The nurses’ experience of receiving nursing care as a patient in an acute general hospital

Shirley Graham

Thesis presented in fulfilment of the requirement of the degree of

Doctor of Philosophy

The University of Newcastle
2013
I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree at any other University or institution.

Shirley Graham
Abstract

This phenomenological study describes what it is like for the nurse to be a patient receiving nursing care in an acute general hospital and relates the understanding gained from this description to implications for health care practice and nursing education. The participants in this study were 45 nurses from all around Australia who had been patients in an acute general hospital for two days or more within the five years prior to the study commencement. Thirty-seven nurses consented to be interviewed either face to face or by telephone and eight nurses submitted their personal account by letter or email.

The experience of the layperson receiving nursing care whilst in hospital has been widely explored. Findings from several studies suggest that while lay people often have positive experiences of receiving nursing care and hospitalisation they also have negative ones (Morse, 1991; Walker, 2001). The negative experiences of hospitalised patients are of global concern and have seen the implementation of many changes to health care services and delivery (WHO, 2008). Anecdotally, many professional nurses who have been hospitalised as patients have expressed concerns about their experiences of being on the other side of the hospital bed. Many of those concerns resonate with those of the layperson but there is a paucity of research available on this topic.

The participants’ narratives representing their experience of being a patient receiving nursing care in an acute general hospital are presented in this study. To answer the question, “what is the nurses’ experience as a patient receiving nursing care in an acute general hospital” I used Giorgi’s (2009) phenomenological approach, which is guided by Husserl.

The findings of this study show that for the participants, being a nurse was an integral part of their personal identity. It was how they defined themselves within the milieu of the hospital setting. Being a nurse was how they saw the world; it was how they thought about and responded to the world and how they felt. Participants could not stop being a nurse. Even when they attempted to leave their nursing behind them and be a patient they thought and acted as a nurse would, thus their nursing knowledge and expectations were a part of their experience. Essentially, being a nurse represented their embodied self. Being a nurse and a patient receiving nursing care in this study incorporates “Becoming ill”, “Knowing and being afraid”, “Being a fly on the wall”, “Being discovered”, “Being a nurse”, “Being objectified”, “Being vigilant” and “Being cared for or not by a nurse”.

The findings of this study add to the body of knowledge about the experience of being a nurse and a patient receiving nursing care. In addition the findings also have implications for the nurse to nurse patient relationship in the provision of nursing care to this group of patients.
Acknowledgements

I wish to thank all of the nurse participants who gave so generously of their time and experiences. Without your contribution the nurse as patients’ voice would not be heard. Your stories inspired and motivated me to keep on with the study.

Thanks are due to my supervisors, Professors Diana Keatinge and Isabel Higgins for all of your time, effort and energies in helping me to develop my writing and critical thinking skills to this level. Thank you especially for your continuing encouragement over the years.

Thanks are also due to my manager, peers and colleagues in the Neonatal Intensive Care Unit at John Hunter Children’s Hospital for study time and continual encouragement.

Friends and family have given me unstinting support in many ways whilst I was studying and writing. However I could not have completed this thesis if I did not have the unquestioning support of my husband Kenny Graham, my children Lee and David and their wives Rénee and Chloe. Their belief in my abilities and the value of this study has been critical in my path to completion. They have given me time, patience, understanding and love during my periods of total focus on writing and episodes of frustration in my aim for completion.
# Table of Contents

ABSTRACT iii

ACKNOWLEDGEMENTS iv

TABLE OF CONTENTS v

KEY TO TRANSCRIPTS X

INTRODUCTION ................................................................. 1
  Background to the study......................................................... 4
  Structure of the thesis.......................................................... 6

CHAPTER ONE
  Literature review.............................................................. 9
  Search Strategy........................................................................ 10
  Nurse and nursing care........................................................... 12
  The nurse patient relationship.................................................. 20
  The good nurse......................................................................... 25
  Being critically ill and being cared for by a nurse......................... 27
  Nurse caring and non-caring..................................................... 36
  The absence of care.............................................................. 39
  Perceptions of nursing care.................................................... 41
  The experience of being a nurse and a relative of the patient.......... 52
  The experience of being a nurse and a patient............................ 56
  Nurse patient experiences and nursing practice.......................... 65
  Review and Summary........................................................... 68
CHAPTER TWO

The methodology, design and method of the study............ 71

Phenomenology................................................................. 73

Phenomenology as a research methodology in nursing........... 78

Husserl’s phenomenology..................................................... 85

Intentionality........................................................................ 90

Phenomenological attitude and phenomenological reduction........ 93

Giorgi’s framework for using phenomenology as a research method... 104

Collection of data..................................................................... 107

Assumptions and preconceptions relating to the study............. 110

Study setting........................................................................... 111

Inclusion criteria for the study................................................. 112

The participants....................................................................... 113

Recruitment.............................................................................. 114

Description of the participants................................................. 119

Ethical considerations............................................................... 122

   Informed consent................................................................. 122

   Confidentiality and anonymity............................................... 123

   Participant care.................................................................... 124

Data storage and access to files............................................... 126

Data Collection........................................................................ 126

   Telephone interviews.......................................................... 129

   Letters and emails............................................................... 130
Data Analysis............................................................................................................. 131
Ensuring rigor in phenomenological research................................................. 138
Review and Summary................................................................................................. 145

CHAPTER THREE

Being a nurse and being ill................................................................. 147
Becoming ill................................................................................................. 149
Knowing and being afraid....................................................................... 160
Being a fly on the wall................................................................................. 163
Being discovered............................................................................................. 169
Being a nurse................................................................................................. 177
Review and Summary....................................................................................... 190

CHAPTER FOUR

Being a nurse on the other side.......................................................... 192
Being objectified............................................................................................. 194
Being vigilant................................................................................................. 203
Being cared for or not by a nurse............................................................. 209
    Being cared for by a nurse..................................................................... 210
    Not being cared for............................................................................... 227
Review and Summary....................................................................................... 244
CHAPTER FIVE

Discussion and conclusion........................................ 247
Being a nurse and being ill........................................... 249
Knowing and being afraid.......................................... 252
Being cared for or uncared for by a nurse.................... 253
Being on the other side of the bed............................... 257
Being a nurse patient.............................................. 260
Implications for nursing practice and education............ 269
The limitations of the study........................................ 272
Future Research..................................................... 273
Concluding statement.............................................. 274
Epilogue – Becoming a better nurse............................. 277
References.......................................................... 281

Appendices

APPENDIX 1. Letter to Directors of Nursing
APPENDIX 2. Flyer advertising research project
APPENDIX 3. Advertisement in nursing journal
APPENDIX 4. Information letter for the research project
APPENDIX 5. Prompts to be used during the interview and demographic questions
APPENDIX 6. Consent form for participants
APPENDIX 7. Expression of interest in professional nursing journal
APPENDIX 8. Demographic details outlining length of nursing experience
APPENDIX 9.  Types of injuries/ illnesses participants had as patients
APPENDIX 10.  Information letter to Employee Assistance Program
## Key to Transcripts

<table>
<thead>
<tr>
<th>Pseudonyms</th>
<th>Participants names have been changed to ensure confidentiality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>Participants are nurses who are patients and for continuity and clarity are mainly described as participants but may on occasion be described as nurse patients.</td>
</tr>
<tr>
<td>( )</td>
<td>Within excerpts of data this symbol represents emotional responses, pauses or body movements</td>
</tr>
<tr>
<td>[ ]</td>
<td>Within excerpts of data this symbol represents words that complete sentences making the data easier to read</td>
</tr>
<tr>
<td>* or ###</td>
<td>Within excerpts of data these symbols identify when names of people or places have been removed to maintain confidentiality.</td>
</tr>
<tr>
<td><strong>Bold</strong></td>
<td>Within excerpts of data bolded words indicate the participant’s voice was raised at this point.</td>
</tr>
</tbody>
</table>
Introduction

The experience of hospitalised patients has been widely explored (Barker, Reynolds & Ward, 1995; Callery & Smith, 1991; Calnan et al., 2013; Carnevale, 1991; Coleman, 1995; Gavin, 1997; Higgins, 2001; Hogan, 2000; Kentisbeer, 2000; Morse, 2000; Walker, 2000; Walker, 2001; Walton & Madjar, 1999) with many studies highlighting a range of positive and negative experiences. Findings from several studies suggest that while ‘lay’ patients often have positive experiences of receiving nursing care and hospitalisation, they also have negative experiences (Gavin, 1997; Fenwick, Barclay & Schmied, 2000; Walker, 2001).

The negative experiences of hospitalised patients receiving nursing care are a global concern (Delamonthe, 2008; Garling, 2008; Institute of Medicine USA, 2001; WHO, 2008). Indeed many changes in health care delivery have been implemented as a direct result of patient satisfaction surveys, publications and reporting in the media (Coulter & Cleary, 2001; Garling, 2008; McDonald et al. 2006). Hospital administrators have also conducted focus groups with patients and staff to obtain patient and staff satisfaction about care and experiences as part of their quality assurance processes, and these have reported on the negative experiences of being a patient (Coulter & Cleary, 2001; Garling, 2008; McDonald et al. 2006).
Although the laypersons’ experience of being a hospitalised patient is being explored and issues are being addressed, the nurses’ experience of receiving nursing care as a hospitalised patient is virtually unexplored. Of significant concern to the research reported here is the anecdotal evidence that suggested a range of disturbing negative experiences for the nurse as a patient. From my reading and from what I have heard from other nurses, most of the letters and anecdotal stories from nurses are overwhelmingly negative and highly critical of the care provided to them by nurses (Anonymous 1998, Anonymous 1999; Ball, 1997; Barber, 2000; Brady, 1999; Harber, 1999; Kentisbeer 2000; Urden, 1997). Of concern is that the negative experiences of nurses, as patients in hospital have not been previously explored in any depth. Although it is likely that nurses who receive nursing care when a hospitalised patient share many aspects of the lay patients’ experiences, nurses’ professional knowledge and their familiarity with the health care context means that they are likely to have different perceptions and expectations of hospitalisation and illness.

In addition to anecdotal evidence of negative experiences of the nurse as a patient identified in letters to editors of nursing journals (Anonymous 1998; Anonymous 1999; Ball, 1997; Barber, 2000; Brady, 1999; Harber, 1999; Kentisbeer, 2000; Mitchell, 2000; Munro, 2000; Urden, 1997; Williams, 1998) there is also a small study by Zeitz (1999) who explored the experience of the nurse as a patient. The aforementioned anecdotes from hospitalised nurses and the research relating to lay patients caused me to question whether there
is a similarity or difference in the experiences reported by the lay patients and nurse patients.

Many nurses acknowledge that by understanding the experience of illness and being cared for from the perspective of the patients, they are able to provide nursing care that meets the needs of patients and they become better nurses for this knowledge (Morse, 2000). With this in mind, it is important to explore the experiences of nurses as patients in order to gain insight and understanding of their experiences and to be able to improve the nursing care for this group of patients.

The purpose of the study reported in this thesis, which was undertaken in Australia, was to describe the lived experiences of nurses who receive nursing care as a patient in an acute general hospital. The aims of the study were to provide an in-depth description of the nurse’s lived experience and in doing so it is hoped that the findings will inform nursing practice and change the way this group of patients are considered and cared for. Ultimately, it is hoped that the findings of this study will provide insight for nurses in a way that leads to better patient experiences. The study findings reported in this thesis show that whilst the experience of the nurse as a patient may have similarities to the layperson as a patient there are several major differences when the patient is a nurse.
**Background to the study**

My personal interest in the experience of being a nurse receiving nursing care developed as a result of my experience as a nurse, nurse educator and more recently nurse manager where my role is to ensure quality and effective nursing care is delivered whilst addressing complaints about patient care and treatment. A further impetus for my interest in this study is that I have often overheard comments from my colleagues that highlight the dread they feel at the thought of becoming a patient themselves. I have heard many of my colleagues recounting their experiences of being a patient and like the letters referred to previously, these experiences have also been negative. I wondered why these accounts were so negative and in what way were they negative. I wondered about the particular events, about the nature of the experiences of nurses as patients and what was happening in terms of the interactions between the nurses and nurse patients. I wondered how to redress the situation.

My interest in the nurses’ experience of being a patient was heightened when, a nurse, in the course of providing a report to a group of colleagues, described a patient as being ‘difficult’. The nurse went on to describe the patient as ‘a nurse in an Intensive Care Unit (ICU)’ and stated that she ‘knows everything’ therefore would ‘listen to nothing’. When listening to this account it occurred to me that while the hospital environment would have been familiar to this nurse patient, the experience of receiving nursing care as a
patient might well have been new and unfamiliar. I related my thoughts to
the nurse who had described the nurse patient as being ‘difficult’ and she
replied that, “all nurses are the same when they become patients”. There was
general agreement within this group of nurses that this was indeed the belief.
I wondered why nurses appeared to be so inconsiderate and highly critical of
their colleagues who had become patients.

In my experience as a nurse providing nursing care for hospitalised patients, I
often feel an affinity with the patient and family because I feel that I
understand their situation. I draw on the writings of nursing theorists Orem
all identified the importance of a positive nurse patient relationship in the
successful provision of nursing care, to guide my nursing practice. I also
identified with Morse (1991) who suggests that a therapeutic relationship
between the nurse and patient is important in providing nursing care that is
of benefit to the patient. Because of this I believe I am able to connect with
patients in a nurturing way whilst supporting the patient and the family
through the patient’s illness and recovery. Connecting with patients, means
that I feel able to assist them when they need it most. Connecting with
patients also enables them to return to their independence as soon as they
are ready. To be able to assist the patient in this way I need to know the
patient as a person and to respect him/her as an individual (Morse, 1991). I
therefore questioned why nurses have such a negative experience as patients
and what can be done to change this for them.
Throughout my nursing career I have observed the impact of illness on a person’s life and that of their family. I have studied many theories on illness such as Parsons Sick role from the 1950’s and read personal reflections of illness from various authors such as Barber (2000) and Frank (2002). However I had never really understood what it means to be a nurse and to be a patient until I had an episode of acute illness myself and I was more than half way through this study. I realised that I had expectations of nurses during my care that may have created challenges and impacted my experience at this time.

**Structure of the Thesis**

The findings of this study are presented in five chapters. In Chapter One I present a discussion of relevant research literature. In particular I discuss studies that have explored nursing care and the nurse patient relationship, being critically ill and being cared for by a nurse. In discussing studies that have explored nursing care, perceptions of nursing care and nurse caring and non-caring were explored. As there is a paucity of available research literature on the nurses’ experience of being a patient, the experience of being a nurse and a relative of the patient was explored. These studies assisted me to gain an understanding of what it may be like to be a patient and what, if anything may be different for the nurse as patient.
In Chapter Two, I outline the methodology, method and the rationale for using phenomenological description in this study. In this chapter, I also discuss the design and plan of the study and provide an outline of the participants. In order to gain a broad understanding of the experience I recruited nurses from all over Australia.

In Chapter Three and Four I present the data analysis and depict the main themes of the study. In Chapter Three I discuss the experience of being a nurse and being ill. The main themes identified are, “Becoming ill”, “Knowing and being afraid”, “Being a fly on the wall”, “Being discovered” and “Being a nurse”. In Chapter Four I also discuss the experience of the participants and explore the experience of the nurse “on the other side of the bed”. Emergent themes included: “Being objectified”, Being vigilant” and “Being cared for or not by a nurse”. Being cared for or not by a nurse includes two subthemes of “Being cared for” and “Not being cared for”. Whilst these themes do not depict the entire experience of being a nurse patient they provide a comprehensive account of the journey and experience of being a nurse receiving nursing care in an acute general hospital.

In the final chapter, I discuss the findings, their implications for nursing practice and recommendations for nursing education and research. Finally, following the interviews with participants in this study some of them reflected on the changes they made to their own nursing practice after their experience
of being a patient. I have included these reflections in the epilogue to this study.
Chapter One

Literature Review

In the following discussion, I critically review contemporary literature relating to the experience of being a patient and being cared for in an acute general hospital from the perspective of a lay person and finally from the perspective of nurses who were patients themselves. The literature concerning caring and non-caring in nursing has also been reviewed as patients, both laypeople and nurses as patients, have identified the importance of a positive relationship between the nurse and the patient for caring to take place. Although there is a lack of research literature on the experiences of nurses as hospitalised patients, several research studies report the experiences of laypeople with illness or disease and their experiences of being in hospital and being a patient. Also located was research and scholarly literature that explored what it is like to be cared for or not cared for by a nurse, what constitutes caring by nurses and the nature of nurse patient relationships.

Whilst I located and reviewed literature pertaining to the nurse’s experience of being a patient and receiving nursing care, I found very little research literature on this topic. This lack of research, in conjunction with the anecdotal evidence, was a key reason for my interest in conducting the study reported in this thesis. As there was a paucity of literature relating to the experience of nurses as patients, I widened the search and reviewed
literature on nurses of relatives who have been hospitalised. I thought that the literature on nurses who have hospitalised relatives may identify a similar situation where although the nurse is not a patient (s)he is a relative and similarly powerless to provide nursing care in that role. In addition, available literature, which focuses on nurses’ experiences of receiving nursing care, is also critically reviewed. In order to fully appreciate the perspectives and experiences of the nurses in this study, and to situate the study theoretically, I reviewed theories of nursing and nursing care.

In the following discussion, I outline my search strategies. I also critically discuss: nursing, nursing care and nurse patient relationships; being critically ill and being cared for by a nurse; nurse caring and non caring; perceptions of nursing care; the experience of being a nurse and a relative of the patient; the experience of being a nurse and a patient and finally the influence of nurse patients’ experiences on their nursing practice.

**Search Strategy**

Several search engines were utilised for the literature search. These included: British Nursing Index, British Medical Journal, Lancet, Clinical Information Access Program (CIAP), Pubmed, Medline, Cochrane, OVID, Evidence Based Practice, Cumulative Index to Nursing and Allied Health (Cinahl), Australian Resource Centre for Healthcare Innovation (ARCHI), Department of Health Policy directives, guidelines and information bulletins (Australia), Department
of Health reports (Australia), World Health Organisation reports, Library of Congress Catalogue, New England Journal of Medicine, University of Newcastle Dissertations, UMI\(^1\) Dissertation Abstracts, Phenomenology online and Google Scholar. Initially, published research findings and discussion documents were restricted to the five years from the commencement of the study but this was expanded to provide a fuller overview of the literature available and in order to gain a more comprehensive perspective on the experience of being a hospitalised patient. Thus, literature from 1987 to 2013 was reviewed.

The search terms used to locate literature relevant to my study included: what is a nurse, theories on nursing and nursing care, being a patient, being hospitalised, nurse patient, nurse-relative of a patient, being a nurse patient, the doctor as a patient and health care worker as a patient. In addition other terms were used including: the experiences of being in hospital, receiving nursing care, being cared for by a nurse, being ill, illness, sudden illness, acute illness, critical illness, nursing care, therapeutic relations, nurse patient relationship, and nurse patient interactions. These search terms were expanded from titles, reference lists and bibliographies in the articles sourced. Some examples of these are: being on the other side, nurse on the other side, the nurse on the bed and nurse on the other side.

\(^1\) UMI Dissertation Abstracts is the full name of this search engine
As a result of these searches the literature reviewed included: research and scholarly literature, unpublished theses dissertations, discussion papers, conference presentations, national and international government health reports, world health reports, textbooks on nursing care, nursing theories, illness and caring, newspaper articles, letters in professional journals and online discussion forums which were in the English language.

In critically reviewing the literature on the experience of being a nurse and a patient, it became clear to me that it is important to identify what it means to be a nurse and indeed, what it means to be a nurse and to provide nursing care.

**Nurse and nursing care**

The word nurse is derived from the Latin words ‘nutrire’, to nourish and ‘nutrix’, nursing mother and it has predominantly been a female role (Coleman, 1995). Throughout the past century nursing education was based largely on a medical model (Newman, 1995) but nurses’ have, over time, developed their own theories on nursing and moved away from the medical model to a more holistic model of patient care and in doing so, nurses have gained a professional identity. To have a professional identity as a nurse is more than clinical knowledge and expertise it is an experience and feeling of being a nurse (Ohlen & Segesten, 1998).
Nursing care has been well described in the literature (Appleton, 1993; Barker et al., 1995; Bowden, 1995; Carnevale, 1991; Gavin, 1997; Goldbort, 2009; Higgins, 2001; Noddings, 1984; Nordby, 2007; Spichiger, Wallhagen & Benner, 2005; Vouzavali et al., 2011; Walsh, 2000 and others). Kirby (2002) described nursing care, as something inescapably personal and emphasised that a ‘good’ nurse will make the patient feel comfortable and provide the nursing care the patient requires without making the patient feel that (s)he is a burden. Noddings (1984) identified that caring involves a “feeling with the other” (p.30). This feeling with the other is not the nurse putting her/himself in the others shoes it is described by Noddings (1984) as the nurse receiving the other into her/himself and identifying with the other in a unique way. What Noddings (1984) identified is that the nurse develops a therapeutic relationship with the patient and rather than projecting her/his beliefs on the patient’s requirements, the nurse gets to know the patient situation and provides care that is needed.

The terms ‘good’ and ‘bad’ nursing care are often used in the literature related to nursing care to describe the quality or type of nursing care received (Appleton, 1993; Carnevale, 1991; Downes, 2006; Heath, 2001; Kirby, 2002; Morse, 2000; Rchaidia, Dierckx, de Blaeser & Gastmans, 2009; Sahlsten, Larsson, Sjöström, & Plos, 2009; Savage & Conrad, 1992; Sørlie, Torjuul, Ross & Kihlgren, 2006; Walsh, 2000; Watson & Smith, 2002). Good nursing care has been described as comforting, being attuned to patient cues of distress and providing nursing measures to alleviate suffering (Carnevale,
1991; Downes, 2006; Morse, 2000). The terms ‘nursing care’ and ‘caring’ are used interchangeably and the ability and willingness of the nurse to provide care has been described as essential in the development of a trusting and therapeutic relationship between the nurse and the patient (Appleton, 1993; Heath, 2001; Rchaidia et al., 2009; Sahlsten et al., 2009; Savage & Conrad, 1992; Sørlie et al., 2006; Walsh, 2000; Watson & Smith, 2002).

Several nursing scholars have developed theories on nursing care that have been influential in moving nursing care forward and bringing nursing into the realms of professionals in their own right. Of interest is that all of these theorists have identified the nurse patient relationship as integral for providing nursing care.

Nursing theorists have described nursing care as an art and a science (Orem 2001, Watson 1999, 2011). In discussing contemporary nursing care, Ray (1991) defines caring as “the energy by which choice is facilitated to bring order (healing or well-being) out of chaos (disease, need, pain, or crisis)” (Ray, 1991, p. 26). Nursing care can facilitate healing (Ray, 1991). Phillips and Benner (1994) stated that nurses have notions of what is good nursing care and what is not good nursing care. In identifying what constitutes nursing care, Watson (1999) said that caring was the art of being human. Watson (2011) further identified caring as the essence of nursing:

*Caring is holistic and is the essence of nursing.*
integrates knowledge of the socio-cultural environment, the technological, economic, political, and legal dimensions into its meaning structure and conceptual foundation. Caring, as complex, captures the genuine science of quality because its science is also the art of practice, an aesthetic, which illuminates the beauty of the dynamic nurse–patient relationship ..../.. Thus, caring is universal and particular, ubiquitous in its appeal as the core of nursing philosophy, and particular in its diversity of expression in nursing practice. (p. xxii)

Thus, caring is an extremely important part of what nursing is all about. Of importance in this process is that good nursing care requires a positive relationship between the nurse and patient. Benner (1984), Orem (2001), Peplau (1991) and Ray (2011) also highlighted the need for a relationship or connection between the nurse and patient in order for caring to happen and healing of the patient to take place.

Orem (2001), Peplau (1991), Ray (2011), Swanson (1993) and Watson (1999) all identified the importance of a positive nurse patient relationship in the successful provision of nursing care, which enables the patient to return to his/her pre-illness state of health. Peplau (1991) was the first to identify the importance of the relationship between the nurse and patient in the provision of nursing care. She noted that a positive nurse patient relationship
is therapeutic and beneficial for the patient (Peplau, 1991). Peplau (1991) described nursing as an interpersonal process that involves interaction between the nurse and the patient to reach their common goal of the patient healing. The nurse provides an accepting climate that allows a caring relationship to develop and build trust (Peplau, 1991).

Swanson (1993) also described the nurse patient relationship as a connection between the nurse and patient. Swanson’s (1993) theory is that caring, knowing, being with the patient, doing things for and enabling the patient, are all part of nursing a person back to a state of health and well being. She describes nursing care that is provided in a non-judgemental way until the person no longer requires this care (Swanson, 1993). Individualised or person centred care is based on a relationship with the patient and as the nurse gets to know the patient in a therapeutic way (s)he can provide the correct level of nursing care and support required to aid the patient to a full recovery from illness, and thus improve the patient’s satisfaction with his/her experience of being a hospitalised patient (Calnan et al., 2013).

Like Peplau (1991) and Swanson (1993), Orem (2001) also described a positive relationship between the nurse and patient as “necessary” for good nursing care. Orem (2001) developed a “self care deficit theory”. Her assumptions were that human beings would be responsible for and provide care for themselves. However, when a person was ill or injured and a patient in hospital (s)he could call on the assistance of the nurse to provide the care
(s)he required until his/her health status was restored. Orem (2001) believed it was the responsibility of the nurse to maintain interpersonal, therapeutic relations with the patient in order to provide the nursing care the patient required to return to health. Theories developed by Peplau (1991), Swanson (1993), Orem (2001) and others inform nursing practice that the importance of a “connection” with the patient is paramount to an effective nurse patient relationship. Thus it is essential for positive health outcomes for the patient and demonstrates nurse caring.

In addition to nurse theorists, other nurse authors have also espoused the importance of a connection between the nurse and the patient. Gadow (2006) believes that a dialogue between the nurse and the patient is important to develop a trusting, knowing relationship in which nursing care becomes more than a ‘moral high ground’ (p. 178). When dialogue is present, nursing care becomes inclusive of the patient and the patients’ needs. If this dialogue is absent, Gadow (1994) argues there is objectification of the patient and the nurse adopts the moral high ground of paternalistic knowing. Downes (2006) emphasised the importance of a connection between the nurse and the patient when critiquing her own practice as part of a text on “The Art of Nursing”. Downes (2006) provided some insight into how the connection between the nurse and patient could be missing in the nurse patient relationship and in this situation the nurse could be perceived as uncaring. She told of her own “almost military like attitude” (Downes, 2006. p. 79), in that she had forgotten the importance of the interpersonal relationship with
the patient and she had become more focussed on completing the nursing tasks that she thought were important for the patient. She said, “As a seasoned nurse, I had become inured to many things to get the job done” (Downes, 2006, p. 79). When Downes (2006) realised that her nursing care was task oriented and that she was becoming impatient because the patient wanted more than nursing tasks, she reflected and changed her practice to be patient centred and in doing so she identified the importance of caring for and about the patient. Downes (2006) was surprised that by stopping and taking the time to listen to the patient she had made the patient happy and received appreciation. She explained:

> The gratitude that she (the patient) expressed was so sincere, that I still get misty eyed when I think of her.... In reality, what I had done was so simple and so basic, I had touched her body with caring hands, and touched her spirit with caring words and a willingness to listen.

(Downes, 2006. p. 79)

Downes (2006) captured what other authors such as Benner (1984), Benner and Wrubel (1988), Carnevale (1991), Kirby (2002), Morse (2000), Valentine (1989) and Watson (1999) described as a connection with the patient or the essence of nursing care. Importantly, Watson (2011) also highlighted how easily the connection could be missed if the nurse is too busy to see the patient as an individual. Benner (1984) argued that without a connection
between the nurse and patient the nurse patient relationship is not therapeutic and therefore may not provide the nursing care that the patient requires, which leads to dissatisfaction for both the patient and the nurse. Furthermore, Pask (2003) argues that:

_Nurses hold a view of themselves and their professional self-identity that is intrinsically linked to, and dependant upon, their capacity to see good in the work that they do._

(Pask, 2003. p. 166)

It is the giving of person-focused care and the ability to provide this nursing care and make a difference to the patient that that nurses value (Pask, 2003).

As Downes (2006) identified, caring in nursing is more than just the act of physically providing care. Caring in nursing has been identified as the ability of the nurse to see beyond the patient to the person (Euswas & Chick, 1999; Watson & Smith, 2002). To get to know the patient as a person and in doing so, identify and provide the nursing care needs of the ill person enabling him/her to return to his/her previous state of health. Indeed caring has been described as central to effective nursing practice and is inextricably bound to the belief system and practice of nursing (Euswas, 1991; Euswas & Chick, 1999; Forrest, 1989; Nightingale, 1992; Watson & Smith, 2002). Consequently, a nurse is a person who can provide nursing care with clinical skills, knowledge, communication skills, and has the ability to connect with
the patient and to implement caring practices for the good of the individual receiving care.

**The nurse patient relationship**

In exploring nursing care, Euswas and Chick (1999) used the data from a grounded theory study, forming part of a doctoral thesis in New Zealand (Euswas, 1991), to provide a phenomenological description of being cared for and caring. Participants included 32 female registered nurses who were providing the care for the 30 adult participants. These participants were patients aged 40 years and over with a diagnosis of cancer. Of the 30 patient participants, 18 were female and 12 were male. Six were terminally ill and the rest were undergoing treatment either medically or surgically for their diagnosis of cancer. Euswas and Chick (1999) interviewed the nurses and patients about care and caring. They also used field notes, memos and patient medical and nursing records to identify themes. In their analysis Euswas and Chick (1999) described the many dimensions of nursing care as inclusive of physical comfort, psychological comfort and “being there” for the patient, which also implies a connection between nurse and patient. Euswas and Chick (1999) stated that for nursing care to be effective the nurse has to be personally and professionally prepared to care. This involves the nurse having a commitment to patient care and the ability to competently deliver the nursing care required. Euswas and Chick (1999) support the work of nursing theorists (Peplau, 1991; Swanson, 1993) as they described the
important aspects of nursing care as, being there for the patient, being mindfully present and developing a relationship of trust whilst actively meeting the needs of the patient.

Similarly, Austgard (2008) identified some common characteristics and core elements that distinguish care from non-care. She conducted a hermeneutic philosophical enquiry inspired by Gadamer’s philosophy (1998), which influenced interpretation and reflection on the content of historical and modern text from nursing theorists such as Nissen, Martinsen, Benner, Erikson and Watson (Austgard, 2008). Austgard (2008) found that there was a relationship between care, concern and love, care and moral practice and care and vision of excellence. She stated that the ability to provide nursing care involves the holistic view of the patient, a view which concurs with other authors who reviewed or provided a theoretical discourse about nurse caring and caring behaviours such as; Euswas and Chick (1999), Quan (2006) and Watson and Smith, (2002). Austgard (2008) concluded that any experience, which excludes the patient as a person, or the patients’ values and experience, should be regarded as non-caring practice.

Hudacek (2008) explored caring in relation to nursing practice in a phenomenological study of nurses’ stories utilising Giorgio’s method of analysis. The study conducted over a twelve-month period, comprised a large number of stories from 200 nurses practicing in America, Slovakia, Tokyo, Tekrit, Argentina, Australia and Cuba. The author stated that 120,000
invitations to participate were sent out and 200 stories were returned. The large number is because of the vast area covered and the author believes that the more subjects there are the greater the variation (Giorgi, 1997). In this study by Hudacek (2008) seven dimensions of caring in nursing were identified including caring, compassion, spirituality, community outreach, providing comfort, crisis intervention and going the extra distance. Going the extra distance was described as doing the little things for the patient that don’t necessarily help in healing but show the patient that (s)he is cared for.

Hudacek (2008) agreed with Austgard (2008), Euswas and Chick (1999) and others, when concluding that nursing care is much more than technical skill. To be effective, nursing care must include many more subtle elements that are deeply personal and involve a connection between the nurse and the patient. Like others, Hudacek (2008) described nursing care as multi-dimensional and complex in that it involves an effective relationship between two comparative strangers. Hudacek’s (2008) study is important in the nursing field as it confirms theoretical discourse and research studies about what comprises good nursing care.

Of note in the literature previously discussed is that fundamental to nursing care is that the ‘connection’ that develops between the nurse and the patient is essential in order for the nurse to know what care the patient requires and how and when to optimally deliver that care. Many authors (Rchaidia, Dierckx de Casterlé, de Blaeser, & Gastmans, 2009; Sahlsten et al., 2009; Shattell,
Hogan & Thomas, 2005; Sørlie et al., 2006; Williams & Irurita, 1998 and others) declare that the interaction between the nurse and patient can have an impact on the patient’s hospital experience as the nurse understands the patient’s needs and is ‘there for them’.

In exploring the experience of being a patient in hospital, several researchers (Almerud, Alapack, Fridlund & Ekebergh, 2007; Parker, 1999; Shattell, Hogan & Thomas, 2005; Sigurgeirsdottir & Halldorsdottir, 2008; Vouzavali, et al., 2011 and others), have found that the role of the nurse is integral in forming a therapeutic relationship with the patient and in doing so improves the patient experience. This therapeutic relationship allows for open communication and thus a connection between the nurse and patient, which is consistent with several nursing theories (Benner, 1984; Orem, 2001; Peplau, 1991). It is believed that this connection between the nurse and patient allows an understanding between what the patient’s needs are and what nursing care the nurse can provide, and this makes the patient feel that (s)he has been cared for (Morse, 1991). However, when this connection between the nurse and the patient is absent, the patient reports feeling uncared for (Morse, 1991).

Many authors have identified the relationship between the nurse and patient as integral to the provision of nursing care (Hogan, 2000; Morse, 1991; Strandberg, 2003; Shattell, Hogan & Thomas, 2005). Valentine (1989), Carnevale (1991) and Morse (1991) described the connection between the
nurse and patient as a therapeutic relationship. Valentine (1989) and Carnevale (1991) clarify this by stating that nursing care includes the ability of the nurse to understand the patient’s situation and provide care. In a grounded theory study, Morse (1991) explored the nurse patient relationship and described the development and maintenance of this relationship. Morse (1991) highlighted relationships that are ‘good’ and/or beneficial to the patient as when the nurse and patient were connected in mutual trust and respect.

Morse (1991) and eight research assistants interviewed 38 nurses from eight different clinical areas. Many were interviewed twice. Some of these nurses had also been patients and they were interviewed from the patient perspective. Unfortunately, Morse (1991) did not identify how many nurse patients were included in the overall participant numbers nor did she highlight any possible differences or similarities between nurse patients and lay patients. However, she identified two types of relationships between the nurse and the patient. She identified these as a unilateral relationship or a mutual relationship. Morse (1991) suggests that the first of these, the unilateral relationship, is present when the nurse and patient are unable or unwilling to connect. For example, if the patient is distressed or has communication difficulties and the nurse does not consider this, the relationship may not develop. This may result in a lack of connection between the nurse and patient. The nurse may not be aware or understand the
patient’s needs and therefore cannot meet them, leaving the patient feeling uncared for and unsatisfied with the experience of receiving nursing care.

The mutual relationship as described by Morse (1991) has four facets within it and these are: clinical, therapeutic, connected and over involved. The first three facets of the relationship are where the trust between the nurse and patient is built up and becomes a relationship of benefit to the nurse and patient. However, the over involved is where the nurse has gone beyond the professional boundaries and become more a personal friend than a nurse. Although the study was conducted in 1991, the findings are still relevant and useful for today’s nursing practice. In considering the patient as a person with his/her own needs, values and beliefs the nurse is accepting her/him for who (s)he is, and in recognizing his/her needs, the nurse then aims to provide for him/her. It seems that when the nurse has considered the patient and met the patient’s needs the patient describes the ‘good nurse’ (Almerud et al. 2007; Davis, 2005; Warelow, Edward & Vinek, 2008).

**The good nurse**

The good nurse has been identified widely in the literature (Almerud et al. 2007; Davis, 2005; Warelow, Edward & Vinek, 2008). Like others, in describing the good nurse Rachidia et al. (2009) described the importance of a positive nurse patient relationship. Rachidia et al. (2009) conducted a systematic review of the literature on cancer patients’ perceptions of the
'good nurse’ from several eastern and western countries published between 1998-2008. Twelve relevant studies, both qualitative and quantitative were reviewed. Rchaidia et al. (2009) defined good nurses as those who understood the patient situation and treated the patient as an individual. The good nurse has the right attitude, knowledge and skills and knows how to engage in nurse patient relationships in which (s)he respects the patient and provides support. Rchaidia et al. (2009) concluded that good nurses do make a difference in the care of cancer patients. Thus, the nurse who treats the patient as an individual and connects with the patient in a therapeutic nurse patient relationship will have the knowledge and understanding to provide the care the patient requires.

Geanellos (2002) conducted an exploration of the literature on the therapeutic potential of friendliness and friendship in nurse patient relationships. She described the most important feature of the nurse patient relationship as friendliness, a superficial relationship where the nurse smiles, jokes, has a warm tone of voice and shows an interest in the client. According to Geanellos (2002) when nurses are friendly, patient’s feelings of loneliness and strangeness dissipate. Alternately when the nurse is unfriendly, there is a negative feeling, which has a lasting impact on the patient's experience of receiving nursing care (Geanellos, 2002). Other authors, for instance Hogan (2000); Strandberg (2003); Shattell, Hogan and Thomas (2005), described similar features to friendliness as the nurse patient connection or relationship. Indeed, this literature supports the work of Morse (1991) as she described a
connection with the nurse and patient where there is mutual trust, but when the connection is missing there is a one sided relationship or no relationship at all, which is unhelpful.

It is clear that the nurse and patient require an effective relationship and one that facilitates a connection between the nurse and the patient to allow the provision of appropriate nursing care. An effective relationship is described as a situation where there is a mutual understanding between the nurse and the patient, a willingness of the nurse to provide care and knowledge of what care is required. Geanellos (2002) and Maata (2006) described it as being friendly but they identified more than friendship. They identified a temporary professional relationship, which Morse (1991) has described as a connection. To further identify the importance of the connection between the nurse and patient in acute illness and the effects of a positive nurse patient relationship on the experience of being a patient in hospital the research literature on the experience of being a lay patient in hospital for an acute illness was reviewed.

**Being critically ill and being cared for by a nurse**

Parker (1999) explored the experiences of being critically ill in an Intensive Care Unit (ICU). The participants in this study were 10 patients in an ICU of a large tertiary hospital in New South Wales, Australia. Parker's (1999) phenomenological study used a clinical field study design and generated data from a triangulation of sources including participant observation, review of
the patients’ notes in ICU and interviews with the patients following their discharge from ICU. The five men and five women in this study were unprepared for their admission to ICU, as their admission to this facility was due to a sudden event or injury.

Analysis revealed several themes including unnaturalness and disruption, which are identified as when the patient’s life as it was known is disrupted with the acute illness and the environment in which they found themselves was not normal for them, and indeed it felt unnatural. Displacement, disablement and struggling to survive were other themes identified by Parker (1999). Participants described displacement and disablement as they were restricted in movement and felt dislocated from the world. The ICU environment was “alien” to participants as their lives had been completely disrupted. Participants felt helpless and dependent on others. Parker (1999) concluded that the patient’s experience in the context of ICU was a “feeling of displacement and confusion”.

Participants in Parker’s (1999) study described struggling to survive as “vigilance”, “a fear of the unknown” and “a fear of death”. The threat of death saw the participants call into action all the emotional forces they could employ in the defence of their personal safety and they became vigilant when reacting to what they thought of as a threat. Vigilance involved the mobilisation of instinctive primitive responses, such as participants reacting violently and lashing out at staff or pulling out tubes with incredible physical
strength when they felt that they were struggling for survival. Parker’s (1999) study identified that participants were vigilant for their own safety.

In describing the nurse patient relationship, participants in Parker’s (1999) study were confident with nurses only when they saw these nurses were genuinely committed to their care. Parker’s (1999) study found that patients perceived the nurse’s commitment to them comprised the nurse being close to them and being attuned to their needs. Being involved and being attuned for patients in Parker’s (1999) study meant the nurse seeing what was happening with the patient and “being together with them as they faced their fears and suffered their pain” (Parker, 1999. p 71). Although the patients could not verbally communicate with the nurse, the connection was still present as they watched what was going on around them, for example when the nurses demonstrated appreciation and anticipation of the patient needs with sensitivity to the patient’s emotional state the patient felt cared for. Patients in Parker’s (1999) study identified the difference between caring and uncaring behaviours from nurses as characterised by presence, closeness and involvement as opposed to absence, distance and disinterest (Parker, 1999. p. 71).

Participants in this researcher’s study were patients in ICU and some were intubated\(^2\) and unable to speak but the researcher identified that even when

\(^2\) an endotracheal tube had been inserted into the airway, past the vocal chord making it impossible to speak
they could verbally communicate the lack of knowledge of what had happened to them and why, rendered them voiceless or unable to speak up for themselves (Parker, 1999). Fear and loneliness patients felt due to their inability to communicate was also identified (Parker, 1999). However, Parker (1999) does not identify how the nurse and patient overcame, or whether or not they did overcome the inability to communicate and the effect it had on the nurse patient relationship.

The nurse patient relationship as described by Morse (1991) does not depend on oral communication for the connection to be present as Vouzavali et al. (2011) identified. Vouzavali et al. (2011) used a hermeneutic phenomenological approach to explore the nurse patient relationship in critical care. This study of 12 participants who were all critical care nurses in Athens identified the “gaze” of the patient as the way patients in critical care communicated most of their needs. The nurse participants in Vouzavali et al.’s (2011) study perceived that patients communicated their feelings, needs and desires through their gaze. Vouzavali et al. (2011) described this gaze as when the patient followed the nurse with his/her eyes and the appeal for assistance, help, support was in the eyes. As participants described the eyes as the “window to the soul” (Vouzavali et al. 2011, p. 146) the gaze was very powerful in that it drew the nurse to the patient and facilitated the patient to nurse connection without oral communication. Indeed, participants in Vouzavali et al.’s (2011) study found the gaze quite disconcerting and disarming to a point that “the nurse cannot think and act freely, when she/he
is aware that someone [the patient] is gazing at her/him” (Vouzavali et al. 2011, p. 146). However, when the gaze was mutual a deeper communication and mutual understanding was achieved and a bond was developed between the nurse and the patient (Vouzavali et al. 2011). Walton and Madjar (1999, p.10) also describe the gaze in the nurse patient relationship but the gaze is identified as a “listening gaze” where it is the nurse who uses the gaze to see what nursing care the patient needs which Walton and Madjar (1999) describe as a “searching” gaze.

Almerud et al. (2007) used a phenomenological approach with nine patients to investigate the experience of being a patient in a Swedish ICU. Similarly to Parker (1999) the study by Almerud et al. (2007) focussed on the experience of being a patient in a technologically intense environment and similarities to Vouzavali et al’s. (2011) study were found, in that critical illness or injury threatened life as it was known. In describing their illness experience in ICU the participants all described a fear of death and a lack of control over their body and events. Almerud et al. (2007) describe this threat of death as perforating the existence of the individual who is confined to the ICU environment and often confined to bed by the technology that surrounds the patient.

In the study by Almerud et al., (2007) thematic analysis revealed families as important as they provided the impetus for the participant to fight for survival because patients perceive that their family members want them to fight for
survival and not to succumb to the injury or illness. Families provide therapeutic support and “for their sakes, the patient fights the battle for survival” (Almerud et al. 2007. p 154).

The similarities with Parker’s (1999) study end there as Almerud et al.’s (2007) findings include a lack of human encounters and the dependency on machine-generated data. Almerud et al. (2007) describe the nurses as the machine caretakers who focus more on the data from the technology than the patient. These authors reported a lack of humanness or person centred care as findings revealed that there was a lack of human connection between the nurse and the patient as the nurse focussed on the technology and did not recognise the patient as a person (Almerud et al., 2007). Thus, participants reported that despite being constantly monitored and observed they did not feel “seen”; indeed, they felt invisible as people as they and the “machines meld into one” (Almerud et al. 2007, p. 155).

Participants in the study by Almerud et al. (2007) described recognising what they labelled as good nursing care. However, what they described was not a positive nurse patient relationship or a connection with the nurse but rather the participants in this study equated good nursing care to being a good patient and doing what was expected of the patient to gain the nurse’s respect such as the patient being compliant or being liked by the nurse. This study points to a lack of person centred care in nursing care in an environment where the technology appears to be more important. Of interest
are participants’ descriptions of feeling invisible and their observations that nursing observation was related to machines rather than the patient. It is apparent in the study by Almerud et al. (2007) that the human connection between nurse and patient was absent in the presence of the technology and the nurse patient relationship was not therapeutic as described by Morse (1991).

Similarly to Almerud et al. (2007), is that participants in an American study by Shattell, Hogan and Thomas (2005) identified being connected or disconnected from caregivers. Participants in this study by Shattell et al. (2005) felt that nurses thought they were superior to the patient or alternatively they were just being unfriendly to them. However when nurses were friendly and showed concern the participants described being connected to the nurse. Shattell et al. (2005) used an existential phenomenological approach to describe the patient’s experience of the acute care hospital. They described both caring and uncaring practices by nurses. This study consisted of 20 participants of African American or Euro American background who had been in hospital for medical- surgical care. One of the main themes described how participants were the recipients of “rough handling” and “not so gentle” treatment, which was identified as when the nurse was described as being rough and not careful when attending to the patients needs, so rough in fact that one participant identified that her parents attempted to intervene. Shattell et al. (2005) asserted that the patient’s experience of the acute care environment was overwhelmingly described in “human to human” terms
defined as the nurse and patient being connected to each other in a positive and nurturing way. These researchers found that the hospital experience for patients is improved by a friendly nurse patient relationship and that caring equates to “tenderness” and “curing” (Shattell et al. 2005. p. 161).

In describing caring practices of nurses, Shattell et al. (2005) described an important finding in their study as “being connected”, which for participants was expressed as a feeling of being cared for as the nurse checked in on them or was friendly and attentive. Similarly, to Morse (1991) and others who have identified being connected as integral in the nurse patient relationship, Shattell et al. (2005) found that the connection between the nurse and patient was integral in alleviating anxieties and ensuring the patient felt cared for.

In addition to describing being connected or disconnected, fear was also described by Shattell et al. (2005). These authors described fear as due to vulnerability, powerlessness and a lack of connection felt by the patients but when patients felt that nurses were “there for them”, in that they felt connected with the nurse, the patients described being less fearful. Shattell et al. (2005) concluded that patients’ determine quality of care by their relationship with the nurses. Thus, as previously identified the nurse patient relationship has an impact on the patients experience of being a patient in hospital.
Of note is that Shattell et al’s (2005) findings also identified the importance, and sometimes isolation, that a single room can provide for the patient. These researchers identified that if the patient was well a single room could provide privacy but if the patient was unwell, the single room that afforded privacy was now isolating (Shattell et al., 2005). Although the authors do not elaborate on this theme, it is important, as it is the only source identified in layperson literature of the meaning of a single room for patients. However, the notion of the importance of a single room is further identified by Zeits (1999) in the nurse as patient literature and is discussed further in the findings of my study.

The studies above suggest that the experience of being a patient in intensive care and acute care is about experiencing uncertainty, vulnerability, fear and being vigilant. Having a sense of a connection or relationship between the nurse and patient however seems to help with alleviating some of the fear and anxiety experienced. This connection was expressed in a range of ways and forms including the patient gaze, friendliness of nurses and receiving care and tenderness.

As has been shown by the research reported previously an effective relationship between the nurse and the patient has a positive impact on the patient experience of receiving nursing care (Austgard, 2008; Euswas & Chick, 1999; Hudacek, 2008) and as noted in the introduction this has the potential to have a positive impact on recovery from illness. To further
understand the impact on the patient of the nurse patient relationship and its central role in the experience of receiving nursing care the literature on being cared for or not being cared for by a nurse was reviewed.

**Nurse caring and non-caring**

Over the past decade there has been a proliferation of literature on nurse caring behaviours as it was recognised that the nursing care patients received affects their overall experience of being a patient (Appleton, 1993; Barker et al., 1995; Carnevale, 1991; Gavin, 1997; Goldbort, 2009; Nordby, 2007; Spichiger et al., 2005; Vouzavali et al., 2011; Walsh, 2000 and others). Thus, there has been more focus on the good and bad aspects of nursing care provided with the aim to improve nursing care, patient satisfaction, patient outcomes and the experience of being a patient.

For instance in an Australian study, Higgins (2001) used a phenomenological approach to explore the experience of being cared for and not being cared for. She included 23 participants who had been admitted for treatment of an acute illness in a medical-surgical unit. Like previous authors, Higgins (2001) identified good and bad aspects of nursing care. Participants identified what they described as ‘bad aspects’ of nursing care through the “inactions” of nurses and due to their behaviours and responses towards patients, such as not answering the patient’s call for help. Good aspects of nursing care were identified when nurses showed that they wanted to do things for the patient
such as ensure comfort by straightening the bed linen. Good aspects of nursing care were also identified when the patient felt that they were treated as an individual and special rather than just another patient. The findings of the study revealed that the experience of being cared for by a nurse included four overlapping themes which identify the nurse patient relationship and links the type of relationship to the experience the patient reports such as: “caring as affirming or denying personhood” (Higgins, 2001, p. 117). According to Higgins (2001) this theme identifies that in affirming personhood the patient feels like the nurse’s friend and has a positive relationship, which Shattell et al. (2005) later supported. Indeed Higgins (2001) concluded that caring behaviours from nurses could promote wellbeing and uncaring behaviours could hinder the patients’ recovery, making it important to ensure that nursing care is positive and promotes the well being of the patient.

A year after Higgin’s (2001) study was published Thorsteinsson (2002) utilised phenomenology in a study conducted in Iceland to explore the perceptions of the quality of nursing care by individuals with a chronic illness. There were 11 participants in Thorsteinsson’s (2002) study. This study is one of chronic illness; however, it has similarities to other studies researching acute illness. For instance, one of the main themes identified was high quality nursing care, which included acts of kindness by nurses, a good attitude towards the patient, the manner in which care was delivered and the perceived competence of the nurses in caring for the patient. The nurses who provided this level of care were described as genuine, trustworthy and honest. In
describing the effects of high quality nursing care participants described feeling good, positive, with improved self-esteem, which confirms the findings reported by Higgins (2001) and Larrabee and Bolden (2001). Alternatively in describing an absence of good quality nursing care participants described the nurses as indifferent, having no interest in the patient, no initiative, a negative attitude and giving the impression the patients were in the way. Like other studies reviewed (Goldbort, 2009 and Walsh, 2000), these findings indicate a link between quality and good nursing care. Thorsteinsson (2002) described quality nursing care as dependent on the personal qualities and clinical abilities of the nurse, for instance the nurse’s caring behaviour, attitude and ability to competently provide the required nursing care. Similarly to Higgins (2001), Thorsteinsson (2002) concluded that nursing care is a vital component of health care and the quality of nursing care can have a great impact on patients’ well being and health.

In another phenomenological study conducted in America exploring patient expectations of nursing care, Davis (2005) identified good and bad nursing care from 11 participants. The most pervasive thread running through stories of good nursing care were “being there” and “being with” the patient. Good nursing care was described as more than just competence and proficiency it involved a calm, gentle demeanour and genuine concern for the patients’ well being which is similar to the findings by Thorsteinsson (2002) and also described by Morse (1991) as a connection between the nurse and patient.
Davis (2005) like Larrabee and Bolden (2001) found that participants expected nurses to be technically competent. However, communication facilitating a connection between the nurse and the patient was also found to be a crucial aspect of nursing care. Similarly to Parker (1999), Higgins (2001) and Almerud et al. (2007) and others, Davis’ (2005) findings revealed that participants found it important for nurses to treat them as individuals, to know what their needs are, to listen to them and understand them.

The aim of Davis’ (2005) study was to understand patients’ care expectations particularly regarding spiritual care. The study by Davis (2005) has provided some insight into patient expectations of care and nurses’ provision of nursing care which seems to show that when expectations of nursing care were not met the patients described bad nursing care and a negative hospital experience. The perceptions of patient care needs are further explored later in this review.

**The absence of care**

The majority of studies or articles reviewed focussed on positive nurse patient relationships. Although these studies mentioned the negative aspect of the relationship emphasis was placed on the good nurse or the positive aspects such as “being there” for the patient, being considerate, recognising the patient as an individual and providing nursing care that is person centred. In contrast to these studies, which reviewed caring practices, Goldbort (2009)
revealed uncaring practices by nurses. Goldbort (2009) aimed to describe the essence of women’s unexpected birthing experience. She explored women’s lived experience of the unexpected birthing process and focussed on uncaring practices of midwives in several states in America. Goldbort (2009) interviewed 10 women who had an unexpected birthing experience, for example, an instrumental birth when a natural birth was planned. Goldbort (2009) used a descriptive analysis using Husserl’s philosophic underpinnings to discover the lived experience and then she conducted a thematic analysis of the transcripts utilising Colaizzi’s method of descriptive phenomenology. She revealed the absence of three critical elements of nursing care. These were caring, connection, and control. Goldbort (2009) stated that the negative experiences were influenced by the participants’ perceptions that the nurses were uncaring and disconnected from them. The negative experiences were also influenced by the participants’ minimal control over what happened to them.

Gilmartin and Wright (2008) further identified negative behaviours or bad nursing care. They used a hermeneutic phenomenological approach to describe and interpret patients’ experiences of day surgery in the United Kingdom. From unstructured interviews with their 20 participants, these researchers’ (Gilmartin and Wright, 2008) findings revealed that patients felt abandoned due to a lack of communication, psychological support and presence from the nursing staff. Gilmartin and Wright (2008) recommended that although the nurses were busy in this modern day surgical unit, if they
used a person-centred approach nursing care received by patients would be improved.

As previously discussed, caring requires a positive connection between the nurse and the patient. All of these studies identify certain aspects of nurse caring behaviours that are identified as good and beneficial to health care and recovery. To develop an understanding of why these caring behaviours do not appear to be common practice amongst all nurses, the literature on the perception of patients about what nursing care was required was reviewed.

**Perceptions of nursing care**

Nurses appear to underestimate what patients’ needs are according to Lauri, Lepisto and Kappeli (1997). Of importance to my study is that anecdotal stories from nurses who have been patients are mainly negative and highly critical of the nurses who provided nursing care (Anonymous, 1999; Ball, 1997; Bilitski, 2003). To gain a broader understanding of what nursing care patients identify as important and how that compared to nurses’ views, the following literature was reviewed.

Lauri, Lepisto and Kappeli (1997) used a quantitative study with a structured questionnaire based on the classification of basic human needs to investigate nurses’ and patients’ perception of nursing care requirements whilst in hospital. Study participants were 92 medical-surgical patients and 69 nurses
in Finland. As this study involved a structured questionnaire the response was limited by the questions asked and these were categorised as vital functions, functional health status, reactions to functional health status and environment. Of concern is that Lauri et al. (1997) concluded that patients’ and nurses’ perceptions of nursing care requirements whilst in hospital did not concur. Indeed nurses underestimated most of the nursing care needs identified by the patients. This means that these needs may not be met if the nurse is unaware of them, so the patient will be unsatisfied with the nursing care (s)he receives. Interestingly, when the results were separated into the two areas of medical and surgical ward it was noted that nurses on the surgical ward underestimated their patient needs and nurses on the medical ward overestimated them. Although there were some suggestions that this may be due to a lack of pain relief in the surgical ward it is unclear what this means for nursing knowledge, as the authors did not elaborate on their findings but suggested further investigation.

Florin, Ehrenberg and Ehnfors (2005) used a descriptive comparative design using a written questionnaire to elicit data from patient-nurse dyads for their study in Sweden. They investigated patients’ and nurses’ perceptions of nursing problems in an acute care setting. The aim of this study was to determine the degree of consistency between nurses’ and patients’ perceptions of presence, severity and importance of nursing problems. The term nursing problems was used to identify the perception of what nursing care patients required that could be addressed within nursing practice. The
level of agreement and disagreement between nurse and patient was used as a measure of consistency. The findings from this study revealed that nurses had considerable difficulty in identifying the needs of their patients. Patients identified several very important needs that were not identified by nurses particularly those of sleep, pain, nutrition, emotions and spirituality. Within the needs that nurses did manage to identify, they underestimated the importance of these needs in 47% of cases (Florin et al., 2005).

Larson (1987) adopted a descriptive method in exploring patients and nurses’ perceptions of important nursing caring behaviours. In a study of 57 patients with cancer, Larson (1987) explored cancer patients and professional nurses’ perceptions of important nursing caring behaviours. Communication was identified as a priority as the patients identified the most important behaviours in this regard as “being listened to”, “being talked to”, “having their questions answered”, “being put first”, and finally having their “nursing needs” attended to (Larson, 1987, p. 191). In Larson’s (1987) study, the nurses identified similar themes to the lay patients but in a different order of importance with attention to nursing tasks as being of the highest priority. Yet, in their letters describing their experience of being patients, nurses who were recipients of nursing care have described communication as most important (Brady, 1999; Barber, 2000) which suggests that nurses, like their lay person counterparts prioritise care needs differently when they are in the patient role.
A few years later in Sweden, Odling, Norberg and Danielson (2002) used a qualitative method to identify nurses’ opinion of the need for nursing care for hospitalised women with breast cancer. Thirty-one nurses participated in the study and like Laurie et al. (1997) and Larson (1987), findings by Odling et al. (2002) revealed a difference between what nurses described as important needs and how these needs were met. The study by Odling et al. (2002) concluded that patient’s needs pertaining to being cared for were not fully known to the nurses and therefore were not met. Each of these studies used different research approaches and yet they all concluded that patient’s needs were underestimated or not known at all and thus were not met by the nurse caring for them.

Wiman and Wikblad’s (2004) study highlights the incongruity between patients nursing care needs and nurses’ perceptions of nursing care required by patients. This study by Wiman and Wikblad (2004) involved both nurses and patients where nurses thought they were providing good nursing care but the patients disagreed. Indeed, what the nurses identified as the patients’ nursing care needs were not the nursing care needs identified by the patients as important. Wiman and Wikblad (2004) conducted a study of five patients suffering a minor trauma and 10 nurses in an emergency department of a Swedish hospital. Although Wiman and Wikblad (2004) outlined their method of data collection and analysis, the methodology used was not defined. The method used by Wiman and Wikblad (2004) was to videotape patient and nurses’ interactions at the time of the trauma treatment, which were later
classified into aspects of caring and uncaring. All interactions were videotaped but because the potential participants were being treated for an injury often causing unconsciousness, consent was sought later when the patient was conscious. The nurses participating in the study were the ones who turned on the video and so they were aware of when their interactions were being recorded. The fact that the nurses had to begin the recording was also one of the limitations of the study because they could choose when to record and when not to record. The findings from this study revealed 61 aspects of uncaring and 36 aspects of caring behaviours some of which are described below. Thus, nurses’ being aware that all actions were being recorded appeared to have little impact on caring or uncaring nursing behaviour which suggests that prior to the study the nurse participants were unaware that their nursing actions were seen as uncaring, which has implications for nursing education.

These researchers’ study findings revealed what has been described as “a new aspect of uncaring” or “instrumental behaviour” (Wiman & Wikblad, 2004, p.426). This behaviour appeared in every encounter between the nurse and the patient and occurred in instances when nurses were attending to nursing ‘tasks’ required by the patient but were ignoring the patient as a person (Wiman & Wikblad, 2004). For example when a patient was being catheterised the nurse performing the task was talking to another health professional and (s)he completely ignored the patient during this conversation while performing a very personally intrusive procedure. The patient had no
privacy, was completely exposed to others in the room and to passers by, as the door into the room was ajar. This is similar to other studies (Almerud et al., 2007; Higgins, 2001; Johanssen, Oleni & Fridlund, 2002) where uncaring behaviours are cited in instances where the patient is ignored and care is not person-centred but task oriented.

Aspects of caring described by patients in Wiman and Wikblad’s (2004) study were similar to other studies, and encompassed being open to, and perceptive of others, capable of predicting and interpreting the patient’s needs, an open attitude, communication skills, genuine concern, being morally responsible and being truly present. Aspects of uncaring were “instrumental behaviour” described as, disinterest, coldness, acts of unkindness, inattentiveness to the patients needs, insensitivity, acting indifferently and inhumanity (Wiman & Wikblad, 2004). It appears from Wiman and Wikblad’s (2004) study that nurse perceptions of most caring behaviours are technical competence which is incongruent to patients’ perceptions as described by Danielson (2002), Florin et al. (2005), Larson (1987) and Lauri et al. (1997) who suggest these include a more holistic approach with person centred care as the focus.

In a descriptive qualitative study used to determine patients’ perceptions of nurses’ skill Wysong and Driver (2009) found that although patients mentioned technical skills as important they were not as important as other skills such as, interpersonal and critical thinking skills as Hudacek (2008)
identified. Graham (2001) and Tomlinson-Levy (2005) also highlighted in discussion papers that although clinical (technical) skills are important attributes, it is recognised that clinical skills and technical competence must include the ability of the nurse to assess the patient situation and act on that assessment to provide the required care. Thus, technical skills are important but nursing care must include the interpersonal and critical thinking skills from nurses (Wysong & Driver, 2009).

Many of the previous authors (Davis, 2005; Euswas & Chick, 1999; Higgins, 2001; Johanssen et al. 2002) highlighted communication as an integral aspect of nursing care and crucial in providing good nursing care however when communication between the nurse and patient is absent or ineffective patients have reported being uncared for (Euswas & Chick, 1999; McCabe, 2004). McCabe (2004) utilised purposeful sampling when she interviewed eight patients in an Irish hospital to explore the patients’ experiences of nurse patient communication. She used a hermeneutic phenomenological approach to identify four main themes. The first two themes were identified as a “lack of communication”, in which participants felt the nurses did not communicate enough with them and they felt uncared for and “attending”, which was identified as being when nurses had more time and were seen to be attentive. In addition, many of the participants formed what they called special relationships with the nurses that they perceived to be genuine. The final two themes identified by McCabe (2004) were those of “empathy”, which is described as when participants trusted nurses who they felt empathised with.
them, knew them as a person and cared for them and “friendly nurses and humour”, where participants appreciated good humour between themselves and the nurse providing care which appeared to improve patients self esteem. McCabe (2004) concluded that when participants felt they were being attended to they felt reassured but a lack of communication left participants feeling unsatisfied with the nursing care they received. Like many other authors, (Cappabianca, Julliard, Raso & Ruggiero, 2009; Gilmartin & Wright, 2008). McCabe (2004) concluded that nurses should communicate in a patient centred way and be seen as professional.

Findings of these studies demonstrate that often patients’ needs of nursing care were not fully recognised or met by nurses caring for them and therefore patients felt uncared for by nurses. The study by Odling et al. (2002) recognized that even when nurses identified what they perceived as the nursing care requirements of the patient they did not meet these identified needs. Yet, patients’ perceptions of good nursing care depended on their needs being met. As a result, patients were often left feeling uncared for and unsatisfied with their hospital experience. Indeed nurses who have been patients have stated that their experience “on the other side” has taught them something as they now have some insight into what it is like to be a patient (Pence, 2002; Rogers, 2003). Some of these nurses have stated that the experience has ensured they will be better nurses in the future, as they will use the experience they have had to improve their provision of nursing

The literature overall appears to highlight a problem which is that patients’ needs are either underestimated or not known at all and are therefore not met, leaving the patient feeling dissatisfied with the hospital experience. Whilst acknowledging this, Cappabianca et al. (2009) put the focus back onto the patient. Cappabianca et al. (2009) found that nursing care plans reviewed for their study covered pathophysiology but did not really get to the core of what patients needs were in their Medical Centre in New York. Cappabianca et al. (2009) set about using a leadership change model to introduce a change in practice, which focussed more on ‘Relationship Centred Care’ (RCC). Patients were asked “What is the most important thing I can do for you today?” This information became centre stage of their nursing care plan.

Cappabianca et al. (2009) then used a grounded theory approach to analyse the information they had received from 400 patients over a three-month period. The participants were patients in neurological, orthopaedic and rehabilitation areas. Eleven themes were identified which related mainly to nurse caring behaviours and some that involved communication with the medical staff and other team members. The themes were identified as “Independence”, “Pain Management”, “Discharge”, “Eating-Drinking”, “Elimination”, “Care Coordination”, “Comfort”, “Patient Education”, “Emotional”, “Family Concerns”, and “Nothing”. Cappabianca et al. (2009)
were surprised that pain management came up so frequently, and they subsequently became more aware of pain and changed the way they managed patients’ pain. Discharge refers to discharge planning and communication around discharge, the final theme of ‘Nothing’ refers to when the patient said the nurse could do nothing for them on the day they were asked. When they received this response, these researchers (Cappabianca et al. 2009) explored the matter further by questioning the patient more to see if there was anything that could be done for the patient on that day. This study by Cappabianca et al. (2009) identifies that when patients’ needs are known, nursing practice and unit policy can be changed to meet those identified needs.

In the previous section it was demonstrated that the most important aspects of effective nursing care are communication, a connection with the patient and finally technical skills. In particular, many researchers have demonstrated the centrality of connecting with patients in order to build a therapeutic relationship. Being connected means to know the patient as a person, respect the patient as an individual and understands the patient’s nursing care needs (Morse, 1991).

A review of the theoretical and research based literature demonstrates that caring requires a connection between the nurse and patient to be effective in the provision of nursing care and that a good nurse was one who related to the patient as a person, was respectful, individualised nursing care and had a
connection with the patient. However, it also demonstrated that nurses often underestimate the patient’s needs and thus do not meet them, leaving the patient feeling uncared for (Lauri et al., 1997; Wiman & Wikblad, 2004). Other author’s such as Cappabianca et al. (2009) have shown that patients and nurses can connect in a therapeutic relationship where the focus is put on to the patient as an individual, the patient’s needs are identified and met and thus the patient feels cared for. In the theoretical literature, Peplau (1991) identified the interpersonal relationship in nursing which described the nurse patient connection allowing nurse caring to happen as did Orem (2001) in her self care deficit theory and Watson (1999) as she encompassed both sensitivity to others in a trusting relationship with caring nursing acts. Thus, with a connection between the nurse and patient that is therapeutic in nature the physical act of nursing care can be delivered in a way that understands the patient’s situation and provides the nursing care that is consistent with the patient’s requirements.

The above discussion has demonstrated that frequently nurses’ and patients’ perceptions of patient needs were incongruent. However, when patients’ perceptions of their needs were identified and met, patient satisfaction could be attained (Yeakel, Maljianian, Bohannon & Coulombe, 2003). Also identified was that nurse patients changed their nursing care priorities when they were a patient, which is unexplained and thus identifies a gap of knowledge in the nurse patient experience.
There is a paucity of available research literature which explores the nurse’s experiences as a patient. Therefore, the available research literature exploring this phenomenon was reviewed and also the small body of literature available on the experience of the nurse as a relative of the patient. This research was reviewed in order to better understand this phenomenon, to identify what, if anything differentiated the experience for nurses to that of laypeople and to ascertain findings about why this might be so.

**The experience of being a nurse and a relative of the patient**

The importance of the family in the care and recovery of the patient in hospital has been identified and explored (Joseph, Laughon & Bogue, 2011; Vouzavali, et al., 2011) but very little is known about the nurse’s experience as a relative of the patient. Salmond (2011) is one of the few authors to explore this experience. She used a qualitative descriptive approach informed by grounded theory to explore the role and needs of nurse family members during critical illness of a loved one in America. Salmond (2011) recruited 22 nurses and used open-ended interviews to gain a description of the experience of being a nurse and a family member of a loved one who was critically ill in hospital. She decided to conduct the study after personal experience demonstrated to her that her “role as a nurse put her in a different position to the layperson” (Salmond, 2011, p. 11). It is clear from the findings of Salmond’s (2011) study that the different position she identified in her own experience was also identified in the experiences of the
nurse-relative participants in her study. Of interest in relation to my study reported in this thesis is that participants also identified that his/her role as a nurse also meant that (s)he was in a different position to the lay person as patient. The core theme identified by Salmond (2011) was that when a relative became critically ill the nurse in the family found that his/her role identity as a nurse fore fronted any other role (s)he had within the family, such as sister, daughter or father.

Nursing knowledge identified the nurse family member as different from the layperson family member (Salmond, 2011). While in today’s technological era, information is available to the layperson and professional alike, nurses’ professional education is likely to enable their synthesis of medical/ nursing terminology often not readily understood by the layperson. Of importance in Salmond’s (2011) findings were that nursing knowledge altered the experience of the nurse-relative even though some of the challenges or tasks were common to all family members.

Salmond (2011) also identified that there is emotional turmoil when a family member becomes ill, and this was heightened in nurse family members because of the nurse’s knowledge base. The nurse family members identified that they knew what could go wrong because of the illness or injury and also because of the potential for hospital-induced error. Thus nurse family members became vigilant for their relative and closely watched what was happening in the hospital (Salmond, 2011). Nurse family members found that
watching what was going on in the hospital was automatic and natural for them as a nurse (Salmond, 2011). However, if the nurse family member had a good relationship with the nurse carer which involved the sharing of information and the nurse family member could see what was happening to his/her loved one then vigilance by the nurse family member was relaxed (Salmond, 2011). It was clear that when the nurse family member had a positive relationship with the staff and gained meaningful information the nurse family member felt less stressed and more confident that his/her relative was being cared for and thus there was no longer the necessity to closely watch over his/her loved one (Salmond, 2011).

Salmond (2011) also found that the nurse family member was the spokesperson for the family and the advocate for the patient. Other family members expected the nurse family member to know what was going on and to inform the rest of the family. The nurse family members identified that they required knowledge to be able to perform this role in the family (Salmond, 2011). However, Salmond (2011) found that mere knowledge and information was not enough for the nurse family member, as (s)he required a positive trusting relationship between the nurse carer and the nurse family member when the information was given and explained. This involved the nurse carer recognising that critical care was not necessarily the nurse family member’s speciality, whilst still recognising the nursing knowledge the nurse family member did have. Advocacy occurred with or without a positive relationship with the staff but patient and family needs were best served
when collaboration existed between the staff and the nurse family member (Salmond, 2011).

Salmond (2011) found that resuming the family role was easier for the nurse family member when (s)he had a good relationship with the nursing staff and trusted that his/her loved one was safe and receiving good nursing care. She concluded that the knowledge base of the nurse family member made the experience different to the non-nurse family member and the nurse role identity of the nurse family member was instilled in each component of the experience (Salmond, 2011). In other words the nurse was fore fronted in the nurse family member.

Whilst Salmond (2011) explored the nurse family member experience when a relative was critically ill in hospital, Cicchelli and McLeod (2012) explored the nurse’s experience of caring for a chronically ill and dying family member who was mainly at home. Cicchelli and McLeod (2012) used hermeneutic phenomenology to explore the lived experiences of five nurses caring for family members living with advanced cancer in Canada. Similar to Salmond (2011), Cicchelli and McLeod (2012) found that relatives’ experiences of having a loved one seriously ill were fraught with tensions and conflicts as they struggled to balance their roles as nurse and caregiver.

Cicchelli and McLeod (2012) found that nurse-relatives were caught in “a web of conflicting expectations”. As with Salmond (2011), Cicchelli and McLeod
(2012) identified that, nurse-relatives’ expectations of what would happen to their ill relative whilst in hospital or whilst seriously ill stemmed from their knowledge as a nurse. Nurse-relatives anticipated the illness trajectory and attempted to meet the expectations of other family members as the knowledgeable person and leader. Cicchelli and McLeod (2012) also identified expectations of the nurse-relative from other health professionals and expectations from the nurse caregivers of themselves. Although the nurse-relative identified conflict between his/her role as a nurse professional and his/her role within the family, which was identified as challenging, all of the nurse-relatives in this study took on the nursing role without question. Cicchelli and McLeod (2012) appear to be agreeing with the study by Salmond (2011) in that the nursing role is fore fronted when a relative becomes ill and the nurse-relative automatically takes on the caregiver role. Although the study by Cicchelli and McLeod (2012) is about caring for a relative with a chronic and potentially terminal illness in the home environment there are many similarities to the study by Salmond (2011). Thus, the literature on the nurse as a patient was reviewed in order to identify whether or not the nurse role was also fore fronted when the nurse was a patient and how the nurse as a patient experienced this phenomenon.

The experience of being a nurse and a patient

There is a paucity of published research on the experience of being a nurse and a patient. Of particular relevance to my study was a study by Zeitz’s
(1999), which was conducted in South Australia with four participants from one surgical ward. Zeitz (1999), one of the few who has paid any attention to the topic of the nurse patient and apparently the only one who has explored acute illness as experienced by the nurse patient, undertook an exploration of the experience of being a nurse and a patient receiving nursing care in hospital. The four participants in Zeitz’s (1999) study were registered nurses who had practiced for more than two years and had undergone an uncomplicated surgical procedure, which was recent but which occurred more than six months before the commencement of the study. Zeitz (1999) did not clarify what she meant by recent or how long ago each participant went through the procedure apart from the fact it was more than six months prior to the interview. This researcher conducted an unstructured interview where she asked the participants to tell her about their experience of receiving nursing care. She does not indicate the duration of interviews or if there was the opportunity for participants to review the transcripts or add to the interview (Zeitz, 1999).

The purpose of the study by Zeitz (1999) was to develop an understanding of the experience of being a nurse patient. As she was exploring life experience, she used a phenomenological approach and she identified 10 themes. Of importance to my study are the themes: “finding a balance” which relates to the nurse patient acknowledging the need for nursing care; “control”, defined as the sense of lack of control felt by the nurse patient; and “acknowledging me”, which refers to the nurse patient being recognised as an individual
(Zeitz, 1999). Similarly to lay patients’ descriptions previously discussed, each of the nurse patients who participated in Zeitz’s (1999) study also described his/her need to be seen as an individual.

In being acknowledged as an individual, Zeitz (1999) describes a connection between the nurse and nurse patient that is similar to the research findings on the experience of the layperson as patient. Zeitz (1999) described this connection as a positive perception of the caring feeling that emanated from the nurses providing care and the “little touches” that made that care special. The nurse patient who expressed this positive perception reported satisfaction with the nursing care received and described the experience as less stressful than the nurse patient who expressed a negative experience of the nursing care (s)he received.

Nurse patients in Zeitz’s (1999) study described the experience of “waiting” when the nurses caring for them said, “I’ll be back”. These participants also described a sense of “I’d done wrong”, when they felt that they had been non-compliant based on their interactions with the nurse and/or their own expectations of what they should be doing. Zeitz (1999) uses an exemplar of a nurse patient being given a commode next to her bedside and the nurse stating “I’ll be back”. When the nurse finally returns to find the nurse patient has independently used the commode the nurse appears annoyed and the nurse patient feels guilty. For these reasons the nurse patient in Zeitz’s (1999) study described dissatisfaction with the nursing care received.
Zeitz’s study (1999) revealed the therapeutic environment as an important aspect of the nurse patient’s experience. Her findings identified the need for and gratefulness of nurse patients’ receiving a single room (Zeitz, 1999). The therapeutic environment and importance of a single room for the patient has only been identified in one other research report in the layperson as patient literature (Shattell et al. 2005). Zeitz (1999) found that the provision of a single room for the nurse patient appeared to acknowledge the nurse patient as a colleague and provided some privacy in illness.

Despite nurse patients’ existing knowledge, Zeitz (1999) stated that keeping nurses-patients informed about what was happening, even when things were not going to plan, was important in allowing the nurse patient a sense of control over the situation they were in. Effective communication between the nurse and patient was also identified to be an integral part of the nurse patient relationship (Almerud et al., 2007; Parker, 1999; Shattell et al., 2005; Sigurgeirsdottr & Halldordsdottr, 2008). Zeitz (1999) states that because of the knowledge and previous nursing experience of the nurse patient if (s)he is not kept informed (s)he would imagine the worst-case scenario, which would increase anxiety for the nurse patient.

The findings in Zeitz’s (1999) study are similar to the research previously described by Almerud et al. (2007), Parker (1999) and Shattell et al. (2005). In her discussion, Zeitz (1999) highlights the nurse patient’s need for nurses
caring for him/her to see her/him as a colleague as well as a patient as central to his/her experience. She argued that the difference between the experience of the layperson and the nurse patient was that nurse patients are able to distinguish appropriate and skilful nursing care that is the nurse patient knows what (s)he needs and how to obtain it.

Although the study by Zeitz (1999) is useful to my study, which is larger and has recruited participants from across Australia, the constraint in size and scope of Zeitz’s (1999) study limits its application. Zeit’s (1999) study appears to be the only research on this topic; however, it has extended the very small body of literature on the subject of the nurse patient.

There is a paucity of research literature available on the experience of being a nurse and patient, however many nurses have written of their experience of this in the form of letters to the editor of nursing journals or more recently as discussions in online forums. These anecdotal experiences and discussion papers outlined below provide some further insight into the nurse patient experience.

It could be said that existing nursing knowledge may be reassuring to the nurse requiring nursing care because it enables him/her to better understand what is happening and what to expect during his/her hospital stay. In a partial personal reflection and review of the literature, Coleman (1995) posed an alternative view when stating that this nursing knowledge may actually
increase the nurse patient’s anxiety or apprehension when in the patient role if nursing care is not delivered in a manner (s)he deems appropriate. For instance, Bilitski (2003) reflected on her own experience of being a nurse patient and being told she was going for a test. She relates how she was not told that this was a routine test for trauma patients, so she pondered on why she had to have the test. Instead of communicating her fears with the nurse providing her care, Bilitski (2003) imagined the worst possible scenario. This confirms one of the findings from the study by Zeits (1999) and Salmond (2011) that identified that nurses as patients or relatives of patients had to be kept informed as their nursing knowledge and experience would lead them to imagine the worst-case scenario.

Brady (1999) (a nurse reflecting on her experience as a patient) described in a letter to the editor of a nursing journal how the perception that she had nursing knowledge became a disadvantage for her as a patient. For example, she wondered if the lack of nursing care, she received whilst a hospital patient was because, being a nurse, it was assumed she would not require the nursing care or information given to the layperson. Brady (1999) emphasised that being a nurse didn’t help her because, as a patient, and faced with having major surgery, insights stemming from her nursing background deserted her.

It is a common misconception that nurses in the patient role will be more informed and less anxious than the layperson (Brown, 2011; Coleman, 1995;
Wagner-Cox, 2005). Barber (2000), (a nurse) reflecting Brady’s (1999) comments that her nursing knowledge was useless to her as a patient also described how this knowledge appeared to disappear as soon as her own health was questioned, and how she temporarily forgot all her training and became fearful. Thus, in this case some nursing knowledge was detrimental. Indeed, rather than nurse patients being more informed and less fearful, Bilitski (2003), Barber (2000), Brady (1999) and Urden (1997), all nurses, described how they as patients, were not offered information, comfort or reassurance from the nurses caring for them, and how, because of this, their fear and anxiety remained.

Many nurses-patients said their nursing colleagues appeared to avoid them when they were patients, which left them feeling confused and alone (Bilitski, 2003; Barber, 2000; Brady, 1999; Kentisbeer, 2000; Mitchell, 2000; Rogers, 2003). Mitchell (2000) and Rogers (2003) wondered why nurses avoided nurse patients but they could not provide a rationale. Coleman (1995) surmised that nurses in the patient role were seen by nurses caring for them as being troublesome and therefore avoided by them. Coleman (1995) stated that nurses in the patient role are often unwilling to be the ‘docile patient’ and, instead, aim to maintain some of the power they had in their former nursing role. According to Coleman (1995) a nurse who is hospitalised as a patient aims for more control in his/her situation and that his/her attempt to achieve this often results in him/her being seen by the nurses caring for him/her as less compliant than the lay person. Watkinson (2008) suggests
that rather than control there is confusion, as nurses do not stop being nurses when they become patients, which in turn may cause confusion of roles and conflict with other nurses as confirmed by Cichella and McLeod (2012) and Salmond (2011). Watkinson (2008) points out that she struggled to remember she was a patient and ‘not a nurse’. She writes that being a nurse and a patient created many dilemmas and an internal struggle for her. Like Watkinson (2008), Lensen (2006) described the blurring of role identity she felt as a patient. She would have liked acknowledgement as a nurse and therefore an acknowledgment of what she was experiencing whilst attempting to ‘swap’ roles from nurse to patient.

Similarly to lay patients, many nurses who have experienced being a recipient of nursing care have described the lack of communication between themselves and the nurse providing care as problematic (Ball, 1997; Harber, 1999; Lensen, 2006; Mitchell, 2000). Interestingly nurses as patients made extra effort to communicate with the nurses and connect with them in a nurse patient relationship (Anonymous, 1999; Kentisbeer, 2000; Williams, 1998). Some nurse patients, knowing how patients are ‘expected’ to behave, have described adopting a docile patient role which (s)he believes is expected of her/him to give the impression of being a good patient (Anonymous, 1999; Kentisbeer, 2000; Williams, 1998). This is similar to the findings in the study by Almerud et al. (2007). Indeed some nurses’ comments on their experience of being in the patient role have reflected the accounts of the lay patient’s experience of being labelled a good or bad patient (Anonymous, 1998;
Anonymous, 1999; Ball, 1997; Barber, 2000; Barker et al., 1995; Brady, 1999; Coleman, 1995; Harber, 1999; Kentisbeer, 2000; Lensen, 2006; Mitchell, 2000; Munro, 2000; Urden, 1997; Williams, 1998). Williams (1998) described the good patient as, one who does not demand or ask too many questions. She stated that the need to be good often conflicted with the need to be cared for and suggested that good patients do not often receive the nursing care they require and have to become bad patients to receive it (Williams, 1998). This may explain the statement by Coleman (1995) that nurse patients are less compliant than lay people as patients because nurse patients know what nursing care they should be receiving.

Indeed Ball (1997), Harber (1999) and Mitchell (2000), all nurses, described feeling like bad patients because they asked for explanations, communication, and time with the nurse caring for them. They relate how other nurses labelled them bad patients because of their efforts to overcome a lack of communication from the nurses, gain their attention and receive the nursing care they deemed they required.

The letters from nursing journals show that nurses are nurses first even when they are patients. This causes internal struggles as described above and can cause conflict with the nurses who are providing the care for the nurse patients. Of relevance to my study, is that each nurse who has been a patient and written of his/her experience has described a change in his/her nursing
practice following the experience. To investigate this further the following literature was explored.

**Nurse patient experience and nursing practice**

Illness changes a person’s priorities in life (Frank, 2002; van Manen, 1998). Heather (a participant in my study) also said “illness changes you”. In order to explore this further I reviewed the literature available on the nurse patient experience influencing nursing practice. Although there was a paucity of research literature available on this topic two studies were located. Picard, Agretelis and De Marco (2004) used a phenomenological design to explore the professional experience of cancer survivorship amongst nurses in an American hospital. The study by Picard et al. (2004) consisted of 25 nurses who were interviewed on two occasions. Participants in Picard et al.’s (2004) study stated that their illness experience and their experience of being a patient changed their nursing practice and this was described as a deepening of compassion for patients and others. Because of their experience as a patient these nurses felt they could place themselves in the patient situation with more ease than previously, they became better listeners and more aware of the need for families to be involved with the patients’ recovery. Picard et al. (2004) concluded that nurses’ professional practice changed because of their own experience and that health care workers could learn from their colleagues’ experience of surviving cancer. Picard et al. (2004) found that the
actual experience for nurses of being a patient was very different from the nurse’s pre-experience perceptions of what it would be like.

This study (Picard et al., 2004) is more about surviving and moving on in life with the diagnosis rather than the experience of receiving nursing care. However, it demonstrates findings such as role ambiguity that may be relevant to nurses who are receiving nursing care in an acute hospital. Picard et al. (2004) described “role ambiguity”, as relating to participants trying to fit their nursing work around treatment to maintain some normalcy, strength and control that their working lives provided. Also, of interest in this study is that the nurses who participated felt that being a patient was like “being on another world” as if the whole experience was totally alien, a finding similar to Parker’s (1999) findings.

Similarly, Redwood (2008) also explored the change in practice after being a nurse patient (in this case midwife-patient3). Redwood (2008) used descriptive phenomenology to explore changes in practice when midwives and nurses become mothers. Her aim was to explore the transition to motherhood. Twenty-two midwives/nurses were recruited in the third trimester of pregnancy. Two interviews were conducted, the first one, prenatally and the second one within twelve months of the baby’s birth. Similarly, to Picard et al. (2004), participants in Redwood’s (2008) study acknowledged a change in their own midwifery/nursing practice. She stated

3 A midwife who is a patient
that this change in practice was far in excess of what the participants initially believed would have occurred, however it is unclear what this change in practice was or whether it was sustained.

Redwood (2008) found that despite midwives having previously assisted in the labour process their expectations of what it would be like for them to experience labour and the actual experience did not match their personal reality. Indeed far from matching their expectations, participants described unpleasant experiences of midwifery care. Of interest, and of relevance to my own study, is that even though the participants in Redwood’s (2008) study described unpleasant experiences with midwifery care they received they did not speak out to the midwife providing poor nursing care or complain to anyone in authority about their unpleasant experience. Redwood (2008) attributed the lack of complaints to a professional allegiance.

Similarly, to other researchers reviewed, Redwood (2008) found control was important to her participants because they suggested that the level of control they were able to maintain affected their beliefs in the outcome of the birth. Some of the control related to the amount of effective communication between professional carers and themselves. This may indicate a connection in the nurse to nurse patient relationship when the participants felt they had some control but it is unclear in the findings.
Even though the study by Redwood (2008) was about birthing and perceptions of this experience the results of the study provides some insight into the nurse patient experience in that role ambiguity was described as well as perceptions of what it would be like to be a patient not meeting the reality. These two studies by Picard et al. (2004) and Redwood (2008), although quite different, identify a change in nursing practice once the nurse has been a patient.

**Review and Summary**

It is a common misconception that nurses in the patient role will be less fearful as described by Coleman (1995), as nurses know what can and often does happen in hospitals. In this chapter the literature review identified what constitutes nursing care, whilst exploring the nurse patient relationship and the impact that relationship has on the patient’s experience of receiving nursing care. Several authors conclude that the relationship between the nurse and the patient during the patient’s experience of hospitalisation has a positive or a negative impact on that experience (Appleton, 1993; Sadler, 1997; Taylor, 1998; Walsh, 2000; White, 1997; Williams & Irurita, 1998).

Nursing care has been described particularly in respect to the way in which nurses are portrayed as ‘good’ or ‘bad’ depending on the nursing care they provide. To further explore this area, perceptions of priorities of care were reviewed. Literature relating to the lay person’s experience has identified that
nurses and patients prioritise care differently thus the patient is often left feeling unsatisfied with the nursing care provided. However, when the care is person centred the patient will be more satisfied with the nursing care received.

Nursing knowledge and the impact that knowledge has on the experience of receiving nursing care was briefly explored. The main differences identified in the literature between nurses and lay people when recipients of nursing care are that the nurse has his/her medical/nursing knowledge base and nursing experience to refer to whilst the lay patient may not have this knowledge. Although nursing knowledge sets the nurse apart from the layperson (Salmond, 2011), in letters to editors nurses who have been recipients of nursing care while a patient in hospital have highlighted that this knowledge is often not useful to them due to the stressful nature of becoming ill.

This critique has identified a gap in the research literature relating to nurses’ experiences of being a patient in an acute care context. This gap is a description of this experience by nurses who have experienced these phenomena. Although, Zeitz (1999) has made some explorations of this topic in her small study my study seeks to further fill that gap. By examining the nurses’ experience of receiving nursing care as a patient in an acute hospital, the perceptions of nursing care required by nurses’ when patients will be further identified, as will role ambiguity and professional allegiance.
In the following chapter, I outline the methodology, method and design used for this study. In doing this I outline Giorgi’s phenomenological approach, which is guided by Husserl’s writings. I provide a brief discussion of Husserl’s main propositions and I present phenomenology as a methodology and philosophical framework.
Chapter Two

The methodology, design and method of the study

Phenomenology is a philosophy and research methodology that uncovers thoughts, understandings, feelings, and behaviours from the perspective of the person. It values human experience by providing an account of the experience of being in the world of everyday life and of living in and through the world (Giorgi, 2009; Salmon, 2012). In the context of this study, the phenomenological view values the experience of the nurse as a patient and the meaning the nurse as patient attributes to the experience. As noted in the introduction to this thesis, to answer the question, “What is the nurse’s experience as a patient receiving nursing care in an acute general hospital?” I used Giorgi’s (2009) phenomenological approach, which is guided by Husserlian phenomenology.

In the early stages of the study, I explored the work of Edmund Husserl (1859-1938) on ‘Transcendental Phenomenology’ in order to gain an understanding of the tradition and philosophy of phenomenology. However, as I discovered more about phenomenology my curiosity encompassed the writings of Martin Heidegger (1889-1976), Jean-Paul Sartre (1905-1980) and Maurice Merleau-Ponty (1908-1961). I also explored contemporary phenomenologists such as Benner (1984), Colaizzi (1978), Giorgi (1975,
Husserl’s writings about the process of ‘doing’ phenomenology are mainly conceptual (Smith, Flowers & Larkin, 2009). Although Husserl provides examples of the result of the process of phenomenological research, these are “scattered throughout his writings and difficult to locate” (Smith, Flowers & Larkin, 2009, p. 15). Giorgi’s (2008) method of conducting phenomenological research uses a modified Husserlian approach and I concluded that Giorgi’s (2009) phenomenological research method was an appropriate method for addressing the research question for this study. This decision was based on Giorgi’s background as a health care professional with much of his research relating to caring and understanding the experience of people when they are ill (Giorgi, 2000a; 2000b; 2005). Giorgi also clarified Husserl’s phenomenology and made modifications, which gave clear direction to the researchers on the method used. Giorgi’s method, consistent with Husserlian phenomenology, involves several clearly defined steps that are outlined later in this chapter.

This chapter presents phenomenology as the methodology and philosophical framework for this study. It provides a discussion of Husserl’s main propositions in relation to phenomenology about intentionality and phenomenological reduction. Husserl’s work is significant in this study because it provides a framework that supports reflection on and consideration
of the nurse’s experience of being a patient and his philosophical underpinnings form the foundation and background to Giorgi’s (2009) research methods.

Further, I also discuss the use of phenomenology as a method of inquiry into the lived experience of being a nurse receiving nursing care. I outline the processes and procedures I used in conducting this study whilst investigating the experience of the nurse as patient receiving nursing care. In the discussion that follows, I justify phenomenology within the context of this study and describe how it is placed within the descriptive phenomenological field of research.

**Phenomenology**

Phenomenology is a branch of philosophy or a variety of distinctive yet related philosophies (Giorgi, 2009). It was Edmund Husserl (1859-1938), who developed phenomenology as a philosophical method of inquiry and he considered phenomenology to be philosophy, approach and method (Husserl, 1931).

The word phenomenology derives from two Greek words: *phainomenon* meaning to show itself (Husserl, 1931) or that, which can be brought to light (Heidegger, 1975) and *logos* meaning reason (Heidegger, 1977/1993). The aim of phenomenology is to provide an understanding of the essence of a
person’s lifeworld by careful and thoughtful description of experience and in doing so understand experience as it is lived pre-reflectively (Husserl, 1964; Schutz & Luckmann, 1973; van der Zalm & Bergum, 2000; van Manen, 1984). Husserl used the term “life world” to indicate a flow of experiential happenings which provide the “thereness” of what appears (Todres, 2005, p. 104) prior to reflecting on it and categorising it.

Phenomenology has been used increasingly as a methodology in social science research and in nursing for more than two decades (Gilmartin & Wright, 2008; Walton & Madjar, 1999). The reason for this is that much of nursing research seeks to answer questions about the nature of human beings, the nature of the environment and the interaction between the two (van Manen, 1984).

As a research methodology phenomenology seeks to understand the whole experience as it was for the person without reducing the experience to a set of numbers or equations and without any pre-conceived cultural or social beliefs about what the experience should be (Crotty, 1996; Giorgi, 2009). In everyday life lived experience involves visible as well as invisible aspects and certain dimensions will always remain initially ‘hidden’ to us (Merleau-Ponty, 1968). The aim of phenomenological research is to explore what is invisible by using that which is visible to guide us (Dahlberg & Dahlberg, 2004). Therefore, as a methodology, phenomenology helps to elucidate human experience from a range of perspectives, the circumstance of these experiences and how they may be described (van der Zalm & Bergum, 2000).
When used in nursing research the phenomenological text has the power to disclose the world as it is lived, and to provide understanding of human experiences in a way that deeply affects or impacts nursing practice (van der Zalm & Bergum, 2000). van Manen (1990) stated:

*All phenomenological human science research efforts are really explorations into the structure of the human lifeworld, the lived world as experienced in everyday situations and relations. Our lived experiences and the structures of meaning (themes) in terms of which these lived experiences can be described and interpreted constitute the immense complexity of the lifeworld.*

(van Manen, 1990, p. 101)

van Manen (1990) stated that the very nature of phenomenology focuses on the human experience as it occurs in the everyday life world (Sokolowski, 2000; van Manen, 1990). It is widely used by nurses conducting nursing research because it is a way of thinking about nursing care in a familiar, simple, yet unique way, and it allows concepts to be developed and understood in a different light to other forms of research, such as quantitative studies that do not address the holistic nature of phenomenology (Madjar & Walton, 1999). As van Manen notes (in Madjar & Walton, 1999, p. 1):
Increasingly the health science professional is becoming aware that people require not only healthcare assistance, surgical intervention, or pharmaceutical treatment, but that the professional must be much more involved in the way that people experience and live with their problems in a different, sometimes deeply personal and unique manner. It is argued that nursing especially, is involved in helping the patient, the elderly, the disabled, or the person who for reasons of circumstance is out of step with the body, to recover a livable relation with his or her psycho-physical being.

van Manen (1984) clarifies that in the phenomenological sense, knowledge itself does not inform practice; rather it is reflection on experience that results in knowledge and understanding, which in turn enlightens practice. That is, reflection on experience using phenomenological text has the effect of making us suddenly ‘see’ something that was previously invisible to us and this visibility provides a deeper understanding of everyday life experience (van Manen, 1997).

As it is the subjective experiences of nurses receiving nursing care as a patient, which is the central concern in this study, phenomenology was deemed the ideal methodology for exploring the participants’ experiences. By using phenomenology to explore nurses’ experience of receiving nursing care whilst hospitalised (as a patient), it is hoped that these experiences will be
brought to light and provide insight and understanding of the phenomena in a way that allows practising nurses to provide more understanding and sensitive care to this group of patients.

Phenomenology as a research methodology is about understanding people in their own unique context, within their own lifeworld, which is the world as we immediately experience it pre-reflectively, rather than as we conceptualize, categorise or reflect on it (Husserl, 1964; Schutz & Luckmann, 1973). Therefore, phenomenology is a suitable research methodology to explore the experience of the nurse as the patient. van Manen (in Madjar & Walton, 1999) clarified:

If we want to be sensitive to the pathic [suffering] nature of nursing and medical practice then we need to pursue forms of research that uses pathic language. Pathic questions cannot be answered by texts that primarily communicate cognitive meaning. And gnostic [diagnostic, prognostic] insights cannot produce pathic experience. To construct texts that can address and reflect on the experience of illness we need to get beyond the objectifying effects of naming the things of our world with labels that distance us from them. We need to write (and read) for tone and pathic understanding, and to this effect our words must be slow, new, single, and tentative. (p. 34)
van Manen’s (1999) argument is that the research methodology chosen to explore the experience of illness has to have language that can describe that experience enabling an understanding of the meaning of the experience. Thus phenomenology was chosen as the research methodology for my study as it aims to provide understanding of a phenomenon (Giorgi, 2000b) and has the language to describe it, which in this case is the experience of nurses receiving nursing care in an acute general hospital.

The purpose of phenomenology as a research approach is to describe and explain, rather than predict (Giorgi, 2000b). As a methodology, phenomenology provides an understanding of the essential structures of the meaning of lived experience from the perspective of the study participants who experience the phenomenon. Phenomenology was used in this study because it offers an approach, which enables the experience of the nurse as patient to be identified and it was the experience of the nurse as patient that was of interest to me. Using phenomenology to explore the experience of the nurse as a patient in an acute general hospital provides a methodology, which focuses on, and promotes the understanding of the nurse as patient’s experience of the care they received. This understanding may be used to develop and/or modify future nursing practice.
Phenomenology as a research methodology in nursing

The methodological approach used for my study is that of phenomenological description. As this study is about lived experience of the nurse receiving nursing care as a patient in an acute general hospital, phenomenological description using Giorgi’s (1997) method was considered appropriate in this study. Phenomenology as a research methodology has grown and different ‘schools’ or ‘tiers’ have been described (Paley, 1997; Speigelberg, 1975) depending on specific influences and in which area of the globe the philosopher lived. Today phenomenological research is used to answer questions about human experience in the nursing and health care field (Madjar & Walton, 1999) and many publications have resulted from these studies, particularly in America (Gilmartin & Wright, 2008).

As phenomenological research has grown there are some critics of the use of phenomenology for studies answering questions relating to health experience. Both Crotty (1996, 1997) and Paley (1997) critiqued phenomenological research in nursing, arguing that it was not true to the intent of traditional European phenomenology. Paley’s (1997) main concern seems to be that nurse researchers use secondary quotes which are the work of their published nursing peers rather than the original work of Husserl and in doing so appear to have misunderstood the main tenets of Husserl’s writing. Overall, Crotty (1996, 1997) and Paley’s (1997) arguments suggested that nurse researchers were not being true to the intent of phenomenology as a philosophical mode.
of inquiry and were misquoting the original founder of phenomenology. The debate about the use of phenomenology in nursing studies began because some of the early phenomenological studies were vague in their method and guiding philosophical tenets (Koch, 1995, 1996) and these were the studies included in Crotty’s (1996) review (Koch, 1996). However, as nursing research has developed, many of these methodological ambiguities have been clarified (Koch, 1996).

Speigelberg (1975) and Giorgi (2009) demonstrated a rigourous method of using phenomenology to study human experience showing a philosophical change. Giorgi (2009) highlighted that description from others “may be challenged from a phenomenological perspective because one is to analyze only that which presents itself to the consciousness of the analyzer, whereas these experiences happen to others” (Giorgi, 2009, p. 96). However, Giorgi (2009) argues that descriptions from others are acceptable in phenomenological research because the researcher’s consciousness is involved with both the presence to the experience and with analysis. Speigelberg (1975) described an act of ‘self-transposal’ when one tried to take the place of the other and he specified a rigourous attitude that fulfils phenomenological requirements for examining the experiences of others. Indeed, as Husserl (1931) described, the use of the noematic clues could be used to work back to the noetic analysis. Therefore, it is not necessarily wrong to apply phenomenology to the study of human experience in this way; rather it is another part of a developing phenomenology.
In defending his work and that of the nurses Giorgi (2000a) has added to the debate. While agreeing with Crotty that there are some poor examples of nursing research purporting to use phenomenology, Giorgi (2000a) refers to the work as a form of scientific phenomenology, which is further clarified later in this section. Giorgi (2000a) is critical of Crotty (1996) and Paley (1997) for being inconsiderate of the dilemma of the nurse researchers in using phenomenology to find their own way as science. Generally in nursing research, a subjective understanding of the experience of the phenomenon from the participant’s perspective is sought. Crotty’s (1996) critique of nursing research is unfair, as nurses’ intentions are not to be philosophers, rather they want to unfold new knowledge to assist them to do nursing or caring work (Giorgi, 2000a) and they want to do this work well. What Crotty calls ‘new’ phenomenology or American continental phenomenology arguably is an appropriate method, if subjective experience is to be examined objectively (Giorgi, 2000a).

Giorgi (2008) provides an extensive discussion of the differences between philosophical and scientific phenomenology and he stated that the method he employed was scientific. Giorgi believed that, “…if one were to follow Husserl’s method precisely as prescribed by Husserl, one would be practicing philosophy” (Giorgi, 2000b, p. 11). He stated that he did not want to ‘do philosophy’. Rather he wanted to perform phenomenological analysis (Giorgi, 2009). Giorgi (2008) wanted to function at a scientific level of analysis rather
than a philosophical one. He also wanted the analysis to be psychologically sensitive in that it would be sensitive to the human experience (Giorgi, 2009). Therefore, he made modifications to ensure that his method responded to a fusion of philosophical phenomenology, human science and psychology. Giorgi (2008) explains this by demonstrating the history of the development of psychology as a health science, which has many similarities to nursing. This science versus philosophy debate is confusing as Giorgi’s (2009) approach is guided by Husserl who was fearful that everything examined by science was through deductive reasoning and it was to this end that phenomenology as a mode of enquiry was developed (Husserl, 1975). In reading Giorgi’s (2008) rationale it becomes apparent that he wanted to please his peers in science and develop a research method that was functional, easy to follow and explored the subjective experience of illness without the depth of philosophy that he believed Husserl had covered.

There are social and historical factors that have influenced the development of the health care field including psychology and nursing. During their development and growth as disciplines, both psychology and nursing were greatly influenced by the natural sciences. Giorgi (1975) argued that as psychology grew into an independent discipline a lot of pressure came from within the professional body as it tried to demonstrate how it could contribute to new knowledge. As a discipline, psychology tried various philosophical methods and different variations of science to find a method that was

---

4 Giorgi was a psychologist and framed his research method around psychology.
accepted in the scientific circles, whilst meeting the needs of the emerging discipline (Giorgi, 2005). He said:

...while the human sciences began by copying the natural sciences, during the latter part of the 20th century, they began to break away from imitative criteria and began to find their own way as sciences. This development has led to a better understanding of humanness and how to avoid reducing human experiences to fit quantitative methods.

(Giorgi, 2005, p.75)

Among the suggested alternatives from qualitative methods of research for psychology was philosophical phenomenology (Giorgi, 2008). Whichever methodology was used by the disciplines of psychology or nursing there had to be some modifications to meet with scientific approval and answer the human experience questions (Giorgi, 2008). Therefore, a nurse could be inspired by a particular philosophy and use its frame of reference and work within it, but at the same time meet the demands of the scientific discipline of health (Giorgi, 2008). Giorgi (2008) found that phenomenology, as a philosophy and method, was the most useful in exploring human experiences and he called this scientific phenomenology. Giorgi argued that; "It is the basic philosophical way of thinking and manner of conveying reality in phenomenology that is of use to the scientist or health professional” (Giorgi, 2008, p. 46). Giorgi (2005) identified that ‘scientific phenomenology’, is a
valid application of phenomenology and he successfully argued and advocated its use.

Phenomenology is growing and developing, but within that development, both the traditional European (philosophical) and American (scientific) approaches to phenomenology have value to nursing. The European approach has value in that critical analysis of phenomena as they present in nursing are necessary for a deeper understanding of the universal meanings of nursing phenomena. The American approach has value, as a requirement of nursing is to understand the human condition and the reorientation of phenomenology towards human science addresses the needs of nursing. This approach can lead one in the direction of uncovering the meaning of life experience from the subjective perspectives of the participants. In nursing, this approach has particular value in that it allows nurses to understand the perspective of the patient in ways that have previously been closed to them. In using a phenomenological approach, I aimed to gain an understanding of the lived experience of the nurse as a patient, receiving care that the nurse more commonly provided for others. A phenomenological approach delves into lived experience to explore thoughts, feelings, and meaning of people. In this study, it is the thoughts, feelings and meaning of what the experience was for the nurse as a patient receiving nursing care that is of interest.

In using phenomenological description to answer the question “What is the experience of the nurse receiving nursing care as a patient in an acute
general hospital?” I used the writings of Husserl in conjunction with Giorgi’s methods as a guide to the analysis of the data. In the following section I present the writings of Husserl and the modifications made by Giorgi (2005) for use in the health care field.

**Husserl’s phenomenology**

Husserl was not the first to describe phenomenology but he is accepted as its founder (Cohen, 1987; Fjelland & Gjengedal 1994; Giorgi, 2009; Speigelberg, 1975). Born in the Bohemian province of Moravia in 1859 to a Jewish family, Husserl was a mathematician who studied astronomy, physics, psychology, and philosophy (Husserl, 1975). He believed that modern science was in crisis as it had forgotten its own roots lie in the lived experience of the human life-world (Husserl, 1975; 1977) and he was troubled that consciousness was treated as a physical thing among things rather than a relationship between things (Husserl, 1931).

Although a mathematician, Husserl (1975) was concerned about the use of deductive reasoning in the study and analysis of human experience. He believed that everything examined by science was through deductive reasoning and human experience was being moulded to reduce phenomena to recognisable and scientifically accepted data (de Castro, 2003; Giorgi, 2009). In studying human experience in this reductionist manner Husserl believed that essential elements of the experience were being missed
(Husserl, 1975; 1977). Smith and Woodruff Smith (1995) stated:

**Each concrete experience falls under two high-level essences or species, called Consciousness and Nature respectively, so that the mental and physical sides of the experience are two aspects of a single event.** (p. 323)

The experience of human beings cannot be identified in a reductionist manner as human beings are living bodies, which includes the physical body and animate organism which Husserl called body-subjects (Husserl, 1975).

In their translation of Husserl’s work Smith and Woodruff Smith (1995) outlined their interpretation of Husserl’s description of humans as body subjects. To Husserl, humans are embodied beings in that the body subject consists of physical and mental attributes that cannot be separated. The physical body consists of physical attributes including where the body is in space and time but it also consists of an animate organism in that it can be moved at will, and the person is "kinaesthetically aware of" the movement (Smith & Woodruff Smith, 1995, p. 324). Husserl believed the mental aspects of the body subject consists of the psyche, the human being and the pure I. The psyche, Husserl (1975) described as the aspect of the living body, which animates it, that is, what makes it a living body. For instance, we do not notice every breath we take, breathing is something that we do subconsciously, and therefore, we have an unaware awareness of breathing.
The human being is an embodied social being who belongs to the world of everyday life (Husserl, 1975) and “the human being is the empirical I, which means that the human being is the “I of everyday experience from which all philosophical reflection begins” (Smith & Woodruff Smith, 1995, p. 324). Finally, the pure I is the subject of intentional experiences or acts of consciousness (Smith & Woodruff Smith, 1995). By this Husserl means that the mind, body and environment is part of a whole where each is affected by the other. Heidegger (1962) similarly described human beings in this way as he said:

Beings have temporality and spatiality. Time and space are fundamental to the understanding of Being and are ontological structural notions. They are embodied lived concepts important for the structure and self-interpretation of Beings. Beings are entities within time, that understand themselves with reference to their past existence and to what they believe they will become in the future. Spatiality does not imply the mere surroundings of individuals. It encompasses the things/persons for which/whom Beings care, with which they experience closeness and are involved with.

(Heidegger, 1962, p. 102)

Thus human beings are embodied social beings. Indeed Merleau-Ponty also
outlined the importance of embodiment. Young (2001) describes Merleau-Ponty as “possibly the single philosopher who has done the most to draw our attention to the pervasive importance of embodiment” (Young, 2001, p. 101). In describing human beings in this way Husserl defined the different ways we as human beings or body subjects know, experience and imagine our bodies and our minds (Smith & Woodruff Smith, 1995). Husserl (1975) believed each individual human being consisted of all of these properties and (s)he would experience phenomena from various aspects.

In describing our own body as an aspect of the world van Manen referred to the way that human beings take for granted the way they live within the world. van Manen (1998) reiterates the words of other philosophers such as Husserl when he describes an ‘unaware awareness’ of the body and its functions and we as human beings experience our body in illness as it comes to our conscious awareness.

Husserl regarded consciousness as the condition for the appearance of all phenomena and intentionality the fundamental structure of consciousness that connects beings to the world (van Manen, 1990). Husserl (1964) believed that consciousness was the only access human beings had to the world. Or rather, it is because we are conscious that we are related to the world. “Thus, all we can ever know must present itself to consciousness” (van Manen, 1990, p. 9). For instance, when we meet other people, we see their body first, in a smile or an outstretched hand to greet us. We rarely think of the other person’s body
or what is behind the smile, but are aware of the gestures of friendliness. Although we are unaware of the other person’s ‘embodied state of being’ we engage in general discussion. Therefore, there is an unaware awareness of the body of the other (van Manen, 1998) and to study life experience, a research methodology such as phenomenology that has the ability to capture the different aspects of the human experience is necessary to truly identify it.

Husserl’s main propositions in relation to phenomenology were the notion of intentionality, phenomenological reduction by époche, bracketing and eidetic reduction. Intentionality or ‘intending’ means the conscious relationship we have to an object (Sokolowski, 2000); Husserl saw phenomenological reduction as the fundamental methodological principle in the study of phenomena (Husserl, 1964). He identified a two-fold reduction in order to get to the essence of the phenomena. These are the phenomenological reduction and the eidetic reduction. Husserl wanted to exclude any pre-conceived theories on the existence of external objects, so he introduced the method of phenomenological reduction to eliminate them (Sokolowski, 2000).

Phenomenological reduction is the consideration of the basic elements of an inquiry without the researcher adding pre-conceived ideas or personal biases (Husserl, 1931). Époche refers to the questioning of assumptions or suspension of judgement in order to fully examine phenomenon. As a mathematician, Husserl used the term bracketing to describe the setting aside of pre-conceived ideas or beliefs in order to look at the phenomena. During
the époche and phenomenological reduction, Husserl (1931) asks us to disregard preconceived opinions in order to look at the whole of things, including our own being as part of the whole, whereas; eidetic reduction leads us from the realms of facts to general essences (Husserl, 1931). All of these concepts are often intertwined as they are used to explain the suspended judgment necessary for phenomenological inquiry to take place and are explored in more depth in the following section.

**Intentionality**

Phenomenology explores experience using bodily awareness, perception and reflection (Husserl, 1964). These forms of experience are intentionality (Husserl, 1964); that is, our experience is directed toward (intends) things through certain images, concepts and ideas, which make up the substance of our experience. The use of phenomenology as a research methodology develops a complex awareness of our experience in time and space (Husserl, 1964). This includes an awareness of other people, their language and meaning and an understanding of everyday events in our social and cultural life-world (Husserl, 1975).

When thinking of intentionality the word ‘intend’ makes one think that it is a plan of action when in fact that has nothing to do with intentionality as Husserl meant (Crotty, 1996). Husserl meant intentionality to be about intending or reaching into, just as extending is about reaching out. The idea
of intentionality is of the human mind reaching into the objects of which it is conscious (Crotty, 1996). The concept of intentionality originated with Aristotle who believed that the mind takes on the appearance but not the substance of the object known (Smith & Woodruff Smith, 1995). Husserlian phenomenology rests upon the belief that meaning is in the intentional relationship between the mind and the world rather than as separate entities (Kearney, 1994). Thus, the mind cannot be separated from the body or the world.

By intentionality, Husserl meant that every act of consciousness takes an object that transcends the act. Sometimes the object toward which consciousness is directed is in the world and sometimes it belongs to the same stream of consciousness as the act itself—for example, when we reflect on our dreams or on our own mental processes—but the object always transcends the act. This means that consciousness is, among other things, a principle of openness. Because of consciousness, we are open to the world, to others, and even to ourselves. Most times, awareness accompanies this openness, but not always, since even unconscious acts partake of intentionality.

(Giorgi, 2005, p. 76)

Audi (1999) described intentionality as an ‘aboutness’. For instance, things that are about other things exhibit intentionality. Intentionality is the idea that
every thought is a thought of something and every judgement an acceptance or rejection of something (Crotty, 1996). Intentionality does not mean that we only ever intend a purpose toward an object or an event. Intentionality may also be about ideas. For example, hopes and fears, whilst they are not intentional acts in their own right, they are intentional phenomena as hopes and fears are about the things of the world in which we live (Audi, 1999). We may hope for a better future or good exam results and fears may be fear about a loss or fear of a failure.

In describing intentionality, Husserl argued that all descriptions of an object, although different, are directed toward the same object (Husserl, 1931). Likewise, in describing a person's consciousness of experience, various views are linked because these represent aspects or different views of the same thing. Through the example of a cube, Husserl distinguished between the real and the ideal. Husserl (1931) suggested that human perception is also varied impressions of phenomena. The example of a cube illustrated a more far-reaching definition of object of consciousness in which object means both that which is tangible, sensory, based in reality as well as intangible things like fear, hope, or wellness. In describing this I found understanding a lot easier if the object was a house as Heidegger (1975) described, rather than a cube, as a house is also a home or it could be a prison to another. My view of a particular house would be very different to another person's view due to our different experiences of this object, which is the house. Husserl (1931) believed that these different views of the same object are linked. He believed
that I, as the researcher, could put aside my views of the house, stand back as a spectator and see the house from the view of another. He called this bracketing (Husserl, 1931), which is further explored later in this chapter.

**Phenomenological attitude and phenomenological reduction**

Husserl was concerned that human experience would be studied with the researcher’s previously held perceptions and beliefs in place, which could influence data analysis (Husserl, 1931). He believed that a different way of thinking such as by adopting the phenomenological attitude was required to capture the essential elements of lived experience without the researcher’s previous held beliefs, thus truly revealing human experience. Phenomenological research enables the researcher to return to the grounding of truths in experience by describing how human consciousness constitutes meaning through pre-reflective acts of perception (Husserl, 1931). Smith and Woodruff Smith (1995) stated that:

> *Husserlian phenomenology seeks the description and analysis of consciousness. Consciousness is to be studied precisely as it is experienced, and accordingly the objects of consciousness, too, need to be characterized precisely as they are given in experience.* //..Phenomenology is to deal with the phenomena, with the objects as we experience them in
Therefore, Husserl offered phenomenology as a way of examining phenomena, before it was reflected upon and interpreted by the researcher’s cultural and social upbringing. He argued that it would allow the researcher to gain an understanding of an experience and he thought this was necessary in order to determine the real nature of the phenomena (Husserl, 1964).

Husserl believed that the use of phenomenology as a means of philosophical inquiry was only possible with the identification and suspension of all assumptions about the nature of any reality (Husserl, 1975). The researcher therefore had to move from the natural attitude to the phenomenological attitude. The natural attitude is how we are in the everyday world. How we walk along the street, view objects and events around us, recognize objects because of their names and due to our previous experiences of them. The natural attitude is the attitude we as human beings are in everyday life (Giorgi, 2005). He stated:

*In the natural attitude, we are constantly evaluating our present experiences in terms of our past experiences. It is important that we do so (and of course, we probably cannot help but do*
so); otherwise, every experience would be a new experience and our lives would become unduly burdensome. However, in allowing such a role for past experience we often diminish the present experience by interpreting it as being identical to the past ones, whereas it is more frequently similar rather than identical. Practically speaking, there is often no consequence to this slurring over of the present and the past as well as the similarities. That is why Husserl was motivated to introduce the “bracketing” of past knowledge about the phenomenon being researched so that critical attention could be brought to bear in the present experience.

(Giorgi, 2009, p. 91)

In other words, there are many different views within the natural attitude, for example, the view of the mother: wife, child, doctor and we evaluate our present experiences in terms of what we know to be true of these views. Many objects present themselves to us and because we have named these objects in the past, we accept them for what we think they are. However, as Giorgi (2009) stated we are diminishing the present experience by accepting it as the same as our previous experience, when in fact it is not the same. In moving to the phenomenological attitude we disengage completely from the natural attitude and focus in a reflective way, on everything in the natural attitude, including what we previously thought was known to us (Sokolwoski, 2000). When the researcher moves from the natural attitude into the
phenomenological attitude, (s)he becomes a detached observer, an onlooker (Sokowolski, 2000). From the phenomenological attitude, we look at and describe, analytically, all the particular intentionalities and world belief (Sokolwoski, 2000).

Husserl (1975) believed that to provide a descriptive analysis of any of the intentionalities in the natural attitude, we could not share in any of them. Husserl states, “This ubiquitous detachment from any point of view regarding the objective world we term the phenomenological époche” (Husserl, 1975, p. 8). Époche is a term from Greek scepticism, which signifies the restraint towards judgment about things. The Greek sceptics said judging should only be done when the evidence is clear (Sokolowski, 2000) and époche enables one to focus on the ‘what’ of the phenomenon (Crotty, 1996). The époche is a philosophical device allowing one to conceal the natural attitude as one begins a phenomenological enquiry (Paley, 1997). Indeed, Husserl (1975) describes époche as the process of suspending judgment in favour of examining the evidence. In the phenomenological époche, the researcher refrains from judging, examines the evidence within the phenomenological attitude by reflection on the connections with the world and with the things in it and considers the world in its human involvement (Sokowolski, 2000). The researcher is no longer simply a participant in the world but is in the phenomenological attitude contemplating what it is to be a participant.
...the intentionalities that are contemplated, the convictions, doubts, suspicions, certainties and perceptions that are examined and described are still our intentions. We have not lost them we only contemplate them. A kind of enhancement of the self occurs in which the same self that lived in the natural attitude begins to live explicitly in the phenomenological attitude and begins to carry on the philosophical life.

(Sokowolski, 2000, p. 48)

For me, this resonates with the descriptions of ‘out of body experiences’, where the person is watching what is going on around him/her but not judging or interfering with the process. What differs from out of body experiences and the change from the natural attitude to the phenomenological attitude is that the researcher may be a detached observer but is able to see the world differently. This change from the natural attitude to the phenomenological attitude provides a change in experience of the phenomena (Kocklemans, 1967) and allows the emergence of a different view.

In describing the process of philosophical analysis and description, Husserl (1931) states that a person is normally in the natural attitude but when that person reflects and focuses on the natural attitude, they adopt the phenomenological attitude and turn to the phenomenon of concern. This is
also known as the transcendental attitude (Sokolowski, 2000). Sokolowski (2000), states that a phenomenological attitude is how philosophical analysis or description is carried out. Husserl (1931) called the change from the natural to the phenomenological attitude phenomenological reduction, which he argued involved a questioning of one’s presuppositions about the world.

Phenomenological reduction was the main theoretical tool that Husserl developed for engaging in a distinctly philosophical form of thinking (Keller, 1999). With phenomenological reduction, the objects of experience are reduced to the phenomenon as presented but the acts of consciousness correlated with such objects belong to a human mode of consciousness (Husserl, 1975). van Manen (2002) described it as a moment of lived meaning with the method of phenomenological reduction aiming to bring about aspects of meaning that belong to the phenomenon of our life world into “nearness” (van Manen, 2002). The phenomenological reduction is not a confinement, a leading away from anything as it preserves the natural attitude and everything in it (van Manen, 2002). Sokolowski (2000) states that rather than depriving one of information, the phenomenological reduction highlights the essence of the phenomena and van Manen (2002) stated that the phenomenological reduction aims to bring into focus the uniqueness of the particular phenomena. My aim is to bring into focus the uniqueness of the experience of the nurse as a patient receiving nursing care in an acute general hospital to identify new knowledge about this group of people and thus inform future nursing practice.
In describing phenomenological reduction, Giorgi (2009) describes reduction happening because a concrete situation that was lived through before any thought about being studied or analysed is later explored and used for learning. Giorgi (2009) agreed with Husserl in that the phenomenological attitude of the researcher had to be assumed, meaning that the researcher had to regard everything from the phenomenological attitude, that is to look at objects as they are experienced pre-reflectively. Giorgi (2009) argued that the researcher had to search for the essence of the phenomena as described by Husserl (1975), and then provide a description of the essence. To find the essence of the experience the unnecessary elements of the experience have to be peeled away in order to reveal the true meaning of the experience (Sokolwoski, 2000).

In order to examine phenomena pre-reflectively, that is before it is reflected upon, Husserl believed that the researcher could ‘bracket’ his/her previous experience to get a true sense of the phenomena (Husserl, 1931). As a mathematician, Husserl used the idea of bracketing in the same way he would a mathematical equation. Bracketing is what one does to achieve reduction (Husserl, 1931). The act of bracketing to achieve the phenomenological reduction is a self-reflective process where the existing world is bracketed, that is inhibiting or suspending all previous held beliefs in existence that accompanies everyday life and scientific thinking thereby giving it a different value (Husserl, 1931). In order to do this, he developed a self-reflective
procedure in which the investigator refuses to permit himself/herself to accept anything as existing unless all possibility of doubt about it has been removed (Husserl, 1931). Husserl advocated a rigorous approach to reflection that would bring the researcher back from pre-conceived ideas about phenomena. This approach demands setting aside all previous knowledge of human experience not based on actual evidence. With this in mind, Husserl developed a framework that allowed the researcher to gain a “naively objective view of human experience from a phenomenological understanding” (Husserl, 1931, p. 133).

Bracketing pre-conceived ideas, thoughts and experiences whilst reflecting on the data allows a fresh approach to the raw data (Giorgi, 2009). In this study, the question asked of the participants was; “can you tell me about your experience of being a nurse as a patient receiving nursing care in an acute general hospital?” Because I am a nurse and a midwife of more than thirty years of clinical practice, I attempted to bracket, or set aside, my perceptions or views about the experience under study. In order to achieve this I reflected on my nursing experience prior to and during the data collection period and recorded this in a reflective journal. I reflected on what I thought it would be like to experience being a patient receiving nursing care and my own experience as a nurse. As I used Giorgi’s method, it was important for me to follow the Husserlian tradition in this sense and with this in mind, I documented my assumptions and listed them in the method section of this thesis. I reviewed and reflected upon my assumptions periodically.
Throughout this study, I used this approach to identify and set aside my assumptions to enable me to suspend belief in the existence of the phenomena which, as Speigelberg (1975) identified, enabled me to concentrate on the ‘what’ of the experience of the nurse as a patient receiving nursing care in an acute general hospital.

Following the data collection period of my study, I became critically ill and received nursing care in both intensive care and a surgical ward. When I was in intensive care, I was too ill to consider the study or my own experience. However, when I was in the surgical ward recovering from my illness, I found myself relating and reflecting on the experiences of the participants in the light of my own experiences. In order to avoid influencing the study findings with my own perspectives or views about the experience I reflected on these and recorded them in my journal. By recording a reflective journal, I was able to set aside my experiences as a patient and recognise my assumptions pertaining to this study. This allowed me to ‘check’ my interpretations of the data in order to ensure that I was analysing the participant’s experience without my own experience influencing it. Giorgi (2008) argues the importance of being able to avoid concentrating on what one would expect to see in order to see the phenomena as lived. From the Husserlian philosophical stance, it is only by suspending judgment that inquiry can proceed without assumptions about the nature of the phenomena observed. Husserl (1931) and Giorgi (1975) describe this as bracketing which results in the postponement of any previous interests or beliefs about the phenomena.
One of the main critics of Husserl’s belief that the researcher could truly bracket his/her own previously held beliefs was Martin Heidegger (1975). Heidegger was a student of Husserl who went on to develop the interpretative phenomenological approach known as Hermeneutics (Annells, 1996). Heidegger’s approach differs to Husserlian phenomenology, in that the researcher brings his/her own understanding and experiences to the research process. Heidegger believed that we are a part of the world and as such cannot be separated from it (Heidegger, 1993).

As a nurse and a researcher, I partly agreed with Heidegger. Whilst I agreed that I could not completely detach or remove my nursing knowledge and experience I could look at the data from the perspective of a nurse researcher but in doing so I would look at it in a different light in that I bracketed what I thought to be true in order to get to the essence of the experience. Giorgi (2009) described this as a disciplinary attitude. In the only difference to Husserl’s phenomenology, Giorgi encourages the researcher to acknowledge his/her disciplinary knowledge and “assume a disciplinary attitude” (Giorgi, 2009, p. xiv). This means that although I, as the researcher, have bracketed my previous experience and assumptions about the phenomena under examination, as a nurse and a researcher, I have read the stories from the participants about their experience assisted by my understanding as a member of the nursing discipline. As van Manen (1990) said:
If we simply try to forget or ignore what we already “know” we may find that the presuppositions persistently creep back into our reflections. It is better to make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories. We try to come to terms with our assumptions, not in order to forget them again, but rather to hold them deliberately at bay and even turn this knowledge against itself, as it were, thereby exposing its shallow or concealing character.

(van Manen, 1990, p. 47)

Another of Husserl’s main propositions was eidetic reduction. Kocklemans (1967) described eidetic reduction as the methodical procedure through which knowledge is raised from the level of facts to the sphere of ideas. Eidetic reduction is achieved through intuition of essences or ideation and is directed at achieving essential insight regarding the phenomena (Smith & Woodruff Smith, 1995). The eidetic reduction makes the world appear as it was pre-reflectively (van Manen, 2002). However, “a true reflection on a particular experience is a thoughtful reflective grasping of what it is that renders this or that particular experience its significance” (van Manen, 1990, p. 32). As Husserl (1931) said:
Of the intuition, correspond the essential relation between ‘existence’ (here clearly in the sense of individual concrete being) and ‘essence’ between fact and eidos. Pursuing such connexions (sic), we grasp with intelligent insight the conceptual essence attached to these terms.

(Husserl, 1931, p. 56)

To begin the eidetic reduction, the phenomenon in question can be compared with other related but different phenomenon. This is known as the eidetic technique of variation in imagination (van Manen, 2002). Through the eidetic reduction, patterns of meaning or themes of a phenomenon can emerge. These themes are the working material for phenomenological writing (van Manen, 2002) and the method used for data analysis are now described.

**Giorgi’s framework for using phenomenology as a research method**

In qualitative methodologies, method means that a certain ‘mode of inquiry’ is chosen and the particular method used depends on the philosophic assumption inherent in the framework (van Manen, 1990). Within phenomenological research, method refers to the research technique and the procedure for carrying out the research. Following in Husserl’s footsteps, Giorgi’s framework for using phenomenology is outlined in terms of a research method, consisting of description, phenomenological reduction, the search for essences and the recognition of operative intentionality (Giorgi,
As previously stated, Giorgi has made an important distinction between phenomenology as a philosophy and phenomenological research as a scientific practice:

*Phenomenological philosophy is a foundation for scientific work; it is not the model for scientific practice. The insights of the philosophy have to be mediated so that scientific practices can be performed.*

(Giorgi, 2000, p. 4)

In order for Husserl’s phenomenology to become a scientific practice, Giorgi (1997) made some alterations but he retained the essential elements and core concepts of Husserl’s philosophy. The major change that Giorgi (1997) made was to use descriptions of experiences from others rather than personal philosophical reflections on experience.

As a psychologist, Giorgi (2009) described how to apply the phenomenological method to psychological phenomena. Whilst much of his work was in psychology, he argued the adaptability of this method to other health care fields and explained:

*The method described is generic enough to be applied to any social science that works with human beings with a few minor
modifications. The key change is that researchers from other disciplines have to assume the attitude of their specific disciplines and show sensitivity to detecting their phenomena of interest even though they are mixed. The raw data consists of descriptions of everyday life but the analysis takes place within a disciplinary attitude as well as within the scientific phenomenological reduction and with a special sensitivity to the phenomenon being investigated. This means that nurses and scientists from other disciplines can use the method. (Giorgi, 2009, p. xiv)

Giorgi (2008) defined the steps relating to his method of phenomenological description. These steps include collection of data, personal reflection and attending to personal experience, exploring relevant literature, tracing sources and meaning of words used in description and finally identifying meaning units (themes) and phrases to illuminate and describe the phenomenon of inquiry (Giorgi, 2009). In using Giorgi’s (2009) method the task of the researcher is to let the world of the participant reveal itself through the description (Giorgi, 2009) and narrative is transformed to phenomenological description through a process of reflection and “imaginative variation”. To achieve this Giorgi (2009) described steps to collect and analyse the data, which are outlined as follows:
**Collection of data**

The most common sources of data collection in qualitative research are interviews, observations and field notes (Burns & Grove, 2010). Interviews provide an in-depth description of experience of phenomena that would otherwise be unobtainable (Gill, Stewart, Treasure & Chadwick, 2008). Individual in-depth interviews can be used to reconstruct perceptions of events and experiences related to health and health care delivery (DiCicco-Bloom & Crabtree, 2006).

Giorgi’s phenomenological research method commences with the researcher gathering detailed concrete descriptions of specific experiences from others who have lived through the phenomena under investigation. He described the concrete descriptions of human experience as the raw data being studied (Giorgi, 2009). The raw data can be obtained by interviews or from written stories of the experience (Giorgi, 2009) and even from drawings (Todres, 2005). In order to be meaningful the raw data needs to capture the complexities of human experience and depict the experience exactly as it was lived, containing all of the ambiguities and complexities of relationships (Giorgi, 2009). Accounts of lived experience obtained by interviews or from written stories are, therefore, most appropriate where little is already known about the study phenomenon or where detailed insights are required from individual participants (Gill, Stewart, Treasure & Chadwick, 2008).
Interviews range from the highly structured style, in which questions are determined before the interview, to the open-ended, conversational format (Thomas, Nelson & Silverman, 2011). The three types of research interviews are: structured, semi-structured and unstructured (Gill, Stewart, Treasure & Chadwick, 2008). Structured interviews are, verbally administered questionnaires, in which a list of set questions are asked. Structured interviews do not allow for any variation in the questions that are asked or allow any additional questions in response to an answer from the questions that may require elaboration. Semi-structured interviews consist of several key questions that help to define the areas to be explored, but also allows the researcher or participant to diverge in order to pursue an idea or response in more detail. The semi-structured interview format is frequently used in health care as it provides participants with some guidance on what to talk about (Gill, Stewart, Treasure & Chadwick, 2008).

When using unstructured interviews the researcher has a brief topic guide, allowing considerable freedom within the interview and the interview takes the form of a conversation. Although there are different styles in qualitative interviewing, an unstructured approach allows the participant to tell her/his story rather than merely respond to specific questions. This encourages a more natural transition to the topic, and ultimately, better data (Broom, 2005). Although the interview is unstructured prompting is sometimes used by the researcher to elicit further information about an issue or event described by the participant, for example the researcher could ask the
participant to expand on something (s)he has said. The aim of prompting is to encourage the participant to talk about an issue or event, without actually directing her/him to any particular conclusion (DiCicco-Bloom & Crabtree, 2006).

Interviews are mainly conducted with the researcher and the participant face-to-face however; telephone interviews can also be used. The disadvantages of using telephone interviews is that the researcher misses out on body language but intonations in speech can be picked up and the participant is more likely to be more relaxed than (s)he would be in face-to-face interviews (Yin, 2013).

In this study I used face-to-face unstructured interviews. I also used unstructured telephone interviews and stories expressed as written letters or emails from participants who lived too far away to meet face-to-face. I used these three methods of data collection to overcome the tyranny of distance and to provide the ability to collect data from around Australia. The raw data for this study consisted of concrete descriptions from participants who were nurses as patients receiving nursing care about their experiences of being cared for by nurses during hospitalisation.

Once the raw data is obtained the researcher describes the structures of the experiences that the participant lived through and presents the findings descriptively. The researcher adopts the phenomenological attitude by phenomenological reduction in order to intuit the essence of the experience
(Todres, 2005). By describing the experience of nurses receiving nursing care whilst hospitalised, the experience was brought into the present and reflected upon in order to gain a deep understanding of the essential meanings of the experience (van Manen, 1990). In obtaining these descriptions I held a phenomenological stance that enabled me to keep myself open enough to live that experience as Gestalt that is, in its wholeness, by trying to prevent any judgment from interfering with my openness to the description. I set aside any prior thought, conception, judgment that I may have had about the phenomenon as described by Husserl (1975). Sadala and Adorno (2002) state that by doing this, the researcher will be placing that phenomenon in époche. I therefore listed my assumptions in my journal and set them aside as previously described.

**Assumptions and preconceptions relating to the study**

My assumptions were that the experience of being a patient was likely to be similar to the layperson’s experience, which is well documented in the literature. However, the nurse’s experience of being a patient receiving nursing care is also different to the lay patient as the participants have nursing and health care knowledge. Health care knowledge and experience that participants have as nurses may have influenced their experience of being a patient receiving nursing care. In addition the nurses’ professional knowledge and understanding of the hospital processes provided them with unique insights into how the health care system worked.
Anecdotally I found that nurses, who had been hospitalised previously as patients, were very critical of their peers or fellow health care professionals. I was acutely aware of this prior to commencing the study from listening to colleagues reflecting on their own experiences of being a patient in hospital. I was also aware that due to the nature of the study participants may use the data collection process as an opportunity to complain and some participants may have been traumatised by their experience and use the study interview to debrief. Although I was expecting some participants to describe a negative experience of being a patient receiving nursing care, I was also expecting participants to reflect on the positive aspects of the experience.

In the following section I outline the study setting, study participants, study criteria, ethical considerations and data analysis utilising Giorgi’s (2009) method of phenomenological description.

**Study setting**

The study was undertaken in Australia. Australia is in the southern hemisphere of the world and is the sixth largest country by total area. It comprises the Australian mainland of seven states with the eighth state being the island of Tasmania. There are 736 public acute hospitals, which provide emergency, surgical and medical services, and 373 private hospitals, which have a variety of acute and non-acute services. Of the 373 private hospitals...
293 are day only facilities for surgical procedures (Australian Institute of Health and Welfare, (AIHW) 2010). Participants resided within seven of the eight states of Australia including: the Australian Capital Territory, New South Wales (NSW), Northern Territory, Queensland, South Australia, Victoria and Western Australia. There were no expressions of interest received from nurses in Tasmania. As each participant had had an episode of acute illness or injury, they had all been a patient in a tertiary referral hospital in a major city or large regional town such as Adelaide, Brisbane, Canberra, Freemantle, Melbourne, Newcastle, Perth, Sydney and Townsville.

Inclusion criteria for the study

This study was about the experience of being a patient receiving nursing care in an acute general hospital. In order to capture the experience, I did not restrict the study to a particular physical condition or ailment as long as the event was in an acute general hospital. Inclusion criteria included nurses who had been a hospital inpatient for two or more days within the previous five years in an acute general hospital. To ensure the study was situated within contemporary nursing practice and due to the many changes in health care over the previous two or three decades it was deemed important that the participant’s experience of receiving nursing care as a patient in an acute general hospital was within a five-year period of the study commencing.
Specific exclusion criteria were developed to ensure that participants included nurses who had received an acute injury or illness or an exacerbation of an illness and were a patient in an acute general hospital. This was to ensure the experience was adequately captured; therefore, the following were excluded:

- Nurses who had been admitted to a non-acute hospital
- Nurses who had been admitted to a hospital in a country other than Australia.
- Nurses with less than 2 days inpatient stay in an acute general hospital within the last 5 years.
- Nurses who had not been working in nursing for more than 5 years before his/her hospital admission because currency of nursing experience is an important aspect of the experience of being a nurse and a patient.
- Nurses who had a mental illness were excluded from the study as it was thought that this experience would differ from one involving a physical illness or injury.

**The participants**

The participants are an important part of any empirical study, and they have to be chosen in accordance with the study’s inclusion or exclusion criteria (Burns & Grove, 2010). In qualitative research, the methodology used identifies the process for selecting participants. Qualitative investigations are
based on recognition of the importance of the subjective, experiential life-world of human beings (Burns & Grove, 2010). In conducting a phenomenological study, I aimed to study the lived experiences of individuals involved in actual situations or places. Therefore, this study used purposeful sampling in order to gain insight and understanding into the experience of concern, which was that of the nurse receiving nursing care as a patient in an acute general hospital. Purposeful sampling provides for the selection of “information rich cases for the study in depth” (Patton, 1990, p. 169). Patton (1990) states that information rich cases are those from which issues of central importance can be shared and from which we can learn. Therefore, it was important for this study to select subjects who were likely to provide rich data. These subjects were nurses, who were currently practicing as professional nurses and who had been hospitalised recently for an acute illness or injury.

Recruitment

As there was a paucity of research on this topic, it was important to me that this study did not focus on one local hospital or one specialty within the hospital but that it would include the experience of nurses receiving nursing care. Therefore, this study needed to be broader than the small study of the nurse patient in a surgical ward conducted by Zeits (1999). Although this type of research can be conducted with a small study sample, a larger study
sample is likely to increase the variations of the experience and therefore improve the researcher’s ability to see what is essential (Giorgi, 2009).

There were several approaches to recruiting potential participants for this study. Initially, a letter containing the study abstract which provided information about the study and a copy of a flyer (see appendix 1 & 2) was sent to all of the Directors of Nursing (DON's) in each public and private hospital in Australia. The letter and flyer were sent to all hospitals including small rural hospitals as I hoped to recruit nurses who had returned to work in these hospitals after their illness or injury. The letter requested permission to display the enclosed information flyer (see appendix 2). The flyer contained an expression of interest inviting nurses who met the study criteria and who were interested in participating in the study to telephone or email me for further information. A further statement in the expression of interest stated that nurses might, if they wish, forward their personal account of their experience of receiving nursing care whilst a patient in an acute general hospital anonymously to the address indicated on the expression of interest. In addition, contact details of my home address; work address, email address and telephone number were provided in the letter and flyer to ensure it was easy for each DON to respond. A few responses (n=3) were received denying permission to display the flyer or any information about the study within the respondent’s hospital setting. Reasons for this were not provided. Over the next six weeks, I only received interest in the study from nurses at my own local hospital and as there was no response (apart from the three letters
denying access) from the other two hundred hospitals I had no way of knowing if the flyers had been displayed.

In light of the absence of a response from the letters to the DONs and the flyer, I explored alternative methods of distributing information about the study to potential participants. I thought that a possible avenue of imparting information to nurses was through professional journals. I read all of the available Australian nursing journals including nurses’ trade union journals to see if there was a way that I could get information and an expression of interest out to nurses across Australia. It was frustrating to find that there was no avenue available to new and/or upcoming researchers to share their research question and gain support. I wrote to a nurses’ union journal expressing my frustration. With this letter, I also attached an abstract about the study and my contact details. A short time later, I received a letter stating that a synopsis of the study proposal abstract would be placed in the June 2004 issue of the journal and I was informed that a new column had emerged because of the letter I had sent (see appendix 3).

In June and July 2004, a few interested enquiries were received from potential participants and I contacted these potential participants and sent them information about the study containing an expression of interest (appendix 4) and a letter containing demographic questions and possible prompts to be used in the study (appendix 5). I also included a consent form (appendix 6). On the return of the signed consent form, I contacted the
potential participants and I arranged an interview with them. As this journal was only circulated throughout NSW, I was only receiving expressions of interest from nurses in that State. Therefore, to ensure nurses from around Australia had the opportunity to be involved in the study other means of advertising were sought.

In August 2004, an advertisement seeking expressions of interest to participate in my study was placed in a widely circulated professional nursing journal (see appendix 7). The expression of interest invited nurses (Enrolled and Registered) who had received nursing care when a patient in an acute general hospital for a minimum of two days within the last five years to participate in the study.

As the recruitment area was the whole of Australia, it would have been impossible to visit each participant in his/her local area due to time constraints and the vast distances in Australia. Therefore, I made a decision to limit the distance I would travel to interview participants. Nurses, consenting to participate in the study and residing within a 150-kilometre radius of Newcastle, NSW were offered face-to-face interviews. However, in order to include participants from a wider area than this allowed, nurses who lived anywhere in Australia and who wanted to participate in the study were asked to provide their personal account of their experience of receiving nursing care when a patient in an acute general hospital on audiotape or in hard copy. I found however, that most of the nurses who wanted to
participate in the study preferred to tell their stories by telephone interview rather than send a personal written account. This was agreed to following a successful ethics variation application to include telephone interviews in the study.

Nurses who telephoned me to express an interest in the study, were asked to provide their names and postal or email addresses so that an information letter outlining the study (appendix 4), a questionnaire asking for demographic details (appendix 5) and a consent form for participation in the study (appendix 6) could be forwarded to them. A stamped addressed envelope was included for the return of the consent form. Nurses who contacted me by email to express an interest in the study were sent an electronic copy of the information letter outlining the study (appendix 4) and were asked for their postal addresses so that a consent form and stamped addressed envelope could be sent to them. All potential participants were also sent a questionnaire seeking demographic data (appendix 5).

The information letter invited potential participants to contact me for any further information or clarification about the study. Consent to participate in the study was by the return of a signed consent form to the researcher in the prepaid envelope provided, or by anonymous return of a personal account relating to the study’s topic as indicated above. Formal consent was not sought for the use of personal accounts (stories) relating to the research topic. Instead, consent was assumed with the returned account. Following the
question seeking background demographic data (appendix 5) each participant was asked to discuss or write about his/her experience of receiving nursing care whilst a patient in an acute general hospital setting.

**Description of the participants**

It was anticipated that participants in the study would include up to 30 nurses who would consent to be interviewed, as well as a number of participants who would consent to writing (or audio-taping) and submitting their personal account. In the end, there were 37 participants who consented to be interviewed either face to face or by telephone. In addition, eight letters/emails were received from nurses who wished to submit their personal account.

The total number of participants interviewed for the study and the number of participants’ personal accounts to be included in the study depended on the adequacy of the data. Saturation or adequacy was attained when enough data had been collected so that there was no ‘new’ information emerging from the data (Todres, 2005).

All participants in the study, except those responding anonymously, were asked for demographic details including age, gender, type and length of nursing experience and whether the hospital admission was for an acute illness or exacerbation of a chronic illness as it was anticipated that these
experiences could differ. To maintain confidentiality demographic data has been grouped as it is thought that linking diagnosis, gender and age may lead to a participant being inadvertently identified by a colleague reading the study findings (see appendix 8).

Study participants were also asked what illnesses or injuries they had which required a hospital admission and nursing care. Some participants declined to provide full information. However, most were willing to share their diagnosis and reason for admission to hospital. Participants’ illnesses and injuries included surgical or obstetric procedures and medical emergencies such as anaphylaxis. A full range of participants’ illnesses and injuries is outlined in appendix nine.

Participants had a range of experiences including midwifery, neonatal, child health, paediatrics, mental health, emergency medicine, cardiac, general medical, surgical, aged care, palliative care, diabetes, education, management, occupational health and safety, schools, health promotion and research. They included nurse educators, managers, midwives, and clinical nurses.

There was one male participant and 36 were female. Three participants declined to complete demographic data. Participants’ ages ranged from under 25 (n=1) to over 40 years of age. Twenty-two of the participants were aged over 40 years. The age range is indicative of the Australian nursing workforce
where the majority of practising nurses are over the age of 40 (http://www.nurseinaustralia.com/nurses-getting-older, 31st May 2010). The majority of participants had 20 to 29 years of nursing experience (n=21) and only one participant had less than five years nursing experience (outlined in appendix 8).

Despite the provision of clearly identified information letters and consent forms there was one participant who was under the impression that the research was conducted by the Health Care Complaint Commission (HCCC) and she was disappointed when she discovered this was not the case. She stated that her experience was so terrible that she wanted to complain. I informed her that she could still make her complaint to the HCCC or the patient safety officer within the particular hospital she had identified. I clarified my position as a research student and doctoral candidate. I outlined the study aims and reiterated that I was interested in the experience of the nurse as a patient receiving nursing care to gain knowledge and understanding of the experience in the hope that new knowledge will be uncovered which will provide understanding and education about the nurse as patient experience. I offered her the opportunity to withdraw from the study, which she declined. After some discussion about the study, we were able to continue the interview and elicit her experience of being a patient receiving nursing care. This interview was conducted in a cafeteria of a Bowling Alley at the participant’s request. It was difficult to transcribe because of the background noise and because the participant took control of the audiotape.
by turning it off and on frequently. I managed this by inviting her to leave the audiotape off whilst we had a cup of tea. My intention was to focus on gaining her trust, as she was obviously very nervous, and ensure she was still interested in being a participant in the study. After some discussion, she completed the interview and decided to continue in the study.

**Ethical considerations**

Ethical approval was granted from the University of Newcastle Human Research Ethics Committee. Ethical considerations related to this study include informed consent to participate in the study, confidentiality and anonymity, participant’s care and data storage as identified in the following section.

**Informed consent**

When potential participants expressed interest in the study by telephoning or emailing me I responded by thanking them for their interest. I reiterated the purpose of the study and what was required of the participants. I also checked the potential participant’s understanding about the study by inviting questions and clarifying that they met the study’s inclusion criteria. For example, although participants did not have to be currently working as a nurse they were required to have had employment as a nurse within the
previous five years. I answered all of their questions about the study at the time of the initial contact.

Following the initial telephone call, I sent all potential participants a letter containing information about the study (appendix 4) and a consent form (appendix 6). This letter identified participant’s rights to confidentiality and my contact details. As stated previously, consent to participate in the study was by the return of a signed consent form in the prepaid envelope provided or by anonymous return of a personal written account relating to the study’s topic.

Confidentiality and anonymity

The names and identifying details of interview participants remain confidential. Prior to interview and as described in the information letter, participants were asked not to use real names of colleagues or hospitals during the interview in order to maintain confidentiality of where the participant had been a patient. Participants were informed that any identifying names or locations of health professionals or institutions would be removed from the transcripts of interviews and/or emails to ensure confidentiality was maintained. In addition, to ensure participant confidentiality no data was linked to a participant's real name and demographic details obtained were grouped (appendices 8 & 9). To further ensure privacy and confidentiality was maintained all transcripts received a code number and pseudonym so that the
name of the interviewee did not appear on the related transcript. I maintained a master list of the codes and the corresponding participants. Only my supervisors and I know participants’ coded identity in the transcripts.

Confidentiality was maintained by ensuring privacy during interviews and in any discussion between the researcher and the supervisors. Face to face, interviews were mainly conducted in private offices or interview rooms within the hospital where the participant worked but away from their clinical area. One interview was conducted at a public place at the request of the participant. As this place was a very busy cafeteria of a Bowling Alley, I chose a table in the corner away from other occupied tables in the hope to maintain some confidentiality. Telephone interviews were conducted when I was alone at home and the participant was alone in his/her own home. Participants were assured that no real names would be used in publication or conference presentations arising from the study.

**Participant care**

Discussions about participants’ experience of receiving nursing care as a patient in an acute general hospital had the potential to cause emotional distress. In the event of a participant becoming distressed during the interview the audiotape was turned off and the interview suspended. Due to the nature of the experience, some participants were at times emotional and one participant became quite distressed when recalling her experience of
being close to death. Noting this, I turned the audiotape off whilst we discussed this, and I offered her the opportunity to withdraw from the study. However, she expressed a desire to continue with the interview. I suggested she seek support from the Employee Assistance Program (EAP), and gave her the information leaflet about their services including contact details. I offered to contact EAP and make an appointment for her, which she declined. Because I was concerned about this participant, I telephoned her the next day to see how she was; I again offered EAP and again this was declined.

Support from the EAP, which provides trained counsellors for staff support in all sectors of health care, was offered to all participants who became distressed during their interview. I discussed the study with staff at the EAP prior to the commencement of the study and sent them a letter informing them of the study and requesting support from their services if required (appendix 10). Although EAP staff agreed to provide support if required it was not required by any participant. In addition, participants were made aware in the information letter that they could withdraw from the study at any time prior to data analysis, without explanation and without fear of their participation affecting their employment status or professional career. Although there were no withdrawals from the study, two people who had consented and would have liked to be included in the study could not be included because of their work commitments and planned absences to work overseas. Both of these participants reassured me that they would make contact by email but they did not. I followed up with an email to the
addresses they had provided. However, when I did not receive any replies, I considered that they had both changed their minds and excluded them from the study.

**Data storage and access to files**

Access to transcripts and audiotapes was limited to me as the student researcher and the supervisors of the project. To ensure confidentiality was maintained computer access to all of the data was password protected and all audiotaped interviews and transcript files were stored in a safe, dry locked area until completion of the study. On completion of the study and examination of the thesis, all audiotapes will be destroyed. Identified transcripts will be stored securely for the required period of five years at the School of Nursing and Midwifery, the University of Newcastle. All research data will be destroyed after the five-year term.

**Data collection**

Data collection involved face to face interviews, telephone interviews and emails. Following receipt of a signed consent form, I telephoned the potential participant, who had consented to be interviewed in person. I clarified my position as a research student and doctoral candidate and checked that they were happy for me to proceed with the conversation at this time. During this discussion, I asked the potential participant if (s)he had any questions
pertaining to the study information letter. I reiterated essential aspects of the study such as how I intended to maintain confidentiality, that a participant could withdraw at any time and that a mutually agreeable time and venue to meet and conduct an unstructured interview in person or by telephone would be organised. I informed the participants that I would be keeping a journal throughout the research to assist me in my thought process of recognising personal assumptions and feelings about the research and to record personal experiences of conversations and interviews with the participants. I reassured participants that there would be no identifying details within this journal and participant confidentiality would be maintained.

In order to elicit the experience from the participant in his/her own words unstructured interviews, which use open-ended questions in a conversational manner (Giorgi, 2009) were used in both face to face and telephone interviews. The opening question asked was, “Can you please tell me what your experience of being a patient in an acute general hospital was like”? In some instances, some prompting (appendix 5) was required to encourage reflection and recall of the participant’s experience. Therefore, the length of the interview depended on the participant’s response and ranged from 40 to 100 minutes.

Immediately prior to each interview I reminded the participant of his/her right to withdraw at any time, I ensured I had written consent and I also reminded each participant that the EAP was available should it be required. Interviews conducted in person were audio taped, with the consent of the participant.
These were generally conducted in offices where privacy could be maintained at my own workplace or that of the participant. I ensured the interview would not be interrupted by turning off the phone and putting a do not disturb sign on the office door. As previously stated, one interview was conducted at a Bowling Alley cafeteria as this was the mid point of travel and the participant requested this venue.

I established a rapport with the participants with the use of empathetic responses and congruent body language. This appeared to encourage the participants to describe their experiences of being a patient receiving nursing care. I did this by initially revealing some information about my years of experience as a nurse, what field of nursing I was currently working in and why this study topic was of interest to me. I chatted with each participant until (s)he indicated that it was time to start the interview. Participants usually did this by pausing in the conversation or directly informing me.

During the interview, I sat facing the participant and listened intently to his/her experience. On occasion, I required clarification of information that the participant was providing and I used prompts to elicit this information, these prompts were noted and recorded in my diary. For example, one participant said, “I expected to be treated with respect as a colleague”. I asked, “Did that happen?”
At the conclusion of each interview, I made notes in my diary of the interview process, contextual features that were relevant to it and any mannerisms of the participant that I had observed. Some interviews were short and I found it difficult to illicit information about the participant’s experience and some prompts were used, others flowed freely as the participant recalled his/her experience. After one interview, the participant offered me a cup of tea. Although the interview style was conversational, once the conversation was no longer being recorded and in the more relaxed atmosphere of sitting having a cup of tea, she began to relay more information about her experience with such rich data that I asked her if we could turn the recorder on and include this information in the study. The participant agreed as she had become more relaxed and keen to tell me of her experience. Although there is a gap in the interview on the audiotape when it had been prematurely concluded, the full interview was successfully transcribed.

**Telephone interviews**

In the telephone interviews the same style of interview and the same opening prompts were used as in the face-to-face interviews. It was also important to establish a rapport with the participant in the telephone interview as it was with the face-to-face interview. To instil confidence in me as a researcher and to enable trust with such potentially sensitive data, I began the telephone interviews by providing some information about myself, as I did in the face-to-face interviews, about the study and why the topic was of interest to me.
Participants generally chatted for a minute or so and then said they were ready to begin the interview.

Interviews conducted by telephone were made from my home to the participant’s home and I made notes of what was being said during the interview. Telephone interviews conducted from my home were conducted during a time that was mutually agreed; I ensured that I was the only one home at the time to reduce the risk of interruptions. I initially attempted to record the telephone interviews but the technology available at the time was insufficient to accurately record. Therefore, as I was listening I was also transcribing. All of the participants had agreed to receive a return telephone call to confirm aspects of the initial telephone interview. Because of the difficulty of listening intently to what the participant was telling me as I documented, I re-read the transcript immediately after the telephone call and on some occasions, I followed up with a second telephone call to clarify some aspect of the interview. Some participants asked me to send them the transcript by email for them to review, which I did.

Letters and emails

Although most of the participants residing more than 150 kilometres from Newcastle NSW wanted to be interviewed by telephone, six participants preferred to send their personal accounts by email or letter. I offered to send a blank audiotape or to arrange a telephone interview for those participants.
Each participant, however, declined this offer preferring instead to write to me. In addition, I received two anonymous letters containing personal accounts.

**Data analysis**

In response to the research question, “what was your experience as a nurse receiving nursing care in an acute general hospital”, participants selected the situations or experiences to be described. My role as the researcher at the time, was to obtain a faithful account of the lived through event(s) or experiences (Sadala & Adorno, 2002). Following each interview, I used my journal to record contextual issues relevant to the interview process. For example, I made a note of any personal gestures or intonations in voice that participants used during the interview.

The data in this study was analysed by applying the reflection and writing process as described by Giorgio (2009). Using this approach analysis began during the interviews as I actively listened to what was being said (Cohen, Kahn & Steeves, 2000). I then followed these three steps;

1. **Obtaining a sense of each description as a whole experience**

On completion of the interviews, and when saturation had been reached, I continued the data analysis phase of Giorgi’s (2009) method by analysing the raw data. The data gleaned from the unstructured interviews and participants’
stories (audio taped interview, telephone interview and personal accounts) were transcribed and analysed using Giorgi’s method of phenomenological description. I transcribed each audiotape. I then laid each transcript and related interview notes from my journal in front of me. I read and re-read each of these several times whilst listening to the audiotape in order to ensure I had captured the data accurately, noting alterations in the pitch or tone in the participant’s voice and any changes in manner. I read and re-read the text several more times to get a grasp of the whole (Giorgi, 2009) and to develop an understanding of the participant’s language. After reading the description of the experience, I read the full transcripts and my notes of the interviews to gain a holistic view of what was being said. This step helps ensure that any a priori thoughts of the researcher do not override the participants’ description (de Castro, 2003). I also followed this step with the transcripts from the telephone interviews and also the personal accounts I had received from participants.

2. The description of the experience and phenomenological reduction

Phenomenological reduction is appropriate for the analysis of human experience, since the purpose of human science is clarification of the meaning of the phenomena experienced by humans (Giorgi, 2009). The raw data in this study was analysed using the process of phenomenological reduction and “with special sensitivity to the phenomenon being sought” (Giorgi, 2009, p. 96).
The phenomenological researcher enters the attitude of the phenomenological reduction in order to become as faithfully present to the intrinsic intelligibility of the meaning of the narratives. In the process of understanding, one is present in not to words in themselves, but to the meaning given through the words.

(Todres, 2005, p. 111)

In phenomenological reduction, the researcher remains closer to the level of lived reality and lived experiences (Giorgi, 2009), which enables the ‘awakening force of astonishment’ to be sustained (Cogan, 2006). As the researcher, I immersed myself in the world of the description by disciplining myself to become open to this by suspending my preconceptions as much as possible. The description reveals an experience of a specific phenomenon in its context (Todres, 2005) and I attempted to see the phenomenon in the description, as this is what the description is about.

I focussed on discrete changes of meaning within each individual description. Each transcript was re-read noticing and marking with a highlighter pen each time a change of meaning occurred with reference to the phenomenon studied. At this stage the description is left intact and the meaning units were marked by highlighter pen for further consideration.
3. Formulation of transformed meaning units

In analysing the raw data in this study, the next step of Giorgi’s (2009) method was followed when themes were identified which Giorgi (2009) describes as meaning units. Giorgi (2009) advocates breaking the text down to manageable units or themes, as it is impossible to analyse a whole text simultaneously. He said:

The meaning units (themes) that emerged through analysis are spontaneously perceived distinctions within the subject description, arrived at when the researcher assumes the psychological [disciplinary] attitude towards the concrete description.

(Giorgi, 2008, p. 11)

In formulating transformed meaning units I aimed to go beyond the language used by the participant to formulate the sense and meaning of the particular expression for what it could reveal about the phenomenon under study (Todres, 2005). Consistent with Giorgi’s (2008) approach once I grasped the sense of the whole experience, I went back to the beginning and re-read the transcriptions, letters and emails once more with the specific aim of identifying themes with a focus on the phenomenon being researched. The themes that emerged following analysis were descriptions of a similar nature in the participants’ experience. The aim was to bring about an understanding
of the meaning of the experience allowing me to grasp the lived meaning of the experiences of the participants in this study (van Manen, 1997). This process provided possible descriptions of the experience. I set out the transcripts, letters and emails and highlighted areas of perceived importance in relation to the experiences of participants and the research question. I put them together as parts of the whole to identify similarities. My aim was not to interpret the participant’s experience but to investigate what was invisible by looking at it from a different angle and in a different way. For example, as can be seen in the following themes I highlighted key words, phrases and statements.

Participant A- I was by myself in a four-bedded room. The lady next to me was being ‘specialled’.

Participant B- I was lonely. I was in a single room. (I) had asked for one but there were times when I thought it would be nice to see somebody but nobody came when you (sic) called.

Participant C- The night nurses were the worst, as I was in a private room they didn’t come in.

Although, not exactly the same, each participant described being alone. My notes around these themes are lonely, different kinds of lonely, isolated, alone. It was clear that Participant A was not alone in the room yet being
alone was described. Participant B had asked to be alone yet described being lonely and Participant C felt ignored, abandoned and alone.

Once the themes were defined, I then went through all of them identifying the themes most relevant to the phenomenon under consideration. These themes were reflected from a nursing discipline. This stage is described as “Transformation of subject’s everyday expressions into everyday language with emphasis on the phenomenon being investigated” (Giorgi, 2009, p. 17). This is obtained through a process of reflection and imaginative variation (Giorgi, 2009). These transformations are necessary because the descriptions given by the participants are expressed in a cryptic way and it is my role as the researcher to clarify the experience in a depth appropriate to allow an understanding of the events. I aimed to attain the essence of the experience expressed in the themes thus identifying themes that would allow a description of the experience. I returned to the data and tested the theme to ensure it was the essence of the experience. I did this by identifying the theme as being representative of the whole and I identified that ‘being alone/lonely’ was of importance to these participants. I then read other transcripts and highlighted other themes.

Analysis progressed as I became immersed in the data by reading and re-reading (Cohen et al., 2000; van Manen, 1990). Giorgi, (2008, p. 15) noted,

...We are not saying that the theories exist in the text. They exist
only in relation to the attitude and set of the researcher. For example, if one were to do a grammatical analysis of the description, one would look at the text differently than if one were to do a stylistic analysis. In changing from one purpose to another, one can feel the gestalt of the text shift. The same is true when one shifts from an everyday attitude to a psychological one or from an interest in emotions to learning. What stands out depends very much upon the researcher’s perspective.

By this, Giorgi (2008) means that the researcher has a vague sense of what the raw data is saying but cannot specify it exactly. It is not until the researcher identifies the essence of the experience as a ‘true invariant sense’ (Giorgi, 2009, p. 133) that the process is successful. By working with the description of the phenomenon, I focused on searching for its essence. The essence is the very nature of what is being questioned (Sadala & Adorno, 2002). In describing his method, (Giorgi, 2009) highlighted the search for invariant essences, which represents the structure of consciousness or experience. The noetic-noematic relation or conscious understanding is a way of entering into the consciousness of the participants, which displays or represents the parts of the experience that contain the lived meanings, the focus of the descriptive task (Giorgi, 2009). When seeking essences, philosophers always seek those characteristics without which the object would not be what it is. However, although thought to be true it must be tested by going back to the data and making sure that the invariant essence completely
grasps all of the critical clues contained within the data (Giorgi, 2009). This process is repeated until all of the themes have been transformed. Giorgi (2009) describes this as universalising. He said:

*Universalising ...transcends psychological interests. It represents a philosophical understanding of a phenomenon but without the pertinent dynamics of precise undercovering (sic) of the nature of the phenomenon.*

(Giorgi, 2009, p. 101)

From Giorgi’s (2009) perspective, universalising is the way in which philosophers seek the universal essence. That is, the universal essence is what makes the object or experience what it is (Giorgi, 2009). The final step of the analysis was to synthesise and integrate the insights contained in the themes into a consistent description of the event (Giorgi, 2009), which are presented in the following chapters but first, I complete this chapter by describing the rigour of phenomenological research.

**Ensuring rigour in phenomenological research**

Whilst Husserl’s (1975) beliefs are dated, he argued that intersubjectivity, was a means by which evidence relating to human experience could become known and that it prevented solipsism which denies the possibility of any knowledge other than the existence of the self. The most common technique
used by Husserlian researchers to ensure intersubjectivity is for the researcher to identify and articulate her/his assumptions prior to the data collection and analysis (Morse, 1994). In relation to this study, my experience as a nurse is an integral part of who I am. For the purpose of this study, and as previously identified in this thesis (p. 110) I identified and set aside my assumptions about the experience of being a nurse as a patient receiving nursing care in an acute general hospital in order to capture what the experience was for the participants.

Husserl also suggested that people view and describe their lives transcendentally, not as a compilation of incidentals, but reflectively as life is lived over time (Husserl, 1975). The term transcendental was used to describe the need to set aside an observer’s natural view of experience. Husserl believed that transcendental subjectivity was an ideal scientific means of understanding others (Husserl, 1975) and argued that it is possible for the phenomenological observer to gather evidence of experience by transcending, or setting aside, personal points of view and common preconceptions in order to get to the essence of experience (Husserl, 1975). However, he was also aware of the danger of granting credibility to descriptions of experience as the phenomenological analysis might become lost in the researcher’s own personal view of what the data is actually saying. Husserl (1975) said:

*I experience the world not as my private world, but as an intersubjective world, one that is given to all human beings*
and which contains objects accessible to all. In it others exist as others, as well as for each other, as being there for anyone.

(p. 34)

In addition to Husserl’s views on maintaining rigour during phenomenological research there are several principles that are essential to maintaining rigour in qualitative research generally. These principles include credibility, trustworthiness, transferability, dependability and confirmability (Denzin & Lincoln, 2005).

During the collection and analysis of qualitative data it is important to have a way of ensuring credibility and trustworthiness of the data. Indeed, to ensure the true essence of the experience is identified three structural forms appear constantly in phenomenological analysis. These are the structure of parts and wholes; the structure of identity in a manifold; and the structure of presence and absence (Sokolowski, 2000, p. 22).

Although themes are the working material for phenomenological writing, it is important that they are not separated from the whole. Aristotle developed a theory about parts and their connection to the whole (Moran, 2000). Following on from Aristotle, Brentano further developed the theory of parts and wholes and their relationship called ‘mereology’ (Moran, 2000). Husserl advanced this theory as he went on to distinguish between concrete and
abstract, independent and dependent parts (Moran, 2000). For example, wholes can be analysed into two different kinds of parts named pieces and moments (Sokolowski, 2000). Phenomenological enquiry has identified an important distinction between pieces and moments (Sokolowski, 2000). Pieces are parts that can exist and can be detached from their wholes. Pieces can also be called independent parts, for example, leaves from trees. When a leaf falls from a tree it can be presented as a leaf, it does not need the tree to identify it as a leaf. It is clear it comes from the tree and is a part of the tree but it can be independent. However, moments in time are parts. Moments in time cannot exist alone. Moments are thus dependent parts of the whole. To clarify, Sokolowski, (2000) provides an example of hearing music when pitch cannot be separated from sound. In phenomenological analysis there is the concern that parts will be separated from their wholes and will be unable to be put together as a true reflection of the whole. To avoid this van Manen (1990) recommends keeping the evolving part-whole relation of the study in mind (van Manen, 1990, p. 167) therefore a true theme can be easily tested and identified as coming from the whole thus meeting the principles for credibility, trustworthiness, confirmability and dependability. In this study, I managed this by continually going back to the transcripts and ensuring the parts, which were the themes, were consistent with the whole experience as described by the participant.

Another structure identified by Sokolwoski (2000) is the structure of identity in a manifold. “That is when we wish to express something we can always
distinguish between the expression and what is expressed, which is the exprimend” (Sokolwoski, 2000, p. 27). For instance, ‘The sun is shining today’ or ‘Today it is sunny’, these two different expressions both have the same meaning and the identical fact can be expressed in various ways. Sokolwoski (2000) warns of being misled into looking for a meaning or fact and in doing so take a moment as a piece. Throughout the analysis of this study, themes and the descriptions retain a complete sense of the whole experience and represent the essence of the experience.

Guba and Lincoln (1989) claim that a study has credibility when it presents faithful descriptions of experience and when co-researchers and readers confronted with the experience can recognize it. Koch (1996) argues the importance of the researcher maintaining self-awareness through the use of a field journal where the content and process of all interactions are recorded in order to ensure rigour in relation to the study. The journal is the record of the interviews and is used for reflection and ongoing review. As previously mentioned on page 100 of this thesis, I maintained a journal throughout the research process. In this reflective journal I recorded interviews, vocal intonations, gestures and physical expressions of participants as well as my thoughts and reflections as the researcher after each interview. During telephone interviews I noted inflections of the voice, pauses and emotion. Data collection and analysis were documented to provide an audit trail. Field notes were kept with dates, times, locations and the subject matter of all
meetings between me and my supervisors and the research participants. Ongoing discussions with my supervisors and journal reflections relating to the audiotapes, transcripts and the analysis of the data sets in whole and in part ensured the studies credibility, dependability and trustworthiness.

In relation to trustworthiness several aspects were considered in the research process. For instance, a pilot study with a range of strategic questions was used to capture as many understandings of the phenomenon as possible. Dependability of the study was enhanced as the same interviewer, myself as a student, conducted all of the interviews using an unstructured interview process with prompts noted (Bowden, 2005). The participants were encouraged to speak freely about their own direct experiences and to give concrete examples to avoid descriptions of how things should be or ought to be. During the last phase of the interview I returned to the main open question to give the participants time for more reflection and the opportunity to provide additional examples as described by Larsson and Holmstrom (2007).

In the face-to-face interviews I used audiotapes, transcripts and field notes to ensure credibility and data accuracy. Journal notes during telephone interviews were taken in the absence of audio recording facilities. To confirm aspects of the interview the journal notes were returned to the participants.
for verification (Sandberg, 1997). In addition, some participants forwarded stories about their experiences by email. Confirmation and validation was sought by consulting with the participants via email (Fleming, Gaidys & Robb, 2003).

Rigour was also established by using methods intended to increase trustworthiness, such as critical assessment of the quality of data collection, analysis and presentation. For credibility, the participants are represented as clearly as possible and direct quotations are used in the text to enable readers “to experience for themselves the participants’ perspectives” (Johnson, 1999, p. 162). Trustworthiness of the quotes was supported through direct verification of transcript accuracy against the audiotapes and field notes. The steps of extracting significant statements and creating formulated meanings from the interviews were done following Giorgi’s (2009) method of phenomenological description. These formulated meanings were examined to accurately reflect the participants’ lived experiences. I organised the formulated meanings into themes and to theme clusters.

In deciding if a study undertaken in one environment is applicable in another, Guba and Lincoln (1989) use the term transferability. Transferability is dependent upon the degree of similarity between two contexts (Koch, 1996). In this study participants are all nurses and were patients in an acute general hospital for a minimum of two days. The study was undertaken Australia wide
to ensure transferability throughout Australia. The study context and environment was fully described to allow readers the ability to judge if the study findings are transferable to the reader’s local context. As I have worked in hospitals in Australia and Scotland I have noticed similarities in hospital layouts, patient care and nursing standards. I suggest that this study is transferable to situations in the United Kingdom and countries with similar health care set-ups.

Finally, a research study may be shown to be dependable when its process can be audited (Koch, 1996). The whole process of this research study is recorded in such a way that another researcher could clearly follow the decision trail I used and could arrive at comparable conclusions given the data, perspective and situation from this study.

**Review and Summary**

In this chapter, I discussed the use of phenomenology as a methodology. I provided an explanation of the methodology, design, processes and procedures I used in this study including the collection and analysis of the data. I discussed the ethical considerations relating to conducting the study and the care of participants and provided background information about the participants and their illnesses or injuries. I outlined some difficulties I had in conducting interviews and how I coped with them. In the following chapters, I present
results of the data analysis. In the first of these, Chapter Three, I present what it was like for participants when they realised they were injured or ill and in need of hospital admission and nursing care. Chapter Four contains the results of the data analysis outlining the experience of the nurse as a patient receiving nursing care in an acute general hospital.
Chapter Three

Being a nurse and being ill

Human beings exist in a state of unaware awareness. In this state, one knows the body is there but expects it to function without having to think about it (van Manen, 1998). For example, as human beings we breathe without thinking about it until breathing becomes difficult or laboured from an injury or illness. It is at this point that we are aware of every breath we take and we realise that something is wrong.

For participants, being a nurse when ill meant that they recognised that they were ill or injured and used their nursing and health care knowledge to attempt to heal themselves. However, participants found that they could not heal themselves and they had to go to hospital. Becoming a nurse patient for participants was like a journey into the unknown in terms of their illness and experience as patients. It was clear from the participants’ experiences that the journey itself was important as they struggled with the tensions of being a nurse, being ill and being a patient. Many participants described their journey as challenging, confronting and mainly unpleasant and yet they were sometimes in familiar territory in terms of their everyday work. In this chapter, the first of two chapters in which the study findings are presented,
discussion is focussed on the way in which the study participants experienced illness and hospitalisation.

As noted in the previous chapter I asked each participant to describe his/her experience as a patient receiving nursing care in an acute general hospital and the participants’ stories started with becoming aware that they were unwell or injured. Analysis of these stories revealed several themes. In the first of these, “Becoming ill”, I describe the participants’ realisation of illness and the refocussing on their bodies and the illness as becoming ill interfered with their normal daily lives.

For participants being nurses was challenging in several ways. One of these was that they had nursing and health care knowledge and experience. Nursing and health care knowledge and experience could be useful to them however; participants disclosed that it also made them fearful, apprehensive, watchful and cautious. They were fearful because they had knowledge and understanding of how events and procedures unfold and how they can go wrong as well as right. Many participants imagined the worst-case scenario because they knew what could and does happen in hospitals. This has been captured in the second theme “Knowing and being afraid” which is presented in this chapter. Following this I discuss how as a patient with nursing and health care knowledge, nurses experienced a sense of being on the outside looking in; in the third theme they described their experience as “Being a fly
on the wall” when the nurses in the ward were unaware that they too were nurses. In the fourth theme in this chapter, “Being discovered”, I discuss how participants intentionally or subconsciously revealed their nursing and health care knowledge and experience, and the implications and ramifications of being known as a nurse for participants. The final theme “Being a nurse” captures the juxtaposition of being a nurse and being a patient. “Being a nurse” for participants was challenging in that they could not stop being a nurse even when ill and a patient in hospital. Indeed many participants attempted to conceal their nursing background but could not conceal it for long.

**Becoming ill**

Becoming ill shows how the illness or injury that was the precursor to hospital admission for participants became the focal point in their lives. Indeed, when participants became ill or injured, they described a heightened awareness of their bodies, of focussing on their bodies in a way that foregrounded the illness or injury to the extent that they realised that they needed to take action to protect themselves and heal.

On becoming aware of their illness or injury, the “nurse” within the participants meant that they drew upon their extensive knowledge and experiences as health care professionals to diagnose and treat themselves, as
they would the patients in their care. For example, Jackie knew that she was having an allergic reaction. Her allergic symptoms, in particular her breathing which was laboured and woke her from sleep, were more severe than usual. In order to help to relieve these symptoms she explained how she repositioned herself in an upright sitting position, as she would reposition a patient, so that she could breathe more easily. She was very concerned about the severity of her allergic reaction and she knew the possible scenarios in this situation. For Jackie, her laboured breathing was an ominous sign that her allergic reaction was potentially life threatening. She was worried and knew she was heading for trouble if she did not act. Jackie’s level of concern was reflected by the double dose of antihistamines she administered to herself in the hope that her symptoms would improve. She did not want to go to the hospital. Jackie’s sense of fear and trepidation is captured in the following as she said:

*The reaction* [to an allergen] *usually presented in an irritating itchy rash and was controlled by anti histamines but it was very intermittent* [in it’s presentation]. [This time] *I woke up in the middle of the night with a feeling of difficulty breathing* (sigh). *I sat up in bed but still had some difficulty, so I sat up in the lounge room. My whole face felt very tight so I looked in the mirror to see what was happening and I hardly recognised myself. I knew I was having an allergic reaction to something and I took a double dose of antihistamines, I was just waiting for them to have an effect.*
remember sitting there hoping that it would settle. I was worried ... 

I didn’t want to go to the hospital. I wanted it [the symptoms of the reaction] to go away.

Jackie treated herself at home unsuccessfully; there was no response to the double dose of antihistamines and her symptoms worsened. Whilst she didn’t feel as unwell as she expected she might in this situation, she made the decision to go to hospital. Later, however, she was unsure of this decision, as the Triage nurse did not respond with the urgency that, based on her experience as a nurse, Jackie thought was warranted. She said:

I was having increasing difficulty breathing and by this time [I] could barely speak. When we, [Jackie and her husband] arrived at accident and emergency we were met by the Triage nurse, who didn’t even bother to stifle a yawn as she asked me what the problem was (shake of head). I tried to speak, but [I] found it very difficult (pause) and I remember thinking; if she can’t see it [the symptoms of the reaction] I must be exaggerating. Maybe there is nothing wrong with me. I mean (pause) I didn’t feel sick.

Jackie didn’t feel as sick as she thought someone coming to hospital should feel, so when she had to explain what had happened to the Triage nurse and the Triage nurse failed to recognise the problem, to notice that Jackie had
difficulty breathing and was having an allergic response, Jackie immediately doubted her own decision that she needed hospital care. Jackie feared getting it wrong as she had self diagnosed her own illness and failed to get it under control. She had not reacted with urgency because she didn’t feel sick, despite her knowledge of the implications of her laboured breathing: that it signalled constriction of her airways with a risk of complete obstruction and could have been a life-threatening event. However, validating her decision, her story further revealed that her condition quickly deteriorated and the nurses took her to the resuscitation area of the Accident and Emergency (A & E) Department for emergency treatment and airway management.

Similarly another participant, Belinda also described having breathing difficulties. Unlike Jackie, Belinda was hospitalised and recovering from surgery when she noticed that her breathing was becoming more difficult, in that she had to concentrate on getting a breathe in. Like Jackie, as Belinda did not feel ill, she was not overly concerned about her condition; nor was she confident that she did not need some form of attention or further help. In the following exemplar, Belinda contrasted the level of seriousness of the problem by saying she wasn’t ‘sick, sick’, she was being more considerate of the busy nurses than she was of herself. Belinda did not want to draw attention to herself and her situation even though her breathing was difficult as she outlined:

5 Securing and protecting the airway to facilitate breathing
In the evening, I started having trouble breathing...it just sort of got worse ... I was waiting for somebody to walk [a] round [the corner from the nurses station to the bed areas]. It was night duty by then. They [night duty nurses] didn’t really come and I was waiting. I didn’t want to press the buzzer ‘cause (sic) you don’t like doing that ‘cause they might be busy or something. So, I thought I might walk down to the desk and get them... So, I got up, took my drip and walked down to the desk. I was really having trouble breathing by then and (pause) I said to them "I’m really having trouble breathing". But they noticed that as well (laugh) and they were really good. I really only had a mechanical problem. I wasn’t sick, sick (sic).

The nurses reacted quickly, sought medical assistance and transferred Belinda to the Intensive Care Unit where she was intubated and ventilated\(^6\) to fix her “mechanical problem”. Belinda’s story revealed that when she finally sought medical assistance, she was surprised by the urgent reaction of the health care team because she did not feel as ill as she thought the reaction warranted.

---

\(^6\) Intubated and ventilated: Belinda had an endotracheal tube inserted into her airways and a mechanical ventilator breathing for her as her airways were swollen and breathing was extremely difficult.
The participants’ professional nursing and health care knowledge and experience meant that they had insight into what was happening to them physiologically. However, they had never been acutely ill themselves or in need of hospitalisation or intensive care before. While participants thought they knew what was happening to them from a physiological perspective they were not convinced of the severity of their situation when they were faced with their own illness. This is because it did not match their expectations about the illness experience or what being ill might feel like. Margaret further illustrated this when a medical specialist had informed her she was ill. She said, “I had acute cholecystitis… and he [the doctor] said, “You need to come in. You need a bed” [in hospital]”. Explaining her response to this she said, “It was sort of a daunting experience. A bit frightening I suppose. Even though I didn’t think I was that sick they told me [that] I was that sick. I didn’t believe I was that sick”.

On becoming ill many participants, like Jackie, described caring for themselves at home and their reluctance to go to hospital, thus possibly delaying medical treatment. Indeed several participants presented to hospital after self-managing their condition when they became aware that the illness/injury was a lot worse than they had imagined or expected. For example, Gloria had been unwell for several days. She acknowledged that it was because she was a nurse that she had attempted to treat her own symptoms and she had possibly delayed the medical treatment she required.

7 Inflammation of the gallbladder that causes severe abdominal pain
It was only because Gloria had unresolved pain that she could no longer tolerate that she sought a medical opinion. However, she felt guilty when the doctor reprimanded her and she realised that instead of healing she had potentially made the situation worse as she said, "I had lots of pain…. The doctor was most unsympathetic. He said, "It’s your fault for leaving it so long". Nurses are like that though, aren’t they? Like Gloria, Eve did not immediately seek medical attention. In fact Eve attempted to ignore her symptoms because she was busy. To have to go to hospital for Eve was an intrusion on her schedule but she knew something was wrong by the level of pain she felt. Indeed the pain alerted her to the fact that she could not ignore the injury and she needed attention. Eve did not really want to go to the hospital but she could not fix the problem or stop the pain as she said:

_I thought they [both ankles] were sprained. They were very painful but I didn’t think it was a break. I managed to get in the car and drove home. They became quite swollen and very painful and I think (sigh) I’ve got a good pain threshold but it was really painful …I had a lot of things to do that night. I was getting a haircut and the next day I was to have lunch with the girls. I had so many things planned, so there couldn’t be anything to be wrong. I just wanted it (sic) strapped really firmly._
Participants’ responses made it clear that becoming ill enough to require hospitalisation was entering uncharted territory. They were reluctant to acknowledge that they were ill and that they required hospitalisation and urgent treatment. However, when participants presented themselves to hospital for treatment they thought and acted like a nurse, they expected a collegial response to the information they were giving to the nurses in charge of their care. The participants expected their colleagues to believe the account of their illness situation, respect them as nursing colleagues and act upon their information. For instance, when Brian had sudden intense pain he realised that something was wrong:

_I had been for a swim in my pool and I had a headache, which I didn’t know where it had come from. It was quite incredible. I realised it was really, really, wrong. So, [therefore] (long pause) I wasn’t normally getting headaches. Anyway, I said to my wife, “I’d better see about this [headache]”._

Brian went to the Accident and Emergency Department of the local hospital and a specialist told him to return if the symptoms he had persisted. Brian’s story revealed a feeling of dread as the symptoms increased and he knew how serious they were but when he sought further advice the situation wasn’t treated with the urgency he thought it warranted. When Brian returned to the Accident and Emergency department he provided written information from the specialist about his previous visit and expected swift attention from staff
but they did not believe him. They dismissed his concerns and he was belittled. He said:

I had my note in my hand. (Deep sigh) I went to the triage desk and I gave the note to the triage nurse and I said, "Look. There's my history. I need to go out the back and get a lumber puncture now". She said, "Oh no. No. No. (Brian’s voice rose emphasising each word). Why would you want that?" And I (Brian sighed and did not complete the sentence). [He went on to say] She said, "Do you know how invasive a lumber puncture is?" She didn't know I was a nurse. I've never had one [Lumber puncture] in my life. I'd seen them before. I didn't want it. But I need to get out the back and she kept saying to me [that] it was invasive. She said, "I wouldn't let this lot do that to me". And you know, from what she said, I had read you should go back home.

In some instances, unlike the lay patient, rather than just presenting themselves to hospital participants considered their nursing colleagues by calling the hospital in advance in order to inform the duty nurses of their condition and that they were on their way to hospital. For instance, on returning from an overseas holiday Diane telephoned the staff at the local hospital, from the local airport, to let them know she had a fractured ankle and was on her way to the hospital. Diane said:
I rang the hospital. Rang ahead and said, "Look, I’m coming in. I’ve got a fractured ankle. It [the injury] happened in another country and I’ve just arrived on a flight”. I wanted to let them know I was coming in.

Diane’s full story revealed how she had injured herself whilst overseas and endured a lot of pain during her return flight, because her fractured bone had not been set and properly treated. Even though she had not disclosed herself as a nurse Diane expected to have her description and diagnosis of the injury accepted and when the nurse questioned and dismissed her explanation she was annoyed. At the time of the interview, Diane was recounting an event that occurred more than a year ago. Despite the time lapse, her emotion was palpable when reflecting on the experience. She said:

A nurse at the A & E said words to the effect of, “We’re totally full. Not accepting any patients, and just because you said you have a broken ankle doesn’t mean anything” and [she] slammed the phone down. Hung up on me! (Diane’s voice was raised as she spoke and she shook her head and raised her eyebrows in mock dismay and disbelief).
Because participants were nurses when they were ill they knew what was wrong and were reluctant to seek help and/or treatment from others for their condition. They thought they could treat themselves. Being unsuccessful in treating themselves, participants then sought treatment from others. Some participants were unsure of their decision to seek treatment because of the reactions of their nursing and medical colleagues and they lost confidence in decisions they had made about their illness diagnosis but others were annoyed that their assessment of their injury or illness were not taken seriously. Further, when participants finally sought help and informed other health professionals of their condition they had not disclosed themselves as nurses, yet they expected collegial respect and understanding from these health professionals.

Being a nurse and being ill for participants meant becoming a patient in hospital. Patients coming into hospital for the first time often fear the unknown as the first time patient has little or no idea what it is like to be in this situation. As previously indicated the participants in this study had professional nursing and health care knowledge and experience of the life-world of the hospital. Whilst having this knowledge could be advantageous and although the participants were familiar with the routines and environment of the hospital, as a patient they experienced these from a different perspective and they were afraid. Knowing and being afraid captures what it means for participants to have nursing and health care knowledge and how it impacts on their experience of being a nurse and being a patient.
Knowing and being afraid

Participants described fear and dread when reflecting on their own experiences. They attributed some of this fear and dread to their professional nursing and health care knowledge and experience, which gave them insight into what was happening, what should be happening and what could go wrong and become life threatening. Knowing and being afraid captures the fear generated from some professional knowledge, which forewarned and heightened the vigilance of participants. Gina said, “Your nursing and health care knowledge doesn’t help you when you are on the other side. Because (grimace) you know what they are going to do (pause) and ehm... (pause) I’d dread it”.

This fear, because of what he knew was also evident from Brian’s recollections. Brian knew the possible consequences of the result of the lumber puncture and the possible events that could unfold from those results. He recalled:

You don’t need to be hospitalised yourself to know it’s a scary experience...I was really scared about what was happening to me. Eventually, when I did go through [to the patient area of A & E] and they did the procedure, they did find some blood in it, in the spinal fluid. So, obviously there had been some (long pause) I’d had a sub-arachnoid bleed or something.
Later, in his recollections Brian confirmed his fear was due to his knowledge as a health professional. He knew very well the things that could go wrong as he said, “*Hospitals are scary places. I think they are scary places if you have no knowledge of what is going to happen* (pause). *They are certainly scary places if you do have knowledge*”.

Fear was evident in many of the participants’ responses. For example, Margaret anticipated a very painful experience. Margaret recalled a procedure she underwent in hospital, it was a biopsy of her liver. She was afraid of the procedure prior to going into hospital and although her colleagues’ provided reassurances that temporarily placated her, her knowledge of the procedure meant that she visualised what she thought was happening during every step of the procedure. Margaret recalled how grateful she was when the nurse came to her aid by intervening and stopping the procedure on her behalf as she described:

*I was terrified. I was actually quite frightened about it because I thought (pause) this is going to be quite painful. I’d been (sigh) I’d been given confidence by paediatric people who had said, "No, no, no. They use analgesia and sedation. You won’t know anything has happened". [However] they [doctor and nurse] started without [Margaret paused and took a deep breath before continuing] they gave me a local penetration at my ribs....*
They were cutting and I could feel it and I said, “Excuse me you’re going to have to stop. That’s hurting”. The person in charge who was a very senior radiologist said, “You are not feeling it because you have local anaesthetic on board”. I said I’m in pain…. He said, “No, it’s only pressure you’re feeling”....

When the trochar went through my diaphragm I lost the ability to breath. My heart rate went up over 200 on the monitor. I was scared. I was sweaty. I was sure they had blown a pneumothorax. The saving part for me was the nurse who was standing there who turned around and said, “Something’s wrong. This patient is in pain and having difficulty breathing”.

Some of the fear described by participants was also due to a change in their level of control. As nurses, participants were used to being in control of events, however as they became a patient they were dependent on others and felt restricted in what they were allowed to do. Heather described a loss of control, and an inability to regain some control, as a patient. As she said, “The main thing about it all [being a patient] is not being in control. [We are] So used to it being the other way around”. Katrina also said, “You feel absolute loss of control, vulnerable, at the mercy of other individuals who you don’t know and who don’t know you. It’s frightening”. Having nursing and health care knowledge for participants meant they knew they were at the mercy of other individuals as Katrina described but they also knew when a
nurse was not competent and this made them even more fearful as Cheryl discovered. Indeed Cheryl was so concerned about a particular nurse’s skills that she was afraid of what could happen. She said:

*I actually asked my family to stay one evening and not go home until night staff came in because I was too frightened. I was frightened to be left on my own with her [the nurse] and that was scary.*

Being a nurse and being ill for participants was frightening. When participants became hospitalised they described how they were watchful of events as they unfolded around them. Initially, they were able to do this surreptitiously because they had yet to disclose their status as a nurse, or they were yet to be “discovered” by colleagues to be nurses. Here they could be a “fly on the wall”.

**Being a fly on the wall**

For reasons described later, most participants did not want to disclose that they were practicing nurses. They were usually “discovered” because of their use of language or their actions. Many participants described the period prior to being discovered as being a fly on the wall as they silently watched what was going on around them. Being a fly on the wall describes how they could
observe the actions of others; nurses, doctors and patients. For example, Margaret stated that she “...was watching the nurses in the ward. Critiquing their practice I suppose”, and Brian, although unwell, watched what was going on around him as he said:

On the one hand you’re lying there, as a patient - but you are also (pause) so tuned in....You know (he appeared to be thinking). You’re just lying there watching. So, from that point of view you see some interesting things (he was slowly shaking his head from side to side and frowning as he was saying this).

As Brian disclosed, being on the patient side and being able to watch nurses’ actions for participants was to be “tuned in”, or aware, seeing events as a patient but with the eyes of a nurse. Being a fly on the wall meant that the participants observed the actions and behaviours of the nurse in charge of care that they did not support or value. In the following exemplar Eve described her first impression of nursing care when she went to hospital. She said:

There was a girl standing there with a bucket. [She was] Standing next to the admission desk with a bucket vomiting terribly and she was pale... She was standing there... There was a nurse sitting inside the Perspex [protective covering over the Triage desk], tapping her fingers... [She was] waiting for
Like Eve, Olive felt very negative about her colleagues and highlighted that her nursing and health care knowledge gave her more insight into the nurses’ behaviour than the lay patient would possibly have. She said, “Being a nurse, I was more observant of their behaviour and they were more interested in themselves. They didn’t want to be there”. Olive described the nurses’ behaviours as “distressing”. Even though Eve described herself as “laid back”, meaning that she is tolerant, patient and forgiving and it takes a lot to distress her, she found the nurses uncaring and their behaviours distressing. As Eve described her experience, her words became slow, hesitant and full of emotion. She said:

*It was a really, really, distressing experience* (pause) *and I’m really laid back. It takes a lot - but I had nightmares about it* (long pause). *It was* a really, *horrible experience. I guess I’d never been in that situation where I could be a fly on the wall* (pause). *Watching what goes on, (sigh) because I didn’t tell anyone I was a nurse.*

I asked Eve to expand on this. She said with reference to one of her observations:
She’d [the other patient] been ordered Toridol\(^8\) [Tramadol] – ehm- and after about six hours she [the other patient] said to the nurse, “I’ve got to have some” and the nurse said to her, “Oh I forgot to tell you. We can’t get Toridol [Tramadol] here. The lady [the other patient] said, “I’ve got to have it. Nothing else will work” and she [the nurse] said, “I’ll give you some Panadol\(^9\)”.

[After the nurse had left] The lady said to me “Panadol doesn’t work”.

Eve continued to be a fly on the wall; her nursing and health care knowledge and experience remained concealed. She described herself as being trapped in the bed and being in the “thick of it”, indicating that she felt she was unable to get away from the situation and was tormented by the fact that she was unable to assist the other patient. As she said:

\[ I \text{ can’t get out of bed. So she [the other patient] ended [up]} \\
\text{(pause) she rang her GP [General Practitioner] and he wrote} \\
\text{out a script [prescription]. Her [the other patient’s] husband} \\
\text{went and got the script (sigh) got the Toridol [Tramadol] and} \\
\text{brought it into the nurse. The nurse said, “We can’t give you} \\
\text{this because it hasn’t come through our pharmacy. We can’t} \\
\text{give you your own medication”, and she [the nurse] said} \\
\text{really nastily, “You shouldn’t be ringing your own doctor. You} \]

---

\(^8\) Pain relief medication

\(^9\) Pain relief medication
are in a hospital, - we take care of your needs” (sigh) I felt like I was right in “the thick of it” and I didn’t like what I was seeing.

Being a fly on the wall meant participants watched what was happening around them. Participants recounted events where they witnessed nurses being unkind, impatient and/or uncaring towards patients. Several participants described care that they thought was unacceptable. For instance, Olive said, “I was observing the nurses with their care with the other people [lay patients] and being a nurse (sigh) I wouldn’t leave anyone there”. Olive inferred that as a nurse, she knew what the nursing care should be like and this was not happening. Eve summed it up as being disappointed in her profession, as she said, "All [of] the things I held really highly as a nurse. None of them happened”.

Although participants observed some unkind and uncaring practices from the nurses, not all of the nurses behaved this way. However, the unkind or uncaring acts stood out. As Katrina said, "Most of the nurses were caring. But there was one nurse on night shift though, who had been nursing for years and should have left about twenty years ago”. When I asked what she meant by this Katrina indicated that the nurse had lost the caring aspect of nursing and she explained:

---

10 The thick of it is a British comedy show but in this context it is meant as –“In the middle of it all”.
There was an old lady opposite, who was confused and wanted to go home. So, (long sigh) she would get up in the middle of the night and sit by her bed. She was sitting on the chair when this nurse came in and went off at her [meaning the nurse was angry and responded angrily] saying, "I’m busy enough without you".

Being a fly on the wall for participants was about being a witness to events as a patient but with the professional background and knowledge of nursing and health care. Participants knew that nursing care requires the nurse to be empathetic, caring and compassionate. Being a fly on the wall meant being embarrassed or frustrated when in their view those nurses being watched got it wrong.

Although participants did not always disclose that they were nurses they found that they were discovered due to the language they used. Participants revealed that they did not disclose that they were nurses because they feared their nursing colleagues would unfairly judge them if it were known that they were practising nurses. To be judged in this context meant that assumptions were made about nurse patients that were not necessarily true. In the following theme I reveal what “being discovered” as a nurse when a patient means for participants.
Being discovered

All of the participants described the challenges and tensions they faced as a patient with professional nursing and health care knowledge. For participants, being discovered as a nurse meant that they believed they would be treated differently in various ways, both positive and negative. Unfortunately for participants, being discovered had many negative consequences for them. Most of the participants found that they could not conceal their status as a nurse; in time, from their conversation, they were ‘discovered’. Participants often revealed themselves as nurses through the language they used and the questions they asked. For instance, Eve pointed out: “...because I was asking medical type questions he picked up on [the fact] that I was a nurse”.

Like other participants, Diane thought that whilst a patient, being identified as a nurse had negative consequences in that the nurses caring for her would have different expectations of her as a patient. Diane disclosed that while she was working as a nurse she heard the assumptions made by nurses about nurses as patients and did not want to reveal her occupation, as she feared these assumptions might be made about her. It appeared that Diane felt that being identified as a nurse when a patient meant she was a burden as she said:

*It wasn’t something I tried to make public. Because there is an assumption that you’ll know everything and [they will say] we*
don’t need to tell you because you know, or the assumption that you should know better because you’re a nurse. Maybe, rightly or wrongly, I didn’t want anyone to assume that I know all the answers or if I did something that I knew wasn’t exactly right... I thought if they know I’m a nurse they’ll [the nurses will] come and rouse on me saying, “You should know better than that”.

Diane’s comments revealed a feeling of being judged. As may be seen from the exemplars, some participants said that if it was known that they were nurses the expectation was that they would be able to do more for themselves such as taking care of wounds, dressings and making their own beds. In addition, they would be expected to know more than the lay patient and thus could take care of their own nursing care.

Many participants disclosed that they wanted to focus on getting well and receive the care they needed rather than complicate things by being known as a nurse. Some participants thought that by being known as nurses they would receive much better care than the lay patient. However, overall participants’ comments revealed that being discovered could hinder receiving attention from nurses and many found it a complication that they did not need during their illness. Tanya identified this when I asked her if the nurses caring for her knew she was a nurse. She responded:
I have worked long enough in the health care setting to have been a witness to many adverse comments from nurses when they “discover” a patient is a nurse. I have found from this experience, some nurses, either feel threatened by nursing a nurse or, worse, make such unnecessary statements as, “She is a nurse. They [nurses] should know better or she is a nurse and they [nurses] know what to do”.

If a patient is a nurse, it seems to be part of the diagnosis. I have never heard, Jo. Bloggs – hernia repair and a Lawyer! Being identified as a nurse, when admitted to hospital as a patient, had the potential to impact on the type of nursing care I would receive.... I felt it would be best to let the nurses’ nurse, and me to be nursed.

Many participants identified that once a patient was discovered as a nurse, this information became part of the handover from shift to shift and as Tanya noted it was almost brandished like a warning. Nurses appeared to feel threatened by the idea of the patient who is also a nurse and participants felt it altered the way in which nurses cared for and regarded them. For example, Gloria had:

...worked with a couple of the nurses. They were friendly. One didn’t come near me. The night nurses were the worst .... [as]
they didn’t come in. They think [that] you know what it’s all about and you’ll call if you’re not all right.

Unlike Gloria, Tanya had not worked in the hospital in which she was a patient. She said it was easier in another hospital where she was unknown to conceal the fact that she was also a nurse. However, as Eve identified earlier, being a nurse was part of who she was and the total separation was almost impossible. Participants’ stories revealed that although they attempted concealment, being a nurse was an integral part of their identity. That they were nurses was always revealed.

Participants suggested that it was obvious to them that when it was known they were nurses they were not treated like lay patients by the nurses caring for them, and the expectation was that they would be involved in their own nursing care. This was evident in Amanda’s experiences. She recalled one occasion where the nurses had what appeared to be unreasonable expectations of her, due to the time of night the incident occurred and the nurse’s expectation that Amanda would attend to her own nursing needs rather than sleep. In this particular incident when the machine delivering intravenous fluids to her vein sounded an alarm, Amanda knew that if she didn’t act on the nurses’ requests, then all of the patients in the ward would be awoken from their sleep. As she said:
When it beeped she [the nurse] shouted down the corridor. -
This was [two] 2 am in the morning, "Fix your machine up will ye?" [you] They were shouting to me from the other end of the ward to fix the machine. So - there was an expectation, - yes they were shouting to me, "Hey Amanda, didn't you hear us? Fix your machine”.

Although they were nurses, participants were also patients, like the lay patients, they were ill and they required nursing care and treatment. However, being discovered as a nurse for some participants meant that this was not taken into consideration when the nurses caring for them expected them to take on their own nursing care like Amanda. Sylvia also described the frustration and difficulty she had in undertaking nursing care when she was ill. She was caught between the need to help the nurse and the inability to do so as she was a patient with restrictions as she said, “It was not as if I could just do it, [nursing care] - because I had so many tubes and drips and bits - and everything coming out of me”. Clare also outlined the expectations some nurses had of her as a nurse. She described some of the requests as implied by the nurses’ actions and use of language, which appeared to demonstrate to her that she did not have a choice. It is unclear if the nurse aimed to protect Clare’s dignity in allowing her to attend to these tasks or if the nurse expected Clare as a nurse to attend to them as there was no conversation between the two. Clare revealed:
Some nurses expected me to do more. Even though I had a drain and catheter in they would ask me to make the bed. One nurse would throw the linen in and say, “You can do that. Can’t you?” Another time I had narcotics and anti-inflammatories. I was to have them by suppositories and the nurse told me to do it [insert the suppositories] - so I did. - That was interesting (she said whilst grimacing).

In addition, Belinda highlighted that she was not given a choice or clear direction on what to do, because she was discovered and was then known to be a nurse she was expected to take care of her own wound site even though she had informed the nurses of her lack of experience in this area. She said, “I hardly ever saw nursing staff. They didn’t come in very often, maybe [they came in] at handover or for medications or something. They (sigh) they gave me stuff to clean my wound and do it myself”. I asked if the nurses had shown Belinda how to do this and she responded:

I think people assumed I knew what was happening and I knew how to do things even though I told them all I knew [about] was babies... I guess I was trying to be a good patient. Doing what they expected you to do.\textsuperscript{11}

\textsuperscript{11}Also described in another section
Being discovered as a nurse could also result in conflict with nursing colleagues if the participant did not comply with the nurse’s expectations. Tanya described how the night duty nurse gave her excellent nursing care when she was ill, evidenced by her description of a dreadful post operative night but a wonderful nurse. However, this changed with the morning nurse as conflict set in. Conflict occurred when nurses expected participants to be compliant without question and they were not. Tanya described how she:

... had a dreadful post op [operative] night and the night RN [Registered Nurse] had been wonderful. I was lying flat on the bed [the next morning] she [the day nurse] came to the right side of the bed and said, ‘The doctor said you are to get out of bed and I am going to get you out of bed’..//.. She wasn’t interested in my pain. She had a mission. Follow the doctors orders....She replied, ‘You are to get out of bed, and I know you know why’ .... It occurred to me, as a patient, in her eyes I was (a) a nurse, (b) a patient, (c) an individual .... I wondered if all the patients on the ward were treated this way, or was it because I was a nurse.

Being discovered for participants also altered the relationship they had with fellow patients. For example, a number of participants indicated that once their fellow patients knew that they were nurses, fellow patients perceived them differently and expected advice from them as Amanda found:
One of the patients came up to me and said, ‘They’ve been talking about you down the way [at the nurses station]’. I said, ‘Oh yeah, why?’ He said, ‘You’re one of these nurses. They are whingeing and bitching about you down there’. I said, ‘Oh, really’. He said, ‘Apparently you are demanding too much, but I know they never go in to you. Not that they come in to us much either. I’m a bit worried though. I have this dressing on and nobody’s looked at it. How often do they check dressings these days…’

Although they were patients, participants still saw themselves as nurses first and foremost. That they were “nurses” was embodied, for example, whilst they were hospital as patients they continued to be in the world of nurses and could not ignore the call of the other patients to attend to their own illness. Participants often described confusion and conflict within themselves as they wrestled with “being a nurse” when they were hospitalised as patients. Being a patient was not as easy for them as “being a nurse”.

Being a nurse when ill has been described as a burden and indeed many participants chose to attempt concealment of their nursing background from others but it is not possible to conceal nursing and health care knowledge or experience from yourself, especially when ill. “Being a nurse” shows how the participants felt frustrated and guilty as they were unable to care for
themselves and they were unable to care for the other patients. Being ill or injured they were unable to nurse.

**Being a nurse**

Being a nurse when a patient meant many things to participants including a lack of confidentiality afforded to lay patients, being constantly visited by nursing work colleagues, being misjudged by nurses on the ward as demanding and also being expected to care for themselves. Also, other patients expected treatment or advice from them. Being a nurse for participants also meant concern for other patients and guilt when unable to nurse themselves or others. However, being a nurse also meant that participants knew how and where to get the nursing care they needed when the nurses on the ward were too busy to provide it for them.

Being a patient in the hospital that participants usually work as nurses meant that their nursing colleagues were quickly aware that they were hospitalised. Like many participants, Jackie found that her colleagues had been informed of the reason she was in hospital and her privacy was not respected as she said, “One of the negatives about an event at your own hospital is that news travels fast. There is no confidentiality. Everyone knows what happened”. For Gloria the lack of privacy was an embarrassment to her when she was undergoing a procedure as she said:
I was worrying though, as a nurse, of people [who she works with] seeing me with my bum in the air. So, I asked them to put paper over the windows so [that] no one could see in and they did [put paper over the window]. But (laugh) apparently that made everyone more curious why the butcher paper was on the window. So more people than usual came in... embarrassing... I had a crappy time in there.

To avoid this situation occurring and to have some privacy, another participant, Patricia decided to drive past her local hospital where she worked and go to one further away. Patricia had balanced the need for privacy with isolation, as her family could not travel to visit her. She said, “I’m a really, private person I didn’t want my records around there [at the hospital she usually worked]. I have to work with all these people [health care staff at her local hospital]. It’s [the hospital she went to] a considerable distance from my home so I didn’t get any visitors”.

In addition to a lack of confidentiality and privacy, many participants described colleagues visiting them in hospital. Several participants who had not disclosed that they were nurses found that their nursing side was revealed because of the people who were visiting them, like Brian for instance. Brian had senior nursing and medical colleagues visiting which raised the curiosity of the nurse caring for him. He was laughing as he said,
“The nurse said, ‘we never get those people in here. So who the hell are you?’” Having colleagues visit and being comfortable at the bedside was not always good for participants. Some participants found that their visiting colleagues referred to work issues seemingly oblivious to their need for rest and recuperation. Cheryl said:

They [nursing colleagues] came in and stayed. I was really sick. My sister was saying, ‘They never know when to leave’. I said, ‘They are nurses. They are comfortable at the bedside. They are comfortable with sick people. You know my cousins and things [family] would call in and go but my nursing friends came in and stayed. One of my sisters got particularly upset that they weren’t letting me sleep. They were not letting me get better.

I asked Cheryl how she felt about this and she responded:

Well, when I got sick of them I just went to sleep. I had a Morphine infusion going and when I got tired of it (visiting colleagues), I just went to sleep... I think my sisters expected that when I started to doze off that they would go but they didn’t. You know, they are nurses; they’re comfortable at the bedside. I was getting sick of the work stuff but you know that
when you have nurses as friends, nurses from work, it’s comfortable.

Cheryl understood why nursing colleagues visited her and stayed at the bedside. She coped by pretending to be asleep as the constant references to work were tiresome when she was ill. Being ill she was unwilling and unable to be involved. She said:

Because I work here, work mates kept calling me. The boss kept coming down and saying, ‘By the way I’ve just had something come from *12 health or something come from * and what do you want me to do about it?’ One of my sisters said, ‘If she comes down here one more time with anything to do with work I’m gonna [going to] choke her.

Only one participant recalled the nurses caring for her considering her privacy in illness. Emma said:

I remember the sister [nurse] that was looking after me saying to Bruce [participant’s husband], 'Bruce we have decided not to let Emma have any visitors. Because she’s so well known in the hospital nobody can believe it’s actually her. It’s [the news of

---

12 Name removed to maintain confidentiality
Emma’s illness] gone [a]round the hospital you know. They’re all coming to see her and she doesn’t look terribly great at the moment’.

Unlike the layperson, as nurses, participants have all cared for sick patients and when they could not take care of their own nursing care participants revealed feelings of guilt at being unwell and feeling the need to be cared for when they didn’t feel they were as ill as others. The following exemplar demonstrates the complexity of Heather’s feelings between relief and guilt as she acknowledged an awareness of how sick patients can be, knowing that she wasn’t that sick but needed to be cared for. She said:

*I was looking across at the oncology [cancer ward]. Across the hallway and I thought, ‘what a selfish bitch’. I don’t feel I have the right to complain when it could be worse’. Being a nurse, ‘I don’t have the right to whinge because through my career I’ve seen people a lot worse. That could be a positive thing that it could be worse. It helps a bit when you do get upset that I don’t have this terminal illness but I also have the right to feel frustrated and angry. Maybe the strong feelings you have as a nurse makes you devalue what is happening to yourself.*
Being a nurse and knowing what they know as nurses meant that participants were always assessing the situation around their hospital bed and deciding if their needs were greater than others. As Mia described, “I didn’t want to ring for assistance because I knew they were busy. I thought the poor things are rushed off their feet but when I did ring, I expected people to acknowledge that I wasn’t demanding” and Vera said, “I didn’t want to buzz for a nurse, even if I needed one”. However, participants felt that they should have been listened to when they did ask for assistance, because although they were patients, as nurses, they had already assessed the situation and only requested help when it was justified. This was often a burden for participants. It meant conflict within themselves as nurses and their needs as patients. Indeed sometimes it meant the nurse patient suffered in silence due to the dilemma of needing attention whilst at the same time realising how busy the nurse was and trying not to bother him/her. Margaret said:

*I was in pain....I didn’t want to hassle them. (shrug of shoulders).*

*They were busy. In fact when you were sitting in the cubicles/patient bed area and you saw the three resuscitation beds all worked at the same time. That put extra pressure on you not to say anything. So, you know (pause) I suppose that in itself [meaning that alone] is frustrating.*

By their responses it was evident that most of the participants felt an obligation to help their colleagues in any way that they could. To do this they
used their “nursing skills” to do nursing tasks that relieved the workload of the nurse caring for them. Colleen said, “I would do things for myself though, because I didn’t want to bother them with little things”. I asked Colleen what she meant by little things and she responded:

Like [for instance], when I needed a blanket I disconnected the IV [intravenous line] and walked off, got the blanket and reconnected [the I.V], because I could and I know what it’s like to be busy and prioritising your patient load.

These participants felt that they had a duty to help their colleagues even though they were unwell. Betty outlined this as she said; “I did feel guilty if I had to press the button to use a pan [bedpan] because I knew they were busy... They had bigger things to do. Being a nurse, we can look after ourselves”. However, participants often found that they were confused about what they could and could not do. For instance Mia, attended to her own needs as much as she could. She was anxious and uncertain about what the boundaries were. Her anxiety appeared to be because of the inconsistent expectations of nurses. She said:

I didn’t ask for a bedpan. I did as much for myself as I could and some nurses would say, ’We can’t let you do that’, and others would say, ’Go for it’. It was very variable. I would get
told off for walking to the ice machine to renew my ice bags
and others would tell me to do it.

Overall, participants found that when they called for help the nurses on the ward judged them as being inconsiderate and bad patients in that they were complaining and demanding so their requests for nursing help were often ignored. It is a common belief by nurses, that when nurses are patients they are demanding. Doris confirmed this when she said, “In my job we get RN’s [registered nurses] in [into the hospital as patients] … and their demands are unrealistic”. I asked, “what do you mean unrealistic?” Doris responded, “Ehm they [the nurse patients] are impatient for things have to be done straight away they don’t realise how busy the unit is”. Nevertheless, the majority of the participants disagreed with Doris as they described only calling the nurse for assistance after every other avenue had been explored. Sandra said, “Probably because you are a nurse, you do so much on your own. You only call the nurse when you are absolutely desperate. By then, you are in a state”. By the time the majority of participants did call for help from the nurse, they expected to be listened to but due to the previous held belief that nurse patients were demanding, nurses on the ward could and did misjudge this call for help.

As being a nurse was part of their embodied self, participants found that they were always thinking like a nurse and this caused many of them to be concerned for others. Sandra confirmed, "It’s hard to just be a patient". For
many participants this experience was one of constantly thinking about what they should be doing as a patient and what was expected of them. For instance, unlike the lay patient Eve was very aware of how much analgesia she was using and as a nurse she knew the positive and negative effects of the analgesia and she knew what the other nurses would be thinking about how much she had used. She said:

*Being a nurse, I didn’t want to use it too much - but as I couldn’t sleep - that also helped me sleep. I only used about a quarter of the syringe but I was very conscious of being a nurse and I was thinking, 'Oh, don’t overdo it'.*

Being a nurse for participants meant constant concern and watchfulness for others as a nurse, with the constraints of being unable to nurse, as the participants were patients. Indeed as many participants voiced their concern for others it appeared to be quite disheartening when their concern went unheard or their requests ridiculed. Diane said, “I could see the guy [male patient in the bed opposite] had breathing problems and I asked them [other nurses] *if they could give him a pillow. They said, 'Not unless you want to give up yours’*.

Like Diane, several participants highlighted their frustration when they could not help others. Participants were concerned as nurses when they were unable to offer assistance that they thought was required. For instance, being
in a room with several older ladies caused Eve some distress as she explained how she was concerned for their nutrition and recovery. She stated:

_They [hospital staff] brought in their breakfast and they didn’t, - the lady beside me, - they put it within arms reach but they didn’t sit her up or anything. I thought - she’s got to eat. The wound will break down - she’s got to eat - and she didn’t. She had a cup of tea there and the tea was just out of range. I couldn’t get out of bed because I had one sprained [ankle] and one broken [ankle] - I couldn’t get out of bed - because what I wanted to do was just move it all closer to her._

Eve further outlined another situation where the nurse in her came to the forefront and she could not get rest as a patient due to her nursing concern for another. She said, “_One lady’s catheter - the urine was dark brown and she was really confused. I kept diagnosing her.... and I kept thinking around and around in my head. - I didn’t get any rest_.” Nigela also shared feelings about the care needs of other patients as she described her nursing concern for others. She said:

_I felt like saying take her back to the nursing home because she’s not getting the care she needs here .... I was more concerned for her. Yes that’s the nurse in me. I really didn’t sit_
there feeling sorry for me. I was more concerned for others. I guess we’re like that as nurses.

Other participants described how being a nurse was fore fronted at times and their own illness put to the background as the sense of obligation to be a nurse became stronger. For instance, Brenda described feeling obliged to use her nursing skills. She noted:

I ended up there in (sic) A & E. It was so busy - absolutely chockers [meaning full]. So full that the beds were pushed together - like a double bed. So - I was in this ‘double bed’ with another woman and the doctor had to squeeze between the two beds and sit on my bed to cannulate this woman. I even held her hand so he could get to it - as you do - you know (shrugged).

Participants knew what was going on around them and they were watchful or vigilant as previously identified. Sometimes this watchfulness or vigilance was not only for themselves but also for their nursing colleagues. As nurses participants could see how busy the nurses were and were able to assess the situation and make decisions on the availability of the nurse to meet their nursing care. Unlike the lay patient, participants had the ability to seek care and support from other sources such as family, friends and their nursing colleagues when it was not forthcoming from the nurse on the ward. For
instance, Vania said the nurses were, “stretched to the limit with minimal time to care adequately for the patients”. Therefore, when Vania was taken back to the ward from theatre at the same time as two other patients, she knew she would not get the attention she required from the nurse on the ward. Vania sought and accepted the nursing care she needed from a nursing colleague who was visiting her. Vania’s visiting nursing colleague automatically filled the nursing care gap in that she provided the post-operative nursing care Vania required when the ward nurse was too busy to do so. Vania said:

One of my nursing colleagues who was visiting me had to care for me re-[regarding] post op [operative] care which included helping me get into my post op bed, hooking me up to IVT [attaching the intravenous therapy] via the new PIC [peripherally inserted central] line that had been inserted in theatre. I was back on the ward for two hours before my nurse could check on my post-op obs [observations]. During this time, my colleague did my obs.

Emma also outlined how busy she observed the ward to be. For Emma the busy ward concerned her in that she would not receive the higher acuity nursing attention she deemed she required. The nurses seemed unaware of Emma’s fears and concerns and that she needed nursing care and support. Unlike Vania, Emma had to seek the nursing care she required. She was so
concerned about the lack of availability of the nurses that she telephoned a colleague to come into the hospital and provide her with personalized nursing care. Although Emma took matters into her own hands and called on the assistance of a colleague to care for her, this action did not appear to alert the nursing staff to her level of anxiety or her belief that she required more intense nursing care. Emma described:

I asked her [a colleague] if she would come and 'special me'
[meaning one on one care] for the night. So she came in, into the hospital, and she looked after me all night....

It was just ideal. You know [meaning do you understand]. I was so lucky to have her.... I hadn’t had my teeth brushed at this stage; I had a lot of blood around my legs and things (sic).
She came in, she did my teeth for me and she washed my hands, all my legs (pause) I was so lucky to have her.

Emma thought she would be in trouble from the nursing leaders for taking matters into her own hands and negotiating the nursing care she deemed she required. However, the Director of Nursing (DON) acknowledged Emma’s nursing assessment skills and offered her the opportunity to decide what level of care she required. Although Emma knew how busy the ward was she was disappointed that the nurses had not identified her needs for increased nursing care and support. She outlined:
The next morning the DON came in with the sister [nurse] and I thought, “Oh. I hope I’m not going to be in trouble”. She [The DON] said, "Sister tells me that your friend has been absolutely wonderful all night. If you need anything, I want you to let me know. If you need a special [one on one nursing care] again I want you to let me know and I’ll get you a special". (Deep sigh) I’ll just say there [at this point] (pause) that I really think it should have been identified that I was fairly high priority, as I’d only come out of intensive care a few hours before. I’d had a, (sigh) you know (sic). I’d had a really horrendous couple of days. I really think they should have identified that I needed a special.

Unlike Cheryl, who found the visiting colleagues tiresome as she was unwell and unwilling to be involved in work discussions, Vania and Emma were grateful of their visiting nursing colleagues as their nursing skills and knowledge were utilised.

**Review and Summary**

Being a nurse and being ill for participants meant recognising and attempting to treat their illness or injury before realising that they needed hospital care. Being hospitalised for the first time was a frightening experience for
participants. Due to the nursing and health care knowledge the participants have, they were afraid of what could happen. Being a nurse and a patient meant confusion and guilt for participants as they felt a duty to attend to their own nursing care and the care of others but were unable to do so. Being a nurse patient in the hospital they usually worked in meant a breach of confidentiality for participants in that their nursing colleagues knew what had happened and was happening to them without any consideration for the participants’ needs for privacy, rest and recovery.

In the following chapter, I explore further, what being a nurse and being a patient receiving nursing care means for participants. In being a patient participants had some similar experiences to the layperson as patient and this was explored in ‘being objectified’. However, unlike the layperson as patient, due to their nursing and health care knowledge and experience participants know what could and should happen in hospital and because of this they were vigilant. In being vigilant they were watchful of events around them that involved treatment they should or should not receive. Participants also felt that the nurses avoided them because of who they were. Being cared for or not completes the data analysis as caring and uncaring practices by nurses are explored.
Chapter 4

Being a nurse on the other side

For participants, being a patient was a constant internal battle, as they tried to accommodate what was familiar and controllable to them in their work lives now being unfamiliar, frightening and beyond their control in their new role as a patient. Participants described their experience of being a patient as “being on the other side” where, from their recollections, it appeared that they found it complex and strange. For instance, Amy said, "It was really weird and really hard being on the other side". Being on the other side for participants was frightening. Cheryl, apparently experiencing this other side as relating to the other side of the bed, metaphorically speaking said she found it, “Scary [being] on the other side of the bed”. Being on the other side of the bed, for participants, was unfamiliar and hostile and they found themselves being watchful of events around them.

When they were on the other side of the bed, participants lost their identity as a professional nurse and an individual person with unique wants needs and desires. They described this as “Being objectified”, the first theme to be discussed in this chapter. The second theme of this chapter, “Being vigilant” identifies participants’ experiences of being on the other side of the bed as a nurse patient.
As identified in the previous chapter, as nurses, participants believed that they should be taking care of their own nursing care and not expecting the nurses on the ward to do it for them. Therefore, being a nurse patient for participants was difficult because of their expectations of themselves as nurses and expectations from nurses about how they should behave as patients. Renee demonstrated this when she said; “My nursing background dominated me as a patient in that I only called for assistance when I had no other option”. This chapter of the study findings reveals further the complexities in being a nurse and a patient. Indeed being a nurse and being on the other side for participants was complex and strange.

The previous chapter pointed out how participating nurses in my study had health care knowledge of hospital routines, diagnostic procedures and outcomes. They attempted to conceal this knowledge but were discovered. In being discovered participants’ described their experiences of being a patient and they found that the care they received when they were discovered as nurses was different from the lay patients treatment. The final theme of the study findings ascertains what it was like for participants, as nurses themselves, to be “cared for or not by a nurse”. This theme has two subthemes, “being cared for by a nurse” and “not being cared for”.

Being objectified

Participants were patients: one among many patients. As patients they were objectified as tasks to be done or dealt with. Like laypeople, participants described losing their identity when they were hospitalised. The theme Being Objectified captures this loss of identity. Being objectified in this study captures a two-fold loss for participants: the first loss is similar to other patients in that they had lost their personal identity. The second loss is unique to them as they also lost their identity as a professional nurse. In relating her experience of being a patient Molly captured this two-fold loss as she stated, "I became invisible". By emphasising "I", Molly suggested that as a patient, she lost what identified her individual self as a person as well as a professional nurse. Lorraine also described this loss as she said:

*I went into a pre admission area and was told to take a number. [They] Made me feel like a number. [it was] Very impersonal. I mean (sigh) I was going for major surgery - and already – I had lost my identity.*

Heather was also objectified. Like Lorraine, she too had lost her identity and was one amongst many being gathered and processed through the surgical list. She did not return to her admitting ward, instead she awoke elsewhere. Heather said:
I really felt like I was on an assembly line. You lose your sense of security. I was anxious and shoved on a trolley with a row of others and you (sic) wake up feeling disorientated. [I had a] Feeling of dislocation. [I was] not well enough to get up and walk around and familiarise yourself (sic) with the environment. All you see are four strange walls. It’s the assembly line. You come in to A go to B and then on to C. [You are] Depersonalised. 

I had a feeling of dislocation. 

Nigela and Brenda’s recollection of events also depict objectification. Objectification took many forms in this study from being treated like a task to be dealt with, to a bed number or diagnosis rather than a person who is ill or injured. For instance, Nigela was very reliant on assistance following a horse-riding accident. In the following exemplar, Nigela shows how a few words can demean a person’s sense of self-importance and status as a person. She said:

I needed assistance with the toilet. When I asked at night they [the nurses] said, "No", and [they] gave me a big pad and told me to, "Wet into that and give it to the orderly when he comes [a]round".

Being totally ignored and treated like a task to be done was another form of objectification that some participants identified. Brenda was emerging from a
semi-comatose state from an anaesthetic, and described how she could hear nurses talking and complaining about the type of day they had. Brenda recalled how one nurse expressed her annoyance that a male patient would not wake up from his anaesthetic state. Turning her focus on Brenda, who was awakening from her anaesthetic, the nurse commented loudly to her colleague, “Well at least she’s waking up. I’ll take her back and that’s one less”. The nurse’s conversation ignored the fact that Brenda, and other patients were present, lucid or awake. She seemingly had no regard for them. The nurse’s use of the third person “she” meant that Brenda was excluded from the conversation and it suggested her presence was unimportant and immaterial to her work. Whilst escorting Brenda on her bed to the ward the nurse and wards man continued to ignore Brenda’s presence and were so engrossed in conversation that they apparently did not notice that their actions had caused her to sustain an injury. Capturing this in her recollection of the experience, Brenda said:

She [the nurse] complained all the way down the corridor with the wards man. When we got to the ward my IV [intravenous] pole was still high and she [the nurse] pushed the bed. The sign for the door was hit by the pole, [it] fell off, [and] landed on my forehead, [which] gashed it, then bounced off here [indicated her right breast] and landed here [indicated her lap]. .... (slow shaking of her head and shrugging of her shoulders) but she [the theatre nurse] didn’t even notice... I was still groggy [under the
effects of the anaesthetic]. *When the ward nurse was getting handover* [a report of Brenda’s condition] *she* [the ward nurse] *asked how the blood got on my pillow and the theatre nurse said, “Oh, probably from her IV. She probably put her hand up to her face”*. So, *I lifted the sign up. I gave it to them and said, “The IV pole”*.

Another participant, Amanda described how a night nurse entered the room in the early hours of the morning in order to take a sample of blood from one of the veins in Amanda’s arm. The night nurse did not attempt to inform Amanda of her intentions nor did she seek permission. This action emphasised Amanda’s objectification by the night nurse. Amanda said, *“Somebody comes into your room in the middle of the night and just takes your arm from under the blanket and starts taking bloods”*. Like Amanda, many other participants described how they had things done to them, as if they were objects or tasks that had to be done rather than being regarded as individuals with whom nurses should establish a relationship. These actions increased their sense of objectification and depersonalisation. For example, despite having professional nursing and health care knowledge, expertise and an awareness of hospital routines, Diane, Brenda, Belinda and Amanda all described being taken unawares when they were given subcutaneous injections without courteous preliminaries, explanation,
permission or consent. The following exemplar reveals Diane’s experience of this as a male nurse’s actions shocked her. She explained angrily in the following:

A nurse whipped around the curtain and pulled back the covers. Didn’t introduce himself and I thought, “He’s going to have a look at my leg”, but he pulled my nightie [night gown] up and gave a Calciparine injection into me (long pause, rapid blinking as if in disbelief). That was my, (shake of head).... Well, he could have told me what he was going to do.

Brenda also described being taken completely unawares as she said, “The nurse came in at two o’clock and just gave it to me, [an injection] like (sic) (Brenda’s level of speech was rising to a higher pitch as she spoke) just put it in subcutaneously”. Belinda also recounted a similar event. She asked what was going on and she reluctantly received an answer. She looked angry and clenched her teeth as she was recalling the story. She said, “She [the nurse] gave it, [the injection] I said, ‘What’s that?’ She said, ‘Nothing. Oh it’s just Calciparine’. And she’d given it to me”.

Diane, Brenda and Belinda were awake when they were injected. They were angry and shocked by the experience. In the following exemplar, Amanda was awakening from sleep when the nurse came in and without
acknowledgement or explanation gave her an injection. Her shock at the experience seemed more intense because she was completely unaware of what was about to happen. She was indignant when she described how:

I was still half asleep and I got whacked in the stomach with Calciparine. - Well I presume it was that.... She never asked, she never said anything; she never uttered a word the entire time (shake of the head, frowning). It was assault.

I asked her what she did about it and Amanda responded, "Nothing, I found that (slow, shaking of the head left to right) actually [I was] quite, probably shocked".

In the situations described above, participants did not intercept the actions of the nurses. Instead, they remained silent. They all described being initially shocked but they did not speak out about the incident. Diane explained that being a patient meant occupying a different “head space” or “zone”. In occupying a different headspace, the participants were feeling vulnerable in their unfamiliar role whilst they were unwell, frightened and unsure of what was expected of them as patients. Diane postulated:

You don’t react as you probably would. I thought I should have said something to him [the nurse who had given her the
injection without acknowledging her], but at the time, you don’t because you’re a bit blurred out by the stuff that’s happening to you. You kind of accept it.

When I asked her to expand on why this should be so, Diane said, “As a patient you react differently to what you would as a nurse. You’re put on a different zone”. Although participants were nurses with health care knowledge and experience, it appears that the knowledge and experience they have as nurses abandoned them at times when in the patient role. Tanya said:

Had I had my wits about me, I would have asked the nurse to hand me the phone. I would have rung the switchboard, asked if a patient advocate was employed in the hospital and if so, send the person to me ASAP [as soon as possible]. But, I didn’t have my wits about me.

The actions of some nurses rendered participants powerless at times. Participants rationalised their lack of action or response because they were in the patient role. For example, Heather said, “It’s an expectation of the nurse that you [a patient] will just sit there and let them do things to you”. In fact, many participants described trying to be good patients by not being intrusive or demanding and by accepting things done to them without complaint. These participants attempted to suppress the nurse within and used their nursing and health care knowledge to defend poor practice. As Belinda said,
"I guess I was trying to be a good patient”. I said, “Can you expand on what you mean by that?” Belinda responded:

Well, doing what they expected you to do. I guess I tried to (sigh) ... Just tried not to complain. Not to make life difficult. Because you know they work under fairly stressful (frown) ... it’s not stressful. It’s fairly busy. They have a fairly large number of patients to look after. So, you want to create the less (sic) work that you can.

Objectification for Renee meant that the personal side of care was absent. Indeed, Renee found it disturbing that nurses could provide technical care without acknowledging her, connecting with her or attempting to establish a relationship. As she said:

Whilst I found the technical/procedural aspects of care, IV [intravenous] therapy, [and] wound dressing, competent, it was the detached manner in which it was provided, that I found unsettling. Nursing, now, with less resource(s), certainly professional and competent though they (sic) [may] be, sadly, slowly, appears to be losing the caring aspect that is nursing.

I am like any nurse, more than aware of how busy a ward can be and how the care needs can change at a moments notice.
However, it only takes a few seconds to ask if there is anything one can do, - a smile - or just being there, - personalisation of care. It all makes a difference.

Being objectified for Amanda was to be treated as a task to be completed instead of holistically knowing and being with the patient. In describing the nurses she said they are, “Extremely task orientated and it was almost back to the old school”. I asked Amanda what she meant by old school and she raised her voice as she responded:

[The focus is to] Get your patients bathed and dressed. As long as the ward looks neat you’ve done your job. Not worrying about providing care or what your patient was actually feeling, - all that (sic), (she shrugged). There didn’t seem to be any insight into what was happening with the actual patients.

Objectification for participants meant they lost what it meant to be them and they were treated like a task, a number or a diagnosis with no thought or consideration for them as a patient and a person. In being objectified participants found that they had to watch out for themselves. Participants knew what could and does happen in hospitals and they were watchful and wary of the actions of nurses to ensure they were not the victims of a hospital
mishap, an adverse event or poor outcome, of which participants described as themselves needing to be constantly vigilant.

**Being vigilant**

To be vigilant is to be watchful, alert and aware (Macquarie Dictionary & Thesaurus, 2006). ‘Keeping vigil’ is not only being within physical proximity of loved ones it is watching intently over them (Derbyshire, 1995). Being vigilant in this context captures what it was like for participants whilst they were watchful and alert for danger or mishaps during their hospital stay. Participants describe being watchful, suspicious and aware of nurses’ actions, especially when it involved their own care and treatment. Being vigilant depicts the participants’ heightened awareness in particular situations, such as when medication was administered intravenously, in order to protect themselves from mishaps, errors and danger.

The following scenarios reveal participants’ urgent need to take action when their watchfulness revealed that they were the subject of what they believed to be potentially life-threatening situations. Participants were not silent bystanders or submissive patients in relation to their treatment. On the contrary, a number of participants described interjecting vociferously in relation to their care and treatment when they felt it was needed and this created conflict between the participant and the nurse. For example, Amanda,
on being woken at four o’clock in the morning as the nurses started infusing her intravenous line with solution, asked the nurse:

“Can you tell me what you are doing?”

She [the nurse] said, “I’m giving you an antibiotic”,

I said, “I’m only due one antibiotic and I had that at two am”.

She said, “No. You’ve been charted for this one”.

I just said, “No, I think you’d better go and check my chart. I’m not due anything”. She said, “Yes you are”. I said, “No. I’m not. You are not putting that in my IV”.

In this exemplar, Amanda shows that she was suspicious of the nurse’s intentions and queried her actions. Amanda was acutely aware that her last antibiotic was given at two am and she knew she wasn’t due another one for many hours. Her instinct in this situation was to stop the actions of the nurse and prevent a situation that she knew would cause her harm. Her actions were later justified as she recalled, “I heard them say, “Oh Jesus. I nearly gave her the wrong one [medication]”.

In contrast to Amanda, who was cautious and directed the nurse to check the prescription, Heather was particularly vocal about the intended actions of the nurse caring for her. She demanded the nurse cease her actions forthwith. Heather provided the nurse with a rationale for her command as she said:
The nurse came in to flush my line, [meaning to insert a fluid into the intravenous line to prevent clotting and blockage] drew up the flush [fluid] in a five-mil [millilitre] syringe (pause) and it was half full of air. She went to disconnect my IV [intravenous line] and I said, "Stop!". She looked at me and I said, "No, you’re not putting that in me until you get rid of the air. I don’t want an air embolus".

In being vigilant, Cheryl also questioned the nurses’ intentions. For Cheryl, the routine treatment the nurses wanted to provide could have endangered her if she required surgery. She tried to gain an understanding of the rationale behind the nurse’s actions but didn’t get a satisfactory response. Indeed, as in previous exemplars, Cheryl felt that she was not being heard or acknowledged. She conveyed a sense of helplessness and frustration that assistance was not forthcoming. Cheryl described the experience as frightening; her nurses were not advocating for her and she lost confidence in the nurses’ ability to care for her adequately. She said:

She [the nurse] said, "I’m just going to give you some" - the nurse said, “Calciparine” and I said, “What for?” And she said -uhm- she said, "All of Doctor #\textsuperscript{13} patients get Calciparine”, and I said, "Why?” and she said, "But all of # patients get it". I said, "But why should I, in my position get it”. She said, "But all of Doctor # patients get it”. I said, "Like my head’s [nursing and health care knowledge]}

\textsuperscript{13} Name removed for confidentiality
telling me I’ve got no diagnosis. Nobody’s talked to me even about a provisional diagnosis and if you are going to take me to theatre why are you heparinising me before theatre?” She said, “Oh well, if you are refusing it”. I said, “Well if you can’t tell me why I should have it. I’m refusing it”.

Cheryl explained how her refusal resulted in conflict with the nurse. She said:

After that, every day, twice a day, they walked to my door with Calciparine in their hand and said, “So you’re refusing your Calciparine are you?” Scary, on the other side of the bed. (Cheryl frowned when saying this). Really, scary. It was like, (pause) Doctors orders. Or all of Doctor # patients have this. And I didn’t feel that they were advocating for me.

As can be seen in the previous exemplars, being vigilant meant that participants needed to communicate assertively and with a presence of mind that needed them to be logical, objective and rational. They drew on their full repertoire of knowledge of disease, treatment and response to disease. In the following exemplar, however, Patricia’s concern and her fears for herself are evident in the use of the phrase, “bark like a dog”. In recounting the feeling of “having to bark like a dog”, Patricia exemplified the constraints on her of being a hospitalised patient. Despite applying her communication skills, and
providing a sound and logical rationale for her concerns she felt she was not heard, acknowledged or understood. As she said:

*I have a tendency to be hypoglycaemic. When I’m eating I can control it but I pressed the bell [nurse assist bell] because I was feeling a hypo [hypoglycaemic episode] coming on and asked for glucose, they argued with me. Argued (shoulder shrug). They said, “You’re on IV [intravenous] fluids”. I said, “Yeah, but there is no Glucose in there”. (She shook her head and sighed). [It is] Really hard as a patient to bark like a dog. You are very vulnerable, weepy (sigh). I’m normally a controlled person. They tried to justify my IV fluids. I asked them to call for the doctor to write up for Glucose (meaning to prescribe the glucose) and they just left.*

Participants identified a heightened vigilance when they lacked confidence in the nurse’s abilities. Amanda said:

*I didn’t actually feel confident in their abilities and one thing I got quite concerned about was infection control. I was in a single room and I was very aware of [the] two other patients in single rooms next to me [who] had MRSA\(^{14}\). Now. I watched them come in and out of those rooms [and] take equipment in and out of those rooms. In*

\(^{14}\) Methicillin-resistant Staphylococcus aureus
one day, I watched one nurse come in and out numerous times and [she] didn’t wash her hands. I felt (sigh, long pause) she was coming into my room after that to take my blood pressure. I actually (pause) I asked her to wash her hands. She got really angry and curt and stormed out of the room.

The combination of having nursing and health care knowledge of what should, could and does happen in hospitals with being a patient meant participants were watchful, aware and cautious about the treatment they were about to receive. At this point in their hospital experience as patients, participants were not objectified. They were vigilant and active to ensure their own safety. This action caused conflict with the nurses caring for them and they were no longer seen as compliant patients. However, participants could not help being nurses. They had an understanding of the role of the nurse and although they were vigilant and active in preventing mishaps for themselves they were also patients who wanted to be cared for and they were considerate of the nurses on the ward.

Both caring and uncaring behaviours by nurses to nurse patients have been identified. The following theme “Being cared for or not by a nurse” presents caring and uncaring behaviours by nurses.
**Being cared for or not by a nurse**

In recounting their experience of being a patient receiving nursing care, participants identified good and bad nursing care, which they equated to the good or bad nurse. In identifying what was good about some nurses’ caring behaviours participants also identified what was bad. They reported the difference between caring and non-caring behaviours from nurses who knew the participants were nurses.

Nurse to nurse patient caring involves an effective nurse to nurse patient relationship. In being effective, the relationship involves a connection between the nurse and the nurse patient that is healing and nurturing which is explored in the final theme: “Being cared for or not by a nurse”. In the first sub theme, “Being cared for by a nurse”, study findings explore the experience of the nurse as a patient being the recipient of caring practices by nurses. Participants identified being cared for by a nurse as receiving nursing care and understanding with acknowledgment as a nurse and a patient, where they are recognised as having nursing and health care knowledge even though they are ill or injured.

As nurses, participants were aware of what was happening around them and appeared to see things differently from the lay patient. When this was taken into consideration participants described a connection between themselves
and their nursing colleagues and they reported being cared for. This connection was different from the connection between the nurse and the lay patient as will now be clarified.

**Being cared for by a nurse**

As established in the literature review caring requires a good relationship between the recipient and the person delivering the care (Carnevale, 1991; Downes, 2006; Morse, 2000). Being connected in human terms, means to establish communication between two people, which will link them in mutual understanding (Macquarie Dictionary & Thesaurus, 2006). Like lay patients, participants described being recipients of good and bad nursing care. Many participants described the good nurse and the bad nurse. Actions of the bad nurse were identified as uncaring. When I asked for clarification on what identified a good nurse Heather gave an example of a nurse she believed was good because she exuded confidence in her nursing skills, which, Heather thought, made her and the other patients feel safe because the nurse knew what she was doing and they felt cared for. The nurse’s confidence improved the overall ambience in the room. Heather said:

*One of the nurses stood out* [was different from the general group]. *You noticed her level of confidence, her ability to brighten up the room. An overwhelming feeling of competence you get from some staff. You notice how much their approach*
has a big impact on how the patients feel about themselves and have confidence in their care and abilities.

In feeling cared for participants described how the nurse involved them in decision-making about their own nursing care and provided them with confidence in the nurse’s abilities to nurse. As will be identified in the next section, participants described uncaring as several things including being wrongly judged when they asked for pain relief. In describing how the ‘good nurse’ would handle this situation Mia said:

*The good nurses would query the painkillers, but in a way that I didn’t feel bad about it. I think there is a real skill in nursing. Being able to put people at ease. I’m not sure that all nurses have this skill.*

In being cared for by a nurse, participants easily identified the nurses who spent time and sat down with them, chatted and demonstrated to the participants that (s)he was concerned for them and interested in what they, as people, were actually feeling. Vera described a situation where the nurse took the time to get beyond the surface of what was happening to her and she described an intense emotional connection she felt with the nurse as she said:
One of the nurses came into my room just for a chat to see how I was going. We got talking and I told her about my sadness at losing my ovary.... She just let me speak and never once interrupted or tried to make light of it. When I said all there is to say I had a tear slip from my eye. When I looked up, so did she. That was the most compassionate moment I have ever felt from another person. I will never forget it.

It appeared to be those nurses who although noticeably busy; had the ability to be there, without being intrusive, and who did not rush the nursing care, that made the participant feel cared for. Mia demonstrated this as she said:

I noticed a difference in nurses. You could see they were busy, but not frantic. It was noticeable in their presence. They did things efficiently but not rushed and left you with a feeling of being attended to. Others weren’t so [as] good at it.

In describing being cared for Amanda told how a nurse designated to care for her, approached her and showed concern for what was really happening with her. The nurse looked beyond the written notes and communicated with Amanda to find out what was really happening. She sat by the bedside putting herself at the same level as Amanda as she sought further information. Because of this, Amanda described her confidence in this nurses’ abilities. She said, “One of them (pause) was extremely good. [She] had very
good assessment skills”. I asked Amanda what made this nurse stand out and she said:

She came in and sat down and said, “There seems to be a lot of issues, and you’re not well. I can see you’re not well, but your notes say you are fine .... I want you to tell me what is wrong”.

Similarly, Sylvia described caring nurses. Sylvia described how due to an acute bowel obstruction she was vomiting and in a lot of pain. She had been vomiting for several days and had begun to vomit faecal fluid, which distressed her. Sylvia described how two nurses understood and empathised with her situation and cared for her throughout the ordeal. She said:

I had these two, wonderful; you could not describe them as anything else other than angels. [They were] cleaning up this horrific mess, giving me mouthwashes, changing bed linen and just ministering to me before I went to theatre, and empathising with the situation, I was in.

Sylvia was in hospital with a minor illness that turned into a life-threatening situation as she began to vomit faecal fluid and subsequently collapsed. She described being in a semi conscious state where, with admiration, she described the caring words from a nurse. Sylvia said, “She kept on calling me
back. Calling me back from wherever I was. Well, I have nothing but respect for the great calibre of nursing care. [She] definitely would have saved my life”.

Like other participants who were critically ill, on realising that they had come close to death, these participants identified a need to know exactly what unfolded and how and why this had happened. Because they were nurses, participants were able to have the ‘gaps’ filled in with incredible detail by their colleagues. By using their nursing and health care knowledge and experience, participants were able to put the pieces of the picture together and knew what it all meant. Participants found that they had a need to know what had happened to them and appreciated the nurse acknowledging their nursing and health care knowledge and experience and trusting them with a full disclosure of events. Emma for instance, explained how she had been in the delivery ward of her local hospital, and the midwife, who reassured her that labour was in the early stages, had examined her. This was Emma’s third pregnancy and she had recognised the signs of early labour. Emma’s husband, thinking that he had plenty of time, went home with the children to organise them for the time that he would be at the hospital with her. In the interim, her condition became serious requiring urgent surgical intervention. Emma had passed blood vaginally and she knew something was wrong. Whilst she thought she had passed an insignificant amount of blood, she was still concerned enough to notify the midwife. Emma soon realised, by the midwives’ and doctor’s quick response and denial of her request to wait for
her husband’s return, that her situation was more serious than she initially thought. She said:

I went in to the toilet. I passed just a pinhead of blood, so I called the staff .... Next thing, they came in to take me to theatre and I said [to the midwife], “Please make them wait”. So anyway, (long pause) they took me into theatre and prepared me, and I sort of thought they were in a bit of a rush.

As soon as she recovered, her husband was at her bedside. Emma had a need to know what happened to her. She asked the nurse and doctor to fill in the details. Emma recalled:

They said they couldn’t stop me bleeding. They’d pull one [part of the placenta] - take one part - and it would just shred away. The placenta had gone through the uterus, through the muscle wall and on to my ureters. And they’d just touch it to separate it and it’d (sic) start bleeding. They had to do a digital aortic clamp on me and my husband said, “What does that actually mean” (pause to recompose) and the doctor said, “They squeeze the aorta together like this, (demonstrated by hand clenching) you know (sic) to save the brain”. (Emma wiped
away the tears from her face). *I was lucky, really, really, lucky*

yeah, (sniff).

Emma’s nursing and health care knowledge and experience meant she knew and understood what the implications were of the events that unfolded for her and her unborn child. In retelling these events, the full impact of knowing how close to death she had been was revealed. Emma had tears rolling down her face and her voice was thick with emotion as she said, “*I came home, I came home to this beautiful baby and my family*”. Emma was aware that she, her baby and her whole family survived this traumatic event. The realisation of how close she came to death was still with her as she recalled the events vividly with the graphic details filled in by her colleagues.

Another participant, Jackie described her experience of receiving intravenous adrenalin for anaphylaxis and subsequent atrial fibrillation. Like Emma, who knew an emergency was unfolding, Jackie too knew that she was in an emergency situation and she knew exactly what was happening to her. Unlike Emma’s situation, Jackie was semi conscious and could hear the voice of a nurse talking to her. This nurse was explaining to Jackie what was happening. The nurse’s words had a calming effect on her even though she knew that it was an emergency. Jackie described how she remembered:
... saying to the nurse, “I can’t feel my legs”. My husband told
me later that I didn’t actually say anything as I collapsed at this
point. He said as soon as they gave me the adrenalin I went
chalk white and unresponsive. Weird (shook her head).

The next thing I remember is movement and a lot of noise,
people shouting orders and the bed was moving fast. I had this
horrible pain. When I tried to breath, it was as if my lungs were
closed and wouldn’t let the breath in. I was trying to think why
this should be so, what was happening to me. I felt very
frightened, as I knew I couldn’t take a breath.

Through the ‘fog’, the voice of one nurse came to me. She used
my name and spoke very calmly telling me what was happening
to me. She told me to breath slowly and not to worry, [and
that] everything would be all right. That voice calmed me. I
believed her that everything would be okay. Later in the resus
(resuscitation) room they were telling me how I had scared
them all. My husband said they all panicked and nearly dropped
the cardiac monitor on the floor when they were rushing me to
the resus room.

Ellen recalls a similar situation where she also knew there was an emergency
unfolding. Ellen described being shocked and going white, but whether she
was told this or surmised it from her nursing experience is unknown. She said:

*I had a huge bleed and the crash team arrived. I thought, “Oh my God”. I’d only been in before to have a baby and this was pretty dramatic. It was a traumatic experience from minor day surgery to having [the] cardiac crash team. It left me feeling (sigh) quite shocked really. When I woke in theatre, the nurses were in a flap [meaning there was panic around her].....*

*The midwife who catheterised me called the crash team, she had put me on the pan and I collapsed. [I]Went this shocking white colour. She was calling my name. Apparently, it all happened so quick (ly). She managed to deal with me and call the crash team. She was very good to talk me through it.*

The unexpectedness of these events left participants feeling shocked and vulnerable but they realised and recognised the work of the nurses caring for them in acting promptly to get urgent attention. Participants found themselves talking about the possibilities of death and their own mortality. As Frank (2002) suggested, talking about death makes it real. For some participants it was so real they were fearful after the event Gina said:
Apparently, it [Gina’s medical condition] was really touch and go [meaning life or death in a critical situation] for about a week. When I was told about everything that happened I wouldn’t go to sleep. I was afraid I’d never waken up (long pause). It (the event) made me rethink my life. Made me realise how much I appreciate my life (laugh). I’ve thought about my parents and been less selfish (long pause). It’s brought my husband and I closer together.

Participants have described the experience of the nurse as a patient as a fearful and alien environment with which they were unfamiliar. However, they felt cared for by the nurse as they described with admiration the care and attention they received as they became critically ill and felt they were close to death. Being near to death and surviving for participants meant recognition of the excellent calibre of nurses that were involved in their nursing care and survival.

Participants mainly described being known as a nurse whilst a patient as a negative experience. However, being known as a nurse patient was also described as useful at times when the nursing and health care knowledge and experience of participants was recognised and they were acknowledged as nurse colleagues. For participants being acknowledged as a nurse meant being cared for. It meant recognition and acceptance by the nurses on the ward as a nurse; it also meant recognition and acceptance of their ability to
take care of some of the nursing work and their understanding of what it is like to nurse.

As revealed in Chapter Three many participants attempted to conceal their nursing and health care knowledge and experience and were discovered. Some nurses initially concealed their nursing background but disclosed it later for their own gain. For instance, Diane eventually disclosed that she was a nurse because she thought she could attend to the subcutaneous injections in a less painful way than the nurse was doing. She felt cared for by the nurse as the nurse acknowledged her nursing abilities. She said:

_I didn’t initially let them know [that I was a nurse] but after [receiving] the Calciparin\textsuperscript{15} [injection] I said, ‘Oh, can I give it [to] myself?’ The nurse said, “Are you sure?” I really don’t mind giving it [to] myself because it hurt [when the nurse gave it]. It really did hurt._

Unlike the layperson, participants wanted to be recognised as nurses. Being cared for by a nurse meant recognition and involving them in care decisions. For example, Amy found comfort in collegial recognition as she explained:

_There was one nurse in particular who would make sure I had pain relief on board. I didn’t have to ask or wait. She would_

\textsuperscript{15} It inhibits blood clotting and is prescribed in the treatment and prophylaxis of a variety of thromboembolic disorders.
say, “You are prescribed … Do you think you need it? Or what about…” She took my knowledge into consideration.

Doris’ nursing and health care knowledge was recognised albeit in an inappropriate manner. Doris was in coronary care and recovering from the acute phase of her illness. She was feeling better when the busy nurse asked her to “keep watch on the patients for her”. Doris described how she reciprocated care in the following situation. She said:

_During the night I woke up with a vasal vagal [vaso vagal] and the nurse was there as soon as I called. Again the care was exactly what should happen. They were really nice. Then again, I was helpful …. One day it was really busy in the main CCU. I was in a sort of annexe [and] there was a young girl there [a nurse in the annexe] on her own and she hadn’t been to lunch. The patients were stable and everything was fine (smile) so I kept watch for her. [I] Said I’d ring the bell if anything happened. (pause whilst appeared to be considering what to say next) I could even see the monitors from my bed. It’s the least we can do to help each other. (sigh) I know what it’s like._

---

Other participants revealed they were nurses for other reasons. For instance, when asked to describe their experience of being a patient all participants discussed their accommodation during their stay in hospital. It was obvious that the location of their stay and the presence of other patients was an important part of their experience. For patients in general, being in hospital often means sharing a room with strangers for the first time. However, it was apparent that many participants expected to be offered a single room if it was known that they were also nurses. Participants felt the nurses cared for them and treated them as if they were special and not ‘just’ a patient when a single room was offered. Indeed many of them described how lay patients were moved to enable them a single room and they did not seem to consider the impact this might have on their fellow patients. Brenda said, “These nurses were great. - You know - they moved eight beds to get me a single room”. Brenda smiled widely as she recollected this. It was evident by her response that she was pleased.

Similarly, Betty described her surprise and pleasure at being given a single room. Here her words portrayed that a single room was a privilege for the ‘important’ patient and so she in return acknowledged the nurses’ recognition of her, by ‘helping’ them in the only way she could as a patient:

    I was actually given the V.I.P [very important person] room

(laugh) which, - I was a bit stunned (smile). They showed me
that courtesy - uhm - by giving me the V.I.P room. So, I just
reciprocated as much as I could - by not ringing the buzzer.

Alternatively, when the single room was not offered to them participants felt uncared for. For instance, Tanya was diagnosed with cancer. A diagnosis such as cancer is often life threatening throwing the sufferer into an unknown future. For Tanya a single room and privacy was of the utmost importance to her, so that she could focus on herself in illness. When the clerk did not understand this and Tanya did not initially receive a single room she described her experience as ‘adverse’. Tanya’s comments demonstrated how, in being allocated a five bedded shared room she felt herded in like cattle thus losing her individuality and sense of privacy to grieve and mourn the loss of her health. She said:

*Reflecting on the adverse experience and treatment, I received as a patient .... As a person going into an uncharted area regarding cancer, I wanted a private room. – I didn’t want to be surrounded - or subjected to the sounds of other patients in a shared room. The room had five beds (voice raised several decibels). I was horrified and told the Clerk, 'I was not staying in the room and if I wanted to go cattle class, I would have gone public'.*

Tanya had not previously identified herself as a nurse but then revealed her status by using her nursing contacts to negotiate a single room. She said, "I
rang a nursing colleague. Explained my plight, and she said she would do some networking”. A single room was negotiated for Tanya because she was recognised as a nurse. The single room meant the participant could focus on his/her own illness instead of the illness of others. It meant privacy and separation from the illness of others. Participants felt the offer of a single room meant the nurse cared for them and understood them.

Being cared for by a nurse meant recognition as a nurse and a patient. For participants the nursing language used connected the nurse and nurse patient in a mutual relationship and identified to the participant their nursing and health care knowledge was being recognised. For Brenda being acknowledged meant that the nurses caring for her used language that accounted for her status as Brenda said:

*I’ve listened to them, how they talk to people. Not talk to nurses. I mean the other people. You know, the public. Just some of them, sometimes the way they ask questions. They didn’t ask me like that because they knew I was a nurse. They asked with more, (pondering) more (shrug of shoulders, sigh). I’m trying to think [of] how to describe it. [It was] as if they knew I knew what it was all about because I’m a nurse. If you know what I mean! If they had asked me the questions the way they had asked the others [laypersons], I would have
thought, “What is this place?” It was as if I got treated better because I was a nurse.

In being recognised as nurses, participants tried to reciprocate, they appeared to have had the constant need to please their colleagues and be one of the team. They did this by being a listening ear for nurses to debrief or by being available to discuss nursing issues whilst a nurse patient but at the same time they endeavoured to be ‘good patients’ in the anticipation that this would put them in a favourable light as far as their nursing care was concerned. Clare said, “I was aware of trying to be happy. To get staff on-side [on her side] and to keep them happy. I always said thank you. I expected to be treated with respect as a colleague”. I asked Clare if that happened and she responded:

Yes. Mostly. I felt I could communicate with the nurses....

[Some] nurses shared their experiences with me. It was really quite interesting. The younger nurses would come into my room and tell me all about their day. [Including] The good and bad points. They [the younger nurses] would confide in me.

Which was great.

In being cared for participants expected professional recognition, respect as a colleague and collaboration. They expected to be connected in a mutual relationship and many participants also expected to be more involved in their
own nursing care than the layperson. Participants wanted information about their own health status and perceived that when a nurse provided information to them this meant (s)he trusted and respected them as nurses. Brenda outlined this as she said:

_The nurses were great. Every time they did my obs [observations] they would say, for example, "Your BP [Blood Pressure] is still high. It’s this [result of blood pressure monitoring]. How do you feel?" They didn’t say that to others. Oh, they would talk amongst themselves but they wouldn’t give results to patients or discuss them._

Being cared for also meant that participants expected to be given technical information that would not have been available to the layperson. The sharing of this information and mutual understanding between participants and nurses cemented a positive relationship between them. Being connected also means ‘being there’ for the other, or ‘being with’ in a way that allows caring to take place.

In the absence of a connection between the nurse and the nurse patient, participants described bad nursing care or bad nurses. Bad nursing care was identified earlier in this chapter where participants found that they were objectified and being objectified has some similarities to the layperson literature. What sets these two themes apart is that in “not being cared for”
the nurses knew the nurse patient was a nurse and yet were uncaring. Not being cared for by a nurse, means being the recipients of unkind and sometimes cruel acts of uncaring and/or being ignored or avoided because the participant is a nurse.

**Not being cared for**

Being nurses, participants trusted their nursing colleagues and expected collegial recognition. They were, therefore, devastated when the nurses ignored their requests because of who they were. Lorraine said:

> I asked for some more pain relief. I asked about four pm....and they said they would call the anaesthetic registrar. I asked again at 10 pm as nothing had been done. Eventually, at two am, the registrar came and by this time, I was tearing my hair out [on edge due to the pain]. My daughter overheard the nurses talking about me saying, “She’s a nurse, demanding, exaggerating”. I couldn’t believe I was left dealing with pain because they thought I was putting it on. This devastated me that nurses would do that. I really felt uncared for.

It can be expected that as nurses, participants would have a better understanding than the lay patient of how busy a hospital ward could be. Diane said she picked her time to ask for assistance, and her frustration is
evident when her thoughtfulness was not recognised or acknowledged by the nurse. The nurse could only see how busy she was and Diane was seen as inconsiderate when in fact the opposite was true. Diane recalled:

\[
\text{I asked if I could get [to] the toilet and several nurses said they were too busy.... Eventually, three hours later, I said, “Please, I need to go to the toilet”. The nurse said, “You’ll just have to pace yourself. If you need to go to the toilet, you’ll need to plan it”.}
\]

Participants found that nurses were uncaring when they misjudged the participants and believed them to be demanding and exaggerating. The frustration of waiting while the nurse considered the request for pain relief was almost palpable in what participants said. Participants identified the frustration they felt when realisation dawned on them that the nurse had ignored their requests because they were also nurses and as such were seen as unnecessarily demanding. Being a nurse for participants was part of who they were, it also meant that they had some insight into what they believed the nurses were thinking about them as nurse patients and this affected their requests for assistance from the nurse. For instance, Olive’s unanswered request for pain relief meant repeating the request and possibly being seen as something other than a person in pain, as she said, “I went seven hours without pain relief. I felt guilty asking for it. [1] Felt like a drug addict and that the staff thought I was putting it on”. Olive justified her need for pain relief
by continuing her story saying that she was so ill that she was transferred to the high dependency unit. Mia too described her need for pain relief medication and her difficulty in getting past the judgement of the nurses to get her needs for pain relief adequately met. She felt guilty as she had to negotiate with the nurses for pain relief and to justify her needs as she said:

*When I asked for Morphine (pause) I got the look* (the look of disbelief. She shrugged her shoulders and took a long pause). The *nurse said, “I’ll have to discuss that with the doctor” or “surely you don’t need that”. I had to justify why I needed the stronger painkillers.*

*Now (pause) I don’t take painkillers at all. So it’s not an addiction thing. I’m sure the nurses had me listed as a drug seeker. After one nurse gave me a hard time, the nurse on the next shift would be equally judgmental. The only break you get is the next day when a fresh face [a nurse she had not yet met] comes on. That is, if they listen to me.*

In another aspect of being a nurse patient, participants described how, when it was known that they too were nurses the nurses on the ward appeared to avoid them and the participants wondered why this was so. In being avoided this way participants felt that they did not receive the nursing care they
expected or indeed felt that they required whilst a patient. To avoid is to steer clear of or to shun (Macquarie Dictionary & Thesaurus, 2006). Gloria experiencing this said, "I found generally [that] the nurses don’t come near you. They make your bed, do the obs [observations] but they don’t talk to you. No, they avoided me”.

As previously identified, to participants a single room represented privacy but also recognition and respect. In reality, as evidenced by participants’ reports, in many cases, the single room that offered privacy also provided isolation and loneliness, as the nurse did not come near them. Chloe discovered that a single room was not the haven she had hoped for as she recalled:

I was lonely.
I was in a single room.
I wanted a single room, - [I] had asked for one, - but there were times when I thought it would be nice to see somebody, - but nobody came when you called.

In recognition of the nurse patient as a colleague, nurses organised a single room for participants. However, many participants found that once in the single room the nurse did not come in and they described being alone and uncared for. Diane elaborated further by describing the single room as a very cold, lonely place. She said:
I was in a private room. I used to call it Siberia because no one came near me. It was pretty cold and I used to say to the pink ladies [hospital volunteers] at times, "Is there anyone out there?"

When asked about receiving nursing care many of the participants described being dissatisfied and unhappy about their experience. Each of these participants made comments such as, "I did not receive good nursing care" or "I did not receive any care". Indeed several participants felt that nurses were inconsiderate of the needs of the nurse patient and focussed instead on superficial nursing tasks that needed to be attended to such as medication administration, rather than investigating how the nurse patient was feeling or coping with the illness or injury. Many of the participants expected that because they were nurses, they would not receive any nursing care. Sharon said, "Well, I’ve had the usual nurse’s experience. No help. Feel neglected". There appeared to be an absence of a connection or a therapeutic relationship between the nurse and the nurse patient even though the nurse and nurse patient both had nursing and health care knowledge and experience in common. Lorraine said, "I really felt uncared for".

Vera also identified an uncaring nurse in that the nurse was physically present but the empathy and caring aspect of nursing was missing. Vera’s story revealed that she had gone through all of the anxieties related to being prepared for surgery. She had been to the operating theatre and received an
anaesthetic for the proposed surgery but at the very last minute, due to a misunderstanding, her surgery was postponed. The nurse in recovery knew that Vera was a nurse, however rather than exploring Vera’s reaction to the cancelled surgery the nurse made her feel like she was in the wrong. Vera explained:

*I cried and cried [about the fact the surgery had been postponed]. The nurse in recovery was getting short with me and said I was being silly. I knew what this mix up meant for me and [I] was quite upset. I later reflected on the lack of understanding or empathy from the recovery nurse and thought my crying was not a problem to her. So why was she so cranky? .... This made me think I must be behaving like a bad patient.*

Fiona also identified a lack of empathy as she said, "As a rule nurses looking after nurses are not all that compassionate". Fiona revealed that she did not know why this was so but it was apparent to many participants that some nurses were not interested in them: who they were, why they were hospitalised and they were not interested in engaging with them, not even as patients. As Olive found, “They only interacted with medications and obs [observations of heart rate, temperature and respiration].... They wouldn’t just come in sit down and say, "How are you?"” Lorraine found that not all of the nurses avoided her. She said, “There were two nurses who were good but
the others seemed to avoid me”. I asked Lorraine what made the two nurses ‘good’ and she responded, “They seemed to chat, spend some time caring”. Lorraine wondered about the other nurses who had avoided her. She pondered, “What happened to the general chatter? Just talking to people”.

Participants stated that the technical aspect of nursing care was provided but it was devoid of the human aspect of care such as empathy, concern, respect, trust and a genuine relationship. Participants wondered why these aspects of caring were missing. One participant, Veronica, was employed as a specialist nurse. In relation to this study, she was a patient in a medical ward. When asked about her experience of receiving nursing care as a patient she said:

*It was basic, minimal nursing. (Sigh) I said to myself, ”Did I judge them? Did I have expectations? All I wanted was a caring, holistic approach. Their approach was very brief, no warmth. My training was very grounded in the holistic approach. I was looking for caring and didn’t get it.*

On reflecting why she was avoided by nurses, Eve recalled conversations she had heard from nurse colleagues when a patient was identified as a nurse and she too considered that nurses might have felt threatened by the nurse patient’s knowledge. She said, “They’ll [the nurses will] avoid that patient because they think they are being judged”. Renee deliberated on why she was not cared for by the nurses. However, when she realised that the nurses only
came to her bedside when they had to perform nursing tasks she, like Veronica, questioned her own behaviour as a patient:

At the change of shift a nurse would introduce himself or herself... after that initial visit, [the nurses] did not visit of their own accord. I did wonder was it because [nursing] staff were aware that I was a nurse and therefore expected to cope or was I such a dreadful patient they were avoiding me?

Participants identified that the nurses rarely chatted to them and, indeed, mainly avoided them, which resulted in frustration when the participant required nursing assistance. For example, Diane found that she was shunned when she sought attention. She said:

They couldn’t find the nurse and I didn’t know who it was. I might have seen her. I’d seen a few. But no one had formally come and said, ‘I’m looking after you for the day’. It was just that they identified that they were not my nurses, when I wanted anything.

Like other participants, Brian also felt that instead of receiving nursing care tasks were done to or for him, which were done without any effective communication as he said:
My big concern is the [lack of] patient care, [I got from] all of the nurses. [In] The six days, all I got from nurses was medication. No-one came to say blah blah, whatever (sic) this is your medication it’s such and such and you may experience some side effects like constipation.

Focussing on tasks without talking to the patient was a concern for Brian. It was also a concern for Sheila. She had told the nurses she did not feel well. She knew something was wrong and was seeking the nurses’ support to find the source of the problem. Her disappointment in their lack of focus on what she deemed important and their inaction was clear as she said:

*I had abdo* [abdominal] *pain and a temp.* [temperature]. *My BP* [blood pressure] *was down but nothing was picked up. I had a nurse arguing with an AIN* [assistant in nursing] *about placement of cuff instead of what my blood pressure was. I just feel overall, there were signs there of something wrong and I was let down. (sigh) I feel let down by them. I was sick (pause) had a low blood pressure and they never did anything about it. They said drink a bit more (somber, slow shake of the head) but I was actually bleeding.*

Heather felt that she was a burden, her needs were ignored or missed and she did not receive the support she needed from the nurses. She thought
aspects of her care were avoided because she was known as a nurse and the nurses did not know how to deal with it. She said:

*I was going through a lot of emotional stuff [things].... I was wondering when and if it [the illness] was going to be fixed. There was a level of frustration and I got upset sometimes...*

*I’m not sure if it is a familiarity thing. If I was upset, I was ignored. I think they [the nurses] were embarrassed to come in and offer support. I can’t say they didn’t notice. I would certainly notice if it was my patient.*

*One day a Nun was visiting someone and she noticed [that Heather was upset]. She [the Nun] came in, spoke to me [and] she got the pastoral care (sic) to sit and talk to me. The nurse didn’t pick up on that. If I was an ordinary patient, they would have noticed that.*

Several participants wondered why the nurses allocated their care avoided their physical and/or emotional needs. Nursing care that the nurses provided was perfunctory and task oriented: devoid of human connection. In acknowledging this lack of nursing care some participants felt that they did not receive the nursing care that they had come to hospital for or that they
needed. Veronica asked, “Did my knowledge threaten them? Basically, I could have stayed at home for all the care I received.”

Although disappointed in their care participants continued to defend their colleagues’ actions or inactions. Elsie outlined how she as a patient did not make extra demands on the nurses’ time. Although she wanted good nursing care she was aware of how her requests for nursing care would be viewed. She said, “My expectation is for professional, appropriate care with the best possible outcome but I don’t like to be labelled a ‘problem patient’ so (I) tend to make allowances for nurses being busy”.

For some participants knowing that they were ill but not receiving the nursing attention they felt they required meant they had to source the care elsewhere but for some participants this resulted in conflict with nurses. For instance, Veronica knew she was unwell; she was not getting the nursing care she needed. Veronica felt the nurse was ignoring her concerns and even though Veronica knew she was causing conflict with the nurse, she left the ward to seek the nursing care that she thought she required. The nurse appeared to know that Veronica was too ill to leave the hospital but the conflict continued. Veronica said:

I packed up all my stuff and was walking out of the ward. She [the nurse] said, “Where are you going?” I said, “ED
She said, “You can’t go out of the ward. You can’t take the pump. You can’t leave the hospital”. I said, “I’m not. I’m too sick”.

Veronica was aware that her illness and possibly her anger was making her irrational but her need to seek care and familiarity drove her to leave the ward and head for the emergency department where she thought she would be cared for. Veronica was walking along the main corridor of the hospital towards the emergency department wheeling her intravenous pole when she encountered some assistance. Veronica knew she was in the wrong by leaving the ward but as she was familiar with the hospital environment meeting the security guard for Veronica was meeting someone who could assist her whereas the layperson as a patient may have seen the security guard as an authority figure and someone who may give him/her into trouble. Veronica said:

*There I was in the gown [hospital clothing] sport bag, plastic bags [and] the security guard saw me. My temp [temperature] was 40.5 [degrees Celsius] I was not rational and I was pretty angry. He said, “You okay? Where are you going?” I said, “I’m going back to ED [emergency department]. I said, “Here you are. Make yourself useful carry my bags”.*
Being a nurse and a patient meant an internal battle within participants firstly as nurses who know how busy the nurse can be and secondly as patients who have nursing care needs. However, in some instances participants did become angry and irrational when nursing care was not forthcoming or they were not treated with caring or kindness.

In describing an incident whilst a patient, Gloria identified a nurse’s actions as uncaring and although she was shocked as something unexpected was done to her, she accepted the nurse’s actions without complaint. In the following exemplar, Gloria described how she was in pain and although she got the nurse’s attention, she did not receive the caring aspect of nursing that she expected. Gloria said:

_The nurse came in as I had said the Morphine was not working. [And] could she do anything as I was in pain? She said, “I can loosen the pack a bit”. Then she just ripped it straight out. I was shocked. It was absolutely horrible. I’d rung her and said, “Is there anything you can do? I can’t bear it”. I was pressing the PCA [patient controlled analgesia] and it wasn’t working. That nurse was cruel. She didn’t tell me, she lied to me. I found it cruel._

That nurses could be so uncaring shocked participants. Sylvia’s experience left her feeling angry, upset and uncared for as the result of one nurse’s behaviour towards her. Sylvia said, “I was pretty unwell but the treatment I
received [from one nurse] really extended my post op recovery because it was pretty bad and ehm it was an individual nurse [who caused the problems]”. I asked for clarification on what these problems were and Sylvia said:

I could smell my wound and it was just (voice raised) absolutely putrid (long pause) and she [the nurse] wouldn’t touch it. I asked could the ehm stoma nurse come [a]round and even really (sic) get it for me [meaning change the dressing]. Because - I had been showered but the supra pubic wound (facial grimace, pause and sentence remained unfinished). So, I guess it’s two individuals then because one refused to touch it then the stoma nurse refused to touch it ..//.. the stoma nurse’s reply was, “You’re going to * hospital anyway. Let them deal with it”..//.. so ehm the whole experience was, you know, pretty unpleasant.

Participants felt uncared for when there was an absence of a rapport between themselves and the nurses. They identified tasks being done to them without the human connection. As identified previously, in being a nurse, participants tended to initially trust the nurses responsible for their care but they were disappointed and sometimes angry when the nurse betrayed their trust. Participants believed that due to the uncaring attitude from nurses and a focus on tasks instead of caring and compassion, the progress of their illness
or injury was misrepresented. Amanda for instance, trusted the nurse to record her condition honestly and accurately, to portray a true record of her physical condition. She was disappointed because the nurse who had seen her to give her medications falsified her record. Amanda explained:

_I was going for a test later in the morning and I actually took my notes. By that stage, my nursing notes for the shift had been written in: "No nausea, no vomiting, [and] no pain. Tolerating oral diet. Observations good..." My entire contact with the nursing staff for that day was the pills and a jab. I never saw a nurse for the rest of the day.... I felt was that was complete 'radar' observations [observations taken without being near or touching the patient]. As far as I was concerned it painted a very different clinical picture than what I was presenting._

As nurses, participants described how they asked for clarification on routines and tests they were to receive that didn’t seem to make any sense to them. However by questioning their nursing and medical colleagues some participants found themselves in conflict with the nurse. Cheryl for example, had received surgery for appendicitis. On admission, she refused to have an MRI (medical resonance imaging) because she experienced claustrophobia and disagreed with the medical doctor that it was a requirement in her
diagnosis of appendicitis. Following surgery, Cheryl was disoriented as she woke from the anaesthetic and she instinctively removed her nasogastric tube. Cheryl firmly believed that the medical doctor had labelled her a bad patient because of her refusal to undertake the MRI and for pulling out her nasogastric tube. As she said:

They [doctors and nurses] find a way to get back at you. I’d disagreed with her [the doctor]. (Cheryl’s voice was rising as she was telling her story to the point of almost shouting) Here she [the doctor] is at the bottom of the bed and she’s telling me, “You’ll get worse before you get better. And you’ll get an ileus\(^\text{17}\) [paralytic ileus] out of this. It’s only a matter of when, and because you’ve pulled the tube out you’ll start to vomit and then we’ll put another tube down” (Shrug and long sigh).

Cheryl seemed afraid of having another naso-gastric tube placed and she went out of her way to avoid it. Her confrontation with the doctor and the absence of a relationship with the nurse meant that Cheryl’s need for pain relief was also compromised. She was silently crying out for help but this was missed, instead Cheryl came across to the nurses and the doctor as a difficult patient in that she did not cooperate with them. She said:

\(^\text{17}\) Paralytic ileus is a disruption of the normal propulsive ability of the gastrointestinal tract (Macquarie Dictionary & Thesaurus, 2006).
I had a PCA [patient controlled analgesia] up with Morphine and there was - no - way I was going to use enough of that to make me vomit and they’d put another tube [nasogastric\textsuperscript{18}] down. So, I wasn’t using it. So, the next thing I know, [a]round they [doctors and nurses] came and they looked at my charts and said, “Oh you’re not using the PCA. We’ll remove it”. And I was thinking, ‘Hello! I’m in so much pain I can’t move and I’m terrified of this tube going down my throat’.

Clare and Chloe also described conflict with the nurses who should have been providing their nursing care. Clare and Chloe both highlighted that although they had received information from the nurse it was in an abrupt manner that did not encourage conversation. Indeed the abrupt manner from nurses sometimes resulted in reactionary conflict as Clare pointed out. By her manner and tone, the nurse suggested that Clare had no right to ring the bell for assistance and when she did she was confronted. Clare said:

\begin{quote}
She said, “You’ve rung the bell. What do you want?” I told her and she said, “You’ve got to eat before you can have that” [medication], I looked at my empty lunch tray in front of me and said, “I have, that’s why I’m ringing now”. So she [the nurse] bristled out [stiffly left].
\end{quote}

\textsuperscript{18} A tube passed through the nostril, down the oesophagus and into the stomach.
Participants found that nurses who were uncaring did not communicate effectively. Indeed, Brian found that partial communication could be easily misunderstood. It is unclear if it was because the nurses knew that Brian was also a nurse that the nurse missed out some important details when describing a procedure to Brian but he did not believe so as he identified:

... the nurse said, 'we need to do a cerebral angiogram so either you need to shave your groin or if you can’t I need to shave your groin'.

What she actually said to me was, we need to shave your groin to x ray your brain. You know, there was a bit of disconnect (disconnection) here, you know. I knew what they were going to do. I was going to have a catheter passed, iodine put through it and all that sort of stuff. I already knew that but I still can recall her saying shave your groin to x ray your brain.

In being uncared for, participants described a lack of connection between the nurse and nurse patient resulting in a relationship filled with suspicion and mistrust leading to conflict, upset and confusion.

**Review and Summary**

Participants have described positive and negative aspects of receiving nursing care. In being cared for and respected as a person who is also a nurse a
connection of mutual respect was created, which made the experience positive. When this connection was missing, in that the participants felt uncared for, they negotiated the care they required in other ways and this caused suspicion and sometimes conflict with the nurse who was responsible for the participant’s care.

Being a nurse and being a patient for participants was a fearful, often frustrating and confronting experience with the fear and frustration sometimes due to nurses caring for them, or due to what they saw as a lack of caring. Like the lay patient, participants described being objectified and receiving task oriented nursing care. However, unlike the lay patient participants described being ignored, avoided and misjudged as a nurse, which resulted in them feeling uncared for and alone.

Although participants recounted an overall negative experience, they also recognised and commended the nurses who were highly skilled, quick thinking and responded appropriately in times of need. Being cared for by a nurse for participants meant recognition that they too were nurses and could make some decisions in their care and treatment. It also meant being connected in a nurse to nurse patient relationship and receiving care, empathy and compassion when it was required.
In the following chapter I will discuss the findings of this study and identify the implications for nursing, nursing education and the need for further research.
Chapter 5

Discussion and Conclusion

This phenomenological study explored the experiences of professional nurses who were hospitalised for an acute illness episode. To answer the question, “What is the nurses’ experience as a patient receiving nursing care in an acute general hospital?” I used Giorgi’s (2009) phenomenological approach, which is guided by Husserl.

In this final chapter of the thesis, I will discuss the findings of this study and bring them together with the literature on the experience of being a nurse and a patient. The main finding of this study is that nurses are embodied beings and being a nurse first and foremost affected every part of their experience as a patient, particularly when they required or were the recipients of nursing care.

In discussing the study findings I will lead from a discussion of the experience of the nurse as patient to the implications of the study for nursing practice and nursing education. The goal is to integrate the findings of this study into the current body of nursing knowledge with the ultimate aim of improving nursing care for this group of patients.
Husserl described the human being as an embodied social being who belongs to the world in everyday life\textsuperscript{19} (Husserl, 1975). The mind, body and environment are all part of a whole where each is affected by the other. The body consists of physical attributes including where the body is in space and time (Smith & Woodruff Smith, 1995). Husserl believed the mind consists of the psyche, the human being and the pure I, and that each individual human being consisted of all of these properties and they would experience phenomena from various aspects (Husserl, 1975). Throughout this study, participants demonstrated that being a nurse was a part of who they were as a person. Indeed the findings of this study show that for the participants, being a nurse was an integral part of their personal identity. It was how they defined themselves within the milieu of the hospital setting. Being a nurse was how they saw the world; it was how they thought about and responded to the world and how they felt. Participants could not stop being a nurse. Even when they attempted to leave their nursing behind them and be a patient they thought and acted as a nurse would. Thus their nursing knowledge and expectations were a part of their experience. Essentially, being a nurse represented their embodied self.

The participants in this study were patients but in their everyday life without illness or injury they are nurses who are accustomed to giving care and tending to others who are sick or injured and being a nurse set them apart from the layperson as a patient. Although, as discussed in Chapter One, \textsuperscript{19} See page 87
Salmond (2011) identified the nurse relative who fore-fronted the nurse side when faced with the illness of a loved one, being embodied for nurse patients has not been brought to light before and has implications for the experience of the nurse as a patient.

The study findings are outlined in Chapter Three and Four. Chapter Three shows how participants reacted in the light of illness or injury and their experience of being a patient, whilst Chapter Four further identifies what the experience of being on the other side of the bed as a patient receiving nursing care was for participants.

Although the study was about the nurse’s experience of receiving nursing care all of the participants’ stories began when they realised they were ill. Becoming ill for participants was when their life world changed and they entered unfamiliar territory, it is therefore of importance to include it in the study findings.

**Being a nurse and being ill**

Being ill had changed the participants’ sense of self and the body (van Manen, 1998). For many participants their professional knowledge gained from being a nurse appeared to result in them being reluctant to acknowledge the existence and intensity of their illness. The study findings revealed that once they acknowledged their illness and were unable to resolve it, these
participants were no longer confident professional nurses but people who were unsure and ill. Although they thought and acted like a nurse would, illness had temporarily denied them their professional nursing confidence. van Manen (1998) captures this experience when he writes:

...it is exactly because a person’s well being is disturbed that (s)he can no longer live in a self-forgetful, passed over relation to the body and all other dimensions of his or her world. Serious illness changes everything: our sense of time and priorities, our experience of space, our felt relation with others, and our sense of self and the body.


Being a patient was unfamiliar to the participants and as nurses they did not act as a patient would. The findings in this study revealed that despite participants’ reluctant acknowledgement that they needed hospitalisation and treatment, when they finally telephoned or presented themselves to the Accident and Emergency ward they expected to be acknowledged as a nurse and their assessment of the illness taken seriously. Even though they had not disclosed to healthcare staff that they were nurses, the very manner in which participants informed the nursing staff of their symptoms and events that had occurred were synonymous with a health care genre where medical language is used to communicate within the routine shift by shift nursing handover. As nurses, they presented their case as a nurse would handover a patient in
her/his care. They did not appear to realise that they presented in this way and were shocked when they were not taken seriously.

Although the participants had not been identified as nurses, they were acting differently to the lay patient. The way they presented did not fit into the usual hierarchy of hospitals as they presented as a person with an illness or injury and they were expected to behave the way a patient would. When they did not behave as expected, as a layperson would, it seemed as if they were put in their place, which is where the nurses who were receiving the information made the assessment and decisions not the ‘patient’. For instance, one participant received the response from the nurse that, “Just because you said you have a broken ankle”, indicating that the participant’s assessment meant nothing. This confused the participants making them doubt their nursing assessment of their illness.

The findings in Chapter Three revealed that nursing knowledge and experience was not initially useful for the participant; on the contrary, it caused fear and dread of being a patient. It is a misconception that due to their nursing knowledge and familiarity with the environment, nurses in the patient role will be more informed and less anxious than the layperson (Barber, 2000; Brady, 1999; Bilitski, 2003; Coleman, 1995 and Urden, 1997). However, Salmond (2011) identified nursing knowledge as being of no benefit to nurse patients due to the stressful nature of becoming ill. The findings from my study confirmed this was true as participants described health care
knowledge leaving them in times of need and their nursing experience only allowing them to recall worst case scenarios making them more afraid and anxious than if they did not have this experience.

**Knowing and being afraid**

Human beings fear the unknown, what they have no say in or control over. Participants were no different as they stated that they dreaded the thought of becoming a patient. Heidegger (1996) stated that fear lies at the ground or the base of all human beings although it is not always recognised or acknowledged. Human beings do not consciously think about what is fearful until they can no longer ignore it (King, 2001). Several participants in this study identified a fear of being a patient. Being a patient may also be fearful for the layperson (Parker, 1999). However, unlike the layperson, participants know what goes on in hospitals, and fear the worst (Zeitz, 1999). The findings from my study identified this fear as participants know about hospital routines and procedures and this knowledge was not helpful in allaying anxieties.

Heidegger (1926/1996), states that as human beings we take care of ourselves. However, if we are afraid of something we are powerless to take care of ourselves as the fear takes over. This indicates a loss of control of the situation as participants could not treat or alter the progression of the illness and had to succumb to the realisation that they required hospital treatment.
The findings of my study revealed that participants felt a loss of control as they were used to delivering care and were now at the “mercy of others”. This is similar to Zeitz (1999) who found that being a patient for nurses removes the perceived control nurses have in the patient care situation. Participants were now dependent on being cared for by a nurse.

**Being cared for or uncared for by a nurse**

Caring in nursing is more than just the act of physically providing care. Caring in nursing has been identified as the ability of the nurse to see beyond the patient to the person (Watson & Smith, 2002) and this requires a relationship between the nurse and the patient. In Chapter One the experience of the hospitalised patient and the effect of the nurse patient relationship on that experience was critically reviewed (Almerud et al. 2007; Gilmartin & Wright, 2008; Morse, 1991; Wiman & Wikblad, 2004). These studies identified the nurse patient relationship as complex and it requires certain aspects of the relationship to work before effective nursing care can be given and received (Almerud et al. 2007; Gilmartin & Wright, 2008; Morse, 1991; Wiman & Wikblad, 2004). Important features of a nurse patient relationship, which had a positive effect on the patient experience, were identified in Chapter One as a connection between the nurse and patient (Austgard, 2008; Downes, 2006; Euswas & Chic, 1999; Morse, 1991; Rchaida et al. 2009; Sahlsten et al. 2009; Shattell et al. 2005; Swanson, 1993). In being connected nurses took time to get to know the patient (Morse, 1991). The nurse showed that the patient
really mattered to her/him as (s)he attended to the little things (Zeitz, 1999),
which was also described as ‘going the extra distance’ (Shattell et al., 2005).

When the patient is a nurse, this relationship is even more complex. I found
the findings from Morse (1991) describing the need for a connection between
the nurse and patient synonymous with the findings in my study where the
connection means recognition of the nurse patient both as a colleague and as
a patient in need of nursing care. Peplau (1991) also identified this connection
in the nurse patient relationship but that it was only possible in a climate of
acceptance. Therefore, in the nurse to nurse patient relationship the nurse
providing the care needs to accept the nurse patient as a nurse who is ill and
in need of nursing care. In addition, the nurse patient also has to accept the
nurse as the carer. Orem (2001) believes it is the nurse’s responsibility to
instigate and maintain interpersonal therapeutic relations. This may have
been difficult and caused role confusion as the nurse and the patient are both
nurses.

My study findings identified that at some point during illness, the participants
need nursing care without having to make decisions for themselves. At this
point they were patients and when they were ill participants just wanted the
nurse to nurse them, as they did not have the capacity to nurse themselves.
However, participants still expected recognition as a nurse who is ill. At other
points of the illness, the participant was well enough and willing to participate
and share the nursing care. In the nurse to nurse patient relationship it is
important the nurse gets to know the nurse patient. This means providing care in a non judgemental way (Swanson, 1993), acknowledgement of the participant as a nurse and a patient, recognising the participant’s skills and experience and identifying what (s)he can and cannot reasonably do, thus, identifying what nursing care the nurse patient requires. It is only then that a therapeutic relationship and a connection between the nurse and nurse patient will be present.

Chapter Four signifies what it meant for participants to be a nurse patient and to be cared for by a nurse. Participants described nurse caring and non-caring behaviours. In describing nurse caring behaviours, participants described that through touch, speech and listening the nurses demonstrated to them that they had an understanding of the nurse patient situation rather than just an abstract, scientific knowledge of the disease process and they recognised the participant as a colleague and also as a person in need of nursing care. Participants in my study also found that when they trusted the nurse’s knowledge, confidence and abilities they felt cared for.

Language can be a powerful and useful tool. Participants felt uncared for when language was used to humiliate them or put them in their place as a patient. A single phrase could dehumanise and objectify them. For instance, instead of being offered toilet facilities one participant was given a pad and told to “wet into that”. Participants also found the use of language identified them as nurses and they were discovered when they had attempted to
conceal their nursing and health care knowledge and experience. In addition the use of language by nurses caring for participants identified that they recognised the participant as a nurse and set them apart from the other patients. The use of nursing and health care language between the nurse and the nurse patient made participants feel acknowledged as a nurse, accepted as a person with nursing and health care knowledge and cared for.

It is of worldwide concern that many of the reports of patient experiences of hospitalisation are negative (WHO, 2008). In a critical review of the literature Chapter One identified that the negative experience reported by the patient may be because health care is organised around what is considered to be effective, efficient and economical rather than listening to the patient and identifying and meeting individual care needs (Mustard, 2003; WHO, 2008). Indeed many authors (Lauri et al., 1997; Odling et al., 2002; Wiman & Wiblad, 2004 and Florin et al., 2005) identified inconsistencies in what patients needs were and what nurses or health care providers thought those needs were. Therefore, the patient’s needs were not met because they were not identified and the patient reported a negative experience. However, if the nurse and patient connected in a therapeutic nurse patient relationship the nurse would have identified the patient’s needs and provided nursing care to meet them (Cappabianca et al. 2009; Gerrie & Nebel, 2010; Maatta, 2006; Morse, 1991; Starfield & Ishi, 2002).
Being uncared for is identified as a lack of a connection between the nurse and patient, unfriendly nurses, and tasks being attended to without the human connection (Cappabianca et al. 2009; Gerrie & Nebel, 2010; Maatta, 2006; Morse, 1991; Starfield & Ishi, 2002). The literature identified that without a therapeutic connection in the nurse patient relationship the patient feels uncared for. The findings from my study confirmed this as participants described a lack of caring. Indeed unique to the nurse as patient this study demonstrated that several participants sought nursing care from others as they called in their colleagues, who were nurses, to care for them.

**Being on the other side of the bed**

In Chapter Four participants described being on the other side of the bed as a patient as ‘being a fly on the wall’ because initially the other nurses did not know that they too were nurses. This meant that the participants could surreptitiously watch what was going on around them without being seen to be watching. Many of them didn’t like what they saw. Being a nurse for participants was part of their embodied self and it appears that they found the actions of other nurses to be a reflection on themselves as nurses. Being a fly on the wall for participants was seeing others as they themselves would be seen, in that, participants were looking at the actions of their health care professionals, mainly nurses, and they could envisage how these nurses’ actions portrayed the image of nurses as a professional body and so they found it distressing when the nurses got it wrong.
Even with modern technology and information available on the Internet, unlike the participants, the layperson as first time patient cannot know what to expect from procedures and tests in hospitals. Reliant on the information they have gained from the Internet and any explanations they have received from health professionals, lay patients enter a relatively unfamiliar world. However, being a patient for participants sometimes meant familiar territory albeit in an unfamiliar role. Many participants described being a patient as “being on the other side” as if they had gone to the ‘dark side’ and were now on the opposing team. For participants, being a patient heralds a change of role: that of being on the other side of the bed as a patient. Indeed Zeitz (1999) also identified being on the other side of the bed. She identified it in her theme “Being in control” indicating a loss of control on the other side of the bed (Zeitz, 1999). My findings identified that it is deeper than a loss of control as participants described being in a different zone as if in a parallel universe, accepting things being done to them that they would not ordinarily accept. What it signified for participants was a loss of their self. Indeed some participants described themselves as being invisible because they had lost what it meant to be them, they had lost the nurse aspect of their self and they had become the patient.

In becoming a patient my study findings revealed, “being objectified”. For participants ‘being objectified’ meant their care was depersonalised, devoid of a personal and interested approach in terms of their thoughts, feelings,
concerns and overall conditions. Yet, the participants like all hospitalised patients were dependent on nurses and others for their care and assistance. At the same time, they were at the mercy of nurses. They were hospitalised patients and accepted all that this meant and often without question.

Heidegger (1926/1996) describes an existential standoffishness, which implies that in everyday existence the person’s fate is decided on by others. King (2001) further describes this state as being dominated by others and having no control over your own destiny. This was true for participants, as they no longer had a say in the management of their health or their own nursing care. Participants have described not being themselves, as they became patients and described a sense of not being in control and being dependent on others. For instance in being objectified participants found that they were the recipients of treatment that were bordering on assault. There were many occasions where injections were given intramuscularly to the participant without the participant’s consent or knowledge of what was about to happen and/or why. For a male nurse to inject a female patient without thought or introduction exemplifies objectification of the patient. Although this may also be so for the layperson, for a nurse it is acutely more disturbing as (s)he is also a colleague. All of these participants accepted this behaviour and did not complain because they were in the patient zone: they did not act as they normally would and wanted to be seen as good patients. They had lost what it meant to them to be themselves and they were accepting of what they thought they should. However, the participants were nurses and this finally
came through as they no longer accepted poor nursing practice and spoke out.

**Being a nurse patient**

Chapter Four demonstrates many of the obstacles participants encountered as nurses. These obstacles were due to a lack of connection in the nurse patient relationship. Participants found that they were not seen by the nurses on the ward as either wholly nurses or patients and thus were confused as they were between roles. Many participants had difficulties in knowing what was expected of them at any given time and they felt guilty when they did not manage to meet these expectations.

My study findings demonstrated that the nurses made assumptions about the skill and knowledge of the nurse patient. With these assumptions came expectations of the behaviour and actions of the nurse patient. Each nurse cannot possibly know all there is to know about nursing as the field has so many specialised areas. Many of the participants did not work in the area where they had become patients so they were not confident in their nursing knowledge of that area and yet they were expected to know. It was due to the need to be treated as a patient without assumptions being made about their knowledge level that participants attempted to conceal or failed to reveal that they were nurses. However, through the health care language used or
their actions participants were often discovered. As nurses, they could not conceal themselves for long.

Chapter Three of the study findings revealed that participants were constantly battling with the juxtaposition of being a patient who is ill and being a nurse who is unable to attend to his/her own nursing care or that of others. It was clear that even when participants were unwell they still had time to think of and care for others. Sometimes this was to the participant’s own detriment. Heidegger (1926/1996) described Da-sein as being lost in ‘the they’ and not listening to its own self as it is hearing the ‘they self’. Heidegger is musing that the person is so in tune with the happenings of others in his/her environment that (s)he fails to see what is happening to herself/himself. This was indeed true for participants. Being a patient, participants found that they could not stop nursing in that they were constantly concerned for others. Being concerned for other patients meant watching out for them, calling for assistance and trying to assist them. In some instances the nursing concern for others meant frustration at being unable to nurse and a feeling of being trapped in a situation where the participants identified nursing care that was required but not happening. This caused frustration and annoyance and constant concern for the other.

van Manen (1998) asks if it is possible for the health care professionals to constantly feel a sense of responsibility for every patient in every experience without losing themselves or becoming emotionally drained or even jaded to
the effects of illness and disease. The study findings in Chapter Three revealed that participants could not stop focussing on what was going on around them and they were concerned for others. This concern caused them to be fretful and frustrated that they could do nothing to help and when they called for nursing assistance they were met with ridicule or annoyance.

Being a nurse patient for participants meant waiting. There are different kinds of waiting. For instance waiting on a bus to arrive is very different to waiting on exam results or a diagnosis of illness. Waiting, has been described in the study by Zeitz (1999) where the participants also found that they were waiting for nursing care and felt guilty for doing things for themselves whilst they waited, or waiting for pain relief when the nurse was busy. My study findings also revealed waiting similar to that of Zeitz (1999). However, another kind of waiting was also identified. That is waiting futilely as the request for pain relief or nursing assistance is ignored because the patient is a nurse and the nurse has labelled the nurse patient as demanding.

Participants described a well-known perception amongst nurses that nurses who are patients are demanding and highly critical of nursing care\(^\text{20}\). Participants went out of their way to ensure they were not perceived as demanding. Indeed, the findings from this study identified that participants were aware of what was going on around them and only called the nurse for assistance when they had no other choice, usually to their own detriment as

\(^{20}\) See Chapter 4
several participants identified. However, participants found that when they called the nurse they were ignored or made to feel guilty for asking for something to be done. They were accused of being inconsiderate of the busy nurse and demanding of things to be done straight away. What the nurse did not realise is that the participant had assessed the situation, waited for a break in the nurse’s busy workload to ask for assistance and this often meant by the time the participants asked for assistance (s)he did need attention straight away. Participants wanted to be recognised for their consideration in not being demanding, that they had explored all other avenues prior to calling for assistance, and when they called they expected the nurse to recognise that they actually needed the help.

Being a nurse for participants also meant being vigilant. Vigilance has been described in the layperson literature (Parker, 1999 and Salmond, 2011). Chapter Three of the study findings revealed nursing knowledge of hospital routines caused an increase in vigilance for participants. As nurses, participants recognised when things went wrong and if they noticed a nursing colleague not doing the right thing they became very ‘vigilant’ and protective of themselves to avoid iatrogenic injury. Participants spoke out to protect themselves and the nurses identified them as troublesome for their outspokenness. It was apparent that nursing colleagues felt judged by their nurse patients due to this watchfulness. Thus suspicion and mistrust surrounded the nurse to nurse patient relationship.
Similarly, in the lay patient literature, (Barker et al., 1995; Harber, 1999 & Kentisbeer, 2000) many participants described feeling uncared for as the nurses designated to provide their nursing care appeared to avoid them. However, unlike the lay patient, participants were avoided because they were nurses. Participants identified that in their own experience nurse patients were highly critical of other nurses and so they were avoided. The study findings revealed that participants were avoided either because it was thought that they should be able to take care of their own nursing care and the nurse didn’t ‘bother them’, or they were being avoided because they may judge the nurse providing the care and the nurse was fearful of getting it wrong. In being avoided participants described being uncared for, where the nurses provided minimal or no nursing care.

In Chapter Four there were many examples of the expectations nurses had of participants as nurse patients confirming the belief that nurses have increased expectations of nurse patients. One participant described some of the requests as being implied by the nurses’ actions and use of language, which appeared to demonstrate to her that she did not have a choice about whether or not she could do what was asked of her. Because she was a nurse it was expected that she would take care of her own nursing work. It is unclear if the nurse was aiming to preserve the dignity of her fellow nurse who was a patient, or if she was avoiding having to do the procedure herself because
there was a lack of communication about the incident and so the participant felt that she had no choice but to take care of the nursing tasks herself\textsuperscript{21}.

My study findings revealed that although nursing knowledge and experience could increase anxiety as participants imagined the worst-case scenario of being a patient, this knowledge and experience was also useful at times. Some participants used their unique insights into how the health care system worked to benefit themselves as patients. Participants as nurses were in an advantageous position compared to the layperson as patient in that they were able to network and use their nursing connections to get attention. When participants were unsatisfied with the care received from nurses or indeed they could see the nurse was too busy to attend to them they were able to source the nursing care from others. These study findings revealed the capacity for the participants to acquire the nursing care they deemed they thought they needed when it was not forthcoming from the nurses.

Although participants attempted to conceal their nursing identity, some revealed it so that they could take over some of the nursing work. Indeed one participant revealed her identity as a nurse patient to gain favour in the allocation of where her hospital bed would be. In gaining a single room from the nurse participants felt a connection with the nurse in that (s)he understood their plight. The study findings revealed that participants could not stop being nurses and could not stop thinking of the illness of others.

\textsuperscript{21} Chapter 4 page 194
Some participants were very ill and did not want to be thinking like a nurse, they wanted to spend time on their own illness and not torture themselves by thinking of others. So the single room was identified as an important haven for participants. However, the study findings revealed that it was not the haven it was expected to be, as it became very isolating and lonely. The importance of the single room has not been identified in the layperson literature but Shattell et al. (2005) and Zeitz (1999) identified its importance in their studies where nurses were patients or relatives of patients. Thus the need for a single room is unique for nurse patients in that they want to be away from the illness of others when ill themselves.

A lack of confidentiality for the nurse patient was also revealed. Nurses are bound by a professional code of confidentiality with patient information. However, when the nurse was the patient this code did not seem to exist as several participants identified. Indeed, it was such a problem for one participant that she drove past her local hospital where she worked to one where she knew no one would identify her as a nurse. Several participants identified that their managers and nursing co-workers were all aware that they were ill and why they were ill thus losing the confidentiality afforded to the lay patient. In addition to this nurse co-workers appeared to feel it was their duty to visit the nurse patient in hospital and participants revealed that this could be troublesome, especially when the co-workers outstayed their welcome or constantly made references to work matters. Although
participants understood why their co-workers visited they were not always welcome.

Similarly to the layperson, participants who had a near death experience were fearful and glad to have recovered (Parker, 1999). They recognised the ‘high calibre’ of nursing care and skills that (would have) saved their lives. They too reflected on their life as if they had received a second chance. In some cases it altered the participants’ life as changes were made based on this reflection. For those participants who had a critical or near death episode they deconstructed events and clarified in their minds what happened. This is an important and unique finding from my study. Participants had a need to know every detail of events when they had been seriously ill. Even when they had been unconscious and unaware of events they were later able to piece together the critical episode as their colleagues who were present seemed eager to fill the missing pieces in for them. This is indeed different from the layperson, possibly because the layperson does not have the knowledge or experience available to them that the participant does. Deconstructing events and knowing what happened to them appeared to make the situation less frightening for participants.

Being a patient receiving nursing care was described by participants as a fearful and alien environment where they were objectified and had to be vigilant to protect themselves. They described conflict, confusion and suspicion between themselves and the nurses who should have been
providing nursing care. Participants described uncaring acts by nurses but they also identified the nurses who cared and supported them during their illness.

Participants all felt special when they were acknowledged as nurse patients. In describing location within the hospital ward and how or if that can make a difference to illness and recovery the nurse patients’ in the previous section described being alone, lonely and at times uncared for. In these instances the nurse patient was describing a lack of psychosocial care and the ‘being there’ of caring described by Benner (1994). In illness many aspects of the sick person’s being in the world become problematic rather than taken for granted and the aim of nursing care is to support the person during illness to gain optimum health and well-being. However, nursing has become highly technical and compartmentalised into specialist nursing care where it is caring for either a specific physical or mental illness. According to Dunlop (1994) the nursing community is aware that this is happening and agree that good nursing is neither purely physical nor purely psychological but encompasses the whole person. This type of nursing care that encompasses the whole person is often cited in the literature as holistic nursing care where the illness is considered in conjunction with the effects the illness has on other aspects of the body and the person’s life. So, although nursing has become more specialised the overall care of the patient should not be forgotten or laid aside.
**Implications for nursing practice and education**

Throughout the study participants stated that the experience had impacted on their own nursing practice and indeed some had made many changes as they now had insight into the experience of being a patient. These changes include listening to patients, not promising what cannot be delivered, be more understanding with pain relief and basically providing true individualised and person centred nursing care. To have knowledge and insight one does not have to have personal experience but one does require the information to understand what the experience was and to use this information to improve nursing practice. Nursing education needs to be enhanced to include this information and to encourage nurses to be patient centred in the delivery of nursing care.

Findings from this study show that a connection with the patient in a therapeutic nurse patient relationship as described by Morse (1991) is important in the care of the nurse patient. Nurse patients are like lay patients in that they are ill but they are nurses and this makes them very different patients. Having an understanding of embodiment and what it means to be a nurse patient for those nurses providing the care would benefit the nurse to nurse patient relationship. Nursing education could use the findings from this study and others such as Zeits (1999) to highlight the importance of the nurse patient relationship and the difference when a patient is also a nurse.
Fear and dread played a large part in the nurse patient experience: the fear of what is to come and dreading it; the fear of what is expected from nurses and if they can deliver it; the fear that their knowledge is not enough or the right kind of knowledge; and the fear of the knowledge they do have as they can only imagine the worst case scenario. It is important that the nurse caring for the nurse patient is considerate and understanding when the fear makes the nurse patient irrational and angry in the event of things not going to plan.

It is important that when a patient is also a nurse this should be recognised and acknowledged in the sense that the information will assist in the nurse patient’s care. Nurse patients need to be acknowledged as a nurse and this can be done by taking the nurse patient’s health care knowledge and experience into consideration, providing information that will allay fear and anxiety, being understanding, and being honest when things go wrong. Through education, nurses could obtain a better understanding of what it is like to be a patient and the experience of the nurse as patient could be improved.

The nurse patient relationship and the need for a therapeutic connection between the nurse and patient has been widely explored and reported (Appleton, 1993; Heath, 2001; Rachidia et al., 2009; Sahlsten et al., 2009; Savage & Conrad, 1992; Sørlie et al., 2006; Walsh, 2000; Watson & Smith, 2002). Yet patients still report a negative experience of being a patient
receiving nursing care (Anonymous, 1999; Ball, 1997; Bilitski, 2003; Gilmartin & Wright, 2008). My study findings also highlighted negative experiences and a lack of connection between the nurse and the nurse patient. It is important for the future of nursing that these issues be addressed with nursing education. However, it is not only newly registered nurses who require this education and support to provide appropriate and adequate nursing care, it is also experienced nurses, as described by Downes (2006), who need to be reminded of the caring aspect of nursing. It is only through knowledge and understanding of the nurse-patient experience that nurses caring for these patients can ensure the nurse-patient experience is positive.

As a philosophy and research methodology phenomenology uncovers thoughts, understandings, feelings, and behaviours from the perspective of the person. It values human experience by providing an account of the experience of being in the world of everyday life and of living in and through the world (Giorgi, 2009; Salmon, 2012). To capture the nurse’s experience of receiving nursing care as a patient, as the researcher, I collected the stories from participants and analysed this data using Giorgi’s (2009) phenomenological approach. The findings therefore represent my account and interpretation of the raw data. I chose phenomenology because it captures human experience within the world and I used Giorgi’s (2009) method of data analysis because his work was synonymous with health and nursing care. I believe I used the best methodology for this research question. The themes identified and the stories contained in the data
collected are my interpretations of the participants’ experiences as they were recounted to me in interviews. My interpretations have been guided by the work of Amedeo Giorgi (2009) whose work was influenced by Edmund Husserl (1859-1938). However, there are some limitations of the study.

The limitations of the study

This study was limited to the nurse’s experience of receiving nursing care in an acute general hospital. The experience of chronic illness and receiving nursing care was not explored and neither was the nurse’s experience of receiving nursing care in a mental health unit. Of the forty-five (45) participants, only one was a male. I would have liked more representation from male nurses but only one other male expressed an interest and then went overseas and was unable to participate.

The data collection included face-to-face interviews, emails, written stories and telephone interviews. Emails and written stories do not identify body language and the nuances in speech that are obtained from face-to-face interviews but they do obtain the story of the experience as depicted by the participant. Telephone interviews were difficult in that I was listening and transcribing as the participant was speaking. Although I could pick up on the participant’s tone of voice, which gave me an indication of the participant’s feelings, I had to use shorthand to transcribe whilst listening to the participant’s story and on occasions I had to call again to confirm what was
said. Having a recording device for the telephone interviews would have ensured that I captured all of the nuances of the interview.

**Future research**

Qualitative research and indeed phenomenology is used more frequently in nursing and health to answer patient experience questions. Through this study I have revealed the experience of the nurse as a patient receiving nursing care in an acute general hospital in Australia. Participants all began their story when they first recognised that they were ill and their life world changed. I believe there is more to the initial experience that could be explored further. For instance, what is the experience of the nurse treating her/him self when ill or injured?

Other questions that have arisen from my findings include why do nurses avoid nurse patients? Why do they feel threatened and unsure of their own abilities when the patient is a nurse? What is the experience of the nurse caring for the nurse patient? The experience of the nurse receiving nursing care in a mental health unit is unexplored as is the experience of being a nurse living with a chronic illness. The experience of the male nurse in any of these settings is also unexplored. Finally, comparing and contrasting nurses’ experiences with patients’ experiences of nursing care may reveal a range of differing experiences and expectations for care. Understanding these
differences might help to inform new models of care. These studies would be of interest and add to the body of nursing knowledge.

**Concluding statement**

The purpose of this study was to explore and understand the nurse’s experience of receiving nursing care as a patient in an acute general hospital. The study arose from overheard comments from colleagues who have had a negative experience as a patient. I was concerned that nurses were being treated differently from the layperson as a patient but not in a positive way as nurses who were ill were being expected to take care of their own nursing and they felt neglected. I wondered why nurses would treat their colleagues in such a way and how the situation could be addressed.

There have been many studies on the experience of the layperson as patient and the nurse patient relationship. The findings in this study revealed the importance of a connection between the nurse and patient no matter who the patient is. The nurse patient connection allows a therapeutic relationship between the nurse and the patient to allow nursing care to take place. Without this connection there is an absence of caring. My findings in this study revealed, extra considerations need to be in place when the patient is also a nurse. These include, acknowledging the nurse patient as a person with health care knowledge and knowing the nurse patient thus being able to
identify when the (s)he needs nursing care from the nurse. Other considerations include being aware that the nurse patient’s health care knowledge may be causing increased anxiety and fear that can be allayed if the nurse provides information and support.

My findings from this study revealed many negative experiences of nursing care for participants. As identified in Chapter One, Downes (2006) identified task oriented nursing, as she had become what she described as a seasoned nurse (Downes, 2006, p. 79) in that she had forgot the personal touches that make nursing a caring profession. Downes (2006) was surprised and touched that the patient appreciated the time she took to care. Participants in this study were the same in that they all needed nursing care and the connection between themselves and the nurse that provides a therapeutic healing environment. Although participants identified uncaring practices by nurses they also identified that nurses were there for them when they were critically ill and needed them. When the participants were critically ill it did not seem to matter to the nurses who the patient were as the need to nurse and care for the patients was fore fronted and the nurses nursed them.

There needs to be more emphasis on creating a positive nurse patient relationship involving a connection between the nurse and patient that is therapeutic in nature. Nurses need to take into consideration the patient’s own knowledge and experience ensuring the patient journey is a positive one.
Finally, the nurse patient needs to be understood instead of avoided. Nurses as patients need to be provided with information, listened to and have their individual nursing care needs addressed.
Epilogue

On concluding their interview of the experience of the nurse receiving nursing care in an acute general hospital, most of the participants reflected on how the experience impacted on their own nursing practice. Although this was not part of the study the reflections are too important to be left out so I have used them to close the experience of being a nurse as a patient receiving nursing care in an acute general hospital. I have titled these reflections as “becoming a better nurse”.

Becoming a better nurse

It is an expectation from the general public that nurses will be empathetic and many will say that they are indeed empathetic as they have an understanding of what the patient is going through. To be empathetic a person has to have the capability to share their feelings and understand another’s emotion and feelings. It is often characterised as the ability to “put oneself in another’s shoes” (Macquarie Dictionary & Thesaurus, 2006). On reflecting on their experience of being a patient receiving nursing care participants concluded that they had previously misled themselves when they thought they understood what patients were going through. The experience has made some participants review their own practice. One participant, Olive believed herself to be a caring nurse. However, she believed that the
experience of being a patient receiving nursing care changed her practice in that she “...became a better nurse. [I am] A lot more compassionate. [I now] Prepare patients for their procedures. It made me very (pause) very aware of the other side of the equation”. Marie also identified:

Over the years helping with lumbar punctures etcetera. I had no concept of what it’s like. You don’t know. (shake of head) I’d said the pushing was the hardest bit and I’ve reassured people but I had no concept at all.

In becoming aware of what needs are important to patients, participants realised that as patients their priorities about what nursing care was important to them had changed as Vera noted:

It was good having some insight into what was happening in my body and what nursing care would be given. I wanted to do all the right things as a patient. What those things were was a surprise to me as they were things that were insignificant as a nurse!

A few participants stated that the experience has changed their own nursing practice. For example, Heather stated, "It ups [improves] your level of care I think. And made me think how I practice as a nurse”. In another situation, being intubated for Gina gave her insight into some practices she had
previously been doing. She said, “I’ll never ‘suck’ someone out like I did before. And (voice raised) changing the trachy [tracheostomy] tube. I know they have to do it. It’s horrible. Very frightening”. Gloria also found the experience frightening as she said:

Being a patient, I’m frightened to be one again. I’m much more aware of acute pain post surgery. Much more aware of what the patient is going through. It doesn’t matter what surgery, minor or not, my recovery was worse than the actual surgery.

After the experience Margaret had of the procedure that caused her so much pain and distress\(^\text{23}\) she said that it would improve her patient advocacy skills, “I now say, ‘they will have analgesia. They will have sedation. And you’re not doing that procedure’”. Sheila agreed and believed the experience “Has helped me in my nursing practice. Made me realise the impact - given me a little bit more empathy”. Sandra realised that she had been irrational when she was acutely ill and she said, “I realise the psychological effect of illness. When people are not rational, it’s not necessarily them. I fully understand now”.

Chloe also stated that her practice had changed to include the patient whilst still caring. She said, “I would give the option of doing some of it yourself. Not all of it”. Patricia added, “One thing I learned - listen to the patient. They

\(^{22}\) The action of inserting a suction catheter into the endotracheal or tracheostomy tube to remove secretions  
\(^{23}\) Liver biopsy previously highlighted
know what they are talking about”. On a lighter note Katrina shared her admiration for the lay patient when she said, “I had to lie on the pan and I couldn’t do it. I remember all these pans I’ve given out and people could do it. I admire them - because I couldn’t”.

Although participants have described good and bad nursing care from their colleagues Sandra reflected on the effect a nurse has on that experience as she said, “I don’t think (pause) until you go through an experience (pause) I never realised the impact a nurse can make on the experience. They are kind of - like a lifeline I think”. With respect for her nursing colleagues Gina said:

I don’t think you appreciate how hard nurses’ work. As a nurse, you don’t realise just how much you do for people until you are having it done to yourself. I don’t think people appreciate nurses the way they used to.

In conclusion, participants felt that the experience has informed their own practice and given them a new respect for many of their nursing colleagues.
References


Benner, P., & Wrubel, J. (1988). Caring is the candle that lights the dark, that permits us to find answers where others see none. *American Journal of Nursing,*(8), 1057.


Quan, K. (2006). What is a nurse? http://healthfieldmedicine suitesuite101.com/article.cfm/what_is_a_nurse_#ixzz0PeZxpSQw


Salmond, S. W. (2011). When the family member is a nurse: The role and needs of nurse family members during critical illness of a loved one. Intensive and Critical Care Nursing, 27, 10-18.


van Manen, M. (2002). Care as worry or “don’t worry be happy”. Keynote address. Fifth International Qualitative health Research Conference Qualitative Health Research, 12(2), 262-278.


Dear Sir or Madam,

I, Shirley Graham am conducting a research project as my PhD studies. I am conducting a study on the nurses’ experience of receiving nursing care as a patient in an acute general hospital. I am writing to request your support in displaying an information flyer within your hospital. The flyer contains information about the study and an expression of interest. The study involves interviewing the participant and asking him/her to describe his/her experience of receiving nursing care as a patient in an acute general hospital. All information obtained from participants will be confidential with identifying names of people or hospitals removed prior to publication of the study findings.

I can be contacted on (02)4943 9226 or by email shirley.graham@hne.health.nsw.gov.au. My research supervisors are Professor Diana Keatinge and Dr. Isabel Higgins from the School of Nursing and Midwifery, the University of Newcastle, NSW.
Should you have concerns about participants’ rights in this research or you have any complaints concerning the manner in which this research project is conducted they may be given to the researcher or if an independent person is preferred to;

The University’s Human Research Ethics Officer,
Research Office, The Chancellery, University of Newcastle, 2308.
Telephone 4921 6333 Email: Human-Ethics@newcastle.edu.au

You are invited to contact the researcher for further information or clarification of the study should you require this.

Yours sincerely,

Professor Diana Keatinge Dr. Isabel Higgins Mrs Shirley Graham
Supervisor Supervisor Student researcher
nurses’ experience of receiving nursing care as a patient in an acute general hospital

Attention nurses

Are you a Registered or Enrolled nurse?

Have you been a patient in an acute general hospital for two days or more in the past five years?

Researchers from the University of Newcastle are conducting a study on the experience of nurses receiving nursing care whilst a patient in an acute general hospital (public or private) and would like to invite you to participate.

There are several ways you can participate in the study:

You can telephone or email (see details below) to receive more information about the study and alternative ways in which you could participate in it.

Or you could forward your account (story) of your experience of the above anonymously to:
Shirley Graham @ Nexus Locked Bag No 1. Hunter Regional Mail Centre NSW 2310

For further information please call Shirley Graham on 0410439226 or email
shirley.graham@hunter.health.nsw.gov.au
before 30th September 2004
Appendix 3

connections

Nurses’ experience of nursing care as a patient in an acute hospital

PhD research by Shirley Graham, University of Newcastle

While ‘lax’ patients’ experience of nursing care has been widely studied, nurses’ own experiences of nursing care in an acute hospital has been virtually unexplored. While many nurses have outlined their experiences of being a patient in letters to nursing journals, most of these letters paint an overwhelmingly negative and highly critical impression of the care provided to them by other nurses.

This qualitative study will study nurses’ lived experience of receiving nursing care whilst a patient in an acute general hospital (public or private); and consider the ‘nurse-as-patient’ experience to make recommendations for nursing practice.

Can you help?

If you are an EN or RN who has received nursing care as a patient in an acute general hospital, you are invited to participate in this study. You must have been admitted to an acute general hospital for at least two days in the last five years, and have been a practicing nurse in the last five years.

To participate in the study or for more information, contact Shirley Graham on 0410 439 225, or email Shirley.graham@hunterhealth.nsw.gov.au.

Introducing a new column for researchers

Connections is a resource for nursing students, researchers, educators and academics who would like to:
- publicise their studies/research to other nurses
- recruit nurses for studies
- find more information; or
- connect with other researchers.

The Lamp cannot accept academic studies for publication, but does accept short summaries of studies (500 words or less) for this column, and requests for information.

You must include your full name and the name of your university/hospital/institution, and write for a broad audience that includes nurses outside your specialty.

Connections is for NSWANA members only.

Send information to:
Julie Venamore
j.venamore@nswnurses.asn.au
9565 2991

the lamp June 2004
Dear Colleague,

You are invited to take part in the research project identified above, which I, Shirley Graham am conducting as my PhD studies. I can be contacted on (02)4943 9226 or email Shirley.graham@hunter.health.nsw.gov.au. My research supervisors are Professor Diana Keatinge and Dr. Isabel Higgins from the School of Nursing and Midwifery, the University of Newcastle, NSW. I am inviting nurses (Registered and Enrolled) who have been a hospital inpatient in an acute general hospital and received nursing care for two days or more within the last five years to participate in the study. Participation involves being interviewed about your experience or sending a personal account of your experience of receiving nursing care as a patient in an acute general hospital.

**Interview:** You are invited to participate in an interview (either in person or by telephone) about your experience of receiving nursing care while a patient in an acute general hospital. A second follow up interview may be required to clarify details. Prior to each interview I will telephone you to arrange a time and place convenient for the interview to take place. In order to ensure that I obtain an accurate record of our discussion I would like to record our discussion on an audiotape. The tape recorder can be turned off at any time during the interview if you do not wish what you are saying to be recorded. The discussion will be transcribed (typed word for word) following the interview. You may, if you wish, review the transcripts of your interview and erase or change anything, which you do not wish to be recorded. I am aware that some experiences may have been unpleasant or upsetting and their retelling may evoke distress. If this is the case I will stop the interview and the audiotape. I will also offer you the opportunity to seek support from a councillor from the Employee Assistance program in your Area Health Service, who are aware that I am conducting the study.

**Personal account:** Alternatively, if you do not wish to be interviewed but do want to participate in the study, you are invited to send a personal account of your experience either audio taped or written to the...
student researcher. An audiotape will be forwarded to you on receipt of the consent form if you indicate that you require this on the consent form.

Participation in this study is entirely your choice. Only those people giving their informed consent will be included in the project. You are assured that participation in this study will not impact on any future health care you may require. As a participant in the study all information you provide will remain confidential and your name or identification will not appear in any transcripts or in any reports about the study. Only my supervisors will review transcripts of the participant’s interviews or personal accounts. All information and data collected will initially be kept in a locked cabinet. Following completion of the study the audiotapes will be returned to you or destroyed if you do not want them returned. All other information will be stored at the School of Nursing and Midwifery at the University of Newcastle for the required period of five years after which time it will be destroyed.

The results of this study will be published, however this is unlikely to happen before 2012. Publication will be in general terms and will not identify any individual or institution. Should you wish to see a copy of the study report you can indicate this to me on the consent form or you can contact me on the number included on this information sheet. This project has been approved by the University’s Human Research Ethics Committee, Approval no. H-737-1203. Should you have concerns about your rights as a participant in this research or you have any complaints concerning the manner in which this research project is conducted they may be given to the researcher or if an independent person is preferred to;

The University’s Human Research Ethics Officer, Research Office, The Chancellery, University of Newcastle, 2308. Telephone 4921 6333 Email: Human-Ethics@newcastle.edu.au

You are invited to contact the student researcher for further information or clarification of the study should you require this. You can decline to take part in this study and if you agree to take part you can withdraw at any time without fear or prejudice and you do not have to answer any questions if you do not wish to, without having to provide a reason.

Thank you for considering this invitation.

Yours sincerely,

Professor Diana Keatinge Dr. Isabel Higgins Shirley Graham

________________________  ______________________  ____________________
Supervisor                  Supervisor                  Student researcher

300
Utilising the qualitative approach all interviews will be unstructured and conducted in a conversational style. The extent to which the questions will be asked depends on the ease with which the interviewee openly discusses her/his experience, feelings, fears and concerns.

Prior to interviews some demographic details will be collected such as:

- <25  25-40  >40
- Male  Female
- Area of nursing experience
- Length of nursing experience
- Registered Nurse  or Enrolled Nurse
- Was this your first time in hospital as a patient
- Was the hospitalisation for an acute illness or exacerbation of a chronic illness?

The main areas covered in the interview will emerge from broad open-ended questions or invitations for comment. The interview will begin with the following introduction: I would like you to reflect on your experience of receiving nursing care as a patient in an acute general hospital and to describe that experience in your own
words. I have provided some questions that may get you started but you do not
have to use them.

Examples of questions to be asked are:

- Can you describe your experience of receiving nursing care whilst a patient in
  hospital?
- Could you tell me what it was like for you as a patient receiving nursing care?
- Could you tell me about your thoughts and feelings when you were a patient
  receiving nursing care?
- What were your expectations of the nurses and their care during your time in
  hospital?
- Were these expectations met? Could you give me some examples?
- Did you feel that you could communicate your needs and expectation to the
  nurses?
- Where these heard and taken into account?
- When you reflect on your experience does anything stand out for you in
  terms of your interaction with or care you received from the nurses?
I agree to participate in the above research project as it has been described in the information letter, a copy of which I have retained. I give my consent freely.

I realise that I can withdraw from the study at any time and do not have to give a reason for doing so. I understand that any information I provide will remain confidential to the researchers. I have had my questions answered to my satisfaction.

I live within 150km of Newcastle NSW and agree to be interviewed for the study.

I want to participate in the study by sending a personal account of my experience and I require/ do not require an audiotape forwarded to me for this.

On the study conclusion I wish/ do not wish to receive a summary of the findings.

Print name: ______________________ Date: ___________

Signature: ____________________________________________

Contact telephone number ______________________________

Researchers

Prof. Diana Keatinge Supervisor/ Chief investigator  (02) 4921 6010

Dr. Isabel Higgins Co-supervisor  (02) 4921 6347

Mrs Shirley Graham PhD student  0410439226
Appendix 7

Expression of interest in local media and a widely circulated professional nursing journal

Attention nurses

Are you a registered or enrolled nurse?

Have you been a patient in an acute general hospital for two days or more within the last 5 years?

Researchers from the University of Newcastle are conducting a study on the experience of nurses receiving nursing care whilst a patient in an acute general hospital and would like to invite you to participate.

There are several ways in which you can participate in the study:

- You can telephone or e-mail (see details below) to receive more information about the study and alternative ways in which you could participate in it.
- Or you can forward your account (story) of your experience of the above anonymously to: Shirley Graham @ NICU John Hunter Children’s Hospital Locked Bag No1. Hunter Regional Mail Centre NSW 2310.

For further information please call Shirley Graham on (02) 492x xxxx during office hours or email Shirley.graham@hne.health.nsw.gov.au before date/day/year.
Appendix 8

Demographic details: Length of nursing experience

<table>
<thead>
<tr>
<th>Length of nursing experience</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5 years</td>
<td>1</td>
</tr>
<tr>
<td>5-10 years</td>
<td>2</td>
</tr>
<tr>
<td>11-15 years</td>
<td>6</td>
</tr>
<tr>
<td>16-19 years</td>
<td>1</td>
</tr>
<tr>
<td>20-29 years</td>
<td>21</td>
</tr>
<tr>
<td>30+ years</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix 9  Types of injuries/ illnesses

Surgical-  
  Appendicectomy (2)
  Cancer- tumour removal (4 - one breast cancer)
  Colonostomy
  Cholecystectomy
  Fibroidectomy- post operative haemorrhage
  Hysterectomy
  Menasectomy
  Pelvic Floor repair
  Sphincterectomy
  Thyroidectomy (2)  (one in ICU intubated post operatively)
  Undisclosed surgery (2)
  Vein surgery

Obstetric-  
  Placental abruption
  Post partum haemorrhage  (following Caesarian section)

Medical-  
  Acute infection
  Acute cholecystitis- chronic liver problems
  Acute pancreatitis (2)
  Allergic reaction- anaphylaxis
  Bilateral pneumonia (2)
  Chest pain
  Endometriosis
  Migraines/ arythmia’s

Neurological  
  Cerebral Vascular Accident (2)
Head injury
Meningeoma

Orthopaedics
Fractured ankle
One fractured ankle other the other ankle sprained
Hip replacement
Knee replacement

Ear Nose and Throat- Sinus infection
Dear Ms Mxxxxx,

I, Shirley Graham am conducting a research project as my PhD studies. I can be contacted on (02)4943 9226 or by email shirley.graham@hne.health.nsw.gov.au. My research supervisors are Professor Diana Keatinge and Dr. Isabel Higgins from the School of Nursing and Midwifery, the University of Newcastle, NSW. I am conducting a study on the nurses’ experience of receiving nursing care as a patient in an acute general hospital. I am writing to request your support should it be required.

The study involves interviewing the participant and asking him/her to describe his/her experience of receiving nursing care as a patient in an acute general hospital. I am aware that some experiences may have been unpleasant or upsetting and their retelling may evoke distress and I therefore seek your assistance in this instance. If a participant becomes distressed I will cease the interview and offer him/her the opportunity to seek support from a councillor from the Employee Assistance program within the participants area health service, which will be within 150km of Newcastle NSW.
Should you have concerns about participants’ rights in this research or you have any complaints concerning the manner in which this research project is conducted they may be given to the researcher or if an independent person is preferred to;

The University’s Human Research Ethics Officer,

Research Office, The Chancellery, University of Newcastle, 2308.

Telephone 4921 6333  Email: Human-Ethics@newcastle.edu.au

You are invited to contact the researcher for further information or clarification of the study should you require this.

Yours sincerely,

Professor Diana Keatinge     Dr. Isabel Higgins     Mrs Shirley Graham

________________________________________   ________________________________   __________________________
Supervisor                      Supervisor                      Student researcher