective of what constitutes a caring and an uncaring encounter with a nurse.

The phenomenological perspective of qualitative research theory guided the methodological approach to the study. The phenomenological research approach directed the researcher to use theoretical sampling, intensive unstructured interviews, and constant comparative analysis. Five women and four men participated in the study, and their ages ranged from 33 to 59 at the time of the study. Data were collected through 18 in-depth, open-ended interviews that were tape-recorded and transcribed verbatim for each participant. The researcher saw the participants in the study as coresearchers and through inter-subjective interaction or true dialogue the essential description of a caring and an uncaring encounter was constructed.

The essential structure of a caring encounter with a nurse -- from the patient's perspective is composed of three basic components: the nurse's professional caring approach; the relationship that develops between the nurse and the patient, which is one of attachment with professional distance; and finally patient responses to the caring encounter, which essentially can be described as encouragement and well-being. The nurse's professional caring approach is a prerequisite for nurse-patient attachment, and together they form the essential structure of professional caring.

From the coresearchers' perspective, the caring nurse is skillful, knowledgeable, and committed to the provision of personalized care, and knows how to safeguard the personal integrity and dignity of each person under her care. The nurse's professional caring approach essentially includes compassionate competence, genuine concern for the patient,
undivided attention when the nurse is with the patient, and an element of cheerfulness. These essential elements are perceived by the coresearchers as evidence of caring. The coresearchers reported that this caring approach by the nurse promoted in them a feeling of trust, which facilitated the development of a professional attachment between them and the caring nurses.

Developing professional attachment is an important aspect of professional caring. It can be conceptualized as a process involving five phases. Initiating attachment is the first phase and requires some reaching out and responding by both nurse and patient. For professional attachment to develop further, mutual acknowledgment of personhood has to occur. This constitutes the second phase, which is crucial to developing professional attachment. It means that the nurse must, in some way, indicate to the patient that she is a person, while at the same time recognizing the patient as a person. Mutual acknowledgment of personhood occurs through some reciprocal self-disclosure, limited, but sufficient to remove the masks of anonymity, remove the stereotypes of patient and nurse, and put people in the picture instead.

Acknowledgment of attachment constitutes the third phase. The patient realizes that attachment has developed, which generates in him a sense of trust. He becomes willing to open up, and feels free to reveal to the nurse some details about his present condition, and how he feels about it. This moves the professional attachment to a deeper level, to the fourth phase of professional attachment development, professional intimacy, or intimacy about the patient’s present condition.

The last phase in the development of professional attachment consists of negotiation of care. As a result of the attachment that has
developed, the nurse is better able to understand the patient and his world. This understanding enables the nurse to appreciate the patient's perspective, which is a prerequisite for truly negotiating care. The nurse works with the patient as an equal toward their common goal, his well-being.

Although the professionally caring nurse is both with the patient and for him, she maintains her separateness throughout the attachment development. This separateness is what constitutes professional distance, a dimension of professional attachment which has to be present to keep caring in the professional domain. It is evident from the data, that keeping a professional distance is an essential aspect of professional caring. People, who are patients, not only wish for a professional attachment, but also for a professional distance as well. The coresearchers clearly articulated that from their point of view, the nurse-patient attachment belonged to a particular setting, or culture, and should be confined to that setting. Furthermore, they emphasized that keeping a professional distance was one important way of keeping the nurse-patient attachment within the professional domain.

It is apparent from the data, that patients' responses to professional caring are very positive. The professional nurse gets to know the patient as a unique individual and treats him accordingly. She communicates to the patient in a way that makes him feel accepted as a normal human being, and legitimized as a person and as a patient. This helps the patient to feel all right about himself and his hospital stay. Professional caring also seems to give the patient a sense of hope and optimism, encouragement and reassurance. To feel cared for also seems to give him a sense of security. All this decreases the patient’s anxiety, increases his
confidence, and positively affects his sense of well-being and healing. It is
evident from the coresearchers' accounts that they were, and still are, very
grateful for their caring encounter, it is a pleasant memory they carry
away from their hospital stay.

The essential structure of an uncaring encounter with a nurse from the
client's perspective is comprised of three basic components: the nurse's
approach to the patient, which is perceived by the patients as indifference to
him as a person; the resulting impersonal nurse-patient detachment with
total distance between the nurse and the patient; and finally the patient
responses to uncaring, which include his conceptions of the meaning of
uncaring and the long-term negative memories of uncaring experiences.

It is apparent from the data that perceived nurse indifference to the
patient as a person is defined as uncaring by the coresearchers. Four
dimensions of an uncaring nurse approach were identified in the data,
characterized by increased indifference, inattentiveness, and insensitivity to
the patient and his needs: apathetic inattention, unconcerned insensitivity,
unkind coldness, and harsh inhumanity.

Perceived nurse indifference to the patient as a person makes the
patient distrustful of the nurse. The patient often perceives the nurse as an
authoritarian person with a need to control. The patient's encounter with the
nurse is characterized by a lack of professional attachment, limited verbal
communication, negative nonverbal communication by the nurse, and a lack
of collaboration and negotiation of care. This is referred to as nurse-patient
detachment with total distance.

It was the coresearchers' unanimous perception that uncaring
encounters with nurses were very discouraging and distressing experiences
for them as patients. They reported having had feelings of puzzlement and
disbelief, to begin with, that developed into feelings of anger and resentment. Because of the patients' vulnerable circumstances, however, they are most often unable to act out their anger and resentment and these strong negative feelings seem to develop into feelings of despair and helplessness. Being uncared for in a dependent situation makes the patient feel very vulnerable and eventually leads to feelings of alienation and identity-loss. The patient feels he has no value as a person, that he is indeed less than a person. The coresearchers also reported negative effects on their well-being and sense of healing. The coresearchers in the current study reported their own perceptions of their vulnerability as patients and their sensitivity to caring and uncaring. Needing and expecting caring in their dependent situations seemed to amplify their responses, both to caring and uncaring.

The findings of the study were discussed in light of literature. It is apparent that perceived nurse indifference to patients as persons, accompanied by limited verbal communication is perceived by patients to be uncaring and makes them distrustful of the nurse, which prevents any relationship formation. Conversely a professional caring approach accompanied by nurse acknowledgement of the patient as a person promotes in them a feeling of trust which facilitates the development of attachment between them. The presence or absence of relationship formation seems to be one of the major difference between caring and uncaring, from the patient's perspective.

**Implications of the Study.**

The purpose of this phenomenological study was to explore the essential structure of caring and uncaring encounters, as perceived by
recipients of nursing care in their interactions with nurses, with the aim of adding to the knowledge and understanding of these phenomena. The findings of the study suggest several implications for nursing practice, administration, education and research. These will be explored in the following subsections.

**Implications for Nursing Practice.**

The importance of caring in nursing practice has been emphasized in nursing literature. Kleinman's explanatory model, as well as some nursing studies, have indicated, however, that nurses cannot assume that their intended caring is always perceived by patients as caring. Therefore, if nursing is to become established as a caring profession, and nurses known as professionals providing professional caring as their unique service to society, they must become knowledgeable about caring and uncaring from the client's point of view. The current study explored that view, and therefore, offers some implications for nursing practice.

According to the coresearchers of the study professional caring is comprised of a caring nurse approach and a caring nurse-patient relationship. The findings indicate that a nurse has to be perceived as caring if a nurse-patient relationship is to develop. This implies that nurses must be sensitive to how their approach is perceived by patients and, furthermore, they have to consciously work at establishing a nurse-patient relationship.

A professional caring nurse approach was, according to the coresearchers, when they perceived the nurse as being competent, administering her care with genuine concern for the patient as a person, giving him full attention when with him, and constituting a cheerful
presence for the patient. This implies that patients wish for a person-centered nurse approach, and yet want nursing tasks to be done competently. They wish to have the nurse’s full attention when she is with them and appreciate it if the nurse provides them with an uplifting cheerful presence.

Developing professional attachment was conceptualized in the study as a process involving five phases: initiating attachment; mutual acknowledgement of personhood; acknowledgement of attachment; professional intimacy; and negotiation of care. Besides having implications regarding the importance of establishing a professional attachment with the patient, the study thus offers some guidance regarding the process of developing such an attachment. Further research is needed, however, to fully illuminate the phases in the nurse-patient relationship.

The coresearchers in the current study clearly articulated that throughout the attachment development the professional nurse kept a distance -- an important dimension, which seems to have to be present in order to keep the nurse-patient relationship within the professional domain. The combination of professional attachment and distance is referred to in the study as nurse-patient attachment with professional distance. The coresearchers seemed not only to wish for professional attachment but for a professional distance as well. This has to be studied, however, on a larger scale before any generalizations about patients can be made.

The findings that indifference to the patient as a person was perceived by the coresearchers as uncaring supports the findings on caring. The reports that lack of verbal communication alone can be perceived by
The patient as uncaring emphasizes the importance of positive verbal and nonverbal communication in nurses' interactions with patients.

The positive outcomes of professional caring, reported by the coresearchers, are encouraging. Professional caring can indeed make a difference. The proposition that professional caring be nursing's unique service to society is supported by these positive patient responses. Maas (1976) has pointed out that professions are created by society to meet certain societal needs that require specialized knowledge and skills. The coresearchers clearly articulated their need for professional caring when in hospital and the positive outcomes of such a caring further supports its significance.

The negative patient outcomes of uncaring should be thought-provoking for nurses. The negative feelings reported by the coresearchers and the perceived negative effects on their well-being and healing are alarming findings, which suggest that professional caring needs to be dealt with more effectively in quality assurance.

In a recent study by Eriksen (1987) the relationship between quality of nursing care and patient satisfaction was examined. Eriksen concludes in her study that staff nurses should be aware that patient reports of satisfaction or dissatisfaction may not be equated with the quality of nursing care they provide. She states, "staff nurses need to be aware that they may receive reports of patient dissatisfaction when they provide high quality physical care" (1987, p. 35). The coresearchers' reports on uncaring, in the current study, indeed emphasize that physical care administered without professional caring is perceived by the patient as uncaring. Adhering to procedure and policy without individualizing care to the needs of each patient may result in dissatisfaction with care. So, who is
to decide what is best for the patient, the nursing care consumer, or the provider?

Gadow (1980a) has pointed out that turning points occur in the history of a profession when radical questioning and clarification of major tenets become essential for further growth. She argues that such a turning point can be recognized now in nursing. She contends that the direction in which nursing develops will determine whether the profession draws closer to the medical model, with its commitment to science, technology, and cure; reverts to historical nursing models, with their essentially intuitive approaches; or creates a new philosophy that sets contemporary nursing distinctively apart from both traditional nursing and modern medicine. It is argued, in light of the current study, that professional caring could be the basis of such a philosophy, and that nurses indeed have to take a stand to enhance and defend nursing's image and ideals as a caring profession.

Implications for Nursing Administration.

The findings of the current study have important implications for nursing administration. The nursing administrator's role in creating or enhancing a caring climate in hospitals has been repeatedly reported in nursing literature (Haspedis, 1969; McClure et al., 1983; Brenner et al., 1986; Mallison, 1988). The current study is valuable in that it provides the nursing administrator with the consumer’s perspective of caring and uncaring. Increased emphasis on consumer rights encompassed in the human rights movement increases the administrator's need to know what the consumer needs and wants. Furthermore, if professional caring is a part of the hospitals philosophy, it is important for the administrator to know what professional caring means to the consumer. The findings of the
current study offer some knowledge and understanding about that. Finally, if professional caring is nursing's unique contribution to society, nurses have to influence the internal structures of health care agencies in order to have professional caring accommodated.

Ray (1981) points out that there has been a proliferation of the "curing syndrome" and an adoption of the cure techniques, often without regard to costs. She asserts that in order to satisfy the increasingly technological and bureaucratic demands of the system, human care at the individual and group level has received less and less emphasis in the system and that it is therefore becoming increasingly difficult for nursing to sustain its caring ideology in practice.

Watson (1985) also voices the same concerns and argues that institutions and community health systems alike are organized and administered in a manner that is incongruent with professional human caring. She states, "because of the one-sided perspective of the traditional health care (illness-cure) system, caring values of nurses and nursing have become submerged" (p. 28-29). Watson (1985) furthermore points out that the concept of a human care function of the nurse is threatened by "the technology, the machines, the high-intensity pace of management, the administrative tasks, and the manipulation of people required to meet the needs of the systems." (Watson, 1985, p. 29).

Similarly, Miller (1987) points out that nursing administrators face daily exposure to aspects of health care delivery systems that are non-humanistic in nature. She contends that organizational functions that focus on high technology, cost efficiency, computerized information systems, and other business methods potentially diminish the importance of caring as a central concept in managing professional nurses who care for patients.
According to Miller (1987) subversion of the humanistic perspective in nursing administration practice may be delineated as a series of professional and organizational pressures. These include: pressure from health administrators to adopt a total business ethic and orientation to delivery of health care; pressure from physicians to place the major focus of nursing care on technological aspects of health care delivery; pressure from ancillary health care professionals to limit the role of nurses in the primary care of patients; pressure from the organization to decrease the processual aspects of nursing leadership and management to "speed up" decision making and strategic planning; and pressure from regulatory and third-party payor agencies to emphasize the efficiency of nursing care to the possible exclusion of care effectiveness.

Miller (1987) contends that this "bureaucratization" of the nursing profession challenges historical nursing values rooted in human caring and emphasizes that it is crucial that nurses in administrative roles support the caring values of nurses in practice. Miller states, "an intellectual accommodation must be made between the pressures to conform to the traditional business philosophy of administration and the humanistic philosophy inherent in professional nursing" (1987, p. 12). She concludes, "the human care component of nursing is too central to our practice to be lost now - just as we are beginning to understand its importance in our professional identity." (1987, p. 12). It is argued that in order to do all this successfully the consumer's perspective must be more fully illuminated. The current study offers insights into that perspective.
Implications for Nursing Education.

Leininger (1979) asserts that the socialization process of preparing competent, sensitive, and humanistic professional nurses as care providers is a major challenge for the nursing profession. Similarly, Watson (1985) asserts that in order for nursing to be truly responsive to the needs of society and make contributions that are consistent with its roots and early origins, both nursing education and the health care delivery system must be based on human values and concern for the welfare of others. She asserts that caring outcomes in practice, research, and theory depend on the teaching of a caring ideology.

Kleinman's explanatory model implies that teaching a caring ideology necessitates introducing the client's perspective. Thus, it is important to teach nursing students what it is like to receive caring and uncaring, and what is perceived by the client as caring and uncaring. The current study provides some insight into that.

The importance of offering nursing students opportunities to enhance their caring has been suggested in nursing literature (Astill-McNish, 1984; Stein, 1986). Nursing education literature has, however, dealt minimally with the problem of enhancing caring. This is understandable since knowledge about professional caring has been limited. The current study adds somewhat to the present knowledge and understanding of caring and uncaring phenomena and thus has implications for nursing education.

Implications for Nursing Research.

This study has provided further knowledge about the patient's perspective of caring and uncaring encounters with nurses. In view of the findings, several areas for further study are suggested:
1. Do a phenomenological study exploring nurses' perceptions of the essential structure of a caring and an uncaring encounter, to find out in what ways their perceptions differ from patients.

2. Study patients' perceptions of uncaring and caring, concentrating on a different age group e.g. the elderly.

3. Concentrate on patients from particular settings e.g. intensive care, extended care, psychiatry, and compare different settings to see if there are any differences.

4. Study uncaring alone and in more depth, e.g. looking at the consequences of uncaring in more depth.

5. Study patients' perceptions of caring and healing and concentrate on their explanatory models regarding how healing occurs e.g. in a particular setting or looking at a particular disease.

6. Look at a particular phase of the nurse-patient relationship e.g. initiation of attachment, or negotiation of care, and study patient responses concerning each phase.

7. Study particular aspects of a caring nurse approach e.g. sober cheerfulness and see how generalizable the coresearchers' perceptions are.

8. Study the particular relationship between degree of nurse indifference to the patient as a person and patient outcomes.

9. Study patient responses to uncaring in more depth and study the prevalence of uncaring in a large-scale quantitative study.

10. Study patient perception of healing in more depth.

11. In an effort to further clarify patients' experiences of caring and uncaring nurses, a replication of this study might be conducted, using a different sample.
12. The current study provided data on how former patients retrospectively perceived caring and uncaring encounters with nurses. A study conducted during the hospital experience would add to the body of knowledge about patients' experiences of caring and uncaring encounters with nurses during hospitalization.

Watson (1985) asserts that nursing has an important humanistic and scientific contribution to make in the field of human sciences and health sciences in pursuing human care as a serious epistemic endeavor. This view is supported by the current researcher and it is hoped that the following prediction by Leininger will come true: "As our knowledge of caring becomes tested and refined, I predict we shall see a marked, more explicit advancement and improvement in the teaching and practice of therapeutic nursing care" (1979, p. xiv).
Bibliography.


Appendices:
Appendix B

Information and Consent

My name is Sigridur Halldorsdottir and I am a registered nurse working toward a master's degree in nursing at the School of Nursing, UBC. I, like many other nurses, believe that caring is the essence of nursing and that nursing is truly a caring profession. I am committed to the improvement of patient care and I believe that increasing caring and decreasing uncaring is one of the best ways of doing that.

People who have experienced caring and uncaring encounters with nurses are the only people who can really tell nurses what it feels like to experience caring and uncaring encounters with nurses. It is important for the nursing profession to get such information straight from former patients in order to increase the quality of nursing care for future patients.

I would be glad to answer any question about the study and if you wish to participate in my study, I WOULD LIKE TO EMPHASIZE THAT YOU CAN REFUSE TO ANSWER ANY QUESTION, THAT YOU CAN STOP AN INTERVIEW AT ANY TIME, AND THAT YOU CAN WITHDRAW FROM THE STUDY AT ANY TIME. I would also like to emphasize that your participation or non-participation will in no way influence your future medical or nursing care. Confidentiality of results will be maintained by coding participants' names with subject identity known only to me. Participants will never be identified with their responses and participants' identity will never be revealed.
I hereby give my consent to participate in the study as described. I acknowledge that the study has been adequately explained to me and that I have a copy of this information and consent form.

Signed _________________________________

Witness _________________________________

Date _________________________________
Sample Interview Questions

A. Caring

1. Could you describe as fully as possible your personal experience of a caring nurse? (Describe what the nurse did and try to analyze why you felt she/he was caring).

2. Could you describe how you felt during the interaction with the nurse?

3. How do you view (think about, feel about) your experience now?

4. How did you view yourself and the nurse during your experience and afterwards?

B. Uncaring

1. Could you describe as fully as possible your personal experience of an uncaring nurse? (Describe what the nurse did and try to analyze why you felt she/he was uncaring).

2. Could you describe how you felt during the interaction with the nurse?

3. How do you view (think about, feel about) your experience now?

4. How did you view yourself and the nurse during your experience and afterwards?

5. What was helpful for you during the experience of uncaring? What could have been helpful?