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Perceptions of Care and Caring:
An Orthopaedic Perspective

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By

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May 2013
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ABSTRACT

“Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn life around,” (Leo F Buscaglia 1924-1998).

Caring is a universal phenomenon (Leininger, 1988a, 1991) that influences the way we think, feel and act and is the focus of debate worldwide. Studied since the days of Florence Nightingale and reflected in the literature are numerous theoretical opinions in the search for a comprehensive understanding of caring in the health experience of human beings (Newman et al., 1991).

This ethnographic thesis has a caring science perspective (caring in orthopaedics) with the aim of acquiring a greater understanding of perceptions of caring in an orthopaedic clinical setting from both patient and health care professional perspectives. There is a wealth of literature relating to caring which attempts to define and interpret its meaning from several theoretical perspectives. In respect of institutional or professional caring, nursing has historically been synonymous with the notion of care and caring, modest research has been attributed to caring amongst other health care professionals in the wider context.

The study used a sequential exploratory mixed methods design and was underpinned by Watson’s Theory of Transpersonal Care in order to discover and illuminate the essential caring behaviours valued by both care givers and care recipients.

A total of 30 patients and 53 health care professionals consisting of doctors, nurses, physiotherapists and occupational therapists participated in the study through a three stage approach consisting of questionnaires, observation and semi-structured interviews.

The findings revealed both similarities and differences between patients and health care professionals relating to the importance of positive caring behaviours revealed during caring interactions. The questionnaires disclosed that patients statistically rated caring behaviours demonstrated by health care professionals lower than the professionals rated themselves. The data analysis from the participant observation and semi-structured
interviews established that although all of the caring caratives according to Watson’s Theory of Care were evident in caring interactions they varied as to the number of times they were exhibited by the respected health care professional groups. Overall patient perception of caring focused upon behaviours related to the caring carative ‘assurance of human presence’ whilst health care professionals considered caring behaviours relating to the caring carative ‘respectful deference’ as the most important.

This thesis highlights the need of the patient to feel ‘cared for’ and ‘cared about’ and in today’s modern health care system caring should not be monopolised by one profession but instead the caring concept embraced and the caring dais shared by other professions.
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CHAPTER ONE
Perceptions of care and caring in an orthopaedic setting:

1.1. Introduction

This thesis explores perceptions of caring and caring behaviours experienced by patients and health care professionals in an orthopaedic clinical setting within an NHS Foundation Trust Hospital in the United Kingdom. It seeks to understand how caring is perceived and interpreted by those involved in caring interactions. The intention of this work is to contribute and expand the knowledge of caring in the field of orthopaedics by investigating what caring means to patients and health care professionals exposing the caring behaviours that are desired and valued during caring interactions. It will be argued that what patients seek from any caring interaction is a need to feel cared for and cared about regardless of the health care professional involved.

The roots of nursing are embedded in the act of caring, caring and nursing are said to be intertwined and history has seen the two synthesized into a single conception, being defined as an ethical or moral principle, as a duty, obligation, dependency or expression within a personal context, (Barnum, 1998; Benner and Wrubel, 1989; Blustein, 1992; Bowden, 1997; Brody, 1988; Brown et al., 1992; Cronin & Harrison, 1988; Duffy, 1992; Fry, 1989; Hopkins et al., 1996; Kuhse, 1993; Mullins, 1996; Stockdale and Warelow, 2000; Watson, 2008, 1990, 1988, Wolf et al., 1994). In the modern health care system, caring ought to be a holistic experience. Holistic care addresses client physical, psychological-spiritual needs and health related factors (Leathard and Cook, 2009; Tjale and Bruce, 2007). It should be embraced, cherished and valued by other health care professions as it has been by the nursing profession.

A significant literature exists on care and caring, with just about every theory covered, Caring as a phenomenon has been studied for many years and from several different perspectives, theoretically (Leininger, 1988; Swanson, 1991; Watson, 1985), ethically (Cooper, 1991; Parker, 1990), philosophically (Gaut, 1988; Mayerhoff, 1990; Ray, 1984) ethnographically (Leininger, 1988) and in various clinical settings (Beck, 1995; Benner, 2000; Ekstrom, 1995; Mullins, 1996; Wolf et al., 1994).
Although caring is, by and large, a part of countless animal behaviour repertoires, as seen in the rearing of offspring in many species, it is the nature of human being that it becomes the central measure of a civilised society. Caring is a human characteristic consisting of many different qualities, all individuals have the ability to care although not all care given is necessarily the same. We can say this about caring because its use in everyday language is varied and as such the term can and often is applied in its broadest sense. We might say that we care for our homes, our country or for a certain object implying attitudes of interest or attention. By comparison the term can be used in a negative sense to indicate distaste for something, for example that we do not care for an object or person. The fact that caring for and caring about something or someone has its origins in the same meaning, suggests a desire to enter into a relationship with the intention of achieving a moral interaction within the world. Furthermore, the human species has extended the notion of care from an innate behaviour of caring for loved ones and those closest to us, to an act that is done on the stranger who is in need (Mayerhoff, 1990; Noddings, 2002). Thus, the act of caring is a powerful personal quality, a socially acceptable virtue and an inherent measure of goodness in society (Heidegger, 1978; Held, 2005; Levinas, 1999). The scope of this study is restricted to care for human beings and in particular perceptions of caring between providers of care and health care users.

Care has been described as existing beyond the realms of physical expression, merging into the dimensions of spiritualism, religious belief and has even been described as the connection of souls (Watson, 1988). Heidegger (1978) remarked that fundamental to human existence is the ability to care concluding that caring is human nature. Thus if we lost the ability to care, we may cease to exist. It is said that the need for care is not defined by race, gender, age, social standing or religion, it is a universal human necessity affected by the individuals physical and psychological requirements (Boykin and Schoenhofer, 2000).

Comparing and analysing perceptions of care and caring from a patient and health care professional perspective is a major issue within the modern health care system in the United Kingdom (UK) today. The significance of analysis and subsequent understanding of these concepts can help design and determine strategies and pathways for caring and
ensure provision of quality multi-professional care. In the rapidly changing health care scene of the twenty first century there are two constants: firstly the patient and secondly the need for care. The need for support and care arises out of an expectation borne from a desire to be looked after and cared for when sick or injured (Boykin and Schoenhofer, 2000; Levinas, 1999; Noddings, 2002). The economic and political reality of the UK modern health care system means that health care professionals are faced with current reductionist strategies such as clinical pathways, Enhanced Recovery Programmes and Quality Improvement Programmes (NHS Institute for Innovation and Improvement, 2010) designed to reduce length of stay, improve patient outcomes, speed up recovery and reduce cost; bringing health care delivery in line with national austerity measures. This new approach to health care provision is not without its critics and there are some who believe that the increasing scope and sophistication of modern health care may be putting a strain on care in the National Health Service, declaring that modern health care systems and initiatives are at odds with care and compassion (Petit-Zeman, 2006; Youngson, 2008).

Youngson (2007, p.37) discussed the need for a paradigm shift away from the ‘machine thinking’ which is shaping the culture of health care in a modern society, to one that gives credence to the complexity of human dynamics and subsequent human processes involved. His call is for a health care culture dedicated to the creation of services fit for purpose delivered within healing environments.

1.2. Scope of study

The focus for the setting of this study is within the clinical realms of the specialty of orthopaedics and orthopaedic trauma. Orthopaedics is a specialist art and science of caring, its uniqueness lies in its objective to restore mobility and prevent functional disability and decline (Davis, 1997). Orthopaedic disease and injury can affect patients socially, functionally and psychologically. Due to the diverse nature of orthopaedic conditions there is a need to view patients as holistic entities taking into consideration their beliefs and expectations of care and caring (Clarke, 2003; Footner, 1998; Jackson, 2003; Tierney, 2004). As Feinstein (2002, p.502) asserts, caring is more than ‘managing
disease’, performing clinical duties, prescribing treatment and performing clinical procedures is not the same as caring.

Within the field of orthopaedics Enhanced Recovery Programmes are currently the focus of debate with rapid implementation encouraged at the highest levels (Wainwright and Middleton, 2010). Given these rapid care delivery programmes there is a need to understand whether it is possible for health care professionals to meet patients expectations of caring when they have only a short space of time in which to get to know their patients, form meaningful caring relationships and demonstrate the caring behaviours patients expect.

The theoretical underpinning of this study utilises Watson’s (1979) caring theory to focus upon the interpretation of perceptions of caring as viewed by patients and health care professionals. Although originally developed as a guide for nursing, Watson’s theory can be applied to other health care professional/patient interactions, such as those between patient and physiotherapist, to gain an understanding of what constitutes caring behaviours and importantly the caring relationship (Fitzpatrick and Whall, 2005). This relationship is referred to as the ‘Transpersonal Caring Relationship’ advocating that it characterises a unique type of human care relationship dependent upon a commitment to protect and enhance human dignity: a caring consciousness which is communicated in order to preserve and honour the embodied spirit and as such reducing the individual to the moral status of an object is prevented (Cara, 1999, p.4).

The caring consciousness of the health care professional is essential in order to connect with and understand the patient’s perspective. Ultimately the one cared for and the one caring both unite in search for meaning and wholeness and even the spiritual transcendence of suffering (Watson, 2001). The aim therefore of this relationship is to enhance, protect and preserve patient dignity, humanity, wholeness and inner harmony. Perception is individual and subjective varying in relation to personal needs, expectations and priorities and it is for the patient to define what care means for them (Janssen and MacLeod, 2010).
1.3. Overview of Chapters

In Chapter Two a literature review was undertaken in an attempt to understand the meaning of caring. Given the many and varied opinions of caring in the nursing and wider literature a concession was made that there could be no single definition of caring applicable to all situations. The literature revealed different perspectives on caring and for ease of discussion have been categorised under the headings of humanism, ontology, relational, ethics and feminism so as to offer the reader a structured approach to understanding the overall concept of caring.

Following this the notion of institutional/professional caring is discussed and the works of theorists such as Leininger (1988), Kitson (1987), Morrison (1992) and Bradshaw (1996) are considered. Caring as a professional trait is seen as a commitment by the carer to ensure a sustained and seamless service in which knowledge and expertise are used to meet the needs of and uphold the integrity of the care recipient. Credence is given to the influences of social history on caring, examining the emergence of caring professions from the 16th century to present date. This was important in helping to understand how caring has shaped and evolved the health care professions evident in the modern health care system. Finally in order to address the specialty focus of this study, perceptions of care in orthopaedics are considered, concentrating on the uniqueness of this specialist art and caring science to understand its importance and commitment of the orthopaedic multi-professional team to a shared purpose of caring.

Chapter Three, Caring Instruments, discusses the measurement of caring, which has predominantly received attention from the nursing profession, although in recent years has been recognised by other health care professionals such as doctors and physiotherapists as a means of improving patient experience and health care services (Quirk et al., 2006; Wright St Clair, 2001). There has been considerable debate in recent years as to how caring can and should be measured, with both quantitative and qualitative instruments featuring in the deliberation. Both methods are discussed and relevant caring instruments are reviewed, this eventually unearthed four instruments that corresponded to the remit of the study. Each instrument is described and evaluated in terms of suitability, validity and reliability and the Caring Behaviours Inventory (CBI) which is grounded in
Watson’s (1979) caring theory was deemed to be the instrument of choice as it conceptualizes care as an interpersonal intervention. Dr Jean Watson, a professor of nursing in the United States of America, is the founder of the Caring Science Institute. She has gained international recognition for published works on the philosophy and theory of human caring and the art and science of caring in nursing. Watson’s Theory of Transpersonal Caring also known as the Theory of Human Caring or The Caring Model originates from Watson’s quest to convey new meaning and dignity to the world of nursing and patient care. More importantly it seeks to offer an ethical-philosophical foundation for what Watson terms “the deeply human dimensions of nursing” (Watson, 1979, p. 50). Watson’s theory focuses on “the centrality of human caring and on the caring-to-caring transpersonal relationship and its healing potential for both the one who is caring and the one who is being cared for” (Watson, 1996, p.141). The theory centres upon three major concepts which are the use of clinical caritas processes and the cultivation of a transpersonal caring relationship within the context of a caring moment (occasion) and caring (healing) consciousness (Watson, 1996). The term ‘carative’ is used in place of ‘curative’ by Watson to make a distinction between nursing and medicine. “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” (Watson, 1985, p.7).

The Caring Behaviours Inventory (CBI) tool is used to measure health care professional and patient perceptions of caring attitudes and actions. The CBI is an instrument designed to assess perceptions in five preordained caring carative categories. The first carative category, respectful deference to others, includes such caring behaviours as being honest with the patient, showing respect and giving patient information in order to assist with decision making (Brunton and Beaman, 2000). The second carative category, assurance of human presence, includes caring behaviours such as helping the patient, talking with the patient, appreciating the patient as a human being and responding to the patient’s call in a timely manner (Brunton and Beaman, 2000). The third carative category, positive connectedness, includes behaviours such as being hopeful for the patient, allowing the patient to express feelings and trusting the patient (Brunton and Beaman, 2000). The fourth carative category, professional knowledge and skill, includes behaviours such as
watching over the patient, provision of education, being confident with the patient and paying special attention to the patient on their first visit (Brunton and Beaman, 2000). The fifth and final carative category, attentiveness to the other’s experience includes such behaviours as provision of good physical care, putting the patient first and relieving the patient’s symptoms (Brunton and Beaman, 2000).

In Chapter Four, Research Methodology, the various stages of this study are presented together with the rationale for the analysis chosen. As a starting point I wanted to determine which caring behaviours were important to patients and the multi-professional orthopaedic team, this formed Stage One and the findings of this stage are reported in Chapter Five which presents a comprehensive interpretation of the top ten caring behaviours as perceived by the different health care professional groups and patients. The overall findings from this stage determined that there were general similarities and differences in the different groups examined. I found that in relation to the results of the CBI questionnaire the patient group differed from the health care professional group demographically in relation to age and educational status. Both groups were predominantly from the same ethnic background, White British. There were more female to male respondents in both groups with the principal marital status in both respondent groups being married. I undertook analysis of the questionnaires employing the statistical software package SPSS version 17.0. Using the nonparametric Mann-Whitney U test analysis of variables allowed me to compare the total CBI scores of caring behaviours between the two groups whereas the nonparametric Kruskal-Wallis test one-way analysis of variance by ranks tested equality of population medians amongst the groups to investigate whether demographic variables were predictors in perception of caring behaviours.

The results of Stage One of this study revealed that overall patients rated the caring behaviours demonstrated by the health care professionals lower than the health care professionals themselves. Further analysis of the data disclosed that education status and health care occupation were found to be predictors of positive caring behaviours whilst gender, patient profession, marital status, age and ethnicity were not. In respect of the five caring carative categories the highest ranking was respectful deference for the
collective and individual health care professional groups and positive connectedness for the patient group.

Chapter Six, Results of Observation Study, discusses Stage Two, observation of caring behaviours exhibited by health care professionals during caring interactions or moments. A total of 16 health care professionals and 8 patients participated and participant observation was employed over two wards and took place over a number of shift patterns. Using Watson’s theory of caring (1979) and the wider literature reviewed in Chapter Two, a theoretical framework was constructed in conjunction with an observation tool in order to help guide, focus and document qualitative evidence of caring arising from the observed interactions. Caring interactions are then told as vignettes and using Watson’s five caring caratives, the caring behaviours are arranged to illustrate their order and frequency of presentation.

In Chapter Seven, Findings and Analysis, the findings and themes emerging from Stage Three of the study, semi-structured interviews, which were conducted following the observations in Stage Two are considered. Using a semi-structured interview guide developed from themes emerging from the previous stages, study participants included in Stage Two were interviewed following the observed interactions to discuss caring behaviours. The analysis revealed that both health care professionals and patients differed and agreed on what they considered to be important caring behaviours. The significant caring carative was shown to be ‘respectful deference’ with the top five subthemes for the health care professionals as (1) compassion, (2) respecting the other’s experience, (3) treating the patient as a human being, (4) spending time with the patient and (5) offering reassurance and support. Whereas for the patient group the significant caring carative was ‘assurance of human presence’ with the top five subthemes identified as (1) compassion, (2) being treated as a human being, (3) good communication, (4) being helpful and (5) providing good physical care.

The findings of the research conducted in Chapters Five to Seven forms the basis of the discussion for Chapter Eight. A central task of this chapter was to determine what is acknowledged as caring by both patients and health care professionals within the specialty of orthopaedics. More specifically, the value of caring is examined in order to
gain further understanding of caring as a multi-professional ideal regardless of the caring behaviours exhibited. The knowledge generated by this research will help lead to a greater understanding of what caring behaviours are valued by patients, helping to deliver more qualitative person-centred multi-professional care. Equally it has been the intention of this thesis to understand the same beliefs inherent in the health care professionals who work within the speciality of orthopaedics; aspiring to achieve that meaningful connection, therapeutic relationship, shared beliefs and understanding which form the caring phenomenon. Eventually drawing together all the facts to construct a theoretical framework of caring. In the Ninth and final chapter, the limitations of the study are considered, conclusions are drawn and recommendations for practice provided.
CHAPTER TWO

Literature Review

2.1. Introduction

During the last 30 years there have been repeated attempts in the literature to understand the meaning of caring. ‘Complex’, ‘ambiguous’ and ‘vague’ are the words used repeatedly as caring theorists struggle to understand and bring meaning to this phenomenon. As authors present new theoretical works their findings relating to caring invariably conclude, that caring as a concept remains elusive (Barnum, 1998; Benner and Wrubel, 1989; Blustein, 1992; Bowden, 1997; Brody, 1988; Brown et al., 1992; Cronin and Harrison, 1988; Duffy, 1992; Fry, 1989; Hopkins et al. 1996; Kuhse, 1993; Mullins, 1996; Stockdale and Warelow, 2000; Watson, 2002, 1990, 1988; Wolf et al., 1994).

This literature review critically analyses caring theories, to investigate what caring means from a number of epistemological bases as both a human and professional trait. The number of scholars working in this field is substantive with each proposing their own model on what constitutes caring and caring behaviours. There is no global definition of the term that can be applied to all caring acts yet this does not seem to deter the plethora of philosophical and theoretical perspectives on caring which continue to be debated in the literature (Beck, 1995; Benner, 2000; Cooper, 1991; Ekstrom, 1995; Gaut, 1988; Gilligan, 1982; Held, 2005; Leininger, 1988; Mayerhoff, 1990; Mullins, 1996; Noddings, 2002; Parker, 1990; Ray, 1984; Swanson, 1991; Watson, 1985; Wolf et al., 1994).

2.2. Review methodology, Electronic Search Strategy and Synthesis.

This literature review was undertaken to explore the emergent theories and themes relating to caring in order to understand the historical and modern perspectives of the concept. It seeks to determine how these theories and themes relate to current perceptions of caring amongst health care professionals and patients in a modern hospital setting.

A systematic search of the literature was performed using search terms such as ‘care’ and ‘caring’. A search using University of Chester access of the following data bases was
undertaken from 1955 up until December 2011. This dateline was chosen to capture some of the earliest published works of care theorists such as Florence Nightingale (1820-1910) and Hildegard Peplau (1909-1999), the first published nursing theorist since Florence Nightingale who emphasised the importance of the nurse-client relationship.

CINAL Plus, Medline, PubMed, British Nursing Index, Cochrane, the cumulative index to nursing and Allied Health Literature, ERIC, Philosopher’s index. The search included papers published in the English language only. Initially studies were selected for inclusion based on title scanning, and then filtered out further by reading of the abstracts (Barroso et al., 2003). This presented a challenge as most papers comprised abstracts of poor quality or no abstracts at all were given, this is a problem regularly encountered (Evans, 2002; Shaw et al., 2004) and as such inclusion of papers based on abstracts alone was difficult and consequently a large number needed to be scanned so that potentially relevant papers were not excluded. Publications were included in the review if they contained various perspectives on theories and works relating to caring.

A thematic narrative review was undertaken of literature from 1955 until present date concerning a given theme as a source of data. Manual searches of some possible relevant journals was undertaken to also identify papers as Dixon-Wood et al. (2006) elude to the fact that electronic indexing of qualitative studies may be problematic.

The selection criterion was specifically set so that abstracts or titles meeting the search terms only were included. These papers were then analysed and selected for inclusion. This method provides a focused survey of the literature guided by the United Kingdom Centre for Reviews and Dissemination guidelines (Centre for Review and Dissemination, 2008).

2.2.1. The Gray literature - identifying unpublished studies

Researchers need to employ a broad range of search techniques in order to locate unpublished studies thereby avoiding selection and publication bias. The World Wide Web provides information on unpublished and on-going trials although the reviewer is undoubtedly faced with a search technique which involves the appraisal of publication of non-peer reviewed publications affecting the quality of the search. The search was
carefully designed so that literature such as un-published dissertations and articles published by obscure journals were represented (Eysenbach and Wyatt, 2002).

2.2.2. Quality appraisal and synthesis

The researcher recognises that focusing only on adherence to the given search terms and not including papers examining concepts of care and caring more widely, may have resulted in some important papers being overlooked. However, the choice was made in order to focus on a manageable number of papers (Appendix 1).

2.2.3. Definitions of terms used:

Caring - a science that encompasses a humanitarian, human science orientation, human caring processes, phenomena, and experiences (Watson, 2002).

Caring behaviours - actions characteristic of showing concern for the well-being of others such as sensitivity, comforting, honesty and non-judgemental acceptance (Roach, 1993; Sherwood, 1997).

Perception of caring behaviours – this is the process by which individuals interpret and organise sensation to produce a meaningful experience of the world (Adams, 1992). In this study perceptions of caring behaviours are defined as those behaviours occurring during the caring interaction between patient and health care professional.

Orthopaedic multi-professional team – for the purposes of this study the team of health care professionals consisted of doctors, nurses, physiotherapists and occupational therapists working within the speciality of orthopaedics

2.2.4. Literature review process

The literature review process was undertaken in three stages. In Stage One a comprehensive search was performed and a “snowball” strategy implemented, that is, to follow up on any additional, previously un-identified references found in the bibliographies or reference list of articles reviewed, or as listed on websites. Snowballing is a technique for finding research subjects. One subject provides the researcher with the name of another subject, who in turn provides the name of another and so on (Vogt,
This allowed for the identification of sources and theorists in the field in order to cast the net as wide as possible reviewing as many caring related theories in the literature.

To illustrate this search, words such as ‘caring’ elicited terms in relation to caring ethics or caring models. These terms as they arose were used to widen the search further. The search covered electronic databases, internet sources, material known to the researcher and hand searching of retrieved publications.

Table 2.1: Stage One Literature Search Strategy

| 1.  | ‘Care’                         |
| 2.  | ‘Caring’                        |
| 3.  | ‘Humanism’                      |
| 4.  | ‘Feminism’                      |
| 5.  | ‘Ethics’                        |
| 6.  | ‘Ontological’                   |
| 7.  | ‘Behaviours’                    |
| 8.  | ‘Caring and Theories’           |
| 9.  | ‘Nursing’                       |
| 10. | ‘Orthopaedic’                   |
| 11. | ‘Model’                         |
| 12. | 2&3, 2&4, 2&5, 2&6, 2&7, 2&9, 3&8, 4&8, 5&8, 6&8, 7&8, 8&9, 8 & 11, 8, 9&10 |

All synonyms and similar words were connected by the use of conjunctions such as ‘or’ and ‘and’ these are depicted in Table 2.1. Using the search terms ‘care’ and ‘caring’ uncovered further search terms such as ‘ethics’, ‘relational’, ‘feminism’, ‘humanism’, ‘nurse’, ‘ontology’ and ‘model’ in various combinations. The search terms were then elaborated by combining synonyms and similar words, for example the word ‘humanism’ was combined with ‘model’ to form ‘humanistic modelling’, (8 &11) and the words ‘nurse’, ‘caring’ and ‘model’ combined to form ‘nurse caring model’(2, 9 & 11).

Stage Two of the process found 1866 articles, books and reports using the search terms and each title and abstract was manually examined and assessed for relevance.
Table 2.2: Stage Two Narrative Review Analysis

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Journals</td>
<td>1797</td>
</tr>
<tr>
<td>Books</td>
<td>41</td>
</tr>
<tr>
<td>Book Chapters</td>
<td>17</td>
</tr>
<tr>
<td>Reports</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>1866</td>
</tr>
</tbody>
</table>

Table 2.2 lists papers included, these were of varying study designs and due to the diversity of the included research and theoretical literature, evaluation was undertaken to identify papers which provided representation of the exact search terms and were of informational significance; in additional the abstract of an article had to be present in the database, papers which did not meet this criteria were excluded.

From Stage Two, the narrative review analysis, several differing perspectives in relation to caring were revealed.

Table 2.3: Stage Three Hierarchical Model of Caring: A literature Analysis 1955 – 2011.

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humanistic</td>
<td>Embraces humanistic principles- empathetic and therapeutic relationships</td>
</tr>
<tr>
<td>Ontological</td>
<td>A way of being- relationship with the ‘other’</td>
</tr>
<tr>
<td>Relational</td>
<td>Caring relationships- seeing oneself as another.</td>
</tr>
<tr>
<td>Ethical</td>
<td>Exploring right or wrong actions- investigating morality in caring</td>
</tr>
<tr>
<td>Feminist</td>
<td>Desire to care, nature Vs. nurture, feminist perspective.</td>
</tr>
</tbody>
</table>
In Stage Three these perspectives were categorised into a Hierarchical Model of Caring and listed with their explanation in table 2.3.

Table 2.4: Further emerging themes on caring

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional/professional Perceptions</td>
<td>Caring as a concept in relation to healthcare professions</td>
</tr>
<tr>
<td>Individual view of caring, incorporating human knowledge and human understanding</td>
<td>How history and social change has influenced care and caring</td>
</tr>
<tr>
<td>Historical/social influences</td>
<td></td>
</tr>
</tbody>
</table>

Finally there were three further distinctive themes which became visible from the literature which required consideration in relating to caring. These are shown along with an explanation of each in table 2.4.

2.3. The Grounding of Caring

Caring has many different meanings and there can be no single definition that may be applied to caring in all situations. The term is used so frequently that its true complexity is often lost (Morse, 1995). There can also be subtle changes in meaning when modified with different words such as ‘one cares for’ or ‘one cares about’ someone or something.

In searching for the etymology of caring, the word ‘aegis’ appears in the literature. ‘Aegis’ from the Greek meaning to support or protect something or someone (Oxford English Dictionary, 2010) has historically been used to denote care (Hank, 2000). Aegis combines the ideals of utilizing whatever is available to relieve pain and suffering of the dependent although it does not help to reach a clear understanding of its meaning. The Concise Oxford Dictionary (Fowler and Fowler, 1967) claim that the term caring is derived from the Old English word ‘caru’ or ‘carian’ meaning sorrow.
Authors use terms such as sympathy, empathy and compassion to assist with definition although these only capture in part the true meaning (Johnstone, 2001; Pusari, 1998; Roach, 1993). Use of such terms only compounds the problem of definition, adding to the list of indefinable definitions. Thus the notion of trying to interpret rather than define caring in its everyday application is evident (Bowden, 1997; Kuhse, 1993).


Caring is the means by which care is conveyed (Stockdale and Warelow, 2000), the basic form of care is described as ‘natural caring’ and, as such, is a moral attitude which signifies a yearning for goodness that has been borne out of an individual’s personal encounter or recollection of being cared for (Flinders, 2001, p.211). Morality informs the means by which we treat individuals, that is to say, we set out not only to do no harm but also to actively contribute to another’s wellbeing. This raises the fundamental issue of the difference between engaging in an act that helps someone and not doing something which then causes harm (negligence). It has been said that the fundamental principles of ethics revolves around beneficence and non-maleficence (Glaser, 1994). The term beneficence implies acts of kindness, mercy and charity (Beauchamp and Childress, 2001) which is undertaken to benefit others, whilst non-maleficence refers to not doing harm to others.
However, it can be seen that in not doing harm (i.e. doing nothing) this can lead to a greater harm in the form of negligence. Four years ago ‘Baby P’ (Haringey Council, 2008), a 17 month old English boy died after suffering in excess of 50 injuries over an eight month period at the hands of his mother’s boyfriend. The parenting male was accused of doing harm whilst the parenting female was blamed for doing nothing (to protect). Thus, caring lies at the heart and soul of being human. This breathe of caring in humanity is reflected biblically as evident in the New Testament which gives a prime example of beneficence in the parable of the Good Samaritan. The Samaritan, in helping a man, a stranger, who had been beaten and left for dead by robbers, showed compassion and mercy for his fellow man and so the act of caring, and the provision of care, were demonstrated as a moral enterprise.

Considering caring in these terms brings care close to virtues representing the concept as a state of mind or attitude which is opposed to egoism, cruelty and indifference. Caring encompasses many qualities such as compassion, kindness, thoughtfulness, gentleness, consideration, concern, empathy, sympathy and love. However, the fundamental concept that underscores all the foregoing is the notion of ‘help’. To help someone necessarily suggests that someone is in need and that another person has the capacity to assist (Smith and Smith, 2008). It is easy to see the love for a child and a parent helping that child to eat, drink, walk and grow. Yet, helping a stranger who is in need lies at the heart of our humanness and try imagining our society without a rescue service; no fire brigade, no ambulance service and no police when we are in need. Even a wounded enemy on the battlefield expects to receive care and medical assistance once the battle is over.

Benner (1984) surmised that caring is not an inert characteristic possessed by human beings but one that is constantly changing and evolving, taking place during some of the most poignant times in an individual’s life. Trying to define caring is not easy, what it means and what it involves are difficult concepts to address mainly because of its’ multi-faceted traits (Smith, 2004) and yet many have sought to do so through different methods. Over the past century the study of caring has included ethical, (Cooper, 1991; Parker, 1990), theoretically, (Leininger, 1981; Swanson, 1991; Watson, 1985), philosophical (Gaut, 1984; Mayerhoff, 1971; Ray, 1984), and scientific perspectives (Beck, 1999;
Benner, 1984; Ekstrom, 1999; Mullins, 1996; Wolf et al., 1994). The literature puts forward different arguments relating to caring in relation to what it is and what it should be which often intertwine or run along parallel planes of thought.

2.4. Caring Theories.

As previously discussed the literature makes reference to the proximity care has to several other virtues such as compassion, benevolence, empathy, sympathy, patience and attentiveness. Some of these virtues focus on behaviour (patience), a number are fundamentally epistemic (attentiveness), whilst others are concerned with the expression of feelings (pity, compassion). There are those who argue that care ethics requires virtues such as attentiveness, responsiveness and competence (Cooper, 1991; Parker, 1990). Others maintain that virtues such as compassion, benevolence and love are so closely associated with care that such relationships are worthy of exploration (Watson, 1985; Wolf et al., 1994).

This literature review does not seek a solitary perception of caring and the quantity of care literature prevents a review of all theories and works relating to the subject. The researcher found that the literature offered various systems of thought based upon values, characteristics and beliefs on caring and so a précis of these examples will be given under the broad headings of (a) humanism (b) ontology, (c) relational, (d) ethics and (e) feminism, so that each perspectives relationship to caring can be examined. Whilst these give us some element of circumscribed perspectives they, in reality, overlap considerably and are offered as an aide to understanding the overall concept of caring.

2.4.1. Humanistic Modelling

Nursing has long been an advocate of the embodiment of humanistic principles, with much of the nursing literature (Bevis, 1998; Mullholland, 1995; Nelson, 1995; Paterson and Zderard, 1976) describing humanistic nursing practice involving an approach in which nurses enter into an empathetic and therapeutic relationship with their patients as it facilitates the ‘development of human potential’ (Paterson and Zderard, 1976, p.63).
The notion of Humanism can be located in the writings of the early Greek scholars, Socrates (470-399 BC), Plato (384-345 BC), and Aristotle (384-322 BC) who believed that by studying human social actions and interactions, particularly those concerning good or evil, an insight into human nature could be gained. In sociology, social action is the term used to describe an act which accounts for the actions and reactions of individuals, these actions can be goal orientated but with little thought to the consequences of the action or goal-instrumental where actions are planned and executed in relation to other goals and after careful consideration of the resulting consequences (Fadul and Estoque, 2010). Social interactions stem from social contacts, a pair of social contacts forms the basis of social interactions which in turn provide the medium for social relations (Fadul and Estoque, 2010).

The French Revolution (1789-1799) and the Enlightenment era of the 18th century led to a greater scientific understanding of disease and disability, and the formation of a medical model of health, which developed with the growth of the medical profession, and viewed health as the absence of disease (Porter, 1999). During this period a noticeable move away from religious authority to a faith in the workings of human rationality appeared (Traynor, 2009). This was more evident after the Second World War (1939–1945) when a strong restatement of humanistic values emerged in response to the Nazi horrors of the concentration camps which so devalued human life and worth. Following on from this in 1948 the newly formed United Nations composed its Universal Declaration of Human Rights. Article 1 states that:

“All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience”, (United Nations 1948 art.1, p.72).

In the same year the World Health Organisation boldly announced its definition of health as, ‘a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity’ (World Health Organisation, 2006, p.1). Despite the best efforts of WHO to dispel the philosophical beliefs of the medical model the notion of well-being remains firmly rooted in disease and illness, which is understandable when there is strong evidence that in times of ill-health people turn to medicine rather than at times when they are feeling well (Bury, 2005). A more recent scholar of humanism,
Lamont (1997), suggests that the goal of life for any human is to work for the happiness of others.

The concept of humanism within the healthcare professions and in particular nursing is based more upon an ideal describing this form of humanism in a paralleled “contrast to medico-scientific reductionism and objectivity”, (Traynor, 2009, p.1560). Traditionally health care professions have formalised ethical statements relating to their basic values, committing to the maintenance of patient dignity, beneficence, individuality and the promotion of patient self-help, these values have been laid down for posterity in ‘Codes of Professional Practice’ and the infamous ‘Hippocratic Oath’ (General Medical Council, 2006).

Nursing has at all times concerned itself with the welfare of the individual but has done so within the confines of working within hierarchical and bureaucratic organisational structures (Playle, 1995) which have served to dehumanise the caring process. This dehumanising practice has been identified within medicine, the illness-cure model or medical model (Parse 1999; Playle, 1995), in which the physician adopts an authoritarian position in relation to the passive, dependent perspective of the patient. This is a fundamental assumption of the model; it is seen as necessary and to be expected. External social or psychological factors are generally ignored or de-emphasized making the disease condition of the patient of major importance thus dehumanising the individual to nothing more than an illness or disability (Bury, 2005; Lawrence, 1994; Porter 1999).

In nursing, humanism has become a traditional valued belief of the profession recognized by some of the leading nursing figures of the last century such as Virginia Henderson (1964) and Florence Nightingale (2011). Nightingale claimed that the ability by the nurse to provide humane sensitive care was quintessentially nursing and Henderson (1964) concurred that the human element was naturally housed within nursing itself. It was Nightingale who recognised the importance of social and environmental contributory factors to health and well-being especially within the nursing environment.

Humanising care and caring may be difficult to implement in certain situations such as where injustice exists globally, and in situation where individuals are quite happy to place
themselves in the ‘hands’ of health care professionals, announcing that ‘doctor knows best’ fervently feeding the medical model of care. In these circumstances the ability to empower individuals to take responsibility for their own lives and make their own decisions may well be an impossible task.

“Care…conceptualized as values and attitudes” (Symanski, 1990, p.138) is a particular feature of caring models where the authors advocate the presence of distinct caring values and attributes. Roach (1993) in his model the Five Cs of caring, lists these qualities as compassion, competence, confidence, conscience and commitment. Sherwood’s (1997) Therapeutic Caring Model reflects the work of Roach and includes behaviours which demonstrate commitment such as empathy, providing support and comfort, preservation of dignity, showing concern and providing a protective environment to facilitate healing interaction. These models were developed to provide nurses with a means of understanding what takes place during the act of caring, what that signifies to the patient and ultimately their effect on the nurse/patient relationship. Both models attach importance to creating an environment which values the inimitability of the individual whilst caring for them from a holistic and humanistic stance. On the whole caring theory is difficult to delineate tangibly. Caring models such as those described seek to illustrate what is effectively seen as the essence of professional caring; despite their efforts the concept remains elusive and open to investigation from nursing researchers who actively pursue new strategies aiming to generate data that will ultimately reveal the value of caring. Patricia Benner (1984, p.213) illustrates this point by asking us to consider the “power” of caring, she describes the caring role as involving the concepts of transformative power, advocacy, healing power, integrative caring, problem solving and participative/affirmative power. This in essence elevates the interpretation of professional care from the mere application of skill to one that acknowledges a humanistic, relational interaction. Fundamentally Benner’s model can be attributed to a naturalistic worldview (Sire, 1990).

In relation to humanistic research there has been a call amongst nursing writers for the embodiment of humanistic principles as evident in nursing practice to be reflected in nursing literature (Leininger, 1985; Morse and Field, 1996; Speziale and Carpenter,
Myers (2000) argues that qualitative research is conducive to understanding lived experiences such as caring, comfort and powerlessness with Basset (2004) arguing against the use of quantitative research to define and measure complex human emotions and attitudes citing unpredictability as the rationale. These arguments are assumptions arising from the use of evidence based practice to inform health care professional knowledge of patient care and care delivery. Wall (2008) suggests that the nursing profession has adopted a traditional, bio-medical approach to research use and evidence based practice, questioning whether this approach is trustworthy in identifying caring values. Wall builds upon the arguments of Mitchell (1997) who stated that this research focus does not serve nurses well in relation to caring and does not provide sufficient direction on how nurses can understand patient experience such as living with loss, struggle, despair, fear, concern or suffering. ‘The realities of practice involve nursing encounters with complex human beings who are living out experiences that cannot simply be changed according to findings from research’ (p.154). The cautions as presented by Mitchell and Wall are rational and logical, especially when considering that not all research findings are useful in practice when ethical or moral standards are applied. How then can any health care professional discover what they need to know in order to care? In a Canadian study, Estabrooks et al. (2005) found that when making decisions in clinical practice, nurses depended upon internal experiential and intuitive knowledge. This ‘knowing’ is accumulated through social interaction type learning activities such as informal consultations with peers and medical staff and structured lectures. The conclusions of this study were noteworthy in relation to receiving knowledge by listening to scientific findings (produced by experts); Estabrooks et al. found this to be an insignificant source of knowledge for nurses. Here the authors perhaps inadvertently, illustrate a certain bias towards nurses’ acceptance of research generated knowledge, giving the impression that empirical approaches to knowledge have yet to mature in the nursing profession.
Caring has been considered an ontology or way of being. The ontology of care was studied by the French philosopher Emmanuel Levinas (1906-1995), his work focused upon the wider impact of human encounters, the feelings of responsibility for others, which led to the concepts of care being defined by a relationship with the other. It is this relationship with the ‘other’ that is central to understanding the philosophy of caring and it is probably more accurate to state that it is a relationship between the self and the other. In helping someone we are basically saying that we need help ourselves should we be in the same situation. Again, the phrase ‘do unto others as we would wish to be done to’ comes to mind. Levinas’ work is based upon ‘ethics as first philosophy’, or the ethics of the ‘Other’. The experience of encountering the Other informs the primacy of his ethics but ultimately it is this encounter that he argues should be a cherished experience, one in which the other persons’ closeness and distance imparts powerful feelings. This is a sophisticated and challenging concept to understand. Simultaneously it provides an insight into the more philosophical view of how we as human beings need to perceive the relationship during the caring process. It could be argued that this is not inherent in every care relationship and therefore, not a natural human attribute but rather one which is borne out of experience. Levinas argued that embedded within our subjective constitution was an obligation to the other. How does our experience of love, compassion, caring which we gain throughout our lives support the ontological argument? If it indeed it does. Heidegger (1973) offers an explanation proclaiming that human beings are orientated towards the future and acting out of the past, and for this reason caring is engrained in our former experience of that way of being. Van Hooft (1996) revisits the work of Levinas and also that of Heidegger to debate the assertion that caring is an ontological structure of human existence. He asserts that this can be reflected two-fold: caring about oneself and caring about another.

Parse’s (1989) *Theory of Human Becoming* takes each individual person’s perspective on quality of life as the aim of nursing practice. Originally developed as a human science it consists of three themes: meaning, rhythmicity and transcendence. Collectively, these principles assume that individuals take part in the creation of self-reality attained through
self-expression and achieved by living their personal ideals in a chosen way; that there are clear opposites in rhythmic patterns of relating included in the unity of life and finally moving beyond the ‘now’ moment creates a path which is personally exclusive in the midst of uncertainty and continuous change.

Benner and Wrubel (1989, p.368) further add to the debate by considering that ‘caring is a basic way of being in the world’, although this sounds a plausible statement it does not reflect the reality of human nature. Not all humans can be considered caring, some are cruel and cold hearted. It is clear that the authors are merely contemplation a deeper sense of caring, one that is described as ontological in that it is explicitly human.

The basis of this theory originates from the work of Heidegger (1978), who presents a complex and idealistic claim that humans are thrown into their world and as a result have no option but to cope with the situations they find themselves in, Heidegger offers no explanation about the inevitable failure to cope and therefore failure to care. Heidegger’s philosophy centred upon the issue of ‘Being’, that is, to make sense of things. The ‘Being’ he refers to is the human being whom Heidegger calls ‘Dasein’, which simply translated means being there (Solomon, 1972).

Heidegger asserts that human beings cannot be taken into account except for being an existent in the world (Warnock, 1970), essentially ‘Dasein’ is to be there and there is the world (Steiner, 1987, p.82). The term ‘Dasein’ is adapted by Heidegger to include ‘Sorge’; ‘Dasein Sorge’ was his term for relating concern and caring about the self and its existence. Heidegger argues that the world appears a complex and unsafe place and when confronted with the world individuals feel anxious and fear. As a consequence the human being or ‘Dasein’ has no option but to care for themselves as no one else can or will (Guignon, 2006). Heidegger’s philosophy has flaws but mainly it appears that he utilizes a sense of obscurantism in order to offer a deep meaning to what is often impossible to decipher. In this way he almost denies the existence of caring between one individual to another. Heidegger may well have been influenced by the events of his time, a leading philosopher during the Nazi rise to power in Germany, his critics especially Buber (2010) who puts forward one of the most comprehensive, concludes that Heidegger does not capture the essence of man and essentially fails to represent man’s true existence.
The on-going ontological debate surrounding the life-long process resonates in a *Theory of Nursing as Caring*, which is a general theory used mainly as a framework to guide nursing practice; the fundamental principle of the theory is that to be human is to care; it is human nature and for an individual to realise their full potential to care is a lifelong process (Boykin and Schoenhofer, 2000).

Watson (1988b) gives a definition of the person as a being-in-the-world. The ‘being’ consists of mind, body and spirit, which are influenced by a unique perception of the self. Importantly she stresses that the key point of access to the body and spirit is the mind and she also relates the spirit to the person’s soul, which is considered the internal and spiritual self. Watson (2008) believes that the most powerful feature of caring is the care of the soul. This is a difficult concept to grasp and the question remains as to where the responsibility lies in caring for the soul, does it lie with the person being cared for or with the one doing the caring? Watson implies that it lies with both who she considers are co-participants in self-healing: they each have the power to heal themselves (Falk-Rafael, 2000; Martsof & Mickley, 1998; Saewyc, 2000; Watson, 2005). Spirituality gives meaning and value to life for many people; it signifies a detachment from the materialistic world and a realisation of the importance of relationships and connectedness. Spirituality has been acknowledged as an integral part of the health and well-being of all individuals (Shea, 2000). Throughout history people have dealt with illness, pain and suffering in spiritual ways (DeLaune and Ladner, 2006). Defining spirituality in terms of caring requires theoretical unity and a universally accepted consistency in terms of language used to describe its dimensions (McSherry and Draper, 1998). Such a universal definition that is able to reflect human individuality can provide a basis for research and ultimately facilitate a thorough study of spirituality (Young and Koopsen, 2005).
2.4.3. Relational Modelling

The idea of a caring relationship is discussed philosophically in the literature, debating whether in order to care or provide caring the caregiver must enter into a relationship with the individual to whom the care is being given. Buber (2010) informs us that this relationship with another is exclusive. Buber goes on to explain that this exclusive relationship can be conditional or unconditional depending upon the individuals involved and what the primary incentive behind the development of the relationship was, for example physical attraction, love, friendship or personal need. Such a relationship has been examined by the French Philosopher Paul Ricoeur (1994) in his work, *Oneself as Another*; he acknowledges ethics as an important part of caring but essentially his work is an examination of the meaning of personal identity or selfhood, seeing oneself as another or another as oneself. This can be ever changing and interacting with the self and other and, so, from an ethical viewpoint is open to interpretation. If we apply this to caring then basically seeing oneself as another would allow us to connect to the other, thus, the other’s problems, concerns and suffering become our own. Ricoeur sees this as a means of promoting the well-being of others whilst at the same time ensuring the promotion of our own well-being.

According to Dudley (1994) an ethics of care and associated responsibility originates from the feelings of interconnectedness by individuals with others. This is said to be contextual and develops from experience. This experience is acknowledged as one of the greatest advantages within a moral theory: that is the experience of being cared for (Held, 2007). In her work relating to an ethic of care Held defines care as an assortment of practices which are undertaken and the diverse standards by which they are evaluated. According to Held an ethics of care is required so that caring practices can be assessed and valued. Other nursing care theories provide a knowledge framework to provide support to nursing practice. Nursing care theories include the work of Paterson and Zderad (1976), Theory of Humanistic Nursing Practice. This theory puts forward the idea that nursing interactions such as doing for or to someone do not take place in isolation but occur as a two way process or relationship.
There are those who would argue that caring relationships must contain characteristics that are necessary for the act of caring to take place. Mayeroff (1990) refers to basic attitudes which must be present for an individual to be considered caring; this opinion, later shared by Ricoeur (1994) and Noddings (2002), suggests that the care givers intentions during the caring relationship are the key components of caring. Mayeroff discusses the virtues of caring which include empathy, trust, hope and courage and argues that ‘being with’, ‘being for’ and ‘being there’ for another person are crucial factors (p.42). What Mayeroff is saying is that we need to be able to understand the world from the other’s perspective before we can understand what the other is experiencing. We need to be receptive and accessible to the others needs and appreciate that the other exists within their own right and should therefore not be made dependant on another or exploited in any way. The other should be empowered to make their own decisions and take responsibility for their own life. However, we should be cognizant of the difficulties that are inherent in this approach when we consider those compulsorily detained for involuntary treatment under the mental health legislation, or those wishing for an assisted death or those wanting to commit suicide, for example.

Caring can be an experience that provides a connection between humans that is not always possible to measure. Strickland (2002, p.79) considers the questions ‘What is caring and how do we know it when we see it?’ Watson (1988b) offered an answer based upon the notion of caring as a science which endorses a pantheistic view of the universe (Carson, 1993). Watson refers to caring as an ‘existential human relational phenomenon’ (2002, p.3) and calls her theory ‘transpersonal care’ as she believes this recognises the unity of life and human connections, which move from the person to others, to community, to world, to the planet Earth and to the Universe as a form of environmental care.

2.4.4. Ethical Modelling

The ethics of care is based upon the theory of normative ethics developed by feminists in the second half of the twentieth century (Pettersen, 2011). It is essentially a theory which explores what defines right and wrong actions giving emphasis to the importance of
relationships. The work of the American ethicist and psychologist Carol Gilligan (1992) is acknowledged as one of the founders of the ethics of care.

Ethics is a type of philosophy which is concerned with the investigation of morality and the way in which human conduct is guided and appraised by thinking (Bullock et al., 2000). Many individuals associate being ethical (or having morals) with how they personally feel about issues which may be influenced for example by beliefs in society, by law or according to religion (Baumhart, 1968). History is replete with rules for distinguishing right from wrong, from biblical “Thou shalt not kill”, (Exodus 20:13) to codes of professional conduct such as the Hippocratic Oath, “First of all, do no harm.” These examples help define what is considered acceptable behaviour.

Being ethical is not necessarily pre-determined by following one’s feeling, as to do so may deviate from what is ethical. If we take the example of equating ethics to religion, it goes without saying that most religions promote high ethical standards. Yet if ethics were to be restricted according to religious teaching then ethics would only be pertinent to religious people (Velasquez et al., 2010). Velasquez et al. offer an explanation for what ethics is, firstly they argue that it refers to “a well-founded standards of right and wrong that prescribe what humans ought to do” (paragraph 1) this usually arises out of obligation, fairness, specific virtues and benefits to society. Secondly they refer to ethics as the study and development of an individual’s ethical standards, which shape our moral beliefs and moral conduct.

Theories of ethics apply terms such as ‘ought’ and ‘should’ facilitating individuals to choose, justify and judge their action (Brody, 1988). Moral principles are the general standards of conduct and serve to form the ethical framework. Considering caring as merely a set of moral principles assumes that the concept is performed as an obligation or duty, (Kuhse, 1993; Stockdale and Warelow, 2000). An individual learns about right and wrong in many settings throughout their lives such as home, school, church and in social environments. This sense of right and wrong is so ubiquitous that it is often regarded as common sense. This then raises the question as to why so many ethical disputes and issues are evident in modern society (Resnick, 2011). Resnick offers an answer by
suggesting that individuals, although recognising right and wrong, interpret and apply ethics, that are determined by life experiences and beliefs, in different ways.

Caring may also be viewed by some as a virtue, that is to say a quality that a person possesses in order to behave with moral principles or ethical ideals (Beauchamp & Childress, 1994). To view caring as virtuous also has its critics, believing that this stance encourages many problems such as emotional detachment, inefficiency and dependency (Cruzer, 1993; Allmark, 1998).

The question of caring as a virtue has been raised in the literature. Griffin (1980) argues that there is a principle definition of what it means to care and divides the meaning into two aspects, firstly the cognitive aspect, if one cares about something it is viewed as of value, concern or interest, whereby good is seen in what is being cared about. Secondly, the emotional aspect, if one cares about something then an array of emotion is felt in relation to it such as anger when injustice is done to a person one cares about. Emotions bring about desires and from these our actions arise.

Allmark (1998) identifies a weakness in the ethics of care and argues that its’ Achilles heel lies in its belief that care and caring are considered good values. Allmark is correct in his statement which can be supported by examples from history, examining the impetus for acts of war and conflict Hudson (1993, p.344) remarks that: “Hitler may well have cared for the success of the German people just as Mother Teresa cares for the comfort of the destitute of Calcutta. But would that have made him a virtuous man?” This example by Hudson is profound in that it serves to inform us that the emotion of caring for someone or something can exist for both good and bad reasons and therefore the existence of good caring and bad caring are evident.

Caring has been identified in the literature as being of significant value for professional behaviour and thereby facilitating good patient care. Gabard and Martin (2003) observed that caring in the context of health care, has several different meanings being described as a virtue (Davis, 2005) and a moral orientation based on an ethical theory of caring, this assumes that relationships with and connections to others are fundamental to ethical decision making (Branch, 2000). Compassionate caring, or benevolence, is seen as a
virtue that implies doing good, it avoids basic harm out of a sincere care or concern for others. Originally described by Aristotle, virtue ethics relates to one’s moral character and is associated with experiencing feelings such as sympathy and regret.

Health care professionals are said to be virtuous practitioners if they possess characteristics such as self-motivation to care, empathy and are able to act altruistically towards their patients (Curzer, 1993). It is possible for an individual to act rightly but not virtuously as their motives are wrong, or have the right motives but act wrongly. Therefore for compassionate caring to exist in its purist form there must be an equal balance of motive and action (Beauchamp & Childress, 2008).

There are two themes that are pivotal to the ethics of care model, firstly, mutual interdependence and, second, emotional responsiveness. The former, mutual interdependence, acknowledges that many human relationships include people who are sick, vulnerable and dependent and that close attention to their needs is the ideal moral response to that situation (Gheaus, 2009). Demonstrating empathy for and interest in others creates the required characteristics of the moral relationship in this model. The second, emotional responsiveness is based on the expressing of emotions appropriately in the caring situation, for example, expressing compassion during the caring relationship is considered to be a morally important factor for the ethics of care (Beauchamp and Childress, 2008).

Baier (1985) gives a philosophical explanation of an ethics of care by stating that it is possible for individuals to do something for others out of love and trust. This takes into account human bonding and friendship, without abandoning the need for obligation or sound ethical decision making.

An ethics of care was described by Joldersma (2001) as a theoretical account of ethics, what it is and how it works in human life. Entering into caring relationships human beings become ethical agents who give and receive care through the virtue of caring. Developed mainly from the early works of Gilligan and Noddings, ethics of care is recognised for its significant effects politically and globally. It has helped to highlight the relevance of such issues as access to medical care, impacts of the environment on health,
socioeconomic status, genetics, education and financial costs associated with caring practices.

The ethics of care has been criticised for being an underdeveloped theory (Baier, 1985; Carse and Nelson, 1996; Deveaux, 1995), for impartiality (Beauchamp and Childress, 2008), ambiguity of principles (Carse, 1991) and finally feminist reservations over the theories’ failure to acknowledge the oppression of women in their traditional roles as care givers (Sherwin, 1992). However, these ethical aims must be subjected to moral norms, which are only meaningful when based upon respect for others, as a result empathy and concern for others develops. Ricoeur uses the term *Solicitude* to summarize these characteristics. This is a complex theory and one which is difficult to articulate in light of its need for individual analysis and the difficulty in interpretation of the terms ‘self’ and ‘other’ (Atkins, 2005).

2.4.5. Feminist Modelling

Caring theory developed by feminists in the late twentieth century, the significance of the care ethics model is the emphasis it places upon the caring relationship and in valuing how we should nurture this ‘natural caring’ for the good of others and ourselves (Noddings, 2002). Noddings states that there are three elements within the caring encounter; firstly the affective state of attention, second, the existence of motivational displacement or ‘motive energy’ which pours from the care giver to the cared for resulting in the care giver responding positively and, third, recognition by the cared for of the interaction which has taken place. Noddings makes a distinction between natural caring and ethical caring. The former she refers to as acting out of a *desire* to care (natural), simply stated as ‘I want’, whilst the latter refers to a *duty* to care (ethical), ‘I must’, (p.81-83).

Noddings describes caring within a feminist perspective of cultural practice and moral development. Interestingly, this perspective suggests that caring in the human sense is a phenomenon and attitude expressing our earliest recollections of being cared for. It also suggests that this form of caring can be taught and nurtured in education (Herbst et al., 2011). The expectation that women perform caring tasks in society stems from the belief
that women are naturally caring by virtue of their psychological make-up (Dalley, 1988). This opinion is supported by the fact that decisive behaviour, rational thinking and competiveness are viewed as masculine traits whereas irrationality, docility and sacrificing personal needs are feminine traits (Jagger, 2001).

Ethics of caring is seen as an influential type of virtue ethics, an umbrella term covering several different theories. It was considered a rival to consequentialism and deontology as it focused upon the importance of character and virtue in moral philosophy (Athanassoulis, 2010). Consequentialism refers to the rightfulness or wrongfulness of an action in relation to the value of the consequences (Darwell, 2003). The most frequently cited version is act-consequentialism which judges the right action as that which produces the greatest good. However, the greatest good is a subjective measure and dependent upon who is doing the judging. Act-consequentialism can be contrasted with rule-consequentialism which refers to an act judged to be right if it accords with a set of rules that are generally held to best promote good. This fits with a society’s court of law who will adjudicate on what is considered to be correct action (Portmore, 2003, Bradley, 2006).

Deontology is concerned with duty and asserts that there are certain kinds of acts that are intrinsically right or wrong. Therefore, there are duties of conduct to operate according to these. In the ‘grey’ areas between right and wrong some deontologists argue for people to live their lives as they see fit as long as it does not cause harm to others or breach other types of duty (Bentham, 2011).

These versions of virtue ethics focus on the feminist thought that men think in masculine terms such as justice and autonomy whilst women focus on terms such as caring and nurturance. This is an argument supported by the work of Noddning (2002) who in comparison prefers to use the term sympathy when analysing the caring approach stating that it captures the emotional state of awareness in the act of caring. Awareness, which is receptive, plays an important part in the caring encounter and provides an understanding of the needs of the cared for and facilitates a response by the care-giver. This theory of caring relies upon the notion that both parties contribute to, and gain from, the caring encounter albeit in different ways. Noddings (1992) recognises that the ethics of caring
exists as a result of a maternal nurturing of ‘natural caring’, stating that: ‘We love, not because we are required to love but because our natural relatedness gives birth to love, this love, this natural caring makes the ethical possible’ (p. 43).

The ethics of care model was initially inspired by the theories of Carol Gilligan (1992), her feminist perspectives on the ethics of care advocated the importance of care and responsibility to others rather than justice and individual rights. Gilligan’s primary work in which she disputes Kohlberg’s (1971) stages of moral development of children led to the beginning of the ethics of care. Her critique centred on Kohlberg’s conclusion that in morality and conflicting ethical orientations men and women differ in their process of development. Gilligan claimed that the opinion was biased against women and stated that whilst men focus upon terms of rules and justice, women think in terms of caring and relationships. Gilligan argues that her concept of a ‘different voice’, referring to the voices of her female test subjects which she claims have been empirically ‘traced’, is characterised by theme rather than gender (Gilligan, 1992). It is interesting that although Gilligan does not wish her ethics of care theory to be attributed unconditionally to women, it is evident that she falls into the same trap of essentialism of which she accuses Kohlberg (Tronto, 1994). Her criticisms were not appreciated by everyone including feminists who were keen to point out that there were no differences between men and women in relation to moral growth (Sommers, 2001). Some feminists maintain that Gilligan’s theory is damagingly reminiscent of a romanticized 19th Century ideology of separate spheres, i.e. gender differences (Epstein, 1990). Others find Gilligan type theories heroic (Mackinnon, 1991). Tong (2009) warns against focusing on the ethical orientations of men and women in relation to caring stating that “we must examine who cares about whom and why before we give the feminist stamp of approval to a ‘caring’ act” (p.89). Despite the debate Gilligan stands by her ethical outlook mainly by emphasising the basic duty, which she states is to help others and minimize harm. Essentially an ethics of care rests on the premise of non-violence; that no one should be hurt, warning that, ‘violence is destructive for everyone involved’ (Gilligan, 1992, p.174).
2.5. Perception of Caring

This thesis seeks to understand perceptions of caring and therefore consideration to what is meant by perception is required. “Everything you see or hear or experience in any way at all is specific to you. You create a universe by perceiving it, so everything in the universe you perceive is specific to you”, (Adams 1992, p. 83-84).

The philosophy of perception concerns itself with how the perceiver uses mental processes and symbols to relate to their internal (proprioception) and external (exteroception) world (Crane, 2005). Internal perception or proprioception gives us the ability to sense what is happening within our own bodies. For example when we place our hand straight up in the air we know exactly where that limb is. External/sensory perception or exteroception allows us to sense what is happening in the world outside of our bodies, such as the ability to touch, hear, smell and taste.

An individual’s view of the world depends upon their perception of it, beginning with the senses external world perception leads to the creation of empirical ideas; it represents the world around us and concerns itself with how one relates these new ideas to pre-existing ones within a mental structure. One of the earliest writings concerning perception can be found in the works of John Locke (Locke and Winkler, 1999), in ‘An Essay Concerning Human Understanding’. In this essay, which has been attributed as one of the fundamental sources of empiricism, Locke discusses the basis of human knowledge and human understanding in respect of God, oneself, objects and natural kinds and depicts the human mind at birth as a blank vessel which can only be filled through the experiences we gain during our lifetime (Jolley, 1999).

In the main external perception has been studied by many philosophers (Berkeley and Woolhouse, 1988; Locke and Winkler, 1999; Ryle, 2000; Varela et al., 1993) over the years and as such has led to a better understanding of communication, reality, self and personal ego. All these philosophical works on perception contrast with each other in many ways so that one feels they have gained a sense of understanding reading the works of one philosopher only to find this disputed by the writings of another.
To illustrate this point, in the philosophy of perception there arises the question of direct or indirect realism, in relation to the nature of conscious experience. Is the world around us the real world or merely a copy arising from internal perception generated by neural processes in our brain? There are two lines of thought in answer to this question. The view of direct realism is that our conscious experience is an internal representation of the real world, in other words, a miniature virtual reality world (Gibson, 1982). On the other hand indirect realism concurs with the accepted view of perception in natural science which argues that the external world is perceived through our own ideas and interpretations rather than as the world really exists (Kant, 2007; Kohler, 1971; Lehar, 2000; Russell, 2009).

**2.6. Institutional / Professional Caring**

The concepts of caring and several main caring theories have already been discussed, it is also important to consider the notion of institutional or professional caring. This requires contemplation in order to take what is considered personal caring and clarify the relationship between the two. Caring as a concept in relation to health care is a highly complex issue which involves a diverse range of disciplines including science, art, philosophy, sociology and religion. It has a long tradition of being difficult to define and almost impossible to determine (Royal College of Nursing, 2003).

The health system of the United Kingdom has and continues to undergo dramatic changes both in terms of roles and responsibilities for health care professionals and changes in the way that health services are delivered. The current Health and Social Care Bill 2011 represents the greatest shake-up of the NHS since its inception (Kingsfund, 2011). Jenson and Mooney (1990) warned that re-organisation of health care services would witness a move from a deontological ethical framework of care which promotes individual caring to utilitarianism which is concerned with the realization of benefiting the greatest number. These changes are in danger of dehumanising care and caring. In recent years Hospital Trusts have moved the focus of traditional caring, as perceived by patients admitted to hospital, to one of productivity and profit making. As the Guardian, (2010 p. 1) reported:
‘Elite NHS Foundation Trusts are gearing up to lure private patients from abroad and home as health budgets are squeezed- a decision made possible after Health Secretary Andrew Lansley said he would abolish the cap limiting the proportion of total income hospitals can earn from the paying sick’.

A hospital is now considered in terms of a business rather than a place to care for the sick and injured. Emphasis is also placed upon the need to reduce length of hospital stay so that Government targets are met and hospitals are not penalised for failing to comply, finding themselves highlighted as poor performers in Government National League tables.

The economic and political reality of the modern health care system means that health care professionals are faced with current reductionist strategies such as Clinical Pathways and Enhanced Recovery Programmes (NHS Institute for Innovation and Improvement, 2010) designed to reduce length of stay, improve patient outcomes, and speed up recovery ultimately saving the National Health Service millions of pounds. Enhanced Recovery Programmes claim to ensure that patients are active participants in their own recovery process, receiving evidence based care at the right time (NHS Institute for Innovation and Improvement, 2010).

Within the field of orthopaedics Enhanced Recovery Programmes are currently topics of debate with rapid implementation encouraged at the highest levels (Wainwright and Middleton, 2010). A patient undergoing a total hip replacement ten years ago would have expected a stay in hospital of approximately ten days, recent Department of Health initiatives such as the Enhanced Recovery Programmes (ERP) and Quality, Innovation, Productivity and Prevention (QIPP) expect length of stay for this procedure today to average no more than two to three days (Department of Heath, 2010). Therefore, by enabling patients to go home from hospital earlier Trusts will save a significant amount of money.

Austerity measures for the National Health Service were announced in March 2010 by the Department of Health which required NHS Trusts to make substantial savings of £20 billion by 2014. Critics of the cost saving plan feared that many frontline services would be affected and subsequently standards of care would fall (The Independent, 23 March,
2010). One such Trust, Mid Staffordshire has been the subject of an intense public, Government and media inquiry into poor care. The Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust (2013) documented that patients and relatives expressed concerns about the lack of compassion and uncaring attitudes shown. The inquiry also reported that the priorities of the Trust were target driven to save money rather than patient focused.

Professional caring; defined by Hawthorne (2005) as a unique relationship centring around responsibility and trust between a health care professional, such as a nurse or doctor and their patient, may not necessarily be thought of as caring in its fullest sense if we consider the definition of Kitson (1987), here Kitson offers a an explanation of caring that is three fold: the carer is committed to the provision of a sustained and seamless service for as long as it is required; the carer has the knowledge and expertise to meet needs; an understanding exists that the relationship upholds the individual integrity of recipient of care.

These three relational characteristics note a division between what the literature terms instrumental and expressive caring activities which are said to denote the important character of caring (Morrison 1992) and which Woodward (1997) refers to as the individual nature of professional caring. What a carer does and the actions involved are said to be predetermined (Leininger, 1988); although skills and knowledge are essential in helping the carer to meet the health care needs of the patient, they should not be considered in isolation of other caring characteristics. To do so may trivialize the individual (Bradshaw, 1996).

In order to enhance the way activities are performed an emotional element is required so that values such as respect for the unique individuality and stated needs of the patient are reflected in the relationship (Morrison, 1992). In applying this to professional caring Griffin (1980) argues that it is this moral emotion of respecting the dignity and autonomy of other human beings, viewed by May (2007) as a motivating and emancipating influence, that is responsible for transforming predetermined action into what we know as caring.
Health care professionals witness human suffering on a daily basis, at the same time they are called upon to provide sincere care for their patients, helping to ease distress (Bolton, 2005; Eide, 2005; McCreight, 2005). The emotions outwardly displayed may not reflect or be consistent with the caring emotions that should be experienced professionally (Merkel, 2002; Smith and Lorentzon, 2005). This emotional process termed ‘emotional labour’ was first conceptualized by Hochschild (2012) in her 1983 book, ‘The Managed Heart’, and relates to the way in which an individual portrays emotions according to fixed social and cultural norms instead of what they may essentially feel (Fineman, 2000; Newbold, 2004; Turner, 2007).

This concept is important to caring, experiencing emotion is necessary for any health care professional in order to deal with morally difficult situations in the caring environment, and to ensure that any interaction is undertaken ethically and with genuine feeling in the caring relationship (Benner, 2000; Glannon, 2005; Soares, 2000). The concept of emotional labour requires us to ‘grapple with the conceptual complexity of defining care especially in relation to its emotional components and demands’ (Smith, 1992, p.9). Smith implies that health care professionals need to concern themselves with describing implicit skills associated with emotional labour, the concept needs to be grounded in formal health care professional education and training so that it becomes visible and valued and therefore the needs of the patient and carer are not ignored or exploited (Huynh et al., 2008). Acknowledging emotional labour helps to embrace the holism of the human experience (Hunter and Smith, 2007), recognise the immense emotional effort that accompanies the act of caring (Archer, 2007; Huynh et al., 2008); its association with self-awareness (Kerouac et al., 2003), role identification (Mackintosh, 2007; Fineman, 2008), its social norms foundation conditioned by personal variables (e.g. age, gender, emotional adaptability) and the organisational environment in which the caring interaction takes place (Schaubroeck and Jones, 2000; McCreight, 2005).

To explore this further it is important to consider if caring relationships in hospitals exist in such a way that they meet the needs of the individuals involved and that moral emotions exist as described. All human beings have a perception of caring which has evolved from their own personal experiences of caring relationships, such as those
between husband and wife, and parent and child. Some caring relationships may be considered more loving than others and involve varying degrees of intimacy.

Health care professionals may be faced with too few resources, such as physical resources in the form of manpower, or psychological resources in the form of emotion. As a consequence caring may be distributed unevenly between those being cared for, implications for ethical caring such as justice and equality in care then become issues for consideration.

When considering professional caring reference must be given to the motivation of health care professionals. As we have seen from the literature thus far the expression ‘to care for’ is used both as a form of moral motivation and the action performed to meet needs irrespective of the motivation. Wanting to meet the needs of an individual is carried out for the best motivational reasons in society in general. However, if we relate this to the nursing profession recent literature warns that individuals may currently enter nursing for reasons of job security, more flexible working hours and good promotional prospects rather than for humanitarian motives (Watters, 2009).

If this opinion is true we could see the emergence of people performing a duty of care regardless of whether they care or not. On the other hand, if the act of care is done and done well then it will be perceived by all involved as a ‘caring act’. Although it may be fair to conclude from this that professional care may never really achieve the richness and complexity that caring achieves out of a sense of love for another person.

2.7. Influences of historical social context

2.7.1. Medical

The history of medicine can be traced back to pre-historic times, the first evidence of surgery discovered in trepanned skulls from the Stone Age (Slack, 1995). The art of medicine has been viewed from several perspectives over the centuries, from a black art involving magic, religious beliefs, common sense practice to the modern day medicine underpinned by scientific research and knowledge. References to medical practice can be
found in most ancient civilisations including the Greeks, Romans and Egyptians where the medical art was closely associated with religion.

One of the first documented writings relating to medical care was contained in the Charaka, an Indian scripture written around 100 B.C. which even at that time recognised ‘doctoring’ as a profession and according to translation the practice of medicine promised to yield a materially and spiritually rewarding life. Charaka laid down a code of ethics for physicians and warned against false practices, placing emphasis on a moral basis of medicine, not just the treatment of disease but of the person themselves (Underwood and Ashworth, 2008).

Medical care in pre-industrial England consisted of a variety of treatments which were offered according to what the ill person could afford to pay (Slack, 1995). Not until the introduction of the Poor Law in 1535 was any system introduced to help provide poor relief for the sick, disabled and mentally ill. The system afforded medical care paid for by the community and administered by parishes. Here the able poor were employed to care for, nurse or treat the sick poor and medical practitioners were chosen from a wide range of those available even those perceived to be physicians of high status (Slack, 1995). The quality of medical care at this time centred on a balance between what the patient wanted and the outcome of the treatment as predicted by the medical practitioner. Dissatisfaction was high at this time and many individuals sued over poor care and poor outcomes (Webster, 2001).

Early hospitals such as St Thomas opened in London in 1553 but were a far cry from the hospitals we know today. These institutions provided care rather than cure, they were places sick individuals attended for comfort, to be washed and fed. Early medical care did not have much basis for treatment; consequently treatment was focused on easing symptoms (Slack, 1995).

As the profession evolved in response to sociocultural and technological advances so did the doctor patient relationship. In the 18th century the patient was the authority on his illness and was responsible for providing details about his symptoms, this changed with
the introduction of new technology such as the stethoscope when the doctor gathered information independent of the patient.

During the 18th century medicine was considered amongst one of the least desirable professions for a person to pursue and physicians were considered of low social standing (Lane, 2001). Doctors were not considered necessary as caring for the sick was seen as a female role such as that of family members, midwives or lay practitioners (people paid to care for the sick with no formal training) (Kelly and Clark, 2010).

The 18th and 19th centuries saw a rise in ‘quackery’, quacks were unqualified persons who went from town to town offering ‘miracle cures’ and dispensing medical advice for profit. They preyed on the poor sick and disabled offering false hope and administering often lethal but patented medicines (Lane, 2001). Unregulated practice continued although medicine as a profession was acknowledged with the passing of the Medical Act of 1858 which created the General Medical Council (GMC) giving rise to regulated medical education, registration and discipline. Despite regulating medical practice it did not outlaw unqualified practitioners and so standards of care varied greatly (Webster, 2001).

The beginning of the medical revolution began in the 19th century and onwards. At this time care remained in the home as hospitals and other institutions were built for the elderly, orphaned, insane and people with communicable diseases such as tuberculosis (Ress, 2001). The caring family doctor emerged, visiting the sick at home, giving birth to the adage ‘to cure sometimes, to relieve often, and to comfort always-this is our work. This is the first and great commandment and the second is like unto it, Thou shalt treat thy patient as thou wouldst thyself be treated” (anon, taken from Hopkins, 2009).

The years 1919-1939 witnessed many important advances in medicine. Horrific as the First World War was it acted as a stimulus for medical advancement which continued after the post war era. Although a greater understanding of the epidemiology of disease and infection had evolved cures were not yet available. Public health had improved, better housing and sanitation introduced, but many of the poor in society where affected by disease brought on by poor basic hygiene, lack of clean air and fresh food (Brunton,
Disease amongst the poor was rife compounded by an inability to pay for medical care and drugs, a luxury only affordable to the upper classes (Kelly and Clark, 2010).

The most significant change in the provision of medical care occurred with the introduction of the National Health Service in 1948 which advocated free medical care for all and promised to care for people from cradle to grave (Webster, 2001).

On the whole ethics of caring in the medical field has been underappreciated (Branch, 2000), whereas nursing practitioners and academics have contributed significantly to the definition of caring as an entity in the literature and advocated the influence of patient centred care, which has led to motivation, adherence and good outcomes in patients; (Benner et al., 1996; Ryan and Deci, 2000; Williams et al., 2000). In the medical profession caring as a moral orientation has been the subject of research and debate (Bradshaw, 1996; Peabody, 1984; Pellegrino, 1985; Spiro, 1992) The classical paper of Peabody was perhaps one of the earliest acknowledgements in the literature to argue that the practice of medicine should include the whole patient physician relationship emphasising that getting to know the patient was a vital component of the art of medicine. Peabody writes:

‘….The good physician knows his patients through and through and his knowledge is bought dearly. Time, sympathy and understanding are needed. The reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. The secret of the care of the patient is in caring for the patient’, (p. 813-818).

Thus the importance and need for medical practitioners to learn the art of caring had been realised.

The humanistic model of caring is characterised as being a moral obligation which an individual looks upon to promote the good of another with whom he or she has a special relationship (Pellegrino, 1985). This type of caring is expected to be provided by both the medical and nursing professions as it is created by the compulsion to act in a beneficent manner as May (2007) commented, care is, “the basic constitutive phenomenon of human existence”, (p.290). From these sources what can be drawn is the idea that human beings are constituted in their human attitudes by care, as May argues that ‘when we do not care,
we lose our being: and care is the way back to being.’ This statement by May has moral implications: “If I care about being, I will shepherd it with some attention paid to its welfare…” (May, p.290). May argues that care must be rooted in ethics, the good life stems from what we hold dear.

We must turn to the concept of medical socialization in an attempt to understand what influences medical caring. Medical socialization refers to the attitudes, beliefs, norms, values and behaviour patterns associated with becoming a doctor (Merton et al., 1957), a complicated and highly structured process. Becker and Greer, (1960) argue that medical students focus on the here and now, forgetting about the process of socialization; a theory they call situational adaptation. This theory assumes that the behaviour of human beings is thought of as a practice in which conduct is shaped and controlled by acknowledging the expectations of those they interact with.

Hafferty (1991) sees this practice as a rite of passage which is entwined with physical and emotional attributes. The process of socialization can be seen as influencing the way in which doctors learn to care but how it is taught is open to debate. Bligh (1999) suggests that clinical contact should be used as the educational vehicle through which caring is learnt, although an important consideration, it trivialises a complex phenomenon and wonders if the medical profession believe there is more to caring than what Bligh advocates.

Caring as a moral orientation in its original form was based on the ethic of care theory, a feminist perspective of morality and ethical decision making (Gilligan, 1992; Noddings, 1992). Gilligan argued that women sought to maintain relationships through solving ethical dilemmas. Individuals practicing an ethic of care faithfully believe that the essence of an individual’s moral orientation is having a connection to others, making ethical decisions on a case-by-case basis out of a desire to be receptive and responsible for others.

Branch (2000) stated that doctors, who are receptive and listen to patients, are demonstrating acts of empathy and concern. Deale and Wesley (2001) explored patient perception of medical care in Chronic Fatigue Syndrome (CFS) only 33% of patients
surveyed labelled doctors involved in their care as caring, supportive and interested in them as individuals. The findings suggest that medical care was evaluated less on the ability of doctors to treat CFS, and more on their interpersonal and informational skills. Dissatisfaction with these factors is likely to impede the development of a therapeutic doctor–patient alliance, which is central to the effective management of disease.

In the caring relationship between patient and doctor, the most crucial element of caring may not be to condense the phenomenon into a collection of behaviours the manifestation of which are in ‘the eye of the beholder’; but rather a collection of abilities that are derived from aptitudes such as being able to understand the patient’s perspective and then reflecting on responses (Quirk et al., 2008). Until the medical profession pursues more democratic thought guidelines rather than seeking to follow those established by Plato which denote the patient as not only physically but morally incompetent, and as such, must be guided by the doctor, the doctor patient relationship will remain paternal and unconditional (Siegler, 1985).

Paternalism in medicine can be simplified as ‘doctor knows best’ and that it recognises only three elements in the relationship, the doctor, the patient and the illness (McKinstry, 1992). The debate centralises around whether doctors are justified in making decisions on behalf of their patients – is it part of the act of caring or one of superiority? Mills (1972) argued that every individual should be responsible for their own happiness and therefore decisions are based on achieving this goal. If we look back to the work of Kant (1958) who stated that all human beings have a duty to express autonomy this ideal along with Mills argument is not realistic because there are those in society who cannot make autonomous decisions for themselves such as the handicapped and mentally ill (Komrad, 1983). Here decisions may need to be made on their behalf, consider the seriously ill patient in hospital, here a degree of autonomy may be lost and so paternalism is required to fill the void. Siegler (1983) sees this as the only justification for paternalism.

If the medical profession wants to be taken seriously as a caring profession and escape its technological and bureaucratic shackles then it must embrace those components that will help adopt an ethic of care (MacLeod, 2000).
2.7.2 Allied Health Professionals

Allied Health Professionals are clinical staff distinct from nursing and medicine. They provide a wide range of services that include diagnostic, therapeutic and direct patient care. Importantly they provide support services to other health care professionals with whom they work (DoH, 2010).

Physiotherapy has its origins in ancient history with the advent of joint manipulation and massage in China circa 300 BC. Also Hippocrates described massage and hydrotherapy in 460 BC. Physiotherapy is concerned with the identification and achievement of maximum movement within the realms of promotion, prevention, treatment and rehabilitation (Swisher and Page, 2005).

From 1910 to 1929 changes in the world and medicine in general; along with 7 million chronically disabled soldiers arising from the 60 million European soldiers mobilized from 1914-1918 during the First World War (Kitchen, 2005), led to the emergence and founding of occupational therapy practice in 1917 (Woodside 1971). Historical references to the philosophical and moral treatment in occupational therapy document the emergence of theories advocating relationships between persons and environment and between the mind and body (Bockoven, 1971; Briggs, 1982; Peloquin, 1994; Yerxa, 1980).

The early 1980s witnessed a rebirth of caring in practice, literature evoked new found interest in the caring relationship between therapist and patient stating that the ability to care for others is related to the ability to care for oneself, this ability is shaped by life experiences (Baum, 1980; Devereaux, 1984; Gilfoyle, 1980; Hightower-Vandamm, 1980; King, 1980,).

Over the last 20 years literary articles have attempted to place more emphasis on understanding the caring experience. Crepeau (1991) argues that the occupational therapist must achieve a balance between the provision of treatment and understanding the life experiences of their patients. This is an important sociological perspective and Crepeau attempts to analyse how the therapist enters into the patient’s life-world in an effort to simultaneously control and manage the treatment process. Central to this
analysis is the concept of knowledge schemata (the beliefs and expectations an individual brings to a given situation) and the focus which occurs during the interaction (Daneshgar and Parirokh, 2007).

References to the study of caring in both occupational therapy and physiotherapy make sporadic appearances in the literature. Wright-St Clair (2001) summarizes caring as ‘more than feeling empathy. It is about connectedness and attunement’. Here caring is seen as existing “….in a continuum: sympathy is at one end, empathy in the middle, and attunement (or caring) is at the other end” (p.189).

Wright-St Clair focuses on the nature of caring as described by Gilligan, Mayeroff, Noddings and Watson in order to explore the idea that an ethic of care may well provide a moral motivation for occupational therapy practice, believing that caring is fundamental to occupational therapy practice. Dychawy-Rosner et al. (2001) build upon the notion of patient-therapist interaction, in this study conducted in Sweden, health care staff experiences were explored among people with developmental disabilities. This study concluded that in order to develop the quality of interventions for supporting daily activity, caring dynamics as experienced by the caring staff, should be identified so that a caring relationship can be created.

Continuing the focus on care ethics, feminism has been acknowledged within the occupational therapy field. Sachs (1989) was one of the earliest to examine two feminist dimensions within the profession (a) the female dominance of the occupational therapist role and, (b) the art of caring, which is associated with the societal role of women, and a fundamental factor of OT work. Sachs argues the need for a feminist conceptual framework rather than the conventional ideology of professionalism in order to approach an understanding of the perception of caring.

Hamlin (1992) used a feminist perspective to explore the foundations of healing and medicine. Tracing the role of women from pre-historic times, into the present and on into the future. Hamlin discusses specific changing paradigms identified as (a) the Prototypic Paradigm: Mysticism and Healing; (b) the Scientific Paradigm: Curing; and (c) the Paradigm of Inclusion: Caring, Curing, and Healing.
Within these paradigms are the role and status of women in society and Hamlin examines the changing position of occupational therapy within this framework, concluding that the role of occupational therapy and its unique contribution to 21st Century health care fit within the Paradigm of Inclusion, that is to say Caring, Curing and Healing. The problem with using a feminist conceptual framework within any health care profession in the 21st Century is that occupations such as OT are no longer a female only vocation, although it can be argued that the profession is currently female dominated, the emergence of male occupational therapists no longer makes it female exclusive and therefore consideration must be given to frameworks which incorporate male perspectives of caring (Peters, 2011).

Additional literature exists which explores the importance of acknowledging caring as an important part of the therapeutic relationship within the field of occupational therapy, (Peloquin, 1994; Rahman, 2000; Sachs 1989, 2000; Sachs and Labovitz 1994, Weinstein, 1998) acknowledging the complex nature of caring relationships, advocating the need to communicate caring in a meaningful way.

Raz et al., (1991) examined the influence of gender on values and behaviour in physiotherapists and reported that female physiotherapists viewed caring as a core value thus influencing their behaviour towards patients. The authors reported physiotherapists felt that the core of their clinical practice was based upon the development of trusting and reciprocal relationships characterised by personal traits such as receptiveness, responsiveness and interpersonal sensitivity. A further study by Jensen et al. (2000) which examined the clinical practice of physiotherapists concluded that they were able to consistently convey a feeling of caring and commitment towards their patients adding to the findings of Raz et al. (1991) stating that the feeling of caring and commitment helped to convey a health care climate which highlighted collaborative and reciprocal decision making between the physiotherapists and their patients. The findings of this study were supported by (Resnik and Jensen, 2003) who identified that caring for patients, empowering patients and establishing a good patient-therapist relationship were the primary goals of the physiotherapist. A more recent study by Greenfield (2006) examined what moral practice meant to five physiotherapists with over 7 years’ experience in the
profession, he reported that physiotherapists used an ethic of care to assist with ethical
decision making and stated that moral issues and dilemmas were ever-present in clinical
practice.

2.7.3. Nursing

Nursing has been called the oldest of arts and the youngest of professions (Donahue,
2010). The art of nursing throughout history has portrayed a profession that embodies the
preservation and restoration of health including the care of the terminally ill. The word
“nursing” is derived from the Latin ‘nutrix’ which means to nourish, by the 16th century
the word nurse was given to mean a person who attends or works for the sick, under the
direction of a physician. Nursing attendants are mentioned in classical literature although
it is not known if these were male or female. Following physicians orders, they prepared
and administered medication and cared for the needs of the sick.

Nursing historically was seen as the work of men and the first recorded established
nursing school in the world in 250 B.C. was mentioned in the Indian writing, entitled
Charaka (volume 1). The writings made reference to men as only they were considered
‘pure’ enough to become nurses. The men were expected to be of good behaviour,
distinguished for purity, cleverness and skill, imbued with kindness and skilled in every
service a patient required (Underwood and Ashworth, 2008).

It is of note that the caring behaviours documented in these writings are reflected in the
work of modern day caring theorists. The art of nursing continued to be practiced by men
during the Byzantine Empire, throughout the Middle Ages during the crusades, the most
famous order at this time was the Knights Hospitallers who cared for the sick and
wounded. The historical custom of men working as nurses is in stark contrast to the
female dominated profession of modern times where relatively few men seek a career in
nursing making up only 5-10% of the nursing workforce in the UK (Mulland and
Harrison, 2008).

Nursing was initially established in charity hospital institutions that administered care to
the poor whilst at the same time excluding and separating them from society (Horden,
2008). Typically at this point in time they were places where the poor sick went to die
rather than be cured, seeking spiritual solace and the last rites (Foucault, 1994). The attraction for men and women to work in such institutions was not to cure the sick but to achieve their own spiritual salvation, caring was therefore seen as an act of Christian duty, motivated by Christian teachings of love and mercy (Peterson, 2002). It was these teachings that impelled the early deaconesses to care for the sick and dying.

The ‘nurses’ bore little resemblance to the carers we know today, they simply cared for and were carers of the dependent sick, injured, elderly, babies and poor. It was only during the 19th century that women became more involved with the art of nursing. One of the greatest influences and role models for the nursing profession was Florence Nightingale, who has been attributed as the founder of modern nursing (Winkel, 2009). In brief, Nightingale was born into 19th century British society and used her position as a well-educated Victorian socialite to improve conditions in military hospitals both in the field and at home. In 1854 at the request of her friend Sidney Herbert, the British Secretary for War, she recruited 38 nurses to work in Turkey to aid soldiers injured in the Crimean War (1853-56), (Gogerly, 2006). She was unpopular with the military authority and medical profession at the time who resented her interference. She was a strong woman who despite the animosity towards her presence revolutionized British military medical care, increasing the standards of sanitation and nutrition which drastically cut mortality rates (Bostridge, 2009; McDonald, 2010). Famous for her pioneering work in the military hospitals during the Crimean War (1853-56), Nightingale was responsible for helping to establish nursing as a more respectable profession for young women of the time. In 1860 the first Nightingale nurse training began and spread throughout the UK and the British Empire. Nightingale also revolutionised future hospital design with the emergence of the Nightingale style wards.

Continuing into the 19th century the employment of parish nurses to care for the sick in their own homes was introduced by the Poor Law Committees. This was seen as costing less than sending the poor sick to the workhouse and was influenced by the politicians of the time who needed to exercise control over these unfortunate individuals (Dean and Boulton, 1980). For the wealthier in society care was provided by visiting charities and, in 1840, an institution set up by Elizabeth Fry trained women from upper class society to
care for the sick in their own homes (Watson, 2001) thereby establishing a social divide in the caring of the sick. Fry was acknowledged as an English prison reformer and social reformer. She was known mainly for improving prison conditions, founding the first prison school for children who were imprisoned along with their parents. When Fry opened her training school for nurses in 1840, the programme became an inspiration to many, amongst them Florence Nightingale. The team of nurses that accompanied Nightingale to nurse soldiers in the Crimean War were from this school (Hatton, 2005).

Although considered one of the oldest occupations within the field of caring, nursing did not achieve professional status until the late 1800s. In the late 1880s professional organisations emerged and by 1930 professional nursing associations existed in 35 countries. In England, the Royal College of Nursing was founded in 1916, although professional control was not given to the General Nursing Council until 1919. After the First World War, in which nurses served on the front line, a State Nursing Registry was set up which guaranteed a minimum level of training for all nurses. (Ethel Fenwick was the first nurse to be awarded state registration- SRN 001). Although this allowed the public to differentiate between trained and untrained nurses, the reality at this time was that standards of training fluctuated (Donahue, 2010).

The late 19th and early 20th centuries saw rapid and considerably major changes emerging within health and social care (Watson, 2001). Black (2005, p. 1394) attributes the transformation of hospitals within the UK to ‘medical advances, nursing reform and improvement in buildings.’

Since 1945 nurse training has grown to encompass different specialities within the field such as orthopaedic nursing. Advances in medicine and public health have projected the nursing profession into the twenty-first century with the expansion of nurse training programmes to degree status (Black, 2005). Nursing has been acknowledged as both the art and science of caring, and has evolved into one of the fundamental support systems of modern medicine. It consists of the ability to express the self, being able to understand and interpret the subjective experiences of the patient and using nursing actions in a creative way (Leininger, 1981; Lindberg et al., 1998).
Caring as an essential component of nursing is a concept that is widely accepted in nursing both historically and in the modern profession today. To try and give a definitive meaning to caring is extremely difficult although from a nursing perspective the effects of a caring approach are believed to enhance patient health and well-being, facilitating health promotion (Baldursdottir and Jonsdottir, 2002).

The emergence of nursing ethics in the 1980s led to the exploration of caring and caring ethics and numerous reports of caring ethics in nursing surfaced (Benner & Wrubel, 1989; Benner et al., 1996; Dinkins and Sorrell, 2006; Fry, 1989; Leners and Beardslee, 1997). Chin and Watson (1994) stated that in order for a trusting nurse-client relationship to emerge the individual nurse must draw upon experience, empathy and effective helping skills. The scientific element consists of an analytic and systematic process to aid in a problem solving approach to clinical nursing problems (Watson 1979). Regardless of which methodology nurses use, it is essential that human caring is evident in every aspect of nursing (Yam et al., 2000). There have been several empirical studies undertaken on caring and these have generally focused upon the patients’ perceptions of caring, what caring is and comparisons between nurse and patient perceptions (Larson and Ferketich, 1993; Lea and Watson, 1996; Von Essen and Sjoden, 1995). These studies have attempted to relate nurse caring behaviours to patients’ feelings of being cared for (Blegen et al., 1998; Bjork, 1995., Chipman, 1991; Greenhalgh et al., 1998; Komorita et al, 1991; Larson, 1986; Meyer, 1987; Morrison, 1991; Morse et al., 1991; Von Essen and Sjoden, 1995).

Duquette and Cara (2000) put forward the argument that if we believe that caring is pivotal to nursing then it is the responsibility of nurses to protect this belief through all areas of their practice. Caring should seek to sanction the professional identity of nursing in situations where humanistic values are frequently questioned and challenged. They go on to state that we should strive to protect the heritage of nurse caring through the clinical application of caring theories and in particular the work of Watson (1988) which advocates caring as being a science which encompasses a humanitarian, human science orientation, phenomena, human caring processes and experiences.
2.8. Perceptions of care in Orthopaedics

Orthopaedics is a specialist art and science of caring, its uniqueness lies in its objective to restore mobility and prevent functional disability and decline (Davis, 1997). Orthopaedic injury and disease can affect patients socially, functionally and psychologically. Due to the diverse nature of orthopaedic conditions it is essential to view patients as holistic entities taking into consideration their beliefs and expectations of care and caring. Equally it is important to understand the same beliefs inherent in the health care professionals who work within the speciality of orthopaedics (Clarke, 2003; Footner, 1998; Jackson, 2003; Tierney, 2004).

The number of studies available in the literature relating to patients’ perceptions of care and caring with the multi-professional orthopaedic team is sparse. Within this search orthopaedic patients’ perceptions appeared in association with satisfaction (Arslanian, 2001; Berg et al., 2007; Davis & Bush, 2003; Fielden et al., 2003; Flynn, 2005), quality (Kneale and Knight, 1997) perioperative care (Gustafsson et al., 2010), nursing care (Kalafati et al., 2009; Love, 1996; Suhonen et al., 2010; Suhonen and Leino-Kilpi, 2010; Suhonen et al., 2008; Watters, 2003) emergency trauma care (Baldursdottir and Jonsdottir, 2002; Muntlin et al., 2006) pre-assessment (Aquilina and Baldacchino, 2007; Lucas, 1998), functional ability (Cohen, 2009; Larsson et al., 1999) paediatrics (Judd 2009) physical needs (Khalaf et al., 2009). It was evident that the investigators have emphasized the importance of caring in relation to achieving successful outcomes. The research undertaken in the majority of these studies has occurred only from a nursing viewpoint. Watters (2009) argues that caring should be the central focus of care for orthopaedic nurses, who care for patients often facing long periods of stay in hospital but does not elaborate on what traits set aside orthopaedic nurses from others.

Santy (2001) believes that the role of the orthopaedic nurse is comprised of six categories: partner, guide, comfort enhancer, mediator, risk manager and technician. Furthermore Santy advocates that the nurse acts as a ‘harmoniser’ when caring for the orthopaedic patient thereby ensuring that all aspects of care given produce an effective whole. This description of the role views the nurse as a protector, shielding the patient from harm,
leading them through the illness trajectory to a desired outcome. The role that Santy alludes to is more consistent with a supportive function, referring to the orthopaedic nurse as ‘multi-skilled’ suggesting that nurses working within the speciality of orthopaedics possess more technical abilities than other nurses. The idea of the orthopaedic nurse acting as partner/guide was also identified by Drozd et al. (2007). The authors proposed that the relationship orthopaedic nurses have with their patients is distinctive. Their study, consisting of two focus groups involving orthopaedic nurse practitioners, built upon the research by Santy (2001) and concluded that discrete themes surfaced which revealed the ‘values, beliefs, philosophies and attributes of orthopaedic nursing’ (p.50). These were patient/guide, patient centred, and family centred, multi-professional team player, comfort enhancer, ensuring a therapeutic relationship, age continuum, skilled technician, role model, and risk manager. This study did not seek the opinions of patients so that a comparison between nurse and patient perception could be drawn. At the time of the literature review no study was found that examined caring from a multi-professional team perspective.

Healthcare professionals assume responsibility where possible to promote and restore health, prevent illness and alleviate suffering. Having the ability to provide clinical expertise that is based on sound clinical knowledge, employing discretionary judgement, having the ability to understand illness and its trajectory, and appreciating the varied human response to illness are all central to professional healthcare practice. Paulson (2004) has argued that the ability to take care of patients takes many years of training whilst the ability to care for others requires that the healthcare professional can project an open and warm presence that allows them to connect with each patient in a personalised way.

The complexity of chronic diseases along with the expanding development in medical care and treatment has led to the need for effective and efficient health care teams (Wiecha and Pollard, 2004). Teamwork has been promoted as being beneficial to the patient for the last century (Bernard-Bonin et al., 1995). However, a consensus of the definition of clinical teamwork is not yet evident.
In 1996 Lorimer and Manion suggested that teams comprise of a group of individuals who are committed to a relevant shared purpose. This purpose has common performance goals, skills which overlap and expertise that complement each other. Importantly a team possess a common approach and focus to their work. The orthopaedic multidisciplinary team tend on the whole to treat patients independently but come together to share information regarding care. Coulter (1997) stated that there should be an increasing drive for patients to be included in the team responsible for the delivery of care. Furthermore, it is accepted that patients need to be well informed about their disease, know the options available to them and have greater control over their treatment. Davis et al. (2000) add to this statement arguing that patients should indeed be partners in their care delivery.

In 1999 Schofield and Amodeo concluded that studies evaluating the impact of clinical teamwork on patient care were significantly weak in terms of research rigour. More recently, research has been undertaken to demonstrate the effectiveness of teamwork in a clinical setting adopting a more rigorous approach (Heinemann et al., 2002). A study by Gittell et al. (2000) explored the effect of several key dimensions relating to team co-ordination, this included communication, shared goals, shared knowledge, problem solving and mutual respect on the quality of orthopaedic surgical care. Improved outcomes were reported where the team demonstrated an increase in co-ordination. However, this study did not research perceptions of care and mainly focused upon technical competence of clinical actions.

Suhonen et al. (2008) examined orthopaedic and trauma patients’ perceptions of nursing care in orthopaedic hospital care settings in four European countries. Differences were found across countries when rating care with Swedish and Finnish patients providing the highest assessments and Greek patients the lowest. Four sub-scales were assessed, seeing the individual patient, explaining, responding and watching, responding achieved the highest assessment in all four countries and seeing the individual patient the lowest except in Greece. Suhonen et al. (2008) concluded that further research was needed to explore whether the cross-country differences were as a result of culture, nursing practices, roles of healthcare personnel or patients.
2.9. Chapter Summary

The opinions of caring are diverse and the literature review undertaken provides us with a critical insight into capturing, in part, the essence of caring. Concepts of care continue to be topics of interest first debated in the early 20th century and well into the 21st.

From the literature it is evident that a blurring of the boundaries exists in relation to professional caring, some professions placing more emphasis on utilizing an ethics of care to inform practice than others. History has predetermined how caring has evolved amongst the professions and since the 19th century caring has been attributed as being the essence of nursing. This is certainly difficult to comprehend given that historically nursing and medicine had one common establishment – disease.

Caring as personified by the doctor in the 19th century has all but disappeared, no more do doctors visit patients at home to ‘care’ and ‘comfort’, although the ‘caring’ nurse is still evident in the patient psyche (Gardener et al., 2001; Schmidt 2003). Caring is a blend of physical and emotional acts which patients expect from all health care professionals, importantly patients need to feel ‘cared for’ and ‘cared about’ in order to truly experience a caring relationship with their care providers.

Leininger (1981) stated that caring had emerged from research and related literature as the essence of nursing and indeed nurse caring has been reported, described and discussed for the past two decades. What is certain is that the delivery of care and the dynamics of being a patient may have changed over the centuries but the reasons for caring have not.

In today’s modern healthcare system the concept of caring in other health care professions is adding a new dimension to the debate. The question this raises is will nursing be a reluctant or willing guide for other health care professions as they seek to embrace the caring concept. The literature does not reveal any study which has explored perceptions of caring between patients and the multi-professional orthopaedic healthcare team, an investigation which this researcher feels requires scrutiny in order to understand and identify the important caring attributes that constitute a good patient experience of holistic care.
Much of the work undertaken into perceptions of caring has focused primarily on institutional or hospitalized care provided by nurses. No one study has explored patients’ perceptions of care with the multi-professional team; it is important to state that this is not a thesis about comparing one health care profession to another. The nature as well as the ability to care and care well is qualities in which all health care professionals should be accomplished. It is the aim of this study to look beyond the somewhat over-crowed niche of single dimension studies which explore patient perception of caring with different facets of the nursing profession. The perceptions of caring with the multi-professional orthopaedic team have not been addressed, and knowledge gaps exist in relation to our understanding of how patient’s admitted to hospital for elective orthopaedic treatment or as a result of orthopaedic trauma perceive caring and importantly how that caring perception meets their expectations of care.

Therefore the objective of this research is to seek answers to the following:

- Which caring behaviours are deemed to be of importance to patients and health care professionals?
- Do differences exist between caring perceptions of patients and health care professionals?
- What, if any, factors may influence perceptions of caring?
- To discover which elements of Watson’s caring theory are exhibited by health care professionals during caring interactions.
- To understand patients’ perceptions of caring that is delivered by the multi-professional team within the specialty of orthopaedics.
- To gain an insight into what perceptions health care professionals have of their own caring behaviours.
CHAPTER THREE

Measuring caring

3.1. Introduction

In order to help understand the conceptualisation and measurement of caring, this chapter will review quantitative caring instruments reported in the literature. It has been concluded from the Literature Review (Chapter Two) that caring is a complex and elusive concept, difficult to define but also difficult to measure (McCance et al. 1997). The measurement of caring is a constant source of debate amongst nursing theorists and researchers, with little or no agreement as to the most appropriate quantitative or qualitative method for measurement. Morse et al. (1991) identified five conceptualisations of caring found in the literature:

- Caring as a human trait
- Caring as a moral imperative
- Caring as an affect
- Caring as an interpersonal interaction
- Caring as a therapeutic intervention

The measurement of care has in recent years attracted the attention of other health care professionals, such as doctors, physiotherapists and occupational therapists (Grogan et al., 2000; Labarere et al., 2001; Sachs, 2000; Romanello and Knight-Abowitz, 2000). One of the reasons for the surge in interest can be attributed to the 1998 Department of Health publication ‘Our Healthier Nation’ which emphasised the importance of obtaining the views of patients as a means of improving services. More recently in the Department of Health publication (2008), ‘High Quality Care for all, patient experience was acknowledged as one of the key elements of quality in the NHS. In the past decade the NHS has been accused of being a paternalistic organisation (Dieppe & Horne, 2002), and until recently it has failed to utilize patient views to improve the quality of health service
delivery (Wensing and Elwyn, 2002), thus revealing a tension between politics and healthcare delivery. Today’s NHS is confronted with an unashamed encouragement through the media to complain about and criticize health care, which can lead to an unrealistic expectation of what can be delivered. This in an era where focus is centred upon cost savings and a reduction in the workforce. For example, recent media coverage of the quality of hospital care has not been favourable, in particular patient and family disclosure of the poor care provided at Mid Staffordshire Hospital NHS Trust only served to trigger a barrage of unfavourable accounts and experiences of failing care in our health service. Such was the concern that prominent religious figures such as Archbishop Vincent Nichols criticised hospital care stating that some NHS Hospitals were “lacking humanity”, failing to live up to the NHS Charter which promotes an environment which “responds with humanity and kindness to each person’s pain, distress, anxiety or need”. Archbishop Nichols argues that there is a lack of “true compassion, deep respect and attentive care of the whole person” (“Archbishop urges compassion in NHS”, 2010, p.8). Such disquiet from the Church adds the domain of spirituality to notions of caring.

Although public concern is justifiable, to generalise on the state of caring in hospitals, both in terms that the care is ‘rubbish’ and the care is ‘fabulous’ is unfair and portrays a sense of guilt by association amongst health care professionals. What makes this generalisation unreasonable is that caring behaviours can be evident in an infinite number of ways that it is futile to expect replication of all caring behaviours in all health care professionals. Ultimately patient views are important indicators of satisfaction with care and therefore measurement is crucial to understanding and achieving quality in caring.

3.2. Measurement of caring

In the debate regarding which method is the most appropriate for the measurement of caring: quantitative, qualitative or a combination of both feature as the most prominent. Watson (2009), for example, advocates the use of qualitative methodologies citing phenomenology as a means of investigating the concept of transpersonal caring. Over the years various quantitative and qualitative tools have been designed in an attempt to measure care. Early quantitative studies tended to focus upon perceptions of physical care and the medical treatments that were given and as a result used scheduled questions
(Abromowitz et al., 1988; Avis et al., 1995; Baker, 1990; Bertakis et al., 1991; Bond and Thomas, 1992; Carr Hill et al., 1992; Cleary and McNeal, 1988; Donabedian, 1997; Duffy, 1992; Eriksen, 1987). The problem with most quantitative approaches to measuring care is that there is a tendency to focus upon predetermined and technical aspects of care, such as taking a pulse, carrying out a physical examination or helping a patient to walk. Rather than permitting patients to express their own detailed views about actual care encounters (Beck, 1999). In addition patients do not appear to use the same value judgements as health care professionals when evaluating quality of care (McGlynn, 1997). Thus quantitative studies have provided knowledge of the relationship between the functional components operationalized within nursing care delivery.

By comparison qualitative studies have provided more in-depth information relating to caring from the patient and nurses’ perspective including the characteristic traits and caring behaviours most valued by both groups (Attree, 2001; Kralik et al., 1997; Radwin 2000; Thorsteinsson, 2002; Williams and Irurita, 1998). Early qualitative studies have assisted in defining various populations, helping to assess the importance of caring and evaluate the meaning of caring to individuals (Cronin and Harrison, 1988; Larson, 1987; Reiman, 1986). The use of formal measurement tools in both quantitative and qualitative nursing research allows some insight into the caring phenomenon providing information which will help to inform nursing practice, measure quality and satisfaction with care, evaluate standards of care given, identify areas of strengths and weaknesses and increase knowledge and understanding of the relationship between caring, health and healing (Watson, 2009). Differing measures of nurse caring have been developed through varying conceptual frameworks and specialised populations, drawing in cultural and anthropological aspects to the overall domain of caring.

In addition some studies have related nurse caring to patient satisfaction ratings and other positive health care outcomes such as feelings of well-being and empowerment in dealing with and coming to terms with illness (Duffy, 1992; Issel and Kahn, 1998; Larson and Ferketich, 1999; Latham, 1996). The measurement of caring is a widely-held focus of study amongst nurse researchers and theorists (Coulter, 1997; Donabedian, 1988; Rubin, 1990; Sitzia and Wood, 1997; Vuori, 1991; Williams, 1994). The challenges facing any
researcher in this field is deciding which instruments to use in the measurement of caring. This is a philosophical dilemma and careful consideration to which method is to be used and with what objectives in mind. Every patient is a unique individual who brings their own set of beliefs, values and morals into the caring relationship. Caring is a complex human phenomenon and requires exploration to capture as much of its meaning as possible (Watson 1988). This may then provide some understanding of the relational-ethical-ontological grounding of caring which can be applied to health care sciences and practice.

3.3. Qualitative approaches to measuring care

“Qualitative research is an emerging approach to inquiry, the collection of data in a natural setting is sensitive to the people and places under study.” (Creswell, 2012, p.44).

There is a gradual but significant increase in the use of qualitative methods because of a growing appreciation of qualitative investigation as an equal but different research method in health care research (Malterud, 2000; Shortell, 2000; Hoff and Witt, 2000; Sinuff et al., 2007; Curry et al., 2009). Qualitative methods are used predominantly to gain greater insight and understanding into complex social processes, to obtain fundamental aspects of a phenomenon as perceived by study participants, (Malterud, 2000), and to discover beliefs, values, and motivations that trigger individual health behaviours (Sofaer, 2002; Crabtree and Miller, 1999). Primarily qualitative methods to measuring care are exploratory in nature seeking to generate novel insights into the subject matter using inductive rather than deductive approaches (Patton, 2002; Pope and Mays, 1995; Glaser and Strauss, 1999). There are several distinguishing features to qualitative methods in comparison to quantitative methods as evident in Table 3.1.

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<tr>
<th>Qualitative</th>
<th>Quantitative</th>
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<tr>
<td>Describes complexity, breadth, range of occurrences or phenomena</td>
<td>Counts occurrences (prevalence, frequency, magnitude, incidence)</td>
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<tr>
<td>Generates hypotheses about a phenomenon, its precursors and consequences</td>
<td>Statistically tests hypotheses</td>
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Qualitative methods are now recognised as being valuable in the construction of patient-centred quantitative instruments particularly in relation to outcome research. For example, several researchers in the health care field have used focus studies to elicit patient perspectives on care which informed the development and validation of questionnaires (Krause, 2006; Kressin et al., 2002; Collins et al., 2002).

Important areas in research benefitted by qualitative methods are studies involving specialist populations, in particular those groups that are traditionally under represented (Napoles-Springer and Stewart 2006). Here the value of using open-ended interviews is acknowledged as they are perceived as less intimidating than surveys, especially in groups historically marginalized in research such as those with low literacy levels (Curry, 2009). The most familiar qualitative methods within the health care research field are focus groups, interviews and observation (Creswell, 2012). Focus groups and interviews are of specific interest since both are seen as precursors in the construction of survey instruments (Sofaer, 2002).

**Focus Groups**

Focus groups have in recent years become a “viable alternative to traditional one-to-one interviews” (Heary and Hennessey, 2002, p. 47). Focus groups consist of carefully planned group interviews that generate data through the opinions expressed by participants in a defined area of interest (Halcomb et al., 2007; Heary and Hennessey, 2002). They are described in the literature as a tool of considerable merit especially when “engaging culturally and linguistically diverse populations” (Halcomb et al., 2007, p.1000). The focus group discussion allows the researcher to explore both the cognitive and emotional responses provided by the participants whilst observing the principal group dynamics.
The advantages of focus groups are, they facilitate an informal and relaxed approach to learning relating the beliefs and ideas of homogeneous groups whilst producing a diverse range of information. Importantly, focus groups acknowledge the participants as experts and due to their flexible characteristics blend well with other qualitative and quantitative methods (Morgan, 1997). Like all research approaches focus groups have their limitations (a) they can be impractical in testing hypotheses in traditional experimental design, (b) when attempting to draw inferences about larger populations or (c) where statistical testing is required. Furthermore the possibility of intimidation within the group setting may affect interaction and participant response (Lewis, 1992).

**Interviews**

Interviews usually take place as a 1-1 interaction between study participant and researcher. An interview can elicit rich data and detail when individual experiences and perceptions are explored (Patton, 2002; Dicicco-Bloom and Crabtree, 2006). The attraction of 1-1 interviews lie in their ability to ensure privacy and encourage good rapport between respondent and interviewer, this can help alleviate respondent fear particularly where negative statements are given during the interview (Hamilton and Bowers, 2006). In more recent years the introduction of telephone or electronic interviewing techniques has helped contact isolated or difficult to reach study participants (Hamilton and Bowers, 2006).

Consideration should be given to the experience of the interviewer who should maintain control of the interview throughout, possess good listening skills, use non-judgemental language, be able to draw out responses encouraging respondents to elaborate on answers; and give verbal and non-verbal feedback (Creswell, 2012).

**Observation**

The collection of data through observation concerns the systematic surveillance of individuals and events so that behaviours and interactions in the natural environment can be studied and learnt from (Pope et al., 1995). The collection of data through observation is of particular significant when the planned outcome of study is to gain an understanding of culture in a given setting or phenomenon, especially when the situation of interest is
concealed or where those under observation have notably different views or cultural practices to that of outsiders (DeWalt and DeWalt, 2010).

The researcher may act as participant or non-participant observer. Participant observers are not known to the study participants whereas non-participant observers are. One of the biggest challenges to non-participant observation is the Hawthorn Effect, or the extent to which study participants alter interaction or behaviour as a result of being watched (DeWalt and DeWalt, 2010).

Following review of qualitative instruments for measuring caring it was decided to use observation and semi-structured interviews in this study.

3.4. Quantitative approaches to measuring care

Measuring caring from a quantitative perspective is challenging; Watson (2009) summaries the extent of the problem by asking how is it possible to justify having empirical objective measures about such an existential human relational phenomenon as human caring. The task faced by any researcher in this field is to avoid, as far as possible, the dilution of such a complex human phenomenon whilst at the same time trying to capture the magnitude and essence of what caring is.

Watson rightly asks how the measurement of caring can be so complex when the concept of caring itself is subject to such influences as individual belief, culture age and gender. Caring can, and does, have many meanings but ultimately its measurement can only seek to scratch the surface of a ‘human trait’ which has a deeper and unique meaning relevant to each individual.

3.5. Literature Search

A search using University of Chester access of the following data bases was undertaken for the years 1984 – 2008. These dates represent a timeline which captures all the major measurement tools on caring that have been reported in the literature. CINAL Plus, Medline, PubMed, British Nursing Index, Cochrane, the cumulative index to nursing and Allied Health Literature, ERIC, Philosopher’s index, to identify quantitative instruments designed to measure various components of caring. Key words such as caring behaviours of nurses (and doctors, and physiotherapists, and occupational therapists), perceptions,
measurement and instrument were entered as search terms to elicit responses. The criteria for inclusion were that (1) the instrument measured perceptions of caring behaviours by either patients, health care professionals or both (2) the instrument is designed for the hospital setting and that (3) it measured this quantitatively.

Caring behaviours are defined as acts, conduct and mannerisms portrayed by health care professionals that convey safety, concern and attention to the patient, such as comforts, trusts, helps, shows concern for and supports. Caring behaviours are assumed to elicit feelings of ‘being cared for’ in the patient (Larson, 1984, Larson and Ferketich, 1993). Because caring seems to a nebulous term, health care professionals may gain a better understanding of patients perceptions of caring through the identification of caring behaviours.

Results showed a total of 29 quantitative caring instruments, of which 14 were designed to measure perceptions of caring by either patients or nurses (Appendix 2). No instrument could be found that specifically measured perceptions of caring with medical staff, physiotherapists or occupational therapists. Appendix 2 summarizes the instruments including conceptual definitions of caring upon which they are based, description of the tool, reported reliability and validity and strategy for item generation.

The most frequently used and reported quantitative instrument for measuring caring behaviours was The Caring Assessment Report Evaluation-Q-sort (Care-Q) (Larson 1984). Caring behaviours are the main focus of 13 out of the 14 (92%) caring instruments, only one measures the patient’s satisfaction with nurses’ caring behaviours.

Of the 14 caring instruments reviewed nine are Likert scales, two are Q-sort, two are visual analogue scales (VAS) and one is a checklist.

These instruments measure caring from different perspectives, such as listening to the patient, being honest with the patient and being kind and considerate. Although caring is mentioned as an affect by most of the researchers, they also suppose that caring is exhibited in behaviour, which can be measured and observed. Of the fourteen instruments, three rate the caring behaviours from the nurse’s perspective; six from the patients’, four from both and one rating is by a trained observer.
In two separate studies undertaken by Swanson (1999) and Hegedus (1999) it was found that patients’ perceptions of caring behaviours differed from nurses. In the study by Hegedus the phrase ‘the nurses explain procedures to me’ ranked as the most significant item for the patients whereas ‘the nurses encouraged me to express my anger and frustration’ was ranked as the most significant item for the nurses. What is interesting in this study is that no single item appears in both the patients and nurses top five significant item lists. Hegedus concludes that expectations of caring behaviours may differ between groups and, therefore, consideration must be given to examining mutual characteristics among different populations. Therefore, the researcher should choose a tool which is appropriate for the study population, i.e. tool for patient rating, tool for nurses rating or one that allows for both group ratings.

In 6 of the 14 instruments an initial psychometric evaluation was performed to establish reliability and validity with small sample sizes, for example the Caring Behaviour Assessment Instrument (Cronin and Harrison, 1988) was conducted with a sample population of 22 participants. Small sample size raises the issue of population representation, limiting the application of influential statistical methodology, such as factor analysis. Without instrument validity and reliability the researcher will not be able to ascertain the relationship between caring and patient outcomes and consequentially the need to obtain evidence-based practice through these instruments will not be realised (Fitzpatrick and Wallace, 2005).

This may be seen as problematic when considering instrument validity, as small sample sizes will increase the risk of type 2 error, causing rejection of the true hypotheses (Burns and Grove, 2004). Sample representation also requires consideration, for example, the Caring Assessment Scale was developed to measure caring behaviours of nurses but used graduate nursing students as the sample population. As a result generalizability of the instrument is limited to graduate nursing students, using the instrument for other groups may invalidate the study. Therefore it is important for the researcher when choosing an appropriate instrument, to consider how their study population differs from that of the original research study population.
3.6. Psychometric Evaluation of the caring instrument

For measurement instruments to be useful to researchers they must be able to produce reliable and valid data. The validity of a measurement instrument is the extent to which it addresses the concept it is measuring (Waltz 1991). The consistency with which respondents respond to and understand the questions asked by the instrument relates to reliability. An instrument cannot be “considered valid if it is not reliable but it can be reliable without being valid” (Parahoo, 2006 p.265). Validity is composed of three criteria-content validity, construct validity and criterion-related validity. The reason for examining content validity is to determine how well the instrument represents the concept being addressed. Construct validity is difficult to achieve and basically relates to how well a scale or questionnaire measures a given theory (Polit-O’Hara et al., 1999). Criterion-related validity is achieved by relating the findings of a given instrument to data collection via other methods such as clinical observation. Data from the present instrument can be compared with criteria from these other sources (Parahoo, 2006).

The major type of reliability reported in the literature on caring instruments is internal consistency. A Chronbach’s alpha is a co-efficient (a number between 0 and 1) that estimates the proportion of variance in test scores which can then be attributed to true score variance. It can range from 0.00 (if no variance is consistent) to 1.00 (if all variables are consistent). For example, if the Chronbach alpha is determined to be .90 this can be interpreted as meaning that the test is 90% reliable. If a test has a strong internal consistency it should show moderate correlation among items therefore a Chronbach alpha of between .70 and .90 is considered acceptable. The alpha does not indicate consistency of the test over a given period of time and, therefore, test-retest reliability should be employed. The majority of instruments report quite a moderate alpha level (.81-.97) in the total scale. Those achieving less than .70 requiring restructure (Agresti & Finlay, 2008).

3.7. Instrument Review

Following review of the literature only four instruments were identified which were designed to elicit responses from patients and carers, these were:-
Each of the instruments will be discussed to determine their suitability for use in the current research study, patient and health care professionals’ perceptions of care and caring in an orthopaedic setting.

Three out of the four instruments conceptual-theoretical basis of measurement are strongly informed by Watson’s theory (1979, 1988). Watson’s caring theory provides a framework for reviewing and categorizing current research. Jean Watson defines caring as a science, which includes arts and humanities advocating caring as being a science which encompasses humanitarian, human science orientation, phenomena, human caring processes and experiences.

This caring science perspective is grounded in a relational ontology and includes a world view of unity and connectedness of all. Watson’s Caring theory recognizes unity of life and connections which move in what are described as concentric circles of caring progressing from individual, to others, to community, to world, to Planet Earth, to the universe (Watson, 1997). The inquiry of caring science embraces ontological, philosophical and ethical studies and more recently feminist studies. Although the theory of caring science was first conceived as a nursing theory it is rapidly evolving as an interdisciplinary trans-disciplinary field of study and has profound relevance to all health, education, human service fields and professions (Watson, 2003).

Watson’s caring theory can be categorized into three key elements, firstly the carative factors, secondly the transpersonal caring relationship and thirdly the caring occasion/caring moment. The carative factors are concerned with the core of nursing and serve to “honour the human dimensions of nursing’s work and the inner life world and subjective experiences of the people we serve” (Watson, 1997, p.50). It is interesting to
note that Watson’s use of the term carative is in direct contrast to the term curative factors as used in conventional medicine. It is important to stress that Watson observes that carative factors can complement curative factors. Informing Watson’s vision for nursing is the human potential for self-healing and transcendence to greater levels of consciousness, “the nurse assists individuals to attain a higher degree of harmony” (Watson, 1988, p.49) by means of a transpersonal caring relationship. The relationship is symbolized by the whole nurse engaging with the whole client, each one conveying their own experience and meaning to the actual caring moment. The value and importance of individual subjectivity within this relationship is acknowledged and consequently the first three of the 10 carative factors in Watson’s theory centre on preparation of the nurse prior to the caring interaction.

There are a total of 10 elements which make up the carative factors:

- Humanistic-altruistic system of value.
- Faith- Hope.
- Sensitivity to self and others.
- Helping-trusting, human care relationship.
- Expressing positive and negative feelings.
- Creative problem-solving caring process.
- Transpersonal teaching-learning.
- Supportive, protective, and/or corrective mental, physical, societal, and spiritual environment. Watson extracts the notion of spiritual environment from sources as diverse as Eastern philosophy, 12th century Hildegard von Bingen and 20th century artist Alex Grey. She places body within spirit within a field of consciousness that is connected and central to all consciousness (Watson, 1999). Watson theorises that the nurse moves beyond creating the healing environments
to becoming a healing environment through the intentional use of consciousness (Quinn, 1992).

- Human needs assistance.
- Existential-phenomenological-spiritual forces. (Watson, 1988b, p.75)

3.7.1. CARE-Q

Originally known as the Caring Assessment Report Evaluation Q-sort, the CARE-Q (Larson, 1984) is the first instrument cited in nursing literature and is by far the most frequently used in the quantitative measurement of caring.

Larson acknowledges some of the early writers in the field of caring theory and philosophy but developed the instrument using a Delphi survey of practicing nurses and patients to determine caring behaviours (Watson 2009). The Delphi method is characterized as a method for arranging a group communication process to deal with a complex problem (Keeney, 2010). The conceptual definition of caring by Larson (1986) is stated as the “intent is to create a subjective sense of feeling cared for in the patient.” The phrase ‘feeling cared for’ is used to describe a sensation of well-being and safety resulting from “the enacted behaviours of another” (p.86).

Using Q-methodology, the instrument identifies which nurse caring behaviours are perceived as being important to patients. With this type of methodology only a given number of cards can be placed in each designated pile thereby ensuring forced choice distribution (Watson, 2009). Consisting of 50 caring behaviours the CARE-Q contains six sub-scales: accessible (six-items), explains and facilitates (six-items), comforts (nine-items), anticipates (five-items), trusting relationship (sixteen-items), and monitors and follows through (eight-items). The 50 CARE-Q items are printed on individual cards so that a deck of 50 cards is achieved.

Participants are asked to place the cards in seven distinct piles in an order ranging from high importance to low importance.

Larson conducted the study using the CARE-Q on 38 female and 19 male hospitalized cancer patients, with a mean age of 48 years, in an acute setting. The study identified the most important sub-scales with nurse behaviours as ‘being accessible’ and ‘monitors and
follows through’, indicating competent clinical abilities. The least important sub-scales reported were ‘trusting relationship’ and ‘comfort’.

The items on the CARE-Q were developed through (a) a Delphi survey of practising nurses on perceptions of caring behaviours and (b) a study conducted to discover patients’ perceptions of nurse caring behaviours. The results of the two studies helped to identify 69 nurse caring behaviours. An expert panel of graduate nursing students was used to assess content validity; they agreed on 60 of the items, the remaining nine items were excluded. The 60 items were then verified by a panel consisting of patients and nurses from an oncology unit. Ten further items were deleted by this panel; the 50 remaining items comprise the CARE-Q.

Test-retest reliability was conducted by Larson at an interval of 30 days using a sample of 82 oncology nurses. The test-retest reliability was found to be 79% for the five most important items and 63% for the five least important items. The CARE-Q has been used to measure caring behaviours with patients and nurses in various settings, psychiatry (von Essen and Sjoden, 1993), nursing home (Smith & Sullivan, 1997), coronary care (Rosenthal, 1992), rehabilitation (Keane et al., 1987), oncology (Larson, 1987; Mayer, 1986; von Essen et al., 1994), hospital setting (Lee et al., 2006; Manojilovich, 2005), although no study reported instrument reliability. This instrument was rejected as very few of the studies have reported on the reliability of the CARE-Q.

3.7.2. Caring Behaviours Inventory (CBI)

The Caring Behaviors Inventory (CBI) was developed originally as a 75 item questionnaire and is described as a second generation instrument to measure caring (Wolf et al., 1994). As a result of psychometric processes the instrument was revised to a 42 item questionnaire (Beck, 1999; Kyle, 1995; Wolf et al., 1994). The CBI contains five correlated subscales: (a) respectful deference to the other; (b) assurance of human presence; (c) positive connectedness; (d) professional knowledge and skill; and (e) attentiveness to the other’s experience. The conceptual-theoretical basis of the inventory was derived from caring literature in general and is grounded in Watson’s (1988c) theory of transpersonal caring, within this framework caring is the standard used to measure treatment and interventions (Wolf et al., 2003).
The clinical carative processes of Watson’s (2001) Transpersonal Caring Theory are comprised of 10 elements:

- ‘Practice of loving kindness and equability for self and other.
- Being authentically present, to/enabling/sustaining/honouring deep belief system and subjective world of self/other.
- Cultivation of one’s own spiritual practices; deepening self-awareness, going beyond “ego self”.
- Developing and sustaining a helping-trusting, authentic caring relationship.
- Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for.
- Creatively using presence of self and all ways of knowing/ multiple ways of Being/doing as part of the caring process; engaging in artistry of caring-healing practices.
- Engaging in genuine teaching-learning experiences that attend to whole person, their meaning; attempting to stay within other’s frame of reference.
- Creating healing environment at all levels (physical, non-physical), subtle environment of energy and consciousness, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.
- Assisting with basic needs, with an intentional caring consciousness, of touching and working with embodied spirit of individual, honouring unity of Being; allowing for spiritual emergence.
The transpersonal caring relationship is seen by Watson as a special type of human caring relationship and is dependent upon the ability of the carer to make a moral commitment in the protection and enhancement of human dignity along with a commitment to the deeper/higher self. The patient must not be reduced to the moral status of an object therefore the carer through a communicated caring consciousness must act to preserve and honour the embodied spirit. Finally Watson advocates that the caring consciousness and the connection that has with the one being cared for has the ability to heal since experience, perception, and intentional connection are taking place.

Watson is describing a relationship that extends beyond a mere objective assessment, demonstrating the carer’s concerns towards the patient’s subjective and deeper meaning for their own health care situation. The existence of the caring consciousness is vital to understanding the other person’s perspective and perception. This signifies the uniqueness and mutuality of the relationship between the carer and the one being cared for. As a result, both individuals are brought together in a search for meaning, wholeness and ultimately the spiritual transcendence of suffering (Watson, 2001).

Watson’s use of the term ‘transpersonal’ provides a description for reaching a deeper spiritual connection for the promotion of comfort and healing in the caring situation, the goal of which is to protect, enhance, and preserve dignity, humanity, wholeness and inner harmony.

In nursing research the CBI is the most commonly used empirical tool for measuring caring and as such its reliability and validity is the best established. Watson (1979) maintains that the carative interventions are interdependent. Each carative intervention is grouped according to its’ interdependency and in developing the CBI Wolf et al. (1994) combined the ten carative interventions to produce five carative categories. It is worth noting that these categories are not progressive and consequentially the order in which they are presented is not significant.

(1) Assurance of human presence: The three carative interventions, formation of a humanistic-altruistic system of values, instillation of faith-hope, and cultivation of sensitivity to one’s self and to others are combined in this category. Assurance of human
presence features caring behaviors such as talking with the patient, helping the patient, appreciating the patient as a human being and responding promptly to the patient’s call for assistance (Brunton and Beaman, 2000).

(2) Respectful deference: combines two carative interventions, developing a helping-trusting relationship and encouraging and accepting expressions of positive and negative feelings. Respectful deference incorporates caring behaviours such as being honest with the patient, showing respect for the patient and providing the patient with information to make decisions (Brunton and Beaman, 2000).

(3) Professional Knowledge and Skill: merges the two carative interventions of systematic use of the scientific problem-solving approach for decision making and promoting interpersonal education and learning. This category relates to caring behaviours such as watching over the patient, paying special attention to the patient on the first visit and being confident with the patient (Brunton and Beaman, 2000).

(4) Positive Connectedness: incorporates only one carative intervention, provision for a supportive, protective, and/or corrective mental, physical, sociocultural, and spiritual environment. This category conveys caring behaviors such as allowing the patient to express feelings, trusting the patient and being hopeful for the patient (Brunton and Beaman, 2000).

(5) Attentive to the Other’s Experience: This final category incorporates two carative interventions, assistance with gratification of human needs and allowance for existential-phenomenological forces. Caring behaviors such as putting the patient first, relieving the patient’s symptoms and giving good physical care are included (Brunton and Beaman, 2000).

The five categories or subscales each have a Cronbach’s alpha range of .81 to .92. The 42 item tool was tested on 541 subjects which consisted of 278 nursing staff and 263 patients; the internal consistency reliability was reported to be 0.96 (Wolf, 1994).
Following Wolfs’ study in 1994 the Likert scale was increased from a 4-point scale to a 6-point scale.

**Table 3.2: Reported internal consistency reliabilities for the Caring Behaviours Inventory (CBI).**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>CBI sub-scales</td>
<td>.89</td>
<td>.81</td>
</tr>
<tr>
<td>Assurance of human presence</td>
<td>.92</td>
<td>.89</td>
</tr>
<tr>
<td>Positive connectedness</td>
<td>.84</td>
<td>.87</td>
</tr>
<tr>
<td>Professional knowledge and skill</td>
<td>.81</td>
<td>.72</td>
</tr>
<tr>
<td>Attentiveness to the others experience</td>
<td>.81</td>
<td>.82</td>
</tr>
</tbody>
</table>

With a sample size of 278 nurses and 263 patients, Wolf et al. (1994) and Evert (2000) assessed the CBI’s internal consistency (Table 3.2).

In a study by Andrews et al. (1996) 26 nurse administrators completed the CBI and the top three highest ranked caring behaviours reported by the researchers were ‘shows respect for the patient’, ‘allows patient to express feelings’, and ‘treats patient information confidentially’.

The CBI is reported to be a tool which has clarity of conceptual theoretical basis, is relatively easy to understand and complete for the participants and valuable in determining perceptions of care with nurse practitioners (Brunton and Beaman, 2000), validity and reliability is not reported. Hospital setting (Yeakel et al., 2003) Cronbach’s alpha for 6 items .89, surgical patients (Coulombe et al., 2002) again validity was not reported, and elderly care (Wolf et al. 2006) content validity from literature sources. The CBI conforms to research needs with different populations, hospital setting (Plowden, 1997), post-operative care (Swan 1998), HIV patients (Williams 1999), surgical patients (Coulombe et al., 2002), trauma patients (Hayes & Tyler-Ball, 2007) and its language is consistent and straightforward gathering information pertaining to interpersonal interactions.
3.7.3. Caring Behaviours Inventory for Elders CBI-E

This instrument was developed by Wolf et al. (2004) to measure perceptions of caring amongst elderly people and their caregivers. The items originated in the Caring Behaviors Inventory (CBI) and the instrument is framed in Watson’s theory (1979, 1988, and 1999). The instrument reflects the position that caring takes place in moments and incorporates a moral commitment to the care recipient, acknowledging the vulnerability that care giver and care recipient share as humans. The original instrument consisted of 29 items and after expert panel review this was reduced to 28 items, several of these items were modified to ensure clarity. A three point Likert scale is used to elicit responses (1=never; 2=occasionally; 3=always) as the authors thought that this would be easier for elderly persons to use, total scores range from 28 to 84.

The CBI-E is a self-administered tool and instructions for use vary based on the respondents’ role as care giver or care recipient. All the items on both questionnaires correspond, for example, question 5 for the care giver version is “being honest with a resident” for the care recipient it is “being honest with you”.

The first pilot study was conducted on 46 elderly people who lived in independent dwellings. Cronbach’s internal consistency reliability coefficient was .94 for the over-all CBI-E. The amount of time respondents took to answer the questions varied greatly (Wolf et al., 2004).

Apart from the original paper discussing instrument development, no other research literature could be found which used the CBI-E. This instrument was rejected for this study on the basis that the tool was designed for use with an elderly population sample only.

3.7.4. Caring Nurse-Patient Interactions Scale (CNPI)

The Caring Nurse-Patient Interaction Scale was developed by Cossette et al. (2005) and is based on Watson’s theory of human caring (1979). The scale was designed to capture caring across various groups of informants, such as patients, nurses, students and family members for research and educational purposes.
Answers to the questions can be rated in terms of satisfaction with caring attitudes, their importance, frequency of occurrence, applicability to clinical settings and care provider competence in behavior adoption.

From the empirical and theoretical literature the original list of 121 items was composed and following a content validity assessment by 13 ‘expert’ nurses this was reduced to 72 items.

The instrument comprises of 10 sub-scales classified as humanism (6 items), hope (7 items), sensitivity (6 items), helping relationship (6 items), teaching (11 items), environment (7 items), needs (10 items), and spirituality (6 items).

Following psychometric studies a shorter version of the scale was adopted for use in clinical research setting with acutely ill patients. Three studies were undertaken using convenience samples of nursing students, the first study involved 332 participants and helped to assess the preliminary psychometric properties, these were face and content validity, reliability, links with social desirability and contrast group assessment (Cossette et al., 2005). Cronbach’s alpha for the 10 sub-scales ranged from .73 to .91. The second study involved 377 participants and was aimed at reducing the number of items so that a shorter version of the CPNI could be produced whilst still reflecting Watson’s theory. The authors achieved this by grouping the 10 carative factors into broader theoretical domains, as a result humanism, hope and sensitivity were categorized theoretically into a humanistic care domain, the helping relationship, expression of emotions, problem solving and spirituality factors categorized into a relational care domain and teaching, environment and needs into a third caring domain, clinical care. A fourth domain was revealed when the results of the study were analyzed, this was grouped as ‘comforting care’. The final CPNI consisted of 23 items.

The third study was undertaken to evaluate the construct validity of the shorter version CPNI using 531 participants, Cronbach’s alpha for the four domains varied from .82 to .93 for clinical care, .89 to .91 for relational care, .64 to .73, for humanistic care, and .61 to .74 for comforting care. Both versions of the CPNI were developed to reflect the 10 carative nursing factors described by Watson (1979, 1988) in order to investigate links between caring, patient outcomes along with teaching caring attitudes to students.
Face and content validity and reliability in the shorter version have been reported by the authors (Cossette et al., 2005). The authors have acknowledged the risk of item reduction in the shorter version which may dilute the wholeness of care as alluded to by Watson and for this reason the instrument was rejected for this study.

3.8. Discussion

The literature has revealed a number of quantitative instruments available to the researcher interested in the measurement of caring. However, there are numerous factors which need to be taken into account in order to help the decision-making process. These include reliability and validity, conceptual-theoretical definition of caring, readability and conceptual basis.

Most instruments use a specific definition of caring to underpin their grounding and several can be attributed to Morse’s (1991) conceptualization of caring as a therapeutic intervention such as the CARE/SAT (Larson and Ferketich, 1993). Only in the CBI (Wolf et al., 1994) is caring conceptualized as an interpersonal intervention, which considers caring as an intimate relationship between care recipient and care provider that is said to heighten the growth of both groups. The CBA (Cronin and Harrison, 1988) focuses on the helping process, whilst the CARE-Q, CARE/SAT and Caring Behaviour in Nurses Scale (CBNS) emphasize outcome achievement. Four of the total instruments reviewed specifically reported caring as actions or as a process, Caring Behaviors Assessment Tool (CBA) (Cronin and Harrison, 1988), CBI (Wolf et al., 1994), CARE/SAT (Larson and Ferketich, 1993) and the Caring Behaviors of Nurses Scale (CBNS) (Hinds 1988).

On the whole the caring instruments reviewed reported acceptable reliability levels with the exception of CARE-Q where test-retest reliability was reported by Larson (1987) as 63% and Komorita et al. (1991) as 64%.

Only two of the instruments, The Caring Assessment Scale (CAS) and the CARE/SAT reported factor analysis through construct validity, despite factor analysis being advocated in the literature (Dixon, 1997; Waltz et al., 1991) this may have been due to
the small sample sizes in the original testing of the instruments. Waltz et al. (1991) suggest that factor analysis is performed using 5 to 10 subjects per item and only the Caring Dimension Inventory, in the caring instrument studies, (Watson and Lea, 1997) met the sample size required with 41 items and 1430 subjects. Although the authors achieved the required number of subjects in their sample to perform a factor analysis this was not conducted. Larson and Ferketich (1993) did perform a factor analysis with the CARE/SAT although the sample size was small (268 participants) and Nyberg (1990) did not report sample size or factor analysis with the CAS. The absence of such data makes it difficult to assess the suitability of the instrument for the required setting.

Only two instruments Holistic Care Inventory (HCI) and the CBA provided information on the readability of the tools with Andrews et al. (1996) reporting on the length of time taken to administer instruments. Six minutes was the shortest mean time to complete the CBI and CARE/SAT where as a mean time of 26 minutes was reported to complete the CARE-Q. The CARE-Q was also found to be difficult for participants to understand with cards not being sorted according to directions.

There is a need to carefully investigate the definition of caring so that an instrument is chosen that best reflects the definition that is being investigated.

Beck (1999) argues that in order to measure caring effectively a concept consensus may need to be reached. The researcher argues that due to the complex and elusive nature of caring a consensus may not be feasible.

Following the review of the research instruments it was decided to collect the quantitative data for this study using the 42-item Caring Behaviour Inventory (CBI), (Appendix 3) as:

- The same questionnaire can be used by both patients and healthcare professionals reducing the need for separate instructions and forms
- It is considered the only questionnaire in this field to conceptualize care as an interpersonal intervention (Beck, 1999).
- Reliability and validity in a variety of health care settings and population samples have been established.
The Caring Behaviors Inventory is grounded in Watson’ (1988) theory of transpersonal care and, therefore, was used as the theoretical framework underpinning this thesis. Permission to use the CBI was sought and granted from the author Professor Zane Wolf (Appendix 4).
CHAPTER FOUR

Methodology

4.1. Introduction

The review of the relevant literature in Chapter Two revealed a clear need for further study of caring as perceived by patients and health care professionals in a general hospital setting and within the specialties of orthopaedics and orthopaedic trauma. Nursing studies have helped to identify caring perceptions of nurses and patients, (Bjork, 1995; Blegen et al., 1998; Chipman, 1991; Dequette and Cara, 2000; Greenhalgh et al., 1998; Komorita et al., 1991; Larson and Ferketich, 1993; Larson 1986; Lea and Watson, 1996; Meyer, 1987; Morrison ,1991; Morse, 1991; Von Essen & Sjoden, 1995) but little is known about caring perceptions of patients and the multi-professional orthopaedic team (Flynn and Whitehead, 2006).

This chapter will present the research methodology employed in the various stages of this study and in addition examine and analyse the relevant methodological issues. A rationale for the analysis chosen for each stage will also be discussed as this will help to provide clarity (Yin, 2008).

4.2. Mixed Method Research

The use of mixed or multi-method research is increasing due mainly to the development and acknowledged legitimacy of both quantitative and qualitative research in social and human sciences (Creswell, 2008). Several authors advocating the potential for mutual learning between quantitative and qualitative researchers are emerging (Brady and Collier, 2004; Guba and Lincoln, 2005; Neuman, 2011). Brady and Collier state that a “major new methodological dialogue” (p.195) has arisen from the intellectual vitality of the two approaches. Guba and Lincoln (2005) discuss how mixed methods can reconcile positivists and postpositivists stating that they can be “retrofitted” to each other in ways that make simultaneous practice of both possible.” (p. 200). Additionally Neuman asserts “the qualitative and quantitative distinction is often overdrawn and presented as a rigid
dichotomy. Too often, adherents of one style of social research judge the other style on the basis of the assumptions and standards of their own style…” (p.177).

In recent years several authorities have emerged advocating the use of mixed methods research and theory (Bergman, 2008; Creswell, 2008; Creswell and Plano Clarke, 2007; Mertens, 2005; McMillan and Schumacher, 2006; Tashakkori and Teddlie, 2003), critically analysing procedures developed to help researchers create research designs out of complex data which consequentially are more easily understood and evaluated. It’s history can be traced back to the early 1980s and has been described as the ‘quite revolution’ as it focuses on trying to put an end to tension between both qualitative and quantitative methodological camps (Tashakkori and Teddlie, 2003).

There is little consistency in the research literature for use of the terms multiple and mixed method approaches. Work undertaken by Tashakkori and Teddlie (2003) attempts to define the differing terminology, their classification is somewhat complex but they offer mixed method as the ’third paradigm’, quantitative and qualitative being the first and second paradigms. They argue that this ‘third paradigm’ possesses its own ‘worldview’ setting it aside from the positivist perspective of quantitative research on one hand and the constructivist perspective of qualitative research on the other. To try and attempt to classify multi-method and mixed method approaches further Tashakkori and Teddlie (2003) make the following assumptions; multi-method designs are on the whole intended to complement one source of information with another, or basically use various data sources to look at a research problem from a different viewpoint. The way, in which this can be undertaken is two-fold, firstly multi-method quantitative studies are contained within a quantitative paradigm but are carried out using more than one method of data collection, secondly multi-method qualitative studies perhaps combining interviews with observational study.

By comparison mixed method designs are more complex and often become the basis for using different ways to conceptualise a problem (Brannen, 2005) For example mixed method research may include the use of a questionnaire followed by observational study. As a result the researcher may start out to look at the problem from differing viewpoints but the viewpoints themselves may offer up such different ways of seeing that the lines of
sight do not converge (Teddlie and Tashakkori, 2003). This view is also acknowledged by Cameron and Miller (2007) who use the metaphor of the phoenix to describe the emergence of the ‘third’ methodological movement, arising from the ashes of the paradigm conflict.

Johnson and Onwuegbuzie (2004, p.14) argue that “mixed methods research, is a research paradigm whose time has come.” Despite their eagerness to declare its emergence it remains a developing and evolving field (Cameron, 2009). Mixed method research endeavours to amalgamate methods from different paradigms, where for example semi-structured interviews and observational studies have been performed so integrating qualitative and quantitative methods, several mixed method typologies have been developed by mixed method theorists (Creswell, 2008; Creswell and Plano Clark, 2007; Mertens, 2005; Tashakkori and Teddlie, 2003). Typologies are the study or systematic classification of types that are composed of similar characteristics or traits; they form part of models or theories (Cameron, 2009). Theorists used typologies to help organise abstract and complex concepts (Neuman, 2006).

The next layer of the mixed method approach becomes more complex, the way in which the methods are combined determines the meaning. For instance, data may be collected from each method concurrently (at the same time) or sequentially (at different times), on the surface these two approaches may not appear different but the first is viewed as two parallel studies where the data is gathered at the same time along with simultaneous implementation once the data has been analysed, whereas the second approach facilitates better integration of the two methods (Creswell, 2008).
Table 4.1: Mixed Method Approaches

<table>
<thead>
<tr>
<th>Mixed Method Approach</th>
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<tbody>
<tr>
<td>1. Researcher makes knowledge claims on pragmatic grounds</td>
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<tr>
<td>2. Consequence -orientated, problem-centred, pluralistic</td>
</tr>
<tr>
<td>3. Collects data either simultaneously or sequentially</td>
</tr>
<tr>
<td>4. Collect both text and numerical information</td>
</tr>
<tr>
<td>5. Final database represents both quantitative and qualitative information</td>
</tr>
<tr>
<td>6. Assumption that collection of diverse types of data provides a better understanding of the research problem</td>
</tr>
</tbody>
</table>

Source: Adapted from Mertens (2005)

Creswell (2008) alludes to the qualities of a mixed method approach as demonstrated in table 4.1. Mertens (2005) charted the characteristics of mixed method and model designs which incorporate both qualitative and quantitative features. The main feature of this mapping process was that Mertens differentiates between mixed method design and mixed model design. Mixed method design uses both methods to answer a research question whereas mixed model design is part of a more complex research programme. Mertens describes the data collection processes as taking two forms, (a) Parallel form and (b) Sequential form. Parallel form is where two types of data are collected and analysed concurrently. Sequential form is where one type of data collection informs the collection of another type.

Creswell’s (1994) earlier work was later built upon by Creswell and Plano Clarke (2007) developing a four type typology, incorporating the parallel and sequential form. These four designs are classified as categories which are associated with variants, timing, weighting and mix and are called triangulation; embedded; explanatory; and exploratory.
Table 4.2: Major Mixed Method Design Types

<table>
<thead>
<tr>
<th>Design Type</th>
<th>Timing</th>
<th>Mix</th>
<th>Weighting/Notation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triangulation</td>
<td>Concurrent: quantitative and qualitative at the same time</td>
<td>Merge the data during interpretation or analysis</td>
<td>QUAN + QUAL</td>
</tr>
<tr>
<td>Embedded</td>
<td>Concurrent and sequential</td>
<td>Embed one type of data within a larger design using the other data type</td>
<td>QUAN [Qual]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>QUAL[Quan]</td>
</tr>
<tr>
<td>Explanatory</td>
<td>Sequential: Quantitative followed by qualitative</td>
<td>Connect the data between the two phases</td>
<td>QUAN – Qual</td>
</tr>
<tr>
<td>Exploratory</td>
<td>Sequential Qualitative followed by quantitative</td>
<td>Connect the data between the two phases</td>
<td>QUAL - Quan</td>
</tr>
</tbody>
</table>

Source: Adapted from Cresswell & Plano Clarke (2007:85).

Table 4.2 summaries the mixed methods research designs typology. Mixed method design is not without its challenges and disadvantages as McMillan and Schumacher (2006) articulate. They argue that in order for mixed methodology to be successfully implemented the researcher should be proficient in both qualitative and quantitative research. They warn that the data collection and resources needed are extensive and that the liberal use of the methodology to studies which mix methods superficially should be avoided.
4.2.1. Quantitative research

Quantitative research fundamentally places the emphasis on measurement when collecting and analysis data. In order to establish what is known as objective knowledge, or knowledge that exists independently of the values and views of those involved, it follows a natural science model of the research process measurement (Creswell, 2012). On the whole it makes use of deduction by means of a hypothesis which has been derived from theory. Quantitative research is determined by its numerical or statistical approach to the research design. The research is independent of the researcher and data collected is used objectively to measure reality (Williams, 2007). Quantitative research is employed to explore variables arising from the data. “Quantitative researchers seek explanations and predictions that will generate to other persons and places. The intent is to establish, confirm, or validate relationships and to develop generalizations that contribute to theory” (Leedy and Ormrod, 2012, p. 102).

4.2.2 Qualitative research

Qualitative research uses an inquiry process to understand a particular phenomenon in the context of its meaning for the participants. Creswell (1994) defines qualitative study as a “process of inquiry used to gain insight into a social or human problem, based on a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting” (p. 2).

Qualitative research requires the researcher to become familiar with their participants’ interpretation of reality. Observing, recording and analysing the phenomena from the perspective of the individual participant. Holstein (2000) states that qualitative inquiry makes the assumption that reality is socially constructed by every unique individual and that as a result that individual develops their own contextual interpretation in life which is unique to them.

The use of qualitative research within health research has become more frequent in recent years (Mays & Pope, 2000., Lloyd Jones 2004., McEwan et al. 2004) Methods developed for synthesizing qualitative study findings have been grounded in the domains of education and health research which has gained momentum in recent years; as such
expanding the recognition of synthesis as a method for combining knowledge and
developing theory from individual studies (Britten et al. 2002). Consequently these
developments within health care research have borne witness to the growth of systematic
review as an instrument for synthesizing evidence on the effectiveness of health care
interventions. Ultimately these developments have led to a renewed vigour in the use of
synthesis in the interpretive paradigm (Mays et al., 2005).

Primarily concerned with how individuals interpret and understand their social worlds,
qualitative research can put forward explanations for unexpected and anomalous findings
which may emerge from quantitative research (Dixon-wood et al., 2004; Green and
Thorogood, 2004). The qualitative approach values the views of respondents and seeks to
understand the environment in which they live (Parahoo, 2006), but greater than this the
approach can help to produce a more comprehensive and generalisable theory or provide
an insight into why interventional processes succeed or fail (Harden et al., 2004).

Several approaches to the synthesis of qualitative data have been put forward, with some
based upon the analysis methods which are used in primary research representing either
an integrative or interpretive method of synthesis (Dixon-woods et al., 2004; Mays et al.,
2005). One such interpretive approach is meta-ethnography which was developed by
Noblit and Hare (1988) in order to combine ethnographic research findings in the field of
education.

This method of synthesis has been particularly evident in health care exploring
experiences of illness and care (Britten et al., 2002; Campbell et al., 2003; Pound et al.,
2005) having the ability to generate a much higher level of synthesis, generate new
research questions and reduce the duplication of research. Dixon-woods et al. (2004)
argue that its strength lies in its attempts to safeguard the interpretive properties of
primary data.
Qualitative research is constructed of complex, context dependent variables and Treise (1999) compares several qualitative characteristics and assumptions with a non-qualitative approach. As a result ontology and epistemology distinctions between qualitative and non-qualitative fields can be made. Qualitative research can be used by a multitude of disciplines in numerous ways, to study any given subject.

Table 4.3: Qualitative and Non-Qualitative Approach Comparisons

<table>
<thead>
<tr>
<th>Qualitative Approach</th>
<th>Non-Quantitative Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assumes multiple and dynamic reallities, contextual</td>
<td>1. Assumes single, stable reality, divisible, fragmented</td>
</tr>
<tr>
<td>2. Seeks understanding</td>
<td>2. Looks for external factors, causes and explanation, systematic association of variables; prediction</td>
</tr>
<tr>
<td>3. Uses a natural setting, observation is uncontrolled</td>
<td>3. Uses controller experimentation and observation</td>
</tr>
<tr>
<td>4. Data precedes theory</td>
<td>4. Theory precedes data</td>
</tr>
<tr>
<td>5. Data considered “valid, real, rich, deep, thick”</td>
<td>5. Data considered “hard, reliable, thin, replicable”</td>
</tr>
<tr>
<td>6. Focus on process</td>
<td>6. Focus on outcomes</td>
</tr>
<tr>
<td>7. Tendency not to generalise findings, contextualization</td>
<td>7. Generalizability</td>
</tr>
<tr>
<td>8. Holistic orientation</td>
<td>8. Particularistic orientation</td>
</tr>
<tr>
<td>9. Said to be “grounded, discovery-orientated, exploratory, expansionist, descriptive”</td>
<td>9. Said to be “ungrounded, verification-orientated, confirmatory, reductionist”</td>
</tr>
<tr>
<td>10. Approach - inductive, naturalistic, searches for patterns, seeks pluralism, ends with hypothesis and theory</td>
<td>10. Approach - deductive, begins with hypothesis and theory, seeks consensus</td>
</tr>
<tr>
<td>11. Considers researcher as the instrument</td>
<td>11. Questionnaire and attitude scale reliant</td>
</tr>
<tr>
<td>12. Uses concepts based on insight, descriptive write up</td>
<td>12. Uses statistical tests and measures, reduces data to numerical indices, abstract language in write up</td>
</tr>
<tr>
<td>13. “Meaning” is the central concept</td>
<td>13. Interpreted meaning given little or no consideration</td>
</tr>
<tr>
<td>14. Personal involvement and partiality, empathetic understanding</td>
<td>14. Research subjects are recruited, detachement, impartiality, objective portrayal</td>
</tr>
<tr>
<td>15. Excludes structured research instructions due to dynamic nature</td>
<td>15. Well-structured and documented research methods</td>
</tr>
</tbody>
</table>

Characteristics and assumptions of qualitative and non-qualitative approaches.
Source: Adapted from Treise (1999)
In examining the qualitative and quantitative approach, Treise (1999) provides a comparison of the characteristics and assumptions of both as described in table 4.3. The chart lists some of the basic differences between the two approaches. In particular clear distinction in ontology and epistemology among the qualitative and non-qualitative groups can be seen.

The qualitative paradigm has also been termed ‘an interpretive framework’ or a “basic set of beliefs that guide action” (Guba, 1990, p.17). All individuals involved in qualitative research are guided by “highly abstract principles” (Bates, 1972, p. 320), which combine ontological, epistemological and methodological beliefs. It is these beliefs which form the researcher’s opinions about the world and consequently how they act within it. These beliefs may be taken for granted, invisible and therefore only assumed. By comparison, some beliefs are known and may be considered controversial or problematic. Ultimately each belief or interpretive paradigm has a particular and somewhat unique impact upon the researcher which in turn influences the questions asked and the interpretation of the phenomena explored (Denzin and Lincoln, 2005).

4.3. Ethnographic Perspective

This research employed a sequential mixed methodology approach in order to study the emerging perceptions of caring. Using a sequential paradigm provided a framework for comparing and analysing differences in caring perceptions between patients and health care professionals. To facilitate an ethnographic perspective of the phenomenon, there was a need to reconstitute mixed methodology from the everyday experiences of the individual subjects. It was the desire to understand the everyday lived experiences of the subjects in relation to care and caring which guided the implementation of mixed methodology and as such the process and data collection were implicitly blended in the everyday reality (LeCompte and Schensul, 2010). This thesis used the ethnographic research tradition which emerged from the field of anthropology mainly from the works of Bronislaw, Malinowski, Robert Park and Franz Boas (Jacob, 1987; Kirk and Miller, 1986). The meaning of ethnography is literally ‘a portrait of a people’ and is considered a written description of a given culture inclusive of beliefs, behaviours and customs collected through the process of fieldwork (Harris & Johnson, 2000).
Described as a social sciences research method, ethnography is dependent upon close-up, personal experience and under certain conditions researcher participation as well as observation. In typical ethnographic research, data collection is usually threefold: interviews, observation and documentation. From these, three types of data is created: quotations, descriptions and document excerpts resulting in the production of narrative description (LeCompte and Schensul, 1999). Narrative description frequently includes charts, diagrams and other artefacts which are all used by the researcher to convey the story (Hammersley, 1991).

Ethnography lends itself well to exploratory research drawing upon a mixture of quantitative and qualitative methodologies and consequently moves fluently from ‘learning’ to ‘testing’ (Agar, 1996) together with emerging and changing research problems, perspectives and theories.

Through ethnographic study the researcher is able to gain insight into the everyday experiences of individuals by using interview and observation to obtain a holistic portrait of the subjects, revealing how people depict and organize their world (Fraenkel and Wallen, 2006). Ethnography has its earliest roots in social anthropology, with a traditional focus on small communities which were thought to share specific cultural beliefs and practices.

This traditional focus has now progressed to encompass new settings and indeed the development of theoretical perspectives eliminate theories about social coherence challenging the traditional view that “culture” is a matter of shared beliefs and practices. Signalling the existence of differences within social groups, with some social scientists argue that “culture” indicates a process of struggle to establish meaning on the part of the individuals who do not have equal access to power (Wright, 1998).

In the field of research today the majority of ethnographers would conclude that the term ethnography can be applied to any small scale social research study performed in everyday settings; employing several methods, the design develops throughout the study; with a focus on the meaning of the individuals’ actions and explanations, rather than their quantification (Hammersley, 2007).
Furthermore, ethnography is viewed as contextual and reflexive, with the important emphasis placed upon the context in understanding events and meanings giving consideration to the effects of the researcher and the research strategy on findings and importantly combining the perspectives of both the researcher and the researched. Reflexivity a relatively contemporary addition to the philosophical matrix of qualitative research signifies the researcher's part in the social world that is being investigated. The subtle balance between the critical thinking of the researcher and the researcher’s interaction with the research environment is essential to the reflexive process (Lamb and Huttlinger, 1989). In ethnographic research being an active participant in the data collection and analysis is key (Aamodt, 1982) and therefore the professional nursing experience equipped the researcher with the ability to collect and analysis the data from a research and professional perspective. This insider vision of the phenomena being studied is an inductive process as data originates from observation, interviews and participant observation.

Through the development of descriptive themes and patterns derived from the informant’s perspective and the interpretation of data obtained from the real world of practice, the insider perspective can be exposed. Leininger (1988) views these approaches as necessary for the generation of nursing knowledge stating that using the informant’s perspective can help generate theory which can lead to more accurate and reliable findings.

One of the advantages of the researcher having extensive experience in the field of nursing meant that large volumes of descriptive data relating to the context of health care practice did not require collection and therefore more focus could be given to the data related to the aims of the study. Ethnographic research is open to bias and subjectivity, but this aside it allows a richer vein of data to be appraised. (Hammersley and Atkinson, 2007 p.16; Morse and Boyle, 1994).

In relation to health care, ethnography can be applied in a number of different ways. It has been viewed as a means of accessing beliefs and practices, allowing these to be analysed in the context in which they occur and so helping to understand the behaviour that surrounds health and illness (Morse and Boyle, 1994; Morse and Field, 1996). It is
therefore of specific value in obtaining patients' views on the experience of illness or delivery of service, recognised as central to a modernised NHS. Ethnography can demonstrate how cultural practices can influence the effectiveness of therapeutic interventions (Prout, 1996) and how ethnocentric assumptions made by health care professionals can hinder effective health promotion (Galanti, 2000; Montgomery, 1993).

Within the context of healthcare, ethnography is considered valuable for several reasons, in particular exploring the cultural perspectives of patients affected by illness and more interestingly cultures of health care workers.

Since ethnographic research is undertaken in natural surroundings and aims to discover the lived reality, ethnographers can spend long periods of time with a particular group of individuals (Leedy and Ormrod, 2012) As a result certain challenges may arise;

- **Observer bias**: The researcher's own subjectivity may influence the objectivity of the data. In ethnographic research, the people being studied are described by the researcher through his/her own cultural thought system; the researcher uses his own terminology to report observations.

- **Impact of observer**: The presence of the observer, and the interaction between the observer and the people being studied, may result in changes in the behaviour of the people being studied.

- **Manipulation by subjects**: The people under observation, consciously or unconsciously, may display or act out certain behaviours in order to please the researcher, they may not perform naturally.

- **Ethics**: Researchers are often faced with ethical issues during their research. They have to decide whether or not to interfere when encountering behaviour that they consider unethical.
4.4. Reflection of other qualitative research methodologies

Following the information generated from the observation and semi-structured interview stages it was acknowledged that various forms of qualitative methodology were available that would offer a rich and meaningful analysis for Stages Two and Three of the research.

After it was decided to use the ethnographic methodology, consideration was given to a number of other methodologies. The selection of qualitative methodologies available has been described by Creswell (2012, p.4) as ‘baffling’, despite which the alternatives considered were, Phenomenology (Husserl, 1970) and Grounded Theory (Glaser and Strauss, 1999).

*Grounded theory*

Grounded theory (Glaser and Strauss, 1999) is a theory that is derived from data, systematically collected and analysed through the research process, the aim of which is to generate rather than verify theory. The process uses numerous stages of data collection and the modification and interrelationship of categories of information (Strauss and Corbin, 2008). Data is collected and analysed and ends only when new data no longer generates new insights, which is described as category saturation. The researcher’s rationale for using grounded theory is to explain a phenomenon from within a given social situation and to distinguish the intrinsic processes operating therein.

Within recent years, following much debate, two different perspectives have surfaced relating to data analysis. Strauss and Corbin (1990), developed a guide on data patterns, which detail how categories could form a structure, by way of higher order codes. This was seen by Glaser (1992) as reducing the way in which data could be analysed, arguing that patterns of categories should rise from the data.

Problems arise with grounded theory from several perspectives, grounded theory does not aim for the truth but rather it attempts to conceptualise what is happening through the use of empirical data. Thomas and James (2006) argue that it is difficult to free oneself of pre-conceptions in the collection and analysis of data as suggested by Glaser and Strauss. Flexibility can be overshadowed by systematic coding requirements.
Grounded theory is not a descriptive method and so attempts to explain individual actions regardless of time or place. Perhaps one of the major criticisms is that with grounded theory (in its purest form) the idea is that the researcher should not engage in performing a literature review prior to undertaking the research, this then begs the question as to how the researcher knows that they are investigating an area worthy of new research (Birks and Mills, 2010). This argument is a misconception of the original premise put forward by Glaser and Strauss (1999). The authors encouraged researchers to utilise material relevant to the field of study, this is taken to mean the use of literature. Later Dey (1993) and Strauss and Corbin (1999) saw the use of literature as the foundation of professional knowledge.

**Phenomenology**

Phenomenology, as proposed by Husserl (1970) is primarily concerned with an understanding of the relationship between states of individual consciousness and social life. It seeks to uncover how human awareness is implicated in the production of social action, social situations and social worlds (Natanson, 1973). Phenomenology views society as a human construction and presents theoretical techniques and qualitative methods that illuminate the meaning of social life.

Focusing on the ‘lived experience’ as described by study participants denotes phenomenology as a philosophy as well as a method. The experience can be drawn from varying sources such as perception, thought, memory, imagination, emotion, and desire. Phenomenology involves studying small numbers of subjects through extensive and prolonged engagement in order to develop patterns and relationships of meaning (Moustakas, 1994). The researcher undertakes a process known as ‘bracketing’ of their own experiences to comprehend those of the participants in the study (Nieswiadomy, 2001). Seen as a theoretical orientation, it does not generate deductions from propositions that can be empirically tested; rather it operates through descriptive analysis of the procedures of self-situation and social constitution, aimed at discovery, not theory testing or hypothesis proving (Giorgi, 1970, Giorgi and Giorgi, 2003).

The fundamental principles of phenomenology (Baker, Wuest, and Stern, 1992) include:
• **Intentionality**: The concept that the “reality” of an object is interwoven with one’s consciousness of it

• **Description**: The way to understand the reality of an object is thus through its description, as articulated in the participants’ own words

• **Reduction or Epoche**: The researcher must “suspend all judgments about what is real” (Creswell, 2012, p. 52)

• **Essence**: Data are coded into themes, then analysed to uncover the central meaning or “essence” of the phenomenon

Whilst phenomenology captures the fundamental spirit of approach as it embraces the subjective realities and lived experiences of participants, it proves problematic in relation to my research specifics, including the process-oriented nature of my topic. Such complexity makes it less amenable to a phenomenological analysis. Furthermore, whilst I seek to understand participants’ experiences and their meanings of caring, my ultimate aim is not to unveil its underlying essence (as in the phenomenological approach) as this has been said in the literature to be a complex and elusive issue.

The concept of *epoche*, which is fundamental to phenomenology, is also problematic. Although it is important to engage techniques which reduce personal bias and preconceived notions, the seeming incommensurability which exists between epoche and the suspension of all judgment about what is real is not suited to this study (Creswell, 2012).

### 4.5. Research Design

A sequential explanatory mixed methods design was employed and involved collecting quantitative data followed by a qualitative data collection phase in order to explain and follow up on the quantitative data from the earlier phase of the research in more depth. Sequential designs in which quantitative data is collected first can use statistical methods in order to determine which findings augment in the following phase (Creswell and Plano Clark, 2007). Anchoring the research topic in mixed methods design can help critique the complexity and meaning of patient and health care professional perceptions of care and caring. Following the guidance of Creswell and Plano Clark (2007) mixed method design,
this research used an explanatory sequential mixed methodology to study the emerging perceptions of caring. The use of a sequential paradigm provides a framework for comparing and analysing differences in caring perceptions. Hence to achieve an ethnographic perspective of the phenomenon, there is a need to reconstitute mixed methodology from the everyday experiences of the individual subjects. It was the desire to understand the everyday lived experiences of the subjects in relation to care and caring which guided the implementation of mixed methodology and as such the process and data collection were implicitly blended in the everyday reality (LeCompte and Schensul, 2010).

**Figure 1: The research design**

The research design is based on a sequential mixed method research design and made the qualitative method dominant and the quantitative method subsidiary, the design has three stages (Figure 1). Collecting both closed-ended quantitative data and open-ended qualitative data helped to gain in-sight into the research problem. The collection of numerical data allowed for the reporting of caring behaviours whereas the qualitative data elicited rich and meaningful accounts of caring.

In the first quantitative phase of the study and after receiving permission from the authors Wolf et al., (Appendix 4) data was collected using the Caring Behaviours Instrument (CBI) tool from 78 participants in an orthopaedic setting at a district general hospital location in order to test patient and health care perceptions of care and caring; and explain what factors influence perceptions of care and caring within the speciality of orthopaedics in both groups of research subjects. The second and third qualitative phases were conducted using observation and semi-structured interviews in order to gain a more in-depth understanding of the factors that influence perceptions of care and caring. In this
sequential explanatory follow up the central phenomenon, caring, was tentatively explored with the participants to help build upon and explain initial quantitative results.

4.6. Rationale for selection of thematic narrative analysis

In ethnographic research, data analysis is a continuous process that transcends the pre-fieldwork stage through to the production of the final written report. Narrative analysis in the context of human sciences relates to a category of approaches to diverse types of text which share a common storied form (Reissman, 2004). These texts are said to be ‘narrative’ through sequence and consequence whereby events are selected, organised, connected and evaluated into meaning for a given audience; representing a storied way of knowing and communicating (Hinchman and Hinchman, 1997). Several typologies exist in narrative analysis (Cortazzi, 2001), thematic, structural, interactional and performative analysis. Thematic analysis focuses on the content of the text, what is said rather than how it is said, the ‘told’ rather than the ‘telling’ (Reissman, 2004). Researchers collect numerous stories and inductively from the data produce conceptual groupings. The typical representation is via a typology of narratives arranged by themes illustrated through case studies or vignettes (Reissman, 2004). Examination of the data sought to acquire essentialist information, which looks at the experiences, meanings and realities of participants, in conducting the analysis.
Table 4.4: Phases of thematic analysis

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description of Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acquaint yourself with the data:</td>
<td>Where necessary transcribe data, read and re-read data, make a note of initial ideas</td>
</tr>
<tr>
<td>2. Generating initial Codes:</td>
<td>Systematically coding interesting features across the entire data set, collating relevant code data.</td>
</tr>
<tr>
<td>3. Searching for Themes:</td>
<td>Collate codes into possible themes and gathering all data relevant to each possible theme. Using criteria of recurrence, repetition and forcefulness in disclosure [Owen, 1984].</td>
</tr>
<tr>
<td>4. Reviewing Themes:</td>
<td>Check to see if the themes work in relation to the coded extracts [level 1] and the complete data set [level 2] thereby generating a thematic ‘map’ of the analysis</td>
</tr>
<tr>
<td>5. Defining and naming Themes:</td>
<td>Ongoing analysis to refine the specifics of each theme and the overall story it tells, generating clear definition and names for each theme.</td>
</tr>
<tr>
<td>6. Producing the report:</td>
<td>This stage presents the final opportunity for analysis. Vivid, compelling abstract examples selected, final analysis completed. Relate back analysis to research question and literature. Write report.</td>
</tr>
</tbody>
</table>

Adapted from Braun & Clarke (2006)

The aim was to go beyond merely describing thematic observation and narrative in an attempt to theorize the significance of the patterns and their broader meanings and implications (Braun and Clarke, 2006). Table 4.4 highlights the phases of thematic analysis as suggested by Braun and Clarke 2006.

The inductive approach of thematic analysis of the narrative was selected for Stage Two and Three as it allows research findings to emerge from, frequent, dominant or significant themes inherent in raw data, without these being restrained by structured methodologies (Bryman and Burgess, 1994). In so doing possible reasons and implications for the observed themes can be theorized and provide a more complex and perceptive analysis of the caring phenomenon (Boyatzis 1998; Roulston, 2001).
Thematic analysis is used as a tool for processing qualitative information that requires a specific ‘code’. This code may be formulated from a list of themes: a complex model of themes, indicators, and qualifications which are all causally related (Boyatzis, 1998, p.4). Themes are primarily patterns that are located in the information, and at the very least serve to describe and arrange the possible observations, but can ultimately facilitate the interpretation of some aspects of the phenomenon being studied. Narrative thematic analysis is seen as a method used in the identification, analysis and reporting of patterns or themes within data, that facilitates the organization and describing of data in rich detail (Boyatzis, 1998).

Thematic analysis is widely used within the research field although there is little consensus about what and how it is applied (Attride-Stirling, 2001; Boyatzis, 1998; Tuckett, 2005). It does not seem to exist in a ‘named’ analysis in the same way as grounded theory or interpretative phenomenological analysis (IPA). Yet it is argued that analysis on the whole is essentially thematic (Meehan, Vermer & Windsor, 2000). Thematic analysis differs from other analytic methods such as IPA, grounded theory or ‘thematic’ discourse analysis. For example, both IPA and grounded theory search for patterns or themes within the data but are theoretically bounded. IPA is linked to a phenomenological epistemology (Smith, Jarman and Osbourne, 1999; Smith and Osbourn, 2008) with experience acknowledged as a key factor (Holloway and Todres, 2003) and is concerned about making sense of an individual’s experience of everyday reality, in such detail, in order to gain a deep understanding of the phenomenon (McLeod, 2011).

Adding to the complex nature of analysis, different versions exist within grounded theory (Charmaz, 2002). Thematic discourse analysis makes reference to a variety of pattern type data analysis ranging from thematic analysis, where socially produced patterns are identified but discursive (lengthy) analysis is not undertaken, to interpretive analysis seen in discourse analysis (Clarke, 2005).

A specific form of discourse analysis, known as thematic decomposition analysis, identifies themes within data but views language as not simply descriptive of real
phenomena but as constitutive of (what we believe or have come to believe as) reality (Parker, 1990; Weedon, 1996).

All of these methods share a common search for given themes or patterns across data sets. This differs from the likes of narrative analysis where the search for themes is confirmed to a data item, such as an individual interview in a biographical format (Murray, 2007). The theoretical and technological knowledge approach as seen in discourse analysis and grounded theory are not required in thematic analysis. Therefore thematic analysis offers more accessibility especially to inexperienced qualitative researchers (Braun & Clarke, 2006). Thematic analysis can be employed with a variety of theoretical frameworks. Consequentially, its method can lie within (a) the realms of essentialism or realism, reporting on participant experiences, meanings and reality, (b) a constructionist method, examining how events, experiences and realities are the effects of a series of discourses functioning within society (Braun and Clarke, 2006), (c) a contextualist method, here lying between essentialism and constructionism, and consisting of theories of critical realism. This gives credence to the way in which individuals use experience to give meaning to their lives (Willig, 1999). In conclusion thematic analysis can be a method employed to both reflect and unravel ‘reality’, although it’s theoretical position must be made clear at all times (Braun and Clarke, 2006).

In thematic analysis it is important to determine the type of analysis to be undertaken. For this research thesis, which investigates an under researched area, it was important to provide a rich thematic narrative description of the entire data set so that important themes are related to the reader. The identified themes, codes and analysis are accurate reflections of the entire data set content. Although depth and complexity is lost, a rich description overall is maintained (Braun and Clarke, 2006). In summary thematic narrative analysis was selected as an appropriate method for the following reasons:

- Thematic analysis is seen as a foundational method for qualitative analysis, acknowledged for its flexibility and ability to produce rich, detailed and complex accounts of data through theoretical freedom (Braun and Clarke, 2006).
- It involves searching for themes that emerge as being important to the description of the phenomenon (Daly, Kellehear, Gliksman, 1997).
• Theme identification is achieved through “careful reading and re-reading of the data” which allows for new themes to arise as the data is explored (Rice and Ezzy, 2000, p.258).

• It can be viewed as an essentialist or realist method for reporting patient experience (Braun and Clarke, 2006).

• It can also be viewed as a constructionist method (i.e. Potter and Hepburn, 2005), examining ways in which events, realities and meanings are effected by a variety of communications within society (doctor/patient interactions, for example).

• It can be a contextualist method characterized by theories such as critical realism (e.g. Willig, 1999). This approach focuses on the way in which individuals make meanings of their experiences as well as how the broader social context impinges on those meanings. Therefore thematic analysis can work to both reflect reality and unravel its surface.

• It is useful for theorising across a number of cases in order to find common thematic elements with research participants and the stories they tell.
4.7. Research Stages

Table 4.5: The Research Process

<table>
<thead>
<tr>
<th>Stage One Pilot CBI Questionnaire</th>
<th>Number of Questionnaires sent out</th>
<th>Number of Questionnaires returned</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients and Health Care Professionals on 2 wards, stratified random sample</td>
<td>15 patients 15 Health Care professionals</td>
<td>19</td>
<td>SPSS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage One Main CBI Questionnaire</th>
<th>Number of Questionnaires sent out</th>
<th>Number of Questionnaires returned</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient and Health Care Professionals, stratified random sample selected from 2 wards within hospital 2. Letter, information sheet, questionnaire and stamped addressed envelope to patients as part of discharge package. Letter, information sheet and questionnaire distributed to doctors, nurses, physiotherapists and occupational therapists</td>
<td>50 patients 50 Health Care Professionals</td>
<td>22 37</td>
<td>SPSS SPSS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage Two Observation</th>
<th>Number of hours</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Participant observation – unstructured on 2 wards</td>
<td>20 hours, 4 Healthcare Professional groups interaction with patients</td>
<td>Data recorded in detailed field notes at the time the observations were made or as close to the time of the event as possible Pattern and theme narrative analysis, ethnographic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage Three Semi-structured interviews</th>
<th>Number Interviewed</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patients invited to participate in interviews, selected during hospital stay across 2 wards, interviewed at home. 2. Letter, information sheet and consent form. 3. Staff selected using stratified random sampling and invited to Participate via letter</td>
<td>8 16 – 5 Doctors, 7 Nurses, 2 physiotherapists, 2 Occupational Therapists</td>
<td>Purpose of study explained, consent form signed, interview session tape recorded Purpose of study explained, interview session tape recorded Thematic narrative analysis ethnographic</td>
</tr>
</tbody>
</table>
The three stages of research design and analysis

The research was undertaken in three specific stages and these are outlined in Table 4.5 which provides a synopsis of the research strategy. There then follows a description of the methodology and rationale for each stage.

4.7.1. Pilot Study

The significance of pilot studies has been given very little recognition in research literature, the value of pilot studies help to facilitate the researcher to collectively reflect in greater depth on the nature of the activity in which they are about to engage (Thabane et al., 2010). It is essential that pilot studies help to direct the correct lines of enquiry in research and should not be used solely to adapt research instruments or as a background in order to inform research questions (Sampson, 2005). Pilot studies can prove useful to the researcher in several ways, for example the internal validity of a questionnaire can be improved, and they can help to assess the viability of the main study, determine the effectiveness of the sampling frame and technique and give definitive evaluation to the logistics of data collection.

Despite these definitive statements pilot studies are open to misuse and research may be undertaken on the basis of results or a hypothesis incorrectly derived from pilot study data (Coffey and Kairalla, 2008; Loscalzo, 2009; Nyatanga, 2005). The pilot study was performed to improve the quality of this research study by using the process and results to direct the research pathway, and reduce resource wastage and risk.

4.7.2. Questionnaires

A questionnaire is essentially a structured technique comprising a list of written questions for the collection of primary data (Beiske, 2007). Questionnaires are a quantitative method of data gathering and are many and varied in design and in terms of purpose, size and appearance (Denscombe, 2007). Due to their simplicity and ease of use they are amongst the most commonly employed techniques for the collection of information in clinical studies (Saw and Ng, 2001). Although not all modalities of information can be
collected through questionnaires, a unique and wide range of data can be captured (Kumar, 2008).

Questionnaires can be designed to enable the researcher to target a particular audience regardless of geographical spread. The use of the questionnaire method as an instrument of scientific enquiry can achieve (a) measurement (b) description and (c) inference. Measurement aims to measure the sociological variables and gather information about individual and group characteristics e.g. age, height. Description describes a given population and inference helps to infer about the given population based on sample studies (Kumar, 2008).

**Table 4.6: Advantages and disadvantages of written questionnaires.**

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cost effective compared to face-to-face interviews, particularly where large sample sizes or geographical areas are involved.</td>
<td>1. Possibility of low response rate.</td>
</tr>
<tr>
<td>2. They are easy to analyse particularly with computer software packages.</td>
<td>2. Questionnaires responses cannot be explored further.</td>
</tr>
<tr>
<td>3. Questionnaires are familiar to most people.</td>
<td>3. As a structured instrument questionnaires do not have flexibility in respect to response format.</td>
</tr>
<tr>
<td>4. Questionnaires reduce bias as the researcher’s opinion will not influence the respondent answer, no verbal or visible clues.</td>
<td>4. Questionnaires may not be suitable for certain individuals or groups.</td>
</tr>
<tr>
<td>5. Questionnaires are less intrusive than face-to-face or telephone surveys.</td>
<td>5. The researcher can never be certain that the person to whom the questionnaire is sent actually fills it in.</td>
</tr>
<tr>
<td>6. The respondent can answer the questionnaire at their own pace.</td>
<td>6. Where the researcher is not present, it is difficult to know whether or not a respondent has understood a question correctly.</td>
</tr>
</tbody>
</table>

*Adapted from Walonick, D.S (2007) Survival Statistics*
There are a number of advantages and disadvantages to using questionnaires and these are listed in table 4.6. The use of questionnaires in this research study allowed participants to respond to the survey in their own time and provided the researcher with an opportunity to review and analyse the results so that the subsequent participant observation and semi-structured interview instruments could follow-up on significant responses.

4.7.3. Observation.

Observation is a method that allows researchers to directly observe individuals in their natural setting (Carlson & Morrison, 2009) or in a controlled environment (Langdridge & Hagger-Johnson, 2009). Observation has been defined as:

‘A tool of social inquiry in which activities and relationships of people in the study community are perceived through the five senses of the researcher’, (Angrosino, 2007, p.98).

Observational methods require the researcher to watch and record human behaviour and related events and objects, interpreting and evaluating the data gathered (Waltz et al. 2009). Observational studies in nursing and healthcare research play a pivotal role when information is sought on the effectiveness of treatment and care, patient reported outcomes and costs in real-life locations (Langham et al. 2011).

Observation as a research method has the distinct advantage of directly accessing the ‘lived experience’ of the individual. Frequently referred to as field research or fieldwork (Spradley, 1980) the method is often used by anthropologists, sociologists and political scientists. It can provide a rich detailed description of the phenomena that is unconstrained by predetermined concepts and categories. Observation methods can be particularly helpful when describing complex observations, and formulating hypotheses about them and about relationships between different components or elements (DeWalt and DeWalt, 2010) such as, for example, a patient’s perception of staff behaviour.

Observational studies focus on the direct observations of the researcher, who in turn aims to immerse him or herself in the world of the subject being studied; with the intention of seeing the world as the subject sees it, rather than as the researcher perceives it to be. The
researcher records observed events, conversations and behaviours by compiling field notes, the primary method of capturing data from observation (DeWalt and De Walt, 2010). The aim of observational research is to produce knowledge (empirical and theoretical) about distinct issues, which can be used by others in a number of ways, for example, the measurement of resource use in hospitals. In healthcare, observation is considered the most important data collection method particularly in studies focusing upon human behaviour and can be used as a stand-alone method or in conjunction with others (Parahoo, 2006).

Observational studies are considered non-interventional, in healthcare this means that the care and treatment of patients is performed naturally in practice without influence from the researcher or study. Observational settings reflect naturalistic as opposed to artificial circumstances (Carlson & Morrison, 2009). As such individual lives, conversations and behaviours are not regulated by particular rules or regulations, allowing for improved observation of the natural progression of disease processes (Bang, 2010). This is important as the ability to observe natural events and occurrences enables healthcare professionals to evaluate the effectiveness of care and treatment in patient populations.

The observation employed in this study was unstructured, this involved recording what was seen or heard. Unstructured observation is a way of looking at a situation to observe something that is naturally occurring. The researcher approaches unstructured observation with no predetermined ideas. The process begins with the selection of a setting and obtaining access to it, observations are made then recorded. As the study evolves so the nature of the observation changes becoming sharper and more focused. This in turn leads to the formulation of purer research questions and selected observations until theoretical saturation is reached (Adler and Adler, 1994).

In unstructured observation researchers are usually acting from a ‘critical’ perspective, as the focus is on understanding the meaning study participants attribute to behaviour or events within the contexts observed (Gillham, 2008). Observation conducted as part of qualitative research is often unstructured.

The environmental opportunities for observers are many, Gold (1958) developed a typology of participant roles in which he discusses the variations which exist in the role
undertaken by the researcher ranging from, complete observer; the participant as observer; the observer as participant and finally to complete participant.

The role that the researcher chooses to adopt is subject to change throughout the fieldwork and can be influenced by the study setting and the research (Hammersley and Atkinson, 2007). Gold (1958, p.217) provides a description of the four observed categories as follows:

<table>
<thead>
<tr>
<th>Role</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete participant: The true identity and</td>
<td>• Does not influence natural events</td>
<td>• May become involved in dangerous practice or behaviours</td>
</tr>
<tr>
<td>purpose of the researcher is kept hidden</td>
<td>• Data validity is increased</td>
<td>• Practices a level of deceit</td>
</tr>
<tr>
<td></td>
<td>• Reduce problems associated with observer effect</td>
<td>• Risk of over-identification with the study participant known as “going</td>
</tr>
<tr>
<td></td>
<td></td>
<td>native” (Frankenberg, 1982).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Infringes the principle of ‘informed consent’</td>
</tr>
<tr>
<td>Participant as observer: Researcher gains</td>
<td>• Observation as a full group member</td>
<td>• Time needed to build trust between researcher and participant</td>
</tr>
<tr>
<td>access to the research setting. Usually has a</td>
<td>• More observation than participation</td>
<td>• Informant may become too much of an observer</td>
</tr>
<tr>
<td>non-research reason for being part of the</td>
<td>• Researcher and participant aware that relationship is founded on research</td>
<td>• Researcher may over-identify with informant</td>
</tr>
<tr>
<td>research environment.</td>
<td>activity</td>
<td></td>
</tr>
<tr>
<td>Observer as participant: Observing without</td>
<td>• Ability to concentrate on data collection</td>
<td>• Level of information is controlled</td>
</tr>
<tr>
<td>being a member</td>
<td>• Improved observation and understanding of events</td>
<td>• Trust in the researcher is needed</td>
</tr>
<tr>
<td></td>
<td>• Researchers role is research focused</td>
<td>• Observed events are sporadic-can cause poor data interpretation</td>
</tr>
<tr>
<td></td>
<td>• Less risk for the researcher to “go native”</td>
<td></td>
</tr>
<tr>
<td>Complete observer: The researcher does not</td>
<td>• Discreet observation</td>
<td>• Lower data validity</td>
</tr>
<tr>
<td>take part in the research setting</td>
<td>• Unknown to participants</td>
<td>• Purpose of observation is not revealed</td>
</tr>
</tbody>
</table>

Given the aim of this study was to explore perceptions of care and caring in a hospital orthopaedic setting the role of observer as participant was the most appropriate role to assume.
Ethnographic methodology is further strengthened by combining observation and interviews, by doing so the phenomena being studied can be more fully understood (Parahoo, 2006). This combination allows the ethnographer to question why individuals act like they do and then explain inconsistences that arise from what people say and do. One of the most important features of ethnographic approach is that study participants may ask questions of the researcher, to which Frankenberg (1982) remarks, that the questions the researcher is asked are more important than the ones the researcher asks. One of the criticisms of participant observation is the risk of over identification of the researcher with the study participants, often referred to as ‘going native’ (Frankenberg, 1982).

Participant observation employed the study of caring behaviours and commentary in order to test the theory emerging from Stage One. Nachmias and Nachmias, (1996) observe that the norms of objectivity, validity and reliability, as well as the designs for causal inferences are, mostly, implicitly embodied in this method. It is desirable in participant observation to ensure that these remain unstructured and flexible to maximize the understanding of empirical phenomena (Wax, 1968). From the previous stage of this study, conceptualizations regarding caring were anticipated and so participant observer stage was employed to test out such concepts. It is stated by Bernard (2011, p.153) that ‘objectivity does not mean (and has never meant) value neutrality … we recognize that the power of the documentation is in its objectivity, in its chilling irrefutability, not in its neutrality’. Thus, the conceptualizations can be examined through the participant observer method.

4.7.4. Semi-structured interviews

Interviews are a systematic way of talking and listening to people. They also provide another means by which data can be obtained by the researcher (King and Horrocks, 2010). Using interviews as part of research allow participants to become involved and importantly express their views. Interviewees are able to discuss their feelings, perceptions and interpretation in relation to a given situation (Gray, 2009). Cohen et al., (2011, p.267) explain, “the interview is not simply concerned with collecting data about life: it is part of life itself, its human embeddedness is inescapable.”
The role of the researcher is concerned with asking questions but this process needs to elicit valid responses (Hoyle et al., 2002). Semi-structured interviews unlike structured interviews are non-standardized; they do not work to a uniformed list of questions. They are used to probe given themes or topics rather than test a specific hypothesis (David and Sutton, 2004). The line of questioning by the researcher is guided by a list of key themes, issues or questions which can change according to the direction of the interview (Corbetta, 2003). The strength of a semi-structured interview lies in the ability of the researcher to probe deeper into the given situation. In addition the researcher can explain or re-phrase questions to provide further clarity to the respondent. The weaknesses of semi-structured interviews surface when interviewers are inexperienced, probing may not be carried out and therefore quality data is lost (Cohen et al., 2011).

4.7.5. Ethical Considerations

Research ethics applies basic ethical principles to scientific research. This helps to ensure that research presented is honest and trustworthy and that the rights of the individuals participating in research studies are protected (Parahoo, 2009). Ethical approval was obtained from the Cheshire Research Ethics Committee (CREC) for the research in October 2007 (appendix 5) and the University of Chester Faculty of Health and Social Care Research Ethics Committee.

Ethics

Accountability

Accountability is a key issue in ethics and is closely related to the concepts of responsibility and authority. In healthcare individuals by law are held accountable for their actions and are required to “provide rationale for these activities to those in authority so that both actions and reasons behind them can be judged” (Thomas, 2008, p. 9).
Avoidance of malificence

The researcher is an experienced nurse consultant and ensured that all those participating in this research were not exposed to any risks or harm. The respondents received verbal and written information (appendices 6 and 7) and were given the opportunity to discuss the research and ask questions. All participants were informed that their decision relating to study participation would not affect their treatment in any way.

Equal opportunity

The stratified random sample ensured that no individual was given preferential treatment. Once data collection started the participants were treated equally, with respect and their dignity maintained.

Informed consent and confidentiality

Each participant was provided with an Information Sheet (appendices 6 and 7) about the research and a Consent Form to sign (appendices 8 and 9). Prior to Stages Two and Three study participants were asked if they had any objections to being observed and then interviewed and conversations being tape recorded, none objected. They were informed that they were under no obligation to disclose anything they felt uncomfortable with and that the tape recorder could be stopped at any point during the observation or interview. Anonymity was ensured by allocating each individual participant in the study a code number. The Data Protection Act (1998) was adhered to at all times.

4.8. Description of the elective and trauma orthopaedic wards

The elective orthopaedic ward comprises of 33 beds, patients are admitted for planned surgery and average patient stay is one to seven days. The ward is relatively modern has a central nurses station and consists of four and six bedded bays and four side rooms. The trauma ward consists of 31 beds, receiving patients directly from the Accident and Emergency Department or fracture clinic. Patients are admitted either for surgery or conservative treatment requiring therapeutic intervention, length of stay varies.
Patients on both wards ranged in age from 18 to 99 years. Patient dependency varied widely, on the elective orthopaedic ward a number of patients were self-caring, whilst others required some degree of help with activities of daily living. On the trauma ward there was a constant high proportion of dependent patients, many of whom had cognitive impairment. The health care professional group consisted of doctors, nursing staff, physiotherapists and occupational therapists. All staff on both the elective and trauma orthopaedic wards were aged 18 years or over. Experience varied as did number of years in post.

4.8.1. Inclusion criteria

For the pilot study and main questionnaire Stage One, patient participants aged 18 years or over were selected for inclusion from the orthopaedic and trauma ward computer in-patient database between March and May 2008. For Stages Two and Three, patient participants were selected for inclusion from the ward in-patient database between January and December 2009. Participants were excluded if they had cognitive impairment, i.e. an inability to think, concentrate, reason or remember, could not speak English. Health care professionals consisting of doctors, nurses, physiotherapists and occupational therapists working on either ward were included in the study.

Table 4.7: Distribution of female and male patients on orthopaedic wards (N = 268)

<table>
<thead>
<tr>
<th>Type of Ward</th>
<th>Percentage of female</th>
<th>Percentage of male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective orthopaedic</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>Orthopaedic trauma</td>
<td>63%</td>
<td>37%</td>
</tr>
</tbody>
</table>

Table 4.7 documents the distribution of male and female patients on the wards.
Table 4.8: Distribution of female and male staff on orthopaedic wards (N=87)

<table>
<thead>
<tr>
<th>Type of Ward</th>
<th>Percentage of female</th>
<th>Percentage of male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective orthopaedic</td>
<td>33%</td>
<td>14%</td>
</tr>
<tr>
<td>Orthopaedic trauma</td>
<td>36%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Table 4.8 documents the distribution of male and female staff participants on the wards.

4.8.2. Population and sample for study

Population

The rationale for screening and inviting those who met the inclusion criteria to participate in the study, was to ensure a sample which captured key population characteristics proportional to the overall population within a given timeframe (See section 4.9.3). The research was performed in a NHS Trust hospital in Cheshire. The Census of 2001 revealed that the overall population of Cheshire is 673,781, of which 51.3% of the population were male and 48.7% were female. Ethnic white groups accounted for 98% (662,794) of the population with 10,994 (2%) in ethnic groups other than white. Of the 2% in non-white ethnic groups; 34% belonged to mixed ethnic groups, 30% were Asian or Asian British, 10% were Black or Black British, 17% were of Chinese ethnic groups, 9% were of other ethnic groups. The population of North Wales is 670,800 (National Public Health Services for Wales 2003). Ethnic white groups accounted for 96% of the population. Less than 1.2% of the population of North Wales represented a Black, Minority or Ethnic Community (BME). The BME communities are mainly concentrated in the Bangor, Rhyl and Wrexham areas of North Wales.
4.8.3. Sampling

Participants were drawn from the population as identified in the inclusion criteria in a random procedure which was stratified by age, gender, ethnicity in the patient group and by age, gender, ethnicity and occupation in the staff group. Sample size is an important consideration and can affect the credibility and reliability of a study (Eisenhardt, 1989; Miles and Huberman, 1994; Parahoo, 2006; Polit-O’Hara and Hungler, 1999; Silverman 2010); therefore for Stage One a stratified random sampling was employed. This type of sampling technique is said to be a useful combination of randomization and categorization proving a valuable technique in both quantitative and qualitative research (Cohen et al., 2011, Keller, 2008). Although these authors considered this sampling to be adaptable, stratified random sampling can be difficult to execute particularly when a number of demographic factors need to be taken into consideration. It has been argued that in stratified random sampling, subgroups which contain more data are considered of greater importance to the study than those containing less (Berinsky, 2008; Dillman et al., 2009; Sax et al., 2003).
<table>
<thead>
<tr>
<th>Technique</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple Random</td>
<td>Random sample taken from the whole population, simplest form</td>
<td>Most common form of sampling, can be highly representative if all subjects participate</td>
<td>Only possible if complete members of population exists - can be expensive, may isolate members of the group, data/sampling changeable</td>
</tr>
<tr>
<td>Stratified Random</td>
<td>Random sample taken from identified groups, separated into layers (strata), subgroups</td>
<td>Can help ensure proportional representation within the sample, e.g. by age, through selection of participants from strata</td>
<td>Can be complex, involves detailed work to define strata</td>
</tr>
<tr>
<td>Cluster</td>
<td>Random samples of successive clusters of subjects (e.g. hospitals), eventually diluted down into smaller groups or units</td>
<td>Possibility of random selection where no list of population members exists but local lists are available</td>
<td>Clusters in levels must be equal and include natural characteristics</td>
</tr>
<tr>
<td>Stage</td>
<td>Clusters and random or stratified random sampling combination of individuals</td>
<td>Probability sample can be complied by random at stages and within identified groups. Able to select random sample even if population lists are very localised</td>
<td>Complex technique combining disadvantages of cluster and stratified random sampling</td>
</tr>
<tr>
<td>Purposive</td>
<td>Deliberate identification of subjects based upon specific characteristics</td>
<td>Provides a balance of group sizes where numerous groups are involved</td>
<td>Population representation may be questioned due to potential subjectivity of researcher</td>
</tr>
<tr>
<td>Quota</td>
<td>Uses elements of purposive and stratified sampling without random selection. Recognises the need for representation of different groups in sample</td>
<td>Selection of adequate numbers of participants with required characteristics ensured</td>
<td>Unable to prove sample representative of given population</td>
</tr>
<tr>
<td>Snowball</td>
<td>Obtain adequate samples through subjects with required characteristics giving names of further appropriate subjects</td>
<td>Can ensure possible inclusion of group members when no lists exists, e.g. drug abusers</td>
<td>Unable to know if sample representative of population</td>
</tr>
<tr>
<td>Volunteer, Accidental, Convenience</td>
<td>Recruiting volunteers, or the consequence of not all those selected participating, or including participants who are available to the researcher</td>
<td>Cost effective means of ensuring adequate numbers for study</td>
<td>Potential to be highly unrepresentative</td>
</tr>
</tbody>
</table>

Despite these concerns the researcher chose this sampling technique as it can provide greater precision in the same sample size, it often requires smaller samples and can guard against unrepresentative samples, (Black, 1999).

4.8.4. Stage One Pilot Study

Rationale

- To understand which caring behaviours are deemed to be of importance to patients and health care professionals?
- To test the readability and reliability of the CBI
- An additional 2 research questions identical to those yet to be examined in the main study were also explored to determine the validity of further study.

- What, if any, differences exist between the caring perceptions of patients and health care professionals?
- What, if any, factors may influence perceptions of caring behaviours?

Overview

A pilot study was undertaken for the Caring Behaviours Inventory (CBI) questionnaire because it was important to investigate readability and reliability to highlight any issues which may arise from understanding the directions for questionnaire completion and pinpoint problems with the administration process.

The questionnaires for the staff participants were delivered via the hospital internal mail service. Patient questionnaires were included as part of their discharge package as agreed with Cheshire Research Ethics Committee, to ensure that patients did not feel vulnerable completing the questionnaires during their hospital stay.

A total of 30 questionnaires were distributed, each questionnaire was allocated a study number for the purpose of data collection and analysis. Each pack provided contained the study information leaflet and a reply paid envelope.
Analysis of the pilot study data

A total of 12 health care professionals and 7 patient questionnaires were returned in the pilot phase of which there were 13 female and 6 male respondents, all were Caucasian. Respondents completed the profile section of the instrument which provided demographical information and details relating to hospital stay for patients.

The patients had undergone either elective orthopaedic surgery \( n=4 \) or had been admitted to hospital as a result of traumatic injury \( n=3 \). All of the patients had undergone surgery within a period of 2 months; they ranged in age from 47 to 79 with a mean age of 63, the mean length of stay was 11(7-23) days. Of the 7 patients most of the participants held or had worked in a professional career \( n=3 \) followed by skilled labour \( n=2 \), commercial business \( n=1 \) and housewife \( n=1 \). The phrase housewife was coined by the patient respondent. Patients had been educated to different levels; 14% had graduated from university, 29% from college and 57% from high school. 4 were married, 1 divorced, 1 widowed and 1 single.

The 12 health care respondents ranged in age from 26 to 48 with a mean age of 34 years old. Of the 12 health care professionals the majority of participants were nurses \( n=6 \) followed by doctors \( n=3 \), occupational therapists \( n=2 \) and physiotherapists \( n=1 \), 7 were married, 1 divorced and 4 were single. They had a mean professional experience of 8 (1-24) years. The health care professionals had been educated during different periods; 75% had graduated from University, 17% from college and 8% from high school.

Amendments made to questionnaires for main study

The pilot test revealed that several questions had been either missed or left unanswered by respondents. There was a consistent issue in respect of readability with one question which asked about ‘giving shots’ an American term for giving injections. The researcher felt that this needed to be expressed in terms more familiar to the research population of this study. The question was changed to ‘giving injections’ prior to distribution of the main study questionnaires.
4.8.5. Stage One Main study Questionnaires

The pilot provided a statistical analysis of perceptions of caring behaviours and a ‘snapshot’ of specified themes inherent in a caring relationship from the perspectives of the respondents. It demonstrated readability and reliability of the CBI amongst the participant groups. Several of the questionnaires were incomplete so to provide more data an additional 100 questionnaires, (50 patient and 50 health care professional) were distributed.

Data analysis

For the purpose of this study age, gender, profession, ethnicity, marital and academic status were included to ascertain whether these had any statistical significance in determining perceptions of care and caring.

57 completed questionnaires were returned, 37 from health care professionals and 22 from patients. The patients had undergone surgery or treatment within a two month time frame; they ranged in age from 26 to 79 with a mean age of 58 years. The mean length of stay was 8 (3-20) days. Of the 22 patients 91% (n =20) were white British and 9% (n =2) Asian, 14 were married, 3 single, 3 widowed and 2 divorced. In respect of education 72% achieved secondary education level, 14% further education and 14% higher education. Employment ranged from professional career 41%, skilled labour 23%, general labour 18%, clerical 4% and housewife 14%.

In all 37 questionnaires were returned from the health care participant group; they ranged in age from 22 to 57 with a mean age of 35 years. 84% (n = 31) were white British, 11% (n=4) Asian and 5% (n= 2) black African. 16 were married, 12 single, 2 divorced, 2 widowed and 5 were living with partners. Of the 37 health care professionals 3% had achieved secondary education level, 75% further education and 22% higher education. The respondents were nurses (n=12), doctors (n=10), occupational therapists (n=9) and physiotherapists (n= 6).

Data was analysed using SPSS version 18; descriptive statistics consisted of mean scores and standard deviation to determine patient and health care professional least and most
important items relating to caring behaviours. All items were grouped into one of the five sub-scales and the overall mean was calculated to determine rank distribution of the sub-scale. Nonparametric testing using the Mann-Whitney U and Kruskal-Wallis one-way analysis of variance was used to examine responses to the CBI according to demographic variables (Corder & Foreman, 2009).

4.8.6. Stages Two and Three, participant observation and semi-structured interviews

The main aim of Stages Two and Three of the study was to observe and explore caring behaviours in the orthopaedic ward environment in order to facilitate a greater insight and understanding of why people behave as they do (Atkinson et al. 2003)

Themes

The themes for development of the observation tool and semi-structured interview guides were formulated following the analysis of Stage One of the study using the CBI questionnaire. However, early themes were highlighted from a number of sources. Firstly, the researcher drew upon her experience as a senior orthopaedic nurse working in the proposed field of research. The ‘lived’ experience of working and researching in an area where the research is to be undertaken has its roots within ethnography and from this perspective, the researcher was able to absorb more subtle lines of investigation found from the ‘specialness’ of that particular culture (Carter and Henderson, 2005). A known and trusted interviewer has been acknowledged as important in order that rich and valid information may emerge from the interviews (Norman and Parker, 1990).

The second source of information is the evidence grounded in the literature. Hart (2001) discusses the critical value of having a thorough knowledge of the literature and how it serves to inform the ‘research proper’. Indeed Hart calls this step in the research process, ‘reviewing the research imagination’ and goes on to argue that ‘The originality of a research topic often depends upon a critical reading of a wide-ranging literature (Hart, 2001, p.26).
Third, an established thematic source for semi-structured interviews was found from the analysis of preceding research methods. The research method of analysing quantitative data to inform further qualitative data collection is one of forty typologies identified by Tashakkori and Teddlie (2003). Indeed, mixed method approaches are widely discussed and advocated within the research literature and this study has referred to a number of authoritative texts on this issue such as Denzin (2009) and Bowling and Ebrahim, (2005).

As a result themes were taken from the CBI centring on the five sub-scales:

- Respectful deference to other
- Assurance of human presence
- Positive connectedness
- Professional knowledge and skill
- Attentiveness to the other’s experience

These sub-scales provided the 5 main themes for analysis.

Qualitative analysis was carried out through data reduction, simplifying, abstracting and transforming, resulting in thematic analysis and theory building (Glaser and Strauss, 1967; Miles and Huberman, 1994).

Consent by staff members to participate in interviews and observation

Study information was initially provided to staff through meetings and informal discussions. An Information Sheet and Consent Form (appendices 6, 7, 8 and 9) were made available. Staff were offered a minimum of 48 hours to consider if they wish to participate and asked to contact the researcher via e-mail or telephone confidentially with their decision. If they agreed, an appointment was arranged, and informed consent obtained.

Patient consent to participate in observation and interviews

The Information Sheets (appendices 6 and 7) were distributed to all patients who met the study criteria. Patients were given a minimum of 24 hours to consider if they wished to take part in Stage Two and Three of the study. The information pack contained a contact
number so that patients could register their interest in taking part. If patients were willing to be interviewed after observation, an appointment was made either to be interviewed at home or in a private quiet room in the hospital, which some patients preferred. Informed consent was obtained prior to Stage Two and Three. Due to Cheshire Research and Ethics Committee (CREC) stipulation patients were to be interviewed after discharge from hospital, CREC felt that interviewing patients whilst in hospital could evoke fear of vulnerability.

**Staff**

A total number of 16 staff agreed to participate in the observation sessions and face to face interviews; they were identified through the sampling process at stage one of the study. Table 4.10 identifies staff from both wards who agreed to take part in stages two and three of the study.

**Table 4.10: Table depicting staff participants for stages two and three of the study.**

<table>
<thead>
<tr>
<th>Staff Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Occupation</th>
<th>Position</th>
<th>Marital Status</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse 1</td>
<td>43</td>
<td>F</td>
<td>Nurse</td>
<td>Team leader</td>
<td>Divorced</td>
<td>Both</td>
</tr>
<tr>
<td>Doctor 2</td>
<td>29</td>
<td>M</td>
<td>Doctor</td>
<td>Senior doctor</td>
<td>Married</td>
<td>Both</td>
</tr>
<tr>
<td>O.T 3</td>
<td>42</td>
<td>F</td>
<td>O.T</td>
<td>Senior O.T</td>
<td>Single</td>
<td>Trauma</td>
</tr>
<tr>
<td>Nurse 4</td>
<td>38</td>
<td>M</td>
<td>Nurse</td>
<td>Junior Staff</td>
<td>Married</td>
<td>Elective</td>
</tr>
<tr>
<td>Doctor 5</td>
<td>29</td>
<td>F</td>
<td>Doctor</td>
<td>nurse</td>
<td>single</td>
<td>Trauma</td>
</tr>
<tr>
<td>Doctor 6</td>
<td>44</td>
<td>F</td>
<td>Doctor</td>
<td>SHO (F2)</td>
<td>Married</td>
<td>Both</td>
</tr>
<tr>
<td>Doctor 7</td>
<td>32</td>
<td>M</td>
<td>Doctor</td>
<td>Consultant</td>
<td>Married</td>
<td>Both</td>
</tr>
<tr>
<td>Doctor 8</td>
<td>25</td>
<td>F</td>
<td>Doctor</td>
<td>Registrar</td>
<td>Single</td>
<td>Elective</td>
</tr>
<tr>
<td>P 9</td>
<td>45</td>
<td>F</td>
<td>Physiotherapist</td>
<td>H.O (F1)</td>
<td>Married</td>
<td>Elective</td>
</tr>
<tr>
<td>Nurse 10</td>
<td>50</td>
<td>F</td>
<td>Nurse</td>
<td>Senior Grade</td>
<td>Divorced</td>
<td>Trauma</td>
</tr>
<tr>
<td>Nurse 11</td>
<td>29</td>
<td>M</td>
<td>Nurse</td>
<td>nurse</td>
<td>Single</td>
<td>Elective</td>
</tr>
<tr>
<td>Nurse 12</td>
<td>53</td>
<td>F</td>
<td>Nurse</td>
<td>specialist</td>
<td>Married</td>
<td>Trauma</td>
</tr>
<tr>
<td>P 13</td>
<td>39</td>
<td>M</td>
<td>Physiotherapist</td>
<td>Staff Nurse</td>
<td>Married</td>
<td>Trauma</td>
</tr>
<tr>
<td>O.T 14</td>
<td>32</td>
<td>F</td>
<td>O.T</td>
<td>Sister</td>
<td>Married</td>
<td>Elective</td>
</tr>
<tr>
<td>Nurse 15</td>
<td>63</td>
<td>F</td>
<td>Nurse</td>
<td>Junior grade</td>
<td>Widow</td>
<td>Trauma</td>
</tr>
<tr>
<td>Nurse 16</td>
<td>20</td>
<td>M</td>
<td>Nurse</td>
<td>Senior nurse</td>
<td>Single</td>
<td>Elective</td>
</tr>
</tbody>
</table>

*Code: O.T = Occupational Therapist H.O = House Officer P = Physiotherapist*

*Table 4.10 details the breakdown of patient participants by age, gender, marital status, occupational and educational level. The nature of the orthopaedic condition or injury is given to provide the reader with the reason for admission to hospital. The participant code allocated for the purposes of anonymity is also shown.*
This table lists the staff participants by age, gender, health profession occupation, job title, marital status and the type of ward they were working on at the time the research was undertaken. This information offers an authentic voice in order to personalise the narratives avoiding the presentation of faceless subjects to the reader (Reissman, 2004).

**Patients**

A total of 8 patients out of 20 who met the inclusion criteria responded to the invitation to participate in Stages Two and Three of the study, agreeing to a face to face interview, table 4.11 details participant information.

**Table 4.11: Table depicting patient participant information.**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Marital status</th>
<th>Occupation</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>78</td>
<td>Male</td>
<td>Married</td>
<td>Retired butcher</td>
<td>Fractured ankle</td>
</tr>
<tr>
<td>Patient 2</td>
<td>62</td>
<td>Female</td>
<td>Married</td>
<td>Health education</td>
<td>Hip replacement</td>
</tr>
<tr>
<td>Patient 3</td>
<td>27</td>
<td>Female</td>
<td>Single</td>
<td>secretary</td>
<td>Knee injury</td>
</tr>
<tr>
<td>Patient 4</td>
<td>51</td>
<td>Male</td>
<td>Divorced</td>
<td>Postal worker</td>
<td>Shoulder Replacement</td>
</tr>
<tr>
<td>Patient 5</td>
<td>84</td>
<td>Male</td>
<td>Widowed</td>
<td>Retired teacher</td>
<td>Fractured femur</td>
</tr>
<tr>
<td>Patient 6</td>
<td>59</td>
<td>Female</td>
<td>Married</td>
<td>nurse</td>
<td>Hip replacement</td>
</tr>
<tr>
<td>Patient 7</td>
<td>36</td>
<td>Female</td>
<td>Living with Partner</td>
<td>Shop worker</td>
<td>Hip resurfacing</td>
</tr>
<tr>
<td>Patient 8</td>
<td>47</td>
<td>Female</td>
<td>Married</td>
<td>housewife</td>
<td>Spinal infection</td>
</tr>
</tbody>
</table>

*Table 4.11 details the breakdown of patient participants by age, gender, marital status, occupational and educational level. The nature of the orthopaedic condition or injury is given to provide the reader with the reason for admission to hospital. The participant code allocated for the purposes of anonymity is also shown.*
This table lists the age of each patient participant, gender, marital status, occupation at the time the research study was undertaken. In addition their reason for admission to hospital is also documented.

4.8.7. Stage Two-Observation on the wards

Data collection

Participant observation was undertaken to identify themes which emerged from health care professional and patient interactions to gain an appreciation of the caring relationship.

On days when observation of care was planned, the researcher sought out those health care professionals who had indicated their basic willingness to participate, to see if they would agree to observation. They were given one to four hours to consider this. Observation did not take place in an area on the wards where an individual patient or member of staff who had decided not to participate in the study might be based. The researcher worked a number of shifts in order to gather data on caring interactions across all multi-professional groups. Observation was carried out on 8 occasions, between 2 and 3 hours on any occasion.

Data management and analysis

The focus of observation, ‘observation of care and caring’, included activities such as team handover report, nurse-patient, doctor-patient, therapy-patient ‘care’ interactions, behaviours and communication. The data collected involved caring actions and commentary during routine patient-professional interactions. Any discrepancy between action and commentary was noted as well as tensions and conflicts between form and content of the caring interaction. Coded field notes were taken and ‘memoing’ formed (Glaser and Strauss, 1999), (appendix 10), this was then analyzed for shared characteristics of perspective (Becker and Geer, 1960; Bernard, 2011). The participant observation element of the study was undertaken using a staged approach adopted by Bernard (1994). Although not all stages were experienced by the researcher they are highlighted as (a) initial contact, (b) shock, (c) discovering the obvious, (d) the break, (e) focusing, (f) exhaustion and (g) leaving. By understanding and using this staged approach
the participant observer was prepared for many of the pitfalls in undertaking this fieldwork.

Establishing the empirical approach to participant observation Zelditch (1962) outlined three elements (a) enumeration of frequencies in relation to the number of categories of observed behaviour, (b) informant interviewing in order to establish the social rules, statuses and sanctions to transgressions of regulated social interaction and (c) participation of the detail of illustrative incidents that may be related to the conceptualisations under examination.

Data management was undertaken employing the systematic fieldwork methods by Werner and Schoepfle (1987) who outline four types of data (a) the ethnographer’s journal, (b) verbatim transcriptions of native texts, (c) documents from official sources and (d) materials classified as falling between (a) and (b). Fieldnotes were taken using journals, logs, and verbatim accounts.

Acknowledgment to participants

All participants who took part in the second and third stages of the study were thanked verbally after each episode of data collection for their willingness to participate for their time and readiness to share their experiences and perceptions of the care they received.

4.8.8. Stage Three, Semi-structured interviews

Areas of inquiry varied between patient interviews and health care professional interviews. A written interview guide was developed to help provide some structure and direction to the interviews.

Patient interviews included questions designed to elicit responses to provide a picture about each patients stay in hospital and their perceptions of care and caring during this time (Appendix 11). Health care professional interviews included questions designed to elicit responses about reasons for working in a caring profession and perceptions of caring (Appendix 12).
Following the informed consent process described earlier the researcher began the interviews with questions which elicited demographic information such as age, gender and employment. This proved to be an effective way to begin the interview and seemed to help put the participant at ease.

This initial questioning and data collection facilitated an easy exchange of questions and answers. The format for the interviews was semi-structured and a list of questions was developed to act as a guide in order to focus the participants on perceptions of caring in the orthopaedic ward environment. During the interviews further questions were used to clarify participant responses and elicit further responses. Participant answers were often restated and summarized to validate and clarify meanings.

The interviews lasted between 50 minutes and 82 minutes in length during which time questions were asked in order to elicit responses relating to care and caring experienced. Each participant was given the opportunity to answer an open ended question at the end of the study thereby providing opportunity to add any additional information relating to their personal experiences and perceptions. All interviewees were identified by a study code and each interview tape recorded with the permission of the participant and then transcribed. Specific references to individuals, wards or places were deleted to ensure anonymity. Following transcription, all tape recordings were deleted.

The audiotapes were transcribed verbatim and coded after each interview. The researcher transcribed each interview using a micro-cassette transcriber. This practice allowed the researcher the advantage of seeking out nuances and thoroughly reviewing the interview before coding began. According to Merriam (1998), the interviewer’s verbatim transcription of recorded interviews provides the best database for analysis. Unlike grounded theory where data is collected until saturation occurs, analysis was not performed until the final participant had been interviewed. This was done so that ongoing interviews were not influenced in any way and the richness of the perceptions and experiences could be gathered without bias.

After coding, the transcripts were copied and kept in a separate, secure location in order to protect the data in case the original set was lost. The transcripts contained only the
interview number originally assigned to the participants and any thoughts or speculations the researcher formed during the process of reviewing the transcriptions. All interview text was transcribed into MS Excel format. Categories to utilise the data were produced in the first instance from the themes isolated in the literature and those identified by the text (Strauss and Corbin, 1998). Occasionally the same text related to different codes, and so the copy and paste function was used to repeat the differently coded text. The main codes where identified and labeled from Watson’s (2001) 10 transpersonal caring clinical caritas then a definition, description and example were given for each.

Table 4.12: Example of codes for semi-structured interview analysis

<table>
<thead>
<tr>
<th>Code 1</th>
<th>Label</th>
<th>Definition</th>
<th>Carative</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Practice loving kindness and equanimity within the context of caring consciousness</td>
<td>Altruistic loving kindness</td>
<td>Assurance of human presence</td>
<td>Humanism – health care professional views patient as complete individual, shows interest in person as more than just a health problem. Accepts patient without prejudice and shows respect, is humane and warm towards patient</td>
<td>“I tell my patients that I am here to help them you know …. Get their trust, yeh, I want them to know that they can trust me always ….. I do care about them …. Care what happens to them”</td>
</tr>
</tbody>
</table>

Table illustrates examples of coding for the caring carative assurance of human presence

This process is demonstrated in (Table 4.12), the label represents a caring behavior which is defined and categorized according to Watson’s caring caritas. Finally the behavior exhibited is described and an example from the interviews given.

A combination of observational notes and interview data were used to create a full and detailed analysis of health care professionals’ and patients’ perceptions of caring.

Analysis was mainly a manual exercise which allows the researcher to become submerged and develop a thorough understanding of the textual data of the field notes.
and interviews (Braun and Clarke, 2006). Each data set was read and re-read and interview recordings listened to. This is an important introduction to the analysis process and allowed the researcher to become familiar with the data and understand the main contents (Sandelowski, 1995).

All text was examined line by line and annotations which reflected the thoughts of the researcher were made in the margins for each interview and field note. Extensive code notes were generated for each interview and included questions formulated by the researcher and a story line for each data set. The researcher frequently moved between interview and field note data to build code notes and story lines (appendix 10).

4.8.9. Generalisability and Replicability for Study

Generalisability and replicability were also given serious consideration in this study. Stake (1978), Guba and Lincoln (1981, 1982) and Goetz and Lecompton (1982) were amongst the first to contribute to the concept of generalisability in qualitative research. Stake (1978) introduced the concept of ‘naturalistic generalisability’ which basically allows for the transfer of results from one study to be interpreted in similar situations as the original.

Although a feasible concept Schoefield (2002) believes that this may only be achieved through the application of explicit comparisons between situations and by using what he terms ‘tacit knowledge’ based upon personal experience. Other researchers agree with this notion alluding to terms such as ‘fittingness’ (Guba and Lincoln, 1981, 1982) ‘comparability’ and ‘translatable’ (Goetz and LeCompte, 1982) and ‘exportability’ (Kitto et al., 2008) to describe the concept.

It is suggested by King et al. (1994) and Taylor (2005) that the hallmark of scientific research is the ability to make inferences which surpass particular observations, importantly what these two authors conclude is that generalisability should be considered a criteria for assessing the value and quality of research. Kitto (2008) upholds this view believing that generalisability and also replicability are not given serious recognition within the realms of qualitative research, stating that they are neither important, relevant nor attainable in relation to research objectives in many studies. In recent years Salkind
(2009, p.89) headlines generalisability as “the name of the game” insisting that research results are only given meaning beyond their original setting when they can be generalised from a sample to a population thus bringing the argument full circle.

The research aimed to explore patient and health care perceptions of caring within an orthopaedic setting in a district general hospital at a specific point in time using a mixed method approach. It was anticipated that the results would provide valuable information to other researchers and could possibly be ‘exportable’ to other similar populations, regions or cultures.

Rigor

In line with a qualitative approach, the rigour of the study is open to assessment through demonstrating dependability (Murphy et al., 1998). The researcher attempted to ensure dependability throughout the study by maintaining a complete record of the research process.

4.8.10. Summary

In Stage One the CBI questionnaires underpinned by Watson’s theory of transpersonal care were used to identify the specified themes inherent in caring behaviours between patients and health care professionals.

In Stages Two and Three, observation and face to face interviews were subjected to in-depth thematic analysis to explore participant perceptions of caring in the orthopaedic setting.
CHAPTER FIVE

Findings Stage One

Caring Behaviours Inventory (CBI) Questionnaire

5.1. Introduction

The purpose of this first stage of the study (figure 2) was to identify and understand caring behaviours as perceived by patients and health care professionals in an orthopaedic setting within a district general hospital; using the Caring Behaviours Inventory (CBI) tool. The Caring Behaviours Inventory (CBI) was developed originally as a 75 item questionnaire and is described as a second generation instrument to measure caring (Wolf et al 1994). As a result of psychometric processes the instrument was revised to a 42 item questionnaire (Beck, 1999; Kyle, 1995; Wolf et al., 1994). The CBI contains five correlated subscales: (a) respectful deference to the other; (b) assurance of human presence; (c) positive connectedness; (d) professional knowledge and skill; and (e) attentiveness to the other’s experience. The conceptual-theoretical basis of the inventory
was derived from caring literature in general and is grounded in Watson’s (1988c) theory of transpersonal caring, within this framework caring is the standard used to measure treatment and interventions (Wolf et al., 2003).

The research questions objectives for this stage were:

- Which caring behaviours are deemed to be of importance to patients?
- Which caring behaviours are deemed to be of importance to health care professionals?
- Do differences exist between the caring perceptions of patients and health care professionals?
- What, if any, factors may influence perceptions of caring behaviours?

The analysis is presented as follows: (a) demographic data and (b) analysis of the distribution and descriptive statistics of the CBI scores.

The data is discussed according to the domains identified by the CBI which form the theoretical underpinning of the study. The five dimensions are: (a) Respectful deference to other, (b) Assurance of human presence, (c) Positive connectedness, (d) Professional knowledge and skill and (e) Attentiveness to other’s experience.

Following analysis of the quantitative data, a summary of the results is presented. The results were used to inform Stage Two and Three of the study which comprised semi-structured interviews and participant observation.

5.2. Pilot Study

Following approval by the Local Research and Ethics Committee (LREC), a pilot study was conducted, 30 questionnaires were distributed to patients and health care professionals who met the study criteria and agreed to participate. The pilot study was undertaken to supply information on the effectiveness of the quantitative stage of the research design, as well as to enhance the investigators’ ability to obtain data through utilization of the CBI. Following analysis of the CBI questionnaire for effectiveness of the approach, it was determined that no major changes were needed. Although the format
and approach of the pilot study were congruent with the study’s methodological style, it was decided not to include the data collected in the main study as a number of questionnaires were not fully completed.

5.3. Presentation of Quantitative Data

5.3.1. Demographic data

Following pilot study analysis the CBI questionnaire was sent to a further 100 participants (50 staff and 50 patients) as identified in the sampling process and who met the inclusion criteria (see Chapter 4 Methodology).

There was a greater number of female participants to male, this was attributed to an overall greater percentage of female workers in the Trust during the research period when a total of 4,186 staff were employed of which 81% were female and 19% male (Countess of Chester NHS Trust staffing figures 2008).

A total of 57 completed questionnaires were returned, 37 from health care professionals and 22 from patients. Each questionnaire was examined to determine validity for use. The researcher ensured that both the demographic information and CBI were fully completed for each respondent; all the data collected from these questionnaires were included in the study.
Table 5.1: Demographic characteristics of Health Care Professional participants (n=37)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>35.11</td>
<td>10.1</td>
<td>22-57</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>25</td>
<td>67.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
<td>32.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>12</td>
<td>32.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>16</td>
<td>43.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>5.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>5.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living with partner</td>
<td>5</td>
<td>13.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Education</td>
<td>1</td>
<td>3.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further Education</td>
<td>28</td>
<td>75.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher Education</td>
<td>8</td>
<td>21.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>10</td>
<td>27.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>12</td>
<td>32.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>6</td>
<td>16.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>9</td>
<td>24.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>31</td>
<td>84.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>4</td>
<td>11.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black African</td>
<td>2</td>
<td>5.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of service</td>
<td>11</td>
<td>9.22</td>
<td>1-31</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table illustrating the demographics of the healthcare participants

The demographic characteristics of the healthcare professional participants (N=37) are illustrated in table 5.1
Table 5.2 illustrates the demographics of the patient participant group (N= 22). All 22 patients had undergone surgery or treatment within a two month time frame; they ranged in age from 26 to 79 with a mean age of 58 years. The mean length of stay was 8 (3-20) days.

Patients had been educated to different levels; 72% had been educated to secondary education level, obtaining ‘O’ level or GCSE certificates; 14% had completed further
education to diploma or NVQ and 14% had completed higher education, achieving a First or Master’s Degree. Of the 22 patients 7 (32%) had been admitted to hospital as a result of traumatic injury resulting from a fall or car accident for example whereas 15 (68%) were admitted for elective or planned orthopaedic surgery such as a hip or knee replacement. The number of admissions to hospital within the last five years varied from 1 to 45 times (mean 3.36, SD 9.39), the high admission rate for one patient was due to a number of different conditions diagnosed over the five year period.

5.4. Instrumentation
The Caring Behaviours Inventory (CBI) was the instrument used in this stage of the study to measure perceptions of caring behaviours amongst patients and health care professionals in the given study location. Permission to use the CBI was granted from the author Professor Zane Wolf (Appendix 4). The CBI (Wolf et al 1994) includes 42 items and uses a six point Likert scale to elicit responses from participants (1=never; 2=almost never; 3=occasionally; 4=usually; 5=almost usually; 6=always). The instrument is underpinned by Watson’s transpersonal caring theory (1988).

Patients were asked to respond to each of the 42 items by indicating the extent to which they experienced caring behaviours during their recent hospital stay and health care professionals were asked to respond by indicating the extent to which they demonstrated caring behaviours.

The five subscales on the CBI include respectful deference to others (12 items), assurance of human presence (12 items), positive connectedness (9 items), professional knowledge and skill (5 items), and attentiveness to the other’s experience (4 items). Scores ranged from 42 to 252 with the CBI, the higher the score the higher the level of perceived caring by the respondent. Test-retest reliability, internal consistency reliability (α=0.95) and construct validity of the CBI have previously been established (Wolf et al., 2003).
### 5.5. Data Analysis Main Study Stage One

SPSS version 17.0 was used to perform the quantitative analysis of data collected in this stage of the study. Descriptive and inferential statistics were utilized to examine each research question. Each participant responded to every question on the instrument, the CBI items were ranked in order of importance to respondents, the 10 most important Caring Behaviours rated by patients and health care professionals are presented in tables 5.3 to 5.8 respectively.

### 5.5.1. Research Question 1

Which caring behaviours are deemed to be of importance to patients?

**Table 5.3: Patient ranking of the 10 most important caring behaviours.**

<table>
<thead>
<tr>
<th>CBI Item</th>
<th>N = 22</th>
<th>Subscale</th>
<th>Rank</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 23</td>
<td></td>
<td>PC</td>
<td>1</td>
<td>4.45</td>
<td>1.18</td>
</tr>
<tr>
<td>Q 20</td>
<td></td>
<td>PKS</td>
<td>2</td>
<td>4.95</td>
<td>0.95</td>
</tr>
<tr>
<td>Q 35</td>
<td></td>
<td>AHP</td>
<td>3</td>
<td>4.40</td>
<td>1.33</td>
</tr>
<tr>
<td>Q 18</td>
<td></td>
<td>AHP</td>
<td>4</td>
<td>4.86</td>
<td>1.12</td>
</tr>
<tr>
<td>Q 3</td>
<td></td>
<td>RD</td>
<td>5</td>
<td>4.59</td>
<td>1.09</td>
</tr>
<tr>
<td>Q 39</td>
<td></td>
<td>AOE</td>
<td>6</td>
<td>4.59</td>
<td>1.05</td>
</tr>
<tr>
<td>Q 1</td>
<td></td>
<td>RD</td>
<td>7</td>
<td>4.40</td>
<td>1.18</td>
</tr>
<tr>
<td>Q 9</td>
<td></td>
<td>RD</td>
<td>8</td>
<td>4.68</td>
<td>1.04</td>
</tr>
<tr>
<td>Q 22</td>
<td></td>
<td>PKS</td>
<td>9</td>
<td>5.00</td>
<td>1.15</td>
</tr>
<tr>
<td>Q 42</td>
<td></td>
<td>AOE</td>
<td>10</td>
<td>4.68</td>
<td>1.46</td>
</tr>
</tbody>
</table>

*Table illustrating patient ranking of caring behaviours. PC= Positive Connectedness, PKS= Professional Knowledge and Skill, AHP= Assurance of Human Presence, RD= Respectful Deference, AOE= Attentiveness to other’s experience.*
The 10 most important caring behaviours to patients were ranked according to overall score for each question. The highest mean was observed in the ‘professional knowledge and skill’ subscale (5.00 and 4.95, respectively). The lowest mean was observed in both the ‘respectful deference’ (4.40) and ‘assurance of human presence’ subscales (4.40). The highest ranked caring behaviour was ‘watching over the patient’ from the ‘positive connectedness’ subscale.

**Figure 3: Frequency of Caring Behaviour sub-scale for patient group.**

*Figure illustrating frequency of caring behaviours. PC = Positive connectedness, PKS = Professional Knowledge and Skill, AHP = Assurance of Human Presence, RD = Respectful Deference, AOE = Attentive to the Other’s Experience.*

Figure 3 illustrates the distribution of sub-scale caring behaviours by percentage in the patient group.
Table 5.4: Health Care Professional ranking of the 10 most important caring behaviours

<table>
<thead>
<tr>
<th>CBI Item</th>
<th>N= 37</th>
<th>Subscale</th>
<th>Rank</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 28</td>
<td></td>
<td>RD</td>
<td>1</td>
<td>5.89</td>
<td>0.39</td>
</tr>
<tr>
<td>Q 39</td>
<td></td>
<td>AOE</td>
<td>2</td>
<td>4.70</td>
<td>1.33</td>
</tr>
<tr>
<td>Q 35</td>
<td></td>
<td>AHP</td>
<td>3</td>
<td>5.79</td>
<td>0.45</td>
</tr>
<tr>
<td>Q 22</td>
<td></td>
<td>PKS</td>
<td>4</td>
<td>5.64</td>
<td>0.53</td>
</tr>
<tr>
<td>Q 37</td>
<td></td>
<td>AHP</td>
<td>5</td>
<td>5.56</td>
<td>0.55</td>
</tr>
<tr>
<td>Q 41</td>
<td></td>
<td>AOE</td>
<td>6</td>
<td>5.43</td>
<td>0.72</td>
</tr>
<tr>
<td>Q 3</td>
<td></td>
<td>RD</td>
<td>7</td>
<td>5.40</td>
<td>0.64</td>
</tr>
<tr>
<td>Q 9</td>
<td></td>
<td>RD</td>
<td>8</td>
<td>5.43</td>
<td>0.80</td>
</tr>
<tr>
<td>Q 11</td>
<td></td>
<td>RD</td>
<td>9</td>
<td>5.40</td>
<td>0.64</td>
</tr>
<tr>
<td>Q 31</td>
<td></td>
<td>AHP</td>
<td>10</td>
<td>5.35</td>
<td>0.78</td>
</tr>
</tbody>
</table>

Table illustrating healthcare ranking of caring behaviours. PC= Positive Connectedness, PKS= Professional Knowledge and Skill, AHP= Assurance of Human Presence, RD= Respectful Deference, AOE= Attentiveness to other's experience.

The 10 most important caring behaviours to the collective health care professional group were analysed. These responses were from all the health care professionals participating in this stage of the research and ranked according to overall score for each question. The highest mean was observed in the ‘respectful deference’ subscale (5.89) which also revealed the lowest mean in the 10 most important caring behaviours (5.40). ‘Treating patient information confidentially’ was the highest ranked caring behaviour from the ‘respectful deference’ subscale.
Figure 4: Frequency of Caring Behaviour Sub-scale Collective Health care Profession group.

![Frequency of Caring Behaviour Sub-scale Collective Health Care Professional Group](chart.png)

*Figure illustrating frequency of caring behaviours. PKS = Professional Knowledge and Skill, AHP = Assurance of Human Presence, RD = Respectful Deference, AOE= Attentive to the Other's Experience.*

Figure 4 illustrates the distribution of sub-scale caring behaviours by percentage in the collective health care profession group.

It was decided to further analyse the collective health care professional group to reveal any differences in ranking of caring behaviours by profession.
### Table 5.5: Doctors ranking of the 10 most important caring behaviours

<table>
<thead>
<tr>
<th>CBI Item</th>
<th>N= 37</th>
<th>Subscale</th>
<th>Rank</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 28</td>
<td>“ Treating patient information confidentially”</td>
<td>RD</td>
<td>1</td>
<td>5.90</td>
<td>0.31</td>
</tr>
<tr>
<td>Q 35</td>
<td>“ Appreciating the patient as a human being”</td>
<td>AHP</td>
<td>2</td>
<td>5.80</td>
<td>0.42</td>
</tr>
<tr>
<td>Q 22</td>
<td>“ Demonstrating professional knowledge and skill”</td>
<td>PKS</td>
<td>3</td>
<td>5.80</td>
<td>0.42</td>
</tr>
<tr>
<td>Q 41</td>
<td>“ Putting the patient first”</td>
<td>AOE</td>
<td>4</td>
<td>5.60</td>
<td>0.69</td>
</tr>
<tr>
<td>Q 8</td>
<td>“ Showing respect for the patient”</td>
<td>RD</td>
<td>5</td>
<td>5.60</td>
<td>0.51</td>
</tr>
<tr>
<td>Q 11</td>
<td>“ Being honest with the patient”</td>
<td>RD</td>
<td>6</td>
<td>5.50</td>
<td>0.52</td>
</tr>
<tr>
<td>Q 37</td>
<td>“ Showing concern for the patient”</td>
<td>AHP</td>
<td>7</td>
<td>5.50</td>
<td>0.57</td>
</tr>
<tr>
<td>Q 32</td>
<td>“ Encouraging the patient to call if there are any problems”</td>
<td>AHP</td>
<td>8</td>
<td>4.30</td>
<td>1.25</td>
</tr>
<tr>
<td>Q 24</td>
<td>“ Managing equipment skilfully”</td>
<td>PKS</td>
<td>9</td>
<td>5.40</td>
<td>0.69</td>
</tr>
</tbody>
</table>

Table illustrating doctors ranking of caring behaviours. PC= Positive Connectedness, PKS= Professional Knowledge and Skill, AHP= Assurance of Human Presence, RD= Respectful Deference, AOE= Attentiveness to other’s experience.

The 10 most important caring behaviours to doctors were ranked according to overall score for each question. The highest mean was observed in the ‘respectful deference’ subscale (5.90). The lowest mean was observed in the ‘assurance of human presence’ subscales (4.30). The highest ranked caring behaviour was ‘treating patient information confidentially’ from the ‘respectful deference’ subscale which correlated with the collective health care professional group highest ranked caring behaviour.

**Figure 5: Frequency of Caring Behaviour sub-scale for doctor group.**
Figure illustrating frequency of caring behaviours PKS = Professional Knowledge and Skill, AHP = Assurance of Human Presence, RD = Respectful Deference, AOE= Attentive to the Other’s Experience.

Figure 5 illustrates the distribution of sub-scale caring behaviours by percentage in the doctor group.

The next professional group to be analysed were nurses.

<table>
<thead>
<tr>
<th>CBI Item</th>
<th>N= 37</th>
<th>Subscale</th>
<th>Rank</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 9</td>
<td>“Supporting the patient”</td>
<td>RD</td>
<td>1</td>
<td>5.91</td>
<td>0.28</td>
</tr>
<tr>
<td>Q 23</td>
<td>“Watching over the patient”</td>
<td>PC</td>
<td>2</td>
<td>5.33</td>
<td>0.77</td>
</tr>
<tr>
<td>Q 36</td>
<td>“Helping to reduce the patient’s pain”</td>
<td>AHP</td>
<td>3</td>
<td>5.66</td>
<td>0.49</td>
</tr>
<tr>
<td>Q 42</td>
<td>“Giving good physical care”</td>
<td>AOE</td>
<td>4</td>
<td>5.66</td>
<td>0.65</td>
</tr>
<tr>
<td>Q 1</td>
<td>“Attentively listening to the patient”</td>
<td>RD</td>
<td>5</td>
<td>4.58</td>
<td>0.90</td>
</tr>
<tr>
<td>Q 18</td>
<td>“Helping the patient”</td>
<td>AHP</td>
<td>6</td>
<td>5.33</td>
<td>0.77</td>
</tr>
<tr>
<td>Q 22</td>
<td>“Demonstrating professional knowledge and skill”</td>
<td>PKS</td>
<td>7</td>
<td>5.66</td>
<td>0.49</td>
</tr>
<tr>
<td>Q 41</td>
<td>“Putting the patient first”</td>
<td>AOE</td>
<td>8</td>
<td>5.33</td>
<td>0.77</td>
</tr>
<tr>
<td>Q 24</td>
<td>“Managing equipment skilfully”</td>
<td>PKS</td>
<td>9</td>
<td>5.41</td>
<td>0.79</td>
</tr>
<tr>
<td>Q 15</td>
<td>“Making the patient physically and emotionally comfortable”</td>
<td>RD</td>
<td>10</td>
<td>5.25</td>
<td>0.75</td>
</tr>
</tbody>
</table>

Table illustrating nurses ranking of caring behaviours PC= Positive Connectedness, PKS= Professional Knowledge and Skill, AHP= Assurance of Human Presence, RD= Respectful Deference, AOE= Attentiveness to other’s experience.

The 10 most important caring behaviours to nurses were ranked according to overall score for each question. The highest mean was observed in the ‘respectful deference’ subscale (5.91). The lowest mean was also observed in the ‘respectful deference’ subscales (5.25). The highest ranked caring behaviour was ‘supporting the patient’ from the ‘respectful deference’ subscale which did not correlate with the collective health care professional group highest ranked caring behaviour. The ‘respectful deference’ subscale was highest ranked along with the collective health care professional and doctor groups.
Figure 6: Frequency of Caring Behaviour sub-scale for nurse group.

Figure illustrating frequency of caring behaviours PC = Positive connectedness, PKS = Professional Knowledge and Skill, AHP = Assurance of Human Presence, RD = Respectful Deference, AOE = Attentive to the Other’s Experience.

Figure 6 illustrates the distribution of sub-scale caring behaviours by percentage in the nurse group.

The physiotherapist group was analysed next.
Table 5.7: Physiotherapists ranking of the 10 most important caring behaviours

<table>
<thead>
<tr>
<th>Question</th>
<th>Subscale</th>
<th>Rank</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 11</td>
<td>RD</td>
<td>1</td>
<td>5.50</td>
<td>0.54</td>
</tr>
<tr>
<td>Q 37</td>
<td>AHP</td>
<td>2</td>
<td>5.33</td>
<td>0.51</td>
</tr>
<tr>
<td>Q 28</td>
<td>RD</td>
<td>3</td>
<td>5.66</td>
<td>0.81</td>
</tr>
<tr>
<td>Q 35</td>
<td>AHP</td>
<td>4</td>
<td>5.50</td>
<td>0.55</td>
</tr>
<tr>
<td>Q 8</td>
<td>RD</td>
<td>5</td>
<td>5.50</td>
<td>0.55</td>
</tr>
<tr>
<td>Q 9</td>
<td>RD</td>
<td>6</td>
<td>5.33</td>
<td>0.52</td>
</tr>
<tr>
<td>Q 2</td>
<td>RD</td>
<td>7</td>
<td>5.33</td>
<td>0.52</td>
</tr>
<tr>
<td>Q 31</td>
<td>AHP</td>
<td>8</td>
<td>5.33</td>
<td>0.81</td>
</tr>
<tr>
<td>Q 38</td>
<td>PKS</td>
<td>9</td>
<td>5.16</td>
<td>0.40</td>
</tr>
<tr>
<td>Q 10</td>
<td>RD</td>
<td>10</td>
<td>5.16</td>
<td>1.16</td>
</tr>
</tbody>
</table>

Table illustrating physiotherapists ranking of caring behaviours. PC= Positive Connectedness, PKS= Professional Knowledge and Skill, AHP= Assurance of Human Presence, RD= Respectful Deference, AOE= Attentiveness to other’s experience.

The 10 most important caring behaviours to physiotherapists were ranked according to overall score for each question. The highest mean was observed in the ‘respectful deference’ subscale (5.50 and 5.66, respectively). The lowest mean was also observed in both the ‘respectful deference’ (5.16) and ‘professional knowledge and skill’ (5.16) subscales. The highest ranked caring behaviour was ‘being honest with the patient’ from the ‘respectful deference’ subscale which did not correlate with the collective health care professional group highest ranked caring behaviour. The ‘respectful deference’ subscale was highest ranked along with the collective health care professional, doctor and nurse groups.
Figure 7: Frequency of Caring Behaviour sub-scale for physiotherapist group.

Figure illustrating frequency of caring behaviours PKS = Professional Knowledge and Skill, AHP = Assurance of Human Presence, RD = Respectful Deference

Figure 7 illustrates the distribution of sub-scale caring behaviours by percentage in the physiotherapist group.
The final group to be analysed was occupational therapists.

Table 5.8: Occupational Therapists ranking of the 10 most important caring behaviours

<table>
<thead>
<tr>
<th>CBI Item</th>
<th>Subscale</th>
<th>N= 37</th>
<th>Rank</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 4</td>
<td>“Spending time with the patient”</td>
<td>RD</td>
<td>1</td>
<td>5.11</td>
<td>0.60</td>
</tr>
<tr>
<td>Q 26</td>
<td>“Allowing patient to express feelings about their disease and treatment”</td>
<td>AHP</td>
<td>2</td>
<td>6.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Q 16</td>
<td>“Being sensitive to the patient”</td>
<td>AHP</td>
<td>3</td>
<td>6.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Q 28</td>
<td>“Treating patient information confidentially”</td>
<td>RD</td>
<td>4</td>
<td>6.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Q 31</td>
<td>“Talking with the patient”</td>
<td>AHP</td>
<td>5</td>
<td>6.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Q 35</td>
<td>“Appreciating the patient as a human being”</td>
<td>AHP</td>
<td>6</td>
<td>6.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Q 37</td>
<td>“Showing concern for the patient”</td>
<td>AHP</td>
<td>7</td>
<td>5.88</td>
<td>0.33</td>
</tr>
<tr>
<td>Q 15</td>
<td>“Making the patient physically or emotionally comfortable”</td>
<td>RD</td>
<td>8</td>
<td>5.88</td>
<td>0.33</td>
</tr>
<tr>
<td>Q 3</td>
<td>“Treating the patient as an individual”</td>
<td>RD</td>
<td>9</td>
<td>5.88</td>
<td>0.33</td>
</tr>
<tr>
<td>Q 8</td>
<td>“Showing respect for the patient”</td>
<td>RD</td>
<td>10</td>
<td>5.88</td>
<td>0.33</td>
</tr>
</tbody>
</table>

*Table illustrating occupational therapists ranking of caring behaviours PC= Positive Connectedness, PKS= Professional Knowledge and Skill, AHP= Assurance of Human Presence, RD= Respectful Deference, AOE= Attentiveness to other’s experience.*

The 10 most important caring behaviours to occupational therapists were ranked according to overall score for each question. The highest mean was observed in the ‘assurance of human presence’ subscale (6.00, 6.00, 6.00, 6.00 and 5.88, respectively). The lowest mean was also observed in the ‘respectful deference’ (5.11) subscales. The highest ranked caring behaviour was ‘spending time with the patient’ from the ‘respectful deference’ subscale which although did not correlated with the collective health care professional group highest ranked caring behaviour. The ‘respectful deference’ subscale was highest ranked along with the collective health care professional, doctor, nurse and physiotherapist groups.
Figure 8: Frequency of Caring Behaviour sub-scale for Occupational therapist group.

5.6. Analysis of data

An analysis of these top 10 caring behaviour items between patients and health care professionals’ perceptions of caring behaviours demonstrate both similarities as well as differences in the rankings. Patient and the collective health care professional groups agreed on 5 out of the 10 most important items. These were items (3), ‘treating the patient as an individual’, (9), ‘supporting the patient’, (22), ‘demonstrating professional knowledge and skill’, (35), ‘appreciating the patient as a human being’ and (39), ‘paying special attention to the patient during first times, as hospitalization treatments’. The third and eight items were ranked the same in both groups these were (35), ‘appreciating the patient as a human being’ and (9), ‘supporting the patient’.
The data was explored further and patient rankings were compared to the individual professional group rankings; as a result it was found that the patient and doctor groups agreed on 3 out of 10 most important caring behaviour items. These were (3), ‘appreciating the patient as an individual’, (22), ‘demonstrating professional knowledge and skill’ and (35), ‘appreciating the patient as a human being’, although none of these items were ranked in the same order of importance.

The patient and nurse groups agreed on 6 out of the 10 most important items, which were (1), ‘attentively listening to the patient’, (9), ‘supporting the patient’, (18), ‘helping the patient’, (22), demonstrating professional knowledge and skill’, (23), ‘watching over the patient’, and (42) ‘giving good physical care’. Again none of the items ranked in the same order of importance.

The patient and physiotherapist groups agreed on 2 out of the 10 most important items, (9), ‘supporting the patient’ and (35), ‘appreciating the patient as a human being’, with none of the items ranked in the same order of importance and finally the patient and occupational therapist groups agreed on 2 out of the 10 most important items, (3) ‘treating the patient as an individual and (35) ‘appreciating the patient as a human being’ as with the other groups none of the items were ranked in the same order of importance. The results demonstrated a principal agreement between the patient and collective health care professional groups (5 out of 10) with respect to the priorities of caring behaviours but interestingly it was the patient and nurse groups that were the most harmonious, agreeing on 6 out of 10 caring behaviours.

Within the top 10 rankings for all groups there were also differences found in the value placed on the subscales, Respectful deference to other (RD), this dimension relates to behaviours which demonstrate a courteous regard for the feelings and experiences of the other individual (Wolf et al., 1994). Assurance of human presence (AHP), this dimension consists of items which reflect an investment in the other’s needs and security (Wolf et al.,1994) Positive connectedness (PC), this dimension included items which reflected an optimistic and constant readiness of the part of the nurse to help the other (Wolf et al.,1994), Professional knowledge and skill (PKS) included caring behaviours which are perceived as proficient, informed and skilful (Wolf et al.,1994) and Attentiveness to
other’s experience (AOE), which demonstrate an appreciation of and engrossment in the other’s perspective and experience (Wolf et al., 1994).

The patient group rated RD (items 1, 3 & 9) as the most valued subscale followed by AHP (items 18 & 35), PKS (items 20 & 22), AOE (items 39 & 42) and lastly PC (item 23). Interestingly, this subscale rating was matched exactly by the nurse group subscale rating, again exhibiting a notable concordance between orthopaedic patients’ and nurses’ views in listing important caring behaviours. The doctors’ group rated RD (items 3, 8, 11 & 28) as the most valued subscale then AHP (items 35 & 37), PKS (items 22 & 24) and AOE (item 41). Caring behaviour items relating to the subscale PC were not ranked in the top 10 for this group. The physiotherapist group rated RD (items 2, 8, 9, 10, 11 & 28) as the most valuable subscale followed by AHP (items 31, 35 & 37), PKS (item 38), PC and AOE subscale items were not rated in the top 10. Finally the occupational therapist group rated RD (items 3, 4, 8, 15 & 28) and AHP (items 16, 26, 31, 35 & 37) as the joint most valued subscales, items corresponding to subscales PC, AOE and PKS were not rated in the top 10.

All groups rated RD as the most valued subscale, relating to behaviours which exhibit a courteous regard for the opinions and experiences of the other individual (Wolf, 2004); this was the only dimension to be recognized by all groups and featured predominantly in the physiotherapist and occupational therapist group ratings. The CBI items relating to this subscale focused on actions such as listening, supporting, being honest, showing respect, encouraging, treating the patient as an individual, ensuring confidentiality, ensuring physical and emotional comfort and spending time with the patient. Of note the items that attained the lowest rankings were, in the patient group, item 5 ‘touching the patient to communicate caring’, (total CBI item score = 76) subscale PC. In the collective health care professional group, item 24 ‘managing equipment skilfully’ (total CBI item score = 113), subscale PKS.

In the doctor group, item 34 ‘responding quickly to the patients’ call’ (total CBI item score = 35) subscale AHP. In the nurses group, item 12 ‘trusting the patient’ (total CBI item score = 51) subscale PC. In the physiotherapy group, item 10 ‘calling the patient by his/her preferred name’ (total CBI item score = 31) subscale RD and lastly in the
occupational therapy group, item 19 ‘knowing how to give injections and medication’ (total CBI items score = 12) subscale PKS.

5.6.1. Research Question 2

Do differences exist between the caring perceptions of patients and health care professionals?

The nonparametric Mann-Whitney U test analysis of variables was used to compare patients’ and health care professionals’ total CBI scores of caring behaviours. This procedure involved a rank ordering of the ratings of patients and health care professionals, with the mean ranks from each group compared and tested for significance to see (a) whether patients or health care professionals placed more importance on caring behaviours and (b) if gender significantly affected perceptions of caring behaviours. The level of significance was set at $p < 0.05$ for each test.

Table 5.9: Mann-Whitney test CBI by participants

<table>
<thead>
<tr>
<th>Ranks</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total caring behaviours inventory score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care professional</td>
<td>37</td>
<td>33.88</td>
<td>1253.50</td>
</tr>
<tr>
<td>Patient</td>
<td>22</td>
<td>23.48</td>
<td>516.50</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total caring behaviours inventory score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mann-Whitney U</td>
</tr>
<tr>
<td>Wilcoxon W</td>
</tr>
<tr>
<td>Z</td>
</tr>
<tr>
<td>Asymp. Sig. (2-tailed)</td>
</tr>
</tbody>
</table>
The results of the analysis showed a significant difference ($p=0.02$) in the total caring behaviours inventory score between health care professionals and patients. The scores of the CBI ranged from 105 – 245 (Mean 187.5, SD 38.93) in the patient group, 170-246 (Mean 211.1, SD 16.71) in the collective health care professional group which was then broken down into individual professions, scores ranged from 170 – 234 (Mean 202.6, SD 18.30) for doctors, 198 – 246 (Mean 221.3, SD 15.50) for nurses, 195 – 208 (Mean 200.5, SD 5.0) for physiotherapists and 186 – 225 (Mean 214.1, SD 13.86) for occupational therapists. The score range indicated that health care professionals unlike patients gave a higher mean value for each item of the CBI overall; suggesting that health care professionals perceived a higher positive perception than patients of their own caring behaviours.

Table 5.10: Mann-Whitney Test CBI by gender

<table>
<thead>
<tr>
<th>Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ranks</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total caring behaviours inventory score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>37</td>
<td>30.34</td>
<td>1122.50</td>
</tr>
<tr>
<td>Male</td>
<td>22</td>
<td>29.43</td>
<td>647.50</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Total caring behaviours inventory score |
| Mann-Whitney U | 394.500 |
| Wilcoxon W     | 647.500 |
| Z               | -1.196  |
| Asymp. Sig. (2-tailed) | .845   |

The results of the analysis showed no significant difference ($p=0.84$) in the total caring behaviours inventory scores between male and female respondents and therefore gender was not a predictor of the overall CBI scores.
5.6.2. Research Question 3

What, if any, factors may influence perceptions of caring behaviours

The non-parametric Kruskal-Wallis test one-way analysis of variance by ranks was used to test equality of population medians amongst groups (Corder & Foreman, 2009). To investigate whether demographic variables such as age, ethnicity, educational standing or profession were predictors in perceptions of caring behaviours. These variables were identified from the findings of previous research studies and required exploration in this study to ascertain if they influence caring (Finfgeld-Connett, 2008; McCormack and McCance, 2010; Webster, 2004; Wolf et al., 2008; Yeakel et al., 2003).

The level of significance was set at $p < 0.05$ for each test.

<table>
<thead>
<tr>
<th>Professional role</th>
<th>N</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total caring behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>inventory score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>10</td>
<td>13.20</td>
</tr>
<tr>
<td>Nurse</td>
<td>12</td>
<td>25.96</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>6</td>
<td>10.83</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>9</td>
<td>21.61</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-Square</th>
<th>Df</th>
<th>Asymp. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.786</td>
<td>3</td>
<td>.008</td>
</tr>
</tbody>
</table>

The results of the analysis indicates that there is a significant difference in the medians $x^2 (2, N=37) = 11.78, p=.01$. Nurses rated an overall greater positive perception of caring
behaviours when compared to the other health care professional groups. The occupational therapist group was the second highest rater followed by doctors and finally physiotherapists.

Table 5.12: Kruskal-Wallis Test
b. Grouping variable: patient profession

<table>
<thead>
<tr>
<th>Patient profession</th>
<th>N</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total caring behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>inventory score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>9</td>
<td>21.38</td>
</tr>
<tr>
<td>Clerical</td>
<td>1</td>
<td>3.00</td>
</tr>
<tr>
<td>Skilled labour</td>
<td>5</td>
<td>18.60</td>
</tr>
<tr>
<td>General labour</td>
<td>4</td>
<td>9.00</td>
</tr>
<tr>
<td>Housewife/husband</td>
<td>3</td>
<td>8.67</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td></td>
</tr>
</tbody>
</table>

| Total caring behaviours     |     |           |
| inventory score             |     |           |

<table>
<thead>
<tr>
<th>Chi-Square</th>
<th>Df</th>
<th>Asymp. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.348</td>
<td>5</td>
<td>.096</td>
</tr>
</tbody>
</table>

The results of the analysis indicates that there is no significant difference in the medians $x^2 (2, N=22) = 9.34, p=.09$ and therefore occupation in the patient group was not found to be a predictor of positive perception of health care professionals’ caring behaviour.
Table 5.13: Kruskal-Wallis Test
b. Grouping variable: academic

<table>
<thead>
<tr>
<th>Academic</th>
<th>N</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total caring behaviours inventory score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary education</td>
<td>17</td>
<td>63.35</td>
</tr>
<tr>
<td>Further education (diploma)</td>
<td>31</td>
<td>62.79</td>
</tr>
<tr>
<td>Higher education (first degree, Masters)</td>
<td>11</td>
<td>28.63</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-Square</th>
<th></th>
<th>Total caring behaviours inventory score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Df</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Asymp. Sig.</td>
<td>.042</td>
<td></td>
</tr>
</tbody>
</table>

The results of the analysis indicates that there is a significant difference in the medians $x^2$ ($2, N=59) = 9.89, p = .04$. Therefore educational level was found to be a predictor of positive perception of caring behaviours for all respondents. Respondents with secondary education status attained higher mean CBI total scores than those educated to other levels.
Table 5.14: Kruskal-Wallis Test
b. Grouping variable: marital status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>N</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total caring behaviours inventory score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>15</td>
<td>29.77</td>
</tr>
<tr>
<td>Married</td>
<td>30</td>
<td>31.37</td>
</tr>
<tr>
<td>Living with partner</td>
<td>5</td>
<td>37.50</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
<td>19.00</td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
<td>44.58</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chi-Square</th>
<th>Df</th>
<th>Asymp. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.366</td>
<td>5</td>
<td>.498</td>
</tr>
</tbody>
</table>

The results of the analysis indicates that there is no significant difference in the medians $x^2 (2, N=59) = 4.36, p = .49$. Marital status was not found to be a predictor of positive perception of caring behaviours in all study respondents.
Table 5.15: Kruskal-Wallis Test

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>N</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>51</td>
<td>36.30</td>
</tr>
<tr>
<td>Black African</td>
<td>2</td>
<td>43.50</td>
</tr>
<tr>
<td>Asian</td>
<td>6</td>
<td>21.68</td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td></td>
</tr>
</tbody>
</table>

The results of the analysis indicates that there is no significant difference in the medians $x^2 (2, N=59) = 4.50, p= .21$. Ethnicity was therefore not found to be a predictor of positive perceptions of caring behaviours in all of the study respondents.

A Spearman’s rank correlation coefficient or Spearman’s rho statistical calculation was performed (table 5.16); this is a non-parametric measure of statistical dependence between two variables.

It was used to determine if there was any statistical significance between the total caring behaviour inventory scores and age.
Table 5.16:

a. Spearman’s rho
b. Grouping variable: age

<table>
<thead>
<tr>
<th></th>
<th>Total caring behaviours inventory score</th>
<th>respondents age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearman’s rho</td>
<td>1.000</td>
<td>-.081</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.541</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>59</td>
</tr>
<tr>
<td>respondents age</td>
<td>Correlation Coefficient</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.541</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>59</td>
</tr>
</tbody>
</table>

The results revealed that age was not a predictor of caring behaviours $p=.541$.

5.7. Conclusion

The CBI tool was utilised in this stage of the study to measure patient and health care perceptions of caring behaviours in an orthopaedic setting. In this study the CBI had a Cronbach’s alpha of 0.912.

A full range of the 6-point Likert scale was demonstrated across all 42 items on the instrument. Each respondent completed the instrument fully including the demographic details requested.

In the analysis of data collected general similarities and differences were examined in the different groups.

In this study the overall scores and the scores obtained for each subscale of the CBI-42, for patients, doctors, nurses, physiotherapists and occupational therapists were relatively high. In addition, the standard deviation of the means was small thus demonstrating that patients and health care professionals perceive that caring behaviours are regularly exhibited and embraced during care interactions. This signals that patients acknowledge and appreciate caring behaviours demonstrated.
The patient group differed from the health care professional group in several ways; the mean age in the patient group was 58 years, by comparison the health care professional group had a mean age of 35 years. It was found that 28 of the health care professionals had undertaken further education (75.5%) but only 3 (13.6%) of patients were educated to this level. By the very nature of their job all the health care professionals were classed in professional employment (100%).

Patients and health care professional respondents were predominantly from the white British ethnic group. There were more female to male respondents in both the patient and healthcare professional groups and the dominant marital status in both groups of respondents was married.

The overall mean score of the CBI was 187 in the patient group and 211 in the collective health care professional group. Statistically a significant difference was found in the overall CBI scores with health care professionals indicating that, although patients acknowledged that caring behaviours were demonstrated by the health care professionals, they rated them lower than the health care professionals themselves. Nurses rated the items higher than doctors, physiotherapists and occupational therapists. The reason for this is not clear but a possible explanation could be that nurses may have a higher expectation and attachment to caring through its historical links with the profession. Nursing is seen as the science of caring, and in today’s world there is an increasing drive to maintain human caring ideology and human caring ideals especially in light of new technology and aggressive treatments (Watson, 2005).

In the collective health care professional, doctor, physiotherapist and nurse groups the highest ranked and dominant sub-scale was respectful deference. This sub-scale relates to courteous regard for the other and includes behaviours such as listening, teaching, supporting, showing respect, being honest and providing physical and emotional comfort. Providing patients with opportunities to express feeling and satisfying patient needs (Brunton & Beaman, 2000). Although congruence was revealed relating to the subscale there was no agreement between any of the groups with the ranking of the subscale item. The difference between the rankings may offer some insight into the conceptual confusion about how individual health care professionals perceive and communicate
respect. This is particularly true given the complexity and ambiguity of modern health care delivery and the expectation of patients to be treated with respect (Gallager, 2007).

The highest ranked subscale in the patient group was positive connectedness which included activities such as being hopeful for the patient, allowing the patient to express feelings and trusting the patient (Brunton and Beaman, 2000).

In recent years connectedness has been the subject of much debate, the most recent and recurring debates centre upon the affective qualities of social interactions with significant other which are of a positive nature (Phillips-Salimi et al. 2011). In this perspective, the definition of connectedness is said to be related to an individual’s perception of the relationship against the quality of the social relationship. Here connectedness is viewed as the belief of the individual that he/she is shown respect, feels cared for and is valued for who they are and importantly understood by the other (Edwards et al., 2006; Grossman & Bulle, 2006; Resnick et al., 1993, 1997, Rew, 2002; Scochet et al., 2006; Whitlock, 2006; Waters et al., 2009).

The dominant sub-scale was respectful deference and the highest mean was observed in the professional knowledge and skill sub-scale. In respect of professional knowledge and skill, the findings are not dissimilar to previous studies which have shown that patients judge nurses on technical aspects of care and so perceived professional knowledge and skill as the most important sub-scale of the CBI (Gooding et al., 1993; Holroyd et al., 1998; Larsson et al., 1998; Papastavrou et al., 2011; Widmark-Petersson et al., 1998; Zamanzadeh et al., 2010).

Assurance of human presence was the dominant sub-scale in the occupational therapist group, although respectful deference was the highest ranked. Assurance of human presence included items such as ‘helping the patient’, talking with the patient’, ‘showing concern for the patient’ and ‘allowing the patient to express feelings’. Presence is seen as a concept which is representative of caring behaviours, is holistic in nature and involves the health care professional encountering the patient as a unique individual in a unique situation, choosing to ‘spend’ his or herself on the patient’s behalf (Doona et al., 1999; Godkin and Godkin, 2004). Here sensitivity is shown towards understanding and
responding to the patients’ stated and actual needs and expectations. Over the past decade the role of the occupational therapist has appeared to shift to include a more intangible dimension which includes helping the patient to find meaning in or of life, providing a sense of presence and giving the patient a sense of control (Rahman, 2000). As a result there has been a realization that the focus of intervention by the occupational therapist has moved away from the notion of ‘doing’ to the concept of ‘being’ ensuring a holistic approach to life and care (Teo, 2009).

There was no agreement between the groups relating to the lowest ranked items, with these falling into 4 of the 5 subscales, Positive connectedness, Assurance of human presence, Respectful deference and Professional knowledge and skill, none of the lowest ranked items were from the subscale Attentiveness to the other’s experience.

The data was examined further to ascertain if demographic variables influenced perceptions of caring behaviours. Education, health care occupation were found to be predictors of positive caring behaviours while gender, patient profession, marital status, age and ethnicity were not predictors.

Following analysis of the quantitative data a second qualitative research stage was conducted in order to elaborate on and explore in depth the data obtained by the quantitative CBI tool. The following chapter details the results of stage two of the research.
CHAPTER SIX

Findings and Analysis of Observations

Stage Two

Figure 9. The process of data collection and analysis

6.1. Introduction

This chapter presents the main themes that arose from the observational stage of the research (See Chapter 4); this stage of the study is represented in figure 9. It is an interpretive account of observed caring behaviours demonstrated during caring interactions between health care professional and patient. Chapter Five presented the caring behaviours valued by patients and health care professionals identified through the use of the Caring Behaviour Inventory tool. Participant observation was employed to discover which of these caring behaviours were most visible during caring interactions. The research objective for this stage was:

- Which elements of Watson’s caring theory are exhibited by health care professionals during caring interactions?
The results are briefly summarised at the end of this chapter as a synthesis of the key points from the observations, findings are discussed in Chapter 8 in order to provide coherence.


Drawing on Watson’s theory of transpersonal care and the wider literature reviewed in Chapter Two, a theoretical framework was developed for Stages Two and Three of the study and is diagrammed in Figure 10. The five categories from Watson (1979) and Wolf (1986) are used as independent variables, which act on perceptions of caring behaviours. Additional independent variables were used as covariates in the model: gender, age, ethnicity and profession.
In this diagram the right hand box lists the dependent variables which comprise caring behaviours as perceived by health care professionals and patients. Those perceptions have been sourced by observing caring interactions between the two groups and then analysing the observed data by means of follow-up interviews. In the left hand box the independent variables are listed these include Watson’s caring caratives which are used to define and group caring behaviours.
Finally age, gender, ethnicity, profession and level of education are variables used to determine if these influence perception of caring behaviours between the two groups.

6.3. Development of the observation tool

A preparatory visit was made by the researcher to both wards so that initial activity could be ascertained. Difficulty was encountered due to the rapid and large amount of information observed at any one time. This difficulty in information gathering in observational study has been acknowledged by previous researchers in the field (Bowman, 1995; Johnson, 1995; Martin & Bateson, 2007). The need to watch and listen continuously was imperative (Hammersley & Atkinson, 2007; Schatzman & Strauss, 1973). It was decided to develop the observational tool so that the caratives of Watson’s (1986) caring theory could be captured in a semi-structured way which liberated the researcher from the assumed and accepted; thereby revealing a richer field for observation. Field notes were made following every observation; this was done in a quite office away from the ward. No notes were taken whilst observing or assisting with caring interactions. Each observation was numbered and notes written were anonymised so that no participants would be identified. To illustrate this, patient participants were referred to in the field notes as P1 for patient one and so on.

6.3.1. Modifying the observation tool

During the preparatory stage of observation of the two wards involved in the study, the researcher experienced difficulty recording all the information observed at the one time without losing track of unfolding events. This has been documented in the literature and acknowledged as an on-going problem in observational studies (Bowman, 1995; Johnson, 1995; Martin & Bateson, 2007).

On completion of the preliminary ward observations, the observation tool was modified to allow for easier data recording. The revised tool was:

- Semi-structured
- Comprised of sections for date, time, ward, personnel involved, activity/interaction, verbal behaviour, physical behaviour and gestures.
• Documented patient condition or traumatic injuries.

• A free text section for notes and comments.

• A box for recording a unique code for each participant (Appendix 13).

Reflective comments following each observation period were made which allowed for the recording of any thoughts or feelings. These could be explored soon after the event and any concerns clarified by the staff involved. For example, on one occasion on the trauma orthopaedic ward a physiotherapist was heard to refer to a particular piece of equipment she was giving to a patient as an abbreviation, this was discussed with the member of staff and the data recorded clarified.

6.3.2. Capturing the data

Attempting to capture the caring interaction in the fullest sense can be a monumental undertaking, it was decided by the researcher to look at ways in which data collection could be enhanced. The use of tape recorders in participant observation has been documented and can help provide far more detail than notes.

The use of audio and video recordings in the collection and analysis of data was first used in the 1940s and 1950s by several social scientists (Bateson and Mead, 1942; Bateson, 1956; Birdwhistell, 1952). In recent years the importance of data recording has been acknowledged by ethnographers (Hammersley and Atkinson, 2007), social psychologists (Potter and Wetherall, 1987) and in researcher methods using focus groups (Barbour and Kitzinger, 1999). One of the fundamental benefits of using recording equipment is that it is less prone to the interpretive filtering effect which occurs when the researcher is writing down their version of the observed events. The account of the observation is therefore likely to be more accurate and detailed (Hammersley and Atkinson, 2004).

There are those who emphasize what they perceive as distinct disadvantages to tape-recording interactions. Some researchers worry about the effects and influence such equipment can have on study participants, such as researcher effects (Bryman, 2004; Hammersley, 1991), context effects (Foddy, 1993) and observer effects (Robson, 2011).
Sacks (1984) describes the positive use of tape-recorded conversations in observation, concluding that, ‘The tape-recorded materials constituted a good enough record of what had happened. Other things, to be sure, happened, but at least what was on the tape had happened (P.26). The researcher decided that recording the exact conversation during the caring interaction was important in helping to capture the integrity of the social processes under observation. Employing the use of a digital recorded allowed for a reduction in background noise from other conversations and activity in the observation area. The recorder was discreetly placed in the researcher’s uniform top pocket.

6.3.3. Respecting privacy and dignity

All patients were informed of their right to decline observation during intimate personal care, at such times the researcher would either leave the area completely or stand outside the bed screens until the procedure had finished. Patient privacy and dignity were protected at all times.

6.3.4. Sample demographics

The stratified random sample participants were drawn from one orthopaedic trauma ward and one elective orthopaedic ward. A total of 16 health care professionals and 8 patients agreed to take part in this stage of the research. See Chapter 4 tables 4.10 and 4.11.

6.3.5. Inclusion Criteria

Each participant was assigned a number for the study in order to protect their identity and to ensure confidentiality. The inclusion criteria for selection of patients for observation and follow-up interview were as follows:

- In-patient on either the elective orthopaedic or orthopaedic trauma ward during the observation session.

- Alert and orientated to give informed consent and willing to participate in a post-discharge interview.

- Can communicate verbally
Can speak English.

Well enough to participate

Inclusion criteria for staff participants:

- Participation consent obtained
- On duty during the observation period.

Staff and patients interested in the study were given an information sheet (Appendix 6 and 7), any questions were fully answered and written consent was obtained (Appendix 8 and 9).

6.3.6. Gaining access to potential participants

The specialty matron and ward managers for each ward were approached by the researcher for permission to (a) conduct the observations on the given wards and (b) access potential participants.

In order to increase the number of potential study participants, each ward was visited at times indicated by each ward manager when staffing levels were at their maximum. Between 09.00 - 12.30hrs for morning shifts, 14.00 – 19.00hrs for afternoon shifts and 20.00 – 24.00hrs for night shifts.

6.4. Observation setting.

The observation stage of the research was undertaken in a district general hospital which was built in 1983 in a nucleus design. The design incorporates a complete functioning hospital which can be easily extended when service needs or budget allows. Nucleus style hospitals are designed to save energy by maximising natural light and ventilation. Departments and wards are linked by a central corridor and are situated on the ground and first floor areas.

The setting for the observation comprised one 33 bedded mixed sex orthopaedic elective ward and one 31 bedded mixed sex orthopaedic trauma ward. Both wards are located on the ground floor of the building; figure 11 illustrates the layout and observation areas on
both wards. The researcher was located in the mid blue coloured areas as indicated on the key during the observation periods.

Figure 11: Scenes Selected for Participant Observation of Caring Behaviours
Two of the six bedded bays closest to the nurse’s station on both wards served as the post-operative observation area for patients following surgery. The nurse’s station was the base for the ward clerk and an administration area where nursing and other health care professionals completed their paper and computer documentation.

Each ward was led by a ward manager supported by a deputy ward manager and a team of registered and non-registered nursing staff. Placements were provided for student nurses. The clerical and administration work was undertaken by ward clerks who would answer the telephone during weekdays and office hours only, outside of these hours the telephone would be answered by nursing or medical staff. Both wards work with seven orthopaedic consultants and their respective teams of medical staff. The physiotherapists and occupational therapists were ward based. In addition the orthopaedic trauma ward had two trauma nurse specialists who provided expert clinical nursing support and advice. A multi-disciplinary meeting took place at 9am on both wards Monday to Friday to discuss patient progress and plan discharge from hospital, this lasted approximately 30 minutes depending on complexity of cases. Both wards ran at maximum bed occupancy with staff experiencing constant pressure to ensure timely discharge. Issues relating to staffing resources were worse on the trauma ward with staff absences due to short and long term sickness.
6.4.1. Working hours

Table 6.3: Health care professional working hours.

<table>
<thead>
<tr>
<th></th>
<th>Doctors</th>
<th>Nurses</th>
<th>Physiotherapists and occupational therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shift patterns</td>
<td>24 hour cover 7 days a week</td>
<td>24 hour cover 7.30am-15.30pm 13.30pm-21.30pm 21.00pm-08.00am</td>
<td>08.30-16.30pm Monday - Friday</td>
</tr>
</tbody>
</table>

Table 6.3 shows the working hours of the health care professionals taking part in the study across both wards. Doctors and nurses were the only professionals to provide 24 hour cover 7 days a week.

On both wards between seven and eight nurses were rostered on an early shift, five on a late shift and four on a night shift. Basic non-nursing duties were provided by a housekeeper who ran general errands and helped patients to eat and drink. Nursing staff were the main care-givers and were apportioned patients such that each registered nurse had one six bedded bay and a side room consisting of differing levels of patient dependency. The ward managers participated in the delivery of patient care except on Mondays’ which were designated ‘administration days’ when management duties were undertaken.

Therapy staff on both wards apportioned their caseload depending on the number of patients requiring physiotherapy or occupational therapy input, there was usually one senior and junior therapist for each ward Monday to Friday. The caseload for the medical staff varied according to consultant allocation, each team comprised a consultant, a registrar, and a senior house officer, with each ward having its’ own house officer (junior doctor). In this hospital setting, at the time of the study, patients on the elective orthopaedic ward were expected to remain in hospital for up to seven days depending upon the type of surgery, age, social circumstances and post-operative progress. Patients on the trauma orthopaedic ward had reported stays of between one and fifty two days,
this was dependent upon the nature of their injury, age, social circumstances and post-operative progress. There were patients on both wards who were deemed medically fit but due to social problems remained in hospital, either waiting residential or nursing home placement or home care packages.

The majority of health care professionals were observed to prioritize their workload according to patient dependency levels, although this differed between the two wards. Staff always gave priority to emergency admissions or emergency situations. The observations were performed during one of the busiest periods the hospital has experienced over the past five years. Bad weather conditions had resulted in an unprecedented number of accident cases admitted to the hospital and the orthopaedic trauma ward.

**Table 6.4 Caseload dependency**

<table>
<thead>
<tr>
<th></th>
<th>Elective Orthopaedic Ward $N=33$</th>
<th>Orthopaedic Trauma Ward $N=31$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent patients</td>
<td>$6 – 10$</td>
<td>Dependent patients $= 25 – 27$</td>
</tr>
<tr>
<td>Independent patients</td>
<td>$23 – 27$</td>
<td>Independent patients $= 4 – 6$</td>
</tr>
<tr>
<td>Total number of emergency admissions during observation periods</td>
<td>$= 4$</td>
<td>Total number of emergency admissions during observation periods $= 31$</td>
</tr>
</tbody>
</table>

This table illustrates that during the observation period the trauma ward had more dependant patients than the elective orthopaedic ward. The trauma ward also had more emergency admissions over the same period of time.

In summary, patient caseload on the trauma and elective orthopaedic wards differed at the time of observation, as demonstrated in table 6.4.
6.4.2. Observation sessions

Participant observation was conducted on 10 occasions comprising eight two hour periods between the two wards, focusing on caring interactions. Observation sessions were arranged to coincide with the personal shifts of the individual health care professionals who had agreed to participate in this stage of the research and had given consent.

Problems considered

Hawthorne Effect

The Hawthorne Effect is a research bias that occurs when participants in a study alter their behaviour to conform to the expectations of the researcher (Leonard & Masatu, 2006). Overcoming this effect can be difficult but was minimised in this study. The researcher knew several of the health care professionals participating in the study which could have led to difficulty in ensuring that natural behaviour was employed. It was noted that there were occasions when the presence of the researcher appeared to influence the behaviour of the health care professional. For example:

“We’ll have to be on our best behaviour today as the nurse consultant is watching us, ha, ha.” (Field notes from orthopaedic trauma ward)

These comments did not affect the qualitative results as the researcher had intentionally observed caring interactions prior to this visit. The observational sessions were conducted at times when the wards were busy and staffing levels low. Researchers in this field have identified the issue of role conflict (Kite, 1999; Wilkes and Beale, 2005) whilst others have recognised the importance of maintaining good relationships during participant observation (Gerrish, 1997; Hammersley and Atkinson, 2007). During the observation sessions help was offered by the researcher but staff were informed that this could not be offered anywhere else in the ward for fear of missing important observational data. If there had been any likelihood of compromise to patient care the researcher would have abandoned the observed interaction to provide assistance as professional responsibility took priority, (NMC, 2010).
During the time spent in the bays or side rooms, the researcher performed a number of care duties and took part in social conversations with patients and health care professionals. This included such tasks as making beds and assisting with bed bathing. The researcher wore a uniform to achieve integration into the ward environment and encourage natural behaviour to help improve the quality of the data collected.

Influence of personal opinion

There were occasions when the researcher was aware of her status as a senior nurse and subsequent opinions on caring and their potential influence on analysis. Acknowledgement of the researcher’s presence as a senior nurse could have led to some difficulty in answering apparently naïve questions. A balance was sought between establishing trust and rapport from the individuals being observed whilst obtaining sufficient data for the study.

Gaining rapport

Prior to each observation the researcher arrived on the ward before shift handover, which allowed for exchange of pleasantries and helped form a trusting relationship. Forming a bond between researcher and study population is important, particularly in the early stages of research and avoids the danger of being labelled a ‘spy’ which continues to be a problem in this field of research (DeWalt & DeWalt, 2010).

6.4.3. Observation framework

Initially the framework for observation outlined by the systematic fieldwork methods by Werner and Schoepfle (1987) were employed which included (a) the ethnographer’s journal, and (b) verbatim transcriptions of native texts. In this study the framework for field notes constructed by the researcher facilitated selective observation (Spradley, 1980) and focused in on the elements of the observation which would address the research questions. The nature of the written information recorded after the observations was allowed to be as wide ranging as possible to elicit qualitative data but in order to provide focus field notes were consequently recorded under the following categories adopted from the four major genres of observation as classified by Whiting and Whiting (1970);
- Location, stage, set
- Personnel including demographic details
- Activity
- Verbal/ non-verbal interaction
- Physical interaction, gestures, body language

Location

Werner and Schoepfle (1987) use theatrical terminology to set the observational scene for their readers. They divide location into stages or sets, each of which is ‘related to each other as parts of a whole and refer to spatial dimension in the life and activities of a human group.’ (p.264)

This classification of location is described as static, and moves from location to stage to set. The geography and general description of each of the wards was an important consideration in the interpretation and presentation of the findings. The layout of both wards provided the environment and set the boundaries within which the care-givers operated. Crucially it influenced the way in which all interactions took place between patients and care-givers. To illustrate this point during one observed session, nurse 4 was caring for twelve patients housed in two separate bays, she became frustrated by an inability to observe all of her patients, her frustration is described in the following field notes,

_The senior nurse was busy preparing an elderly lady for surgery in bay C, a call bell was activated in the first six bedded bay A... “Look at this, I’m here trying to get this poor old soul ready for theatre and their (patients) ringing for me in that bay, how can I be in two places at once. I know what it is... I need eyes in the back of my head... and the next thing you know they’ll be here with the theatre trolley and I haven’t finished getting this lady ready.” Nurse 4._
**Personnel**

All persons or ‘actors’ that are relevant to the location, stage or set are included. Here specific persons or groups may be the focus of attention. Immediately prior to each observational session, notes were taken to document the current status of the ward in terms of numbers of staff, number and allocation of patients relevant to the observation and the nature of their condition. This information helped to clarify the content and context of the health care professionals’ work at the time of observation and was recorded on the data collection form (Appendix 13).

**Activity**

Werner and Schoepfle (1987) liken activity to a performance by given actors in a given location, stage or set. Describing the interaction being observed, such as helping a patient to mobilise, this helps to set the scene for the reader.

**Verbal/ non-verbal Interaction**

The researcher’s impression of how the health care professional introduced him or herself to the patient, level and type of communication that took place. Tone of voice e.g. empathetic, sympathetic.

**Physical Interaction**

The researcher’s impression of physical behaviours:

- eye contact
- facial expressions
- body language
- touch

The researcher wrote up the field notes as soon as possible, predominantly the same day, and included as much detail as possible.
Objects

- Objects or ‘props’ that are important to the action of the person or persons being observed, this may include medical equipment/devices forming part of the activity.

6.4.4. Themes derived from observation data

Observed interactions between health care professionals and patients revealed diverse caring behaviours which were repeatedly demonstrated.

Table 6.5: Most frequently observed caring behaviours

<table>
<thead>
<tr>
<th>Observed caring behaviour</th>
<th>Carative Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spending time with the patient</td>
<td>1. Respectful deference to other</td>
</tr>
<tr>
<td>2. Communication</td>
<td>2. Positive connectedness</td>
</tr>
<tr>
<td>3. Giving good care</td>
<td>3. Attentiveness to the other’s experience</td>
</tr>
<tr>
<td>4. Giving reassurance and support</td>
<td>4. Respectful deference to other</td>
</tr>
<tr>
<td>5. Helping the patient</td>
<td>5. Assurance of human presence</td>
</tr>
<tr>
<td>7. Demonstrating empathy</td>
<td>7. Positive connectedness</td>
</tr>
<tr>
<td>8. Ensuring comfort</td>
<td>8. Assurance of human presence</td>
</tr>
<tr>
<td>10. Listening to what the patient has to say</td>
<td>10. Respectful deference to other</td>
</tr>
<tr>
<td>11. Giving information and instruction</td>
<td>11. Respectful deference to other</td>
</tr>
<tr>
<td>12. Demonstrating mobility aids, managing equipment</td>
<td>12. Professional knowledge and skill</td>
</tr>
</tbody>
</table>

This table documents the most frequently observed caring behaviours which have been categorized according to Watson’s carative factors.
6.5. General observations

Nursing staff were the dominant group in terms of physical presence on the wards. The doctors undertook formal and informal ward rounds reviewing patients under their care. Therapy staff had contacted with patients requiring physiotherapy or occupational therapy input.

The orthopaedic trauma ward was extremely busy, patient call buzzers were constantly activated, the ward telephone rang constantly. It was observed that patient contact tended to be task orientated, such as attending to general hygiene needs. Patients on the trauma ward had been admitted via the accident and emergency department having sustained a traumatic injury that required surgery or conservative treatment. The majority of patients were high dependency calling for intense physical and emotional support from all staff pre and post operatively. Anxiety and distress was evident in many of the patients as a result of their traumatic experiences, with several elderly patients having cognitive impairment/dementia due to co-morbidities such as Alzheimer’s’ disease. The ward was a frenzy of activity as a result of a continual and intense workload. On the elective orthopaedic ward, the atmosphere was one of relative calm and silence. Patients were admitted to the ward for planned surgery or treatment, due to the high volume of scheduled theatre cases each day the ward was busy. Health care professional contact was task orientated although the majority of patients were self-caring. Emotional support was mainly part of any educational or counselling required and was clearly evident in the observed contacts. At the time of the observed sessions there were no patients with cognitive impairment on this ward.

Staff on both wards dealt with interruptions as they endeavoured to care for patients during the observed sessions. These included general telephone enquiries, enquiries from other hospital personnel entering the ward, and visitors. The most noticeable interruption for the senior nursing staff was the number of times they were called away from patient care to discuss bed occupancy figures, one nurse was called to answer the same enquiry three times, from various hospital personnel. The highest number of observed interruptions per hour per session was 12 on the trauma ward and 7 on the elective ward.
The amount of time each health care professional spent with their patients depended upon
the task being performed, for nursing staff contact could be as little as five minutes in
order to take a blood pressure or a temperature and as much as one hour to perform a bed
bath. Medical staff spent between five and thirty minutes on average with their patients
and therapy staff between twenty minutes and one hour.

Orthopaedic trauma ward observations

Six caring interactions were observed during pre-arranged sessions on the orthopaedic
trauma ward. Two early shifts, one late shift and one night shift were worked. The
interactions facilitated the emergence of a myriad of caring behaviours demonstrated by
each of the health care professionals observed. The caring behaviours were demonstrated
via physical or verbal interactions and in most cases by a combination of the two. It was
noted that as the dependency of the patients was high on this ward staff were constantly
late for breaks or late going off duty. Some took their break in the ward managers’ office,
as they were unable to leave the ward. The observations from this ward are presented as
six vignettes; findings will be discussed after each.

6.5.1. Observation 1

It had been a busy evening on the ward but by 20.00 hours things had started to settle
although the staff were still busy with patient care. The phone rings at the nurses’ station,
it rings for some time before it is answered by nurse 4 a staff nurse of eight years.

- Nurse 4. “We could do with someone here of an evening just to answer
  this thing,” pointing at the telephone.
- She was in charge of the ward on this particular shift; she appeared tired
  and somewhat flustered.
- She picks up the telephone and after talking for a couple of minutes she
  puts it down.
- She shrugs her shoulders.
- “We have another admission coming, male, fractured ankle; they’re
  bringing him up from accident and emergency in about 10 minutes
(referring to patient 1). That doesn’t give me much time to get things sorted, still have the gents in there to do.”

- She gestures her head towards a side cubicle.
- “I think I’ll put him in there, I don’t think he’d thank me for putting him in with the other men.”

This was a reference to bay C which was full of elderly confused male patients.

- She starts to prepare the bed and goes off down the ward to get equipment.
- Within a matter of minutes two porters wheel patient 1 onto the ward.
- As Jenny comes back down the ward she notices the trolley and porters.
- “Christ, they don’t give you a minute do they?”
- She turns to the porters, “I thought they said ten minutes?”
- One of the porters shrugs his shoulders, “Where do you want him?”
- “In the cubicle,” nurse 4 replies.

- A nurse from the accident and emergency department rushes onto the ward.
- “Sorry I’m late, forgot the prescription chart.” She proceeds to give handover to nurse 4.
- The handover takes place in the doorway of the cubicle, and then the staff nurse from the accident unit bids a hurried farewell to the patient and rushes off the ward.
- The time was 20.30 hours and the night staff were beginning to arrive on the ward.
- “It’s going to be a late one tonight,” Nurse 4 shouts to one of the staff as they walk onto the ward.
- “I’ll be with you as soon as I can, just had an admission from accident and emergency, do me a favour, make a cup of tea for this man.”

- Nurse 4 starts to attend to the patient; she introduces herself and then immediately gives an apology.
“Look I’m sorry, it’s been really busy this evening, just give me a minute and I’ll be back with you.”

She asks the patient what he prefers to be called.

“Right, I’ll be back in a minute.

Nurse 4 rushes off to empty a catheter bag for a patient in the adjoining bay then after five minutes she returns to the cubicle.

“Sorry about that, right, now let’s get you sorted”

Nurse 4 then spends time admitting patient 1 to the ward, using a dynamap (a machine for monitoring blood pressure and pulse).

She takes the readings talking to her patient.

“Are you in any pain?”

Patient 1 shakes his head.

Nurse 4: “Oh, I see they gave you some morphine in the department, well if you start to feel anything err pain just let me know, ok?”

Patient 1: “Yes, I will.”

Nurse 4 rummages in the patients’ emergency notes; she pulls out a piece of paper and writes down the readings from the dynamap machine.

She then looks up at her patient.

Nurse 4: “We can give you something to eat and drink, they’re making you a cup of tea, and do you fancy anything to eat? I’m afraid it’s only sandwiches, no hot meals at this time of night.”

Patient 1 replies that a cup of tea is fine and that he is not hungry.

He is clearly distressed.

As she finishes her tasks nurse 4 notices how upset patient1 is, she stops what she is doing and spends some time chatting with him offering reassurance and support; her voice is softly spoken and she encourages patient 1 to tell her what is distressing him.

At one point during the conversation she puts her hand on his for a few moments before withdrawing it.
Nurse 4: “Do you want me to give anyone a call for you, perhaps your wife?”
Patient 1: “No I’m fine I’ll ring my wife in the morning if I can?”
Nurse 4: “Of course anything you want.”
“Ah, here’s your cup of tea, that’ll make you feel better.”
She laughs and patient 1 gives a little smile.
“I’ll be back in a moment, just got to let the night staff know what’s happening, here’s your call bell, just press that if you need anything, we need to get that ankle elevated so I won’t be long, I’ll get a hand and we’ll put that leg up on a frame.”
Twenty minutes pass while nurse 4 hands over care to the night staff, once handover is finished the night staff tell her to go home.
“I’ll just give you a hand elevating his ankle.”
Nurse 4 promptly picks up the frame and enters the cubicle, the night staff nurse follows.
“Right, we need to put your leg up on this frame; it’ll help reduce the swelling and pain.” She explains to patient 1.
Patient 1 nods. The task is completed quickly.
“Right are you going now?” Asks the night staff nurse.
Nurse 4 replies that she has not finished her documentation and she’ll do that before she goes home.
She approaches patient 1, putting her hand on his arm.
Nurse 4 introduces Patient 1 to the night staff nurse and asks if there is anything else he needs before she goes off duty.
Patient 1 shakes his head and thanks her for her kindness.
The time is now 22.10 hours, nurse 4 goes off duty forty minutes after the end of her shift.
Summary of findings and analysis for observation 1.

It was evident from the observed session that the nurse (nurse 4) was particular busy with emergency admissions which was compounded by an existing cohort of high dependency patients under her care on the observed shift. Despite her heavy workload she still demonstrated a number of caring behaviours during her interactions with patient 1. Critical analysis of this vignette reveals evidence of all five caring caratives although each one differs as to the number of times it is observed by the researcher during the caring observation. The analysis is represented in the following table.
Table 6.6: Analysis of caring interactions during observation 1.

<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette Line number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respectful deference</td>
<td>Developing and sustaining a helping-trusting authentic caring relationship.</td>
<td>Attentively listens and allows patient to express feelings.</td>
<td></td>
<td>38, 38</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduces self to patient.</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is sensitive to the patient’s needs.</td>
<td></td>
<td>20, 29, 35, 38, 40, 45, 54.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Being there for the patient.</td>
<td></td>
<td>27, 38, 54.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asks patient preferred name</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>2. Assurance of human presence</td>
<td>Practice loving-kindness and equanimity within context of caring consciousness</td>
<td>Demonstrates respect for patient and is interested in the patient as more than a health problem.</td>
<td></td>
<td>26, 28, 39.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is humane in approach, shows warmth, consideration and kindness.</td>
<td></td>
<td>53</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recognizes the vulnerability of the patient</td>
<td></td>
<td>29, 31, 35, 38, 39, 42, 44, 45, 53, 54.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Touches patient’s hand</td>
<td></td>
<td>38</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Touches patient’s arm</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Smiles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment.</td>
<td>Assists in making the patient comfortable. Verbally assess patient in relation to symptom control e.g. pain</td>
<td></td>
<td>29, 31, 49.</td>
</tr>
<tr>
<td>4. Professional knowledge and skill</td>
<td></td>
<td></td>
<td></td>
<td>49.</td>
</tr>
</tbody>
</table>
5. Attentiveness to the Other’s experience.

Assistance with gratification of human needs.

Monitors patient condition closely. Takes account of basic needs e.g. diet and fluids. Is responsive to the patient’s needs. Provides comfort.

<p>| | | | |</p>
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</thead>
<tbody>
<tr>
<td>27.</td>
<td>20,35,43.</td>
<td>31,38,40,45</td>
<td>31,38,45,49,54.</td>
</tr>
</tbody>
</table>

This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.

The dominant caring carative was assurance of human presence with a total of 15 caring behaviours observed in this category. Demonstrating a humane warm approach, being kind and considerate were the most observed behaviours arising from both verbal and non-verbal interactions. Caring behaviours from the caring category respectful deference were the second most frequently observed (14) and focused upon the ability of the health care professional to be sensitive to the needs of the patient.

Attentiveness to the other’s experience was the third most frequently occurring caring behaviour (13), this alluded to providing comfort and responding to the needs of the patient.

The fourth was positive connectedness where behaviours such as assessing the patient in relation to control of symptoms such as pain relief were observed (5) and finally professional knowledge and skill where explanation of treatment in relation to injury was provided to the patient (1).

Physical and non-verbal interaction included smiling and touch which was observed on two occasions.
6.5.2. Observation 2

09.00 hours on the trauma ward, by the nurse’s station the daily multi-professional meeting is taking place. The ward is busy; lots of activity, three patient call bells are ringing. Ward telephones are constantly ringing, noisy environment particularly on the main ward. One of the senior nurses is giving the daily report on each patient to the ward based physiotherapists and occupational therapists. Occupational therapist 1, is working with physiotherapist 1 this morning to assess patient 9, a 61 year old man who had sustained an injury to his knee whilst on holiday in England. Patient 9 is an ex-patriot who now lives in the Philippines and is classed as a bariatric or obese patient. Occupational therapist 1 and physiotherapist 1 have had difficulty communicating with patient 9 on previous visits because they say that he does not listen to their advice and wants to do things his way which are not possible. The assessment needs to be undertaken in order to facilitate his travel back to the Philippines, comply with airline safety regulation because of his poor mobility and ultimately ensure that he is safe once he reaches home.

- Occupational therapist 1 and physiotherapist 1 walk into bay D towards patient 9 who is situated in the corner bed reading a newspaper.
- Patient 9 looks up.
- Patient 9: “Look out here’s trouble.”
- He points to the staff approaching his bed.
- Occupational therapist 1: “Behave yourself, what are you like?”
- Occupational therapist 1 wiggles her finger at patient 9 and smiles.
- Occupational therapist 1: “Right then, we’re going to have another go at getting you sorted out this morning so that we can get you home.”
- The researcher says hello to patient 9.
- Patient 9: “whose side are you on, theirs or mine?”
- Researcher: “I’m on the side of what’s best for you.”
- Patient 9 laughs and shakes his head.
- Occupational therapist and physiotherapist 1 want to see how patient 9 manages to transfer independently from the bed to his wheelchair.
• Patient 9 is not happy.

• Patient 9 “I can manage so you can go away; I don’t want to be bothered.”

• Occupational therapist 1 and physiotherapist 1 both discuss the importance of the assessment as they will need to know how he will cope once he returns home; Physiotherapist 1 says that the health system is not as good in the Philippines so patient 9 will need to have equipment to take home.

• Patient 9 is unhappy.

• Patient 9: “What’s all the fuss about?”

• Patient 9 waves his hand.

• Patient 9: “I’ll manage despite you lot.”

• He looks down and starts to shuffle his newspaper.

• Patient 9: “You lot weren’t around to help last time I hurt myself and I managed then so why are you bothering now?”

• Occupational therapist 1 and physiotherapist 1 try to reason with patient 9, they talk with him calmly.

• Physiotherapist 1: “We need to make sure you’re safe at home”, we’re trying to help you get home, we care about how you are going to manage, that’s why we’re here now, spending time with you so that we can do that.”

• Patient 9 raises his voice, he starts to get up from his bed, then flops back down, he sighs heavily.

• Patient 9: “I manage fine at home, my wife will help me, if I say I can cope, I can cope” (raises his voice).

• Occupational 1 tries to explain again the need for assessment but patient 9 interrupts then starts swearing at occupational therapist 1.

• Patient 9 “Bloody interfering lot.”

• Physiotherapist 1 keeps quiet.

• Patient 9: “You’re all obstructive and you’re not helping me to get home.”

• After several minutes of arguing patient 9 complies with occupational therapist 1 request.
• Occupational therapist 1 and physiotherapist 1 help patient 9 to transfer from bed to chair but he does not perform the transfer activity well.

• **Patient 9:** “I was a carpenter in my younger days you know and I can make any bloody thing I want, better than any of this crap you’re making me walk with.”

• Occupational therapist 1 and physiotherapist 1 talk to patient 9 about the numerous problems around discharge due to his obesity, including airport and airline issues.

• Occupational therapist 1: “come on you know what the airline has said, we’ve spoken with them, and now that we know what we have to do we can help you with what you need.”

• **Patient 9:** “Well what’s that got to do with you… I’ll sort it out once I’m at the airport and.. the airline will understand (long pause) I’m a good customer of theirs.”

• Occupational therapist 1 and physiotherapist 1 attempt to get patient 9 to try the transfer again, patient 9 clearly does not want to do this and starts getting verbally aggressive.

• **Patient 9:** “You’re not bloody listening; I want to discuss going home first.” He slams his fist on the bed.

• Patient 9 grabs the frame and pulls it towards himself, nearly hitting occupational therapist 1 with it in the process.

• **Occupational therapist 1:** “Careful!”

• **Patient 9:** “If you let me do it my way I’ll be out of here quicker”.

• Occupational therapist 1 tries to steady the frame.

• **Patient 9:** “You lot don’t care about what I want”

• **Occupational therapist 1:** “Right have you finished; you’ve had your rant now let’s concentrate of what you need to do”.

• **Physiotherapist 1:** “We’re here to teach you and support you through this, we’ve spent a lot of time with you so if we didn’t care we wouldn’t be here now would we?”

• Patient 9 laughs, he then apologizes,
Patient 9: “Sorry, what do you want me to do?”

Occupational therapist 1 discusses what they want him to do and gives a demonstration with the walking frame.

Soon after this patient 9 starts to disagree with how to transfer from his bed to the chair, he swears again.

*Patient 9 “Bloody Staff...you don’t care.”*

Physiotherapist 1: “Come on if you just put your mind to this you would do it really well, I don’t think you’re really trying.”

Physiotherapist 1 puts his hand on patient 9’s shoulder but patient 9 pushes his hand off.

*Patient 9: “I’m doing it my bloody way, leave me alone and I’ll do it”.*

Occupational therapist 1: “We’re here to help you get home, we’ve listened to you now you need to listen to us, we want to make sure that you’re safe to go home”

*Patient 9: “I know what to do and how to do it, you don’t bloody listen. cos if you did I’d be home by now.”*

Patient 9 attempts the transfer his way.

Occupational therapist 1 watches, a puzzled look comes across her face.

*Occupational therapist 1: “Well….yes, em..you made a right pigs ear of that (laughs) now you’ve done the pigs ear version let’s do the right version”.*

*Patient 9: (laughs and mumbles) “pig’s ear version”.*

Physiotherapist 1 eyes move back and to between occupational therapist 1 and patient 9 he tries to get patient 9’s attention by patting him on the arm.

Patient 9 doesn’t respond.

Patient 9 huffs and puffs trying to get himself off the bed and onto the chair.

*Patient 9 “This is ridiculous, why do I have to do it this way, I know what would be better.”*

*Physiotherapist 1:”Look we’re not prepared to go over old ground, there’s no compromise, you do it this way or the wrong way and if you do it the wrong way then we can’t say that you’re safe to go home”.***
• Patient 9 interrupts again, occupational therapist 1 becomes frustrated she shakes her head and looks at Physiotherapist 1 and raises her eyes towards the ceiling.

• Patient 9 changes the conversation.

• Patient 9: “I want to take my wife out tonight to that place across the road for a nice meal, why can’t you sort that out?”

• Physiotherapist 1 sighs heavily.

• Physiotherapist 1 looks over to occupational therapist 1, he shakes his head.

• Occupational therapist 1: “You keep going over old ground, I’ve told you that we can’t give you permission for that, you need to speak to sister or matron, you’re not focusing on this and you’re not listening and you’re just doing your own thing, look, keep your foot off the floor”.

• Patient 9 folds his arms and turns his head away whilst physiotherapist 1 is talking.

• Patient 9 pauses in between answers to fiddle with his hospital wrist band and to shake his head at comments from occupational therapist 1 and physiotherapist 1.

• Patient 9 points his finger at occupational therapist 1.

• Patient 9: “Listen to me.”

• Patient 9 then makes demands relating to discharge from hospital.

• Patient 9: “I want to go off the hospital premises to take the wife and daughter out for a meal in the hotel across the road… I want to speak to the person who can give permission and until I get that I’m not doing anything else for you.”

• Patient 9 doesn’t have any further eye contact with occupational therapist 1 or physiotherapist 1.

• He laughs at comments and gestures with his hands towards his wheel chair and then transfers.

• Occupational therapist 1 and physiotherapist 1 try to instruct him further.

• Patient 9 puts his hand up.
• *Patient 9:* “Shut up.”
• He wheels himself away from occupational therapist 1 and physiotherapist 1.
• Patient 9 puts his hands up in the air.
• He leaves the ward bay.
• *Patient 9:* “The sooner I’m out of here the better, bloody NHS, who needs it?”
• Physiotherapist 1 and occupational therapist 1 shake their heads, occupational therapist 1 shrugs her shoulders.
• Occupational therapist 1 turns to researcher and says: “There you go, we’re here to help and all we get off him is abuse. I know he wants to go home but..er..he’d get home quicker if he just listened.”
• They both exit the bay.

*Summary of findings and analysis for observation 2*

This observational session revealed an intense interaction between the two health care professionals (physiotherapist 1, occupational therapist 1) and patient 1. The staff had concerns which had evolved as a result of previous contact with the patient which they shared with the researcher after the observation. The patient displayed an array of behaviours that included annoyance, anger and dissatisfaction during the interaction.
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1. Respectful deference</td>
<td>Developing and sustaining a helping-trusting authentic caring relationship.</td>
<td>Stays calm when the patient is angry. Let’s the patient express and channel difficult emotions.</td>
<td></td>
<td>22,23,28,41,53,78.</td>
</tr>
<tr>
<td>2. Assurance of human presence</td>
<td>Practice loving-kindness and equanimity within context of caring consciousness</td>
<td>Shows patient that he or she will be there for them if they need anything Encourages patient to have confidence in their abilities.</td>
<td>Laughs Smiles Touch</td>
<td>6,23,44,51,53</td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment.</td>
<td>Supports patient in order to achieve independence.</td>
<td></td>
<td>15,23,26,34</td>
</tr>
<tr>
<td>4. Professional Knowledge and skill</td>
<td>Systematic use of scientific problem-solving method for decision making. Promotion of interpersonal teaching-learning.</td>
<td>Helps the patient to recognise the means by which problems can be resolved successfully. Attempts to help patient identify effects of behaviour</td>
<td></td>
<td>7,15,26,31,34.</td>
</tr>
<tr>
<td>5. Attentiveness to the other’s experience.</td>
<td>Assistance with gratification of human needs.</td>
<td>Helps the patient with care they cannot perform themselves.</td>
<td></td>
<td>15,33,34,63.</td>
</tr>
</tbody>
</table>

*This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.*
Critical analysis of this vignette demonstrates the presence of caring behaviours even in difficult caring interactions. The most frequently observed caring carative was professional knowledge and skill with 9 observed caring behaviours. These included helping the patient to resolve problems successfully and helping the patient to identify the effects behaviour has on recovery and rehabilitation. The caring caratives respectful deference, assurance of human presence and attentiveness to the other’s experience were all demonstrated through 8 caring behaviours each. Here the two health care professionals maintained their composure during the interaction with a demanding patient, managing to sustain the focus on helping him towards his rehabilitation goals. They allowed the patient to convey his feelings and concerns without being judgemental, ultimately supporting him through his transitional pathway of care from a dependent to an independent person.

Finally attentiveness to the other’s experience was revealed through 2 caring behaviours which related to providing care and support with tasks the patient was unable to perform for himself. Physical and non-verbal interaction was observed on a few occasions in the form of laughter, smiling and at one point in the observation the physiotherapist touched the patient to communicate caring but this was dismissed by the patient (Line 51). The two health care professionals tried to use humour as a means of communication, which at times was reciprocated by the patient.

The physiotherapist demonstrated a higher number of caring behaviours relating to the caring carative respectful deference whilst the occupational therapist exhibited a greater number in respect of the caring caratives professional knowledge and skill and attentiveness to the other’s experience. In relation to assurance of human presence and positive connectedness an equal number of caring behaviours were observed.

6.5.3. Observation 3

08.45 hours on the orthopaedic trauma ward, it is a very busy morning. Bay D, 6 bedded ward, all beds are occupied. Yesterday evening a 92 year old lady, patient 10, was admitted to the ward from the accident and emergency department. She had been found lying on her front room floor by her home carer. The carer thinks that she may have been
lying there all night. The trauma team have decided that she needs an operation to fix a broken hip and the Registrar Doctor 4 has come to the ward to talk to her.

- Nurse 3 the trauma specialist nurse accompanies him to the patient’s bedside.
- Doctor 4 stands at the bottom of the bed, while nurse 3 taps patient 10 gently on the arm.
- Patient 10 opens her eyes and looks around, she sees nurse3 and smiles.
- Nurse 3: “This is the doctor he has come to see you about your broken hip.”
- Doctor 4 waves his hand, “Hello, how are you, I’m here to talk to you about your hip.”
- Doctor 4 stands at the bottom of the bed with his arms folded.
- Nurse 3 asks doctor 4 if he would like to examine patient 10.
- Doctor 4: “No, not really, I’ve seen all I need to see on the x-ray.”
- Doctor 4 picks up the patient’s prescription chart and looks through it.
- His eyes remain focused on the chart.
- Doctor 4 does not look up from the chart and says: “Alright dearie, you’ve broken your hip and we’re going to fix that for you this afternoon, do you have any questions?”
- He looks up waiting for a response and raises his eye brows.
- Doctor 4 asks nurse 3 if the patient is deaf.
- Nurse 3 looks at doctor 4 and shakes her head.
- She gestures towards the bed.
- Nurse 3 asks doctor 4 to move closer to patient 10 as she may be able to hear him better. Doctor 4 moves closer to the bed.
• Patient 10 looks at doctor 4 and then starts to cry.

• Doctor 4: “Why are you crying dear?”

• He stands with his arms folded then after a short moment moves closer to patient 10.

• Patient 10 goes quiet.

• Nurse 3 puts her arm around patient 10 and comforts her.

• Patient 10 holds on tight to nurse 3.

• Nurse 3: “I think she’s very frightened and a little muddled about what is going on.”

• Nurse 3 reassures patient 10 and tells her that everything will be okay.

• Patient 10: “Can I go home; my husband will be worried about where I am.”

• Doctor 4 looks at nurse 3

• He nods slightly and coughs to clear his throat.

• Doctor 4: “You will not be going home today, you’ve had an accident, you’ve broken your hip and we need to put a pin in it to fix it, you’ll be here for a few days yet I’m afraid.”

• Patient 10 looks up, she is upset, and tears roll down her face.

• Nurse 3 reaches for a tissue and wipes her face.

• Patient 10: “I feel fine, this leg hurts a little but…”

• Doctor 4 shakes his head; he interrupts patient 10 as she is speaking.

• Doctor 4: “No, no you are not fit enough to go home yet, you’ve had a nasty fall and need an operation and that takes time to get over.”
• Patient 10 shakes her head, “Have I really, well I knew I’d had a fall but I didn’t realise it was that bad, fancy that”.

• Patient 10 looks at nurse 3.

• Patient 10: “What do I do now?”

• Doctor 4 explains that she will need to get back on her feet and not to worry because the nurses will look after her and sort her out.

• Patient 10 is still crying she is disappointed that she can’t go home.

• She is worried about her husband and her dog.

• Nurse 3 tries to console her and pats her on the hand.

• Nurse 3: “Don’t worry we’ll sort all that out for you and we’ll look after you until you’re better, is that alright?”

• Patient 10 nods but is still upset.

• Patient 10: “What’s this here?”

• She points to her intravenous line; she then starts pulling at it.

• Doctor 4: “Don’t do that dear, if you pull that out we’ll have to put another one in.”

• Nurse 3: “It’s okay, that’s there to stop you getting thirsty.”

• Patient 10 is suddenly quiet, she appears tired, and her eyes close.

• She falls asleep still holding nurse 3’s hand.

• Nurse 3 looks at doctor 4 “I’ll just stay with her a little longer, until I feel she has settled.”

• On the way out of the bay nurse 3 reminds doctor 4 to wash his hands.
• **Doctor 4**: “Why I haven’t touched her.”

• He turns and exits the bay.

• Nurse 3 looks at the researcher and raises her eyes.

*Summary of findings and analysis for observation 3*

The researcher observed two different interactions taking place within the one observation. Nurse 3 exhibited more caring behaviours towards patient 10 than doctor 4. As a result the caring behaviours attributed to each of the health care professionals involved in the observation have been analysed separately.
<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette line number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respectful deference</td>
<td>Developing and sustaining a helping-trusting authentic caring relationship.</td>
<td>Allows patient to express concerns and fears. Listens respectfully and is attentive to the patient</td>
<td></td>
<td>15,16,23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29,48</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>21,29,39,48.</td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment.</td>
<td>Offers comfort and support. Anticipates needs of patient.</td>
<td>Create healing environment through authentic presence, voice, eye contact.</td>
<td>21,24,29,39,48.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40,45.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>24,40,45.</td>
</tr>
</tbody>
</table>
Critical analysis of this vignette found that the most frequently observed caring caratives were assurance of human presence and attentiveness to the other’s experience, 9 caring behaviours were exhibited for both caratives. The nurse in this vignette on the whole displayed more physical and non-verbal interaction with the patient through the medium of touch, facial expressions and eye contact which helped to promote human connection. There was recognition of the vulnerability of the patient, an acknowledgment of fear and anxiety and a demonstration of humanity towards the patient and her situation. The nurse was respectful in her approach and at all times looked to provide both physical and psychological comfort and well-being.

Professional skill and knowledge was revealed in 6 caring behaviours, the nurse spoke in a calm and reassuring manner and ensured that the patient’s concerns were addressed in a positive way (Line 45). Respectful deference and positive connectedness did not feature as often as the other caring caratives but were evident in the observation. These were revealed in behaviours where the nurse listened attentively thus allowing the patient an opportunity to express anxiety and concern about her condition. Physical and emotional comfort was bestowed upon the patient, what emerged was a sense that the nurse was protective and supportive of her patient by anticipating her implicit needs throughout the caring interaction.

This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.

<table>
<thead>
<tr>
<th>5. Attentiveness to the other’s experience.</th>
<th>Assistance with gratification of human needs.</th>
<th>Makes patient as comfortable as possible. Helps the patient to feel less anxious. Respects the patient’s perception of their world and needs.</th>
<th>21,48</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>24,40,45.</td>
<td>16,23,40,48.</td>
</tr>
</tbody>
</table>

This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.
By comparison doctor 4 did not appear to achieve a ‘connectedness’ with the patient from the onset of the interaction, and following analysis negative caring behaviours were evident throughout.
Table 6.9: Analysis of caring interactions during observation 3 for doctor 4

<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed negative behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette line number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respectful deference</td>
<td>Developing and sustaining a helping-trusting authentic caring relationship.</td>
<td>Did not demonstrate awareness of the patient’s style of communication.</td>
<td></td>
<td>2,6,11,13,19, 50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Was not sensitive to the patient’s needs.</td>
<td></td>
<td>6,11,18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did not encourage the patient to express feelings.</td>
<td></td>
<td>18,31</td>
</tr>
<tr>
<td>2. Assurance of human presence</td>
<td>Practice loving-kindness and equanimity within context of caring consciousness</td>
<td>Failed to listen to the patient fully, seemed pre-occupied.</td>
<td></td>
<td>10,11,31</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interrupted the patient during the conversation.</td>
<td></td>
<td>11,18,31</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Called the patient “dearie”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failed to acknowledge the vulnerability of the patient.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or corrective mental, physical, socio-cultural and spiritual environment.</td>
<td>No warmth towards patient.</td>
<td></td>
<td>2,6,10,12,13, 18,44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No clarification regarding treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No demonstration of support.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Professional knowledge and skill</td>
<td>Systematic use of scientific problem-solving method for decision making. Promotion of interpersonal teaching-learning.</td>
<td>Did not comfort patient when upset.</td>
<td></td>
<td>18,19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failed to offer explanation.</td>
<td></td>
<td>32,44</td>
</tr>
<tr>
<td>5. Attentiveness to the other’s experience.</td>
<td>Assistance with gratification of human needs.</td>
<td>Failed to respect what was important to the patient.</td>
<td></td>
<td>27,32</td>
</tr>
</tbody>
</table>
This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.

The doctor in this vignette did not reveal many caring behaviours, perhaps the most compelling evidence was that at no stage during the interaction did the doctor have any physical contact with the patient. He avoided eye contact at times and failed to recognise the vulnerability of his patient. The highest number of negative caring behaviours (19) was in relation to the caring carative assurance of human presence, the doctor failed to listen to the patient or acknowledge her vulnerability.

Terms of endearment such as ‘dearie’ and ‘dear’ have received press attention over recent years but mainly from a nursing perspective. The main consensus of opinion from organisations such as help the aged is that such terminology is not only patronising but dehumanises the elderly patient. The Nursing and Midwifery Council (NMC) published a document entitled ‘Guidance for the care of older people’ (NMC 2009) in which they set out a package of ideas aimed to help nurses provide more fundamental care for elderly patients including how patients should be addressed. To date no similar document has been published by the medical profession.

The respectful deference caring carative involved 11 observed negative caring behaviours centred upon the development of a helping-trusting-authentic relationship. The doctor failed to elicit a communication style which was respectful and also sensitive to the needs of the patient. 7 negative caring behaviours arose from the caring carative positive connectedness; the doctor did not exhibit any supportive behaviour towards the patient or explain fully the treatment plan. Lack of information giving was also evident in relation to the caring carative professional knowledge and skill for which 4 negative behaviours were observed. Finally for the caring carative attentiveness to the other’s experience two negative behaviours were expressed, the doctor failed to recognise what was of importance to the patient concerning physical and emotional care.
6.5.4. Observation 4

13.50 hours on the orthopaedic trauma ward, it is a busy afternoon, three call bells are ringing. A trolley arrives on the ward signalling the start of the afternoon theatre list. Nurse 6, a senior staff nurse is working the late shift; she is mentoring a student nurse 7 and together they are looking after the patients in bay D.

Patient 5 is an 84 year old patient; he was operated yesterday to fix his broken hip.

- Nurse 6 has noticed that his wound is leaking and has stained his bed sheets.
- She beckons to nurse 7.
- Nurse 6: “We’ll start with patient 5, his wound is leaking.”
- Nurse 7 nods and looks over to patient 5.
- Nurse 6 walks out of the bay and returns five minutes later with a dressing trolley.
- She calls over to nurse 7.
- Nurse 6 “can you get some clean linen please and we’ll get cracking.”
- Patient 5 is asleep in bed.
- Nurse 6 looks at George asleep.
- Nurse 6: “I really feel bad disturbing him, he looks so peaceful, but I need to sort out that dressing otherwise he’ll get uncomfortable.”
- Nurse 7 nods.
- Nurse 6 puts her hand on patient 5’s arm and gently pats it.
- Nurse 6: “hello there, have you been having a good sleep?”
- She smiles at him.
• Nurse 6: “I’m sorry to disturb you but your wound is leaking a little and we need to sort it out.”

• Patient 5 mumbles and opens his eyes.

• Nurse 6 smiles at him.

• Patient 5: smiles back, “what do you want to do”.

• Nurse 7: “We need to change your hip dressing, it’s leaking a bit and it’s gone on your sheets.”

• Nurse 6: “Is that okay?”

• Patient 5 nods.

• Nurse 7 pulls the curtains around his bed.

• Nurse 6 explains that she has a student nurse working with her today and points to nurse 7.

• Patient 5 turns his head and looks at nurse 7 then smiles.

• Nurse 7 smiles back and says hello.

• Patient 5 lifts his hand.

• Nurse 7 touches his hand.

• Nurse 6 and nurse 7 prepare to change his dressing.

• They talk back and to, including patient 5 in their conversation while they prepare the dressing.

• Nurse 6 looks at patient 5 and explains that she is going to remove the old dressing first, she tells patient 5 that this may be a little uncomfortable but won’t take long.

• Nurse 7 takes hold of patient 5’s hand and squeezes gently.
• Patient 5 winces a little.

• Nurse 6 looks up, has eye contact with patient 5.

• *Nurse 6:* “Okay it’s off, are you alright, sorry about that.”

• Patient 5 nods.

• Nurse 6 checks the wound and then applies the clean dressing; she carefully secures it in place and tells patient 5 that she has put extra padding on because the wound is still leaking slightly.

• *Nurse 6:* “There we go, now, we just need to change your bottom sheet to make it all fresh and comfy for you.”

• Nurse 6 and nurse 7 work together to change patient 5’s bottom sheet, keeping him covered at all times whilst they undertake the task.

• When finished nurse 6 exits the bay to dispose of the dirty linen and dressings.

• Nurse 7 finishes making patient 5 comfortable.

• She pulls his bedside trolley up to the bed.

• Nurse 7 asks patient 5 if he would like a drink of water, she fills up his cup and offers it to patient 5.

• Patient 5 takes the cup, has a sip of water and hands it back to nurse 7, he thanks nurse 7.

• Nurse 7 asks patient 5 if he has had enough to drink and whether he wants anything else.

• Patient 5 shakes his head.

• Nurse 7 records the amount of water patient 5 has drunk on his fluid balance chart.
• Nurse 7 pushes back the curtains and walks towards the patient in the next bed.

Summary of findings and analysis for observation 4

The senior nurse (nurse 6) displayed a wealth of caring behaviours in this observed interaction. Importantly the student nurse (nurse 7) was able to recognise and imitate the caring behaviours of her mentor.
Table 6.10: Analysis of caring interactions during observation 4 for nurses 6 and 7

<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette line number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respectful deference</td>
<td>Developing and sustaining a helping-trusting authentic caring relationship.</td>
<td>Exhibits an authentic presence, displays sensitivity. Engages in caring, effective communication.</td>
<td>13,15,20,34.</td>
<td>13,15,19,20,29,30,34, 42,44.</td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or corrective mental, physical, socio-cultural and spiritual environment.</td>
<td>Uses touch, vocal tones, eye contact and facial expression. Help provide comfort. Offers diet and fluids. Ensure that the patient has everything they need. Puts patient area tidy once interaction completed. Respects privacy.</td>
<td>12,14,17,27,33.</td>
<td>15,36,37,40,44. 44 41,47. 22</td>
</tr>
</tbody>
</table>
Critical analysis revealed that in this vignette the senior nurse and student nurse worked together to create a caring relationship which helped establish a human to human transaction that was caring and meaningful. The fact that the senior nurse anticipated the needs of the patient, in respect of wound dressing and changing bed sheets, showed that the comfort of the patient was upper most in her thoughts.

The interaction revealed a wealth of caring behaviours, although these were evident in those that originated from the senior nurse, as the interaction progressed, the student nurse replicated similar behaviours when she was with her mentor and then alone attending to the patient.

The most frequently observed caring caratives were assurance of human presence (14) positive connectedness (14) and attentiveness to the other’s experience (14).

Caring behaviours from the three carative categories helped to create an interaction where the patient was respected, supported and protected. The use of touch and facial expressions, such as smiling, helped to convey a warm and humane approach, acknowledging the patient as a human.
Covering the patient during treatment ensured privacy and dignity, and a few thoughtful statements by both nurses signified a genuine concern and empathy for the patient’s situation and comfort. The caring category respectful deference exhibited 13 caring behaviours. The authentic presence of both nurses facilitated an open and honest I-thou relationship. They were able to enter into a respectful and effective dialogue with the patient, listening to concerns and responding to needs.

Professional knowledge and skill depicted caring behaviours of nursing staff who were equipped with an ability to help the patient cope with the stress of his condition, and who provided the patient with relevant information about the treatment they were about to give. This information was explained in language which was easily understood and as such helped the patient to formulate questions in return.

6.5.5. Observation 5

18.25 hours, trauma orthopaedic ward.

Patient 3 is a 27 year old female patient admitted to the orthopaedic trauma ward after falling on ice while on her way to see her boyfriend. She has damaged ligaments in her knee and needs an operation to repair them. She is in bay A, a three bedded annexe of the ward, having just arrived from the accident and emergency department. The main ward is a hive of activity and the late staff have just arrive on duty. Patient 3 has endured a long wait in the emergency department and is upset about her accident and pending surgery. She is a registered drug addict and has had previous admissions to the hospital and trauma ward.

Doctor 2 a 29 year old Senior House Officer has arrived on the ward to consent her for the operation. She makes it clear that she is not looking forward to seeing patient 3; having met her on previous occasions she says that patient 3 is always abusive.

- Doctor 2 walks towards bay A, she pauses for a moment and feels in her pocket, pulling out a pen. She pulls the screens around patient 3’s bed.
• *Doctor 2*: “Hello, we meet again?”

• Patient 3 nods.

• Doctor 2 asks patient 3 if she remembers her from a previous admission to hospital.

• *Patient 3* nods: “Yeh, you saw me when I did my ankle in.”

• Doctor 2 nods and smiles.

• Doctor 2 asks patient 3 to tell her about how she fell and what had precipitated this.

• Patient 3 starts to tell doctor 2 about her fall, she is angry because one of the doctors in the accident and emergency department accused her of being ‘high’ on drugs, something she is strenuously denying.

• Doctor 2 nods and opens the case notes she has brought with her. She asks patient 3 if she has taken any drugs recently.

• *Patient 3 is annoyed at the question*: “No I bloody haven’t, wish I had, I wouldn’t have felt the bloody pain, would I?”

• Doctor 2: “What happened this time then?”

• Patient 3 describes how she fell on the ice outside her home explaining that she was going a few hundred yards down the street to see her boyfriend.

• Doctor 2: “Ok well I need to get some details off you and have a listen to your chest, same routine you know.”

• Patient 3 sighs and asks how long doctor 2 is going to be; she is rubbing her arms and rocking back and forth in the bed.

• *Patient 3*: “Look can I get my methadone first; you can come back later can’t you?”
• Doctor 2 shakes her head; she looks at patient 3 for a few moments.

• **Doctor 2:** “No because I need to get on with this, we’re very busy today and I have to get this done. So if it’s alright with you I’ll explain what we’re going to do and if you’re happy get you to sign the consent form, ok?”

• She pauses, waiting for a reply.

• **Patient 3:** “Well I suppose I haven’t got a choice have I?”

• Doctor 2 is reading patient 3’s notes; she does not look up as she continues the conversation.

• **Doctor 2:** “Well you have, you don’t have to have the operation, but then your knee won’t get better will it.”

• Patient 3 pulls faces at doctor 2; patient 3 looks at the researcher and shakes her head.

• Doctor 2 looks up

• **Doctor:** “Right, I need to ask you some questions and then we can get things sorted out. I think you’re going on tomorrow’s list.”

• Patient 3 tells doctor 2 that she wants to go home today and doesn’t want to stay in hospital.

• **Doctor 2:** “Well that’s not going to happen, it’s late, your knees in a bit of a mess and needs sorting out”

• Doctor 2 continues to ask patient 3 about her fall and obtains the information she needs.

• She then performs a clinical examination to ensure that patient 3 is fit for surgery.
• During the examination she looks at patient3’s arms, she notices marks and asks about them.

• Patient 3 explains that they are marks from when she used to take heroin.

• Doctor 2 tells her that they look quite recent and asks if she has used heroin recently, this was important for her to know as it may cause problems with the surgery.

• Patient 3 becomes angry and starts to talk about discharging herself.

• Doctor 2 shakes her head.

• *Doctor 2:* “I don’t need this today; right what do you want to do, stay and have your operation or go?”

• Doctor 2 gestures with her hands and stares at patient 3 waiting for her answer.

• Patient 3 looks at doctor 2 for a few seconds and then rubs her knee. She is clearly agitated, and is grabbing at her hands.

• *Patient 3:* “I’ll stay, couldn’t get out of here anyway could I, I’ll do what you want, give me that consent form.

• Doctor 2 then discusses the operation and asks if she has any questions.

• Patient 3 shakes her head and holds out her hand for the form.

• Doctor 2 passes the consent form and points to where patient 3 needs to sign.

• Patient 3 scribbles her signature on the form and then grabs doctor 2’s hand.

• *Patient 3:* “Now can I have my methadone, I should have had it hours ago and I need it soon.”

• Doctor 2 takes the consent form, pushes back the screen and walks away from the bedside shaking her head.
• She rummages for a prescription form from notes and prescribes the methadone.

• She asks which nurse is looking after patient 3.

• **Doctor 2:** “Have we got some methadone on the ward?”

• One of the nurses nods.

• **Doctor 2:** “Can you give her some now please, it may help her calm down and I’ll come back and see her later.”

• Doctor 2 leaves the ward.

**Summary of findings and analysis for observation 5**

The doctor (doctor 2) anticipated a difficult interaction with patient 3 based upon prior meetings.

This was also true of the interaction observed and although at times doctor 2 displayed some negative behaviour, she still demonstrated concern and support for patient 3.
<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette line number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respectful deference</td>
<td>Developing and sustaining a helping-trusting authentic caring relationship.</td>
<td>Does not confront patient harshly about her drug addiction. Keeps calm and in control of feelings when the patient is angry.</td>
<td>31</td>
<td>11,38,40,48</td>
</tr>
<tr>
<td>2. Assurance of human presence</td>
<td>Practice loving-kindness and equanimity within context of caring consciousness</td>
<td>Is able to see things from the patient’s point of view. Acknowledges the patient’s situation. Is non-judgemental</td>
<td>9,46.</td>
<td>46,48</td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment.</td>
<td>Is able to create a healing environment around the patient’s rituals and routines.</td>
<td>46,48.</td>
<td></td>
</tr>
<tr>
<td>4. Professional knowledge and skill</td>
<td>Systematic use of scientific problem-solving method for decision making. Promotion of interpersonal teaching-learning.</td>
<td>Accepts the patient for who they are and provides information at a level they can understand.</td>
<td>17,27,38</td>
<td></td>
</tr>
<tr>
<td>5. Attentiveness to the other’s experience.</td>
<td>Assistance with gratification of human needs.</td>
<td>Respects the patient’s needs.</td>
<td>46,48</td>
<td></td>
</tr>
</tbody>
</table>

This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.
Critical analysis showed that the most frequently observed caring behaviours in this vignette fell into the carative category respectful deference, of which there were 5. The doctor managed to remain calm throughout the interaction despite the patient’s focus on wanting to leave hospital and then needing her methadone. During the observation the doctor, did on a few occasions, appear to become frustrated at the patients demands (lines 17, 21, 34) but did not allow this to affect her concern for the patient’s well-being. The caring carative assurance of human presence revealed 4 caring behaviours in this category. Although there was an element of friction between doctor and patient, the doctor managed to remain non-judgemental in relation to the patient’s drug habit and did demonstrate an element of compassion towards her predicament. In the caring carative professional knowledge and skill, 3 caring behaviours were observed and mainly centred upon the doctor’s ability to unconditionally accept the patient for who she was. This ability was also evident in the caring behaviours exhibited in the caring caratives positive connectedness (2) and attentiveness to the other’s experience (2) where the doctor was able to ensure a caring environment by taking into consideration the patient’s needs and daily rituals.

6.5.6. Observation 6

11.15 hours orthopaedic trauma ward. The ward is busy, with emergency admissions and patients coming from and going to theatre.

Patient 8 is a 47 year old female patient admitted during the early hours of the morning with acute back pain. She is being investigated for a possible spinal infection. Doctor 1 is a 29 year old senior house officer working with the spinal consultants’ team. He has come to the ward to check on her progress.

Patient 8 is currently on bed rest in bay G until investigations are complete.

- Doctor1 introduces himself to patient 8 and shakes her hand.
- He explains that he has come to check on her progress.
- He pulls the screens around the bed and leans on her bedside locker.
• Patient 8 nods and tries to turn over in the bed to face him.

• Doctor 1 asks patient 8 to tell him the history of her symptoms and

• Patient 8 tells him about her back problem and says that she is in a lot of pain.

• Doctor 1 listens patiently as patient 8 talks.

• He maintains eye contact with her throughout.

• He only talks when she has finished speaking and then only to ask another question; he then waits for her answer.

• **Doctor 1:** “What is the pain like at the moment?”

• **Patient 8:** “It’s really bad and the nurses have said that they can’t give me anything else for it at the moment.”

• **Doctor 1:** “One a scale of one to ten, one being no pain and ten being the worst pain ever, how would you score your pain at the moment.”

• **Patient 8:** “Ten.”

• **Doctor 1:** “That bad?”

• Patient 8 nods and starts to cry.

• Doctor 1 pats patient 8 on the hand and says that he is going to have a chat to the pain team to get them to assess her pain and bring it under control.

• Patient 8 nods, she wipes the tears away from her face.

• **Doctor 1:** “Well I think..em.. I don’t want to examine your back if you’re in a lot of pain right now because that would make it worse, let’s sort out your pain relief and I’ll come back when you’re more comfortable.”

• **Patient 8:** “Thank you doctor, I don’t think I could stand being moved at the moment.”
Doctor 1 walks out of the bay and goes over to the nurses’ station. He speaks to the ward manager and asks if the pain team have visited the ward this morning. Apparently they are on their way down.

He asks the ward manager to speak to the team.

The ward manager says that she will ask them to see her first.

Doctor 1 returns to patient 8’s bedside.

He takes her hand and talks to her in a soft gentle voice.

He explains that her pain is due to an infection around one of the discs in her spine, further special x-rays are required and a MRI scan has been arranged to ascertain the extent of the infection.

He explains what the scan is and what it will help to do.

Patient 8 sighs; her voice is a little strained as she asks doctor 1 if the problem is serious and what could happen if it was. Her eyes are fixed on his face.

He has eye to eye contact with her.

Doctor 1: “Well, worst case scenario is that it could affect the spinal cord and cause damage which could mean problems with the feeling in your legs and a loss of power.”

He continues to tell her that he doesn’t believe that this will happen and she is receiving antibiotics which will help her body fight the infection.

He asks if she has any other questions for him.

Patient 8: “No thank you doctor, you’ve really explained things to me and I feel I’m in good hands.”

The pain team arrive to see patient 8.
• Doctor 1 chats to them and throughout he includes patient 8 in the conversation.

• The team stay to discuss pain relief with patient 8.

• Doctor 1 shakes her hand and informs her that he will be back later to see how she is feeling.

• Patient 8 thanks him again.

He exits the bay.

Summary of findings and analysis for observation 6

In this observation positive caring behaviours were exhibited throughout, acknowledge and gratification from the patient was evident during the interaction.
Table 6.12: Analysis of caring interactions during observation 6

<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette line number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Assurance of human presence</td>
<td>Practice loving-kindness and equanimity within context of caring consciousness</td>
<td>Shows that he is interested in patient as more than a condition. Is humane and warm in approach, shows loving kindness. Is respectful to patient. Being there for patient. Sees things from the patient’s point of view. Shows genuine concern. Honours human dignity</td>
<td></td>
<td>5,7,8,9,14 16,18,24,28</td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment.</td>
<td>Has concern for and ensures patient’s comfort. Uses touch and facial expressions to communicate and create a caring environment. Encourages patient to ask questions. Explores what things are important to the patient.</td>
<td></td>
<td>18,20,21,34 1,8,16,24,28 31 6,10,12,25,29</td>
</tr>
</tbody>
</table>
This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.

This observation illustrates a number of caring behaviours exhibited throughout all five caring caratives. The most frequently observed behaviours emerged from the caring carative assurance of human presence (30). The doctor demonstrated a clear interest in his patient and maintained a humane approach throughout. Respect was shown at all times and this was borne out by the doctor exhibiting a genuine concern regarding the patient’s pain control and not wanting to make the pain worse by performing an examination there and then. The patient’s pain control was a priority which he concentrated upon, resolute in his determination to act as the patient’s advocate in addressing this issue. The caring category positive connectedness (15) was represented by caring behaviours relating to the doctor ensuring the comfort of his patient. Throughout the observation he uses touch and facial expressions such as smiling to communicate a
fundamental caring milieu. These caring behaviours also merge with those exhibited within the carative category of attentiveness to the other’s experience (11) where the doctor explored and recognized the specific needs of his patient; knew what was important to her during this particular interaction and was positively responsive. There were 9 observed caring behaviours in the carative category respectful deference. Here these relate to establishing a trusting-authentic caring relationship. At the point of first contact the doctor introduced himself so that who he was and his status was apparent. He spent quality time with the patient and maintained an unhurried approach, listening, providing information, encouraging the patient to express her anxieties and concerns and ultimately followed through in relation to what he said he was going to do which strengthened the caring relationship. The final carative category professional knowledge and skill was evident in 6 caring behaviours which centred upon the provision of information around care and treatment. The doctor was able to provide in-depth answers to the patient questions and was honest and open in the process.

6.6. Elective Orthopaedic Ward Observations

Four caring interactions were observed during four pre-arranged sessions on the orthopaedic trauma ward. Two early shifts, one late shift and one night shift were worked. The interactions facilitated the emergence of a myriad of caring behaviours demonstrated by each of the health care professionals observed. The caring behaviours were demonstrated via physical or verbal interactions and in most cases by a combination of the two.

The dependency of patients was much lower than on the orthopaedic trauma ward. It was noted that staff were able to take their breaks on time and were not late off duty at the time of the observations.

6.6.1. Observation 7

14.10 hours side room 2 elective orthopaedic ward.

Patient 2 is a 62 year old female patient she has osteoarthritis and is two days following a total hip replacement. She is a retired health care educator.
This afternoon she is being taken to the therapy room at the end of the ward by Physiotherapist 2, a senior physiotherapist, to practice ascending and descending stairs in preparation for her discharge home. Physiotherapist 2 has asked nurse 5 the deputy ward manager to help with the task.

- Patient 2 is sat in her chair waiting for physiotherapist 2 and nurse 5 to arrive, she says that she is anxious about the assessment because she feels tired today and not at her best.

- Nurse 5 arrives first; she smiles at patient 2, patient 2 smiles back.

- Patient 2 turns to nurse 5 and says “I’m not looking forward to this, I feel a bit out of sorts today.”

- Nurse 5 looks concerned and asks patient 2 if she is okay and if she feels up to the assessment.

- Patient 2 looks down and rubs her leg, then looks up at nurse 5.

- Patient 2: “Just tired I think, feel like I’ve run a marathon these past couple of days.”

- Nurse 5 goes over to patient 2 and puts her arm around her.

- Nurse 5 tells patient 2 that feeling tired is perfectly normal after a major operation and if she really didn’t feel up to doing the stairs then they could postpone until later in the day.

- Patient 2 thanks nurse 5.

- Patient 2: “all I really want is to get home and putting off the assessment will delay that.”

- Physiotherapist 2 arrives; she rubs her hands and asks if patient 2 is ready.

- Nurse 5 explains that patient 2 is feeling a bit under the weather today but has decided to still do the assessment.
Physiotherapist 2: “That’s good, it won’t take long and then you can have a good rest afterwards.”

Nurse 5 fetches patient 2’s slippers and dressing gown and helps her to put them on.

Physiotherapist 2: “Right we’ll walk down to the room and then I’ll go through what we’re going to do.”

Patient 2 nods and pulls her walking frame towards herself and starts to get up from her chair. She winces a little before straightening up.

Physiotherapist 2: “You okay; remember what I said about using the arms of the chair to help push you up.”

Patient 2 nods.

Physiotherapist 2: “That’s great, you did that really well, right let’s get going.”

Using her frame, patient 2 walks slowly down to the therapy room.

Physiotherapist 2 and nurse 5 follow. Physiotherapist 2 offers words of encouragement as patient 2 continues walking.

After a few minutes they arrive at the therapy room, physiotherapist 2 points to a chair.

Physiotherapist 2: “Have a rest there for a minute and then I’ll explain what I want you to do.”

Patient 2 sits down and looks at physiotherapist 2, waiting for her next instructions.

In front of patient 2 is a flight of stairs designed to be used as a teaching aid.

Physiotherapist 2 explains what patient 2 needs to do.

Physiotherapist 2: “We’re here to help so don’t worry, shall we have a go?”
• Patient 2 nods and makes a grab for her walking frame.

• *Physiotherapist 2:* “Right now don’t forget what I said, just take your time, it’s not a race.”

• Throughout the assessment physiotherapist 2 and nurse 5 offer words of encouragement and support.

• Patient 2 completes the last step and then flops down into the chair.

• *Nurse 5:* “You did very well; I think if we have another go tomorrow just to make sure then I can’t see why you couldn’t go home by Friday.”

• Patient 2 becomes tearful.

• Nurse 5 goes up to patient 2, puts her hand on patient 2’s shoulder and asks if she is okay.

• Patient 2 nods.

• *Patient 2:* “I’m just…em… just pleased at the thought of going home to my husband.

• Nurse 5 hugs patient 2.

• *Physiotherapist 2:* “Shall we wheel you back to your room, you look shattered.”

• *Patient 2:* “Yes please.”

• Nurse 5 disappears and returns a short while later with a wheelchair.

• Physiotherapist 2 and nurse 5 help patient 2 into the chair and wheel her back to her room, chatting with her as they do so.

• Nurse 5 helps patient 2 to settle onto her bed, she pulls her bedside table up to her chair so that she can reach her book.
Nurse 5: “Would you like a cup of tea?”

Patient 2: nods and smiles: “That would be smashing, thank you.”

Nurse 5 exits the side room returning a short while later with a cup of tea and some biscuits.

Summary of findings and analysis for observation 7

In this observation two health care professionals (nurse 5) and (physiotherapist 2) worked together to help patient (patient 2) gain knowledge and confidence in order to achieve her goal of getting home to her family.
Table 6.13: Analysis of caring interactions during observation 7

<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette line number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Assurance of human presence</td>
<td>Practice loving-kindness and equanimity within context of caring consciousness</td>
<td>Show that they are interested in patient as more than a condition. Humane and warm in approach, show loving kindness. Are respectful to patient. Being there for patient. See things from the patient’s point of view. Show genuine concern. Encourage confidence in patient. Asks patient’s opinion of how they would like things done.</td>
<td>Touch Eye contact Smiles</td>
<td>2,4,8 7,8,17,33,36 4,14,17,23 Demonstrated throughout. 8</td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or</td>
<td>Motivate patient. Demonstrate empathy to</td>
<td></td>
<td>13,19,21,26,29</td>
</tr>
<tr>
<td>4. Professional knowledge and skill</td>
<td>corrective mental, physical, sociocultural and spiritual environment.</td>
<td>situation. Has concern for and ensures patient’s comfort. Uses touch and facial expressions to communicate and create a caring environment.</td>
<td>14,23,39,40,41</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Assistance with gratification of human needs.</td>
<td>Acknowledges and respects the patient’s individual needs. Helps reassure patient. Responsive to the needs of the patient. Honest with the patient. Participate in the caring moment. Knows how to deliver healing treatments and operate specialist equipment. Ensures patient comfort. Helps patient to feel that they are in control of the situation.</td>
<td>Throughout assessment</td>
<td>8,13,15,17,19,21,23,26,28,37.</td>
<td></td>
</tr>
</tbody>
</table>

This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.
In this vignette the most frequent carative category was Attentiveness to the other’s experience with 23 caring behaviours observed overall. There were 19 caring behaviours which fell into the carative category of assurance of human presence, 17 for professional knowledge and skill, 14 for positive connectedness and 9 for the carative category respectful deference. In respect of the two health care professionals the prevailing category for the nurse was attentiveness to the other’s experience followed by assurance of human presence, positive connectedness, respectful deference and finally professional knowledge and skill. By comparison the principal carative category was professional knowledge and skill, followed by attentiveness to the other’s experience, positive connectedness, assurance of human presence and finally respectful deference.

The two health care professionals observed were respectful to the patient throughout the observation; they both listened attentively and showed concern and compassion towards the patient’s expression of feeling unwell. They provided encouragement and support in helping the patient channel her negative feelings and were constructive and honest in their comments which helped the patient to achieve her goal of going home from hospital. Both health care professionals used touch and facial expressions such as smiling to communication caring. They took the time to explain and demonstrate the tasks, continually reassuring the patient about her progress and achievements. Recognition of the individual needs of their patient was evident in their unhurried approach to all activity, continual encouragement; support and education were a means of empowering the patient.

6.6.2. Observation 8

11.20 hours, bay 4. Patient 4 is a 51 year old patient who is four days post-surgery following an operation to replace his shoulder. John has suffered with osteoarthritis and the operation has replaced his worn out joint.

He has developed an infection and the nursing staff ask doctor 5, the house officer to assess the wound. Nurse 2 is the staff nurse working in bay 4 this morning; he accompanies doctor 5 to review patient 4.
Patient 4 is lying on top of his bed, his arm is in a sling and the wound is covered by a large dressing. Patient 4 has his eyes closed.

- Nurse 2 pulls the screens around the bed.

- *Nurse 2*: “Hi there, doctor is here to see you.”

- Patient 4 opens his eyes and looks at nurse 2. He then sees doctor 5.

- *Patient 4*: “Oh hello doctor.”

- *Doctor 5*: “Hello, how are you today?”

- *Patient 4*: “I’m okay…well apart from the pain in this shoulder, is there an infection in there?”

- Patient 4 looks worried as he asks his question; he touches his shoulder then stares at the dressing for a few moments.

- *Patient 4*: “It’s been leaking like that since the operation. Is that normal?”

- Patient 4 glances at doctor 5.

- Doctor 5 steps nearer to patient 4, fixing her eyes on the dressing as she does so.

- Nurse 2 asks doctor 5 if he should remove the old dressing so that doctor 5 can look at the wound.

- Doctor 5 nods her head.

- *Doctor 5*: “Yes…em…I’ll have a look, has anyone taken a swab?”

- Patient 4 shakes his head.

- *Nurse 2*: “Er, not sure, I think one may have been sent yesterday. I’ll just check with Sister.”
• *Patient 4:* “They came yesterday to do my dressing and said they were taking a swab because it looked inflamed. It was a stick type thing they used.”

• Doctor 5 nods to patient 4.

• *Doctor 5:* “Sounds like they did.”

• Patient 4 nods.

• *Nurse 2:* “I’ll just go and get a dressing pack...to take the dressing down...I won’t be a minute.”

• *Doctor 5:* “Okay.”

• Whilst nurse 2 leaves to get the dressing doctor 5 sits on the chair besides patient 4, she looks at him and smiles.

• *Doctor 5:* “How are you feeling in yourself?”

• *Patient 4:* “I’ve been better mustn’t grumble.”

• Patient 4 looks down at his hands, doctor 5 stares at him for several moments. Patient 4 looks up but doesn’t make eye contact at first.

• *Patient 4:* “Do you think it’s infected, I mean you know can you tell by looking at it?”

• Patient 4 turns to look at doctor 5.

• Doctor 5 makes eye to eye contact with patient 4.

• *Doctor 5:* “Well, yes and no, we could do with the swab results and then we know what we’re dealing with.”

• Nurse 2 returns with the dressing trolley, he smiles at patient 4.

• *Nurse 2:* “Here we are. I’ll open the packs doctor; just tell me what you need.”

• Patient 4 looks at the packs on the trolley and then looks at doctor 5.
• Patient 4: “Blimey nurse are you going to do some major operation or something?” (Laughs)

• Nurse 2 laughs in response.

• Nurse 2: “No, don’t worry; I wasn’t sure what doctor wanted so I brought everything” (Laughs).

• Doctor 5 asks nurse 2 to open several of the packs for her, patient 4 looks on with interest.

• Doctor 5: “Right, I’m going to get nurse to remove this dressing and then I can have a good look at your shoulder, is that okay?”

• Patient 4: “Whatever you’ve got to do doctor, I’m in your hands.”

• Nurse 2: “we won’t do anything without telling you first.”

• Doctor 5 nods in agreement.

• Patient 4: “Okay, that sounds a bit worrying.”

• Patient 4 looks puzzled.

• Nurse 2: “Sorry, didn’t mean to worry you. I just meant if doctor needs to feel around the wound and that she’ll tell you before she does it, isn’t that right doctor?”

• Doctor 5: “Yes, right let’s have a look, this might hurt a little, just tell me to stop if it gets too uncomfortable.”

• Doctor 5 starts to feel around the wound.

• Patient 4 winces and then closes his eyes.

• Patient 4: “Ouch!” he opens his eyes suddenly.

• Patient 4: “What was that?”
• Doctor 5 stops what she is doing.

• *Doctor 5:* “Sorry that was me just pressing on this red area here.”

• She points to one area of patient 4’s shoulder.

• Patient 4 strains his head to look. His face grimaces.

• *Patient 4:* “Urh..that looks angry, what does it mean?”

• *Doctor 5:* “It looks as though you may have a little bit of infection there…em..right I’ll just give the wound a clean and pop a fresh dressing on then I’ll have a chat with the consultant.

• Patient 4 nods; he turns and looks at nurse 2.

• Nurse 2 smiles.

• *Nurse 2:* “Alright…you’ve missed the hot drinks; I’ll go and get you one. What do you fancy, tea, coffee?”

• *Patient 4:* “Thank you, cup of coffee please, one sugar.”

• Doctor 5 finishes the dressing; Nurse 2 wheels the trolley away and goes off to fetch patient 4 his drink.

• Doctor 5 sits back down in the chair next to patient 4.

• She spends the next ten minutes discussing the infection in his shoulder.

• She maintains eye contact throughout and at one point pats his hand.

• Patient 4 looks down; nodding his head he listens to what doctor 5 has to say.

• *Doctor 5:* “Is there anything else you want to ask?”

• *Patient 4:* “I don’t think so thank you doctor, so you’ll let me know about the results of the swabs then, how soon will you get them back?”
• **Doctor 5**: “Well should be later today, then once we know we can get things sorted and I’ll come back and have a chat again then…are you okay then?”

• **Patient 4**: “Oh, yes…yes thank you, you’ve explained it all to me, it’s still disappointing what’s happened? I suppose it’s one of those things…still can’t be helped. Will it be you who comes back to see me?”

• **Doctor 5**: “Yes, I’ll come back later.”

• **Patient 4**: “Oh good, okay then see you later…bye.”

• Patient 4 holds up his hand, he gives a little wave.

• Doctor 5 smiles and exits the bay, patient 4 sighs.

• Nurse 2 returns with a cup of coffee.

• **Patient 4**: “Isn’t she nice that doctor… she’s very good, nothing seems to be too much trouble for her.”

• Nurse 2 nods.

• **Nurse 2**: “Okay then…right I’ll have to crack on do you need anything else before I go?”

• **Patient 4**: “No, thanks…see you later.”

*Summary of findings and analysis for observation 8*

This observation focused upon providing reassurance and support to the patient during treatment. The doctor and nurse work together integrating knowledge and skills to create a positive experience supporting and being hopeful for the patient at a difficult time during treatment.
<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette line number</th>
</tr>
</thead>
</table>
| 1. Respectful deference | Developing and sustaining a helping-trusting authentic caring relationship.             | Gives time to the patient. Listens to patient’s problems and concerns. Does not reduce presence during caring moment. Encourages patient to express concerns. Follows through on statements. Helps patient to deal with negative feelings. Offers encouragement. | Touch Eye contact Smiles            | Demonstrated throughout 61,62,  
60,  
10,  
57,72  
61,66  
66 |
| 2. Assurance of human presence | Practice loving-kindness and equanimity within context of caring consciousness | Show that they are interested in patient as more than a condition. Humane and warm in approach, show loving kindness. Are respectful to patient. Being there for patient. See things from the patient’s point of view. Show genuine concern. Motivate patient. Demonstrate empathy to situation. Honours human dignity | | 5,22,23,28,30,34,50,  
56,62,64,71,  
5,23,35,39,43,50,  
57,60,61,64,  
5, |
| 3. Positive connectedness | Provision of supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment. | Has concern for and ensures patient’s comfort. Uses touch and facial expressions to communicate and create a caring environment. Pays attention to the patient when they are talking. | | 44,50,54,66  
34,56,62,71,  
12,28,35,39,49,62,64,68 |
4. Professional knowledge and skill

| Assistance with gratification of human needs. | Acknowledges and respects the patient’s individual needs. Helps reassure patient. Responsive to the needs of the patient. Honest with the patient. Participate in the caring moment. Knows how to deliver healing treatments. Ensures patient comfort. Helps patient to feel that they are in control of the situation. | 44,49,54,57,61,64,66,72,75 |

5. Attentiveness to the Other’s experience.

| 22,61 |
| 5,23,37,39,43,64,66 |
| 5,13,23,64 |

This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.

In this vignette the doctor was the principal health care professional in terms of the number of observed caring behaviours. The caring carative attentiveness to the other’s experience was the dominant category with 33 caring behaviours of which 24 were attributed to the doctor. There was a clear manifestation of participation in the caring moment, evident by the way in which the doctor from the onset acknowledged the need to address the concerns of the patient regarding the possibility of a wound infection. Her calm and attentive actions, coupled with an honest approach to the provision of information, helped to reassure and comfort. The nurse was also an active participant in
the caring moment providing comfort and attending to the patient’s stated and unstated needs.

Assurance of human presence was the second dominant category with 27 observed caring behaviours. There was an open connectedness between all three participants in this observation emphasized by the ability of both health care professionals to appreciate the vulnerability of the patient, to listen and react positively to concerns and anxiety. This facilitated the transformation of the task (assessment of wound) from a purely clinical interaction into a healing interaction. Professional knowledge and skill contained 22 caring behaviours; again this category was represented chiefly by the actions of the doctor using her expertise to ensure that a full explanation was provided in relation to care and treatment. The provision of information was enhanced by the doctor actively encouraging the patient to ask questions in order to gain further understanding of his condition thereby assisting the advancement of patient knowledge. In the carative category of positive connectedness 16 caring behaviours were noted, these behaviours on the whole centred upon the provision of a supportive and protective environment for the patient, addressing physical needs and psychological issues arising from patient concern in respect of wound problems. Finally respectful deference with 9 caring behaviours promoted the formation of a helping-trusting relationship, one of the important observations made were regarding both health care professionals who provided a reassuring presence which did not diminish during the caring moment.

6.6.3. Observation 9

14.25 hours bay E. Patient 6 is a 59 year old retired nurse, she underwent a total hip replacement two days ago. The occupational therapist and the nursing team leader have come to assess her in preparation for discharge home. The bay is busy as a consultant ward round is taking place. The nurse decides to take patient 6 to the treatment room where it is quieter and there is more privacy. The nurse and occupational therapist want to instruct patient 6 on how to manage dressing and undressing after her hip replacement. They gather all their dressing aids and walk with patient 6 down to the room. The room has two chairs.
• Patient 6 peers into the room, she gestures towards the chairs with her head.

• **Patient 6:** “..Where do you want me to sit?”

• **Occupational therapist 2:** “If you sit on that chair to your left please.”

• **Patient 6:** “Right…here ..is this okay?”

• **Nurse 1:** “Yes, that’s the one, great, I’ll help you down.”

• Nurse 1 helps guide patient 6 onto the chair.

• Patient 6 looks at nurse 1 and smiles, patient 6 looks a little flushed.

• Nurse 1 smiles back.

• **Nurse 1:** “Are you okay…it’s not too hot in here for you is it?”

• **Patient 6:** “No I’m fine.”

• Occupational therapist 2 pulls up the second chair and sits down besides Patient 6.

• She puts her hand on Patient 6’s arm.

• **Occupational therapist 2:** “Right, now that you’ve had your new hip, we need to go through what we did in the hip class, so when you go home you’re not going to do something that may dislocate it.”

• **Patient 6:** “Oh right, you mean making sure I don’t sit on something too low and all that stuff?”

• **Nurse 1:** “Yes, I know we’re going over old ground but..well we just need to make sure that you’re happy with everything…bit of the boring stuff really…but important.” (Laughs).

• Patient 6 laughs back.

• **Patient 6:** “Come on then, show me what you want me to do.”
• *Occupational therapist 2:* “You can always tell the ex-nurses can’t you they’re so bossy.” (Laughs).

• Patient 6 looks slightly embarrassed; she looks down for a moment then looks back at occupational therapist 2.

• Occupational therapist 2 claps her hands together.

• *Occupational therapist 2:* “Right let’s get started.. “

• Patient 6 is in her underwear and dressing gown, her outdoor clothes are in a bag which has been brought down to the room by nurse 1.

• *Nurse 1:* “What are you putting on... this and this?”

• Nurse 1 holds up a skirt and blouse.

• Patient 6 nods and points towards the bag lying on the floor.

• *Patient 6:* “I need to change my underwear so there should be some clean ones in there as well.”

• *Nurse 1:* “Great we can show you how to manage these.”

• Over in one corner of the room is a large white cupboard, occupational therapist 2 walks across the room and opens the cupboard door. She riffles around and pulls out some equipment.

• She turns to patient 6 and holds up a long silver stick.

• Occupational therapist 2: “This is a helping hand.”

• *Patient 6:* “Yes, I remember them when I was nursing, very handy things.”

• *Nurse 1:* “They’re good for helping you grab things..pick things up off the floor...you can use them for a number of things and they’re great for helping you get your clothes on as well.”
- **Occupational therapist 2:** “Right let’s get started, I’ll give you a demonstration and then you can have a practice.”

- Occupational therapist 2 proceeds with the demonstration, patient 6 looks on, she smiles from time to time.

- **Nurse 1:** “Okay your turn.”

- **Patient 6:** “Do I get points out of ten...(laughs)…em., like this.is that the right way round?”

- Patient 6 starts to put on her clothes using the helping hand.

- She tuts as she tries to manoeuvre her clothes over her operated leg first.

- **Occupational therapist 2:** “That’s it well done, you’re doing it…”

- Patient 6 shakes her head.

- **Occupational therapist 2:** “You’re doing great…look it’s the first time you’ve done this so …good.”

- About ten minutes pass and patient 6 has put on her underclothes and skirt. She lets out a big sigh.

- **Nurse 1:** “There you go, done, see everything is fine isn’t it?”

- **Patient 6:** “Well, yes..em…I’ve done it here with you two helping me but when I go home I won’t have you there will I?”

- **Nurse 1:** “..And that’s why we’re going through all this now.”

- **Occupational therapist 2:** “Look, don’t worry, we’ll have a few more practices…then let’s see how things are then. If you still feel as if you need a bit more help then we can arrange for the team to come out to you at home.”

- **Patient 6:** “Oh, the team can come out, I’d feel so much better…I know I’ve got my husband at home but, well he won’t know this sort of thing will he,”
that would be good. I’d feel more settled in myself if you could come to see me.”

- **Nurse 1:** “That’s no problem, look we’re here to make sure that you’re happy with everything and that you’re safe when you go home…so let’s see, you should be home by Thursday, er, so let’s say I ask the team to call out on Friday morning …before the weekend and they’ll see how you’re doing.”

- **Patient 6:** “Yes…oh thank you, I feel better now. I’m a tough nut really…I know I’m an ex-nurse but when you’re on this side of the fence it’s different…you feel quite vulnerable…and people expect you to er manage. Someone said to me the other day, “Oh being a nurse you’ll sail through this.” Well you don’t, I have the right to the same consideration as anyone else..em…so thank you for helping me.”

- **Nurse 1:** “That’s okay…you’re very welcome.”

- **Patient 6:** “I think I’m ready for a cup of tea now.” (laughs)

- **Nurse 1:** “Well you’ve earned one.”

- Nurse 1 wheels patient 6 back to the bay in a chair, occupational therapist 2 follows behind with patient 6’s belongings.

- Once back in the room they make sure that patient 6 is comfortable.

- Nurse 1 goes off to get patient 6 a cup of tea.

- Occupational therapist 2 chats to patient 6 and constantly offers reassurance about her progress, she then hugs her.

- Nurse 1 returns with a cup of tea, nurse 1 pulls up the bed table and places the drink on it.

- They ask if she is okay and then leave.
Summary of findings and analysis for observation 9

This observation provides another example of two health care professionals working together in order to facilitate a positive experience for the patient. They acknowledge the vulnerability of the patient and provide reassurance and support in order to allow the patient to feel that she has control of her recovery and treatment.

Table 6.15: Analysis of caring interactions during observation 9

<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette line number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respectful deference</td>
<td>Developing and sustaining a helping-trusting authentic caring relationship.</td>
<td>Does not hurry the patient. Listens to patient’s problems and concerns. Does not reduce presence during caring moment. Encourages patient to express concerns. Follows through on statements. Helps patient to see the positive aspects of their situation. Helps patient to deal with negative feelings and provides on-going encouragement.</td>
<td></td>
<td>44,46</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>43,44,46</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>15,54</td>
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<td></td>
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<td></td>
<td></td>
<td>32,33,55</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40,44,46</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38,40,41,44,46</td>
</tr>
<tr>
<td>2. Assurance of human presence</td>
<td>Practice loving-kindness and equanimity within context of caring consciousness</td>
<td>Show that they are interested in patient as more than a condition. Humane and warm in approach, show loving kindness. Respectful to patient. Provide reassuring presence. See things from the patient’s point of view. Show genuine concern. Encourages</td>
<td>Touch Eye contact Smiles Hug</td>
<td>8,9,12,15,27</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>52,53,54,56</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38,40,44,48,50</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>9,32,38,40,44,46,54</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td>43,44,46</td>
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<td></td>
<td>15,43,44,46</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>38,40,41,44</td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment.</td>
<td>confidence in patient and Motivation. Demonstrate empathy to situation. Has concern for and ensures patient’s comfort. Uses touch and facial expressions to communicate and create a caring environment. Respects patient privacy. Ensure patient has everything they need before leaving room.</td>
<td>46,54</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>5. Attentiveness to the Other’s experience.</td>
<td>Assistance with gratification of human needs.</td>
<td></td>
<td>38,40,41,43, 44,46</td>
<td></td>
</tr>
<tr>
<td>Patient. Participate in the caring moment. Knows how to deliver healing treatments and operate specialist equipment. Ensures patient comfort. Helps patient to feel that they are in control of the situation. Appreciates what the patient is experiencing and helps patient deal with negative feelings.</td>
<td>44,46,52,53, 54,55,56 40,44,46 54 31,32,33 9,52,53,54, 55,56 44,46 44,46,54</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.

The most frequently observed caring carative in this vignette was attentiveness to the other’s experience, for which a total of 36 caring behaviours were exhibited. Both health care professionals displayed a similar number of traits attributed to this category. A large number of these can be accredited to the acknowledgement of and respect for the individual needs of the patient. They offered reassurance to a patient lacking in confidence and who felt that her own progress was slow moving. Through their honest responses they provided comfort, encouragement and motivation which helped empower the patient to take control of her rehabilitation progress.

Assurance of human presence was revealed in 33 caring behaviours and again both health care professionals demonstrated an equivalent number of behaviours in this category. There was a genuine concern for the patient’s situation and throughout the observation their approach was warm and humane. The patient was comforted and reassured by the
presence of the two health care professionals and physical contact consisting of touch and a hug signalled an inherent practice of loving kindness.

The caring carative categories of professional knowledge and skill was disclosed in 23 caring behaviours, respectful deference in 18 and positive connectedness in 13. Unlike the two highest ranking carative categories there was a noticeable difference in the number of caring behaviours credited to the two health care professionals. The occupational therapist demonstrated a greater number of caring behaviours proportionate to explaining the activity, by means of demonstrating the use of dressing aid equipment and using an unhurried approach throughout. Helping the patient to appreciate positive accomplishments during the rehabilitation task, whilst at the same time listening and problem solving in order to help the patient reach her desired goal.

The caring behaviours shown by the nurse in these categories were more evident in her capability of speaking in a calm and reassuring manner and paying particular attention to the patient’s symptoms. She provided a supportive and protective role using both verbal and non-verbal language to create a caring healing environment.

6.6.4. Observation 10

18.35 hours side room 3. Patient 7 is a 36 year old patient and has rheumatoid arthritis. For most of her adult life she has suffered with the disease and as a result has been in hospital on numerous occasions for surgery to replace arthritic joints.

She underwent a hip resurfacing operation this morning and doctor 3 her orthopaedic consultant has come to the ward to check on her progress.

Patient 7 has an intravenous drip for fluid replacement and a Patient controlled analgesia (PCA) pump which provides pain relief. She has control of the pump and presses a button which releases the medication. Patient 7 is awake.

- Doctor 3 walks up to the bedside.
- Doctor 3: “Hello there…how are you feeling this evening?”
- Patient 7 sits up and smiles, she looks tired.
• **Patient 7:** “A little groggy still but not too bad.”

• **Doctor 3:** “Do you have any pain?”

• **Patient 7:** “No, I’m okay, I’ve got this.”

• Patient 7 holds up the control for the PCA.

• Doctor 3 nods.

• **Doctor 3:** “Good…it looks to be doing the trick.”

• Doctor 3 smiles

• Patient 7 looks at doctor 3.

• **Patient 7:** “Did everything go okay this morning…what did my hip look like?”

• Doctor 3 nods her head several times and points to patient 7’s hip.

• **Doctor 3:** “It went as well as I expected..em..your hip joint was very worn…but we knew that from the x-rays.”

• Patient 7 sighs and thanks doctor 3.

• **Doctor 3:** “I didn’t have to replace the hip fully as I, em, thought. .it was…er…okay in the socket..so..er…I just put a new surface on your hip bone.”

• **Patient 7:** “Is that better…I mean is it better than you thought?”

• Doctor 3 nods her head

• **Doctor 3:** “Yes because there was more of the bone that we could preserve..er…than we thought…so yes much better.”

• **Patient 7:** “Oh I’m so glad; does that mean I don’t need to stay in too long?”
• **Doctor 3:** “That’s right, you could go on Friday providing everything is okay and the physios are happy with you.”

• Patient 7 smiles.

• **Patient 7:** “Oh that’s good, I have to get back to my daughter she’s already missing me and I’m missing her.”

• Patient 7 starts to cry.

• Doctor 3 pats her arm.

• **Doctor 3:** “I know you’ve had a rough ride with your arthritis…it must be hard but just think you have a new hip surface in there now so all that pain you had will be gone. You can spend..em… quality time with your daughter instead of..er..being in pain when you want to do things with her.”

• **Patient 7:** “I know, I know…I’m really grateful for that so I mustn’t moan…thank you, you’ve really been so kind.

• **Doctor 3:** “That’s okay, can I..er..have a look at your hip?”

• Doctor 3 gestures towards the bed, patient 7 nods.

• Doctor shuts the side room door. She pulls back the bed clothes and looks at patient 7’s wound and leg.

• Patient 7 strains to look at the hip and asks if everything looks okay.

• Patient 7 looks at doctor 3, a few moments pass.

• Doctor 3 presses around the dressing. She looks up at patient 7 and nods.

• **Doctor 3:** “Yes, everything looks fine. I was just making sure that there was no leakage from the wound, but it looks great.”

• **Patient 7:** “Good, good. Can I get up later on…to go to the toilet..er..I hate those bed pans.”
• Doctor 3 scrunches up her face, she umhs for a moment.

• *Doctor 3:* “I think it’s a bit early…can you put up with them for tonight and I’ll tell the nursing staff that they can get you up tomorrow.”

• *Patient 7:* “I suppose so under protest.” (laughs)

• *Doctor 3:* “I know, I wouldn’t like to use them, I can’t imagine myself on one of those things.”

• They both laugh.

• *Doctor 3:* “So anything else you want to ask me?”

• *Patient 7:* “Er, no. I can’t think of anything…em…I’ll probably think of more when you’ve gone.”

• *Doctor 3:* “That’s alright, just keep them in there (points to head)...I’ll be back tomorrow, you can ask me then.”

• *Patient 7:* “Okay, thank you…bye.”

• Doctor 3 exits the side room.

• Researcher makes sure that patient 7 is comfortable and that she has her call bell to hand before leaving the room.

*Summary of findings and analysis for observation 10*

This observation demonstrates the concern of the doctor for the well-being of her patient. Her caring behaviours help the patient to cope with the stress of the illness channelling and expressing difficult emotions and providing a means by which these problems can be resolved.
<table>
<thead>
<tr>
<th>Carative category</th>
<th>Carative intervention</th>
<th>Observed behaviour</th>
<th>Physical and non-verbal interaction</th>
<th>Vignette line number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respectful deference</td>
<td>Developing and sustaining a helping-trusting authentic caring relationship.</td>
<td>Listens patiently to problems and concerns. Does not reduce presence during caring moment. Helps patient to see the positive aspects of their situation. Helps patient to deal with negative feelings. Helps patient to channel difficult emotions. Answers patient positively. Is not pre-occupied during conversation.</td>
<td>Touch, Eye contact, Smiles</td>
<td>Demonstrated Throughout 16,19,21,26,34</td>
</tr>
<tr>
<td>2. Assurance of human presence</td>
<td>Practice loving-kindness and equanimity within context of caring consciousness</td>
<td>Show that they are interested in patient as more than a condition. Humane and warm in approach, show loving kindness. Respectful to patient. Provide reassuring presence. See things from the patient’s point of view. Show genuine concern. Encourage confidence in patient. Motivate patient. Demonstrate empathy to situation.</td>
<td>Touch, Smiles</td>
<td>5,25,26,40</td>
</tr>
<tr>
<td>3. Positive connectedness</td>
<td>Provision of supportive, protective and/or</td>
<td>Uses touch and facial expressions to communicate</td>
<td></td>
<td>25,40</td>
</tr>
<tr>
<td>4. Professional knowledge and skill</td>
<td>Systematic use of scientific problem-solving method for decision making. Promotion of interpersonal teaching-learning.</td>
<td>and create a caring environment. Respects patient privacy. Recognises patients stated and unstated needs.</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acknowledges and respects the patient’s individual needs. Helps reassure patient. Responsive to the needs of the patient. Honest with the patient. Participate in the caring moment. Knows how to deliver healing treatments. Ensures patient comfort. Helps patient to feel that they are in control of the situation. Appreciates what the patient is experiencing and</td>
<td></td>
<td>5,25,26,37 14,16,21 14,16,19,37 25</td>
<td></td>
</tr>
</tbody>
</table>
This table illustrates caring observed by category, intervention, behaviour and physical/verbal interaction, the vignette line number is provided for ease of reference.

This final vignette is concerned with the observation of an interaction between a senior doctor and patient. The dominant carative category was assurance of human presence for which 23 caring behaviours were observed. This was followed by attentiveness to the other’s experience (20), professional knowledge and skill (14), respectful deference (11) and positive connectedness (7). From the onset the doctor was aware of the patient’s feelings and anxiety and consequently her presence alone was reassuring for the patient. The doctor showed a genuine concern which was demonstrated through her verbal interactions and reinforced with eye contact, facial expressions such as smiling and the use of touch to communicate caring. The doctor was also able to instil hope and confidence by means of motivation, compassion and empathy for her patient’s situation and experiences. It was evident that a patient/doctor bond had already been established before this observed interaction but strengthened further by a mutual respect which allowed for further development of an authentic caring relationship. The ability of the doctor to listen and pay attention acknowledges the uniqueness of the patient, accepting the patient for who they are in respect of individual beliefs and values.
6.7. Overall findings

The caring carative categories were found to differ in number and order of rank between the four health care professional groups. These are presented in table 6.17

Table 6.17: Rankings of caring carative categories by health care profession

<table>
<thead>
<tr>
<th>Group</th>
<th>Caring carative category</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>Respectful Deference</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Assurance of Human Presence</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Positive Connectedness</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Professional Knowledge and Skill</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Attentiveness to the Other’s Experience</td>
<td>1</td>
</tr>
<tr>
<td>Doctor</td>
<td>Respectful Deference</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Assurance of Human Presence</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Positive Connectedness</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Professional Knowledge and Skill</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Attentiveness to the Other’s Experience</td>
<td>2</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Respectful Deference</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Assurance of Human Presence</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Positive Connectedness</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Professional Knowledge and Skill</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Attentiveness to the Other’s Experience</td>
<td>3</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>Respectful Deference</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Assurance of Human Presence</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Positive Connectedness</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Professional Knowledge and Skill</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Attentiveness to the Other’s Experience</td>
<td>5</td>
</tr>
</tbody>
</table>

This table demonstrates the order of ranking of caring caratives as evident in the vignettes by healthcare professional group.
6.8. Chapter summary

This chapter has presented the findings of the observation stage of the study. The research question for stage two was:

- Which elements of Watson’s caring theory are exhibited by health care professionals during caring interactions?

By observing the caring interactions between patients and health care professionals, it was possible to gain an insight into the caring behaviours occurring and determine which elements of Watson’s caring theory were present in the caring moment. All of the caring carative categories were evident in each of the vignettes although the number of times that they were exhibited varied between the respected health care professionals. In the nursing group attentiveness to the other’s experience was the most frequently observed caring carative category, whilst in the doctor group assurance of human presence was the prevailing category. Interestingly, in the occupational therapy and physiotherapy group professional knowledge and skill was the principal caring carative category, although the rankings varied for the other categories in these two groups. There was a general desire to ensure a culture of caring within the developing health care professional/patient relationship, evolving from the observed interaction which in these vignettes can undeniably be classified as caring interactions.

Following the observed interactions, exit interviews were undertaken in order to explore the themes arising from the caring carative categories exhibited by the health care professionals. It was also considered important by the researcher to investigate how these caring behaviours were perceived by the patients involved in the individual caring interactions and what impact these had upon their experiences of care whilst in hospital. The findings of the interviews will be discussed in chapter Seven.
CHAPTER SEVEN

Findings and analysis

Stage Three Semi-structured Interviews

7.1. Introduction

This Chapter presents the main categories and themes arising from the interview data as represented in figure 12. Chapter Five revealed the caring behaviours valued by patients and health care professionals whilst Chapter Six explored how visible these behaviours were during caring interactions. Using the caring caratives from the Caring Behaviour Inventory tool (Wolf et al 1984), the data presented here offers insights into how health care professionals perceive and interpret their own caring behaviours. Patients were interviewed to gain an understanding of how they perceive and interpret the care given. The setting for the data collection will be discussed together with the demographic data of the patients and health care professionals who participated.

Figure 12: The process of data collection and analysis
The research objectives were:

- To understand patient’s perceptions of caring that is delivered by the multi-professional team within the specialty of orthopaedics
- To gain insight into what perceptions health care professionals have of their own caring behaviours

7.2. Interview

Observation was used to gain insight into caring interactions between health care professionals and patients, although it affords an understanding into the phenomenon being observed it is impossible for the researcher to uncover what participants are thinking during these episodes (Breakwell et al., 2006; Hendry 2001).

Following on from the observational Stage Two of the study, interviews were conducted as soon as possible after the observation period whilst events were still clear in the participants mind (Offredy, 1998). Due to Local Research and Ethics stipulation, patient participants were interviewed as soon as possible after discharge. All but two of the patients were interviewed following observation. One patient was unable to be interviewed as he was flying home to the Philippines immediately following discharge from hospital and the second, an elderly lady, had died several days following her operation.

7.2.1. The semi-structured interview guides

Two semi-structured interview guides (see appendix 11 and 12) were developed by the researcher, one for the purpose of interviewing staff participants and the other for patient participants. They were constructed of a number of questions which were open-ended, singular, neutral and clear in order to minimise imposition of predetermined responses when gathering the data; to avoid dichotomous responses (e.g. ‘yes’, ‘no’) that prevent the participant from providing in-depth responses, and to ensure that the participant understands the questions being asked (Patton, 2002). The aim was to gain a richer and deeper understanding of caring and caring behaviours, amplifying and adding to the quantitative data already obtained through the CBI instrument. Although the questions
were written in a certain sequence, the researcher did not always follow this order being mindful of the fact that not every question needed to be asked or answered in the exact same way with each participant. The interviews were kept within the agreed domain although the researcher was prepared to follow unique avenues if they were likely to add to the study. Questions were only asked where the participant failed to report them on their own within the interview or in order to clarify and understand a particular response.

The staff and patient interviews focused on the following themes:

**Table 7.1: Interview themes staff semi-structured interview guide**

<table>
<thead>
<tr>
<th>No:</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The general background and experience of the staff member</td>
</tr>
<tr>
<td>2.</td>
<td>Reason for working in health care</td>
</tr>
<tr>
<td>3.</td>
<td>Positive and negative aspects of job</td>
</tr>
<tr>
<td>4.</td>
<td>What does caring mean to individual</td>
</tr>
<tr>
<td>5.</td>
<td>Meeting patient expectations</td>
</tr>
<tr>
<td>6.</td>
<td>Constraints to care giving</td>
</tr>
<tr>
<td>7.</td>
<td>Additional comments</td>
</tr>
</tbody>
</table>

*Themes composed for semi-structured interview questions for staff*

Prompts were included relating to the five subscales of the CBI, respectful deference, assurance of human presence, positive connectedness, professional knowledge and skill, attentiveness to the other’s experience.
Table 7.2: Interview themes patient semi-structured interview guide

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Admission to hospital</td>
</tr>
<tr>
<td>2.</td>
<td>Admission process, e.g. communication</td>
</tr>
<tr>
<td>3.</td>
<td>Care given, caring behaviours</td>
</tr>
<tr>
<td>4.</td>
<td>Respect, empathy, information</td>
</tr>
<tr>
<td>5.</td>
<td>Knowledge and expertise of staff</td>
</tr>
<tr>
<td>6.</td>
<td>Experience, honesty, trust</td>
</tr>
<tr>
<td>7.</td>
<td>Expectations</td>
</tr>
<tr>
<td>8.</td>
<td>Additional comments</td>
</tr>
</tbody>
</table>

*Themes composed for semi-structured interview questions for patients*

Prompts were included relating to the five subscales of the CBI, respectful deference, assurance of human presence, positive connectedness, professional knowledge and skill, attentiveness to the other’s experience.

**7.2.2. Reliability and validity**

In order to establish validity a series of measures were taken. To overcome the possibility of obtaining irrelevant data the researcher guided the interviews to elicit the desired information by asking specific questions. To establish the reliability for this stage of the study, a substantial review of relevant literature was performed so that the researcher was able, where required, to direct the conversation in the right direction. A standardized interview guide was constructed and used; understanding of the answers given by the participants was tested by the researcher summarizing the meanings and explanations given. This allowed the participant to evaluate the quality of the interpretation and revise where necessary (Healey & Rawlinson, 1994). Finally confidentiality and anonymity were maintained throughout in order to establish validity.
7.2.3. Setting for the interviews

Health care professionals

The health care professional interviews for this stage of the study were undertaken in a quiet room situated away from the ward areas in the main hospital building. This room was chosen by the researcher as a convenient place for the participants where privacy and confidentiality could be maintained. Each interview began with a preamble setting the parameters of the interview, confidentiality and possibility of withdrawing from the study at any time. The participants were assured that there were no right or wrong answers and that the researcher was interested in their views and opinions which were important contributions to the study. Consent was taken by the researcher prior to commencement of the interviews. The recording system was always checked before each interview. The researcher asked each question in a slow clear voice and the interview always ended with the statement ‘this is the end of the interview with…. (Participant number). None of the health care professionals voiced any concerns regarding voice recording of the interview. At the beginning of each interview a series of general questions were asked to help put the respondent at ease, these questions formed part of the interview guide.

Patients

Following observation in the ward setting patients were approached by the researcher and asked if they wished to participate further in the study. Each patient that agreed was provided with a study information sheet (see appendix 6) and a contact number for the researcher. On contacting the researcher a mutual date and time was arranged for the interview. The majority of patient interviews were conducted in the patients’ own home setting, although two patients asked to be interviewed prior to discharge and therefore a quiet, private room was identified for this purpose. The interviews were conducted using the interview guide developed from the data which emerged from Stage One of the study (Appendix 11).
7.2.4. Analysis of participant observation and interviews

The observations and interviews allowed a rich level of data to be collected and thematic analysis was undertaken using the 5 subscales of the Caring Behaviours Inventory (CBI) tool (see Chapter Five) and the corresponding carative interventions.

<table>
<thead>
<tr>
<th>5 Carative Categories</th>
<th>Corresponding Carative Interventions of Watson’s Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Respectful Deference</td>
<td>Development of a helping-trusting relationship. Promotion and acceptance of expression of positive and negative feelings</td>
</tr>
<tr>
<td>2. Assurance of human presence</td>
<td>Formation of humanistic-altruistic system of values. Instillation of faith-hope. Cultivation of sensitivity to oneself and to others</td>
</tr>
<tr>
<td>3. Positive Connectedness</td>
<td>Provision of a supportive, protective and/or corrective mental, physical, sociocultural and Spiritual environment</td>
</tr>
<tr>
<td>4. Professional knowledge and skill</td>
<td>Systematic use of scientific problem solving method for decision making. Promotion of interpersonal teaching-learning</td>
</tr>
<tr>
<td>5. Attentiveness to the other’s experience</td>
<td>Assistance with gratification of human needs. Allowance for existential-phenomenological Spiritual forces</td>
</tr>
</tbody>
</table>

*Watson’s caring caratives (1984)*

7.2.5. Findings

Health care professionals and patients expressed differing opinions and perceptions of caring behaviours and the themes are shown as code notes. Tables 7.4 and 7.5 detail examples of the themes and associated carative categories.
### Table 7.4: Staff coded data

<table>
<thead>
<tr>
<th>Reference</th>
<th>Code note</th>
<th>Carative Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>S1.1 Having compassion, others experience</td>
<td>RD</td>
</tr>
<tr>
<td>Doctor</td>
<td>S1.2 Giving respect</td>
<td>RD</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>S1.3 Spend more time</td>
<td>RD</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>S1.4 Being fair and equal</td>
<td>RD</td>
</tr>
<tr>
<td></td>
<td>S2.1 Having someone there</td>
<td>AHP</td>
</tr>
<tr>
<td></td>
<td>S2.2 Effective communication</td>
<td>AHP</td>
</tr>
<tr>
<td></td>
<td>S2.3 Being helpful</td>
<td>AHP</td>
</tr>
<tr>
<td></td>
<td>S3.1 Touch</td>
<td>PC</td>
</tr>
<tr>
<td></td>
<td>S3.2 Be at one with</td>
<td>PC</td>
</tr>
<tr>
<td></td>
<td>S3.3 Someone who is trusted</td>
<td>PC</td>
</tr>
<tr>
<td></td>
<td>S3.4 Make a difference</td>
<td>PC</td>
</tr>
<tr>
<td></td>
<td>S4.1 Specialist</td>
<td>PKS</td>
</tr>
<tr>
<td></td>
<td>S4.2 Developing Skills</td>
<td>PKS</td>
</tr>
<tr>
<td></td>
<td>S4.3 Team working</td>
<td>PKS</td>
</tr>
<tr>
<td></td>
<td>S5.1 Providing best care and service</td>
<td>AOE</td>
</tr>
<tr>
<td></td>
<td>S5.2 Delivering Quality Care</td>
<td>AOE</td>
</tr>
<tr>
<td></td>
<td>S5.3 Improve care</td>
<td>AOE</td>
</tr>
<tr>
<td></td>
<td>S5.4 Patient experience</td>
<td>AOE</td>
</tr>
<tr>
<td></td>
<td>S5.5 Patient expectations</td>
<td>AOE</td>
</tr>
</tbody>
</table>

**Coding key:**
- **RD** = Respectful deference to others,
- **AHP** = Assurance of human presence,
- **PC** = Positive connectedness,
- **PKS** = Professional knowledge and skill,
- **AOE** = Attentiveness to the other’s experience.

Following analysis of the health care professional data the patient data was coded.
Table 7.5: Patient coded data

<table>
<thead>
<tr>
<th>Reference</th>
<th>Code note</th>
<th>Carative Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P1.1</td>
<td>Being compassionate</td>
<td>RD</td>
</tr>
<tr>
<td>P1.2</td>
<td>Giving respect</td>
<td>RD</td>
</tr>
<tr>
<td>P1.3</td>
<td>Not being judgemental</td>
<td>RD</td>
</tr>
<tr>
<td>P2.1</td>
<td>Having someone there</td>
<td>AHP</td>
</tr>
<tr>
<td>P2.2</td>
<td>Good communication</td>
<td>AHP</td>
</tr>
<tr>
<td>P2.3</td>
<td>Being helpful</td>
<td>AHP</td>
</tr>
<tr>
<td>P2.4</td>
<td>Being cared about</td>
<td>AHP</td>
</tr>
<tr>
<td>P3.1</td>
<td>Being in good hands</td>
<td>PC</td>
</tr>
<tr>
<td>P3.2</td>
<td>Sensing my situation</td>
<td>PC</td>
</tr>
<tr>
<td>P3.4</td>
<td>Touch</td>
<td>PC</td>
</tr>
<tr>
<td>P4.1</td>
<td>Specialist</td>
<td>PKS</td>
</tr>
<tr>
<td>P4.2</td>
<td>Explaining things</td>
<td>PKS</td>
</tr>
<tr>
<td>P4.3</td>
<td>Developing Skills</td>
<td>PKS</td>
</tr>
<tr>
<td>P5.1</td>
<td>Make a difference</td>
<td>AOE</td>
</tr>
<tr>
<td>P5.2</td>
<td>Providing best care and service</td>
<td>AOE</td>
</tr>
<tr>
<td>P5.3</td>
<td>Being attentive</td>
<td>AOE</td>
</tr>
</tbody>
</table>

Coding key: **RD** = Respectful deference to others, **AHP** = Assurance of human presence, **PC** = Positive connectedness, **PKS** = Professional knowledge and skill, **AOE** = Attentiveness to the other’s experience.

### 7.2.6 Analysis of findings

The findings from the semi-structured interviews will be discussed according to the carative category. Each health care participant was first asked what their reasons were for wanting to work in a caring profession. The question was asked as an ice-breaker in order to help the respondent relax and discuss a topic that they felt at ease with. The replies given varied and gave an insight into what motivated each individual to care for others. Some participants were very clear on their motives for becoming health care professionals. The use of the word ‘help’ featured extensively in the responses to this question, with some interchanging the words ‘help’ and ‘care’ to explain their reasons for working in their chosen professions.

“*Just wanted to look after people, help them……care for them, it was as simple as that.*” (Nurse 2)
“I thought it would be challenging and very pragmatic, I like problem solving and I think it’s good to help people by utilising those skills”. (Interview Occupational Therapist 1)

“I wanted to work in health care because I do feel, you know, I am able to help people basically through my job. I think it’s nice to be able to help and care for people. It’s very rewarding to do that sort of thing.” (Interview Doctor 2)

“I have always had a feeling that I wanted to help people and I found that people who are in some way incapacitated whether physically, emotionally or socially, I am naturally drawn to them.” (Interview Nurse 5)

“Oh, that’s a good question, let me see, I started off as a health care worker to see if I liked it first of all. I did I really enjoyed looking after people and helping them you know when they’re sick or unable to do things for themselves.” (Interview Nurse 7)

“I wanted to look after people to the best of my ability, being there for them you know, helping them and doing everything really to be able to deliver the best care”. (Interview Nurse 3)

For one particular nurse and occupational therapist caring was seen as a basic human characteristic, both respondents referred to a desire to nurture as the motivation for entering into a caring profession.

“I think it’s in my nature, em, I want to help people, that sounds a bit fickle doesn’t it but I do I want to help people, especially people who are not well. I want to nurture them, care for them and get them back to health, so, I think it has to be part of your make up. I believe that it has to be part of your make up, it can be something you learn but I think that the impetus has to be there from the beginning, you have to want to help people.” (Interview Doctor 1)

“I think it’s in my nature……wanting to help people, that sounds a bit fickle doesn’t it but no just to look after them, nurture them and get them back to health,
so I think that comes from me as a person, comes from within, I think it has to be part of your make-up.” (Interview Occupational Therapist 2)

“It’s nice to be able to sort of give some help to people basically.” (Interview Nurse 6)

“I wanted to work in health care because I am able to help people basically through my work as a doctor. It’s nice to be able to sort of give some help basically. That’s quite rewarding to be able to do that. I think as a doctor you’re in quite a fortunate position you can sort of get hands on with the care and make a difference that way.”

(Interview Doctor 3)

Some of the health care professionals gave reasons relating to the practical nature of their respected professions as the attraction and incentive. Two nurses spoke of their interests in becoming health care professionals aroused by conversations with other nurses.

“My friend trained as a nurse and I used to listen to what she’d been doing on the wards and that...so because I enjoyed the contact you got with people I thought I’d like to try nursing.” (Interview Nurse 4)

“I was at college and that’s when I met up with some student nurses.... Well they were training to be student nurses and that’s when I became interested in pursuing that career. Just listening to their general conversations about things that they would be doing out in the hospitals and community. I found it fascinating and was interested in what they were talking about.” (Interview Nurse 1)

Whilst two medical respondents stated that the attraction was being able to provide care and help people by pursuing a surgical career, indicating that the technical aspect of the ‘professional role’ was the appeal.
“I’m not really sure, I always wanted to do surgery, you see people with a clear problem and you fix it. As to why I came into medicine I don’t really know, I suppose because the subject appealed to me.” (Interview Doctor 4)

“Because I enjoyed science, my mum was a doctor and it was just a career path I followed. I enjoyed my training, my degree and I developed an interest in surgery and then orthopaedics, fixing bones and all that, you know, that’s what I decided to do.” (Interview Doctor 5)

The physiotherapist respondents felt that their practical abilities and interest in sports led them into a caring profession, although neither made reference to caring for or helping people as part of the rationale.

“I suppose I’ve always been good at sports and it took me a long time to make up my mind as to what I wanted to do. I like dealing with sports injuries and so I thought I’d do physiotherapy and orthopaedics.” (Interview Physiotherapist 1)

“I just thought physiotherapy sounded interesting, good career option, I liked sports so it was something like that ....I didn’t want to do nursing, I wasn’t interested in nursing more the allied professions, but why I don’t really know that, can’t really say.” (Interview Physiotherapist 2)

7.3. Definition of caring

The value of caring and the ability to care for another was seen as having an authentic concern or interest in the others well-being. When the health care participants were asked the open-ended question, “what does caring mean to you?” each defined caring in their own words and from their own experiences. None of the respondents related any of their definitions to any particular caring theories. Despite this each spoke about their concept of caring in a thoughtful and meaningful way. This initial question was followed up with questions relating to behaviours or events noted during the observed sessions.
Interview Observation 9

Researcher: “As a health care professional, what does caring mean to you?”

Nurse 1: “Well I suppose to me it’s about valuing the individual...your patient...it’s about being interested in them as a person and having a real concern for their problems and needs.”

Researcher: “Do you find that a natural thing, having concern for people?”

Nurse 1: “Well, er, yes, sort of, I mean I think you don’t really give it a lot of thought when your there with your patient. It just sort of happens. I don’t think I go to work and say to myself...right, you’ve got to be concerned for your patients today...no...em...it doesn’t happen like that...it’s just instinctive.”

Viewing caring as instinctive was discussed by another health care professional in the following interview.

Interview Observation 8

Doctor 5: It (caring) doesn’t come with a manual...in fact when I was doing my training it was all very technical...I think they (the tutors) thought that we were naturally caring people...to go into the profession, you know. There were no lectures about it...it’s just part of who I am.”

Researcher: “…and who is that?”

Doctor 5: “ooh, that’s hard...I think that I’m someone who really believes in helping others...I want to do good things for others, as a doctor, yes, help them...and...er...try and do what I can for them. I have been given these abilities as a doctor it’s about using those well to care for others.”

Attending to basic needs and having a ‘good attitude’ was seen as a fundamental caring behaviour by one nurse.
Interview Observation 8

Nurse 2: “It’s about doing things for your patient’s like helping them to...er...basic needs are catered for really. I suppose we’re lucky on here...that we’ve got a lot of patients that are fit and able and can do that themselves, but you still go round and check.”

Researcher: Do you think it’s anything else?”

Nurse 2: “Yes, I believe it’s how you treat people...it’s...a...er...good attitude as well as physical things.”

Researcher: “Can you tell me what attitude you think is important in caring?”

Nurse 2: “Kind. You need to be kind to people and...em...think about what they’re going through and try to just think about them and do things for them that they can’t do for themselves.”

The notion of “doing things for the patient” was not necessarily seen as a positive behaviour, with one physiotherapist respondent.

Interview Observation 2

Researcher: “Do you think that even though you have to be quite firm with patients caring can still be evident in what you do?”

Physiotherapist 1 “caring for the patient and about the patient doesn’t mean taking control and doing everything...you have to help them to help themselves...I don’t think that it’s necessarily not caring if...em...you...er...have to be firm, sometimes cruel to be kind.”

Researcher: “Does that worry you that you have to be cruel to be kind sometimes?”

Physiotherapist 1: “No, no not really...I...em...don’t see it like that...I don’t actually mean cruel. I’m not a cruel person, God forbid. I don’t think I would be here if I was that way. Sometimes you have to get the patient to realise that doing
everything for them is not helping, it’s giving them the ability to do things for themselves that’s what I see as caring... in my role.”

One of the occupational therapists talked about how she used a light hearted approach to communicate caring to her patients.

Interview Observation 9

Researcher: “You seem to use a lot of humour in your caring interactions, is that something you feel helps to achieve a connection with your patients?”

Occupational Therapist 1: “I think that when you show someone you care about them, a bit of humour can help break the ice and it starts to open up a channel of friendship.. if you like, it helps you to connect with people.”

Researcher: “Do you find that easy to do?”

Occupational Therapist 1: No..ha...ha, you probably realised that from yesterday, no it’s not easy, you don’t ever get two relationships alike, you know. I’m not adverse to cracking a joke..if I think it will help. Saying funny things to patients and bantering off patients, well, I think it’s all quite nice and builds a healthy atmosphere.”

Researcher: “Even though it wasn’t a two way process?”

Occupational Therapist 1: “Well no I don’t think that’s..er...quite right...I ..er...suppose that he was a bit awkward and wasn’t in the mood for a laugh...you know I could see his point....there was a two way process going on, we weren’t seeing eye to eye and he was very ...er...rude at times but I think that when he calmed down he knew that we were on his side...and what we were doing and saying was..em...out of a sense of caring.”

The notion of friendship as part of caring was mention as part of building trust between care-giver and patient.
Interview Observation 1

Researcher: “How easy is it to build up a caring relationship with your patient?”

Nurse 4: “…normal everyday friendships build up over years but in nursing you don’t have the luxury of time to be able to build up that friendship. It sometimes happens over a matter of minutes… the patient has to trust you and you have to trust the patient.”

Researcher: “What happens if that trust fails to emerge?”

Nurse 4: “I not sure that it does ever fail to happen…It’s hard to put into words what I’m trying to say but it’s like you treat people like you would want to be treated yourself, with kindness…being open and receptive to the needs of your patients so that they put their trust in you…it’s a special kind of relationship”

Having a relationship that is ‘special’ was seen as rewarding and complimentary and getting that right was to some the ultimate accolade.

Interview Observation 10

Researcher: “Do you see your caring relationship with your patients as being unique?”

Doctor 3: “.Yes...er...I do in a way...em...having a trusting caring relationship with a patient is perhaps the ultimate goal, it like signifies that you’ve really connected to that person...it pays the ultimate compliment...knowing that you have that special relationship.”

Researcher: “How does that happen do you think, that unique relationship?”

Doctor 3: “It’s unique I suppose because every patient is different, they er. have different needs and so you form a different bond with them.

Researcher: What about patients you only meet for a short period of time?”
Doctor 3: “Certainly I think you feel more connected to the patients that are in for a long time...it’s patients like that you just know you’ll never forget but even when...I do a lot of day case surgery and things and even those patients, I think there’s still a connection, although you’ve only maybe operated on them for 15 – 20 minutes, while you’re operating on them you think it could be your relative that’s there. So I think there is still a connection there...definitely.”

7.4. Caring Carative 1.

7.4.1. Respectful deference to others

Respectful deference to others relates to behaviours which demonstrate a courteous regard for the feelings and experiences of the other individual. All of the health care participants interviewed made reference to respectful deference related caring behaviours.

The most dominant subthemes in relation to respectful deference were, having compassion, respecting the others experience, spending time with the patient and providing reassurance and support. Here health care professionals made reference to the notion of entering into the patient realm, acknowledging awareness of and sensitivity to the others experience.

7.4.2. Subtheme (1). Compassion

Compassion was a recurring subtheme in patient interviews and although viewed differently by each participant it was clearly perceived as an important caring behaviour, revealing the development of a connection or bond between the care-givers and their patient.

Interview Observation 7

Researcher: “Tell me about how you feel when you’re caring for people?”

Nurse 5: “Caring for other people can always be challenging......you have always got to remember that you are delivering care to people and have compassion for them and their situation.”
Researcher: *What do you mean by challenging?*

Nurse 5: “If you’ve got people with multiple problems, say physical and psychological, it can be very challenging...and I would say physically and psychologically challenging for us as nurses. You feel sorry for them and sometimes you know that you’re not going to get rid of the problems they have but hopefully you can make things better. I think that can often take a lot out of you, you give something of yourself to that person, a piece of yourself, which can take it out of you that’s challenging.”

Researcher: *“How does that make you feel?”*

Nurse 5: “It makes me feel good. It gives me this feeling of wellbeing. Does that sound strange? I think it connects you to that person..”

Some of the health care professionals referred to compassion as an act involving physical expressions of care such as touching the patients hand or showing love and tenderness during the caring moment. It was also seen as a way of demonstrating a real connection or bond during the caring moment.

*Interview Observation 8*

Researcher: “I noticed that you touched your patient at times when you were talking to him, do you see that contact as important?”

Nurse 2. “Yes, I think it is important, it shows you care and if you didn’t care then you wouldn’t be able to give them the right care. I mean you can do your job technically but that is only half of what the patient wants.....they want the emotional aspects of care as well and the contact.”

Researcher: “Do you think that’s always possible?”

“No sometimes you haven’t got the time; it’s so busy on the ward. It really upsets me when I can see a patient is clearly upset, worried, whatever, but you can’t find five minutes to stop and talk to them, offer a reassuring smile or comforting hand.
It’s sad, really sad that we’re so stretched that we don’t have time for our patients.”

**Interview Observation 3**

Researcher: *Is compassion important?*

Nurse 3: “Well it’s multi-factorial isn’t it, caring, respect, compassion I could go on but I think when you’re in this profession you need to be compassionate... but also you wouldn’t be human if you didn’t care for another to me it’s a way of saying I care.”

**Interview Observation 1**

Nurse 4: “I think compassion is a big thing, it’s letting someone know that although you might not fully understand what they’re going through you can give them a hug or just listen to them. I can’t describe exactly what it is but it’s part of your make-up as a caring person you know.”

The ability to set aside their own problems and show concern and caring was a common theme amongst several of the respondents. Compassion was seen as a means of support, helping to facilitating caring behaviours.

**Interview Observation 9**

Researcher: *What do you think compassion brings to the caring relationship?*

Occupational Therapist 2: “*It’s important...we’re in the business of caring......it’s about supporting and having a true interest in your patient....you have a responsibility to care for your patients....ensure that you show compassion at all times no matter how busy or stressful things get. If you have true compassion then I think everything else just flows from there.*”
Interview Observation 8

Researcher: “Do you think you are compassionate?”

Doctor 5: “………..on the whole I do have compassion for my patients, I really feel for them and want to do my best for them…it’s back to caring, if you care then you have compassion, yes, they go together. I always try to think that no matter what sort of a day I’m having, they’re probably having a worse one.”

The indication of giving sympathy or compassion in a relationship indicated a desire by the health care professional to share someone else’s pain or suffering and demonstrated awareness of the patient situation and subsequent needs.

Interview Observation 10

Researcher: “What is it about compassion that is important to you as a health care professional?”

Doctor 3: “I think there are two sides to caring that are important, one side is the compassionate side where you try and understand what they are going through and that is hard to achieve at times, particularly when you’re really busy and you know you need to go and see a patient, you have to make the time because I feel if I were that patient I’d want someone to be compassionate towards me. The other is with my doctor’s hat on……..what can I do for this patient…what do they want…how can I make them better.”

One health care professional did not view compassion exclusively believing that it needed to be a shared quality. In a hospital setting caring is more likely to occur in an environment which consists of supportive teams of health care professionals. This team approach may allow other caregivers to share the ‘care giving’ experience.
Interview Observation 7

Researcher: “How important is team working to caring?”

Physiotherapist 2: “Sure, I think it’s essential health care professionals have that caring attitude, caring ethos......it comes about through good team work....compassion... because if not we would be in big trouble not just us but other health care professionals as well, it’s something that has to be demonstrated and shared by all. At the end of the day a team approach is more likely to give the patient more support.”

Nurse 5: “It is important because the patient wants the whole experience to be a good one and that can only happen if we work together to make that happen.”

One doctor admitted to having real difficulty showing compassion when faced with certain situations. Making reference to her patient whose injuries were sustained as a result of the effects of drug addiction, she struggled with her emotions and the way in which the caring interaction played out.

Interview Observation 5

Researcher: “Do you sometimes find it difficult to show caring behaviours towards some patients?”

Doctor 2: “It depends on the situation or the person; I find it difficult to have compassion for some because their circumstances may be self-inflicted. I know as a doctor I’m supposed to keep negative feelings out of the situation but sometimes it’s difficult. I mean we’re all human aren’t we and at times I’m expected to ignore bad situations and remain impartial.”

Researcher: “Is it hard to do that?”

Doctor 2: “It can be, I know that I may come across as if I didn’t care about the patient but that’s not what I’m thinking. I try to do my best for them...like the girl yesterday, she really tried my patience but that doesn’t mean I don’t care about her...it just means I’ve not got much patience...there’s a difference.
7.4.3. Subtheme (2). Respecting the other’s experience

Respondents were asked about developing a caring relationship with patients and which important caring behaviours helped to facilitate this.

Here staff discussed the necessity to consider the patient’s feelings, for some of the health care professionals it was an important way of entering into the patient experience, demonstrating sensitivity to and awareness of their situation.

Interview Observation 3

Researcher: “What do you think helps form a caring relationship?”

Doctor 4: “A caring relationship...you mean the doctor patient relationship?”

Researcher: “Yes”

Doctor 4: “Well you have to establish a rapport with your patients if you’re doing your job properly you get positive feedback you want to maintain those standards, especially in the health service today...we all want to know that we’re performing properly.”

Researcher: “So you value the opinions of your patients?”

Doctor 4: “Of course, yes. my patients’ opinions are valuable to me...I want them to know that my skills are very good and that they are in good hands.”

Researcher: “Good hands technically?”

Doctor 4: “Yes.”
Researcher: “And from any other perspective such as good caring hands?”

Doctor 4: “That goes without saying... of course in caring hands.”

Researcher: “Do you think that patients’ need to be shown caring through the way we communicate with them or say through our body language?”

Doctor 4: “I don’t think that’s necessarily so, I mean so long as they know that you’re going to be putting things right for them and so on then I think that’s what matters.”

Interview Observation 3

Researcher: “What do you think helps form a caring relationship?”

Nurse 3: “I think it’s just something that happens.... when you see people coming in after accidents you really feel for them. I want to go up to them and tell them that everything is going to be okay. I guess you have to weigh people up; you can’t be like that with everyone because some people don’t respond to sympathy.

Researcher: “So do you believe that sympathy helps?”

Nurse 3: “Yes it does but it’s not the only thing.. there’s lots more to it you’ve got to try and understand the problems the patient has in order to be able to treat them properly and put yourself in their shoes.”

Researcher: “How are you able to put yourself in their shoes?”

Nurse 3: “To be honest, I can’t physically do that...em..I mean I try to think how I would feel if that had happened to me and in that situation how I would want to be treated with kindness and consideration. I would want to know that my last days were surrounded by people who cared about me.”

Another health care professional believed that the caring relationship starts to evolve from the first contact helping to gain an understanding of the patient’s experience.
Interview Observation 6

Doctor 1: “It all happens in those first few minutes, it’s all about the way you conduct yourself with the patient, you need to understand how things affect them, what they are going through almost immerse yourself in their problem.”

Researcher: “Can you explain that a bit more.”

Doctor 1: “Well I like to make the patient feel that they are the most important person in the room...all my energy is focused on them for the time I am with them if you do that then they know you are genuinely interested in them. That’s when it starts...the relationship...patient’s appreciate you even if they don’t you have still formed a relationship and each time you see them it adds to the rapport."

Researcher: “So the relationship is enhanced each time?”

Doctor 1: “Yes...it does because it’s a bit...a bit like a snowball...em...really I suppose, isn’t it? Each time you have that contact...you just keep that cycle going round.”

Understanding the patients’ perspective and being responsive to the patient’s situation can ensure that the health care professional is ‘tuned in’ to their client’s needs.

Interview Observation 2

Researcher: How do you know that you are meeting the needs of your patients?”

Occupational Therapist 1: “The majority of patients who come in are very frightened, it’s about seeing things from their perspective, talking through their concerns, that helps me to understand some of what they’re going through and helps me plan for their needs...whatever they may be.”

Researcher: “Do you think that you meet your patient’s needs?”

Occupational Therapist 1: “Yes I like to think I do, I know sometimes I don’t always get it right but that can be because the patient isn’t always receptive, like this morning for instance, I mean you could see how frustrating things were and
he wasn’t having any of it. How do you meet needs that are unrealistic, how do you walk away from a situation like that and say I met his needs today?”

Researcher: “Do you think you failed this morning?”

Occupational Therapist 1: “No, I wouldn’t say I failed to meet his needs. I know what he needs but we just have different views on how we get there.”

Sometimes being sensitive to the patients experience was not easy, this was reflected in the ability to stimulate a positive caring relationship.

Interview Observation 5

Researcher: “Do you feel that you meet your patient’s expectations of a caring relationship?”

Doctor 2: “….sometimes I think I get it wrong, like this morning we do have a relationship and I think that deep down inside she knows that I do care for her. I don’t want her to throw her life away…she knows that…I think we have this understanding in our relationship.”

Researcher: “How can you be sure of that?”

Doctor 2: “I don’t suppose I can…be really sure of that I mean…no…but sometimes it’s just something that’s an unspoken understanding…does that make sense?”

Researcher: “Em..yes.”

Doctor 2: “I think when you build up a relationship with someone…over time…they know who you are and what you are trying to do, it’s a kind of relationship that’s one of listening and understanding.”

Actively listening to the patient was seen as an important part of the healing process and caring moment. For some health care professionals it was seen as a means of establishing a positive relationship, helping to engage with the patient, and exhibiting a positive presence.
Interview Observation 8

Researcher: “What do you think is important in establishing a good caring relationship?”

Doctor 5: “I think the important thing is to just listen to the patient because that gives them the opportunity to express any concerns or ask questions, which means they’re happy and know what’s going on.”

Interview Observation 1

Nurse 4: “I think it’s just like being attentive and listening to people because that way you get to know what’s really troubling them or what they need….I suppose it’s about being there for your patients….turning the table and saying what is it that you want instead of us imposing our ideas about treatment and care upon them.”

Interview Observation 2

Physiotherapist 1: “…the most important thing is to listen to your patient, you can learn a lot about the person from this and I think it helps form a bond, they know that you are interested in them not just as a condition or whatever….it’s part of the healing…the treatment if you like…..it helps the patient to deal with their situation and helps me to understand it.”

Some health care professionals felt that there were barriers to developing the caring relationship and often referred to a conflict of opinion. Importantly although the notion of ‘the patient knows best’ was frequently acknowledged it was not necessarily accepted.

Interview Observation 5

Researcher: “In the caring relationship do you ever have problems accepting patient’s views?”

Doctor 2: “Some patients have been in so many times with the same problem or on-going problems…..so they know what they need or want and how things should
be...you have to take that on board and be guided by them. The only trouble is that what they want is not always what’s best for them.”

Researcher: How do you get round this?”

Doctor 2: “I try and get a good rapport going with them so that I can at least let them know what I think would be best...although I still respect what they want.”

Interview Observation 2

Researcher: “Do you find it difficult to establish a caring relationship with a patient who is unreceptive?”

Occupational Therapist 1: “… maybe on occasions it’s about having a good relationship and trying to see things from their point of view and respecting their decisions.....we often label people as awkward or difficult because they don’t conform.”

Researcher: “Does that go against your values as a health care?”

Occupational Therapist 1: “Somewhat......I feel guilty about that because I don’t think that at times we really stop and ask why people are like that.....I know most of the time it’s probably because they believe they know what’s best and I should be more sensitive to this but it can be frustrating.”

Interview Observation 2

Researcher: “Do you find it difficult to establish a caring relationship with a patient who is unreceptive?”

Physiotherapist 1: “Sometimes, well not difficult as such but as you saw some patients can put things in the way. I mean you’re there to help them and you want to gain their friendship and respect, form that type of relationship but some patients well it doesn’t seem to matter to some.”

Researcher: “Does it matter to you?”
Physiotherapist 1: “I would have to say it does because sometimes you go all out to be caring and helpful and you don’t get anything back…it’s saddens me because I’m not sure what went wrong, why we couldn’t form that relationship.”

One doctor talked about the sheer magnitude of trying to individualise caring and consequentially a caring relationship.

Interview Observation 3

Researcher: “Do you ever discuss with the patient what they want from a caring relationship?”

Doctor 4: “asking patients about how they’re feeling, what they need and all that do you mean... whilst they're in hospital....I find that really hard. I wouldn’t have been able to do that with the patient this morning because she wouldn’t have been able to have the conversation...so yes that would be hard to do.”

Researcher: “Why is that hard?”

Doctor 4: “They have different personalities, different needs and to be perfectly honest when you’re looking after different patients you treat them as human beings, but you don’t have time it’s very busy. I think I would need a degree in psychology and lots of time...time I don’t have.”

Researcher: “Why do you feel that you need a lot of time?”

Doctor 4: “...em..well, I use all my time just getting the medical details. .I leave the rest up to the nurses, that’s their job really.to do all that stuff.”

One senior and experienced nurse felt that being able to acknowledge the others experience was not easy. She was able to offer comfort but was unable to fully appreciate the extent of the patients’ situation.
Interview Observation 3

Researcher: “How does it make you feel when you see patient’s upset?”

Nurse 3: “It is difficult, how to empathise with patients when you’ve never been in that situation yourself, how can you? You just can’t it’s impossible, I really have a hard time with this, but then again I think no point beating myself up about it, what can I do…….all I can do is listen and work with the patient to help them through their journey”.

Researcher: “The use of the word journey is interesting could you clarify this”.

Nurse 3: “I mean a journey through illness, so in the case of our patients admitted it is a journey that takes them from pain and disability to comfort and mobility, most health care professionals don’t have any personal experience of this journey and so we can’t give empathy as a result of illness experience but we can be compassionate and relate a genuine concern for their situation”.

Trying to enter into the patient experience was also seen as challenging by a doctor who whilst clearly attempting to comprehend the subjective nature of the experience in order to become sensitive to the patient’s needs, found it difficult to fully cultivate the understanding.

Interview Observation 7

Researcher: “Do you ever ask your patient’s about what they are experiencing?”

Doctor 1: “I...yes, if the situation calls for it.. I mean....then I always say to the patient tell me what you are feeling.”

Researcher: “Does that help you?”

Doctor 1: “As a doctor I feel that I ought to know what my patients are experiencing, anticipate their fears and concerns but then I think to myself that I would need to be some kind of mind reader or something to be able to know these
things. If I could it would make things a whole lot easier. It’s hard to know, it’s hard to be able to fully understand and appreciate the whole patient experience.”

7.4.4. Subtheme (4). Spending time with the patient

Spending time with the patient can be an important way of demonstrating caring and although health care professionals are caring for patients on a daily basis, the majority of time with each patient is spent on performing technical tasks. Some health care professionals felt that just being visible to patients constituted spending time with them.

Interview Observation 4

Researcher: “How important is patient contact to you as a health care professional?”

Nurse 6: “Very...I like to touch base with my patients straight away. I think that is really important...as soon as I’ve had handover then er...that’s me done with the formal stuff and I’m off to see my patients.”

Researcher: “What is it about seeing your patients first that’s so important?”

Nurse 6: Well that’s what we’re here for isn’t it? I mean they’re the most important part of nursing the patients. I always want to go straight into the bay...like this afternoon and then patients can see you; they know that you’re there.”

Researcher: “Is there anything that prevents you from spending time with your patients?”

Nurse 6: “Some people say things like oh, you’re really busy today or I can see that you’re really busy or whatever, but I say I’ve always got time for you and as long as you’re kind of...er.. like keeping in touch with them. I’ll go past a patient and I’ll shout “How are you?” you know.. so as long as you’re maintaining that contact.”

Researcher: “What about this afternoon,
Nurse 6: “I come in on shifts like today and I always go round my patients and say hi I’m Diane...em...I’m looking after you today. So at least I’ve made contact with them.”

Others felt that spending time with their patients was more than acknowledging their existence in the caring environment. To some it was important to speak to the patients on a one-to-one basis which allowed for the development of a deeper caring relationship.

Interview Observation 3

Researcher: “Tell me about the time you spent with Florence this morning.”

Nurse 3: “She needed someone to be there for her, I’m sure you noticed how frightened and upset she was, but it’s not just the odd patient you need to be with...em...just sitting down with them and listening to what they have to say. It’s important for me to have some time...em...quality time with my patients when I can.”

Researcher: “Can you explain what you mean by quality time.”

Nurse 3: “Quality time, it’s like how can I put this, it has to be meaningful to the patient It has to have a purpose attached to it...that’s the way I see it.”

Researcher: “What about this morning, can you tell me about the purpose then?”

Nurse 3: It was really to let her know that she had someone there with her. I think it lets people know that you care for them and care about them. I’m not explaining it very well ...I know, but you get this deep sense of caring.”

Spending time with patients can also help foster the care giver, patient relationship; making time for patients, discussing illness or injury, explaining treatment options and care management can help form a bond between the two, helping to provide the care-giver with some insight into the giving experience.
Interview Observation 8

Researcher: “What does having time to spend with your patients mean to you?”

Doctor 5: “It means a great deal. I only wish that I had more time to spend with them... and that can sometimes mean neglecting other things.”

Researcher: What determines the amount of time you spend with your patients?”

Doctor 5: “How much time I spend with them depends on what is happening and how much the patient wants to know. The younger patients are more interested.”

Researcher: “What about the older patients, do you give them the same amount of time?”

Doctor 5: “I think sometimes there might be a little bit of inequality with younger patients, probably you talk to them a little more, you feel they understand it a little bit more and they tend to be more interested. Some of the older patients say don’t tell me the gory details I don’t want to know but the younger patients do. I think these conversations help create a bond.”

Spending time with the patient facilitated the formation of the caring relationship. It was also considered by one nurse to be a friendship which helped bring the care-giver and patient closer together.

Interview Observation 9

Researcher: “You spent some time with your patient this afternoon; can you tell me what value you place on the contact you have with your patients?”

Nurse 1: “It’s vital, it’s all about being there for the patient and being almost a friend but in a professional way. A professional relationship and being an approachable individual, I think that’s what I mean by being a friend, being a friendly face that they see.”

Researcher: “Do you think that creates something unique?”
Nurse 1: “Definitely being there for them and spending time with them and even giving them a friendly hug that brings something vital, a kind of special sense of care and the patient will say, thank you for that...that makes me feel the job is worthwhile.”

Many of the health care professionals expressed concern over their inability to find quality time to spend with patients. They clearly felt that this was detrimental to care and saw it as a barrier when trying to fully engage with patients.

*Interview Observation 7*

Researcher: “Do you always find time to spend with your patients?”

Physiotherapist 2: “I do but that’s not sometimes the issue I have to find time to see my patients but it’s the quality of that contact that’s important, you don’t always get enough time you’re so busy...em...giving people time with the caveat that you don’t always get that time to do what needs to be done...”

Researcher: “Can you elaborate on that a little about not keeping promises.”

Physiotherapist 2: “When I first started I’d say I’ll be back in 10 minutes. I don’t say that anymore because sometimes it can’t be done and I think you should keep true to your word.”

*Interview Observation 1*

Researcher: “It was a very busy evening shift yesterday, how did you feel about that?”

Nurse 4: “You get used to it being like that most of the time it’s a very busy ward...how do I feel about it...well...it’s very frustrating, you might not always have time available to talk to them, that’s a frustration.”

Researcher: “Do you think the patients’ appreciate that you don’t always get the time?”
Nurse 4: “I think most of them do, they say things like you’ve had a really busy day but what worries me are the elderly patients..em..in particular the ones who are confused, they don’t realise and you feel really bad because they don’t understand that you haven’t got time...you go past their bed and they’re calling to you .but you’re in the middle of something and you have to say that you’ll be there soon...but you know you won’t…it’s hard to do that...”

Researcher: “How does that make you feel?”

Nurse 4:“Guilty...very guilty.”

Researcher: “Guilty, tell me why?”

Nurse 4: “...em...because we’re supposed to be there for our patients and you can’t always be there at that exact time when..er...perhaps they need you.”

Interview Observation 8

Nurse 2: “I would like to spend more time with somebody providing explanations and giving them time to talk but you find that that can be hard going at times because you’re thinking about the next job that you’ve got to go and do or the next person you need to see and so on.”

Interview observation 9

Doctor 5: “…you have your lunch hour to see your patients....there’s not enough time really to give any quality of care that you want and to keep your eye on the ball to make sure you’re not missing things.”

Interview observation 10

Doctor 3: “I try and find some time to sit with my patients to make sure they are happy and understand what is going on and they can have input into their care but it doesn’t happen as often as I would like because of constraints placed on my time by other things. If you’re on call you get even less time.”
A few of the health care professionals revealed a genuine dedication to care-giving in their own time, going the extra mile and displaying a commitment to the well-being of their patients.

Researcher: “What do you do about the time constraints on your job?”

Doctor 3: “…….a lot of my time’s spent over and above my hours only because I want to provide the best possible service for my patients. It’s not just what you do 9-5; there are the on-calls, the academic side of things…

Researcher: “Would you say you were conscientious about the care you give?”

Doctor 3: “Yes…I think I would say that..em..when you are conscientious you do come into work a bit earlier because you’re interested to see how you’re patients are getting on. You go and see them first thing in a morning and sometimes stay late to see them.”

One nurse talked about her coping strategy for dealing with the inability to provide time for her patients. This involved learning to avoid feelings of guilt and upset, referring to an ability to ‘switch off’ rather than worry about what was unachievable.

Interview observation 7

Nurse 5: “You can’t be everything to everybody; you start to use mechanisms for switching off but the problem is you feel guilty. I want to spend more time with my patients but the work load can sometimes be so overwhelming.....I know I don’t spend enough time with my patients, I feel that I don’t give quite what I want to give... but what can I do?”

Another nurse relayed her negative feelings about the amount of time she had to spend with her patients; although she found this disconcerting she attempted to alleviate her concerns by offering a positive outcome to her lack of contact.
Interview observation 3

Nurse 3: “It makes me feel bad and you go home feeling oh, flipping heck I really neglected so and so today and that makes me feel awful. I mean you’ve not neglected them but you may not have been there for them as much as you would have liked.”

Researcher: “Does that bother you?”

Nurse 3: “Somewhat, maybe that’s my perception that I’m taking away rather than the patients….the patient may be sitting there thinking I’m actually quite fine here, I’m enjoying the peace and quiet and not be bothered, whereas I’m thinking oh ….they’ve been on their own today, so you know it’s only what I’m taking away from the situation.”

Getting the balance right was seen as problematic, some patients could make more demands on the health care professionals time than others. The care-giver sometimes struggled with the need to develop and maintain a caring relationship in order to ensure that patients were treated equally. Some of the health care professionals felt unable to be firm with patients who demand more of their time, perceiving this to be a personal weakness.

Interview observation 9

Occupational Therapist 2: “There is of course always a time issue….you know once you get started before you know it 15 minutes have passed and you’re thinking I’ve got to get on to see my next patient and they’re still telling you about their Auntie Ann who’s just died so sometimes you’ve got to put a stop to the empathy stuff at some point because you haven’t got the time to be listening to all that, I wish I could be that assertive though….I find it very difficult to stop them in mid conversation.”
Interview observation 8

Nurse 2: “Sitting with them having a little chat, “How are you today?” you know is simple basic care but you have to take care…er…time can run away with you and you’re trying to spread yourself around and get to see everyone. I want to be equitable, although when there is a genuine need to spend more time with someone then that’s fine I just get on and do that.”

7.4.5. Subtheme 5. Providing reassurance and support

Recognizing and being aware of the vulnerability of the patient creates a caring relationship that appreciates the need for reassurance and support by the care-giver. Reassuring and supporting the patient can impart a sense of hope and strength to continue when the outlook may be unknown or bleak.

Interview observation 8

Researcher: “How do you let your patients know that you care?”

Doctor 5: “It’s about supporting your patient and holding their hand through the entire process, we can’t always make things better, sometimes the outcome is inevitable.”

Nurse 2: “I do try my best to make sure that the patient is happy and where I can I’ll try and answer their questions because I think that helps them to cope with what they have to face and it helps reassure them....”

Dealing with problematic and sensitive situations can be very difficult for both the patient and care-giver. Providing support can help an individual face the future, it can signify the value that the care-giver places on the significance of the patient as a human being.

Interview observation 8

Doctor 5: “I know the patient was upset a bit and afterwards the nurse came up to me and ask me what I said to the patient because they were upset.”

Researcher: How does that make you feel?”
Doctor 5: “…I think oh my goodness what did I say?”

Researcher: “So what do you do?”

Doctor 5: “I go back to the patient later and speak to them, leave the waters to settle first...em.. and go back when they are..er.. calm...ask what it was that upset them and..er... try and go through things again with them. Maybe they didn’t understand the first time or something you said was too scary for them.”

The technical ability of the health care professional was discussed and acknowledged as an important consideration; patients need to feel safe and secure, knowing that the person providing the care is competent to do so.

Interview observation 9

Researcher: “Tell me about the care you gave today and what that means to you.”

Occupational Therapist 2: “Well to me it’s giving that person what they need and the person giving it should be the most appropriate person with the right skills giving the patient what they need when they need it.”

Researcher: “How do you ensure that happens?”

Occupational Therapist 2: “I will take into consideration not just the fact that they might have knee pain but how that is affecting their life as in work, home life, physical activity, that sort of thing. It affects different people in different ways and can have a devastating effect on them when they can’t do what they want or need to do. I think OT wise we look at the whole patient and try to get them functioning the way they really want to. We always set agreed goals with patients at the beginning of their treatment, we try and find out what they want not necessarily what the doctor wants. I think you have to give that support and help, it’s really important to think...er.. what does this patient actually want from you as a health care professional.”

Researcher: “Do you find that rewarding?”
Occupational Therapist 2: “I like to help them with any concerns they have and support them or get the right person to support them if I can’t. Getting things done in this respect gives me a...a...better sense of achievement....providing and supporting them.”

Two therapists noticed that the use of touch helped when patients were upset and found that this physical contact enhanced the caring relationship.

Interview observation 7

Researcher: “How do you offer reassurance and support?”

Physiotherapist 2: “...you know we tend to touch the patients a lot as physios...that’s something we do, just a hand, if patients are upset, which they often are, then that physical touch I think helps... it helps you to connect with them.”

Interview observation 9

Occupational Therapist 2: “I’m a touchy feely person.....but it’s just the reassuring hand if you like...I know not everyone likes that so you have to weigh people up but I believe that physical contact like that helps to reassure people.”

The use of nonverbal cues indicated sensitivity to the patients need for reassurance and support. Being responsive to those needs signifies a respect for the patient as an individual and as a human being. In some situations non-verbal cues were seen as being more powerful than words.

Interview observation 4

Researcher: “Tell me how you reassure your patients.”

Nurse 7: “..........it’s picking up on something that the patient may have...em.. a particular concern or worry about.”

Researcher: “How do you pick up on that?”
Nurse 7: “Sometimes they don’t tell you but you can see it in their eyes…em..fear or upset... that sort of thing. Then you need to be able to do something about it even if it’s just going over to them and talking it through or making a phone call to somebody, or just getting extra information. It’s about doing the best you can to support someone.”

7.5. Caring Carative 2. Assurance of Human Presence

Definition: The formation of humanistic-altruistic system of values. Instillation of faith-hope and cultivation of sensitivity to one’s self and others.

7.5.1. Subtheme (3). Treating the patient as a human being

Health care professionals were asked about respecting patients as individuals during care giving. Here respondents talked about their ability to see past the illness or injury and humanise the care giving.

Interview observation 1

Researcher: “Tell me about respecting your patients.”

Nurse 4: “It’s not just about the person in the bed, that person is a human being and that person has needs and wants, they come as a whole package you know, it’s (care) got to be holistic and as far as I’m concerned you’ve got to deal with the whole package, you just can’t deal with the symptom or the injury.”

Concern for the human element in care giving was evident and several respondents intimated that they related to the patient on a human, caring level rather than as a set of tasks.

Interview observation 6

Doctor 1: “Even when you are really busy, you shouldn’t lose sight of the fact that you’re caring for a person, a human being……yeh it can feel as though you’ve got this job to do and that job to do, and quite often you only see the task and not the person.”
Interview observation 2

Occupational Therapist 1: “You have to see the patient as something other than a disease or an injury.”

Interview observation 9

Nurse 1: “Treating my patients as a knowledgeable human being is what I like to do no matter what their level of understanding may be. You have to empower your patients so that they can make their own decisions about their treatment and care and not let them sit back and accept whatever is done for them.”

Although acknowledging the importance of relating to their patients as fellow human beings some health care professionals revealed that in certain situations they found it difficult to accept the diversity of humanity.

Researcher: “Do you see people for who they are when you’re in that caring relationship?”

Interview observation 5

Doctor 2: “….of course you treat people as human beings but sometimes you’re faced with an emergency situation or a difficult patient you focus on dealing with that and then the disease or the injury take over.”

Interview observation 7

Physiotherapist 2: “The problem is that you start your day…everyday with this list in your head of things that need doing... Basically these things have to be done otherwise the patient will suffer...I feel guilty at times because I know I see the tasks as more important than the patient at times and that...er...dehumanizes things.”

The ability as a caregiver to recognize the wholeness of the person was demonstrated in a discussion with one health care professional, describing how being non-judgemental,
even to patients who were deemed ‘difficult’ revealed a special quality and awareness for the concern of others.

Researcher: “Do you feel that you sometimes judge people?”

Doctor 2: “I sometimes let things get in the way of how I feel…”

Researcher: “How do you deal with that?”

Doctor 2: “I have to remind myself that…er…treating people as equal is crucial in caring. It doesn’t matter if they have an obviously different view on something to you. You have got to be fair and equal with everyone and I think that is important. I am not to judge a patient…no…you have to put your thoughts aside and get on and treat them just like you would any other patient.”

The student nurse referred to her professional code of conduct in order to support the commitment to caring for the patient.

Interview observation 4

Nurse 7: “We have a code of conduct that we adhere to that we treat people the way in which we would wanted to be treated ourselves, as a human being and not as a disease, …that we’re not to be disrespectful… that we are kind and considerate and caring.”

One nurse viewed caring as an emotional humanistic relationship between herself and the patient. She refers to her relationship with patients as ‘cold’ or ‘warm’ in order to describe the level of emotional involvement.

Interview observation 4

Nurse 6: “I believe that you get a level of relationship when caring for another human being, you…em..need to treat them as a human being…em..basically. Some of the relationships can be quite cold and some can be quite warm in how they are, you know, and I try to make my relationships warm.”

Researcher: “Can you explain how relationships are made warm?”
Nurse 6: “I’m not sure really… I think basically when you get the odd patient that is quite difficult to nurse then you might not get the same warmth as those, you know, who are pleasant and easier to nurse. I might not be as positive towards those but you still don’t give bad care but I don’t think you get that professional attraction to the patient. It’s like a kind of buzz you get from helping someone, some patients are very grateful for all that you do for them and then there are those that no matter what you do it’s either not right or you don’t get a please or thank you and so you feel different towards them. Like I said you don’t give the care any differently, you still treat them like any other person…human being… but..em.. Mentally you don’t have the same endearment to them.”

Effective communication was also seen as a means of demonstrating respect for the individual as a human being by the care giver. Expression of concern for the patient can be present during the caring communication. Here the health care professionals discussed wanting to develop a trusting relationship instilling faith in the care givers ability to do whatever was right for the patient.

Interview observation 6

Doctor 1: “Good communication is important and very high up on my list…good listening skills and I think you have to be honest with people. Patient should be able to feel that they can talk to you and trust you and you respond by being able to give them hope in what you are doing for them.”

Occupational Therapist 2: “I think communication is the most important thing really…..for a lot of patients. Speaking with them at the right level so you’re not confusing them with terms you know, you’re not baffling them with science, and the other thing is they just want to feel they can trust you so you come across as a pleasant person who listens to people, I think that makes them feel cared for.”

Interview observation 10

Doctor 3: “ I like to give my patients time to talk about their treatment and importantly listen to what they say……I use this to help plan out their care
and...well it’s more than that really...it’s about being an advocate for your patients.”

Interview observation 8

Nurse 2: “I always ask my patients what they want......it shows respect for them as an individual and ...em...doesn’t take them for granted. We’re here for them aren’t we? I mean you look to do what is best for them...at all times, talk to them, listen to them and then you get to know the person.”

Time constraints and work load can be a frustrating hindrance to delivering care; three of the health care professionals interviewed made reference to the way in which they believed such issues impacted upon their ability to care whilst still maintaining the humanistic qualities associated with care giving.

Interview observation 2

Researcher: “Are there negative aspects to caring?”

Physiotherapist 1: “Sometimes working in this job I think we become a little...em...detached from the caring side of it. It’s all about ‘bums on beds’...I mean...Where’s the humanity in that... where’s the benefit to the patient, it becomes like a number crunching game, a statistical game and you know we have got to get them through the system. Well it’s not a production line in a factory.......these are people we are dealing with not some product.”

Interview observation 1

Nurse 4: “Of course....it’s a nightmare, you don’t have enough staff on the ward to cope with the workload and you can see patients that you need to get to but can’t. All the time you’re being asked to get patients out of hospital and so you can’t get to the little old lady in bay C because your time is taken up with pushing people through the system. Then when you do get to see that patient it’s all too late because they’ve had an accident and wet the bed or something and I feel like no one thinks about these people as human beings....it’s criminal.
Interview observation 10

Doctor 3: “I sometimes ask myself if we’re really in a hospital because I think that money comes first and patients second, it’s like the patients are not the priority, and they’re just numbers in the bigger scheme of things.”

7.6. Patient findings

Patients were asked to talk about their recent admission to hospital in order to help the respondent relax and discuss a topic that they felt at ease with. Four out of the eight patients interviewed had been admitted to hospital as an emergency admission and the researcher was very conscious that this question could have evoked painful memories. However, this did not cause any of the four patients any undue stress or upset and they were able to discuss their experiences comfortably. It was interesting to note that three out of the four patients admitted as an emergency described feeling foolish or stupid about their accidents.

Patient 1: “I slipped down some steps and broke my ankle, silly thing to do. I was trying to decorate the front room and I was up on the ladders and thought I had my foot secure but didn’t and fell off. It was awful, so painful, I knew I’d done something straight away and I yelled for the wife to come and help. She just rang for an ambulance, I felt so stupid.”

One patient recollected how she felt embarrassed by her accident at the time but recounted the experience with amusement.

Patient 3: “Well, it was bad at the time but now I just look back and laugh because I think to myself how on earth I did that...probably not concentrating or watching where I was going.”

Another patient discussed how he had been told to stay indoors by his daughter but felt that she was being over cautious about the weather at the time and was reluctant to break his daily routine.
Patient 5: “How did I break my hip? By being a proud and stupid old man and not letting someone else go to the shop for me. Oh it was so quick I don’t remember actually falling over very well, except I know that it was icy outside.”

Not all the patients admitted to hospital as an emergency had sustained a fall, one patient had been experiencing back problems for several weeks.

Patient 8: “I had been feeling under the weather you know for weeks, pain and aching in my back, I went to the doctors, then to clinic to see the specialist and then scans and tests and the next thing is I’m in hospital with an infection in my spine. Can’t understand it, silly thing to happen really, I suppose you don’t know what’s round the corner.”

By comparison the four patients who were planned admissions to hospital expressed their feelings of anxiety and worry about going into hospital and impending operations.

One patient had been admitted to hospital on three previous occasions all of which related to an on-going hip problem. Prior experience and knowledge of “what was to come” did not alleviate her fears of going through more surgery.

Patient 2: “I think you always worry; you can’t help but worry because you’re having an operation, you’re having an anaesthetic and you know there’s always risk attached to those things.”

These fears were echoed by a patient who also had been in hospital on a number of occasions.

Patient 7: “I’ve been in and out of hospital over the past 2 years, the last admission was my fourth one in that time but it doesn’t matter how many times you’ve been in… you still get nervous about it all and worried that everything is going to be alright.

Trying to cope with mixed emotions about their pending surgery was evident in discussion with two patients. Conveying their joy and relief of having their operation
which meant an end to pain and discomfort, but at the same time there was an expressed fear of something going wrong.

Patient 4: “I was relieved to be going into hospital because I was in a lot of pain and knew it had to be done, but then obviously anxious in another because it’s surgery you know and all the things that go with that.”

Patient 6: “I was a nervous wreck the day I went into hospital, I cried because I was really scared, you read about these things that go wrong and then I saw this programme were this woman woke up in the middle of her operation and could feel everything. But at the same time, you know I’d been waiting for that day for what seemed forever, because I was in a lot of pain and discomfort so I was glad to be in hospital.

7.6.1. Caring Carative 1. Respectful Deference

Description: Development of a helping-trusting relationship promotion and acceptance of expression of positive and negative feelings.

7.6.2. Subtheme (1) Compassion

Acknowledging the care-giver as demonstrating caring and compassion was very important for all of the patients interviewed. They felt the health care professional needed to possess this quality in order that a caring relationship could be established. They also intimated that the health care professional should have an understanding and appreciation of their illness or injury so a bond could be formed between the two parties.

Caring relationships can form naturally and almost effortlessly possessing a sense of harmonization between patient and care-giver, two patients gave examples of such relationships.
Interview observation 7

Researcher: “Tell me about the care you received during your stay in hospital.”

Patient 2: “…it was good..em..there was a nice atmosphere..er ...like when I got back to the ward after my operation the nurse was someone I knew from the last time I was in hospital and she remembered me and that was really nice, somebody who remembered and she was fabulous. So I was thinking ‘Oh’, you know, ‘I’m in good hands’, and she was so kind and considerate and nothing was too much trouble. You could tell that she was a very caring and compassionate person.”

Patient 4: “…well she seemed to know what I needed..er...at times she had this sort of second sense...I remember one day I was thinking about needing the toilet and she just appeared and asked me if I wanted anything..er...I know you could say that was coincidence but well it happened…”

One patient felt that his caring experience was something more than the staff doing their job. The vulnerability of the patient in the caring environment quite often means that the effects of the caring relationship are interpreted as something much stronger than expected.

Interview observation 4

Patient 5: “The staff were all very caring, they were doing their job, but it was more than that. What I’m saying is that when someone is caring and understanding then it tells me that they’re thinking of me and sympathizing with my situation, I matter to them.”

One patient summed up her care as simply feeling;

“Loved and looked after.” (Interview observation 10)

One patient referred to the staff going out of their way to help meet his concerns, addressing issues which he had with his wife who was disabled. As the main carer for his wife, he was anxious about how she would cope without him. He interpreted the actions
of the staff as something more than caring for him and because of their concern for his wife he felt a heightened sense of caring.

*Interview observation 1*

Patient 1: “As soon as I came in they put me at ease, I was really worried about my wife, she wasn’t very well at the time of my injury and all I could think about was her but they were all very good. I could see that they were all very busy but they went out of their way to sort things out for me and kept my wife informed of what was going on, yes, that eased my mind a lot. I knew I was in good hands because if they were bothered enough to do that for me then that was great….yeh, well it shows real compassion doesn’t it.”

Not all of the patients felt that same bond with the health care professionals delivering their care. They found that some of the staff were not able to enter their realm and empathize with their situation.

*Interview observation 5*

Patient 3: “Very few are empathetic with you because they don’t understand unless they’ve actually been through it... what the pain is like. Yeh..you assume that they do and I think that’s quite different to knowing what it’s all like and sometimes when things are a little difficult, some of them were a little impatient because they think you should be moving around quicker, but sympathetic... na...I think they would have to be me to understand.”

The quality of the caring relationship determines whether the patient’s experience has been positive or negative. Unfortunately for this same patient the encounter was negative; she cited examples of being made to feel like a task rather than a person and that staff failed to understand what she was experiencing.

Researcher: “Tell me about your experiences.”

Patient 3: “I don’t think they were interested in me...because I’m an ex addict you know...yeh. they weren’t kind to me...ay..you were there, .you saw how that one
doctor spoke to me...accusing me of still taking the hard stuff. What the fuck...oh...sorry can I say that on the tape...oh just wipe over that bit...ha...ha. Yeh like you would think should be there...you know being nice. Isn’t that what they’re supposed to be nice and all that. I felt like I was a task.”

Researcher: “Tell me what you mean by a task.”

Patient 3: “I mean they came to do a job like that doctor and all that........but they were very...well I think they were judging me..I think they thought I was a nuisance.”

Emotional support was a particular focus for one patient who felt that although her care was good the ward staff were so busy that she did not get, in her words any “quality time” with the staff. She felt that this support would have improved her ability to handle worries and concerns arising from her operation and subsequent rehabilitation.

Interview observation 1

Patient 1: “Everyone was very good, I had good care but...er.. sometimes I think what was done was all very...em... rushed at times. The staff were so busy they didn’t really have time to sit and listen (pause) that’s what I think was lacking, being able to talk to them because I times I was very worried.”

7.6.3. Caring Carative 2. Assurance of human presence

Definition: Formation of humanistic-altruistic systems of values. Instillation of faith-hope and cultivation of sensitivity to ones’ self and others.

7.6.4. Subtheme (2) Being treated as a human being

Two of the patients interviewed felt that during the caring interaction the staff established a caring relationship which enhanced and preserved their dignity and humanity. They recognized the inclusion in their care planning and management as an important consideration, one that gave them a sense of partnership in the caring moment and ultimately the caring relationship.
Interview observation 9

Researcher: “Do you feel that you were valued as a patient.”

Patient 6: “I felt that I could give my opinion about what I wanted and that the staff were okay with that, they valued my opinion and that was importance to me because it made me feel that they valued me as a person...they saw me as a person and not some condition.”

Interview observation 4

Patient 5: “I hoped that the care would be good and it was but it was more than that, it was the way in which the staff made you feel as through what you wanted and you were important to them, yes, I suppose it made me feel valued and that we were in this together.”

Interview observation 10

Patient 2: “…it’s the little things that they do and say that says...er...they know they’re dealing with a person...they ..em...respect you for who you are.”

Handing over control to the patient by health care professionals reinforced the feeling of worth and value as a human being. A patient who had been hospitalized on a number of occasions recalled a positive relationship with one of the doctors. She felt that being included in any decisions relating to her treatment helped her to have a positive experience and crucially a positive relationship with the care-giver. She saw the role of the health care professional as one of nurture and support throughout. Allowing the patient to be in control indicates a willingness on the part of the care-giver to empower the patient and assist them to experience a good caring relationship.

Interview observation 6

Patient 8: “They were very good, very pleasant and made me feel that it was my opinion that counted...I was relying on them for guidance to help me through, one doctor told me that I was in the driving seat, he was just the passenger which I thought was a nice way of saying it was up to me.”
The same patient found that this empowerment extended to her basic physical care. She explained that the day after her surgery she was feeling unwell, when the staff came to help her get washed they acknowledged how she was feeling at that moment and respected her individual needs.

Patient 8: “One day I didn’t feel particularly well, I could see them starting to help others get washed and sit out of bed, I thought I can’t do it...I just felt so unwell, really sick and didn’t want to be bothered and the staff nurse said that if I didn’t feel like a wash at that time I could have one later when I felt like it which I thought was very nice... I wasn’t a task... she respected my wishes.”

One female patient had been admitted to the orthopaedic elective ward for hip surgery; she recalled how one of the doctors had spoken about her operation and discussed the surgical options. She was surprised at being given the final decision.

Interview observation 10

Researcher: “Do you feel you were allowed to make decisions about your care?”

Patient 7: “I remember the doctor, she was very good and I saw her almost every day, she was very good and he was informative, she cared and she listened to me and my concerns. She said that I could decide what I wanted to do about my hip, she went through the options then said I could have a think and let her know.”

Researcher: “Were you happy with this?”

Patient 7: “I wasn’t sure you know...em... what to say because she was the expert...what if I made the wrong decision...I mean I’d go along with what she thought was best.”

Another male patient admitted to the trauma ward discussed how he was happy to be a passive partner in the caring relationship and seemed completely at ease with this status. He indicated that had the need arose, he would have taken a more active role in his own care.
Interview observation 1

Patient 5: “I didn’t want to be in a position to have a say about being involved in my care. They were the experts, I wasn’t and I was totally in their hands.”

Only one patient interviewed had negative experiences in respect of having a role in care planning and decision making. Stating that she was never consulted about what she wanted and felt she couldn’t ask questions relating to her care for fear of ridicule.

Interview observation 5

Researcher: “Were you encouraged to ask questions?”

Patient 3: “No…I don’t think so...em...sometimes I wasn’t keen to ask questions or anything because you felt that they didn’t want to talk to you at times and that made me feel a bit stupid. I don’t think they were interested in me you know as a person.. I think they had things to do and just did them.

Researcher: “How about planning your care?”

Patient 3: “I would say that apart from when it was time to go home, you weren’t included in the care planning by your bedside, which was all done away from you. In fact I wouldn’t know what was in my care plans.”

The patient went on to talk about lack of information and inclusion in her overall care. She was angry about what she termed “a failure to acknowledge her existence.”

Patient 3: “…I couldn’t fault the care but it was basically if they needed to do something with me they did it and that’s where it ended. No one asked me what I wanted... how I was coping, that didn’t happen, I might as well have left my shoulder there and told them I’d be back to pick it up when they’d finished with it... so my experience was not brilliant, things could have happened that didn’t. I basically felt that they were focusing on the shoulder problem and not on me.”

One of the patients who had generally been happy with her care overall relayed an incident in the anaesthetic room. She said that she had not been instructed to remove her
underwear before going to theatre. Just before her operation a member of the theatre staff noticed she was still wearing them. This made the patient feel uncomfortable and embarrassed, what she required was the staff to be responsive towards her needs and feelings.

*Interview observation 7*

Researcher: “Did you feel you were respected throughout your stay in hospital?”

Patient 2: “On the whole yes but...em...there was this one incident...I mean I can laugh about it now but em...I was in theatre and the staff were checking my details and one of them said ‘Oh, you’ve still got your knickers on and...er... there was nowhere to take them off because I was in the anaesthetic room so they had to take them off for me and I found that very embarrassing, it wasn’t nice and she didn’t consider me as a person in all this.’”

7.6.5. Subtheme (3) Good communication

Patients felt that good communication was important in helping them to understand and cope with their treatment. When asked about whether they felt that they had received sufficient information about their care and treatment several patients agreed that they had.

*Interview observation 10*

Patient 7: “They really explained things well you know without the explanation being too modified, it was great and I got the information I wanted...before my operation the doctor went through all the things and told me everything and then she asked me if I had any questions.”

One patient explained how the information given had helped alleviate fears instilling confidence about her mobility so that she felt able to cope on her discharge from hospital.
Interview observation 9

Researcher: “Tell me about the information you were given by the staff.”

Patient 6: “…because I was keen to get out of hospital as soon as possible they gave me enough information to make me realise that I could manage when I got home. That helped me because it is frightening going home after an operation..yes…em… they gave me lots of advice.”

Not all patients appreciated everything they were told, with one patient recollecting that some information was too much information and would have preferred not to have known.

Interview observation 1

Patient 1: “I was told everything, including some of the things I didn’t want to hear but that was me ..I’m not very good at the gory details…I could have done without that, but I was very pleased with how they took the time to tell me about my treatment and what I could and couldn’t do.”

By comparison one patient felt that the staff were frequently too busy to stop and talk and that the opportunity to promote intentional human connection was lost.

Interview observation 5

Researcher: “Do you feel you were given enough information?”

Patient 3: “When I got downstairs to the ward the staff were very busy so it was difficult to discuss things with them……but you couldn’t catch them to ask them anyway.”

Researcher: “What about when the doctor came to see you?”

Patient 3: “she came in, focussed on what she had to do, never said a word about what do you want to know..em..or anything like that. Now anybody when they walk in can say ‘How are you?’ or, you know, I don’t even remember it happening ha..ha, .probably still under the influence, .ha...ha.”
7.6.6. Subtheme (4) Helping the patient

Patients were asked about how helpful the staff had been during their hospital stay. On the whole patients felt that the staff were available when needed, it was interesting to hear how some patients felt uncomfortable asking for help when they could see that the staff were busy. Even when talking about their experiences in a negative sense they felt compelled to justify not getting help by offering an explanation in support of the staff.

Interview observation 7

Researcher: “Tell me about the staff.”

Patient 2: “…really nice really helpful and in fact one of the physios who I didn’t even know stopped me yesterday and pointed out that my crutches were too high and I hadn’t realised they were. So she lowered them down just there and then on the corridor, she thought I looked uncomfortable and so stopped to help me and that was lovely.”

Interview observation 8

Patient 4: “I really had a bad time that day getting out of bed and Peter came in and he saw I was struggling and asked me why I hadn’t rung the bell. I said that I knew the ward was very busy and so didn’t want to bother them and he said I wasn’t to think like that and to always ring because they were here to help me.”

Interview observation 10

Patient 7: “…they taught me how to use a Zimmer frame so I had a couple of tries and I found it difficult at first but they kept going over things with me and helped me to get the hang of it, they wanted to make sure that when I got home I was safe and capable of getting around.”

Interview observation 5

Patient 3: “I didn’t get helped out of bed until the day after my operation which I felt upset about. The physios came the day before but said because it was late in
the day they’d leave me, I felt I could have got up at that time with their help but it was their attitude. One thing I would say is though with the ward staff, once you could get yourself out of bed they were never really bothered about helping you.”

Researcher: “What happened when you got up?”

Patient 3: “There wasn’t even a chair to sit on whilst you were having a wash. I had to try and manage the best I could without help. I had to try and have a wash holding onto the sink. Sometimes the help just wasn’t there, I felt as if I was left to get on with it.”

Interview observation 1

Patient 1: “…the staff were very busy so at times it was a case of manage yourself or wait a long time to get any help, that’s not their fault, I mean it was a really busy ward.”

7.6.7. Caring Carative 3 Attentiveness to the other’s experience

Definition: Assistance with gratification of human needs and allowance for existential-phenomenological-spiritual forces.

7.6.8. Subtheme (5) Giving good physical care

The researcher wanted to elicit responses that referred to how well staff provided physical care and met the patients stated and unstated physical needs. Overall the consensus of opinion was that the staff made patients feel as comfortable as possible. This feeling of comfort went further than a sense of physical wellbeing; psychologically it made some feel ‘secure’ or ‘loved and cared for’.

Interview observation 6

Researcher: “How did you find the care overall?”

Patient 8: “There were staff who were just good care givers. Obviously there was a lot going on, the ward was busy but I can’t praise everyone enough. I watched them with this little old lady, she was crying and shouting out all the time but they
really looked after her and they were washing and feeding her. She looked really well cared for, it was nice to see how they looked after her.”

Interview observation 7

Patient 2: “…the team, together they worked perfectly, really caring, attentive, very over worked. I didn’t see the impact of that, no negative things I was really happy with the care I got. They seemed to know exactly what I needed, I suppose they’ve seen it all before and know what you need. If I had to sum it up I would have to say loved and cared for.”

Attention to detail for some patients was apparent in the caring interaction and signalled that staff were able to care in a way that was described as more instinctive than taught. This acknowledged an instinctive caring consciousness which manifested in the caring acts taking place during caring moments.

Interview observation 4

Patient 5: “It was the little things; it was obvious that they had been doing this for a long time but those things you just can’t buy. You could put someone through 12 years of training and you still wouldn’t have those skills, they’re instinctive you know. They met my needs and when you have care like that it helps you feel that they are there for you and not just doing their job. It made me feel safe and secure.”

Interview observation 10

Patient 7: “They made me feel secure and that made me feel less worried about things, I wasn’t somebody shut away in a side room, even though I was in the side room some of the nurses, the way they looked after me, especially on nights, was really, really good. I couldn’t thank those staff enough because they nurtured me through that experience and the care they gave was second to none.”
Interview observation 8

Patient 4: “I felt very helpless because I had to stay in bed for a few days and they looked after me very well. Overall I had good nursing care; some of the staff were exceptional in the care they gave. The day after my operation my wound was leaking, there was no problem, they noticed it and changed the dressing. Once the wound started to blister and they said I was allergic to the dressing and they went to look for one I wasn’t allergic too. They got this other nurse to look at it, I think she specialized in wounds, anyway she told them to use this special dressing and that was great. So they made sure that I had the best advice and care.”

Three patients indicated that although care was good the question was raised as to the caring intention. Furthermore, negative responses to patient issues and concerns by health care professionals, generated a perception by the patients that they were seen as a nuisance and felt uncared for.

Interview observation 5

Patient 3: “The physios gave good care that’s all I can say..em.. but you know they didn’t engage a lot and I think that should be part of good care, don’t get me wrong, I mean I was happy with the care they gave, I’m just saying that I felt sometimes that they were more interested in caring for my knee than me..er..myself. I asked one nurse if I she could have a look at my dressing and she just snapped at me saying she was too busy and it would have to wait. You hear about infections and that; I was worried and wanted someone to have a quick look. Its basic care and even if you are busy there’s ways of saying so. That really upset me, I thought she doesn’t care.”

Interview observation 9

Patient 6: “I couldn’t fault the care it was great, no, everyone was good, you had the odd exception, some staff were a bit distant and you got the impression that they were there to tick a job off their list and move onto the next but no, on the whole good.”
Interview observation 1

Patient 1: “I can’t be too critical of the care I mean you came into contact with so many staff that some were okay, some were good, some fantastic and there again some were awful. It’s a shame in a way because I think if you have a bad experience in hospital it doesn’t matter how good everything else is that one…er... negative can really let everything else down.”

7.7. Chapter summary

Each patient and health care professional interviewed following the observed interactions was keen to discuss their own perceptions and interpretations of caring behaviours. Some patients were, at first, a little hesitant to elaborate on any negative aspects of care but as the interview progressed they relaxed and consequently their statements became more profound.

The health care professionals seemed to hesitate on questions concerning their own interpretation of caring and what it meant to them as individual providers of care. The researcher felt that this was due to the diversity of the nature of caring rather than an inability to answer the question. Some of the health care professionals gave quite generalized answers relating to caring where others referenced their answers to personal experience. Each answer only served to endorse the conclusions drawn from the literature review in Chapter Two, caring is complex, ambiguous and subsequently a utilitarian view of this phenomenon will possibly not be reached.

From the health care professional interviews the top five subthemes and their associated carative categories were identified as:

- Being compassionate - Respectful Deference
- Respecting the other’s experience – Respectful Deference
- Treating patient as a human being – Assurance of human presence
- Spending time with the patient – Respectful Deference
• Reassurance and support – Respectful Deference

In this group four out of the five top subthemes fell into the Respectful deference category.

In comparison the top five subthemes and their associated carative categories evident from the patient interviews were identified as:

• Compassion – Respectful Deference
• Being treated as a human being – Assurance of human presence
• Good communication – Assurance of human presence
• Helping the patient – Assurance of human presence
• Giving good care – Attentiveness to the other’s experience

Here three out of the five top subthemes fell into the Assurance of human presence category. The caring caratives and their associated subthemes shown in diagram 1 and 2 are representative of the caring behaviours that are important to the health care professionals and patients. From the semi-structured interviews in was concluded that the health care professionals considered caring behaviours that fell into the respectful deference caring carative as the most important whereas patients valued caring behaviours relating to assurance of human presence as the principal caring carative. Chapter Eight will discuss the research findings.
Diagrams 1 and 2: Main themes derived from interviews
CHAPTER EIGHT

Discussion

8.1. Introduction

The aim of this research study was to explore patient and health care professionals’ perceptions of caring within an orthopaedic setting of an NHS Foundation Trust Hospital from an ethnographic perspective. Orthopaedic patients have rarely been asked about their perceptions of care and caring and never before has a study investigated this in relation to the multi-professional orthopaedic team. In that respect this study was groundbreaking. All respondents stated that they had benefitted from participating in the study signifying the importance of obtaining opinions of care and caring.

With its earliest roots in anthropology, the traditional focus of ethnographic research has progressed in recent years to encompass new settings and its application has grown to include small scale research studies with focus on the meaning of individual’s actions and explanations, rather than quantification (Hammersley, 1991).

The researcher brought to this study over thirty years’ experience as a Registered General Nurse with a specific interest and qualification in the field of orthopaedics; working as a Clinical Nurse Specialist for 10 years and in 2007 appointed to the position of Consultant Nurse in Elective Orthopaedics, the first post of its kind in the United Kingdom.

8.2. Discussion of results

Within the framework of Watson’s theory of care, caring behaviours exhibited and valued by health care professionals were uncovered and compared to those valued and desired by patients. These insights are now discussed within a proposed conceptual framework that will illustrate the complexity of perceptions of caring in the orthopaedic setting. The discussion will extract information revealed during analysis of the data to aid in the confirmation of knowledge and the emergence of new knowledge in the way that patients’ perceive the care they received and health care professionals’ perceive the care they gave.
8.3. Caring Behaviours

The first broad area that emerged from the research findings was that of caring behaviours as valued by patients and health care professionals. This provided a foundational knowledge base upon which further qualitative information was obtained in order to construct a theory of caring.

Caring behaviours are fundamentally actions that are characteristic of showing concern for the well-being of others and encompass a wide range of activities. The research found that patients and health care professionals have similar and yet different opinions as to which caring behaviours they value and indeed display during caring interactions.

Using the Caring Behaviours Inventory (CBI, 1984) questionnaire allowed the research participants to convey which caring behaviours where of importance. The responses of the patients to the CBI revealed a critical reflection of their perceptions of caring behaviours during recent periods of hospitalization.

An important finding of this study emerged from analysis of the questionnaires. Although caring behaviours were ranked according to importance for each patient participant the scoring for each of the caring behaviours described in the tool was significantly lower compared to those valued and ranked by the health care professional participants \((p=0.02)\). Statistical analysis confirmed that the health care professional group, unlike the patient group, gave a higher mean value for each item of the CBI overall. This is a significant finding as it indicates that health care professionals perceive a higher positive perception than patients of their own caring behaviours. For caring to be meaningful there needs to be a common understanding between patient and health care professional as to what constitutes caring behaviours (Larson, 1981). Health care professionals cannot assume that what they perceive as caring behaviours are viewed by patients in the same light or that patients view those behaviours as they are intended (Zamanzadeh et al, 2010). Put simply, healthcare professional’s espoused beliefs about care and caring may not translate into everyday caring behaviours or practice. Therefore it is imperative that health care professionals seek to validate the care they provide with the patients they care for (Christopher & Hegedus, 2000; Widmark-Peterson et al., 2000). Otherwise any
discrepancy in perceived importance of caring behaviours between health care professional and patient could result in the needs of the patient being unmet and subsequent dissatisfaction with care received (Chang et al., 2005). Generally empirical studies on caring in relation to nursing have unearthed similar significant differences in perceptions of caring behaviours (Chang et al., 2005; Hajinezhad et al., 2011; Larson, 1984; Larsson et al., 1998; Papastavrou et al., 2012; Widmark-Petersson et al., 2000). The analysis of the CBI data for this study has added new information to the knowledge base in relation to other health care professionals. Although findings show similarities and differences were apparent in respect of health care professional’s perceptions of what constitutes caring and patient’s perceptions of what makes them feel cared for. In comparing the top ten most important behaviours the patient sample and collective health care professional sample agreed on five out of the ten behaviours, (1) treating patients as individuals, (2) supporting the patient, (3) demonstrating professional knowledge and skill, (4) paying special attention to the patient during first times as hospitalization treatments and (5) appreciating the patient as a human being. It is important to stress that although significant differences in means exist between the top 10 most important caring behaviours and the 10 least important caring behaviours, it is not appropriate to assume that the 10 least important items are any less important to the respondents.

The most frequent caring behaviours reported by all participants in Stage One of this study were attributed to the caring carative of respectful deference. Although the order in which this carative or subscale was ranked differed amongst all of the groups but was most prevalent in the physiotherapist group. The occurring frequency of this subscale compares with Brunton and Beaman (2000) who reported that respectful deference was the most frequently occurring carative in a study of nurse practitioners. Respectful deference is concerned with the development of a helping-trusting human caring relationship (Watson, 1979). This relationship is formed as a result of entering into the experience of the patient; through effective communication processes the patient is able to explain their own perceived level of illness and caring needs. Interestingly aspects related to spiritual and emotional needs during the caring interaction and formation of a caring relationship were considered less important by all respondents when the corresponding questions of the CBI were analysed. Spirituality definitions consistently
include the search for meaning and hope (Highfield, 2000; Miller et al., 2003; Mytko, 1999; Walton, 1996). On a clinical level emotional and spiritual needs may interrelate (Clark et al., 2003). Spirituality has been shown to decrease levels of anxiety and depression; furthermore the literature supports the notion that caring for spiritual and emotional needs in patients employs behaviours such as support, sensitivity, empathy, comfort and attentiveness (Clark et al., 2003, Miller et al., 2003; Watson, 2001; Walton, 1996). It is probable that respondents to this study may have viewed spiritually in terms of religious needs rather than relating it to behaviours such as empathy and offering support. This interpretation of the CBI question supports one of the fundamental disadvantages of self-administered questions, the inability of the respondent to ask for clarification of the questions being asked (Parahoo, 2006).

Caring relationships are by their very nature based upon the ideal that in order to care or be perceived as caring the caregiver must enter into a relationship with the person to whom the care is intended (Paterson & Zderad, 1976).

Reflected in the CBI responses for the patient group, the required behaviours for this relationship are indicated as being treated as an individual, being listened to and being supported throughout treatment and recovery. Being treated as an individual is an important part of forming an I-thou relationship as opposed to an I-It relationship (Buber, 2010). This type of relationship must be exclusive and unique in its intensions, the incentive behind the development of the relationship must be determined from the onset (Buber, 2010). For the patient group the goal is to attain a partnership in care with the multi-professional team which best serves their health care needs. Oflaz & Vural (2010) maintain that patients give relevance to instrumental caring behaviours such as taking a blood pressure. This is because they consider that patients recognize technical nursing activities more than others, taking the greatest proportion of nursing time. Watson (1985) felt that instrumental care could be fundamental to establishing a caring moment. In subsequent studies nurse caring was found to be associated with expressive and relational behaviours (O’Connell & Landers, 2008) rather than instrumental care (Papastavrou & Efstatthiou, 2010). In the majority of observation vignettes this was found to be true in this study, with health care professionals displaying positive caring behaviours through

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the medium of technical activity. What was evident from the findings was that on the whole technical activity was the trigger for the caring interaction. Patient need, which can be physical, psychological, social, triggers a technical activity which triggers a positive/negative caring moment. It was rare to see any health care professional approach a patient that wasn’t activated by a technical activity or by being solicited to do so. This was acknowledged during staff interviews:

Physiotherapist 2: “The problem is that you start your day...everyday with this list in your head of things that need doing... Basically these things have to be done otherwise the patient will suffer...I feel guilty at times because I know I see the tasks as more important than the patient at times and that...er...dehumanizes things.”

Nurse 4 “you go past their bed and they’re calling to you...but you’re in the middle of something and...em...you...em...have to say that you’ll be there soon...but you know you won’t...”

Patient 6 “some staff were a bit distant and you got the impression that they were there to tick a job off their list and move onto the next but no, on the whole good.”

During the interviews healthcare professionals were asked to describe what caring meant to them. Each gave thoughtful and meaningful answers using terms such as ‘valuing the patient’, showing interest in the patient’, ‘helping the patient’ and ‘showing concern for the patient’. Several respondents talked about caring as being ‘instinctive’ or that they were ‘naturally caring’. This is reflected in the work of several researchers in the field of caring who refer to the basic form of care as ‘natural caring’ and as being a moral attitude, setting out to do no harm but rather actively contributing to the well-being of others (Davis, 2005; Flinders, 2001; Gabard & Martin, 2003).

The notion of helping someone encompasses many qualities such as compassion, kindness, thoughtfulness, gentleness, consideration, concern, empathy, sympathy and love. It suggests that someone is in need and that another person has the capacity to assist. One important comment was that caring was “part of who I am”. This can be seen as arising from the ontological model of caring which is considered a way of being and is engrained in our former experiences and is a structure of human existence (Heidegger,
1978; Van Hooft, 1996). By comparison patients referred to their perception of caring as “being in good hands”, “kind and considerate”, “compassionate”, and of feeling “loved and looked after”. Compassion was an important subtheme in the interviews and throughout the observations and was perceived as an important caring behaviour for patients and healthcare professionals. There was a sense that patients needed to feel that someone understood and cared about them. A compassionate approach was a source of comfort and well-being. Compassion was referred to by most staff respondents as an act which involved physical expressions of care, touch, being tender, empathetic. Staff felt that it was important to show compassion during caring interactions rather than just carrying out the technical aspects of care. They felt that caring and compassion were synonymous and that one could not exist without the other. Staff found it difficult to define compassion in terms of its importance and what it added to the caring relationship. They did relate compassion to the notion of ‘helping the patient’ and trying to understand what the patient was experiencing in terms of illness, pain, anxiety. Ricoeur (1994) discusses the idea of seeing oneself as another, concluding that the ‘others’ problems, concerns and suffering become our own and this allows us to connect with the other. The patient respondents emphasized how fundamental this was to the caring relationship, they too intimated that the healthcare professionals should be able to understand and appreciate their patients’ illness or injury in order to form a close bond.

Previous research has shown that the patient experience is influenced by illness, episode of care and the context of the care situation (Aiello et al., 2003; Bleich et al., 2009; Larabee et al., 2004; Quintana et al., 2006; Stockdale and Warelow, 2000). Johansson et al. (2002) stated that effective factors influencing satisfaction with caring included the socio-demographic background of the patient. In order to ascertain if similar predictors were present in this study the CBI contained further questions relating to socio-demographic data. The findings of this study indicated that there is an association between educational level ($p=0.01$) and health care profession ($p=0.04$), both these influenced the ranking of caring behaviours and were found to be significant indicators of positive perceptions of caring behaviours. Those with secondary education status attained higher mean CBI total scores than those educated to other higher levels. Consistent with other research this study demonstrated that patient gender, age, marital status and
ethnicity do not have a profound impact on satisfaction with care and were not found to be significant indicators of positive perceptions of caring behaviours. (Aragon, 2003; Cronin & Harrison, 1988; Hall & Press, 1996; Soleimanpour, 2011). This is not the findings of all studies as Greenhalgh et al. (1998) found that male nurses were less likely to be accessible, carry out caring behaviours or form trusting relationships.

It was found that nurses rated a greater positive perception of caring behaviours overall compared to the other health care professional groups. This indicates that nurses know their patients well enough to judge what aspects of caring patients consider important in order to feel cared for.

The occupational therapist group were the second highest raters followed by doctors then physiotherapists. As in previous studies data analysis showed higher educational levels were predictors of higher dissatisfaction ($p=0.05$). (Quintana et al., 2006; Sahin et al., 2006; Soleimanpour, 2011; Thi et al., 2002).

Quality of care is a dynamic theory: it is dependent upon factors including individual perspective, timescales over which it is measured and the purpose of any applied measures (Chin and Muramatsu, 2003; Currie et al., 2005). Different healthcare professionals have varied opinions as to what constitutes quality health care (Degeling & Maxwell, 2004; Firth-Cozens, 2001; Flynn, 2005). According to Attree (2001), patient satisfaction, meeting patient’s physical and psychosocial care needs tend to be a focus of the nursing profession. This may well have been true ten years ago but the research literature demonstrates that many healthcare professions are beginning to take interest in these particular care needs and outcomes. Certainly the professional groups are by no means homogenous and therefore views of members of the same profession could differ (Currie & Suhomlinova; 2006; Ferguson & Lim, 2001; Willcocks, 2004;). This study adds to this argument in that interview statements were noted to vary amongst the same healthcare professions.
8.3.1. Watching over the patient

The highest ranked caring behaviours for patients fell into the caring carative subscale respectful deference with patients indicating ‘watching over the patient’ as the most valued. This caring behaviour represented patient’s knowledge that health care professionals were close by and providing an element of surveillance. Several of the patients interviewed stated that knowing staff were close by engendered a feeling of safety.

Patient 7: “They made me feel secure and that made me feel less worried about things”.

Patient 2: “...well she (the nurse) seemed to know what I needed...er...at times she had this sort of second sense...”

Whilst staff felt that being visible was an important element of caring:

Nurse 6: Well that’s what we’re here for isn’t it? I mean they’re the most important part of nursing...em...the patients. I always want to go straight into the bay...like this afternoon and then you see...em...patients can see you, they know that you’re there.”

The science of caring not only allows for the provision of physical care but also facilitates the ability of the individual health care professional to move beyond the realms of attending to physical needs into psychological and even spiritual care (Watson, 2001). Watching over the patient incorporates this holistic approach to care consisting of a circular pathway moving from the physical to the psychological to the spiritual back to the physical. The notion of watching over the patient relates to a desire to be kept safe (Schmidt, 2010), it is an acknowledgement that the positive presence of the caring professional helps to create a healing environment that is supportive, protective and corrective within the physical, psychological and spiritual pathways of care. These caring attributes were determined by Roach (1993) in the Five Cs of Caring and by Sherwood’s (1997) Therapeutic Caring Model in which they attach importance to creating a healing environment by valuing the inimitability of the individual patient through the demonstration of certain behavioural characteristics. The healthcare professional enters into a relationship via empathetic and therapeutic means in order to provide humane
sensitive care. Henderson (1964) argued that this humanistic practice was quintessentially nursing and that was probably true of its time. With the realization by other professions that humanism is a valued belief, Henderson’s statement can no longer remain applicable solely to nursing practice as this study reveals that patients value its emergence in other health care professionals. The patients in this study recounted incidents where they felt uncomfortable in summoning help when the nurses appeared too busy. Likewise nurses voiced their concerns more than the other health care professional groups at lack of time spent with their patients.

Watching over the patient is a complex care need and often not fully met a factor evident by the low scoring for the overall question in the patient group but even more telling from the health care professional respondents. Only the nurse participants who completed the CBI ranked watching over the patient in their top ten caring behaviours, it was absent from the other professional groups top ten ranking and featured very low in the overall rankings of the 42 question CBI in respect of the health care professional groups. The watching over the patient item exhibited the most striking difference in that although it ranked first in the patient sample it was not ranked in the top ten collective health care professional samples.

There may be several reasons for these discrepancies, the ‘watching over the patient’ item relates to patient knowledge that staff are close by and providing a degree of surveillance, ultimately promoting a feeling of being safe and protected from harm. Watching over the patient is such a basic skill and so integrated into the health care professional psyche and day to day routine on the wards that perhaps it is taken for granted by health care professionals and as such goes unreported as a caring action.

It may also be seen by other health care professions as a nursing task and responsibility as they are a constant presence on the ward whilst the others consider themselves visiting professions. Alternatively the health care professionals may have interpreted ‘watching over’ to have a more spiritual or religious intent.

There is also the realization that there may have been a negative understanding of the meaning, health care professionals may have felt that due to staffing shortages, time
constraints or increased workloads the ability to ‘watch over’ the patient can never be fully achieved. The evidence supporting this finding was discovered in the analysis of the data arising from the observations. One of the dominant subscales observed during the caring interactions was ‘assurance of human presence’. The category of “assurance of human presence includes such caring activities as helping the patient, talking with the patient, appreciating the patient as a human being and responding quickly to the patient’s call (Brunton & Beaman, 2000).

In England musculoskeletal conditions are a significant cause of ill-health, the prevalence of these conditions generally rises with age (Health and Safety Executive, 2012). Therefore as the elderly population increases so too does the number of people with these conditions. Recent changes in health care means that health care professionals need to care for patients with higher acuities and complex care needs (DoH, 2006). Developing the skills and caring behaviours to deal with these needs is a difficult balance to achieve and maintain for any health care professional. Bednarski (2009) discusses similar problems with caring but argues that integrating a caring culture into a modern technological health care system is possible. The findings of this study agrees with Bednarski to some extent, in that it is possible for modern care and traditional caring to co-exist, after all caring behaviours are not such complex creatures that they are no longer able to survive in the twenty first century care systems of our modern age.

In this study patients above all wanted to feel safe, and one of the basic concepts or caring behaviours that health care professionals can portray is one of establishing a presence which helps to engender a feeling of safety. This aspect of caring has received little in the way of extensive acknowledgement in the caring literature (Schmidt, 2003). The exact reason for this oversight is unknown; one explanation could be the preoccupation of researchers into more visible and measureable clinical activities such as satisfaction with care.

Larson and Ferketich (1993) found that the item ‘checked on me frequently’ was a measure of satisfaction with nurse caring behaviours suggesting like this study, that ‘watching over the patient’ is considered important to the caring experience. More recently Needleman et al. (2002) conducted a study into quality care in US hospitals and
found that failure to rescue, which was defined as a mortality related to hospital acquired complications, was an outcome indicator sensitive to nursing staff. Put more simply, nurses felt that the task of keeping the patient safe was one of their primary responsibilities.

In this study, because the patients were asked to rank the caring behaviours in order of importance for the different health care professional groups, it was possible to determine that they felt that ‘watching over the patient’ was not just an important caring behaviour for nursing staff but for all health care professionals they came into contact with and who were responsible for the delivery of care. Despite this viewpoint the medical staff felt that watching over the patient was a nursing responsibility. This is truly an old fashioned belief and recent literature calls for doctors to adopt a new stance on caring in medicine, “your responsibility is to your patients…..showing them understanding, arousing confidence, providing support, hope and spiritual energy…..The patient is first, the disease is secondary” (Gutierrez-Calleros, 2010). The art of patient care has also been discussed in the literature, the message is clear-the science of medicine is not unimportant; but the doctor should have concern for the humanity of the patient which should not be so overwhelmed by the science as to be non-existent at the bedside (Warth, 2011). In the interviews doctors referred to the pressures of work which leads them to primarily treat disease, consequentially the ability to establish a personal relationship is overshadowed by the need to ‘get on and do the job’. Although treating disease or injury may be seen as impersonal, the care of the patient should be anything but. Orthopaedic patients want a relationship with their carer; this is already well documented in the nursing literature (Kalafati et al., 2009; Love, 1996; Suhonen et al., 2010; Suhonen and Leino-Kilpi, 2010; Suhonen et al., 2008; Watters, 2009). However, they also value the same relationship with other members of the multi-professional orthopaedic team. They want to be regarded as individuals and they attach relevance to actions that they ” didn’t have to do” or “went out of their way” as illustrations of a genuine and unique relationship with the individual health care professional.
8.3.2. Treating patient information confidentially

In the collective health care professional group and medical group the highest ranked caring behaviour was ‘treating patient information confidentially’. The researcher found this to be a very unusual ranking although in studies conducted by Larson (1984) and Larsson et al. (1998) ‘treats patient information confidentially was also among the top 10 caring behaviours.

The safeguarding of patient confidentiality is derived from the broader philosophical concept of privacy and includes the safekeeping of patient information, non-intrusion and freedom to act without interference (Beauchamp & Childress, 2001).

The reason why this particular caring behaviour had been rated so highly was difficult to explain. It was noted that at the time of conducting Stage One of the study, the Trust had launched an awareness campaign on confidentiality, in particular, the Data Protection Act (1998).

The Data Protection Act is an act of parliament in the United Kingdom which defines law on the processing of data on identifiable living people; it is the main piece of legislation that governs the protection of personal data. Confidentiality is an ethical principle associated with the act and is embedded in several professions. Certain types of communication between a person and professional are “privileged” and may not be discussed or divulged to third parties. The Trust clinical governance department had incorporated presentations on confidentiality into mandatory training sessions for all staff groups. This could offer one explanation as to the ranking.

‘Treating patient information confidentially’ falls into the caring carative of respectful deference, which centres upon the development of a helping-trusting relationship. The patient trusts the health care professional to engage in activities which promote safe, ethical, legal and risk reducing behaviour. Thus treating patient information confidentially helps to establish and sustain a trusting relationship community. Each and every health care professional is required to work within the boundaries of their code of professional conduct. Confidentiality features predominantly within these codes setting down a framework to which a set of values, behaviours and relationships are attached.
When a patient is ensured of confidentiality another tier is added to the patient/professional relationship, here the tier is one of trust. The interview findings demonstrated that the health care professionals valued the caring behaviour ‘providing reassurance and support’, again the provision of reassurance can manifest in issues related to ensuring confidentiality. The patient gains reassurance in the knowledge that confidence is a priority of the health care professional helping to build a trusting relationship.

**8.3.3. Supporting the patient**

In the nursing group the highest ranked caring behaviour was ‘supporting the patient’. This incorporates behaviours that relate to ‘comforts’ but interestingly this was low ranking in the patient group (8th) and as such is in accordance with previous studies (Chang et al., 2005; Holroyd et al., 1998; Larson, 1984; Mayer, 1986; Smith, 2011; Zamanzadeh et al., 2010). The low ranking of this particular caring behaviour was seen in the collective health care professional group (8th), and physiotherapy group (6th) but was not in the top ten doctor or occupational therapy group rankings. According to Watson (2001) provision for a supportive and protective environment is essential from a mental, physical, socio-cultural and spiritual environment. Watson separates these variables, which are said to be interdependent, into internal and external factors which the nurse directs to provide support and protect the physical and mental health of the patient.

Comfort has been seen as one of the goals of nursing and as an integral part of the day to day task of the nurse (Bottorff, 1991). It has long been acknowledged in the nursing literature that nurses are unable to clearly define what constitutes comfort, preferring to characterize discomfort such as pain, anxiety, nausea. As such comfort and discomfort are contrasted with comfort defined as “physical or mental well-being” (Flaherty & Fitzpatrick, 1978; Paterson & Zderad, 1988). Do we suppose that if a patient is in pain and we give a pain killing injection to relieve the pain then the patient is no longer uncomfortable; surely comfort must be more than relief of physical discomfort. Comfort forms part of a patient’s way of being in the world and is echoed in his or her everyday lived experiences. Asking patients what signifies comfort can truly bring health care professionals closer to the lived experience of the patient. This allows for a deeper
understanding of the phenomenon rather than trying to”conceptualize, categorize or theorize about it” (van Manen, 1984, p.1).

A patient will know what constitutes comfort; this may be an inner peace, a feeling of safety or having no pain. Patients in this study on the whole felt that staff did provide support but the level and type varied. Some described staff as having little empathy, of not being interested in them, and feeling that they were a nuisance. Physical and emotional support was seen as fundamental, mainly patients felt that physical care given was good but as the staff were constantly busy quality time was poor and no time was afforded by staff to “sit and chat”. The only time this appeared to happen was during the performance of technical tasks. This was seen as lack of psychological support and led to a negative experience of care. The positive experiences of support were referred to by some patients as feeling ‘secure’ and ‘loved and cared for’. The staff that supported their patients more were said to have ‘gone the extra mile’ and their ability to care in this way was seen as instinctive rather than as taught. This is a really important finding as patients felt in this study that some staff had natural caring abilities whilst others did not.

8.3.4. Being honest with the patient

In the physiotherapy group the highest ranked caring behaviour was ‘being honest with the patient’. This caring behaviour did not rank in the top ten patients, nursing or occupational therapy groups, it ranked 9th in the collective health care group and 6th in the doctor group. Being honest or truth telling with patients is a relatively new concept in the ethics of health care (Pantilat, 2008). Historically, when paternalism was a defining characteristic of the doctor-patient relationship, the truth was withheld by some doctors when they perceived that being untruthful was of more benefit to the patient (Srivastava, 2011). Being honest also implies respect for the patient and is derived from the philosophical principle of respect for the truth i.e. veracity (Roberts & Dyer, 2003). Some of the patients interviewed talked about being directed by staff and wanting them to makes decisions on their behalf, this has been alluded to in previous research studies (De Haes & Koedoot, 2003; Jefford & Tattersall, 2002; Makoul, 2001). It is difficult for health care professionals in situations such as these to empower patients and ensure shared decision making. Providing patients with information so that they are given
options for treatment can facilitate a relationship based upon trust. (Panagopoulou et al., 2009). Several patients in the study stated that they didn’t want to be part of the decision making process and were happy to put their trust in the health care professional concerned. Some discounted poor communication or lack of information in ways that actually preserved their confidence in the professional concerned. For most patients in this study trust meant trust in the personal integrity of the health care professional and in their knowledge and expertise, although they accepted that things were not always perfect. The physiotherapists ranked this as their most important caring behaviour and yet failed to identify trust as an essential element of establishing a good caring relationship when asked during the interviews.

Nursing staff in particular discussed in the interviews how normal everyday relationships were usually built up over many years and yet they were expected to build a trusting relationship with patients in “a matter of minutes” and describe trust as a two-way process. Trust was acknowledged as helping to form a ‘special’ relationship and one doctor in particular referred to achieving a trusting relationship as the “ultimate goal”. Concluding that trust forms the basis of a unique relationship that assists a special connectedness between caregiver and care recipient. Importantly building a trusting relationship can help patients feel more confident and can encourage patients to take more control of their care and treatment.

8.3.5. Spending time with the patient

Only the occupational therapy group identified ‘spending time with the patient’ in their top ten ranking of good caring behaviours; Although not ranked by the other health care professionals in their top ten this was a behaviour alluded to in the interviews and anecdotally, especially in relation to recent publicity in the media indicating that in particular nurses do not have enough time to provide high quality standards of care, or indeed speak to patients. An article in the Mail Online (Martin, 2012) discusses how Prime Minister David Cameron is urging nurses to consider the main focus of their jobs, caring. Joyce Roberts from Patient Concern added to the debate stating that hospitals are too concerned with targets and saving money to care (Martin, 2012). Unsurprisingly, healthcare professionals are still seen as strong advocates of quality care principles.
Quality care is noted to be “the prevailing objective in all professional documents and the basis of many public and private statements made by individual healthcare professionals” (Davies et al., 2007, p. 12). The notion of spending time with patients has been the focus of several studies related to this topic. Westbrook et al. (2008) argue that the amount of time nurses spend with patients is paramount to the care of patients and satisfaction of nursing staff. Whereas others identified that spending time in direct care activities was a determinant of improved patient outcomes which resulted in fewer errors (Aiken et al., 2002; Duffield et al. 2011). Some qualitative studies have explored how time spent in clinical work has led to increased satisfaction with medical staff (Mechanic, 2003) and how dissatisfied they are with excessive paperwork, time wasted looking for other health care professionals (Miller et al., 1997) or documents and equipment (Lambert et al 2000). Spending time with the patient had rarely been considered in the specialty of orthopaedics until recently when studies have emerged exploring perceptions of nurse caring behaviours (Berg et al., 2007; Gustafsson et al., 2010; Hayes, 2007; Suhonen et al., 2009; Watters 2009). Seeing the individual patient was one of the lowest subscales scored in a European study, only Greek patients rated this subscale as important, this finding was attributed to cultural differences (Suhonen et al., 2009).

Westbrook et al. (2008) conducted a time and motion study to quantify how doctor’s time was distributed between activities through the working day. They concluded that two-thirds of the doctors time was divided into three main categories, professional communication, social activities (e.g. meal breaks) and indirect care. Most alarming was their finding that overall the doctors they observed spent only 15% of their time providing direct patient care. The findings of this study add further value to these results in that only the occupational therapists ranked spending time with the patient in the top ten caring behaviours, although patients did not rank this behaviour in their top ten. Other studies have found similar results where patients reported experiencing minimal individualized care as a result of lack of time spent with them (Attree, 2001; Berg et al., 2007; Kralik et al., 1997; Wallace et al., 1999). One explanation for this could be that the patient group may have interpreted ‘spending time with the patient’ in the same context as ‘watching over the patient’. Patients did comment on several occasions during the
interviews that staff were busy and unable to attend to some of their needs and therefore
did not afford them the desired amount of time for care.

From the patient interviews two themes relating to spending time emerged ‘helping the
patient’ and ‘giving good physical care’. It is easy to see how patients may have grouped
these caring behaviours together as it would be impossible for health care professionals to
help patients and provide good physical care without spending time with patients. In
support of this statement, one of the main themes to emerge from the health care
professional interviews was ‘spending time with the patient’. Negative comments were
made by patients relating to staff who were unavailable or unapproachable. These
negatively appraised traits were apparent to patients when staff had a hurried manner
which patients interpreted as lack of time to communicate, listen to their concerns or
simply spend time with them. During the interviews patients reported valuing the health
care professionals spending time when they were feeling unwell or needed support or
reassurance. In this study spending time was perceived as being there for the patient.
Health care professionals acknowledged the need to spend more time with their patients
but experienced difficulty achieving this due to workload. This had a negative effect upon
staff who reported low job satisfaction as a result. This too was highlighted by patients in
the interviews although they were quick to point out that the staff were always kept busy
and understood why time spent with them was short. Drenkark (2008) uncovered similar
results when evaluating the impact of reducing workload whilst implementing key caring
behaviours. The findings demonstrated an increase in job satisfaction and co-working
relationship because staff spent more time with their patients. Spending time with the
patient can bring about a sense of partnership between care giver and care recipient.
Where the patient feels that their care needs are discussed and opinions valued as part of
a shared decision making process.

Other studies have reported positive outcomes linked to time spent with patients. These
included time spent giving information or during consultations. The positive outcomes
included patient ability to recall information given, confidence in managing own
treatment and improved compliance with treatment (Coulter & Ellins, 2006; Saultz et al.,
2005). Some of the health care professionals interviewed felt that not spending time with
their patients meant that their caring behaviours and quality of contact were perceived as poor. Both health care professionals and patients in this study were able to identify the main barrier to spending time with the patient, workload. Despite calls from all corners of the United Kingdom for nurses in particular to spend more time with their patients, time is the key. Importantly time is finite, no matter what demands health care professionals face there are only 24 hours in a day. Leebov (2009) argues that spending more time with the patient is not the answer, particularly in the current health care system. The researcher agrees that the way forward is not to increase the time spent but rather decrease paperwork, decrease target chasing and improve staffing levels.

8.4. Discussion

The purpose of undertaking this research was to try and establish whether there exists a difference in the way in which care and caring are perceived by patients and the health care professionals that are responsible for delivering care in an orthopaedic setting within a district general hospital. By gaining a greater understanding of caring perceptions and behaviours knowledge can be generated that will help to attain a more focused and person-centred caring experience. Ultimately improving and ensuring the delivery of high standards of multi-professional care. In the health care setting human needs and the need for care are complex, varied, occasionally elusive and multifactorial. The literature on caring refers consistently to the elusive nature of caring, (Chipman, 1991; Dyson, 1996; Fry, 1989; Gaut, 1984; Komorita et al., 1991; Kyle, 1995; Lea and Watson, 1996; Leininger, 1988; Mangold, 1991; McCance et al., 1997; McFarlane, 1988; Morse et al., 1991; Morrison, 1991; Pollack-Latham, 1991; Ray, 1984; Smith, 1992; Staden, 1998; Stockdale and Warelow, 2000; Valentine, 1991; Watson et al., 1999; Webb, 1996; Wilkes and Wallis, 1998; Yam and Rossiter, 2000).

It has been argued in this study that caring can be founded on positive goals such as teaching someone to walk following hip surgery or instilling confidence into someone to achieve independence on discharge from hospital. Equally negative goals can be realized through caring acts and interactions. These can include refusing to help wash a patient because to do so would defeat the object of achieving independence for that individual. The balance is difficult to perfect and calls for the health care professional to exercise
self-restraint in certain circumstances. More importantly, health care professionals need to understand that sometimes caring actions may cause more harm than good, philosophically, the decision to help or not lies with the individual health care professional and justified through their ethical and moral standpoint. The ability to provide ‘good’ and ‘right’ care is not a taught imperative but rather one that relies on many other traits: trust, worldly wisdom, knowledge of the patient, professional experience, physical, psychological, spiritual needs and the avoidance of projecting one’s own beliefs and opinions into the caring encounter, unless there is good cause to do so.

Such an ideal is far from the realms of reality due to the diversity of caring interactions and the individuals involved. It is the intention of the ethical perspective that ‘good’ and ‘right’ care should inform the practice of the health care professional.

The link between nurse caring behaviours and patient satisfaction has been well documented in the literature (Flynn, 2005; Green et al., 2005; Wolf et al., 2008). Research is beginning to emerge within other singular professions in relation to caring behaviours and satisfaction with care such as in medical research (Branch, 2000; Deale and Wesley, 2001; Macleod, 2000; McKinstry, 1992; Quirk et al., 2008; Siegler, 1985) and allied health professions such as physiotherapy and occupational therapy (Dychawy-Rosner et al., 2001; Jensen et al. 2000; Peters, 2011; Resnik & Jensen, 2003; Wright St-Clair, 2001). The link between the caring behaviours of the multi-professional team in the orthopaedic setting and patient satisfaction had not previously been the focus of any research study.

Health care services need to deliver care that is focused on reducing length of stay, improved recovery rates and clinical outcomes whilst reducing waste and costs. Trauma and orthopaedic services in general are dependent upon medical equipment and surgery to help with diagnosis and treatment; indeed musculo-skeletal problems are a major part of the work for the NHS. The multi-professional team working within the field of orthopaedics is confronted with the need to meet targets, comply with the ever increasing number of Government initiatives, whilst meeting the expectations of care desired by their patients (Mudd, 2003). Increasing recognition that caring, or lack of it, can impact on effective, efficient and safe health care service delivery has led the current government
to make care and compassion, along with other quality dimensions, a top priority. Such schemes include those designated by Commissioning for Quality and Innovation (CQUIN), introduced in 2009 as a national framework for locally agreed quality improvement schemes. Commissioners such as Primary Care Trusts reward excellence through local quality improvement goals (DoH, 2010). CQUINs have seen the introduction of Enhanced Recovery Programmes which focus upon improving patient outcomes and speeding up recovery times after surgery in order to reduce length of stay (ERPP, 2010). A reduction in NHS spending has meant that hospitals are expected to defend and promote high quality care in a tighter economic climate (DoH, 2010), here the Quality, innovation, productivity and prevention (QIPP) programme challenges the NHS to be prepared and rise to the challenge without compromising care. Such initiatives are needed if the NHS is to survive but it is important that caring does not become lost or compromised in the drive to improve efficiency, productivity and financial gain.

The collation of the data analysis and discussion identified similarities and differences in perceptions of caring between patients and the orthopaedic multi-professional team. These findings are specific to this research study, so too are the perceptions of caring described by patients and the orthopaedic health care professionals responsible for the delivery of care. Do health care professionals seek to understand and put into everyday practice the caring behaviours that patient’s value and desire during caring interactions and fundamentally periods of hospitalization? Is it reasonable to say that the probability of getting this right for each and every patient is unrealistic? There are two over-arching reasons why this is true; first, recent literature and indeed history bear witness to the changing face of health care provision which is nearly always at the top of the political agenda (Corrigan, 2009; De Silva, 2011; Kodner, 2009; Naylor and Goodwin, 2010; Webster, 2001). Hospitals and health care services are evolving from deontological ethical frameworks of care, which have always been considered strong advocates of individual caring to that of utilitarian frameworks. This has witnessed a move from the traditional caring focus of the hospital to one concerned with the realization of benefiting the greatest number (Jenson and Mooney, 1990), with the emphasis firmly on productivity and profit making. Concern has been highlighted in the past that caring is under threat from greater emphasis on disease, cost, effective treatment protocols and
priorities given to financial constraints and government targets (Finfgeld-Connett, 2007). McSherry et al. (2012) warn that nurses are increasingly being portrayed as uncaring by the media and that public confidence in the profession to ‘provide safe, quality and compassionate care is being eroded’, (p.9).

Recent catastrophic events arising from one NHS Trusts’ drive to make savings came at a cost to standards of care and ultimately human life (Mid-Staffordshire Inquiry 2010, 2011). During the public inquiry into standards of care at the hospital Tom Kark Q.C. heavily criticized an NHS system where “the patient doesn’t seem to be in the picture”. The Trust was under pressure to save money, patients were not considered and their opinions largely ignored.

Secondly, the notion of caring remains one of the least understood concepts used by health care professionals (Watson, 1979), and remains poorly defined (Kyle, 1995) although this study does not agree with the sentiments of Kyle (1995) that it is elusive and imprecise in professional practice. Caring is unique to each and every individual and it is the right of that individual to define caring based upon physiological, psychological, social and spiritual need. Caring is evident in professional practice but rather than being imprecise it can be dependent upon many variables such as staffing levels, busy ward environments and individual patient need (Ball, 2012; Needleman et al., 2002; RCN, 2010).

This study agrees with the work of Kuhse, (1993), and Brown et al. (1992) that the etymology of caring is complex. Difficulty was encountered by the participants in this study when describing caring and understanding its meaning and exclusivity in caring practice. What is more attainable from the results of this study is the idea that the interpretation and perception of caring is more important to the individual when a caring interaction takes place than attempting to arrive at a universal definition. According to Watson (1988b, 1999), the caring interaction or occasion is a focal point in space and time when the patient and health care professional come together in a particular way so that a caring moment is formed. These individuals have the ability to unite in a human-to-human transaction brought about by their unique phenomenal fields. A phenomenal field is a totality of human experience based upon past history, present moment and future.
imagined (Watson, 1999). When a patient reflects on a caring interaction they are able to assess whether the caring behaviours displayed were acceptable.

Their acceptance may be based on a number of related factors which they use to justify their conclusions, for example, stating that the carer was not visible in the environment and that certain care was not performed but then adding that the ward and subsequently the staff were busy and did not have time to provide that particular element of care. Here dissonance exists between patient and health care professional in relation to aspects of care. So that a socially constructed view of the healthcare professional as a caring person is maintained, patients can often deflect their criticisms of poor care and provide explanations for the lack of good caring behaviours. This is so that the illusion of healthcare professionals as caring is sustained. Of particular note was the fact that healthcare professionals colluded with patients to maintain this illusion. They too offered up explanations for poor caring behaviours this is perhaps that they, like patients, would like to be seen as upholding the perceived reality of their respected caring professions.

In the continuing search for a working definition the use of caring in everyday language and practice was examined. Tronto (1994) explored the countless meanings of caring, remarking that in relation to everyday language the meaning of caring is indicative of an act that assumes a burden or responsibility. This ideal may perhaps be viewed as having a moral concern and it has been noted previously in the literature that the burden of proof, in terms of the relationship between morality and caring lies within an ethic of care (Bullock, 2000; Davis, 2005; Gilligan, 1982; Resnick, 2011; Velasquez et al., 2010) This does not signify that the burden or responsibility is virtuously assumed and history has witnessed burdens and responsibilities undertaken for both good and bad reasons (Allmark, 1998; Hudson, 1983). The move from caring as a burden, to caring as a responsibility is evident in the reflections of the health care professionals and supported by the accounts of the patients in this study. Caring is synonymous with health care professions and is presupposed to being a naturally occurring phenomenon during caring interactions between health care professionals and their patients (Hawthorne, 2005). What was evident from the observations and interviews with the health care professionals was that caring acts and behaviours were performed because they as individuals cared for
their patients rather than because it was a job they were paid to do. This is seen in several of the observed interactions and highlighted in the interviews, such as through the expression of praise of caring attitudes (“she was really kind and thoughtful….more than doing just a job”), caring actions (“he held my hand and made me feel valued….that’s not taught, that’s something you have in you from the start”).

Equally, values or ideas revealed the ability of the health care professional to see caring about other things just as valuable as caring for the individual (e.g. patient’s home environment, pets). Although on occasions this can be misinterpreted by the patient as caring for or about trivial things it is one of the many facets of caring. Nodding (1984) believed unconditionally that caring about or for other things is not genuine caring. It is important when keeping in mind the aims of this thesis to argue that this sentiment is not necessarily true and that in order to achieve the goals of the caring act it is possible and sometimes essential to extend conceptually and metaphorically the caring act to include someone or something other than the one being cared for. This thesis agrees with the work of Watson (1979) who defines caring as a relationship that reaches far beyond the physical act, to show concern for every aspect of the patient’s health care situation. In the health care environment, caring about things other than the patient but which ultimately achieve the caring intention and goal is morally and ethically relevant.

Reflected in the findings from both the observations and interviews, patient participants in this study recounted how they were in need of communication with all healthcare professionals and the ability to exchange information in a ‘friendly’ environment. The need for verbal and non-verbal contact was especially valued such as eye contact, touch, being seen and being listened to. The ability to share personal feelings and thoughts in an open and honest manner were valued, these findings are supported by other studies (Clarke and Wheeler, 1992; Eyle, 1995; Henderson et al., 2007; Lucke, 1997; Wilkin and Slevin, 2004).

The major strength of this research is the assertions emerging from the patient care experience as a whole. Perceptions of care and caring have not been established from the patient and multi-professional team perspective in the orthopaedic setting before and what is clear is the desire of the patient to experience positive caring behaviours from all
health care professionals during their period of hospitalization. The intricacy of caring perceptions from both patients and health care professionals enables the researcher to acknowledge the complexities of caring behaviours exhibited during caring interactions, forming naturalistic generalizations about the information obtained from the research (Creswell 1998; Miles and Huberman, 1994).

Several important insights into perceptions of caring within an orthopaedic setting have been gained from this research study. These relate to an overall understanding of the caring behaviours that are considered of importance to patients’ and health care professionals’; the differences that exist between the caring perceptions of both groups and the factors which influence these perceptions. The important message is that patients regardless of age, gender, education, ethnicity or profession want to experience good care from the multi-professional team. They do not consider good care to arise from one source, namely nurses, but from all healthcare service professions they come into contact with. Patients have clear expectations of what caring behaviours need to be exhibited in order to feel cared for. Healthcare professionals need to discover what their patients’ value most from the caring relationship and during caring interactions. As depending upon the need for interaction may influence the caring behaviours required to be demonstrated. Healthcare professionals should not wait for patients request for care – they should ask. Caring may remain elusive in terms of a generalized definition but what is possible is that most patients are able to define caring from an individual perspective through the medium of perception. Only when this is achieved can patients be assured that those caring behaviours will be evident during caring interactions.

8.5. Answering the research questions.

1. Which caring behaviours are deemed to be of importance to patients and health care professionals?

The perceptions of what patients and health care professionals believe constitute important caring behaviours are documented in table 8.1. Here the 10 most important caring behaviours are listed for each group.
<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Collective Health Care professional Group</th>
<th>Doctor Group</th>
<th>Nurse Group</th>
<th>Physiotherapy Group</th>
<th>Occupational Therapy Group</th>
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<tr>
<td>Watching over the patient (PC)</td>
<td>Watching over the patient (PC)</td>
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<td>Being confident with the patient (PKS)</td>
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<td>Appreciating the patient as a human being (AHP)</td>
<td>Appreciating the patient as a human being (AHP)</td>
<td>Appreciating the patient as a human being (AHP)</td>
<td>Appreciating the patient as a human being (AHP)</td>
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<td>Helping the patient (AHP)</td>
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<td>Treating the patient as an individual (RD)</td>
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<td>Helping the patient (AHP)</td>
<td></td>
<td>Treating the patient as an individual (RD)</td>
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<td>Paying special attention during first visit (AOE)</td>
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<td>Attentively listening to the patient (RD)</td>
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<td>Attentively listening to the patient (RD)</td>
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<td>Supporting the patient (RD)</td>
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<td>Supporting the patient (RD)</td>
<td>Supporting the patient (RD)</td>
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<td>Demonstrating professional knowledge and skill (PKS)</td>
<td>Demonstrating professional knowledge and skill (PKS)</td>
<td>Demonstrating professional knowledge and skill (PKS)</td>
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<td>Giving good physical care (AOE)</td>
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<td>Showing concern for the patient (AHP)</td>
<td>Showing concern for the patient (AHP)</td>
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<td>Putting the patient first (AOE)</td>
<td>Putting the patient first (AOE)</td>
<td>Putting the patient first (AOE)</td>
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<td>Being honest with the patient (RD)</td>
<td>Being honest with the patient (RD)</td>
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<td>Showing respect for the patient (RD)</td>
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<td>Showing respect for the patient (RD)</td>
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<td>Managing equipment skilfully (PKS)</td>
<td>Managing equipment skilfully (PKS)</td>
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<td>Talking with the patient (AHP)</td>
<td>Talking with the patient (AHP)</td>
<td>Talking with the patient (AHP)</td>
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<td>Making the patient physically and emotionally comfortable (RD)</td>
<td>Making the patient physically and emotionally comfortable (RD)</td>
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<td>Giving instruction or teaching patient (RD)</td>
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<td>Giving the patient’s treatment and medications on time (PKS)</td>
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<tr>
<td>Calling the patient by their preferred name (RD)</td>
<td>Allowing patient to express feelings about their disease and treatment (AHP)</td>
<td>Being sensitive to the patient (AHP)</td>
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<td>Treating patient information confidentially (RD)</td>
<td>Treating patient information confidentially (RD)</td>
<td>Treating patient information confidentially (RD)</td>
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<td>Encouraging the patient to call if there are any problems (AHP)</td>
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<td></td>
<td>Spending time with the patient (RD)</td>
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</tbody>
</table>

caring behaviours as indicated by staff and patient groups

2. **Do differences exist between caring perceptions of patients and health care professionals?**

All participants in Stage One of this research study identified that the caring behaviours as listed in the Caring Behaviour Inventory (CBI) tool were evident in caring interactions. The importance given to the caring behaviours differed in ranking according to group. Most items ranked fell into the ‘respectful deference’ subscale, although each of the five subscales was represented. Similarities and differences were found between all groups.

3. **What, if any, factors may influence perceptions of caring?**

The CBI data was analysed to ascertain if demographic variables influenced perceptions of caring behaviours. Education and health care profession were found to be the only predictors of positive caring behaviours in this study.

4. **To discover which caring behaviours are exhibited by health care professionals during caring interactions.**

All of the caring carative subscales were evident in each of the observations made during caring interactions. The number of times each was exhibited varied according to health care professional observed. In the nursing group ‘attentiveness to the other’s experience’
was the most observed caring subscale, in the doctor group ‘assurance of human presence’ dominated the observations whilst in the physiotherapy and occupational therapy groups ‘professional knowledge and skill’ was the most frequent subscale.

5. To understand patient’s perceptions of caring that is delivered by the multi-professional team within the specialty of orthopaedics.

Semi-structured interviews were carried out to determine which caring behaviours were perceived as important to patients following the ward observations. The dominant subscale was ‘assurance of human presence’. The behaviours were identified as:

- Compassion – Respectful deference
- Being treated as a human being – Assurance of human presence
- Good communication – Assurance of human presence
- Helping the patient – Assurance of human presence
- Giving good physical care – Attentiveness to the other’s experience

6. To gain an insight into what perceptions health care professionals have of their own caring behaviours

Semi-structured interviews were undertaken in order to determine which caring behaviours were perceived as important to health care professionals following the ward observations. The dominant subscale was ‘respectful deference’. The behaviours were identified as:

- Being compassionate – Respectful Deference
- Respecting the other’s experience – Respectful Deference
- Treating the patient as a human being – Assurance of human presence
- Spending time with the patient – Respectful Deference
- Reassurance and support – Respectful Deference
8.6. Orthopaedic Caring Framework Development

Following the analysis of the research data an orthopaedic caring framework was constructed. The framework has been devised to provide structure and frame thought in relation to the importance of caring behaviours for the orthopaedic multi-professional team. This framework reflects the caring behaviours valued by patients during caring interactions. The framework is underpinned by Watson’s theory of transpersonal care (2001) and reflects the caring behaviour subscales as portrayed in the Caring Behaviours Inventory tool (Wolf et al., 1989).

The model of the caring framework (diagram 3) is formed in a circle, indicating a circular holistic view which orthopaedic patients value of caring behaviours. The given caring behaviours can signpost healthcare professionals towards implementing and evaluating their practice through the application of the caring framework. The patient lies at the centre of the framework indicating the true focus of caring.

Framework Context

During times of ill-health or the need for hospitalized treatment individual patients and healthcare professionals are brought together in caring moments, throughout which positive caring behaviours are sought and valued. As individuals confront these life situations their ability to effectively identify, analyse and evaluate caring issues, as well as seeking satisfaction with care, can be difficult for them to quantify. This study has discovered that in relation to caring behaviours there are several different and mutually contrasting trajectories, each with its own personal roots, dynamics and impact occurring during the caring moment. Each trajectory of caring involves particular players (e.g. doctors, nurses, patients), implies specific interrelations between each and follows particular directions according to desired health related outcomes. Competing trajectories during caring interactions may transpire; these can lead to unstable and undesirable caring relationships. This research has placed the patient voice firmly and succinctly into a caring framework, in order to encourage positive caring relationships. The disposition of an individual patient to identify good caring behaviours is strongly influenced by attitude, values, and beliefs about caring and about the role of each healthcare
professional in ensuring that positive caring behaviours are demonstrated during caring interactions.

What constitutes good caring behaviours may be unfamiliar to some staff and therefore presenting healthcare professionals with a framework for caring offers the greatest possibility of learning, engaging and attaining high levels of care and caring. This framework, which can be generalised and replicated into any number of caring and learning environments, provides an opportunity for healthcare professionals to identify those caring behaviours that are desired by patients through a structure for learning about caring behaviours. This structure can be adapted according to the requirements of the patient or healthcare professional group. To illustrate this point, the outer circle could relate solely to medical staff and the interconnecting circles containing the caring behaviours could be expanded or customised to this group following further research (see diagram 3). Additionally, the patient who is at the centre of the illustrated framework could be replaced by the student nurse. In this instance, the outer circle would contain the patient and the caring behaviours in the interlinking circles would consist of knowledge that must be learnt and drawn upon in order to respond appropriately and competently during caring moments, thus the framework could be adapted for training purposes, providing students with a repertoire of strategies for highlighting the importance of caring.

The resolution of caring issues requires responsible behaviours and sound practices relative to patients and the varying environments and situation in which they are cared for. Competent responses to age, culture, gender and ethnicity require consideration and one of the positive things about this framework is the idea that the outer circle could contain these variables and the inner connecting circles focus on the understanding of these and effects they may have on caring.

Never has the need been greater to promote caring, compassion and commitment in the National Health Service than at this present time. The Francis Inquiry (2013) into the failing at Mid Staffordshire NHS Foundation Trust between 2005 and 2009 has firmly stated that at all times the first priority is to the patient.
This newly developed caring framework puts the patient at the heart of care and caring ensuring that desired caring behaviours that promote feelings of being ‘loved,’ ‘watched over’, ‘cared about’ and ‘cared for’ are visible, attainable and sustainable for all healthcare professionals.

Diagram 3:

*Orthopaedic Caring Framework (Flynn, 2012)*

A framework depicting patient perception of orthopaedic multi-disciplinary caring
8.7. Summary
This chapter has explored the principle findings in relation to patient and health care perceptions of care and caring in an orthopaedic setting. The key findings of this study are:

- This is the first study to explore patient and health care perceptions of care and caring in an orthopaedic setting

- The most valued and evident caring behaviours arising throughout the study were from the subscale ‘respectful deference’. These were focused on developing a helping-trusting relationship and caring activities such as being honest with the patient, showing respect for the patient and provision of information.

- An essential element of meeting patient care expectations was ‘spending time with the patient’.

- Only education level and health care profession were found be predictors of positive caring behaviours.

- The concept of caring is relevant to all health care professions and correlates to forming a helping-trusting relationship that focuses on person centred care
CHAPTER NINE

Conclusions and Recommendations

9.1. Introduction

The main aim of this chapter is to consolidate the key findings from this study so that the original research objectives presented in Chapter Two may be addressed.

This study employed a combination of methodologies to explore patient and health care professional perceptions of care and caring. The use of questionnaires, participant observation and semi-structured interviews allowed the nature of caring to be elucidated in detail, particularly in relation to how both patients and health care professionals perceived the attributes of caring behaviours.

This study has highlighted a gap in the current literature into perceptions of care and caring within an orthopaedic setting and between patient and health care professional. It has demonstrated the need for a critical approach, adding to the traditional and historical research into perceptions of caring obtained from studies involving patients and nursing staff.

Patients’ perceptions of care and caring are a well-researched field within nursing but should not be seen as exclusive remaining forever within the domain of the nursing profession. The questionnaire and descriptive findings from this study support work previously conducted in this area. Various accounts and thoughts of what constitutes good caring behaviours as valued by patients and health care professionals across accounts illustrated the importance of making patients feel safe and secure, spending time with patients, ensuring confidentiality, providing support and being honest.

9.2. Future Research

It has been widely acknowledged that there are many issues arising from the use of mixed methodologies; this study is able to demonstrate how the employment of three distinct yet complementary methodologies can work well.
The use of the Caring Behaviours Inventory (CBI) proved a useful tool in determining and comparing which caring behaviours are valued by patients and health care professionals respectively. This questionnaire should be used further in this field to examine other issues such as a comparison of perceptions of caring behaviours between orthopaedic trauma patients and patients admitted for elective orthopaedic surgery.

The use of participant observation provided an in-depth insight into caring interactions and behaviours displayed by health care professionals. The subsequent semi-structured interviews allowed for an in-depth understanding of how health care professionals perceived their caring behaviours and importantly how these behaviours resulted in satisfaction or dissatisfaction with care given.

Further study into this area would gain from multiple observation and interviews with participants to construct a more substantive insight into perceptions of caring behaviours and ultimately satisfaction with care.

The issue of patient perception of caring behaviours with other health care professionals also requires consideration. A longitudinal study could be undertaken to explore perception of caring at different stages of the inpatient journey where the patient has contact with different health care professionals.

The respondents in this study proved to be good informants and gained a great deal themselves from the interviews. Patients felt that the interviews helped give them closure to their experiences of being care for, whilst the health care professionals commented that the interviews helped them to reflect on the care they provided, in some cases causing the health care professional to declare that they would always ensure to include their patients when evaluating care given.

9.3. Implications for practice

Caring has always been categorized as the “art of nursing” and the professional literature indicates that perceptions of caring are subjective and closely related to personal experience of health, ill-health and life generally. According to this study, Watson’s theory of transpersonal (1979) care might help make caring visible to patients and offer a
means by which patients can be assured of a positive caring experience. Importantly this study has demonstrated that patients do not see caring behaviours as lying solely in the domain of the nursing profession but as the responsibility of all healthcare professionals.

Nationally, as the population of the United Kingdom expands along with life expectancy, the demand for healthcare will also increase and so too will the expectation for high standards of care and caring (DoH, 2010). The development of the caring framework has implications for helping to identify positive caring behaviours:

- in various healthcare settings
- amongst differing healthcare professional groups
- amongst differing patient populations
- during the education and training of current and future healthcare professionals

Caring behaviours need to positively impact on care and ultimately patient satisfaction. This framework can support and advise healthcare professionals to identify how attitudes towards caring influence their willingness to recognise and choose among value perspectives and their motivation to participate in the improvement, protection and preservation of care and caring.

Overall this study has important implications for health care professional practice, education and research. Knowing what patients value in terms of caring behaviours should be used to shape educational curriculum for care in professional practice across the caring professional spectrum.

9.4. Limitations

Several limitations in this study are worthy of note.

- First participants comprised a random sample and only represented participants from a single district general hospital and within one area of specialty.

- In addition the relatively low number of ethnic minority participants may limit generalizability.
The number of participants in this study totalled 81, 22 patients and 37 healthcare professionals participated in Stage One and 8 patients and 16 healthcare professionals participated in Stages Two and Three. The small number of participants was another limitation of this study.

9.5. Conclusions

It is apparent from the data that caring remains a complex and dynamic construct that is determined by individual perception. Furthermore, it is a fluid concept; it is ever changing being defined, redefined and evaluated according to the caring interaction and the individuals involved.

New contributions to the literature

At the time of writing, for as much as can be said, this thesis has made new contribution to the literature in the following areas:

- A significant finding was that patients desire caring behaviours from all health care professionals that are responsible for delivering their care. Health care professionals acknowledged similar valued caring behaviours to those of the patients.

- A second significant finding was that patients continually re-evaluated their satisfaction with caring behaviours during the interview process, this has implications for health service providers who wish to elicit a good caring relationship with their patients during time constraints where the window of opportunity for doing so is short lived. This can be in situations where patients are admitted to hospital on enhanced recovery pathways or as day case admissions. The importance for health care professionals to ensure positive trusting caring relationships are formulated from first contact is so that patients perceive positive experiences of care and caring during even the briefest interactions.

- A third significant finding arising from the research was the identification of the difference in the total Caring Behaviors Inventory score for health care
professionals and patients. This indicated that health care professionals perceived a higher positive perception than patients of their own caring behaviors. This is significant because it suggests that health care professionals believe they are meeting patient perceptions of caring, a sentiment which patients do not fully agree with. This signifies the need for health care professionals to ask patients what they value in terms of positive caring behaviors during caring interactions rather than assume what is valued. Although empirical studies on caring in relation to nursing have unearthed similar significant differences in perceptions of caring behaviours (Chang et al., 2005; Hajinezhad et al., 2011; Larson, 1984; Larsson et al., 1998; Papastavrou et al., 2012; Widmark-Petersson et al., 2000), none have examined perceptions of caring behaviours with the multi-disciplinary orthopaedic team.

- Methodology, this is the first study in its field to employ an explanatory sequential mixed methodology to investigate perceptions of care and caring between patients and the multi-disciplinary team in an orthopaedic setting within a District General Hospital.
- Development of an Orthopaedic caring framework to provide structure and frame thought in relation to the importance of caring behaviours for the orthopaedic multi-professional team. Importantly this framework can be adapted and developed further to reflect the varying health care environments or healthcare professionals. It can also be developed as a learning tool to assist in the promotion of attitudes and values that are deemed important constituents of caring.
9.6. Reflection

My doctoral process has been slightly unusual, unlike most doctoral students at the time of my registration; I was in full-time employment having worked 32 years in the nursing profession. The last five years of which have been in the role of nurse consultant in the specialty of orthopaedics.

I have been a student at the University of Chester for ten years, firstly as a Masters student and more recently as a PhD student. Over the course of my PhD studies I have grown and learned more than I ever thought possible.

The decision to embark on doctoral studies was partly fuelled by the encouragement of my Masters Dissertation supervisor and my own desire to explore further a topic close to my heart – ‘caring.’

After much deliberation and discussion with family and work management I submitted an application for a study award at the hospital. To my delight the application was successful and finance was secured. I applied to the University to enrol on the MPhil programme of study which was approved.

I clearly remember attending the induction evening. I was amazed at the number of students embarking on the same journey. I was even more surprised at just how few part-time students were attending. The majority were full-time students, representative of the different faculties within the university. During the evenings events we were all asked to give a brief resume of our areas of study, I listened intently to the variety of topics covered, from Monkeys to Limestone paving and even research about the film ‘Lord of the Rings.’ I was simply amazed at the coverage of topics.

I remember having a real crisis of confidence, thinking that I pride myself on knowing my limitations and, was my ability to do a PhD more of a challenge than I expected. These negative thoughts were soon laid to rest during my first supervisory meeting with Professor Tom Mason and Professor Elizabeth Mason Whitehead.

This journey has been fraught with challenges which have been both academic and personal. Academically on several occasions I have questioned my ability to continue the
journey, two main incidences spring to mind that extenuated this. First getting my research proposal through panel, this took three attempts. Second, a negative experience at the Local Research and Ethics Committee research who criticized my study for having large participant numbers. One committee member even stated that she “wasn’t prepared to let me loose on patients until I had my numbers sorted out!” It’s hard to take experiences like these and turn them into a positive learning experience but that’s what I did. I wasn’t prepared to let either of these dampen my enthusiasm for attaining my goal.

On a personal level there have been episodes of anxiety, pain and distress. I have two children who both have major health problems, my daughter has a cardiac condition and has been in and out of hospital for treatment and my son has had five cardiothoracic operations during the course of my PhD. Trying to hold down a full-time job, a part-time PhD and look after two sick children has tested my physical and mental strength to the limit but family and supervisory support has always helped me through.

Perhaps the greatest test of my journey came with the news that one of my dearest supervisors Tom was diagnosed with cancer. Throughout his battle with this dreadful and unforgiving disease he and his wonderful wife Elizabeth, my principle supervisor, still found the time and energy to continue to provide their unfailing support despite what they both must have been going through. I had the chance to say goodbye to Tom a week before his death, when we met for my annual progress report. Even at that time he never stopped taking an interest in my research and giving his advice. His vision of how my research could influence practice was thought provoking and during many discussions his mind was always occupied with the ‘given’ and importantly the possibilities. When Tom died, I felt I had lost my way and a part of my PhD that I would never be able to replace. What motivated me to carry on was the strength I saw and took from Elizabeth, a true inspiration.

I suppose if I was to describe myself I would say that I have always been a thinker, but during my PhD journey I have sharpened my critical analysis skills greatly and learned to ask “why” on so many different levels. I have developed the ability to dig myself into a text as deeply as possible in order to obtain the most minute detail to gain knowledge and
understanding of the subject of caring. My ability to write and express my ideas, arguments, thoughts and knowledge has grown immensely with each year of study.

I have learned how to sustain a logical argument which is organized and well supported which has helped to develop a more personal complex thought process. I have enjoyed my academic growth and always looked forward to the time I could spend writing. I hope that this enjoyment is reflected in my writing. Weekends were time out to spend with family and relax from the pressures of work and study.

The limitations in this reflection are transparent, some of my thoughts are perhaps too personal and there is a great mix of feelings, joy for what I have achieved and the support and encouragement of Elizabeth, sorrow for the loss of an inspirational, wonderful supervisor and friend, Tom.

9.7. In conclusion

This thesis offers a new and unique insight into patient perceptions of caring within the field of orthopaedics, with significant findings and methodological strategies which will hopefully, accord a more refined consideration of such experiences. In final reflection, despite the paths travelled and the profound writings found and read, the arguments put forward and the conclusions reach; it is reasonable and realistic to accept that this study has neither conclusively mapped nor finally conquered the elusive phenomenon of care and caring.
9.8. Publications and Conferences


Papers under review:


Papers Under construction:

Flynn, S.D., Mason-Whitehead, E. Caring: An Orthopaedic Perspective.

Conferences


- Presentation International Orthopaedic Conference, Qawar, Malta. October 2006.


- Presentation International Orthopaedic Conference, Malta, October 2009.

- Presentation International Orthopaedic Conference Southern Ireland, February 2010.

- Poster presentation International Collaboration of Nurses Conference Dublin, September 2010 (won best poster prize).

- Presentation International Surgical Nursing Conference Southern Ireland, March 2011.
Positions of Esteem

- Forum Committee Member, RCN Society of Orthopaedic and Trauma Nurses.

- Royal College of Nursing Orthopaedic Nurse Representative, Department of Health workforce planning 18 week orthopaedic group.

- Reviewer, International Journal of Orthopaedic and Trauma Nursing

- Rater, McMaster Online Rating of Evidence System

- Editorial board member International Journal of Orthopaedic and Trauma Nursing
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Executive Summary, Haringey Council 2008.


Oxford, UK.

Medicine, 12(1).


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Heary,C.M. Hennessey,E. (2002). The use of Focus Group Interviews in Paediatric
Health Care Research. Journal of Paediatric Psychology. 27 (10, 47-57.


Hightower-Vandamm, M.D. (1980). Nationally Speaking: Caring is the key, it always has been. The American Journal of Occupational Therapy, 34 (3), 239-240.


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NHS ordered to make massive savings. Retrieved April 14th, 2010 from www.independent.co.uk/.../health-nhs-ordered-to-find-massive-savin...


Resnick, M.D., Bearman, P.S., Blum, R.W., Bauman, K.E., Harris, K.M., Jones, J., Tabor, J., Beuhring, T., Sieving, R.E., Shew, M., Ireland, M., Bearinger, L.H., & Udry, J.R.


Speziale, H.S., & Carpenter, D.R. (2007). *Qualitative Research in Nursing: Advancing the Humanistic Imperative.* Philadelphia: Lippencott Williams & Wilkins,


www.kingsfund.org.uk/NHS-Reforms


## Appendix 1: Perspectives on the concept of caring

<table>
<thead>
<tr>
<th>Paper</th>
<th>Humanistic</th>
<th>Feministic</th>
<th>Ethical</th>
<th>Ontological</th>
<th>Relational</th>
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<td>Baier (1985)</td>
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<td>Beauchamp &amp; Childress (2001)</td>
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<td>Benner (1984)</td>
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<td>Boykin &amp; Schenhfer (1993)</td>
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<td>Buber (2004)</td>
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<td>Carse (1991)</td>
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<td>Carse &amp; Nelson (1996)</td>
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<td>Carson (1993)</td>
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<td>Dudley (1994)</td>
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<td>Fry (1989a &amp; 1989b)</td>
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<td>Gilligan (1982)</td>
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<td>Glaser (1994)</td>
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<td>Heidegger (1927)</td>
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<td>Held (2005)</td>
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<td>Henderson (1964)</td>
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<td>Joldersma (2001)</td>
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<td>Kohlberg (1971)</td>
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<td>Lamont (1997)</td>
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<td>Levinas (1991)</td>
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<td>Mayeroff (1971)</td>
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<td>Nightingale (1946)</td>
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<td>Author &amp; Theory</td>
<td>Paper</td>
<td>Caring concept</td>
<td>Analysis</td>
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<td>1. Baier A.C (1985)</td>
<td>Postures of the mind: Essays on mind and morals. University of Minnesota Press P210-219</td>
<td>Ethical &amp; Feministic</td>
<td>Feminist perspective on ethics of care, calls for a change in how we view morality and the virtues, moving towards virtues that are exemplified by women such as taking care of others, patience, the ability to nurture and self-sacrifice. These virtues are said to have been marginalised by society as it does not value the contribution of women.</td>
<td></td>
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<tr>
<td>2. Beauchamp T.L &amp; Childress J.F (2001)</td>
<td>Principles of biomedical ethics,</td>
<td>Ethical</td>
<td>Developed a four principles framework which offers a</td>
<td></td>
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</tbody>
</table>
Biomedical ethics

| Biomedical ethics | Oxford University Press | Theory of nursing as caring grounded in several key assumptions:
|-------------------|-------------------------|---------------------------------------------|
(2) Persons live their caring moment to moment
(3) Personhood is living life grounded in caring
(4) Persons are whole or complete in the broad consideration of medical ethics issues generally, these are:
(1) Respect for autonomy – respect for the decision making capabilities of autonomous individuals enabling them to make reasoned informed choices.
(2) Beneficence – balancing of benefits against risk and cost
(3) Non-maleficence – avoidance of harm
(4) Justice – notion that patients in similar positions such be treated equally.

(1) Persons are caring by virtue of their humanness
(2) Persons live their caring moment to moment
(3) Personhood is living life grounded in caring
(4) Persons are whole or complete in the
<p>| 4. Buber M (2004) Human Existence Theory | I and Thou, Continuum, London | Relational | Theory on human existence, categories modes of consciousness, interaction and being through which individuals engage with others. Argues that a person is at all times engaged with the world through one of these modes. I – Thou is a relationship stressing the mutual, holistic existence of two beings. |
| 5. Carse A (1991) Ethical caring theory | “The voice of care”. Implications for Biomedical Education Journal of Medicine and Philosophy. 16:5-28 | Ethical | Argue a need for more attention to relationship and care as the focus of ethical commitment, particularly in illness. |
| 6. Carse A &amp; Nelson H.L (1996) Ethical caring theory | Rehabilitating Care. Kennedy Institute of Ethics Journal 6(1) | Ethical | Put forward strategies for addressing problems with the ethic of care: (1) addressing the problem of exploitation as it threatens care |</p>
<table>
<thead>
<tr>
<th>7. Carson V.B (1993)</th>
<th>Spiritual caring theory</th>
<th>Relational</th>
<th>Based upon the concept of Christian caring which emphasizes the encouragement of a spiritual transcendence with Jesus Christ rather than existential phenomena or humanistic interchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirituality: Genetic or Christian? Journal of Christian Nursing p 24-27</td>
<td></td>
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<td>(2) sustaining caregiver integrity (3) securing social justice on a broad scale among relative strangers (4) addressing the dangers of conceiving the mother-child dyad normatively as a paradigm for human relationships</td>
</tr>
<tr>
<td>8. Gilligan C (1992)</td>
<td>Feminist ethic theory</td>
<td>Feministic</td>
<td>Women and men make decisions about what is right and what is wrong based upon different value systems. Women are motivated by a sense of trust or caring whereas men use an idea of justice to make moral decisions</td>
</tr>
<tr>
<td>In a different voice: Psychology Theory and Women’s Development. Harvard University Press</td>
<td></td>
<td></td>
<td>Women and men make decisions about what is right and what is wrong based upon different value systems. Women are motivated by a sense of trust or caring whereas men use an idea of justice to make moral decisions</td>
</tr>
<tr>
<td>9. Fry S (1989)</td>
<td>Towards a theory of nursing ethics, <em>Advances in Nursing Science</em> 11, 9-22</td>
<td>Ethical</td>
<td>Theory influenced by the works of Gilligan. Fry maintains that care is a central concept for nursing ethics, advocating that care is a virtue rather than a mode of being</td>
</tr>
<tr>
<td>10. Glaser JW (1994)</td>
<td>Three Realms of Ethics: Individual, Institutional, Societal, Kansas City, Sheed &amp; Ward</td>
<td>Ethical</td>
<td>Glaser defined the existence of three realms in which we currently practice, the individual, the institutional and the societal. The individual realm is concerned with the good of the patient, focusing on rights, duties, relationships and behaviours between individuals. The institutional realm is concerned with the good of the organisation and focuses on structure and systems that will facilitate institutional goals. The societal realm is concerned with the common good and is the most complex realm.</td>
</tr>
<tr>
<td>11. Heidegger M (1927)</td>
<td><em>Being and Time</em> New York, Harper</td>
<td>Ontological</td>
<td>Complex philosophy concerned with the notion of “being”. Heidegger begins with the hermeneutics of “Da-sein” (there-being) a term used by Heidegger to refer to being which understands its</td>
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<td>Theory</td>
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<td>12. Held V (2005)</td>
<td>Ethics of Care Theory</td>
<td>Relational</td>
<td>Examines what is meant by “care” and what a caring person is like. Where other theories demand impartiality above all, the ethics of care understands the moral import of our ties to our families and groups. It examines ties and focuses on caring relations rather than the virtues of the individuals. It fundamentally explores how values such as justice, equality and individual rights can link to values such as care, trust, mutual consideration and solidarity.</td>
</tr>
<tr>
<td>13. Henderson V (1964)</td>
<td>Nursing care Theory</td>
<td>Humanistic</td>
<td>Characterized her view of modern nursing as embracing self-understanding and a universal sympathy for understanding of the diverse human being (p67). Categorises nursing activities in relation to caring</td>
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</table>

own being. Da-sein is conscious being and is said to be a kind of being which understands the existence of beings other than itself.
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<tr>
<th>No.</th>
<th>Author(s) and Year</th>
<th>Title and Source</th>
<th>School</th>
<th>Notes</th>
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<tbody>
<tr>
<td>14.</td>
<td>Joldersma C (2001)</td>
<td>Relational ethics theory</td>
<td>Ethical</td>
<td>Described nurses role as substitutive (doing for the person), supplementary (helping the person), or complementary (working with the person), with the goal of helping the individual to become as independent as possible or lead to a peaceful death.</td>
</tr>
<tr>
<td>15.</td>
<td>Kohlberg L (1971)</td>
<td>Theory of moral reasoning</td>
<td>Humanistic</td>
<td>Kohlberg developed stages of moral development his theory holds that moral reasoning, which is the basis for ethical behaviour, has six identifiable development stages. Each stage is more responds more adequately to moral dilemmas than its predecessor. Maintains that the process of moral development is principally concerned with lifetime justice.</td>
</tr>
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<td>16.</td>
<td>Sherwin S (1992)</td>
<td>Feminist Bioethical</td>
<td>Ethical</td>
<td>Derived from the explicitly political perspective of</td>
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Joldersma builds upon the works of Levinas & Heidegger arguing that pedagogy is a set of asymmetric relations in which each side of the relation is "other" for the other side. He makes it explicit that pedagogy is an asymmetric relation between persons.
|---|---|---|---|---|
| | | 17. Ricoeur P (1992) 
Relational ethics theory | Oneself as another. University of Chicago Press | Relational |
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|   | 18. Sherwood GD  
(1997)  
Therapeutic caring | 19. Nightingale F  
(1946)  
Humanistic Nursing Theory |
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<tr>
<td><strong>Meta-synthesis of qualitative analysis of caring: defining a therapeutic model of advanced nursing.</strong></td>
<td><strong>Notes on nursing, what it is and what it is not. Philadelphia: J P Lippincott</strong></td>
<td><strong>Humanistic Nursing, New York, John Wiley &amp; Sons</strong></td>
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<td><strong>Advanced Practice Nurse 3(1) 32-42</strong></td>
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<td><strong>Humanistic</strong></td>
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| Nurse-patient interactions characterised by 4 essential patterns.  
(1) Healing interactions  
(2) Nurses knowledge  
(3) Intentional response pattern  
(4) Therapeutic outcomes  
Emphasizes importance of engendering an environment that places value on the uniqueness of individuals whilst caring for them from a holistic and therefore humanistic viewpoint. | Essence of nursing relied on the nurse’s capacity to provide humane, sensitive care to the sick which would facilitate healing, focuses on nursing and the patient environment relationship. | First to combine the concepts of humanism with the philosophical and methodological framework of Existentialism and Phenomenology as a way of examining experiences of the nurse-patient relationship.  
Deal with nurse caring |
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<th>Author(s)</th>
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<tbody>
<tr>
<td>21.</td>
<td>Leininger M (1988)</td>
<td>Transcultural Theory</td>
<td>Ethical phenomena believing that these may be experienced from the reference points of nurturing, of being nurtured or of the nurturing process.</td>
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<td></td>
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<td>Caring as an Essential Human Need, Wayne State University Press</td>
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<td>22.</td>
<td>Leininger M (1991)</td>
<td>The Theory of Culture Care Diversity and Universality</td>
<td>Anthropological perspective viewing human beings as inseparable from their cultural background. Social structures influence care recipients view of their world which affects their health and illness patterns. Maintains that caring is a universal phenomenon, although meanings of concept varies across cultures. In her taxonomy of caring constructs lists caring behaviours such as compassion, trust, nurture, concern and presence.</td>
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<td>In Culture Crae Diversity and Universality: A Theory of Nursing, National League for Nursing, New York</td>
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<tr>
<td>23.</td>
<td>Levinas E (1991)</td>
<td>Theory of responsibility for the other</td>
<td>Ontological Derives primacy of ethics from the experience of the encounter with the &quot;other&quot;. The encounter with another is a privileged phenomenon in which the other person's proximity and distance are strongly felt.</td>
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<td></td>
<td></td>
<td>Otherwise than being, or beyond essence. Dordrecht Kluwer</td>
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<td>24.</td>
<td>Mayeroff M (1971)</td>
<td>Virtues of caring theory</td>
<td>Relational Caring is basically a virtue, a trait of character. Caring consists of a set of fundamental attitudes that a caring person must possess in order to be considered caring. Qualities of caring include, trust, hope, devotion, humility, courage and being</td>
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<td>On Caring, New York, Harper Rowe</td>
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<td>27. Lamont C (1997) Humanistic caring theory</td>
<td>The philosophy of Humanism, Humanist Press</td>
<td>Humanistic</td>
<td>Scholar of humanism proposes that the main goal of human life is to work for the happiness of others within the confines of the natural world. Humanism is said to be a progressive life stance, free of supernaturalism, leads to an ability to lead meaningful ethical lives that add to the greater good of humanity.</td>
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<td>Author(s)</td>
<td>Title of Work</td>
<td>Perspective</td>
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<td>28.</td>
<td>Roach MS (1984)</td>
<td>Nurse Caring Theory</td>
<td>Humanistic</td>
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<td>30.</td>
<td>Watson J (1979)</td>
<td>Theory of Nursing Care</td>
<td>Ontological &amp; Relational</td>
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<td>32.</td>
<td>Watson J (1988a)</td>
<td>Human Caring as a moral context in nursing education</td>
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<td>34.</td>
<td>Dudley V (1994)</td>
<td>Feminist Perspectives</td>
<td>Relational</td>
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<td>Nursing Care Theory</td>
<td>on the Ethic of Care</td>
<td>Ethical</td>
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<td>Nursing care theory</td>
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<td>Primacy of Caring</td>
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<td>From Novice to Expert, Excellence and Power in Clinical Nursing Practice</td>
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<td>Menlo Park Addison-Wesley Publishing Company</td>
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<td>responsibility is devised from a person’s ability to feel connected with others. Female approach to morality characterised by nurturance and emphasizes responsibility to others.</td>
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<td>Speaks of the power of nursing. Caring involves the concepts of: transformative power integrative caring advocacy healing power participation power problem solving. More than an application of skill, is relational and involves nurse’s response as a human being, first, the secondarily in the nursing role, considers a naturalistic viewpoint</td>
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## Appendix 2- Caring Instruments

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<tr>
<td>Care Assessment Instrument (CAI) (Watson, 2009, p.29)</td>
<td>1. Delphi survey</td>
<td>Larson, P. (1984) Important nurse caring behaviours perceived by patients with cancer. Oncology Nursing Forum. 11(6). 46-50.</td>
<td>Perceptions of nurse caring behaviours and ability to care</td>
<td>Q-Sort 50 cards employ a 7-point scale to rank perceptions of nurse caring behaviours. This is the most commonly used instrument worldwide, can be complex and time consuming for participants.</td>
<td>N = 57 oncology patients</td>
<td>Expert panel of graduate nursing students, test-retest Content and face validity</td>
<td>References: general nursing theories of caring. A priori development Informed by the care needs of cancer patients</td>
<td>Nurses</td>
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<td>Instrument</td>
<td>Strategies of item generation</td>
<td>Publication Source</td>
<td>Measurement focus</td>
<td>Instrument Description</td>
<td>Participants</td>
<td>Reported Validity/ Reliability</td>
<td>Conceptual-Theoretical Basis of Measurement</td>
<td>Instrument rated by</td>
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<tr>
<td>Caring Behaviours Assessment Instrument (1988) (Watson 2009, p. 85).</td>
<td>1. Literature review</td>
<td>Cronin, S. &amp; Harrison, B (1988). Importance of nurse caring behaviours as perceived by patients after myocardial infarction. <em>Heart and Lung</em>, 17(4), 374-380</td>
<td>Perceptions of nurse caring behaviours</td>
<td>63 items, 7 subscales, 5-point Likert rating</td>
<td>N = 22 post-myocardial infarction patients</td>
<td>Cronbach’s alpha established. Face and content validity obtained. Internal consistency reliability: seven subscales: .67 to .90</td>
<td>Caring defined as “the process by which the nurse becomes responsive to another person as a unique individual and perceives the other’s feeling, and sets that person apart from ordinary” (p376) Uses Watson’s theory of caring</td>
<td>Patients</td>
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<td>Professional Caring Behaviours (Watson 2009, p. 107).</td>
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<td>Harrison, E. (1995). Nurse caring and the new health care paradigm. <em>Journal of Nursing Care Quality</em>, 9(4), 14-23.</td>
<td>Perceptions of nurse caring behaviours of families and nurses of inpatient hospice clients</td>
<td>2 forms (28 items each) 4-point Likert scale</td>
<td>$n = 16$ nurses, inpatient hospice $n = 15$ family members of hospice patients</td>
<td>Content validity Test-retest reliability Cronbach’s alpha .92 and .94</td>
<td>Only references general caring theory literature. Relates to nurse caring behaviours as perceived by families</td>
<td>Nurses and family members</td>
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<td>Holistic Caring Inventory (1988, 1996) (Watson 2009, p. 176).</td>
<td>1. Literature review</td>
<td>Latham, C.L.P. (1996) Predictors of patient outcomes following interactions with nurses. <em>Western Journal of Nursing Research.</em> 18(5), 548-564</td>
<td>Holistic focus on humanistic caring from an individual’s outlook on life, ability to adapt, need for nurturance and need for contemplation Each of the 3 holistic model concepts were related to patient expectations of nursing behaviours that include information giving (cognitive), assisting with feelings (affective), effective verbal communication (interpersonal), caring non-verbal communication (behavioural) and empathy about the patient’s current situation (perceptive ability) p.176. Holistic care includes physical, psychological, sociocultural and spiritual care realms.</td>
<td>39-item, 4-point Likert scale (1 = strongly disagree to 4 = strongly agree) 4 caring sub-scales: physical caring, interpretive caring, spiritual caring, and sensitive caring</td>
<td>1988: 218 adult hospitalized patients 1996: used with 120 acutely ill hospitalized adults from 2 medical units of 2 medical centres 1997: 94 hospitalized adult patients over 18 years of age with oncology, cardiac and respiratory problems. Summarized that patient were less anxious when caring was demonstrated. 1997: hospitalized patient sample that even moderately low levels of caring affected patients’ satisfaction out comes</td>
<td>Inter-item correlations (.34) and item-total correlations ranged from .41 to .71 for 4 subscales: Physical Interpretive spiritual and sensitive caring. Cronbach’ s alphas interpretative = .89 Spiritual = .91 Physical = .90 Sensitive = .90</td>
<td>Howard’s (1975) holistic dimensions of humanistic caring theory</td>
<td>Patients</td>
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Examines empirical approach as opposed to theoretical basis. No specific theorist identified although Larson (1986) and Gaut (1986) cited.
Appendix 3: CARING BEHAVIOURS INVENTORY

Patient Questionnaire

Study No……..

Directions:

Please read the list of items that describe caring by medical staff. For each item, please circle the answer that stands for the extent that a doctor or doctors made caring visible during your current stay in hospital.
Remember, you are the patient.

1. Attentively listening to the patient.
   never               almost never               occasionally               usually
   almost always         always

2. Giving instructions or teaching the patient.
   never               almost never               occasionally               usually
   almost always         always

3. Treating the patient as an individual.
   never               almost never               occasionally               usually
   almost always         always

4. Spending time with the patient.
   never               almost never               occasionally               usually
   almost always         always

5. Touching the patient to communicate caring.
   never               almost never               occasionally               usually
   almost always         always

   never               almost never               occasionally               usually
   almost always         always

7. Giving the patient information so that he or she can make a decision.
   never               almost never               occasionally               usually
   almost always         always

8. Showing respect for the patient.
   never               almost never               occasionally               usually
   almost always         always

9. Supporting the patient.
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<tr>
<th></th>
<th>never</th>
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<tr>
<td>10. Calling the patient by his/her preferred name.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
<td>usually</td>
<td>almost always</td>
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<tr>
<td>11. Being honest with the patient.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
<td>usually</td>
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<td>12. Trusting the patient.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
<td>usually</td>
<td>almost always</td>
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<td>13. Being empathetic or identifying with the patient.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
<td>usually</td>
<td>almost always</td>
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<td>14. Helping the patient grow.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
<td>usually</td>
<td>almost always</td>
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<td>15. Making the patient physically or emotionally comfortable.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
<td>usually</td>
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<td>16. Being sensitive to the patient.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
<td>usually</td>
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<td>17. Being patient or tireless with the patient.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
<td>usually</td>
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<tr>
<td>18. Helping the patient.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
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<td>19. Knowing how to give injections, etc.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
<td>usually</td>
<td>almost always</td>
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<td>20. Being confident with the patient.</td>
<td>never</td>
<td>almost never</td>
<td>occasionally</td>
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21. Using a soft, gentle voice with the patient. 

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22. Demonstrating professional knowledge and skill. 

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23. Watching over the patient. 

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24. Managing equipment skillfully. 

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25. Being cheerful with the patient. 

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26. Allowing the patient to express feelings about his or her disease and treatment. 

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27. Including the patient in planning his or her care. 

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29. Providing a reassuring presence. 

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30. Returning to the patient voluntarily. 

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31. Talking with the patient. 

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<td>almost always</td>
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32. Encouraging the patient to call if there are problems.
never  almost never  occasionally  usually
almost always  always

33. Meeting the patient's stated and unstated needs.
never  almost never  occasionally  usually
almost always  always

34. Responding quickly to the patient's call.
never  almost never  occasionally  usually
almost always  always

35. Appreciating the patient as a human being.
never  almost never  occasionally  usually
almost always  always

36. Helping to reduce the patient's pain.
never  almost never  occasionally  usually
almost always  always

37. Showing concern for the patient.
never  almost never  occasionally  usually
almost always  always

38. Giving the patient's treatments and medications on time.
never  almost never  occasionally  usually
almost always  always

39. Paying special attention to the patient during first times, as hospitalization, treatments.
never  almost never  occasionally  usually
almost always  always

40. Relieving the patient's symptoms.
never  almost never  occasionally  usually
almost always  always

41. Putting the patient first.
never  almost never  occasionally  usually
almost always  always

42. Giving good physical care.
Directions for Patients:
Please complete the following information. Kindly circle or write in your answer:

1. Sex: 1. female        2. male
2. Age: _____

3. Marital Status: 1. single
   2. married
   3. Living with partner
   4. divorced
   5. widowed
   6. separated

4. I would describe by ethnic origin as: (Please circle one)

   WHITE
   (A) British    (B) Irish    (C) Any other white background

   MIXED
   (D) White & Black Caribbean    (E) White & Black African
   (F) White & Asian    (G) Any other mixed background

   ASIAN OR ASIAN BRITISH
   (H) Indian    (J) Pakistani    (K) Bangladeshi
   (L) Any other Asian background

   BLACK OR BLACK BRITISH
   (M) Caribbean    (N) African    (P) Any other black background

   OTHER ETHNIC GROUPS
   (R) Chinese    (S) Any Other Ethnic Group
5. Educational Level:  1. High School
               2. College HE
               3. University

6. Highest qualification earned ......................................

7. Profession/Job............................................................

8. Number of admissions to hospital in the last 5 years ...........

9. Reason for current admission ...........................................

10. Number of days in hospital.............................................

11. Ward: ......................................................

Thank you for completing this questionnaire.
Appendix 4

To: <>
From: "Flynn, Sandra" <>
Date: 05/28/2008 05:50AM
Subject: CBI

Dear Professor Wolf

In 2006 I wrote and asked your permission to use the CBI for a study I was undertaking into perceptions of caring as part of a PhD, which you kindly gave.

I have recently started my data collection and would like to distribute the questionnaires to medical staff and therapy staff as well as nurses and patients. I have already piloted the questionnaire with these staff members and there have been no problems and no tool modifications are required. I would be grateful if you could let me know if you have any objections to me using the CBI to elicit responses on perceptions of care from medical and therapies staff.

Kind regards

Sandra Flynn

Countess of Chester NHS Trust

England.
Dear Sandra:

You have my permission to use the CBI instrument in your study with the groups named below.

Best wishes,

Zane Wolf

-----"Flynn, Sandra" <> wrote: -----
Appendix 5: Ethics Approval

Cheshire Research Ethics Committee
Research Ethics Office
Victoria Building
Bishop Gore Complex
Rose Place
Liverpool
L3 3AN

Telephone: 0151 330 2070
Facsimile: 0151 330 2075

17 October 2007

Mrs Sandra Dawn Flynn
Clinical Nurse Specialist in Orthopaedics
Countess of Chester NHS Foundation Trust
Liverpool Road
Chester
Cheshire
CH1 1UL

Dear Mrs Flynn

Full title of study: Perceptions of caring within an orthopaedic setting
REC reference number: 07/H1017/85

Thank you for your letter of 2 October 2007, responding to the Committee’s request for
further information on the above research and submitting revised documentation.

The further information was considered by a Sub-Committee consisting of the Chair and two
Committee members.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the
above research on the basis described in the application form, protocol and supporting
documentation as revised.

Ethical review of research sites

The Committee has not yet been notified of the outcome of any site-specific assessment
(SSA) for the research site(s) taking part in this study. The favourable opinion does not
therefore apply to any site at present. We will write to you again as soon as one Research
Ethics Committee has notified the outcome of a SSA. In the meantime no study procedures
should be initiated at sites requiring SSA.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the
attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

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<td>Participant Information Sheet</td>
<td>3</td>
</tr>
<tr>
<td>Response to Request for Further Information</td>
<td>4</td>
</tr>
<tr>
<td>cv Dr Eric Whitehead</td>
<td></td>
</tr>
<tr>
<td>CV Prof Tom Mason</td>
<td></td>
</tr>
</tbody>
</table>

**R&D approval**

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.


**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following:

a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website https://www.nationalres.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx.

b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk.

07/H1017/85 Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project

Yours sincerely

Mr Jonathan Deans, FRCS
Chair Cheshire REC

Email: rob.emmett@liverpoolpct.nhs.uk

Enclosures: Standard approval conditions [SL-AC1 for CTIMPs, SL-AC2 for other studies]

Site approval form

Copy to: Mrs Mary Fisher-Morris
R & D Manager
Countess of Chester NHS Foundation Trust
Liverpool Road
Chester
Cheshire
Appendix 6: Patient Information Leaflet

Countess of Chester Hospital

Invitation to take part in research study about perceptions of caring in an acute hospital orthopaedic setting.

My name is Sandra Flynn and I work as a Clinical Nurse Specialist at the Countess of Chester Hospital. I am undertaking a piece of research which will help me to understand how patients feel about the care they receive in hospital.

You are being invited to take part in this study. Before you decide if you wish to take part it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully. You may also wish to talk to members of your family or others about this study. Ask if there is anything that is not clear or if you would like more information.

Thank you for reading this leaflet.

Why is the study being carried out?
The purpose of this study is to find out what patients think about the care they receive from healthcare professionals, such as doctors, nurses, physiotherapists and occupational therapists whilst receiving treatment in hospital. The study is part of a student research study and will ask you questions about what you like and don’t like about the care you receive. The information you give will help us to understand what care patients want and expect, which we can use to improve the services we provide.

Why have I been chosen?
You have been chosen because you are currently receiving or are about to receive hospital treatment and your views are important in helping us to ensure we provide and maintain high standards of care. The research is being carried out on six adult wards in the hospital.

Do I have to take part?
No, it is up to you to decide whether or not to take part. You do not need to decide straight away. However, you may find it useful to spend time
reading this information leaflet so that you are able to fully consider your decision. You may keep this information sheet. Taking part in this research is voluntary, and you can withdraw from the study at any time without giving a reason. If you decide not to take part or withdraw from the study, the standard of care you receive will not be affected.

**What will happen to me if I take part?**

The researcher will observe your care over a two-hour period, whilst staff carry out your care and treatment as usual. This session will be tape recorded. If you do not wish the researcher to be present at certain times or during any aspect of your care she will do so in accordance with your wishes.

As a registered general nurse, the researcher will take any action necessary if she observes you or another patient at risk at any time. When the observation session is complete, the researcher will ask you if you are willing to participate in a short interview which will be carried out in your own home or at a location convenient for you. If you agree you will be asked questions about the care you received during the observation session. The researcher will take short notes and also record the interview. You only need to answer the questions you want to and can ask for the interview to be stopped at any point. If during the interview you discuss care that you were not happy with, the researcher may ask if you wish to take this up with the hospital. If you do, she will discuss how you go about doing this. No action will be taken by the researcher without your permission.

It may be necessary to contact you at home by telephone if further information is required. Permission for this will be sought by the researcher before contacting you.

**What are the benefits?**

There are no personal benefits to you taking part in this study. However, the information you give us will help provide a better understanding of what care patients want and expect from their hospital. This may lead to changes which will ultimately help us improve the care patients receive.

**Will taking part in this study be kept confidential?**

The information collected during the course of this research will be held on a protected database at the Countess of Chester Hospital and only the researcher and research supervisors will have access to it.
All the information will be coded and will not be passed on to any third parties. At the end of the study the results including quotes from interviews will be used in reports, academic papers and presentations, care will be taken to ensure that no information made public can be attributed to any individual. The interview tape and its transcription will be stored securely at the University for up to seven years to allow for dissemination of the study results. After this time they will be destroyed as confidential waste.

What happens to the information collected?

The information collected during the course of this research will be held on a protected database at the Countess of Chester Hospital and only the researcher and research supervisors will have access to it. All the information will be coded and will not be passed on to any third parties. It will not be possible to identify any individuals from any reports. At the end of the study the results will be published in nursing journals and be reported in international meetings. Again, the identity of participants will be kept confidential. All information will be destroyed as confidential waste when the study has ended.

Who is organising and funding the study?

This study is under the supervision of Professor Tom Mason and Doctor Elizabeth Mason-Whitehead - Reader, University of Chester and has been funded by a career development award from the Countess of Chester Hospital NHS.

Who has reviewed the study?

The study has been reviewed and approved by Cheshire North West NHS Research Ethics Committee, Countess of Chester Research and Development Committee and University of Chester Ethics Committee.

Who do I speak to if problems arise?

If you have any complaints about the way in which this research project has been, or is being conducted, please in the first instance, discuss them
with the researcher. If the problems are not resolved, then the normal National Health Service Complaints mechanisms are available to you.

For further information please contact:

Sandra Flynn
Clinical Nurse Specialist, Orthopaedics
Countess of Chester Hospital NHS Foundation Trust
Liverpool Road
Chester
CH2 1UL

Telephone:
Bleep:
Invitation to take part in research study about perceptions of caring in an acute hospital orthopaedic setting.

Introduction

I would like to invite you to take part in a research study that will involve you talking about your perceptions of care and the care that you provide to patients. Please take time to read this information carefully. It explains why the research is being done and will help you to decide whether you would like to take part. If you have any questions about the research, or would like more information, please contact me on the telephone number below.

The study

This study is being undertaken to find out what healthcare professionals think about the care they provide to patients. Similarly patients will be asked about the care they receive from healthcare professionals who will include medical staff, nurses, physiotherapists and occupational therapists.

You have been chosen because you are involved with the delivery of care to patients and your views on the care that you give are important in helping us to ensure we provide and maintain high standards of patient care.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

**What will happen to me if I take part?**
The researcher will observe the care you provide to your patients over a two-hour period, this session will be tape recorded. If you do not wish the researcher to be present at certain times or during any aspect of care provision she will do so in accordance with your wishes. When the observation session is complete, the researcher will ask you if you are willing to participate in a short interview which will be carried out within 24 hours. If you agree you will be asked questions about the care you gave during the observation session. The researcher will take short notes and also record the interview. You only need to answer the questions you want to and can ask for the interview to be stopped at any point.

The interview will last approximately 1 hour and will take place in a quiet location within the hospital. The interview will be asking questions about your thoughts on and experiences of caring and what factors may influence these.

If you agree the interview will also be tape recorded. During the interview you can ask for the tape recorder to be switched off at any time and the interview stopped. All information will be treated confidentially.

**Who is organising the study?**

This study is under the supervision of Professor Tom Mason and Professor Elizabeth Mason-Whitehead - Reader, University of Chester and has been funded by a career development award from the Countess of Chester Hospital NHS.

**Who has reviewed the study?**

The study has been reviewed and approved by Cheshire North West NHS Research Ethics Committee.

**What happens to the information collected?**

The information collected during the course of this research will be held on a protected database at the Countess of Chester Hospital and only the researcher and research supervisors will have access to it.
All the information will be coded and will not be passed on to any third parties. At the end of the study the results including quotes from interviews will be used in reports, academic papers and presentations, care will be taken to ensure that no information made public can be attributes to any individual. The interview tape and its transcription will be stored securely at the University for up to seven years to allow for dissemination of the study results. After this time they will be destroyed as confidential waste.

Thank you for reading this information.

Sandra Flynn
Nurse Consultant Orthopaedics
PhD Student
Tel:
bleep

October 2008.
Appendix 8: Consent form for observation and follow-up interviews (Patient)

Countess of Chester Hospital NHS Foundation Trust

Identification Number for this trial: October 2008.

CONSENT FORM (Version 2)

Title of Project: Perceptions of care and caring within a hospital setting.

Name of Researcher: Sandra Flynn

Please initial box

1. I confirm that I have read and understand the information sheet (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I agree to being observed whilst I receive care/treatment by health care professionals. I agree to take part in a follow-up interview and give my permission for the observation and interview to be tape-recorded. I understand that the information given will be entirely confidential and not disclosed to any third parties. The information will be destroyed after 12 months.
_________________             ___________________
Name                               Date
  Signature

_________________         _________________
Name of Person taking consent       Date
  Signature
  (if different from researcher)

_________________   _________________
Researcher                                Date
  Signature

When completed, 1 copy for participant: 1 for researcher site file.
Appendix 9: Consent form for observation and follow-up interviews
(Staff)

Countess of Chester Hospital  NHS Foundation Trust

Identification Number for this trial:
October 2008.

CONSENT FORM  (Version 2)

Title of Project: Perceptions of care and caring within a hospital setting.

Name of Researcher: Sandra Flynn

Please initial box

1. I confirm that I have read and understand the information sheet (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. 

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I agree to being observed carrying out care/treatment of patients recruited to the study. I agree to take part in a follow-up interview and give my permission for the observation and interview to be tape-recorded. I understand that the information given will be entirely confidential and not disclosed to any third parties. The information will be destroyed after 12 months.
_________________      ___________________
Name                              Date
Signature

_________________   ___________________
Name of Person taking consent              Date
Signature
(if different from researcher)

_________________   ___________________
Researcher                             Date
Signature

When completed, 1 copy for participant: 1 for researcher site file.
Appendix 10: Data analysis example

Examples of significant statements coded per source

P3: Yeh..well...em..I suppose she (doctor) was only doing her job (O5).

D2 was looking through the case notes, she reads for several minutes. At this point P3 points her finger and asks “Aren’t you going to get me my methadone? D2 glances up and replies, “I haven’t finished yet, just wait a moment, I’m doing something important.” (O5)

The clinical nurse specialist (N3) sits down at the bedside of the patient and takes his hand (O3).

P1 was lying in the bed; he looked pale and was quiet, N4 approaches, she looks and smiles (O1).

P9 was attempting to stand up using a frame; OT1 steadies his balance as he grabs his frame (O2)

P7: “She was lovely, really em..you know kind.” (I10)

Data analysis codes for data sources above:

I5O5P3: Interview 5 Observation 5 Patient 3
O5D2: Observation 5 Doctor 2
O3N3: Observation 3 Nurse 3
O1P1N4: Observation 1 Patient 1 Nurse 4
O2P1OT1: Observation 2 Patient 1 Occupational therapist 1
I10O10P7: Interview 10 observation10 Patient 7

Appendix 10: Data analysis example (continued)

Example B initial developing thematic framework: Theme 1 Respectful deference. The prefix S or P is used to denote staff or patients.

S/P1.1 Having compassion, others experience
S/P1.2 Giving respect
S/P1.3 Spend more time
S/P1.4 Being fair and equal
S/P1.5 Attitude towards others
S/P1.6 Being open and honest
Example C: Example of significant statements coded source and the categories in example B.
Theme 1: Respectful deference

N5: “Caring for other people can always be challenging……you have always got to remember that you are delivering care to people and have compassion for them and their situation.” (I7O7)

N6: “Very… I like to touch base with my patients straight away..I think that is really important...as soon as I’ve had handover then er..that’s me done with the formal stuff and I’m off to see my patients.” (I4O4)

PH2: “...you know we tend to touch the patients a lot as physios...that’s something we do, just a hand, if patients are upset, which they often are, then that physical touch I think helps... it helps you to connect with them.”(I7O7)
Appendix 11: Semi-structured Interview Schedule for patients

Version 1
Date: August 2007.

Perceptions of caring within an orthopaedic setting.

Ref No: 07/H1017/85

The interview will last for approximately 1 hour and will proceed roughly as follows:

1. Introduction
   (a) State my name and who I am
   (b) State why I am there, explain the nature of the study.
   (c) Reassure the patient that anything they say will be kept confidential.
   (d) Ask their permission to conduct the interview and record the conversation, obtain written consent.
   (e) To begin ask warm-up easy to answer questions such as how are they? How are they progressing? To make them feel comfortable.

2. Main Interview Questions- these consist of questions directed to elicit responses to provide a picture about each patients stay in hospital and their perceptions of the care they received during the observation period.
   The questions are expected to prompt further questioning and discussion to delve deeper into the caring experience.

Ice breaker questions

Coming into hospital
   Can you tell me about your recent admission to hospital?
   Why did you need to be admitted?
   How long had you been unwell or had the problem for?
   Was it an emergency admission or planned?
   Were you worried about coming in to hospital?

Care
   Discuss care during observation period
   Caring interaction
   Caring behaviours

Themes to discuss relating to the above
   Communication
Knowledge and giving of information
Respect
Empathy/provision of help and support/attentiveness

Honesty and trust
Meeting and responding to needs, stated or unstated (psychological, physical, spiritual, social).
Inclusion in care planning

Experiences
Tell me about any positive experiences during your stay in hospital
Tell me about any negative experiences during your stay in hospital

Expectations of care
Do you feel that your expectations relating to your care were met?
Did you receive the care you wanted?
Was the care better or worse than you expected?
If you had to come back into hospital in the future how would you feel?
Is there any other aspect of your care which you would like to discuss?
Appendix 12: Semi-structured Interview Schedule for Staff.

Version 1
Date: August 2007.

The interview will last for approximately 1 hour and will proceed roughly as follows:

1. Introduction
   (f) State my name and who I am
   (g) State why I am there, explain the nature of the study.
   (h) Reassure the patient that anything they say will be kept confidential.
   (i) Ask their permission to conduct the interview and record the conversation, obtain written consent.
   (j) To begin ask warm-up easy to answer questions such as how are they? How are they progressing? To make them feel comfortable.

2. Main Interview Questions- these consist of questions directed to elicit responses to provide a picture about the care the staff gave during the observation period. The questions are expected to prompt further questioning and discussion to delve deeper into the caring interaction.

Ice breaker questions
How long have you worked in your profession?
Why did you want to work in health care?
What does being a health care professional mean to you?

Caring
As a health care professional what does caring mean to you?
What caring behaviours are important to you?

Care
Discuss care during observation period
Caring interaction
Caring behaviours

Themes to discuss relating to the above
Communication
Knowledge and giving of information
Respect
Empathy/provision of help and support/attentiveness
Honesty and trust
Meeting and responding to needs, stated or unstated (psychological, physical, spiritual, social).
Inclusion in care planning

**Barriers to caring**
Discuss any constraints, positive, negative.

Are there any other comments you would like to make regarding care?
### Appendix 13: Direct Observational Field Notes

<table>
<thead>
<tr>
<th>Study Code No.</th>
<th>Notes:</th>
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</table>

<table>
<thead>
<tr>
<th>Location: Hospital</th>
<th>Date: 14/5/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage: Ward</td>
<td></td>
</tr>
<tr>
<td>Set: Bay C</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Condition:</th>
<th>Time: 09:15</th>
<th>Morning shift commenced at 8:00am</th>
</tr>
</thead>
</table>

| Personnel: (Tick to indicate presence) | |
|----------------------------------------| |
| Doctor                                | |
| Nurse                                 | |
| Occupational Therapist                | |
| Physiotherapist                       | |
| Patient                               | |
| Researcher                            | |

Patient elderly gentleman suffered fractured ankle, surgery 5 days ago to fix, is in a below knee cast. Bariatric patient requiring additional support packages for home and specialist bariatric equipment. English gentleman who lives abroad with second wife and 12 year old daughter, fell whilst in UK visiting relatives.

| Activity: Bed to chair transfer and discussion relating to discharge home. | |
|----------------------------------------------------------------------| |
| Patient approached by OT and Physio, no formal introduction made as staff know patient well. Researcher introduced by OT. OT tells patient that she would like to see how he manages to transfer independently from the bed to his wheelchair. Patient not happy, says can managed and doesn't want to be bothered. Conversation about need for assessment, how he will cope once he returns home, health system not as good in Philippines so will need to have equipment to take home. Patient feels that he will not need all the recommended equipment and does not see "what all the fuss is about", and will manage. He says that he has got by in the past when he has injured himself and "you lot were not around to help me then so why are you bothering now?" OT and physio try to reason with patient using phrases such as "need to make sure you're safe at home", "we're trying to help you get home", "we care about how you are going to manage". Patient gets angry, "I manage fine at home, my wife will help me, if I say I can cope, I CAN COPE", (raises his voice and says each word slowly). OT tries to explain again the need for assessment but patient interrupts then starts swearing at OT, physio keeps quiet. Patient says staff are obstructive and not helping him to get home. Eventually after several minutes arguing he complies with OT request. Does not perform transfer activity well, wants to design own equipment for home says he was a carpenter and can design any equipment. There are apparently numerous problems around. |
discharge due to his obesity, including airport and airline issues but patient keeps insisting that these are minor hurdles which he’ll sort out once he’s at the airport and the airline will understand.

<table>
<thead>
<tr>
<th>Verbal behaviour and interactions:</th>
<th>Patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient very angry and aggressive verbally. Talks over staff and constantly interrupts them. Not listening.</td>
<td>He asked researcher when introduced “Whose side are you on theirs or mine?” Researcher replied that they were neutral. OT and physio try to get patient to do a bed to chair transfer, patient clearly does not want to do this and starts getting verbally aggressive. “You’re not bloody listening” He wants to discuss going home first. Does not really listen to staff, constantly talking over them. “If you let me do it my way I’ll be out of here quicker”. “You lot don’t care about what I want” Starts to talk about a time when he was arrested getting off a plane- completely out of context to current situation. OT says “Right you’ve had your rant now let’s concentrate of what you need to do”. Patient laughs then apologies, “sorry, what do you want me to do?” but soon after keeps repeating that staff don’t care, swears again. Told he is not doing the transfer correctly and argues that he is, “I’m doing it my bloody way, leave me alone and I’ll do it”. Continues to mutter under his breath.</td>
</tr>
</tbody>
</table>

| Staff: | “We’re here to help you get home, you need to listen to us we want to ensure that you’re safe to go home.” OT tells patient that she wants him to do a bed to chair transfer. Patient unhappy, reluctant, wants to be left alone. Knows what to do and how to do it. Finally after 5 minutes agrees to do transfer. After attempting transfer OT says “you made a right pigs ear of that, now you’ve done the pigs ear version let’s do the right version”. Patient laughs at comment and mumbles “pig’s ear version”. OT softly spoken at first but voice gets louder during discussion laughs when patient laughs Tries to crack jokes to lighten atmosphere but patient does not respond. Physio hardly speaks but responds to some of patient’s comments by stating that he is “not prepared to go over old ground, there’s no compromise, you do it this way or the wrong way and if you do it the wrong way the we can’t say that you’re safe to go home”. Patient tries to interrupt again, frustration in physio voice when patient does not listen to the instructions, shakes head and looks at OT, eyes roll back in head. Both OT and physio do not respond to some of the patients’ questions comments or actions but make grunting noises as if appeasing patient. Conversation lasts for approximately 6 minutes, patient just venting anger but not really specifying what is making him angry apart from his focus now concerns wanting to take his wife out for a meal. |
### Physical behaviour and gestures:
- Arms folded when angry
- Turns head away frequently
- Fiddles with wrist band
- No eye contact
- Points finger
- Shakes head frequently

Physio has sound of despair in voice towards end of conversation, sighs heavily.
States "you keep going over old ground, I've told you that we can't give you permission for that, you need to speak to sister or matron, you're not focusing on this and you're not listening and you're just doing your own thing, look keep your foot off the floor".

### Patient:
- Constantly folds arms and turns head away when OT talking
- Pauses in between answers to fiddle with wrist band and shake head at comments
- Points his finger at OT- "listen to me", makes demands relating to discharge from hospital. Wants to go off hospital premises to take wife and daughter out for a meal in the hotel across the road. Wants to speak to the person who can give permission for him to go out of the hospital.
- Very little eye contact with OT or Physio
- Occasionally laughs possibly out of frustration, not at comments
- Gesturing with hands towards wheelchair
- Performs activity without listening to advice from OT or Physio
- Wheels himself away from OT once in wheelchair pouts, hands up as if to gesture stop conversation. Leaves bay doesn't want to continue conversation.
- Loses focus, shows disinterest by playing with wheelchair, pushing it back and forth.

### Staff:
- Physio leans on walking frame, does not communicate with patient a lot except for the odd sentence. Shakes head in disbelief at comments patient is making e.g. "You lot don't bloody listen to my side of the argument, all I want is to get out of here and take my wife and daughter home".
  (patient has lived abroad for past 10 years and comes to the UK to visit relatives)
- OT stands with arms by side but folded when patient gets verbally aggressive.
- Shakes head when patient turns away
- Hand gestures - puts hands up to head, gestures hands when explaining, talking.
- Keeps eye contact with patient most of the time.
- Only physical contact by OT or Physio is to steady patient during bed to chair transfer.