ARE THE COUNSELLING SKILLS NURSES LEARN IN TRAINING APPARENT IN THEIR EVERYDAY INTERACTIONS WITH PATIENTS AND CARERS?

A thesis submitted to the University of Manchester for the degree of Professional Doctorate in Counselling in the faculty of Humanities.

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50,000 WORDS
Do nurses use counselling skills in their everyday practice?

Abstract

Are the Counselling skills nurses are taught during their initial training evident within the stories they tell about their interactions with patients and carers?

This research evaluates whether nurses working in general hospital settings utilise the counselling skills they are taught during their initial nurse training when they practice as qualified nurses. A narrative Enquiry methodology was used to gather stories about everyday nurse patient interactions from eight nurses working in a variety of general hospital settings. The stories were tape recorded and transcribed before being subjected to qualitative descriptive analysis, a variant of content analysis, which yielded a number of themes. The analytical process incorporated the use of a hermeneutic circle to reinforce the reliability of the analysis and three types of skill were identified within the narratives. The narratives suggest that nurses do use counselling skills regularly when interacting with patients and carers, in particular the skills of information giving and empathy. These skills are interrelated in nursing practice and their usage stems from the personal experiences of the nurses involved, rather than any training received prior to their qualifying as registered practitioners. While the sample size is relatively small, the findings might suggest there could be some worth in further research to determine the relational skills possessed by those wishing to enter nurse training. This type of investigation has a resonance with current calls for reform of nurse education and might allow for training in the area of interpersonal skills to become more personalised.

Ethical permissions for the study were obtained from NRES, The Ethics committee of the United Lincolnshire Hospitals Trust and the University of Manchester.
Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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I wish to thank my supervisor Professor William West for his guidance, support and patience during the time I have known him. I have, I know, drawn extensively on these qualities of his and he has borne the assault on his academic sensibilities which I have sometimes represented with good humour and good grace.

My wife and children have shown the same qualities (particularly in relation to my use of technology) and I am grateful for their help in supporting me to complete this project and their faith that eventually I would. They have, just by being who they are, provided unconditionally the environment I needed to be able to “get on”.

I would like to thank Joan for her skills as an organiser, facilitator and word processor. At times I know I’ve challenged these abilities, but she has remained a friend throughout and her help has been invaluable and is much appreciated.

Finally I wish to thank the people who very kindly allowed me to listen to and tape record their stories. Their generosity in giving me time and their honesty in answering my questions is very much appreciated.
PROLOGUE

The well known American “philosopher” Mike Tyson is quoted as having said “everyone has a plan until they get a punch in the face” a statement which has a resonance for me as a trainee researcher.

Not because I’ve suffered violence along the way, though Mr. Tyson probably was speaking literally, but because I have found that while I had an inkling of how this project would work out I had no real control over the final product.

This has made me aware of the extent to which anyone trying to conduct research has to be prepared to work with what comes out of that research and react, almost “in the moment” to things which were unexpected.

While the above might make me sound a little fatalistic, it’s a view which has also encouraged me to think about aspects of the research process over which I do have control. One such aspect is the way the work is presented and I will offer an explanation for my chosen presentation style here.

This work is based on narratives. I tell stories as a teacher and listen to stories as a counsellor, I can relate to and I like stories.

People when they tell a story, do so in their own way, they use words and language they know will help the listener to understand and they have a vested interest in getting their message across. I have tried to use the same principles here in my writing. The language is language I would normally use and the style is the one I am comfortable with.

I expand on this point below in the methodology chapter, and try to follow academic hegemony in so doing. Here I would like to ask that as you begin to read this work you bear in mind my use of the first person pronoun and at times colloquial style are an artefact of my attempt at producing a narrative.
CHAPTER ONE
INTRODUCTION

Preamble
1.1 “My Story”

During my “formative” years, which given my working life has so far spanned five decades, were a long while ago, I was fortunate enough to be the focus of the attentions, interest and concern of a number of very wise, generous, well-meaning and insightful professionals from educational, theological and “youth work” backgrounds. Nowadays the proximity of such folk to a teenager might be expected to invoke thoughts of trouble, delinquency or waywardness, but the reality was a smidgen more prosaic and accordingly much less colourful.

As a catholic boy of school leaving age in a fairly deprived area of a major English city, I was fortunate enough to be identified as having “potential” and it was the hope of the folk mentioned above that they might help me to fulfil it. That I managed successfully to scorn their efforts is a matter of record, but the message given to me by one of those who tried patiently to engage with my arrogantly vacuous disdain for any kind of authority has remained with me and has relevance and a resonance here.

Father Vincent Whelan was the parish priest in the area where I lived then. He was well known (though not by me at the time) as a proponent of “Liberal” Catholicism and famous for his work with the poor of the inner cities. He was, in the nineteen seventies, the subject of television documentaries and a regular contributor to Granada’s night time “God slot” The Epilogue.
With a prescience I might describe as “spooky” and which he’d have had no time at all for, Fr. Whelan told me I was “good at interpreting the meaning of things for others” and ought to think about using this “talent” as the basis for making a career in my future life. The message went in one ear and promptly out the other. I went away and started work in a department store where I stayed for a few years. I remember attending an in-store celebration for a man who had been working with the company for twenty five years, at which the chap was given a cheque for twenty five pounds and during which someone played the spoons; the event made me restless and I started to apply for jobs which promised some form of training and maybe a brighter future. The first response I received was from the local Mental hospital and I started training with them as a mental health nurse thirty five years ago. I’ve been in nursing ever since, most recently as a teacher within a university school of nursing, interpreting the research of others for my students!

Had I taken Vincent Whelan’s advice years ago I might have moved along the path to success more quickly and perhaps gone a bit further; I could equally have been a teacher for years and become unhappy with my lot as some seem to do. As it is I’ve had opportunities not just to interpret things for others, but to move beyond this and help people interpret things for themselves, as a nurse, a teacher and a counsellor; a basis for a career which has brought me a good deal of satisfaction. Each of these activities, nursing, teaching and counselling is social in nature. Each involves talking with and to people and if one wants to “perform” as well as one can, each demands a degree of reflection as to whether one has “got it right”.

It is in part my own reflecting on whether I’ve got it right that has led to my engaging in this research and in so doing hopefully move beyond
being “just” a conduit for carrying the ideas of others and begin generating some information of my own.

1.2 The story of the Study

This thesis is about the counselling skills used by adult nurses in their everyday, normative interactions with patients and carers. I have chosen to focus on adult nurses specifically, because this group of professionals, when they are “learning their trade” as students, are encouraged to think about the communication skills they bring to the caring encounter through the “lens” of counselling, I am involved in this teaching process and am interested in whether this approach “works”.

All Nurse training programmes in this country incorporate a focus on communication skills. (Bach and Grant 2009) This is a term used interchangeably with the phrase interpersonal skills to denote the verbal, non verbal and paralinguistic abilities required by the nurse when providing a care service to patients. Bach and Grant (2009) in an attempt to illustrate the difference between the two terms describe communication as being “the reciprocal and effective process in which messages are sent and received between two or more people” (Bach and Grant 2009 pg.168) while they argue that interpersonal skills are “exhibited when nurses demonstrate their abilities to use evidence based and theory based styles of communication with their patients, clients and colleagues” (Bach and Grant 2009 pg.169).

Trainee nurses are taught about the importance of being able to communicate well and are given guidance as to the skills which may facilitate this activity. Counselling is used in nurse education to provide the frameworks within which these skills may be contextualised for
practice (Ashmore and Banks 2003). The whole ethos of training rests on the belief that interpersonal skills are learned and can therefore be taught. While the content of nurse training courses in England is defined by the Nursing and Midwifery Council (NMC) and the same body outlines the competencies each nurse should develop in training (NMC 2010) there is evidence of wider interest in the topic of communication and interpersonal skills competency in nursing.

The International Council of Nurses (ICN) in its Frameworks of competence for Generalist nurses (2003) and Specialist nurses (2009) stresses a skills based approach to training and argues that all nurses must be able to engage in “Therapeutic Communication and Interpersonal Relationships”. The ICN (2003, 2009) identifies competencies which will underpin this particular ability and which all nurses should be able to demonstrate. These competencies include the ability on the part of the nurse to “Listen to others in an unbiased manner respecting the point of view of others and promoting the expression of diverse opinions and perspectives” and “facilitate access to information or refer requests to the appropriate person” (ICN 2009 pg.22).

Hancock (2004) at the time the president of the ICN suggested that this organisation had a responsibility to offer guidance to countries worldwide in relation to the content of training programmes for nurses and this guidance has been applied in 130 countries including the United States of America through the American Association of Colleges of Nursing (AACN 2012) and in Australia on the recommendation of the Community services and Health Industry skills Council (2013).

ICN recommendations also underpin moves to implement competency frameworks for communication in nurse training programmes in countries such as Taiwan (Lin, Hsu, Li, Mathers and Huang 2010) Iran (Dehaghani,
Akhormeh and Mehrabi 2012) and China (Liu, Kunaiktikul, Senaratana, Tonmukaayakul and Eriksen 2007)

Each country has to design training programmes to be congruent with its own cultural and economic situation and attempts to create truly standardised courses have proved problematic. This is evidenced by authors such as Cowan, Wilson Barnett, Norman and Murrells (2008) who note the difficulty the European Union has found in attempting to ensure nurses, who may now travel and work in any area of the European Community, have the skills to meet the particular cultural demands of any country they may choose to practice within.

The European Union’s “Tuning” project (2011) set up by the European Commission Directorate of Education and Culture identifies a range of competencies which any nurse training within a European Community country should be expected to gain during training. This set of competencies includes a number related to “communication, interpersonal skills including the use of new technologies” (Tuning project 2011 pg 46). One of these (competency 16) suggests the nurse should be “able to communicate effectively (including the use of new technologies) with patients, families and social groups including those with communication difficulties” while another competency (No.19a) argues nurses should “be able to use counselling skills” (Tuning project 2011 pg.46/47)

When reading about this uniform but loose consideration of communication and interpersonal skills within nurse training curricula from around the world I was reminded of an experience that had made me consider the topic from an international perspective before. My own musings were of a much more basic nature than either the ICN or the EUDC though.
During 2011 and 2012 I had the opportunity to take part in a European Union funded research project considering some of the issues which impact on movement of nurses between countries of the European Community. This project was titled “Training requirements and nursing skills for healthcare mobility” (TRaNSforM) and there were partner universities from Turkey, Ireland, Portugal, Belgium, Britain, Finland and Germany. One of the major barriers we found to working mobility for nurses within the European Union was an inability to speak the language of the country one might have wished to work within. Language is not one of the competencies discussed within the Tuning project document (2011) but it underpins any ability to communicate whether one is using new technologies or not. The issue of nursing mobility within Europe and language as a possible barrier to good communication has also been raised in the House of Lords by Lord Robert Winston in September 2011.

Leaving aside the invisibility of language in some of the guidelines focussing on what a nurse needs to be able to do in relation to communicating the competency statements above in themselves don’t make specific recommendations as to what the communication and interpersonal skills they speak of should look like. This means that individual teachers in individual schools of nursing in each country have a degree of autonomy in terms of how the guidelines and competencies are interpreted which has led, in part, to the lack of standardisation in training in this area which I discuss further below.

The demands on myself to interpret ideas from such guidelines and directives have meant the personal skills I describe above (in interpreting information for others) have been utilised in designing the training programme, identifying which skills will be taught within it and delivering this training so the skills might be applied by my students in their practice context.
To help teach others the interpersonal skills which underpin good communication like many of my colleagues I have turned to the area of counselling to help put these skills into the context of nursing practice. While there is a debate about whether nurses need to be able to use counselling skills as part of their role (Brown, Crawford and Carter 2006, McLeod 2008) like many schools of nursing my own draws on the ideas of theorists such as Egan (2011) Rogers (1957, 1961) and Heron (2005) to help trainees reflect on how they might act in patient care situations which will be challenging. Thus student nurses are taught to utilise the interpersonal skills which underpin the counselling process to aid their communication while engaged in patient care.

In an attempt to gauge to what extent, if any, adult nurses utilise the counselling skills they are taught during their training within their practice afterwards, I have asked eight adult nurses working in a general hospital to tell me stories about interactions with patients and carers and have analysed these stories to evaluate the presence of the counselling skills the nurses were encouraged to use.

My investigation therefore is based on a narrative enquiry methodology in order to gather “data”, combined with an analysis of that data (the stories) which mirrors the qualitative descriptive approach described by Sandelowski (2001, 2010). These concepts are discussed in more detail below.

1.3 The Reason for the research

Because I work as a lecturer in nurse education I have alluded to my interest in this topic in terms of my involvement in the teaching of the counselling skills nurses are encouraged to use while they are in training.
To some degree then this thesis represents the findings of an evaluation of my own work (or at least work to which I have contributed). In and of itself this could serve as a reasonable, if somewhat banal, explanation for my motivation in conducting this piece of research, but being mindful of the need to illustrate some reflexivity in this enterprise I will attempt to justify, in a personal context, my choice of topic.

The reader shouldn’t be too worried that I might start self-indulgently invoking the ideas of Maslow, Freud or even Herzberg at this point, I’m merely falling into line with the thinking of writers such as Etherington (2004) who believe that choices researchers make in relation to what they select to study and how they choose to study it may have a degree of personal resonance. Topic and Method are not hit upon haphazardly, but usually arise from the context of the researcher’s experience and this is focussed upon here in the interests of “placing” the researcher in the research process. I have been a nurse in both the mental health and adult (general) fields of care for much of my working life. My own training, in mental health some thirty five years ago and in general nursing four years after that, included a focus on communication based on the use of counselling skills.

I have been fortunate enough to have practised in both of these areas of care and can relate easily enough the use of counselling skills to mental health nursing. Various forms of talking therapies have long been advocated in the treatment and relief of depression and anxiety for example and currently Cognitive Behavioural Therapy, a form of counselling, is even being “trialled” in the treatment of those folk with psychotic illness who are intolerant of strong psychotropic drugs (Tomlinson 2012).
Taking time specifically to “talk” in mental health nursing is both appropriate and necessary in the therapeutic sense. As a general nurse though, I never felt the same dynamic applied. Very often it was difficult to find the time to spend with someone to listen to their concerns or share their thoughts and feelings about what was going on for them and on those occasions where I might see this activity as a priority, I would somehow feel guilty about letting my colleagues get on with the “real” work while I sat and “chatted”. Reflecting on my experiences as a general nurse I wonder whether I ever utilised the basic counselling skills I was taught, even where I could see they may have been helpful. I probably never went beyond displaying what Brown, Crawford and Carter (2006) identified as Brief Ordinary and Effective communication skills (smiling, nodding, chit-chat) and hearing and evaluating what contemporary adult nurses have to say about their interactions with patients and carers will offer me the opportunity to evaluate whether modern nurses take a different approach.

The other “driver” for my interest in the way nurses interact with people during the course of their work also has a personal underpinning, but relates to what might be seen as the more mechanistic task of ensuring “quality” in care. In recent times the importance of the service users’ perception of the quality of care has been stressed. The revised National Health Service (NHS) outcomes framework (DOH 2012) for example, identifies five domains of care which ought to be considered as central when it comes to guaranteeing a quality experience of healthcare for the patient. These include, as one would expect, the need to ensure people don’t come to harm from injury or infection whilst receiving care and in domain number four there is a statement that suggests “healthcare providers should be interested in ensuring that people have a positive experience of care”.

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The National Institute for Health and Clinical Excellence (NICE) have produced a quality standard relating to communication between patients and nurses in adult general hospitals (NICE 2012). This statement makes it clear that “patients will experience effective interaction with staff who have demonstrated competency in relevant communication skills”, but beyond promising that these will be measured in patient satisfaction surveys, doesn’t say much about what indicates good communication. The Royal College of Nursing (RCN) have also contributed to the arguments that communication has a major impact on the patients experience of healthcare with their Principles of Nursing Practice (RCN 2011); and the Nursing and Midwifery Council (NMC), the body which regulates nursing and nurse education in England and Wales, has identified communication as underpinning the essential skills of being caring and compassionate (NMC 2007).

Though each of these august bodies has indicated the importance of nurse patient interaction, when it comes to the patient judging the quality of care he or she has received, the actual skills nurses are taught in order to ensure that interaction is effective and satisfactory is left up to the individual university schools of nursing. I hope that the nurses I speak with will indicate in their stories not just whether what they’ve been taught “worked for them”, but offer some insight into what the counselling skills utilised contribute to patient care.

In the light of concerns raised by recent negative reports outlining a lack of interest in patients and relatives (Abrahams 2011) a lack of caring or compassion for patients and relatives (Mid Staffordshire Foundation Trust Public Inquiry 2013) and even physical abuse of vulnerable patients at Winterbourne view (DoH 2012) it is both timely and appropriate to want to enquire into how nurses interact with patients and relatives.
These reports represent findings which have been generated from narratives of patients and their relatives, these narratives are made public in part so that healthcare professionals can learn from them.

As a nurse I hope that those I speak with offer a very positive view of their interactions with patients and their relatives, as a researcher I hope to be able to identify the skills which underpin these interactions. As a teacher of course I would like to think I may have contributed to any ability evident among my respondents to interact effectively with their patients but more importantly I wonder if the narratives generated by this project might have value as learning aids in themselves?

1.4 Choice of method

The third chapter of this thesis focuses on methodological issues and I have rationalised my choice of narrative enquiry as an approach to gathering data in that section of this work. Here it seems appropriate to confess a predilection for stories. As a teacher, a counsellor and a nurse, I have listened to and told stories for most of my working life. Each of the work roles I’ve had is essentially social in nature, to be sociable demands interaction and in each of these roles I have had to be mindful of the caveat that it wasn’t always what I had to say that was important. I have learnt to be patient in my dealings with folk and allow them to speak, hearing stories was to me therefore the most congruent manner in which to gather data for this project.

While the choice of narrative enquiry as a method suits my own preferences in terms of a way of doing research it is also the most appropriate means of trying to find out about what it is I am interested in. A person’s experience of a phenomenon can only be illustrated by and through what they have to say about that phenomenon. (Dewey 1976). While any researcher cannot guarantee that what he or she is told is
“truth” pragmatically there is no other means of gathering information about how a person has experienced something than to ask them about it. Stories represent the most normative means by which people make sense of their experiences (Dewey 1976, Connelly and Clandinin 2006) and narrative enquiry is represented by storytelling.

I have to accept that because experience is impacted upon and changes over time (following yet more experience) anything I may report here is representative of a “snapshot” of the way in which the nurses I spoke with view how they interact with patients and their relatives and their views of the skills they use in so doing. As an approach to research for this project narrative enquiry is congruent, valid and pragmatic.

1.5 Context of the research

While I have given above my own reasons for choosing the topic and the method for investigating it, I have not made an argument that the research is in any sense unique. Indeed in terms of the topic such an argument could not be sustained, many people have considered the communication skills nurses use, the communication skills nurses prefer to use and the teaching and learning methods used to help nurses develop those skills in the first place.

For instance, Burnard and Morrison (1988, 1990) carried out research focussed on the use of the various skills within Heron’s six category intervention framework by both qualified and student nurses; Burnard (1995) also interviewed student nurses to find out what they’d learned from their communication skills training. Swadi and Graham (1998) reviewed the length of training in hours nurses received in the area of communication and interpersonal skills and tried to measure the acquisition of those skills. Cassidy (2005) did a similar exercise in trying to identify whether empathy increased in individual nurses after
undertaking a short course in counselling skills and Smithies (2006), in a study carried out as part of an M.Phil. here at Manchester University, investigated the use of Objective Structured Clinical Examinations (OSCEs) to test the ability of students to reproduce what they had been taught under exam conditions.

These and many other studies have had an evaluative purpose and have generated a range of qualitative and quantitative data relating to the efficacy (or otherwise) of the training in communication skills nurses receive and the skills they use in their practice. As yet no one has attempted to ascertain from qualified nurses’ narratives to what extent those skills form part of their normative interactions with patients and carers and my hope is that this small study may begin to address that knowledge gap.

1.6 Structure of the thesis

Following this introduction there is a chapter reviewing literature related to the topics of communication, interpersonal and counselling skills in nursing. I outline why these subject areas are relevant to the practice of nursing, discuss how these skills are facilitated in nurse education and consider which skills are used in nursing practice.

The third section of the work focuses on the methodology used to gather and analyse data. Included here is a consideration of processes such as gaining ethical approval, seeking participants and some reflection on my own experience of these researcher tasks. The findings from the analysis are then presented in the following sections. These include separate considerations:

- in chapter four of “non-verbal and paralinguistic skills”. Non verbal skills are representative of the mechanistic skills of communication.
• in chapter five illustrations of “information giving” which is shown to be a skill with both instrumental and relational qualities

• and in chapter six illustrations of empathic understanding, the most relational of the abilities underpinning interpersonal communication.

The final section offers a discussion of the findings and allows me to reflect on the research process, in addition to making suggestions as to where this research fits in with what is already known about the topic and proposing ideas for further research.

My hope, just now, is that you are prepared to be patient, as non-judgmental as you can be at this stage and form an understanding of what I’m trying to do. I’m asking from you what I’m hoping to find evidence of in the coming pages.
CHAPTER TWO
LITERATURE REVIEW

Preamble

This chapter focuses on some of the literature available around the topics of communication, interpersonal and counselling skills in Nursing. It affords me the opportunity to provide an overview which will hopefully illustrate for the reader the importance of this element of the training nurses receive and the current context within which that training is delivered.

I go on to consider the strategies utilised within schools of nursing to equip students with the skills they need for practice before examining how this learning is transferred into clinical contact with patients.

Relevant literature was sought from a number of electronic databases including CINAHL AMED, ASSIA, SCIENCE DIRECT, PSYCHINFO and the ETHOS database of University Theses. The reference lists of texts felt relevant to the study were also used to source further relevant literature. My original intention was to include literature which had been published within the previous ten years to my commencing the research but where books, papers or articles were felt to be particularly pertinent I have utilised elements of the work contained therein.

While it may appear obvious that any service occupation should facilitate within its practitioners the ability to relate to its customers nurses as the largest occupational group in healthcare are expected to go beyond this. (Hough 2010).
Understanding, kindness and compassion are demanded of the nurse by the Department of Health (2013) and expected by patients using the health services (Mid Staffordshire Foundation Trust Public Inquiry 2013). These demands and expectations create the political context within which nurse education is delivered and this context is worth some consideration.

2.1 Reflexive statement

It is my belief that the interpersonal skills nurses use in their encounters with patients are important. I help to teach those skills and do so from the perspective of counselling. As someone who has practiced as a counsellor a teacher and a nurse I believe that some of the skills used in a counselling encounter mirror those a teacher might use to facilitate learning and those nurses use to show they care. Recently questions have been asked as to whether nurses do actually care at all. The “Francis report” (Mid Staffordshire Foundation Trust Public Inquiry 2013) raised doubts about whether some of the nursing staff delivering care in some of our hospitals were either caring or compassionate. The events at Winterbourne view hospital (Department of Health 2012) resulted in criminal prosecutions of care staff and the review of quality of care and treatment at fourteen Hospital trusts in England (Keogh 2013) driven by higher than average mortality rates have all been given extensive media coverage. Allied to the regular dissemination in some of the press of stories about how badly individuals have been treated by the health services in general and by members of the nursing profession in particular nursing has come under scrutiny in the last few years more than I can remember being the case during most of my career.

As a nurse and a teacher of nurses I am dismayed and concerned about the possibility of the people for whom we provide a service ceasing to trust or have faith in my profession to care for them when they are at
their most vulnerable. I am also left wondering whether the skills I help to teach, which mirror those interpersonal activities most closely associated with caring, are actually being transferred into practice. In part this has motivated my research and it has also made me reflect on how nursing is currently viewed by those who have to receive care.

2.2 Perceptions of Nursing

Nursing is one of those professions which has been of interest to researchers for decades (Derbyshire and Gordon 2005) it has inspired curiosity in a way that occupations such as accountancy or physiotherapy for instance never have. This may be because of the iconography associated with nursing, Nightingale and her lamp wandering around the corridors of scutari as described by Longfellow in his poem Santa Filomena for example or it may be due to the omnipresence of nurses in television and film medical dramas. The first of these has left the public with the image of the nurse as an angelic healing caring figure while the latter has, over time, depicted nurses as angels, doctors handmaidens, matronly battleaxes or “sex bombs” (Derbyshire and Gordon 2005). It may be that concern over these stereotypes is what has motivated nurse researchers to try to gauge public perceptions of the profession but it seems more likely to me that people form their impressions of any profession from their actual contact with members of that profession as much as from televisual or film portrayals.

2.2a. Public Perceptions of Nursing and Nurses

The Social Research Institute in its annual poll asking about the public’s views on health and social care (Ipsos Mori 2012) offers some rather disquieting background evidence. In that poll (Ipsos Mori 2012) one thousand and one people were asked about their experiences of the
National Health Service. Some 75% of respondents were satisfied with the experience of their last stay in hospital while only 65% said they were treated with dignity and respect by staff. That a quarter of those polled were less than satisfied and more than a third felt less than respected should be of concern to any healthcare professional, nurses form the largest element of the healthcare workforce and spend more time with patients than any other professional group. When asked to comment in a YouGov poll on National Health Service nursing care 26% of respondents claimed to have had experience of poor care, 47% of respondents said nurses were less caring than they used to be and 41% said they felt nurses were less professional than they used to be (YouGov 2012). Interestingly 61% of those respondents who had a more negative view of nursing care felt that for one reason or another the “new nursing degree programmes” were to blame. Reason for me, and the likes of me, to be concerned perhaps?

In the digital age it seems reasonable that nurse researchers should include the internet as a source of data relating to the public image of nursing which is what Kalisch, Begeny and Nuemann (2007) chose to do. These authors in 2001 carried out a content analysis of 144 websites and in 2004 repeated the exercise analysing 152 websites using the term nursing to retrieve information from the “net”, 93% of the sites were American, 5% were British and the remaining 2% Canadian in origin. (Kalisch et al 2007) The majority of these were either professional nursing or managerial recruitment sites about 10% were designated either “other” or as “entertainment”.

In the main the findings are fairly “mixed” given the focus of many of the sites. 70% of the sites suggested nurses were educated and intelligent, 60% said nurses were committed, respected, competent, trustworthy and accountable while 43% described nursing as scientific. Allusions to caring
are missing from the results and each of the findings above had presented with a reduced percentage figure from the earlier analysis in 2001 (Kalisch et al 2007) The only descriptor which showed a percentage increase between 2001 and 2004 was “nurses are attractive and well groomed”.

In an earlier American study Huffstutler, Stevenson, Mullins, Hackett and Lambert (1998) all nurse educators, asked each of their 277 prenursing degree students to interview 3 members of the public, 831 in total, and put three questions to each person.

The first question “nursing is…?” generated two main themes in the answering. The public described nursing as caring and nurses as helpers of others but they also suggested the profession was subordinate to medicine. The second question “In my opinion nurses are…?” again generated caring as an answer along with patient, compassionate, honest, friendly, sincere and determined. Some people, on the basis of having experienced poor care from nurses said they were unfriendly, unkind, mean and rude. The profession can be judged on the basis of interactions with an individual. Huffstutler et als (1998) third question asked about the most important requirement for becoming a nurse. People said to be a nurse one had to be kind, caring, helping, compassionate, sacrificial and have good social skills.

When nurses are asked about their views of the profession a different picture emerges.

2.2b Nurses perceptions

In an English study Brooke, Andrews, Andrews, Thomas, Wong and Rixon (2004) 592 student nurses and 58 newly qualified nurses by questionnaire and followed up the results with 7 focus groups and a
number of telephone interviews. The study was investigating whether being involved in nursing changed one's perception of it and how. Students said that on the whole their perception of nursing had altered during their involvement with it and generally in a negative manner. For example the students claimed they had underestimated the academic demands that would be placed on them, the responsibility they were expected to take on and the stress caused by long working hours, shortages of staff and the poor prospect of real material reward. The good points identified were to do with satisfaction from looking after people which compensated for some of the negative aspects of nursing and the opportunities available to one when they qualified as a nurse. (Brooke et al 2004).

One finding which has a resonance with the results of the YouGov (2012) poll was that the students felt the training course was too academically focussed and didn’t really prepare them for the reality of nursing work (Brooke et al 2004).

More recently the Royal College of Nursing (2013) carried out its biannual employment survey which generated responses from 9754 members of that organisation. Some of the results make for fairly dispiriting reading. The majority of people who responded worked within the NHS and the results offer an insight into how nurses feel about the profession in that context. The survey revealed that 70% of nurses saw nursing as a rewarding career, and 67% of people said they were enthusiastic about their jobs. The average patient to nurse care ration was reported as eight patients to every nurse and 37% of nurses said they had been harassed or abused by a patient or a relative in the previous twelve months. Only 43% of nurses said they would recommend nursing as a career to anyone else.
The dissatisfaction evident within some of these responses may be partly explained by the perception of low rewards, lack of recognition, shortages of staff and less than sympathetic management support which the survey also records (RCN 2013) but won’t be assuaged by the critical scrutiny nursing is currently under. This is the context within which those I interviewed practice their profession and it will be interesting to see whether any of the factors mentioned here feature in their stories.

2.3 Rationalising a place in the curriculum
2.3a Communication as a nursing staple

The ability to communicate well is seen as essential to anyone working within the helping professions (Moss 2008) and it is important that students have the time and the opportunity “to learn in more detail about communicating in healthcare settings in order to interact as effectively as possible” (Bach and Grant 2009, pg.1). Some authors see it as important to prepare students “to interact and create constructive, communicative relationships with patients” (Rosenburg and Gallo Silver 2007 pg.2) so as to improve the quality of care those patients receive (Mc Ewen and Harris 2010) while others (Ammentorp, Sabroe, Kofoed and Mainz 2011) argue that good communication between patient and healthcare provider is “important for the patients experience of the healthcare service” (Ammentorp, Sabroe, Kofoed and Mainz 2011 pg.270)

2.3b A universal place in the nursing lexicon

Nurses have to be able to relate to patients and their loved ones when these people may be at their most vulnerable or frightened. This means that the nurse has to have the ability to “cope” with interactions which may be emotionally and cognitively challenging and hence the skills which underpin this ability need to be considered when preparing the nurse for professional life.
I have outlined in my introduction the manner in which the terms “communication skills” and “interpersonal skills” are used almost interchangeably within nurse education and have posited the view that the field of counselling has become the focus for identifying the particular skills which student nurses are taught. These skills are held by some nursing theorists to simultaneously represent and underpin the human activity with which nursing is most closely associated, caring.

2.4 The Caring Agenda

Gastmans (1999) puts forward the view that caring in nursing is a moral attitude. This author argues that caring is comprised of internal attitudes and external actions, together the combination results in caring behaviour (Gastmans 1999).

The external actions or skills are easier both to identify and measure and are therefore more likely to be amenable to facilitation. Jerome (2009) identifies the external skills of caring as being those associated with the development of a therapeutic relationship. Listening, showing an interest and helping a person to feel respected and understood would all be expected of the nurse showing a patient he or she cared.

The nursing theorist Jean Watson (1999,2009) argues that caring can only be demonstrated and practiced interpersonally. Caring, according to Watson (1999) consists of ten carative factors which result in the satisfaction of certain human needs. Among these carative factors Watson (1999) includes “sensitivity to oneself and others” (3) “initiating a human care relationship” (4) “expressing positive and negative feelings” (5) and engaging in a “creative problem solving caring process” (6). The fact that
Watsons thinking was influenced by the work of Carl Rogers (1961) has echoes in some of these descriptors.

Caring according to Watson (1999) is complementary to curing, the science of caring is the science of nursing, curing is the focus of the medical model. Other nursing theorists have investigated caring from a behavioural perspective and utilised interpersonal skill indicators in so doing. Larson (2002) developed the CARE Q (Caring Assessment Report Evaluation Q sort) which measures 50 indicators of caring behaviour including (19) “listens to the patient” (27) “when with a patient concentrates only on that patient” and (33) “helps the patient clarify his or her thinking in regard to his or her illness” while Wolf, Devine and Miller (2003) produced the Caring Behaviours Inventory (CBI) which draws on the work of Watson and which focuses on 42 indicators of caring behaviour including (1) “attentively listening to the patient” (13) “being empathetic or identifying with the patient” and (16) “being sensitive to the patient”.

Teaching student nurses counselling skills is synonymous with teaching them some of the skills of caring. According to Tuckett (2005) it is the interpersonal; relationship which makes the difference between nursing and caring.

2.4a Statutory body’s agenda

The NMC (2010) issue guidance as to what should constitute nurse education curricula. Currently such programmes are underpinned by four themes which should be apparent throughout courses and one of these is “communication and interpersonal skills”. (NMC 2010) Each individual training institution has the autonomy to decide how themes are integrated into its programmes which makes it likely that the approaches to the facilitation of individual themes across the whole of nurse education
will not be standardised. The theme identified here, Communication and Interpersonal skills, relates to the interactional abilities nurses will need for their dealings with clients and carers. The NMC (2010) have issued guidance as to what they expect an “adult” (general) nurse to be able to “do”, broadly speaking, after three years training in the form of “essential skills clusters” (NMC 2010) sets of skills essential for nurses. One of these essential skills clusters is related to the area(s) of Care, Compassion and Communication.

2.5 Impact on education

Student nurses have to meet certain learning outcomes congruent with this skills cluster before the end of their training and there are eight such outcomes which reflect competence in these three areas of care. The most pertinent of these to my project here is number six which states; “People can trust the newly registered graduate nurse to engage therapeutically and actively listen to their needs and concerns, responding using skills that are helpful, providing information that is clear, accurate, meaningful and free from jargon “(NMC 2010 pg.110). Specifically the graduate needs to be able to “consistently show the ability to communicate safely and effectively with people, providing guidance for others on how to do so” and “communicate effectively and sensitively in different settings using a range of skills and methods” (NMC 2010 pg.110).

The NMC (2010) are demonstrating that the nurse’s communication and interpersonal skills are an element of nursing practice which they deem important from the perspective of the people receiving that care. It is also evident that they can broadly identify what might be expected from the nurse in order to provide interactions which patients can be satisfied with as part of an overall care package. It is this desire to improve the patient’s perception of the care they receive, as well as public and political
demands for that care to be of an acceptable standard that underpin the next “driver” identified in relation to interpersonal skills training in nursing.

2.6 The Quality Agenda

Perspectives on quality

Quality in relation to healthcare is usually thought of in terms of outcomes of therapeutic intervention (medical or surgical), infection rates, reduced waiting times or any other quantitative measure pertinent to the service the patient receives. More recently it has been accepted that the patients perception of the quality of care he/she has received (customer satisfaction) is just as valid a measure of overall quality as is data related to throughputs and outputs.

The importance of communication between healthcare professional and patient when it comes to the patient’s perception of the quality of care received has been the subject of investigation for nurse researchers and for government. In terms of research for example Otani, Hermann and Kurz (2011) in a survey of American patients using a private hospital system, found that the most important elements of care when judging quality were identified as feeling respected by the nurses and doctors involved and being treated with courtesy, while Shattell (2004) in her review of American literature around the topic of nurse/patient interaction, found that communication from the nursing perspective was a central element of nursing practice and that from the patient’s perspective nurses who had a good degree of interpersonal competence allied to cultural and social insight provided the most satisfactory standards of care.

Within the American healthcare system the body charged with both certifying healthcare institutions and making recommendations about best
practice, the Joint Commission, has identified improving communication among healthcare workers as a “National patient safety goal” (2008). This body maintains a “sentinel event” database which records incidents of harm to patients and identifies what it calls miscommunication as the “primary root cause of sentinel events across all (care) categories” (Krautscheid 2008 pg.1)

Attree (2001) in an English study interviewed 34 medical patients and 7 of their relatives with a view to identifying what they felt constituted good quality care and what they felt led to poor quality care. The poorer quality care indicators were identified as care being routine and being delivered in an impersonal manner by nurses who didn’t seem interested in their patients as people. Good care was identified as being individualized, related to need; patient focussed and delivered by nurses who had developed relationships with their patients and who seemed to care. (Attree 2001).

In another British study Luker, Austin, Caress and Hallett (2000) interviewed 62 members of community nursing teams who were involved in looking after people at the end of their lives or delivering palliative care. These nurses felt that getting to know the patient and their families personally was crucial if they were to deliver good quality of care and satisfy not just their patients, but also themselves, that they had done as much as they could have done for the patients involved.

2.6a Resulting guidelines

In 2012 the National Institute for Health and Clinical Excellence (NICE) published its clinical guidelines paper number 138, which gives detailed advice to healthcare providers on how to “improve the experience of care for people using adult NHS services”. Included in this advice are a number of “quality statements” some of which refer to the interpersonal
relationships between patients and staff (NICE 2012 pg.5) These statements include a focus on concepts reflected in the research noted above, for example; “Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty” as well as “Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills” (NICE 2012 pg5).

2.7 Concerns illustrated

In recent years evidence that nurses may not always be communicating with patients in a manner which suggests either care or compassion has been a cause for concern. The Health Service Ombudsman, Ann Abraham, in 2011 raised the issue of older people being treated less than respectfully by healthcare personnel. She presented ten case studies showing that care offered to older people in particular was lacking in respect and compassion and didn’t involve these people in decision making about the form their care might take (Abraham 2011).

The CQC in their annual review of 2012 offered the argument that many hospital services failed to meet their basic standards of care quality, including having respect for patients and involving them in treatment decisions relating to their care. (CQC 2012). In their analysis of why this might be the CQC (2012) suggested that too many patients with too many complex needs and not enough healthcare resources (including staff) meant it was becoming increasingly difficult to deliver person centred care (CQC 2012 pg.6).

More recently the Report of the Mid Staffordshire Foundation Healthcare Trust Public Inquiry (2013) also known as the “Francis Report” outlined a series of failings in care which were related to a desire by the
management of that trust not to acknowledge errors and failings in patient care because of its needs to meet government targets in order to gain foundation trust status.

A number of patient’s relatives gave evidence to the inquiry alleging shortages of staff, uncaring healthcare professionals, sub-standard care and difficulties in having their concerns heard and recognised by the trust. One witness Julie Bailey, a social worker, described what happened while her mother was a patient at the Mid Staffordshire hospital. Ms Bailey told of how nurses had ignored her mother’s needs, told lies about the care she was receiving and made it obvious that she and her family were unwelcome on the ward where her mother was being cared for after she had raised concerns about the quality of care her mother was receiving. (Mid Staffs. Foundation Trust Public Inquiry 2013). Ms Baileys view of some of the nurses she met as uncaring and lacking in compassion was echoed by other witnesses to the inquiry and as a result its chairman, Lord Francis QC, makes a number of recommendations about the way in which nurses are trained and regulated in his final report. Among these are suggestions that anyone wishing to undertake nurse training should be required to take an aptitude test to check whether they have the necessary compassion to become a healthcare professional, a requirement that all putative nursing students should have practical experience of care work prior to commencing their training in order to ensure they understand the practical nature of the caring role and a recommendation that training be standardised nationally so as to ensure a basic level of ability in every nurse in the competencies identified and demanded by the NMC (2010).

The Department of Health has responded to the recommendations positively. Its “Hard truths” report (DOH 2013) confirms the government will introduce what it terms “values based recruitment” and has already
begun a pilot study wherein a number of prospective student nurses are gaining practical caring experience prior to commencing their training. This will be evaluated and possibly rolled out nationally (DoH 2013). The Department of health takes the view that nurses need to be trained in a manner which ensures care will be kind and compassionate (Hard Truths, pg.93) and is committed to acting on the recommendations made within the Mid Staffordshire Foundation Trust Public Inquiry (2013).

It’s worth remembering at this point however that neither the CQC (2012) nor the Mid Staffordshire Foundation Trust Public Inquiry (2013) wholly blamed nurses or other healthcare professionals for the failings in care they identified. Both the CQC review (2012) and the Mid Staffs Public Inquiry (2013) made the point that the pressure in healthcare to meet government targets or directives of one type or another played some part in creating a culture which allowed poor standards of care to become acceptable and tolerated.

2.7a Reflexive statement.

Throughout my own nursing career I have not come across the lack of caring described in the reports mentioned above. I have witnessed interactions between nurses and patients which could have been conducted differently and which may have resulted in a better outcome for both parties, indeed I’ve been involved in some myself, but these were more due to what Heron (2005) might have termed making an invalid intervention rather than deliberately, or perversely, setting out to offend a person.

As a teacher of nurses I believe that the students I see entering the profession are well intentioned and motivated to do what they can to help others. That belief is reinforced by much of what is known about the
motivations of nurses both students and their qualified colleagues, from research. Caring as a motive for entering and staying within the profession features strongly in much of the literature.

2.7b Motivation to nurse.

Studies from Australia (Dockery and Barns 2005, Newton, Kelly, Kremser, Jolly and Billett 2009, Eley, Eley, Bartello and Rogers-Clark 2012) from Ireland (Mooney, Glacken and O’Brien 2007, America (Prater and McEwen 2006, Gambino 2010) and Britain (Morris-Thompson, Shepherd, Plata and Marks-Maran 2011, RCN 2013) all illustrate that nurses, both students and their qualified counterparts, have caring as a universal intrinsic motivation for their entering nursing.


The “desire to care and help” (Mooney et al 2007), the “opportunity to care” (Eley et al 2012) the “desire to help” and “caring” (Newton et al 2009) and the wish “to do for others” (Prater and McEwen 2006) were the top themes to emerge from the research.


Morris-Thompson et al (2011) conducted 40 focus groups with between 15 and 40 nurses in each, three main themes were identified, one of
which was “privilege”. Nurses felt they were privileged to be able to be with people at times in their lives which were momentous, birth, death, experiencing pain and joy (Morris Thompson et al 2011). A second theme was “fulfilment” which denoted the satisfaction which came with the privilege. Dockery and Barns (2005) surveyed 1884 nurses, 5% of whom were male, using a questionnaire. These nurses valued nursing as “interesting and varied work” as their priority while the female respondents described helping others and working with people as their next two main motivations for staying in nursing. The male respondents differed slightly citing “job security above “helping others” (Dockery and Barns 2005). The study by Gambino (2010) who surveyed 150 nurses and the RCN survey (2013) of 9754 nurses reflected some interesting similarities. Both found that while nurses were committed to providing the best care they could for their patients, Gambino (2010) found that many nurses wanted to move away from bedside nursing which reflects the RCNs (2013) finding in regard to the number of people who would like to leave the profession and both studies (Gambino 2010, RCN 2013) found that nurses felt high nurse-patient ratios, long hours, tiredness, little reward or recognition and staff shortages were the main reason for dissatisfaction with the profession.

Gambino (2010) argued that where the younger qualified nurses in her survey were concerned the idealism they had felt on entering the profession had dissipated over time in contact with care work. She describes this as “reality shock” and suggests that to avoid it nursing education should consider ensuring its prospective entrants are given prenursing experience of care, similar to that proposed by the Mid Staffordshire Foundation Trust Public Inquiry (2013), and that nursing should make renewed attempts to encourage more mature entrants, who might be more likely to want to stay with one employer, into training (Gambino 2010).
Having established the need for communication and interpersonal skills training as part of the nurse’s education the next section of the chapter will focus on the form that training takes and how it is delivered.

2.8 Counselling or Customer care?

Focus in training, a reflexive statement.

In their literature review of communication skills training in nurse education in 2002 Chant, Jenkinson, Randle and Russell identified a number of issues which they described as problematic. One of the anomalies they highlighted was the lack of standardisation in training and teaching methods used to facilitate learning in this area and another related to the differences across training schools in terms of what communication skills were taught (Chant et al 2002). This has a resonance with the desire to see training standardised espoused within the Mid Staffordshire Foundation Trust Public Inquiry (2013)

I have had teaching positions in schools of Nursing in three different higher education institutions and from my own experience I can relate to both of Chant et al’s (2002) findings. It seemed unlikely that this situation would change with nurse educations further integration into the university system due to the autonomy each institution has in designing and developing programmes to meet NMC (2010) proficiencies but the recommendations described above may lead to greater homogeneity in this area.

Ideas posited by Chant et al (2002) in relation to a lack of focus in training on skills such as telephone conversations with relatives, handing over clinical information to colleagues in the health care team and
speaking with certain client groups (the older patient, people utilising sexual health services and those at the end of life for instance) all have a resonance with me. Their discussion of preferred teaching methods (and the lack of concern for students preferred learning methods) is also an issue I have encountered myself. Teaching methods for communication skills include lecturing, discussion, reflection and various forms of role play, but there is little agreement among teachers and facilitators as to how these methods, singularly or in combination might best be utilised. This latter has been compounded somewhat for me by the lack of time which was dedicated within the curriculum to communication and interpersonal skills in each of the institutions I have experience of. In my current post for instance twenty one hours of “contact time” is reserved for learning communication skills within the three year programme. The time, or lack of it, institutions set aside for teaching skills in this area of care is also alluded to in Chant et als (2002) review.

2.8a Training focuses on mechanistic skills

The actual communication skills training provided for nursing students has been labelled “mechanistic” (Hartrick 1997, Kruijver, Kerkstra, Francke, Bensing and Van de Wiel 2000, Salmon and Young 2011) in the sense that it tends to focus on the development of discrete skills such as questioning and reflecting for example (Hartrick 1997, Kruijver et al 2000, Salmon and Young 2011) which students are encouraged to learn through practice repetition allied to peer feedback in role play. Similar concerns were raised by Freshwater and Stickley (2004) who suggested that a focus on emotional intelligence in training might go some way to encouraging a more “relational” approach which allowed students to utilise their own natural abilities to form relationships with patients. Salmon and Young (2011) termed training methods focussed on skills development “reductionist” arguing that holding a conversation could not be atomised into skills in any case. They assert that assessment
in this area of care is a vexed issue because showing one has gained skills is not the same as being able to use those skills in practice and simply having skills does not suggest any compatibility with sincerity which patients and carers value more in any case (Salmon and Young 2011).

Salmon and Young (2011) advocate the use of SEGUE (a 32 item communication skills checklist approved by the American Accreditation Council for Graduate Medical Education) as a means of identifying skills to be taught and for use as an assessment tool (SEGUE stands for Set the stage, Elicit information, Give information, Understand the patients perspective and End the encounter). Stickley (2011) suggests the use in schools of Nursing of what he terms the SURETY model (Sit at an angle, Uncross legs and arms, Relax, Eye contact, Touch and use Your intuition) as a replacement for Egan’s SOLER (Sit squarely, Open posture, Lean forward, Eye contact and Relax) so perhaps a focus on the more mechanistic skills and identifying these via an easily remembered but reductionist acronym is more difficult than these authors might want readers to believe.

2.8b What are the options?

Just now a number of approaches to training can be identified. These range from the use of counselling models as a basis for developing the skills necessary for interacting with patients through encouraging students to use brief ordinary communication skills (as with positive customer care initiatives) to the rather more extreme “scripting” of key words and phrases for use in conversation with patients advocated by the NHS confederation (2008).
Scripting Interactions.

The folk I interviewed had not had training based on the NHS confederations view (2008) that at “key times” (as when breaking bad news or dealing with a complaint perhaps) nurses should be trained to use “key phrases” so as to improve the patients perception of the interaction. This approach rather resembles an attempt to put in place a “pathway” for communicating which is designed to eradicate problems and would, I feel, be resisted by most students anyway. My respondents had received training based on the other two approaches noted above.

**BOE approach**

Brief Ordinary and Effective communication skills are advocated for healthcare personnel in training by Brown, Crawford and Carter (2006). These authors take the view that in health care practitioners such as nurses have little time to spend with individual patients and this precludes the need for training in skills which would be useful in a conversation lasting longer than about five minutes. This view rests on the assertion by Brown et al (2006) that modern life represents a “blip” culture within which lots of interactions occur between lots of people in a very short space of time. They argue that a patient may not see the same doctor or nurse twice and that what is really important is that when the doctor or the nurse interacts with the patient they do so effectively.

Brown et al (2006) recognise that because interaction is going to be brief it has to be effective to ensure patient satisfaction and therefore the best skills for nurses to have and to utilise are ordinary ones such as saying hello, using eye contact and smiling. Training every nurse to be mindful of the need to use these Brief, Ordinary and Effective skills (Brown et al 2006) is probably representative of a good start in terms of ensuring interpersonal competence, whether it will equip nurses to cope with
situations more demanding than passing someone in a corridor has yet to be evaluated.

**Counselling skills approach**

It is probably the likelihood of encountering more demanding interpersonal situations that has led to the inclusion of a focus on models of counselling in nurse education. This “third way” is advocated by the likes of McLeod (2008) who takes the position that many professions, nursing amongst these, have an “embedded counselling role” as part of the professional role. This demands that practitioners regularly have to spend time listening to clients and attempting to help them manage difficulties and according to McLeod (2008) is why nurses need some training in counselling skills. In his paper McLeod makes it clear he believes this training ought to be facilitated by counselling teaching professionals and not nurse teachers as is currently the case. In defence of nurse teachers who facilitate communication and interpersonal skills training, many of those I have worked with have qualifications in and experience of counselling anyway. While a number of models of counselling are drawn on for the training of nurses in communication skills, those which I have seen most often utilised are based on the work of Egan (2011), Heron (2005) and Rogers (1961).

While the above may suggest there isn’t standardisation in training across either institutions or programmes, there is some literature which outlines attempts to evaluate the effectiveness of the training provided. While much of this is focussed on training provided for qualified nurses as part of post registration education (often for nurses working in specialist areas of care such as cancer nursing) there are however examples of work carried out to investigate the efficacy of what’s offered to students.
2.9 Does training work?

The studies mentioned above represent good examples of a literature base which is still developing. Chant et al (2002) wrote following a review of the literature into the communication skills training which was delivered as part of nurse education programmes. Their paper identifies eight separate sets of problems with this element of the nursing curriculum including variability of provision, lack of specific focus on common communication difficulties encountered in practice, too much focus on mechanistic skills, an over reliance on traditional teaching methods and little consideration being given to factors which impacted on communicating well in practice such as social, environmental or hierarchal factors. (Chant et al 2002). The best hope for dealing with the issues identified in the work and improving the communication skills of student nurses according to Chant et al (2002) lies in reducing what they call “the theory practice gap” by making sure teaching is more rooted in and related to practice. This would need a change in the way lecturers work so that they spent more time in practice, remaining aware of the “reality” of nursing work and alongside this Chant et al (2002) suggest encouraging nurses working in practice to engage in teaching in the schools of nursing.

Another paper mentioned above, the study by Kruijver et al (2000) focussed on reviewing literature related to “communication training programmes in nursing care”. These authors reviewed fourteen studies concerned with the delivery and evaluation of communication skills training programmes to both learner and qualified nurses and their findings reflect much of what is outlined by Chant et al (2002). In the main training programmes were between six and twenty four hours duration, focussed on the development of skills which would help the nurses improve interaction and facilitate patients expressing their needs and were based on teaching methods which included lectures, discussion and role play (Kruijver et al 2000).
2.9a Impact on new and experienced trainees

The training reviewed seemed to have less impact on the practice behaviour of more experienced nurses than the learner nurses involved and in only two of the fourteen studies reviewed was there evidence that patient care had improved. This improvement was indicated by nurses displaying better interviewing skills and spending more time listening to patients viewpoints in relation to their experience of illness and treatment for it. One finding from the review which resonates with what Chant et al (2002) asserted about the “theory practice gap” was the perspective related by those undertaking training that the trainers spoke about communication in very general terms and didn’t try to reflect how the skills being considered might be used in specific practice settings. Kruijver et al (2000) argue this perceived failure to synthesise what’s being taught to where it will be used on the part of the trainers represents a significant cause of doubt on the part of learners that the skills might be useful. The thrust of most training according to Kruijver et al (2000) was to inculcate into recipients two sets of skills. These would be represented by instrumental behaviours (those which nurses engage in to convey information to patients about issues such as conditions and prognosis) and affective behaviours or skills which help nurses offer comfort, show respect and develop trust. Again there is some accord between the work of Chant et al (2002) and Kruijver et al (2000) in the sense that both studies suggest trainers find it easier and more fruitful to focus their efforts on altering the instrumental or mechanistic behaviours of learners in their programme, as these are the groups of skills more likely to be more easily transferred into practice.
2.9b Participants view of training

In another evaluative study carried out a little later than those noted above, Arranz, Ulla, Ramos, Rincon and Lopez Fando (2005) conducted a questionnaire based survey of six hundred nurses who had all attended a counselling skills programme they had facilitated. The study was based on a self-report methodology and the main finding was that the nurses questioned felt that the training they’d received left them feeling better able to cope with their work demands in relation to communication (Arranz et al 2005). Exactly what the positive impact of the training looked like isn’t specified in the study (presumably because this would have meant more time consuming qualitative enquiry), but the survey did also show that the nurses felt the training had itself helped with their own ability to reduce their “experienced” work related stress.

While the nurses in Arranz’s et al (2005) study reported some benefits from engaging in training, there is no suggestion in the study that any skills improvement which translated into practice occurred as a result of the programme. Where such improvement has been noted training has usually been combined with a relatively recent phenomenon in general nursing practice, clinical supervision, which I return to below.

2.10 Training methods

The most commonly used methods of facilitation for interpersonal skills training are lecturing and simulation.

2.10 a Simulation

Simulation in one form or another plays a large part in the training strategies utilised within nurse education to help students develop the communication and interpersonal skills for practice (Kutzin 2010). This approach includes role playing with peers, role playing with actors and
can involve making use of information technology and computer generated virtual reality.

In terms of the development of skills in a broader sense Barneuf and Haigh concluded that simulation can be very useful in reducing the theory practice gap as a result of their literature review around the topic of 2012, while Ricketts (2011) suggests that simulation also increases the confidence in the student to carry out the skill being practiced.

There are however caveats, the relationship between practice in a safe environment and learning isn’t as straightforward as one might suppose it to be in relation to developing skills in communicating. For example Krautschied (2008) argued that telling students something wasn’t enough, allowing them to practice in a simulated environment would both help develop confidence and help reduce the theory practice gap. She introduced into her American university a simulation scheme to help nurse/doctor communication. Students were taught how to hand over clinical information to one another using the Situation, Background, Assessment and Recommendations (SBAR ) framework and tested on their achievement of these skills by use of an Objective Structured Clinical Examination (OSCE).

Two hundred and eighty five students underwent training and on examination not quite eighty per cent of these were deemed competent in the use of the framework to pass on clinical information. This, Krautschied (2008) felt was a very positive indication of the efficacy of simulation as a learning method, but she also pointed out that the number of practices needed to be successful on assessment was seven. Repetition of the simulated situation was necessary and resourcing this has implications for educational practice. However not all authors share Krautschied’s (2008) positive view.
2.10b Simulation using actors

Training which involves students working with actors simulating patients has been evaluated in a number of studies with fairly inconclusive results.

Zavertuik, Huff and Munro (2010) discuss one such study from their American university, wherein forty one students were divided into a control group and what they term an “intervention group”, twenty students forming the latter. All of the students attended communication skills training focussed on developing the skills of making introductions, gathering information, imparting information and clarifying or agreeing goals with patients. The “course” consisted of two one hour lectures around these topics which everyone attended, while the intervention group also had an extra ninety minutes of simulation with actors practicing these skills. On assessment Zavertuik et al (2010) found that the twenty students who had experienced the simulation were better at the more complex skills of gathering and imparting information and agreeing goals than the group who had not. There were no differences in the way students from either group managed the more straightforward task of making introductions.

In a Scottish study Pearson and McLafferty (2011) organised a cohort of one hundred and eighty seven third year students into small groups to take part in three hour ward simulation exercises (WSEs) as part of their pre-qualifying management studies. One of the aims of the exercise was to promote what was described as effective communication among other “non-technical and administrative managerial care skills”. In groups of between six and eight the students were asked to manage a simulated ward scenario in a dedicated skills laboratory, working together collaboratively using high tech mannequins as patients to provide a focus for their care. The sessions were evaluated by means of questionnaires the students completed and Pearson and McLafferty (2011) found that
some ninety six per cent of the students felt they communicated with one another very well, or well during the exercise, while eighty seven per cent of the students found the exercise useful for learning generally. Approximately eighty six per cent of the students felt the exercise had enabled them to reflect on their further learning needs and most of these identified “assertiveness” and “confidence” as elements of communicating they believed could be improved. Pearson and McLafferty (2011) concluded that the simulation exercise encouraged reflection in the students and argued that this could lead to further independent study in the area of non-technical skills.

Whereas Zavertuik et al’s (2010) study attempted to show that simulation made a difference to the skills developed by students, the work by Pearson and McLafferty concentrates on the way the students felt about the exercise and what it meant for their development.

Mullan and Kothe (2010) carried out a similar type of evaluative exercise with their students at an Australian university. These authors facilitated a two week course for some two hundred and nine first year students which incorporated lectures, discussions and a formal simulation exercise involving role playing. The two hundred and nine students completed a pre-course questionnaire asking them to comment on their skills and carry out some self-rating in relation to these and seventy four of the students completed a post course questionnaire repeating that exercise after the training. These students reported that they were satisfied with the course and that they felt it had improved their skills. Mullan-and Kothe (2010) found that there was a correlation between the levels of satisfaction students expressed with the course and the impact they felt it had had on their skills, but that there was no correlation between the self-rating of skills improvement and performance in assessment. This raises
a question about the efficacy of students’ judgements regarding their own levels of skill which is illustrated elsewhere in the literature.

2.10c Lecturing

In another American study from 2010 Betcher investigated how students felt about their abilities to communicate with patients who were being treated for cancer. Eight nurses were offered what Betcher (2010) described as an eight hour didactic intervention which included some input on communication via simulation which was videotaped and which led to debriefing and feedback. While there was little alteration in the performance of skills, as a result the students did feel better able to and more confident in portraying a caring attitude as a result of the course.

Weissman (2011) conducted a similarly small scale study looking at the confidence nurses felt in holding therapeutic conversations with people at the end of life. She offered a group of nine students two and a half hours of intervention consisting of viewing and discussing twenty five PowerPoint slides and compared their views about end of life conversations with eight students who did not benefit from the same intervention. Weissman (2011) found no difference between the confidence that those who had received the intervention expressed in their abilities to hold therapeutic conversations and those students who had not received the intervention to do the same thing. She did note however some difference in attitudes between the two groups.

One of the more interesting issues raised in the Weissman (2011) paper for me was her assertion that when she examined American textbooks aimed at student nurses, she found that only two per cent of these textbooks contained a focus on end of life care. Only some eleven per cent of this concerned itself with nurse to patient communication at the end of life.
2.10d Inter Professional Learning

Seargeant, Macleod and Murray (2011) facilitated four workshops for students from twenty different healthcare professions, in all some five hundred and eighteen students attended. The focus of the training was on elements of communication, in particular essential communication skills, delivering difficult messages, dealing with patient and family anger and managing conflict in the workplace. Role play was used to enable practice. On evaluation (which was by questionnaire) 98% of the students said they felt interprofessional learning was useful and particularly so from the point of view of finding out about what other professionals did. 55% of students predictably enough said they didn’t like role play, but most students felt their skills could be improved as a result of taking part in it. The participants were not willing, or did not feel able, to take what they had learned back to their colleagues in practice (as trainers themselves) so the impact for patients was difficult to gauge (Seargeant et al 2011).

Other studies have found that interprofessional learning is generally valued by participants for enabling them to learn more about how other professionals’ work than for enabling them to meet any particular learning outcome.( Priest, Sawyer, Roberts and Rhodes 2005, Reising, Carr, Shea and King 2011)

2.10e Involving service users

In an attempt to increase realism some facilitators have utilised patients or service users in teaching. Costello and Horne (2001) arranged for pre-
registration nursing students to be given three “teaching sessions” by patients within one six week period. The sessions were evaluated by questionnaire and students said they found the experience beneficial in that hearing the service user perspective enhanced their own understanding of what it meant to provide a “quality service” to patients.

Another study which considered classroom teaching by service users, showed that it could impact on the approach nursing students took in assessing the needs of patients. Wood and Wilson Barnett (1999) brought service users into the classroom to help teach students on a mental health nursing course. Half of one cohort was taught by service users during their sixth term and the other half of the same group during their seventh term. During the eighth term students were tested on their skills in mental health needs assessment through being shown a video of a simulated assessment and a questionnaire. The results showed differences between the two groups of students even though both groups had received the same intervention. The students who had received training from service users in term six were better able to show understanding of the impact of symptoms on a person’s life and were more adept at expressing their meanings in lay terms avoiding the use of medical jargon (an indicator of more empathic understanding) than were their colleagues who had received the training in term seven. Wood and Wilson Barnett (1999) suggested that this meant involving service users earlier in training was likely to be more efficacious in bringing about behavioural change than utilising them later.

Repper and Breeze (2007) in their review of the literature on user carer involvement in the education of health care professionals cite Klein’s (1999) study which utilised service users to help with the training of medical students. These third year students were divided into two groups, one of which received some teaching with cancer patients and the other
who received teaching with patients who didn’t share that diagnosis. The group who had worked with the patients who had cancer were found to be more willing, when examined using videotaped recorded simulated interviews, to be collaborative in the way they worked with patients and more likely to understand the patients’ wishes even when these went against accepted medical protocols. Klein (1999 cited by Repper and Breeze 2007) found that after two years when the students who had worked with the cancer patients were followed up in practice, the changes in their attitudes and communication behaviours had been maintained.

Repper and Breeze (2007) conclude from their review that while no work has been done which shows how involving service users in training (through simulation or other methods) impacts positively on the practice of professionals, there are benefits which accrue from this approach. Students who are trained by service users are judged to be more empathic and able to understand the needs and experiences of patients by the service users who helped to train them. The other benefit, from a communication skills point of view, identified by Repper and Breeze (2007) from involving service users in the education of healthcare students related to the highlighting to those students by service users of the importance of interpersonal skills rather than technical abilities.

2.10f The future?

Information technology is likely to play a larger part in simulated learning in the future. In one recent study Ambersold, Tachannen, Stephens Anderson and Lei (2012) trialled “second life”, a virtual environment. Fifteen students delivered a scripted performance as avatar participants in a nursing scenario. Students not involved in the exercise as avatars could follow the avatar interactions on a projector screen and evaluate how these worked and whether they could be improved. Students felt the “second life” environment represented a very positive means of learning
about nursing procedures and encouraged reflection on ones virtual performance but they also felt the exercise was a bit like “gaming” (Ambersold et al 2012) This technology has the potential to relieve pressures on other facilitation resources (skills labs for example) and is relatively inexpensive to access, I feel it will play an increasing role in facilitation in the future. Ambersold et al (2012) suggest the approach is ideal for students who have grown up with computer technology.

2.11 Variables which impact on efficacy of training

2.11a Supervision

In the same year as the Arranz et al study, Heaven, Clegg and McGuire (2005) carried out a randomised control trial which found that where supervision formed part of the training package, the participants in the training programme felt better able to deal with client concerns and worries than did those who had undertaken a training programme which didn’t include the supervision element. These authors (Heaven et al 2005) facilitated a three day training programme in communication skills and half the participants were offered supervision to discuss their practice over the four week period following the course. The format used was “one to one” and sessions lasted for a period of one hour. Those offered supervision felt it gave them the opportunity to both discuss practical issues and remain focussed on the manner in which they related to patients. The group which were not offered the supervision felt less able and less confident to implement the same skills in practice. Though the course focus was on responding to client concerns and the supervised cohort felt better able to do this in practice, Heaven et al (2005) found that neither those who had received supervision, nor those from the other half of the group who had not, became any better able to “pick up” on or recognise “cues” from patients who wanted to converse about issues distressing them. This might suggest that it is the instrumental (or mechanistic) skills of communication which are most likely to be
considered important by students undertaking courses, or perhaps that the affective or more facilitative skills are regarded as more “difficult” to integrate into practice.

2.11b Failure to access supervision.

Supervision as offered by Heaven et al (2005) would allow nurses to reflect on their practice in a “safe” non judgmental forum. They would have the opportunity to discuss concerns and anxieties, seek advice and gain reassurance in relation to the way they work. The Department of Health (1997) and the NMC (2008) have both supported the regular provision of clinical supervision for nurses but many of the “adult” (general) nurses I know do not have access to this outlet. One study by the Northern Irish practice and education council for Nursing and Midwifery (NIPEC) carried out in 2006 suggested that 65% of general nurses had no experience of accessing supervision as part of their practice. Even where supervision is made available nurses may not choose to access it and expose their practice to scrutiny, no matter how gentle or well intentioned. Kolvik, Hyrkas and Saavinen (2011) studied uptake of supervision where it was made available and found that only 31% of nurses who could have accessed it chose to.

2.11c The theory practice gap

Difficulty in integrating skills into practice is a theme which seems to run right through the literature related to training and Kruijver et al (2000) identified this as one “variable” which couldn’t be controlled by those putting on training programmes. Kruijver et al (2000) took the position that nurses may not be able to rationalise how what they are taught in school actually synthesises with practice. The most obvious strategy for eliminating this variable was utilised by Wilkinson, Leliopoulos, Gambles and Roberts (2003) who offered nurses working with cancer patients the
opportunity to identify the practice problems they faced and used these as the basis for simulated situations on a three day communication skills course they facilitated. This seemingly encouraged participants to value how the skills taught could be useful in communicating therapeutically with their clients, but Redley (2010) offers a different perspective on the reasons for skills taught on courses not being transferred into practice. This author studied the skills used by nurses involved in assessing the needs of clients who had self-harmed. Findings suggested that the clients’ stories about what had led them to harm themselves, or why they had acted the way they had, were either ignored or “cut short” by the nurses interviewing them.

2.11d Healthcare workers desire for control

Redley (2010) offers an interesting analysis of why this might be. He cites two main reasons relating to clinicians which are responsible for this inability to use in practice affective or more facilitative communication skills. One is related to the clinicians need to “manage” the encounter in a professional manner and the other is concerned with the professionals need to maintain an emotional distance between the client and themselves in order to achieve the overriding aim of “interaction management”. This suggests that the clinicians involved were not failing to recognise cues as Heaven et al (2005) assert, but were looking to direct the interactions because the cues offered were likely to lead them into conversations they felt ill equipped to deal with (Redley 2010). This may indicate another variable which the training process cannot control, fear or anxiety on the part of the professional in regard to whether their skills will “work”, understandable enough perhaps when their interactions involve conversations with people who have tried to kill themselves.

The alternative to supervision as a means of encouraging longer term change in nurses communication practices is probably on-going training in
the form of what Sheldon (2005) called “consolidation workshops” (Sheldon 2005 pg.310) effectively update sessions following longer courses. This author reviewed twenty one communication skills courses aimed at helping cancer care nurses develop their skills in therapeutic communication and concluded that any intervention seemed to yield only short term benefit with some skills seemingly more easily transferred into practice than others. Sheldon (2005) suggested that the fairly mechanistic skill of using open ended questions was one which most programmes encouraged nurses to use in practice up to six months after the end of such a course, by which time most of the other skills taught were no longer part of most nurses’ communication repertoire.

2.12 Skills in practice

That more mechanistic (Chant et al 2002) or instrumental (Kruijver et al 2000) skills are the ones which more easily transfer into practice is reinforced by much of the literature available which is focussed on the embedded counselling role of the nurse (McLeod 2008).

McLeod and McLeod (2011) assert that the counselling nurses engage in cannot reflect the counselling one might expect in a therapy room. The context is different, the environment is different, and what is expected of the counsellor (the nurse) will also be different (McLeod and McLeod 2011). The nurse working on a ward is going to have to find the time to talk, work out whether some form of counselling is what is required and then make a shift from the nursing role to the counselling role. (McLeod and McLeod 2011) because often for a nurse on a ward the opportunity to listen comes along when one is carrying out another more clinical task (Fleisher, Berg, Zimmermann, Wuste and Pehrens 2009). Most counselling interactions are aimed at influencing in some way the health status or the state of well being of the patient (Fleischer et al 2009) and
these interactions are likely to be more instrumental in nature (Kruijver et al 2000, Williams and Gossett 2001). Given that McLeod and McLeod (2011) include “giving advice”, “providing information” and “clarifying and ensuring understanding” as skills needed in the role of embedded counsellor (McLeod and McLeod 2011 pg.44) this seems reasonable and if one accepts Scheiner and Knipfers (2006) proposition that the nurse has to respond to what the patient wants, almost inevitable. Skilbeck and Payne (2003) argue that most patients have an understanding of what they want from an interaction and that the nurses role is to respond to that. Conversations are contextual, they develop between two parties and it would be wrong if the nurse were to try to dictate the direction they took, which as Redley (2010) suggests, some try to do.

2.12a Skills most often used.

Information Giving appears to be one of the most commonly cited counselling skills used by nurses. According to McLeod and McLeod (2011) providing information is a normative part of the embedded counselling role and this is confirmed by studies from various parts of the world which take into account differing care contexts and varying patient conditions. Towers and Diffley (2011) describe the work of nurse counsellors who see patients undergoing cancer treatments at a major London hospital. These practitioners are trained as nurse and as counsellors and can provide a specialist counselling service to folk living with cancer and their families.

While the nurse counsellors within this team can offer a range of therapeutic approaches to suit varying patient needs their main focus is on providing support and problem solving (Towers and Diffley 2011). One of the support strategies used is the provision of “information prescriptions” for individual patients. This enables sharing of safe, appropriate and useful information about conditions, treatment options
and alternatives to those needing support at a difficult and sometimes frightening period in their lives. The service is well evaluated by those who use it with patients suggesting it is less threatening to be able to obtain support from nurses within the cancer care team than it would be to see a mental health professional which might be the alternative. (Towers and Diffley (2011).

Most nurses are not qualified as counsellors however and the support strategies they use are accordingly more limited but the provision of information is a constant in the literature. In the field of cancer care where one might expect nurses to have to engage in quite difficult conversations on a regular basis information giving as a counselling strategy is highlighted in studies by Peereboom and Coyle (2012), McLennan, Lasiter, Miller, Amlin, Chemness and Helft (2012) and Zamanzadeh, Azizzadeh, Rahmani and Valizadeh 92010).

Peereboom and Coyle (2012) put forward a strategy aimed at guiding nurses through end of life decision making conversations. They argue the nurse needs to engage in an “ask-tell-ask” type of interaction with the patient to ascertain what the patient knows or feels about the situation he/she is in and work to ensure there is mutual understanding of this through hearing what the patient has to say and offering information to deepen understanding or promote insights (Peereboom and Coyle 2012). McLennan et al (2011) tape recorded the interactions 27 nurses had with patients with cancer and carried out a content analysis of the data collected.

Nurse in this study showed a willingness to listen to what patients wanted to say, a desire to act as an advocate for the patient or work as a mediator between patient and medical staff to clarify the patient’s wishes and ensure these were met and an ability to provide information which
would empower the patient in decision making (McLennan 2012). Similar feelings were evident in a study by Johanson and Lindahl (2011) who carried out narrative research with 8 nurses who worked on medical and surgical wards with patients who had palliative care needs. These nurses spoke about the privilege of being able to assist people who were nearing the end of their lives and the feelings of satisfaction which accrued from being able to make a difference at this time. One of the strategies utilised to ensure patients actually had the opportunity to make decisions about their care was to make time to listen to them and ensure they were made aware of what options were available to them in terms of care (Johanson and Lindahl 2011).

Ensuring patients were empowered to look after themselves was the focus of a randomised controlled trial by Cebeci and Celik (2006). Working with patients who had undergone surgery to have coronary artery bypass grafts they offered a group of 57 patients a pre discharge programme of counselling and training and compared the results with a group of 52 patients who were offered the usual pre discharge guidance. The pre discharge counselling and training package consisted of education and “tailored” information which was aimed at facilitating patients to self care after discharge.

The patients offered the counselling package experienced less anxiety than those who were given the routine discharge preparation and reported that they felt more confident managing their care without the need to seek expert advice (Cebeci and Celik 2006).

While it seems apparent from the above that nurses are keen to ensure patients have the information necessary to help them make choices about their care a different note is struck by the work of Zamanzadeh et al. (2010). Two hundred patients and 40 nurses were surveyed to ascertain
which nursing behaviours were seen as most important by either group in terms of delivering care to people with cancer. Patients in the survey placed a high premium on being given information and being kept up to date with how their treatment was progressing as well as knowing someone was accessible if they needed anything, whereas the nurses tended to underestimate the importance of this aspect of care to patients (Zamanzadeh et al 2010).

Research into the practice of “public health nurses” (those nurses whose main focus involves health promotion) shows, perhaps predictably, many rely on their ability to provide information and offer advice in an accessible and respectful manner to impact on the health behaviour of their patients.(McLeod and McLeod 2011). In areas of nursing such as “nutrition counselling” in mother and baby clinics (Limonen, Isolanvi and Laitinen 2012), dietary counselling for the overweight (Magnusson, Kjellgren and Winkvist 2012),counselling to aid smoking cessation (Wilson, Fitzsimons, Bradbury and Elborn 2006) counselling to aid smoking cessation where the person has advanced lung disease ,though the authors argue this has to have a more confrontational tone ( Korz, Wesseling Huibens, West and Van Schayck 2008) and counselling aimed at reducing alcohol consumption (Geirson, Bendtsen and Spok 2005) These two skills form the foundation of nursing practice.

A literature review for the Cochrane collaboration considering “person centred approaches in clinical consultations” (Dwamena, Holmes Ravner, Gaulden, Jorgenson, Sadigh, Sikorski, Lewin, Smith, Coffey and Olumu 2012) reiterates the point. Information about illness and treatment options is highly valued by patients .They want it to be delivered by someone who shows a genuine interest in them as a person and not simply as a disease and who attempts to understand their point of view (Dwamena et al 2012)
The assertions of Dwamena et al (2012) reflect the demands made by patients, statutory bodies, government and nurse education. I have considered each of these in this chapter.

I have made an attempt to illustrate how the training of nurses seeks to equip them with the skills Dwamena et al (2012) describe and have offered an insight into how this is transferred into practice, mainly in the form of instrumental communication skills. Different approaches to gaining information have been illustrated within this chapter and in the next I seek to outline my own strategy for identifying what students take into practice from the communication skills training they receive. My hope is that the reader will find my assertions coherent and plausible.
CHAPTER THREE
METHODOLOGY

Preamble

Research is about “truth”, about identifying “what is”, the means by which conclusions are arrived at, or by which “facts” are established, must be transparent and easily understandable or accessible to any audience the research might reach.

Some schools of thought in counselling suggest that some people avoid any focus on their emotions or feelings by ‘intellectualising’ and over analysing experiences they might have had. (Golche 2002). More recently Egan (2011), one of the bestselling authors in the world of counselling, has reiterated the need for a listener to be able to identify the blind spots in the story they are hearing – to listen for what is not being said or for what is being “covered up”.

It is not surprising then, that as a counsellor coming to research, I wonder if some writers are tempted, in an effort to give their work a scientific gloss and increase its credibility, to over egg the methodological pudding – describing their approach to research in an over complex manner which casts a mystique which has to be ‘overcome’ by a reader.

Here in setting out my own approach to making sense of the stories told to me, I have tried to remain conscious of the need to be clear about how and why I have used the methods I have chosen. I try to set out what it was I did to collect data, how I have tried to ensure that the data represents a true and accurate account which the “story teller” is happy to see analysed and the process by which that analysis was carried out. I will try to illustrate clearly the means by which conclusions were reached and offer rationales for these.
The academic nature of this enterprise demands that the language used to achieve the above reflects that which might be found in any similar thesis; my aim is to use this language to facilitate rather than to obscure the reader’s understanding of the research process I went through. I have tried to utilise a narrative writing style here as this can enhance both the relevance and the accessibility of the “science” I am engaging in. My hope is that it should more clearly connect my own personal ideas to and with ideas from that “science”. (Avraamidou and Osborne 2009).

While there is some risk in this approach I feel it more likely to allow me to be clear and fairly succinct in delivering my message and it should, at the very least, help me avoid using what Sword (2009) referred to as “the impenetrable impersonal prose which has become the trademark of writing in the social sciences” (Sword 2009 pg.319).

3.1 Narrative Enquiry as an approach

Narrative enquiry is the term used to describe narrative research. A narrative is a story, the truism is that everybody has one and a narrative researcher seeks to collect stories and conduct an analysis of one type or another on these. (Holloway and Freshwater 2007).

Narrative enquiry in nursing is a relatively new concept and the term has only been used in the Cumulative index to Nursing and Allied Health Literature (CINAHL) since 1997 (Ingmor, Ohlen and Berghorn 2000) but as an approach it is underpinned by sound ‘scientific’ principles. For example it is linked to the naturalistic paradigm. A paradigm according to Polit and Beck (2004) is “a world view, a general perspective on the real world” (Polit and Beck 2004 pg 13).

According to these authors there are two main paradigms which relate to ‘nursing research’, and accordingly to research into any other area of life,
the positivist paradigm and the naturalistic paradigm. Positivism emphasises the rational and the scientific. The ontological assumption (statement about the nature of reality) which underpins this view is the reality of the studied and known. The ‘world’ is an objective reality independent of human involvement or observation and every ‘event’ has a cause.

Researchers working from a positivist perspective seek to understand the underlying causes of natural phenomena and believe this is best done as objectively as possible. This belief in rationalism and science is related to the modernist movement of the 17th and 18th centuries and reflects an epistemological view, (the way in which the researcher is related to the researched) that suggests researchers can be ‘independent’ and not influence that which is researched.

The naturalistic paradigm serves as a counterbalancing view to this approach and as the theoretical base for this perspective is more recent it is known as postmodern. (Polit and Beck 2004). Epistemologically the researcher relates to and interacts with the researched and the results are an artefact of this interactive process. Ontologically reality is subjective within the naturalistic paradigm and constructed, mentally, by individuals.

This ‘traditional’ bifurcation of paradigms is not accepted by Munro-Hendry who asserts that it is socially constructed (2010). She feels that the on-going view of interpretive approaches as ‘new’ is incorrect and damaging to science. Narrative research for Munro-Hendry is the oldest form of inquiry (2010) and because of the information stories yield about the physical symbolic and metaphysical aspect of human life she sees it as straddling any methodological or paradigmatic divide. The separation of views about types of research is seen as divisive and reinforcing what Munro-Hendry (2010) calls methodological zealotry when researchers
would benefit from a deeper understanding of “epistemological diversity and complexity as a way to strengthen research”, particularly science (Munro-Hendry 2010 pg. 72).

3.1a Why Narrative enquiry?

In the case of narrative enquiry the researcher seeks to access information about a phenomenon and the easiest – most normal – means of achieving this is interaction with people who have direct experience of that phenomenon. The narratives are developed from memories of personal experiences and, as such, represent a valid means of illustrating the perspectives of the narrators. This is perhaps best encapsulated in the definition of the method offered by two authors long associated with its development.

“People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Narrative inquiry, the study of experience as story then is first and foremost a way of thinking about experience. Narrative inquiry as a methodology entails a view of the phenomenon. To use narrative inquiry methodology is to adopt a particular view of experience as phenomenon under study.” (Connelly and Clandinin 2006 pg. 477).

Narrative enquiry is one genre within a range of qualitative approaches to research. By qualitative research I am referring to what Denzin and Lincoln (2005) called in their “initial generic definition” (pg. 3) “a situated activity that locates the observer in the world. It consists of a set of interpretive material practices that make the world visible. These practices transform the world; they turn the world into a series of
representations including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level qualitative research involves an interpretive naturalistic approach to the world; which means that the qualitative researcher studies things in their natural settings attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them”. (Denzin and Lincoln (2005) pg.3). The definition is lengthy, but I felt it worth quoting in full.

3.1b A pragmatic approach to data collection

I view narrative enquiry as the most pragmatic approach to data collection that I might have adopted. Hearing nurses telling of how they actually communicate with patients and carers, in story form, offers I feel as a teacher the best means of illustrating what Armitage (2000) termed the “humanly relevant application of learning”.

As an approach to research narrative enquiry is viewed in the same pragmatic manner by a number of those theorists who write about it (Bruner 1986, Bruner 1996, Polkinghorne 1995, Clandinin and Connelly 2000, Connelly and Clandinin 2006 and Clandinin and Rosiek 2006). Each of these authors view a narrative as being representative of the thinking of the person telling the story and thus as a means of the narrator illustrating to the listener how he or she understands and represents the world.

Bruner (1986) and Polkinghorne (1995) posit the view that a narrative actually represents a way of thinking. Bruner (1986) asserts that people think in two modes, the paradigmatic and the narrative. In the paradigmatic mode one engages in the sort of empirical reasoning which underpins for example putting forward an argument. The narrative mode of thinking on the other hand provides a different order of insight for a
listener which is based on both thoughts and feelings (Bruner 1986) For Polkinghorne (1995) “narrative knowing” focuses on the personal, the specific and the particular and these dimensions of experience are expressed through a story.

Bruner (1986) Polkinghorne (1995) Connelly and Clandinin (2006) Clandinin and Rosiek (2006) and Kramp (2010) share this view that narrative represents a way of knowing. Narrative is seen as part of the human beings cognitive repertoire and is something we are automatically able to engage in from an early age. There is no formal education in story telling yet everyone can do it. Bruner (1991) combined the notions of the narrative mode of thinking and storytelling as an activity in his assertion that stories are the most universal means of organising and articulating experience, being able to offer a narrative is a conventional form of behaviour which is culturally transmitted. The inability to either tell or understand a story is medically termed dysnarrativia and is noted as a symptom of neurological conditions such as dementia. Being able to deliver a narrative is a normative human ability and so to ask a participant in a research study to do this is simply to ask for something “everyday”.

The narrative researcher has the responsibility of interpreting the meaning of the experience illustrated within the narrative and is perhaps best placed to do this if he/she has some insight into the context of the story teller. As someone with a nursing background who is also a teacher and a counsellor I should be well placed to make as accurate an interpretation of the stories I am told, in relation to their counselling skills content, as anyone. I am certainly in a good position to judge whether those stories have the quality of verisimilitude (realism or “ring” of truthfulness) which is according to Bruner (1996) the most that can be demanded from personal qualitative data.
The term verisimilitude raises the question of whether narratives may be trusted as either proof or truth. This is an issue considered by narrative theorists. (Polkinghorne 1995, Bruner 1996 Clandinin and Connelly 2000, Connelly and Clandinin 2008 and Clandinin and Rosiek 2006) and in the main their assertions about the worth of narrative data rest on what Clandinin and Rosiek (2006) summarize as the pragmatic ontology of experience. This term derives from the work of Dewey (1976) and his consideration of the nature and the value of experience and in essence the suggestion is that experience is important, the only way to find out about experience is to ask and the person asked has to use narrative to provide their answer. There is no other and no better means of ascertaining a person’s understanding of his/her own experience.

Dewey (1976) proposes that experience is the fundamental ontological category from which all forms of enquiry, narrative or otherwise, proceed. The person interacts with his or her environment in a conscious and reflective manner which results in an ongoing change in the knowledge that the person has about the “world”. Knowledge arises from experience and is validated by the persons constant returning to experience. Dewey (1976) argued that this meant knowledge developed and changed over time, it has a temporal quality, and thus any single representation of knowledge (as with the narratives I am collecting) is always going to be selective. Narrative theorists (Polkinghorne 1995, Bruner 1996, Clandinin and Connelly 2000, Connelly and Clandinin 2006, and Clandinin and Rosiek 2006) all accept the pragmatic argument made by Dewey (1976) asserting that lived experience is something which has to be taken seriously. It is a source of important knowledge and understanding. When one takes into account the fact that experience will alter knowledge the obvious implication for my project here is that this work can only represent a snapshot of which counselling skills are present in those
stories told to me at this time. Another enquirer at some point in the future would be likely to hear stories which illustrate skills discovered, tested and developed through experience in the intervening period.

Temporality or the passing of time is not the only factor which shapes experience. Connelly and Clandinin (2006) highlight the impact two other “commonplaces”, sociality and place, have on the concept. These two notions one of which relates to interaction with other people and the other the context within which that interaction occurs both have an influence on how a person gains and interprets experience. The nurses I am collecting narratives from provide a service to other people, often very sick people. They do this in conjunction with others who have similar professional value systems to themselves in places described by one of my respondents as being “scary”.

The peculiarities of this social context might represent a challenge to some researchers in terms of understanding the experiences illustrated in the narratives the nurses offered but for me again by reason of my own experiences, they make it more likely I should be able to recognise the verisimilitude (Bruner 1996) of what I am told.

Clandinin and Rosiek (2006) take the view that these factors which contribute to the shaping of experience and therefore the narrative may themselves become the focus of study by the narrative enquirer. These authors (Clandinin and Rosiek 2006) suggest “…narratives don’t just reflect the individuals experience they allow for enquiry into the social, cultural and institutional narratives within which individuals experiences are constituted, shaped expressed and enacted. Narrative enquirers study the individuals experience in the world an experience that is storied both in the living and the telling and which can be studied by listening,
observing, living alongside another and by writing and interpreting texts” (Clandinin and Rosiek 2006 pgs.42-43).

My own project seeks to try to interpret narratives for only one element of experience. As an approach to research narrative enquiry could allow for consideration of so much more that is highlighted within these stories. The scope of my task here doesn’t allow for such a wide ranging reading of the narratives but utilising this pragmatic methodology has opened my mind to research possibilities for the future.

3.1c Other Possible Approaches?

There are a number of ways in which the above could be achieved and perhaps I need to explain why I chose Narrative Enquiry as my own method of investigation as opposed to for example Grounded Theory or Interpretative Phenomenological Analysis (IPA).

IPA is described as a research approach which allows for the interviewees views on his/her lived experience to be investigated (Reid, Flowers and Larkin 2005, Biggerstaff and Thompson 2008). It is used for instance, to gain service user views about their own experiences of illness or their own experience of healthcare interventions in relation to that illness (Fade 2004). It is an inductive and idiographic approach as is Narrative enquiry and the analytical processes which are applied to data are very similar in both methods. I chose not to utilise IPA because the phenomena under investigation have to form the focus of the interview (in an overt manner) and because I am interested in whether nurses use of counselling skills is evident in the stories they tell about their practice; I felt concentrating on the interviewees experience of using these skills to the exclusion of all else would not have helped in answering the question I am asking. Etherington (2004) suggests that research has to be carried out in a manner which answers the question one is interested in asking, a view
which mirrors Patton’s (1990) assertion that the research question will suggest the method the researcher chooses to answer it as well as Lennie and West’s (2010) equally pragmatic argument that when considering methodology the practitioner researcher has to be mindful of the nature of what’s under investigation, what he/she (I) wishes to know and how he/she (I) wish to know it.

Grounded Theory is useful for the development of theory and the “reverse engineering” of hypotheses (Glaser and Strauss 1967, Glaser 2002). The data collection methods and the processes of analysis used are similar to those which are associated with Narrative enquiry and again the approach is inductive, but the underlying purpose is very different to my own approach. I do not seek to generate a theory, I am not looking to make a statement about whether nurses use counselling skills effectively in their practice or not. I am aiming to evaluate whether there is evidence in the stories they tell about their practice to suggest nurse’s use the counselling skills they are taught.

Through conducting a series of interviews and facilitating nurses in telling stories about interactions with clients and carers, I hope to gain an insight into and create a representation of how these nurses use counselling skills in everyday interactions with clients and carers.

3.2 The Process

As I note above I take the view espoused by Sandelowski (2000), that narratives or stories may be analysed for ‘themes’ or elements of commonality with other stories from similar subjects in similar circumstances. She calls this type of enquiry ‘naturalistic’ in that there may not be too many other ways of finding out what one wants to know and uses the term ‘qualitative’ description to describe the end product of this analysis (Sandelowski 2000).
Overcash (2004) suggests that thematic analysis is a method commonly utilised to identify concepts which are emphasised in the data. This emphasis has three points of reference, Recurrence, Repetition and Forcefulness (Overcash 2004). Recurrence reflects the fact that the same point may be made more than once in a narrative, perhaps in slightly different wording or phraseology. Repetition is present when the same point is emphasised using the same wording or phrases and forcefulness reflects this quality alongside emphasis carried in the paralinguistic communication of the narrator. Polkinghorne (2005) separates analysis of the narrative from analysis of what is in it. He argues that the story itself may be analysed from a range of perspectives, or so as to identify what is implicit, but may be consciously unspoken within it. This latter he terms paradigmatic analysis (Polkinghorne 2005).

Ku Lai (2010), uses the term “socio-structural analysis” to describe what she calls examining the ‘facts’ in a story. She argues this is similar to paradigmatic analysis (Polkinghorne 2005) in that the researcher seeks to decode, recognise, recontextualise and abstract the data in a story (Ku Lai 2010) and I draw on these ideas in examining the narratives I have collected to identify skills not overtly described as such by my narrators. Thus, theorizing about and analysing the content of narratives for ‘themes’ is an accepted form of narrative enquiry and indeed thematic, or content analysis, is common to many forms of qualitative research.

Sandelowski (2000, 2001, 2010) posits the view that many qualitative healthcare researchers spend too much time and energy in arguing that their methods represent a form of grounded theory, phenomenology or ethnography, when their findings show no evidence that these methodologies were in fact used. This is a view shared by Neergaard,
Olesen, Anderson and Sondergaart (2009) who call this attempt to relate work to a particular approach “methodological acrobatics”.

One of the benefits of using the qualitative descriptive method was that it allowed me to offer an interpretation of the data I had gathered which was as close to that data or “data near” (Sandelowski and Borroso 2007) as possible.

Utilising this method means that my findings can be criticised possibly for remaining ‘surface’ rather than “penetrating” (superficial rather than deep?), but on the other hand what I have done and what I have found as a result are transparent. There is no transformation of what is essentially a thematic evaluation into arguments about what is actually ‘going on’ under the surface with individual narrators, nor are there interpretations of what people really meant.

3.2a Reinforcing Reliability

The above does not mean that in adopting a qualitative description approach to analysis here that I have abandoned any responsibility to interpret or analyze the data. Simply presenting data in snatches, verbatim from an interview, may allow a reader to form an opinion about what he or she is seeing, but on the basis that data does not speak for itself (Neergaard et al 2009), as a researcher I have a duty to clarify or contextualise the views expressed by those who provide that data. This has been done with reference to theory from communication frameworks as clearly and as concretely as possible.

Thematic content analysis is not the only approach one could take to analysing narrative data. Reissman (2006) identifies what amounts to a “typology” of approaches to narrative enquiry which includes Thematic,
Structural, Interactional and Performance analysis. Here I am drawing on elements of thematic analysis applied to narrative.

Elliott (2005) in describing the forms that narrative enquiry can take includes in her typology “content analysis”. I have already laid claim to using this as the basis of my own interpretation of the methodology here. Other authors have described “holistic” analysis as an approach (Holloway and Freshwater 2007, Elliott 2005) while Holloway and Freshwater (2007) also suggest that the researcher needs to be aware of the impact on their analysis of concepts such as “sjuzet” and “verisimilitude”! The first of these relates to the manner in which a narrator re-arranges the chronology of events in a story so that some parts might take longer to “cover” than others, whilst the latter indicates the need for the story to sound “textually coherent” and “contextually congruent”.

This representation – the story – once it is ‘out’ - is open to interpretation or analysis and as someone with an insider’s knowledge of the world of these nurses, I felt able to interpret what these stories meant in terms of the use of counselling skills for a wider audience. The naturalistic quality of the research lies in the belief that it could not have been conducted in any other manner without my becoming very obvious and maybe invasive. For example, if I had taken an ethnographic approach (through participant or non-participant observation perhaps) to finding out how nurses interact with clients and carers in practice – the resulting story – arguably – would be mine as a researcher.

Using narrative enquiry as an initial means of “getting a picture” of the nurse’s view on how he or she uses counselling skills in practice, represents a “safe” exploratory strategy and in taking this path I hope that the stories illustrated are the practitioner’s – not the researcher’s.
3.2b Verifying thematic analysis

Because qualitative research involves interpretive practices (Denzin and Lincoln (2005)) and the interpretation is mine, I have utilised what Bruner (1991) called a hermeneutic circle in analysing the stories or narratives I have collected. This means that I have invited the narrator of the story and a colleague familiar with communication skills framework used in nursing, along with my supervisor, to form a “hermeneutic circle”. In this way people will read the transcripts of the interviews I conducted and my own analysis of these so as to ‘check’ that any themes I identify “ring true”.

A very similar approach to this hermeneutic circle is that of “reflecting teams” advocated by Gergen (2000). He argues that as well as the likelihood of ensuring that the researchers data collection and data analysis technique remains valid and reliable, the reflecting teams also serve as a forum for debate and deliberation about the data itself, part of the data analysis process! As an attempt to ensure that my assertions were valid and reliable this approach combined the notion of “member checking” (Lincoln and Guba 1985, Holloway and Freshwater 2007) and that of “peer debriefing” (Polit and Beck 2003). Member checking involves asking the interviewee/narrator to read through the transcript of the interview and my initial analysis of it and offer a view as to the accuracy of the transcript as well as any thought they might have on my interpretation of it. Lincoln and Guba (1985) argued that this is a very important step in establishing the credibility of any qualitative data, but Giorgi (1989) took a different view about the member checking process; he suggests that in asking the interviewee to check a researcher’s interpretation of the material within a transcript, the role of the interviewee as a research participant is being exceeded! From my own perspective asking these qualified nurses to check the transcript and my
interpretation of it helped me to ensure their “safety” as research participants, as much as it helped ensure reliability and validity in my process. This was something I felt ethically compelled to do and I explain why this was so below.

Peer debriefing is described by Polit and Beck (2003) as being a technique which enhances the credibility of an analysis of qualitative data. It means simply that other people, in this case my supervisor and one of my work colleagues, read the transcripts and my analysis of them and were able to agree or disagree with what I found, or at the very least ask me to justify my assertions about the data. Peer debriefing allows for questions about technique of analysis, data interpretation and reflexivity to be asked and should thus contribute to the credibility of the research exercise.

3.2c Reflexivity

Having mentioned the concept of reflexivity above it seems appropriate to describe its relationship to the research process and begin to clarify my own position regarding some of the more obvious factors, (insiderism/out siderism, hierarchical considerations and “closeness” to the topic itself), which the reader might suspect could impact on attempts at ensuring reliability. Reflexivity is seen as a concept which is difficult to define (Hallawell 2006), but which is increasingly demanded of qualitative researchers (West 2001, Finlay 2002, Pillows 2003, Etherington 2004, Van Houghten 2004, Hallawell 2006, Brannick and Coghlan 2007 and West 2009). It should comprise “an analysis of the way in which the researcher and other intersubjective factors affect the research process” (Finlay 2002 pg.210) and according to Pillows (2003) should incorporate a focus on “who I am, who I think I am, what I’ve done and what I feel – from the researcher’s point of view - and how these things might affect data” (pg.176). Essentially, some space must be given over within the project to illustrate my motives, my beliefs and my experiences (in so far
as they relate to the topic) and highlight how I have attempted to ensure these factors have not impacted, in a negative manner, on the process. The authors noted above (West 2001, Finlay 2002, Pillows 2003, Etherington 2004, Van Houghten 2004, Hallawell 2006, Brannick and Coghlan 2007 and West 2009) agree that “self-reflexivity” positions the researcher within the research process and has become part of all qualitative research methodologies.

It is my hope that I have shown reflexivity throughout this work, that is ultimately for the reader to judge, I have certainly attempted to remain “self-aware” throughout the research process and devoting time to the topic of reflexivity here is, for me, about bringing a sense of what Pillows (2003) calls “positional validity” to this enterprise. This could, I am aware, place my inclusion of personal reflection within this chapter as representing what Finlay (2002) termed a rhetorical device to fend off criticism of “unconscious” researcher bias, my true aims are however a little different. Firstly I believe that as an artefact of utilising a qualitative methodology it is right that I should try to articulate what Brannick and Coghlan (2007) called my reflexive awareness and secondly as an act of deconstruction, something I have to engage in anyway as a teacher and a counsellor, this reflection can only aid my development as a researcher as well (Etherington 2004).

3.2d The method and me

Narrative Enquiry was naturally attractive to me as a means of investigating the research topic because as a counsellor I am, as Hiles (2002) puts it, a narrative researcher anyway. I hear stories as part of my work and I have to try to make sense of these both for my own understanding and in partnership with the client telling me the story. Usually the stories I hear are dictated by what’s in the clients mind at the time, or by their need to put into words their “take” on an event or a set
of events which are important for them. This telling to me may represent
the first attempt the client has made to express their feelings about or
thoughts on, the events to anyone. It is both a privilege and a great
responsibility to be trusted by someone in this way and I have to be very
careful not to interpret or judge in any authoritative manner what the
events “should” mean for the client This demands the ability to listen
attentively and to encourage reflection in the story teller without overly
interpreting what’s being said, or unconsciously encouraging someone to
change their account to suit my own understandings of what “should be”.

I felt that these skills would be ideally suited to collecting stories and in
particular in helping me remain mindful that the narratives I collect do
actually belong to the respondents to my request for interviewees. Mair
(1989) used a very evocative term to describe what he saw himself doing
as a psychologist and therapist; he called himself a professional
conversationalist, and in many respects both as a teacher and as a
counsellor I can relate to what that might mean. I am “licensed” to both
listen to and tell stories; I believe that stories (or narratives) make up
most discourse anyway and from my own professional and personal
perspective feel that listening to stories represents the most normative
path to data collection that I could have engaged in.

3.2e The topic and me

Whether nurses use what they’ve been taught in practice is a question
I’ve been concerned about for much of my time as a teacher of nursing. I
have worked (and still work) as a nurse myself and when I reflect on what
I’ve been taught and how this impacts on my own practice, I realise that
it must, but I am only easily able to illustrate how this is so with
examples of skills I have been taught in a very behavioural fashion.
“Hand washing” with its six stage technique and resuscitation with its
“A,B,C” spring readily to mind, but I’m aware I must have applied to my practice more than these two examples of “theory” just to get by as a nurse.

Working mainly as a teacher now, one of the individuals charged with passing on information which should impact on practice, I am curious as to whether people may struggle, as I struggle myself, to relate what they’ve been taught, what I may have taught them indeed, to “reality”. Part of me (the part that’s a teacher) hopes that this curiosity can be satisfied in the affirmative, but the me that’s a nurse suspects it won’t be. The part of me that’s becoming a researcher is conscious that I have to remain aware that I don’t prejudice my enquiry one way or the other; the abilities I have as a counsellor are what I will draw on to underpin this “objectivity”.

My personal interest in the topic would from a positivist perspective raise eyebrows, but from the point of view of authors such as Moustakas (1990) having such a personal interest in and some experience of the topic being researched is a pre-requisite to the “good” qualitative research process. Moustakas (1990) takes the view that research should be seen as heuristic enquiry, heuristic meaning discovery, often by trial and error or experimental means, and that such a “quest” can be more fully engaged with and carried through more passionately and honestly, by someone who starts out with personal experience of the phenomena under consideration. My engagement here is based on the evaluative nature of this exercise. I am interested in whether what I teach has any place in the real world of these nurses and whether this place is illustrated within the stories told to me by practitioners of nursing, some of whom will have been my students.
The “self-dialogue” evidenced here is aimed at illuminating my “frame of reference” in relation to my research interest and is also part of Moustakas’ (1990) heuristic process. Other elements of this model reflect the methodology I’ve used.

Hearing stories for Moustakas might represent “engagement”, reflecting on those stories (as data) could be labelled “immersion” and “explication”, the term Moustakas uses to describe the examining of what comes out of that “immersion” probably reflects my analysis (Moustakas 1990). I have not to my mind conducted a heuristic enquiry however; for example, I lay no claim to pursuing a strategy of what Moustakas (1990) called “incubation”, the deliberate spending of time on activities unrelated to the research process, but remaining mindful enough of the research in that time to “notice” phenomena related to the topic, as these crop up as part of that other activity.

To offer an illustration of what I understand this to mean, I remember one evening listening to local radio, it was about 11pm, I was reading a Stephen King book and the programme on the radio was a “phone in” type show. The presenter took a call from a man who “sounded” middle aged, he “sounded” like he had been drinking and he’d rung in to offer a view about the demise of a nightclub in the area which he had spent time at in his younger days. “Old haunts” and “good nights out” seemed to be the theme for the show and apart from thinking “typical local phone in fodder” I took little real notice until out of the blue the caller told the presenter he had been drinking because that day he had been told he had lung cancer!

The feeling of pathos was instantaneous and my level of interest rose immediately, I became very interested in what the presenter would say, how he would handle this development (he did so very well with patience,
interest and what I’d call a good deal of human understanding) and was aware immediately that this mirrored what I am investigating.

These moments occur for me in the “natural order of things” and I am not certain what they add to the research process. Moustakas (1990) seems to take the view that the heuristic process will impact on the researcher in a developmental way as much as it will help bring about “research”; the researcher will find his/her beliefs changing as part of the research process, and that element of his thinking didn’t, I feel, really apply to my project.

While I am carrying out research WITH people who have stories to tell and while I am able to relate to those stories on an experiential level (I’ve been there myself) I am ultimately analysing the stories as “data”, my research is ON the stories. Using some of Moustakas’ framework here does, I feel, help me to show a degree of what West (2009) called “critical subjectivity” though and also goes some way toward demonstrating I have drawn on different perspectives and ideas to find a method which “works”.

3.2f Me as the researcher

Whereas a closeeness to and a feeling for the research topic is valued by Moustakas (1990), those same qualities would be problematic for other commentators. I have explained that as a nurse I have much in common with my respondents, I have also taught some of them and am based at the same working site as all of them.

These factors for Morse (1999) for example are not “positives”. That author offers the view that “It isn’t wise for an investigator to conduct a qualitative study in a setting where he or she is currently employed or has a work role” (pg. 61). More “personal” interests in a topic can be seen as
being likely to impact on impartiality and objectivity (Brannick and Coghlan 2007) and both views are especially pertinent when one considers the implications of what is termed “insider research” for reliability. Simply put, more objective research is carried out by “outsiders” who can stand outside of the community they are studying and abstract material from the research experience (Burgess 1984). I cannot claim to stand outside of the community I am studying; I am a nurse and have had the same experiences as many of my respondents. For me this in many ways served to equalise the relationship between the participants and myself, made me seem more like “one of them”; I could also relate to and empathise with what I was told and understand it in their context, from the perspective of these factors I am an “insider”.

3.2.g Insiderism / Outsiderism.

For Hallawell (2006) empathy and being able to be seen as an equal are the major benefits to the insider researcher. I am familiar with my respondents as people and with most of their work contexts as a nurse, but most of them know me only as a teacher.

In the health service this doesn’t impact in any hierarchal sense, people who work in education have no line management responsibilities and are not seen as a “boss”, in this sense I pose no “threat”. This does not mean that I am not perceived as different though - an authority of sorts, someone whose status when my respondents were students might have been seen as “high”. In conversations with people about work this can be problematic. Most nurses perceive the existence of a theory practice gap and it could be that my respondents might have been at first apprehensive about telling me how things are “in reality”. I remember being told not long ago by a ward sister (not one I interviewed) that I lived in a “tutorland bubble”. I hadn’t said or done anything to merit this
appraisal; she was just telling me that as a teacher I am in some way insulated from the harsher realities of nursing life. It is known that belief in the existence of this theory practice gap develops throughout training; the view may be typical in fact and for me it represented something which could have had a bigger impact on my research than any notion of hierarchy. The belief that I might only recognise the “ideal” and not the “real” as acceptable was the biggest concern I had to deal with; it seemed to me this is what may have prevented people from speaking freely and my belief is that this is what really marked me as an “outsider” carrying out this research.

3.2h Coping with this dynamic

To counteract this effect I believed I had to make a conscious effort not to “go native” as I felt this could only lead to an increase in the doubts individuals may have had about me and instead take steps to normalise our interactions as much as I could. I invited people to meet with me in the school where I am based, away from their own workplace and at a time convenient to them. This prevented distraction and interruptions and allowed me to give the respondent my full attention. I ensured coffee and Danish pastries were offered and there was always a “chat” as a preamble to the interview starting. These steps to show my efforts to respect people were enough, I found, to put most at ease and allied to the efforts I made to listen, not interpret and not judge what was said, helped mitigate any other factors which could have got “in the way” adequately.

The actual result of my having a pre-established relationship with my respondents was positive in terms of both the interview process and data collection. Knowing those who volunteered to be interviewed by me meant that issues like developing rapport and developing trust with one another were “speeded up” somewhat. There was for instance no need to negotiate what McConnell-Henry, James, Chapman and Francis (2010)
describe as the four phases to developing rapport with participants. These four phases—initial, exploration, co-operation and participation (McConnell et al 2010) are said to be the stages in relationship development a researcher and a respondent would need to go through in order to reach a position where genuine data might be elicited (the phase known as participation) Even though I may not have met a respondent for two or three years prior to this research, it turned out to be the case that in all interviews I was able to begin to collect data almost immediately after ensuring refreshments and visitor comfort had been seen to.

3.3 Sampling

In line with the thinking of Devers and Frankel (2000), I had to consider the characteristics of the specific research subjects I was interested in. This meant deciding on what Mason (2010) calls “selection criteria” and developing a sampling frame (Devers and Frankel 2000).

I sought to interview nurses who worked in a general hospital who had trained between 2000 and 2007 and who had at least three years nursing experience. This meant that my ‘sample’ was drawn from those who had entered nursing while the “Making a Difference” curriculum was being operationalised from 2000, but who had entered training no later than 2007. These nurses would have had no special training in communication skills as would be the case for those students enrolled on mental health nursing courses for example. Describing these characteristics relates to a purposive sampling technique (Mason 2010, Devers and Frankel 2000, Marshall 1996) which is also defined as non-probability sampling. I placed an advertisement on hospital notice boards describing my project and asking for interested people who met the criteria described above to contact me direct for further information.
3.3a Sample size

In her 2005 paper on trustworthiness and reliability in counselling research, Morrow suggests that when one is deciding how many people to interview when using a qualitative methodology “numbers” should not be a primary concern. Her argument (Morrow 2005) is that the researcher should be more concerned with gathering material which is “data rich” and that from her own experience aiming at around twelve interviews is usually enough to assure a representative range of views or experiences in relation to a particular phenomena is collected for analysis. Morrow (2005) illustrates the absence of any consensus within the research community about sample size when she cites Pollio, Henley and Thompson’s (1997) view that any number of interviews between three and five at the least, to hundreds at the most, may need to be carried out in order to show thematic patterns across transcripts. This is compared by the same author (Morrow 2005) to the position advocated by Patton (1990) who she cites as sharing her own view that “validity, meaningfulness and insight have more to do with the richness of the data than the number of respondents” (Patton 1990 pg.151).

Following discussion with the School of Education Research Approval Panel, I limited my sample size to eight participants. There were a number of reasons for this. Narrative enquiry means collecting individual stories from participants – checking my interpretation with the participants and in my case sharing that interpretation with members of a hermeneutic circle. This is time consuming and rendered a large sample impractical for my purposes.

The specific characteristics of my sampling frame (Devers and Frankel 2000) meant that I was not seeking what Mason (2010) calls “heterogeneity” in the participants I spoke with. I do believe that people are individuals with their own unique experiences and interpretations, but
the number of criteria I had set for participants and the extent to which I felt these had to be met, meant that the ‘pool’ within the hospital from which a suitable sample could be drawn was somewhat limited. In addition to the above I was not seeking to generalise my findings to a wider population (Marshall 1996), but rather to gain some insight into the meaning of a particular concept in the working lives of a group of nurses (Mason 2010). This approach to the research question has not been taken before and could possibly illustrate whether a larger study utilising a similar methodology could be worthwhile in terms of adding anything to what is known about the topic under investigation.

I conducted eight interviews on a one to one basis with volunteers prepared to relate their experiences of using counselling skills in practice. Of the eight respondents six were female and two were male. Nursing is still a profession within which the majority of practitioners are female. Only about one in ten nurses is male (Jones 2008) in any case so the preponderance of women in my sample was perhaps to be expected. I have spent my life in nursing interacting with female colleagues so this aspect of the investigation raised no concerns for me.

Each of these interviews was tape recorded with the permission of the participants and each of the recordings generated was transcribed, so that the paper transcript became an artefact amenable to analysis. Each participant had the opportunity to comment on and edit the transcript produced from the interview they took part in. After my initial analysis of the data I met with each of the participants again in order to give them the opportunity to read, evaluate and discuss my interpretation of the transcript as outlined above. The transcripts and my analysis of these as well as the comments of the interviewees were made available to my peer de-briefers, who were able to ensure that my approach to analysis remained consistent and that no bias entered into my dealings with the
data. Above I relate the view of Gergen (2000) that the interaction between the de-briefers and the researcher (reflection team) is itself an analytical experience during which debate about ideas takes place and perspectives on the data can be formed and changed. This is in line with the thinking of Silverman (2005) who asserts that the interchange going on here (within the hermeneutic circle or reflection team) is actually part of the process of data analysis and should be seen as such.

Though these stories are open to more than one interpretation by following analytical guidelines (thematic analysis may be applied to any form of data) and using the hermeneutic circle (Bruner 1991, Kinsella 2006), I have made maximum effort in ensuring my conclusions have reliability and validity (Bruner 1991, Sandelowski 1991, Sandelowski 2010, Ayers and Poirier 1996). Both Bruner (1991) and Sandelowski (1991, 2010) accept that a narrative is a version of reality which “cannot be governed by empirical verification (Bruner 1991 pg 6), because people can lie, or exaggerate, or change information about their actions. The narrative approach though still offers the best means of naturalising the research process (Sandelowski 1991 pg. 162).

3.4 Hearing the stories (Interviewing)

Broadly speaking data is collected via an interview. Narratives are elicited using what Coombes, Allen, Humphrey and Nesle (2009) call “in depth interviewing techniques.” These draw on work by Legard, Keegan and Ward (2003) and a number of ‘benefits’ accruing from this approach are identified. The in depth interview allows for structure to be combined with flexibility. The interviews I conducted reflected this in that they always commenced in a fairly structured manner, but then proceeded at the pace set by the interviewee and in the direction chosen by him/her.
Interviews are obviously interactive and this gives the interviewer the chance to focus conversation on particular aspects of the narrative. In doing so, the interview is likely to lead to ‘new’ knowledge being generated, as the interviewee gets the opportunity to consider avenues of thought he or she may not have explored previously. This learning and ‘reflection’ will depend as much on the ability of the interviewer to use questions, prompts and probes as it does on the memory of the interviewee. For someone with a counselling background this means of collecting research data is probably as congruent as any which exist.

Most approaches to counselling highlight the importance of the relationship between the helper and the helped and the skills needed in initiating and developing a rapport are the same skills which underpin the process being facilitated by the researcher here.

The interviews I conducted were semi-structured in nature (Polit and Beck 2004). This format reflected the fact that while I knew what it was I wanted to ask, I couldn’t be sure of the answers I might get. I prepared a ‘topic guide’ (Polit and Beck 2004) rather than a list of questions and this served to ensure I was mindful of the areas I wanted to cover, but gave the interviewees the chance to speak freely and offer as much information and explanation of it as they wanted.

In steering clear of using a very structured approach to my process, I was mindful both of the need to gain data which was as rich as possible (Holloway and Freshwater 2007), in the sense that it reflected the participants own story; the belief that interviewees prefer to be given the opportunity to speak in an unrestricted manner (Gibson 1996) and my own desire to focus on the topic I was interested in investigating.
Even with the transferability of counselling skills and choice of approach which should suit the interviewee, there are still factors which can impact on the relationship between the researcher and the researched. Narrative enquiry is an approach to research which gives the interviewee a good deal of control in the research relationship, but according to Holloway and Freshwater (2007) the balance of power is still held by the researcher. Trust has to be developed in the relationship before the participant’s vulnerability can be overcome and this means the researcher has to be sensitive to the needs of the interviewee. (Russell and Kelly 2000). In fact these authors argue for the development of an “I and Thou” relationship (Buber 1970) which illustrates and promotes the humanity of researcher and researched before reciprocity can be fostered.

Reciprocity is important in narrative enquiry because ‘meaning’ is created through collaboration. I believe I know this to be the case from my experiences throughout my time working “with” people, but I did briefly consider the approach to interviewing in narrative enquiry advocated by Jones (2003), which suggests that a “single initial narrative inducing question “(pg.61) could be utilised to encourage a person to talk about themselves, or their experiences, at length. This forms the introduction to what Jones (2003) calls a “minimalist passive interview technique” which allows the interviewee to speak without interruption, as the foundation of a biographic narrative interpretive method of carrying out narrative enquiry. This author’s work was focussed on the life histories and identity formation of informal carers and his interviews lasted for between 45 and 60 minutes.

Jones (2003) gives an example of the question he used to generate the narrative and I offer it here to illustrate his process “I would like you to tell me the story of your life. Take as much time as you would like. I am not going to interrupt you, but I will be taking notes. When you are
finished we will take a break for about 15-20 minutes. When we resume I will be asking you a few more details based upon my notes of what you have told me.” (Jones 2003 pg.63). Jones claims that his interviewees were able to speak fluidly with little encouragement from him except for interjections such as “take your time” when someone fell silent, or what he calls “unconscious body language” and making eye contact. Such an approach seems “ideal” in some ways but I found a more conversational format more naturally suited to my purpose here.

According to McCance, McKenna and Boore (2002) there are no standard set of procedures which apply in narrative enquiry, as compared to other forms of qualitative analysis. There are no clear guidelines as to how data should be used and while there are diverse frameworks for narrative analysis (Labov and Waltesky 1967, Ricouer 1991, Mishler 1995, Polkinghorne 1995, Sandelowski 2000,2010), there exist no directives for how these should be used.

3.5 Analysis

Knight’s (2002) view of how to conduct thematic content analysis relates two stages. The first of these he describes as the indexing and coding of the data, which is then followed by a process of interpreting the data and reflecting on these interpretations so as to refine ideas about them. This view is succinct, but perhaps not quite as detailed an explanation of the process of analysis as transparency demands. At the other end of the didactic continuum is the fourteen stage process outlined by Burnard in 1994 which tends to stress the steps to be taken in order to ensure rigour in the act of identifying themes within the data.

These steps include taking notes after each interview so as to record ones feelings about what one might have heard (1), reading through the
transcript so as to develop a feeling for what topics are covered within the data (2), reading the transcripts again to begin to identify categories (3) through asking colleagues to carry out these activities and checking your findings against theirs (6) and member checking (11) to thinking about how to present ones findings(14).

The format I chose to follow is one adapted from the model advocated by Newell and Burnard (2006) which outlines six stages to the process and which guided me through data analysis in a fairly straightforward manner. This process is inductive and pragmatic (Newell and Burnard 2006) and could underpin content or thematic analysis of data generated from most types of qualitative investigation.

3.5a Stages of analysis

Stage one advises making notes about what you think or feel about the individual interview just after its taken place, Newell and Burnard (2006) liken this to taking “field notes” and argue these may be useful later on in the research process.

At this time I also chose to ask my interviewees to read the transcript to check that it represented a true reflection of our conversation. Stage two entails reading the transcripts for general themes and to get an initial idea of what participants might be saying,

at stage three the data is read again and the process of identifying categories within it begins. I have illustrated this stage of the analysis in Fig.(i) which shows that I was able to identify 20 categories within the transcripts of the interviews I conducted.

Stage four involves putting these categories together where they have similarity and this represents the initial stage of theme identification. This
was the point at which I asked the participants to consider the work I had carried out and it is the point at which the hermeneutic circle I’d formed also checked and verified my thinking. This stage of the process is illustrated in Table 1 and Fig (ii). Both show four themes having emerged from the comparing and combining of the twenty categories.

Stage five entails re-examining the categories and themes and making changes and alterations after discussion with the hermeneutic circle. At this stage I initially incorporated two categories from the theme “intuitive” into the theme “skill” which still left four themes as illustrated in Table 2 and Fig.(iii) before taking the decision to incorporate the final two categories making up the theme “intuitive” into the theme “skill” leaving three themes as a result of the analysis, this is shown in Table 3 and Fig.(iv).

The sixth stage of Newell and Burnards (2006) model relates to presenting the findings of the research process. Narratives represent a rich source of data and each of the twenty categories identified by me initially would merit discussion in their own right.

My interest in this project though is to consider the skills apparent within the narratives and so I am limited to considering those categories which make up that particular theme. The two skills most apparent within this theme and to which most of the categories relate are “information giving” and “empathy”.

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Fig. (i)

People understand more than we might think. Do the best you can. Training suggests don't get too involved. It is important to spend time with people. People have complex needs. Giving information is important. Nurses talk to one another. Dealing with carers and relatives can be difficult. One can ask, "Why me?" People ask, "Why me?" Nurses don't deal well with people's emotions. Environment issues are important. Information is understood more than we think. Engaging with people is important. Moving on quickly without understanding is important. Important is understanding the impact of interaction. Personal attributes, qualities, skills matter.
TABLE 1

Theming First Attempt

SKILL

Skill (20)
Personal qualities, personal assets, natural attributes (18)
Being clear in terms of language used, ensuring understanding (14)
Giving/Breaking bad news (memorable event) (13)
Nurses don’t deal well with other people’s emotions (8)
Engaging with people, relating to them, trying to understand them, is important (15)
Information giving is important; it enables people to make choices (4)

UNCERTAINTY

Unexpected complications of care (memorable event) (12)
People ask “why me?” Some things are impossible to know (11)
Training suggested nurses shouldn’t get too involved with people (9)
Do the best you can, even under difficult circumstances (7)

ORGANISATION

Environmental issues (17)
Other patients need you too, moving on quickly (16)
Nurses talk to one another about patients (for support) (10)
Issues around dealing with carers and relatives (6)
It is important to spend time with people (1)

INTUITION

Communicating with a view as to how this may impact in the future (19)
Importance of prior learning experience and reflection (15)
People may understand more than we give them credit for (3)
People have complex needs nurses have to be able to read these.
Skill

Personal qualities, attributes, assets

Personal care, complications, unexpected

Training

Don't get involved too deeply

Why me?

People ask

Do the best you can

Moving quickly

Another one to talk to

Nurses don't deal well with people's emotion

Giving bad news

Engaging with people is important

Dealing with relatives, careers

It is important to spend time with people

Impacts of interaction

People have complex needs

Environment issues

Fig. (ii)

SKII
TABLE 2
Theming Second Attempt

<table>
<thead>
<tr>
<th>SKILL</th>
<th>Skill (20)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Personal qualities, personal assets, natural attributes (18)</td>
</tr>
<tr>
<td></td>
<td>Being clear in terms of language used, ensuring understanding (14)</td>
</tr>
<tr>
<td></td>
<td>Giving/Breaking bad news (memorable event) (13)</td>
</tr>
<tr>
<td></td>
<td>Nurses don’t deal well with other people’s emotions (8)</td>
</tr>
<tr>
<td></td>
<td>Engaging with people, relating to them, trying to understand them, is important (5)</td>
</tr>
<tr>
<td></td>
<td>Information giving is important, it enables people to make choices (4)</td>
</tr>
<tr>
<td></td>
<td>Communicating with a view as to how this may impact on the future (19)</td>
</tr>
<tr>
<td></td>
<td>Importance of prior learning experience and reflection (15)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UNCERTAINTY</th>
<th>Unexpected complications of care (memorable event) (12)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People ask “why me?” Some things are impossible to know (11)</td>
</tr>
<tr>
<td></td>
<td>Training suggested nurses shouldn’t get too involved with people (9)</td>
</tr>
<tr>
<td></td>
<td>Do the best you can, elven under difficult circumstances (7)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>Environmental issues (17)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Other patients need you too, moving on quickly (16)</td>
</tr>
<tr>
<td></td>
<td>Nurses talk to one another about patients (for support) (10)</td>
</tr>
<tr>
<td></td>
<td>Issues around dealing with carers and relatives (6)</td>
</tr>
<tr>
<td></td>
<td>It is important to spend time with people (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INTUITION</th>
<th>People may understand more than we give them credit for (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People have complex needs nurses have to be able to read these.</td>
</tr>
</tbody>
</table>
Fig. (iii)

Skill

Personal qualities, attributes, assets

Engaging with people

Giving bad news

Nurses don't deal well with people's emotions

People have complex needs

Dealing with relatives and carers

Environment

Issues

Moving on quickly

Unexpected complications

People talk to one another

Why me? People ask

You can do the best

Training

Personal experience

Considering impact of interaction

People understand more than we might think

People have complex needs

Nurses don't deal well with people's emotions

Giving bad news

Engaging with people

Important is information giving

Nurse's bad news

Being clear

Personal attributes, qualities

Personal skill
TABLE 3
THEMING THIRD ATTEMPT

SKILL

Skill (20)

Personal qualities, personal assets, natural attributes (18)
Being clear in terms of language used, ensuring understanding (14)
Giving/Breaking bad news (memorable event) (13)
Nurses don’t deal well with other people’s emotions (8)
Engaging with people, relating to them, trying to understand them, is important (5)
Information giving is important, it enables people to make choices (4)
Communicating with a view as to how this may impact in the future (19)
Importance of prior learning experience and reflection (15)
People may understand more than we give them credit for, intuitive (3)
People have complex needs, nurses have to be able to read these, intuitive (2)

UNCERTAINTY

Unexpected complications of care (memorable event) (12)
People ask “why me?” Some things are impossible to know (11)
Training suggested nurses shouldn’t get too involved with people (9)
Do the best you can, even under difficult circumstances (7)

ORGANISATION

Environmental issues (17)
Other patients need you too, moving on quickly (16)
Nurses talk to one another about patients (for support) (10)
Issues around dealing with carers and relatives (6)
It is important to spend time with people (1)
Fig. (iv) - Skill

Personal qualities, attributes, assets

- Being clear
- Giving bad news

- People don't deal well with people's emotion

- Engaging with people is important

- People have complex needs
- People understand more than we might think

- Personal experience
- Considering impact of interaction

- Giving information is important
  - Unexpected complications of care
  - Nurses ask "Why me?"

- Unemployed
  - "Why me?"/wages
  - Training

- "Do the best you can"

- Moving on quickly

- Dealing with carers and relatives

- Nurses talk to one another to one talk

- Dealing with geriatric patients in a realistic way

- Not too involved

- Environment issues

- Important is information giving

- Personal emotion
- People don't deal well with people's emotion

- Giving bad news

- Clearing peoples'

3.6 **Ethical Issues**

In doing what I could beforehand to encourage people to talk, I had to be mindful of the possible pitfalls which can come with storytelling involving healthcare professionals. This meant that I had to consider a number of ethical issues prior to meeting my participants.

I had advertised for expressions of interest from nurses with five to ten years’ experience who were currently working in a general acute hospital setting. All registered nurses have to practice according to a code of conduct (NMC 2008) and this ‘code’ places responsibility on nurses to report episodes of poor or unsatisfactory care which are reported to them.

This meant that I had to consider ethical issues related to the nature of the study prior to commencing the interviews (West 2002). In particular I had to inform participants of my duty to report on any instances of dangerous or unsafe practice they might tell me about. In making this responsibility or duty explicit to the prospective interviewee, I hoped to avoid any conflict between responsibilities to one party and responsibilities to another (Stopes 2007). This need, under the code (NMC 2008) had to be made clear by me in order for the participant to be able to give informed consent to the interview.

Above I have described the use of “member checking” as a strategy to underpin the credibility of the data collection and analysis process (Lincoln and Guba 1985, Holloway and Freshwater 2007). Asking interviewees to read the transcripts prior to analysis also ensured that they had the opportunity to correct any mistakes they may have felt they had made in telling their stories, or to illustrate further points they wished to make clear or even have elements of the story they feel less sure about “taken out”.
There are other ethical considerations peculiar to undertaking narrative enquiry and I discuss these below, but the ‘consent’ implications had to be dealt with prior to interview in this study.

The preparations I made prior to interview were designed to help me to collect data through the eliciting of stories deliberately. This differs from using ‘critical incidents’ to direct the participant’s thinking, or from recording spontaneous story telling (tape recording those narratives offered informally or by chance.) (Czarniarskwa 2004). Because I wanted the narratives to be stories which I was sure had been willingly shared by interviewees informing participants about the opportunity for checking the transcript formed an important part of my pre interview information giving.

While this might seem to be labouring the point in regard to interviewee preparation, I felt it important to be guided by West’s (2002) assertion that the resulting impact of an interaction between two people cannot be predicted; but by giving as much information as possible about the process beforehand, I hoped to help the prospective interviewees make their decision about getting involved in a more considered manner.

3.6a Seeking permission for the Study

Because the participants in the study were all health service employees, I had to make an application to the National Research Ethics Service (NRES) before going ahead with advertising for interviewees. The paperwork required by NRES is comprehensive and has to be filled out with care. Applications to their Research Ethics Committee (REC) have to be booked in, in advance of the application to carry out a study being considered and the applications have to be accompanied by examples of documentation, such as information sheets for participants and copies of consent forms. In addition, guarantees of indemnity insurance, in case
anyone is ‘injured’ as a result of the research and evidence of university approval of the project are required by NRES before a study may be considered.

The process of gaining ethical approval and permissions to carry out a research project can be complex and protracted. It is necessary to ensure that research is ethical and that no person will be harmed as a result of being involved in research and the NRES overviews all projects impacting on the NHS, patients or staff, to ensure safeguards are in place and these demands are met.

3.6b Issues around the ethics application

In 2005 the Department of Health (DOH) ad hoc advisory group on the operation of NHS research ethics committees, suggested that applications to conduct research should be considered using what is termed “proportional ethical review” (DOH 2005). This means essentially that any application should be subjected to the amount of scrutiny by a research ethics committee that it warrants. Projects which represent low risk to participants would be given less scrutiny (and spend less time going through the committee), than projects which represented a higher risk to participants. Equally where good quality of consent was evident, less scrutiny would be required than for a project where poor quality of consent would be likely. According to Hunter (2006) this would result in two major benefits for the researcher and for society. Uncontroversial projects would be processed by the committees quickly and those applications which were more controversial would be considered by research committees more critically. Hunter (2006) actually opposed the change proposed by the DOH (2005) as he felt it would ultimately lead to a lack of standardisation between regional research ethics committees. Hunter might be described as an ethicist and his view is supported by Davies, Wells and Czarkowski (2008) who argued that standards, while
desirable, may be difficult to implement, (they were considering the United States situation), but in order to achieve protection for the public and research participants and promote ethically sound research these had to be centrally devised.

These authors (Davies et al. 2008) are also ethicists and it seems there is evidence of a tension about the notion of “proportional ethical review” between those who sit on the committees and the Department of Health.

My own project could be considered “Low risk”, the quality of consent from subjects is obviously ‘good’ and the work is uncontroversial. I would have benefitted from proportional review. This was not available in the East Midlands at the time I was seeking ethical approval, so between applications to NRES (National Research Ethics Service) which later became IRAS (Integrated Research Application Service) and the Research and Development Facility (R & D) covering the hospital trust I was looking to recruit subjects from, gaining approval took approximately nine months.

Ethical permissions were also sought from the University of Manchester who were my ‘designated sponsor’ for this project.

At this point I hope I have given a reasonable explanation of:
What I want to do.
How I want to do it.
Why I want to do it the way I have chosen - and
Who it is I wish to get information from.

The next chapters are focussed on what I found out.
Please read on.....
CHAPTER FOUR

MECHANISTIC SKILLS

Preamble

The analysis of the data showed that there were a number of "skills" evident in the stories many of the nurses I spoke with told me about their experiences with patients and relatives. In the main, the skills identified were not reflective of what one might expect in relation to "microskills" which form the basis of much of the communication and interpersonal skills training these nurses will have received. Rather, qualities such as empathy and altruism stand out and these seem to be more easily (or obviously) achieved by those with personal experience of the phenomenon the patient or relative is going through. There is evidence in this data of the nurses utilising interventions such as those posited by Heron (2005) and the more generalised skills identified by Brown et al (2006), but integration of the skills identified by Egan (2011) is somewhat less clear.

The nurses I spoke with had throughout their training spent a total of twenty one hours focussing on communication and interpersonal skills related to patient care. This time represents the combination of lectures, seminars and discussions, focussed on the four models of communication which formed part of their training programme and the element of practice through role play and simulation, which forms part of the teaching and learning approach to the topic. The twenty one hours described here constitutes the "contact" time between students and lecturers/facilitators, but would not include the time students are expected to spend reading and researching around the topics studied, nor does this time include any reflection on their clinical practice which students might engage in.
4.1 Microskills

This term is used to denote specific communication skills which may be used for a particular purpose. The term is associated most closely with the work of Egan (2011) and he identifies microskills relating to non-verbal and verbal communication which can be utilised to facilitate effective interaction and helping. These are most representative of the mechanistic or instrumental skills spoken about by Chant et al (2002) and Kruijver et al (2000).

In terms of microskills of Non-verbal attending, Egan (2011) is credited with using the acronym SOLER to denote the need for a “listener” to show a person that he/she is willing to hear what they have to say and is actively attending to them (Egan 1975). This suggests Egan(2011) means Sitting squarely (orienting oneself) to the person, adopting an Open posture to show willingness to accept whatever is offered by the speaker, Leaning forward to show interest (leaning backward doesn’t necessarily show disinterest though), making appropriate Eye contact with the person and trying to be Relaxed during the interaction. Use of the skills encapsulated within SOLER is said to promote active listening within the “helper” and to allow more uninhibited self-expression within a speaker. With these issues in mind SOLER has been advocated as useful for nurses when interviewing to gather health assessment data (Crouch 2005) and is argued to be vital to the listening process by Burnard (2002), who took the view that listening itself is the most important human action a nurse engages in to develop therapeutic relationships with patients.

Many facilitators will add their own thoughts to the skills proposed by Egan within the acronym, for example in suggesting that sitting squarely is not as comfortable as sitting at an angle to someone when in conversation, and some authors have offered their own acronyms,
SURETY by Stickley (2011) is one such, but SOLER remains the best known acronym relating to microskills and is the term the nurses I spoke with will have been taught.

Stickley (2011) posits the view that the SOLER acronym is over thirty years old now and does not feature any reference to empathy or compassion at a time when these are a major concern for healthcare policy makers. He believes that empathic skills for non-verbal communication could be taught in a “less mechanistic” manner than that proposed by Egan (Stickley 2011 pg.395) and SURETY represents the six areas of skill to be considered if one wishes to create “a practical therapeutic space” (Stickley 2011 pg.397). The six letters of the acronym stand for - Sit at an angle to the client, Uncross legs and arms, Relax, Eye contact, Touch and (use) Your intuition. The “new” elements of this model are Touch and Intuition and while I am unsure of whether SURETY represents a more accurate representation of the non-verbal skills of empathy than SOLER, its production by Stickley does suggest the attempts by nurse educators to relate the training they facilitate to the times within which we live is dynamic.

Whichever approach is favoured, the focus on non-verbal microskills is complemented by a consideration of skills of active listening. These are “framed” as verbal skills, which enable a listener to facilitate a speaker in telling his/her story and perhaps in doing so working out for themselves ways in which they might improve the situation they find themselves in. Rogers and Farson (1957) described the benefits to relationships and problem solving of active listening and the skills have been described by authors such as Egan (2011) and Nelson Jones (2009) from a counselling perspective. The skills include practices such as reflecting, paraphrasing, clarifying, summarizing, self-disclosure, challenging using immediacy and being able to make a data based hunch. In nurse education the rationale
behind the use of the particular skill in conversation is explained and contextualised.

None of the nurses I spoke with mentioned the acronym SOLER in relation to their interactions with patients or their relatives, regardless of the nature of that interaction. A number of my respondents did however offer indications that they were mindful of their non-verbal communication when dealing with people. Few of the people I interviewed mentioned by name any of the verbal microskills which underpin active listening; again though there are indications that these nurses were mindful of how they were perceived by the people with whom they were speaking and aware of what they hoped to achieve through utilising certain skills in conversation.

Initially I will try to illustrate this with reference to paralinguistic skills, those features such as tone of voice, volume of speech, speed of speech delivery, all of which can convey a message which reinforces or which contradicts the verbal message actually being delivered by the nurse.

4.2 Paralinguistic Skills

There is not a major focus on paralinguistic skills in nurse training, so to find two of the nurses here showing an awareness of the importance of this area of interaction in their stories was to some extent a little surprising.

“H”, who works mainly night shifts on a medical unit had been describing for me a night when a male patient had wanted eye drops which he normally took himself at home, but which had not as yet been prescribed for his use in hospital. This gentleman had persisted in asking “H” for the medicine and had disturbed many of the other patients on the ward in his
attempts to have his demands satisfied. “H” was describing how the patient had asked him the same question a number of times and stated;

“Yes, that, at one stage my tone of voice must have changed because he said I’m not wanting to argue with you” and I said, I’m not arguing with you, I’m just trying to tell you that I cannot give it without the actual prescription”.

(H pg.13)

I put it to “H” that his recognition of tone here might be a skill and he replied;

“But even, how should I put it, being a human being, the fact that it’s almost like a record almost, tenth time around, I was not getting fed up, but I could feel it welling up and the other people they were fed up with it and he must have realised I was getting a bit edgy, shall we say, for him to say to me “I’m not wanting to argue about it”, so I thought well why don’t you just accept what I’m saying then mate?”.

(H pg.13)

I was curious as to whether “H” thought he had ever got this judgement about the tone of his voice wrong and he asked me whether I was referring to his dealings with patients or staff members. “H” suggested that his view of what constituted appropriate interaction did to some extent depend on who he was speaking with, I asked him to elaborate;

“No, the staff would (tell him he’d got it wrong) I’m quite sure tell you there and then, however the patient maybe would not want to moan or criticise you in case they, they’d be worried in case it affected their relationship with you in the future, so maybe the patient would bite their
There are two issues implicit in what “H” is intimating here. Firstly, he has an awareness of the need to consciously control his paralinguistic communication “in the moment”. Secondly there is an underlying desire not to offend or threaten patient sensibilities. While most basic training programmes would not include a focus on paralinguistic elements of communication, there is a developing literature concerned with its relationship to nursing practice.

Schreiner, Clifford, Crotton and Sevin (2004) point out the benefits of the nurse controlling factors such as tone of voice and the volume they speak at when dealing with a patient who may be upset or frustrated. This fairly straightforward notion has been extended into a framework for “de-escalation” by Luck, Jackson and Usher (2007). These authors offer the acronym “STAMP” to identify areas of paralinguistic communication which they consider need attention from the nurse, so as to forewarn of aggression and enable them to act to prevent it. The initials here represent the need to avoid making Staring eye contact, be aware of one’s Tone and volume, recognise Anxiety in oneself and in the other person, avoid Mumbling and unnecessary Pacing or similar distracting movement (Luck et al 2007).

While “H” does not suggest he explicitly looked for any of these signs in the patient, he does allude to being aware of an increasing edginess in himself and acting consciously to prevent displaying this to the patient;

“.....I’m trying to say that, without making it sound horrible, what I’m trying to say is your eye drops could not be the doctor’s priority, I can
understand your eye drops are your priority to you, but there could be a medical emergency elsewhere in the hospital and I just said without being rude you’ve got to be patient.....”

(H pg.5)

Of the nurses I spoke with “H” was the only one to admit that at times he experienced annoyance with his patients;

“....we’re all human beings with our own frailties and fallibilities and at times you do know the odd one is being a complete and utter bugger, out of almost like spite and then at times I’ll admit, I do think at times, no mate, because of your attitude you can wait a few minutes because there are people over here that never complain and they get left alone because of you complaining all the time....”

(H pg.5)

Which reinforced, for me, the suggestion that “H” is mindful of the effect he can have on others, sometimes has to work to control his responses and generally, such a quality is valued in those who practice nursing.

Watson (1999) developed a theory of nursing based on what she described as caring. She identified ten elements of what she termed the “philosophy and science of caring” and argued that these represented the basis of nursing itself (Watson 1999). One of the elements central to Watson’s (1999) caring thesis is sensitivity to oneself and to others and “H” may be illustrating this particular caring quality in his story here. Certainly it seems to be the case that “H” is evidencing an internalised desire to protect the dignity of his patient in his not wishing to demean this gentleman, or leave any lasting impression that he is a “miserable so and so”.

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This concern with dignity is currently a major focus for the statutory bodies which control nursing and for the Department of Health itself and “H” seems to manifest it in the way he respects the patient’s right to express his view, even though he had responded to the patient’s requests a number of times with the same answer. Giving people respect is one of five ways in which nurses have been found to act to maintain patient dignity (Yea Ping, Lun Fang 2010) and in displaying a degree of sensitivity to his patient here “H” is acting to meet what Baillie (2009) describes as a basic human need.

Another example of the nurse’s desire to respect the patient’s dignity comes from “L”. She is a sister in an X-ray imaging department and was telling me about how she likes to be friendly to patients, engaging them in conversation to “take their minds off” some of the diagnostic or therapeutic procedures they may be undergoing which “Lynne” describes as “scary”. During our conversation “L” told me;

“Yes, some of the patients talk to me more than I talk to them and some of the patients don’t want to talk to me, they don’t want to know…”

(L pg.10)

I asked “L” how she recognised who wanted to talk and who didn’t and she told me;

“…it’s not just verbal is it? It’s the facial, the body language you just pick up on these things”.

(L pg.10)

I asked her if she had ever made a mistake in identifying who wanted to engage in conversation and who didn’t and “L” said she had. We went on
to discuss how she became aware the patient didn’t really want to “chat” and “L” explained;

“You can usually just tell by how they look at you and how they react to you”

(L pg.10)

“Which I paraphrased by suggesting “something changes?”
“L” replied;
“Yes, the tone of voice

(L pg.10)

Suggesting that the inverse of the process “H” had described was occurring at this time. Whereas “H” had moderated his own tone to show respect to his patient, “L” had used a change in her patient’s voice tone to alter the manner in which she was conducting her part of the interaction.

The only other example of paralinguistic communication obvious in the stories told to me came from the conversation I had with “D”. This nurse works on a unit which provides care for private patients within an NHS hospital and she had described to me her experience of looking after a gentleman who had quite severe health problems and who was seemingly at the end of his life. During our conversation “D” had told me that on occasion she had to break bad news to patients and relatives. This according to “D” demanded what she described as a “holistic” approach to the person, which included some consideration of emotional factors.

“Yes, we have to look at everything because you have to deal with the emotional side of things, but as they say when you’re told about death there’s certain phases that the person has to go through, and before they
get to the acceptance stage they’ve got the anger stage, the resentment stage before they even accept what’s happening”.

(D pg.13)

This statement shows that “D “ has some knowledge in relation to what Maciejewski, Zhang, Block and Prigerson (2007) called a “stage theory of grief” and that she is willing to adapt this to inform her practice. From her focus on anger and resentment here, it seems likely that the grief framework “D” has in mind is that of Kubler-Ross (1969). This set of ideas is commonly considered during nurse training and some theorists (Downe-Wamboldt and Tamlyn 1997) suggest that the healthcare professions generally are too dependent upon them, seeing the stages as suggestive of a linear outline of the grieving process every individual will go through.

I share the view posited by Maciejewski et al (2007) that an attempt to direct ones practice using accepted evidence is probably the best any professional helper can do under trying circumstances. I asked “D” if anyone had ever reacted angrily to her when she had given them bad news, she replied;

"I’ve been quite lucky; no they haven’t been angry at me.....” which she underpinned with;

"....a lot of patients and relatives can see as well that we genuinely care.

To us it’s not just a job, we care about these patients”

(D pg.13)
I felt I had to ask “How do you convince them that you care?” which was when “D” illustrated her belief in the efficacy of paralinguistic communication, stating;

“It’s the way we show, the way we talk to them. We talk nice and calm to them, you don’t talk loudly, you talk in a nice calm voice, try and keep your voice the same tempo and you always sit down, you don’t look over them when you talk to them, you sit down and talk to them”.

(D pg.13)

Though there is mention here of the paralinguistic element of communication being considered “D” describes using it in tandem with non-verbal communication (sitting down, reducing height differences) to reinforce the message she wishes to send. I consider non-verbal communication below and focus here on the perceived importance of tone, volume and tempo in the voice. It seems that “D” is mindful of the need to deliver the bad news message in a sensitive, but honest manner. She indicates that she considers consciously how this aspect of care should be carried out or delivered and is in that sense prepared for what can be a very demanding and emotional situation. The Resuscitation Council (2006) have offered guidance to healthcare professionals relating to the breaking of bad news and “D” in her narrative reflects some of this advice.

In the view of the Resuscitation Council (2006) the professional should be prepared to allow enough time to be with the receiver of the bad news so as not to “rush” the encounter; he/she should be clear and accurate in any explanations offered and also be ready to engage in conversation with the receiver, answering questions or discussing issues raised. In describing her awareness of the importance of tone, volume and the tempo she speaks at, “D” is reflecting this advice. It is known for instance
that tone of voice is important in the communication of emotion (Rothbaum and Nowicki 2004) and when combined with other non-verbal cues, it can help with the development and maintenance of relationships (Carton, Kessler and Pape 1999). The generally held belief is that “psychologically healthy” people have the facility for social cue decoding (Gardner, Pickett, Jefferis and Knowles 2005) which allows for a positive response to the messages being relayed.

Managing to control tone, tempo and volume of speech will also minimise the appearance of anxiety in the nurse to the patient’s relatives. This is congruent with the desire “D” voices to appear calm in front of the patient’s relatives and also reflects the facility she has to prepare for this type of encounter. “D” indicates her active effort to prioritise time in saying;

“....I would say to the rest of my colleagues that I’m working with on that side, I’m going in here, I don’t know how long I’m going to be and this is what we’re going in here for, then they’ll leave us alone and they’ll give us the time that I need”.

(D pg.13)

The act of prioritising time to talk to the patient and relatives gives “D” the opportunity to prepare for the task of being involved in breaking bad news. Part of this preparation is focussed on monitoring the paralinguistic elements of her communication.

In our discussion “D” also described the importance of non-verbal elements of communication, whereas “H” had not alluded to these explicitly. Research from areas such as Neurobiology has shown that there has to be a congruence between paralinguistic and non-verbal elements of communication for a degree of “affective prosody” to be
achieved between individuals (Ethofar, Anders, Erb, Herbert, Westhoff, Kessler, Grodd and Wildgruber 2005). This concept is inextricably linked to empathy, so it may be safe to assume that other nurses in identifying non-verbal elements of communication as being important within their narratives also had in mind the paralinguistic elements discussed above. While only two of my respondents included a consideration of paralinguistic elements in their narratives, most of the individuals saw non-verbal behaviours as important enough to warrant a mention.

4.3 Non-verbal Skills

In nurse education the focus on non-verbal communication has been limited mainly to skills the professional might use to reinforce to the patient or the relative his/her willingness to listen to what they have to say.

In current curricula this is achieved through a consideration of the skills encapsulated within Egan’s (2011) acronym SOLER, though authors such as Stickley (2011) and Brown, Crawford and Carter (2006) and Crawford and Brown (2011) have offered supplemental thoughts on how the skills of attending might be enhanced, in the case of the latter where brief contact between patient and professional is the norm.

Egan does allude to the need to be aware of more than that suggested by his famous acronym in discussing the worth of controlling face behaviour, voice behaviour, space and appearance for example (Egan 2011) he doesn’t dwell on these issues possibly accepting that those interested in helping will already have the necessary insights. Certainly Egan’s suggestions are enough for Burnard (2002) who asserts that nurses need two sets of attributes from counselling theory and practice to be effective in their helping. One of these he identifies as skills, non-verbal behaviours along with verbal skills consciously used make up this attribute, while the
other qualities are derived from Rogers (1961) conceptualisation of “necessary and sufficient conditions” for helping (Burnard 2002 pg.149).

SURETY which is the acronym suggested by Stickley (2011) which has been discussed above doesn’t really add to what Egan (2011) has to say when one takes into account features absent from SOLER, but present in his writings, while the Brief, Ordinary and Effective model suggested by Brown, Crawford and Carter (2006) outlines verbal and non-verbal skills useful in very brief encounters between professionals and their clients. These are not really intended to help with showing an interest in hearing what a patient or relative may have to say over a period of time, but will, the authors argue, leave an individual more satisfied with the brief period of contact they are more likely to experience in dealings with healthcare professionals in “high turnover, fast paced medical interventions” (Brown et al 2006).

The model of choice then for non-verbal skills in nurse education and training has been and remains one based on Egan’s SOLER acronym.

None of my respondents mentioned SOLER during the conversations I had with them, nor did the acronym feature as an element of any reflection engendered by the recounting of the stories from practice they told me. Four of the nurses I spoke with described using some of the non-verbal skills encapsulated in the acronym, but only one nurse related consciously using more than one skill in a conversation with a patient.

This single nurse “L” was explaining how she remembered learning some Communication skills as part of her training;

“...also I really value my nurse training, I really value it because whatever I had I think it makes me understand, so maybe I’m a caring
person and its probably my strength. I think probably my communication skills make me understand what I do and how I do it; just the open posture and the eye contact and that’s not the kind of thing you grow up thinking, well I’ve got to have an open posture you know, or if I look at somebody too much that’s uncomfortable, so that’s where my nurse training came in with regards to communication skills.

(L pg. 13)

Previously “L” had made it clear that she valued friendliness as a basic approach to her patients and she had been explicit in her faith in some of the Brief, Ordinary Effective skills such as smiling when first meeting someone, as described by Brown et al (2006), as a means of beginning to develop a relationship with the patient and put them at ease. Egan (2011) also notes the importance of facial expressions, such as smiling, when showing interest in the client though this isn’t indicated in SOLER.

The assertions “L” makes about her own conscious use of non-verbal behaviour are congruent with the core philosophy she espouses in her story about the importance of making clinical environments less “scary” for patients, ”L” places a premium on showing her patients she is “there for them”. She links this to her own experience of hospitalisation saying;

"I’ve not been into hospital as a patient very much, but I have had some experience and I can understand what it’s like to be intimidated, to be scared…”

(L pg.6)

Before suggesting how she helps reduce these same feelings in others.

"It doesn’t take much, it doesn’t take much to look at people and nod and smile and have a warm atmosphere”.

(L pg.6)
That “L” doesn’t always see acting on this empathy as a purely technical part of her job role is illustrated by her broad view of which skills can be useful. Referring to her own hospitalisation and being worried about her health she said;

“ ....it’s so nice if somebody just looks up at you, gives you a bit of a wink or a smile, just to know that, to know, well you know that people care”.

(L pg.6)

In addition to being the only respondent who mentioned more than one of the SOLER skills, “L” was also the only nurse who linked knowledge of these skills and their use to her original nurse training. Other respondents did mention training, but didn’t allude to it with quite the same positivity shown by “L”.

I was discussing with “K” a nurse who works on a busy surgical unit the difficulty nurses have in knowing whether to stay with relatives who have very recently been bereaved, I had asked “ ....can you teach people how to be with people who’ve just been bereaved?” The answer “K” gave was interesting;

"erm, I don’t think you can to be quite honest, I think you learn that. The books, there’s textbooks saying that you should do this, this and this, but I think every situation’s different, so I think you just have to learn it and then if you do make mistakes you learn from them and feel a bit better next time”.

(K pg.12-13)

This learning the “right way” from experience seems to be a common theme in relation to having to communicate in difficult situations and “K”
returned to it later in our conversation when she told me about the sudden death of her own father and how she felt she had learned how others might feel as a result of this. I had asked if there was something about that experience which had changed the way she worked, “K” said “yes” and I went on “that you couldn’t get from a textbook?” to which she replied;

“No I don’t think you can get it from a textbook you have to experience it before you, personally, that’s what I think....”

(K pg.15)

In casting doubt on the efficacy of the teaching she had received “K” was not alone. “A”, who worked in a medical ward catering for people with chronic chest conditions, suggested that there was an even greater theory practice gap than “K” alludes to here. “A” was describing the necessity to involve the patient and their relatives in care planning, especially at the end of life. She had told me that it isn’t possible for every person who wanted to go home to die to be able to do so and we were discussing the issue of nurses spending time with dying patients. “A” had conceded that at times nurses may be too busy to spend a lot of time with someone in this position and she had mentioned some of the specialist services available in this situation, she went on

“....but also nurses I don’t think, I may be wrong, but sometimes don’t deal very well with other people’s emotions. I think again that comes down to the way, it depends on how you were trained, but we were trained not to get too involved, to that point where you became too emotionally involved, but I’ve always thought you couldn’t do your job effectively if you don’t get a certain degree of emotional involvement....”

(A pg.5)
While the views described here may seem incongruent to the embedding of counselling skills in nurse education, to put “A’s” statement into perspective the NMC as recently as 2008 reiterated their guidance regarding the need to maintain appropriate professional boundaries between nurses and patients and this guidance may be open to different interpretations by different teachers on nurse training programmes.

Other examples of nurses operationalising Egan’s (2011) advice came from “D” who advocated the need to sit down with patients and relatives when involved in breaking bad news.

“...try and keep your voice the same tempo and you always sit down, you don’t look over them when you talk to them, you sit down and talk to them....”
(D pg13)

and from “R” who works in an intensive care unit and who gave a fairly prosaic account of the manner in which nurses practice the skill of relaxing. We were talking about the need to deal with relatives of dying patients very sensitively because the circumstances around the time of bereavement are remembered for ever and “R” had explained the need for the nurse to think about how he/she dealt with people and appeared to them. He stated;

“IT's like the duck or the swan gliding across the water. Gliding across, But working furiously underneath”
(R pg.120)

This statement reflects “R’s” belief that the nurse has to appear to be calm and in control even if he/she doesn’t feel in control in difficult and uncertain situations. While it isn’t a direct reference to how one should
communicate in specific interactions, it is representative of the type of professional behaviour which is recommended to and valued by nurses.

The one nurse respondent who’s role involves interviewing patients pre-treatment is “J” and she will undoubtedly spend much of her time sitting down with patients taking time to elicit their concerns about bowel cancer and discussing treatment options. Though she didn’t include in her dialogue with me any reference to the SOLER skills of attending, “J” did make it clear that an awareness of her patient’s non-verbal behaviour was important in alerting her to their mental state and feelings about the interaction they were involved in. Dealing with one lady who was very upset. “J” described her thus;

“...she could hardly speak for crying...”

left “J” wondering whether to go on with the consultation

"I just asked her if she wanted to carry on”
and meant that she had to interpret (fairly obvious) non-verbal permission to carry on;

“...she just nodded a lot really”.

(J pg.8)

Head nodding is described by Egan (2011) as a gesture which conveys permission to carry on or gives encouragement and it was in this manner which “J” interpreted the patient’s behaviour. Speaking about this lady’s countenance at the time “J” remarked;

“Yes, even though I remember her face...the look of misery, she obviously she must have been in bits the first time she came...”
This illustrates the ability “J” has to interpret signs such as facial expression, gestures, general appearance and what Egan (2011) calls observable autonomic physiological responses (paleness, crying) in terms of someone’s probable mental state.

4.4 Touch

While these signs may appear rather obvious, in exhibiting an ability to interpret them accurately without further upsetting her patient “J” is displaying a degree of empathy with the lady. When she told me about being with the lady while she was in this very upset state I had, erroneously, expected “J” to go on to talk about offering her patient comfort through touch. The lady was accompanied by her husband, but “J” didn’t refer to either him or herself responding in this manner which rather surprised me.

Chang (2001) and Evans (2002) have both analysed the use of touch in nursing and agree that there is a “typology” of touch suggesting it serves five main purposes in patient care. These include, touching to provide physical comfort, touching to provide emotional comfort, touching as part of a social role, touching to provide mind and body comfort and touch to share spirituality (Chang 2001, Evans 2002).

Touch as part of care is seen as an accepted and reciprocal element of the relationship between a nurse and a patient, but Evans (2002) does suggest a male nurse may need to exert more caution in this area than a female, particularly when looking after a woman.
On reflection I may have been expecting “J” to describe performing a social role (as a woman and as a nurse) and possibly assumed this is what I was going to hear, however there were other examples in my data of nurses utilising this form of non-verbal communication.

Stickley (2011) in his SURETY model makes his belief that touch is an important element of showing concern explicit. While there is no allusion to touch in SOLER Egan (2011) does speak of the need for the helper to be aware of notions such as space and proximity and suggests that if a helper does what is in his/her heart then one can’t be wrong. Some nurses seem to accept touch as something intrinsic to the nursing role. “L” for instance very early in our conversation described her job role to me thus;

“....My job, as is every nurse’s job, is to be a patient’s advocate. It’s to be there to support patients through the procedure whether it’s an X-ray procedure, just a simple procedure, or a pacemaker or an angioplasty, these can be really scary for patients; and also to scrub up and assist the surgeon or consultant cardiologist in doing the procedure, so I could be a scrub nurse, a circulating nurse, or I could be there just to hold the patient’s hand”.

(L pg.1)

If one were to consider “L’s” view against the typologies of Chang (2001) or Evans (2002) it would appear that touch is offered by her for purposes of emotional support and this was also the case with the only other nurse who described using this form of non-verbal communication.

This was “K” who in describing being with the family of a woman who had just died told me that if they were crying she would offer a tissue. I was curious if she would go further to offer support and asked
“... Are you a touchy person?” to which “K” replied;

“umm, I can be, I can be, I hold their hands and stuff like that if they want it, I mean some people don’t want it”.

(K pg.11)

Though “K” isn’t as definite in her view as “L”, she is illustrating an awareness of what Stickley (2011) calls appropriateness in her reticence. Some people will not really want the closeness of proximity to another which comes with being touched and others will want this type of comfort intermittently as evidenced by what “L” had to say about her relationship with a young woman who was dying in her care. We had spoken about how her relationship with this lady had developed and “L” told me about the level of contact she has established;

“I was in and out, we might have built up a relationship but she doesn’t always want me there, like when she’s got other family members she just needs to know that I’m there if she needs me. I might, I did actually hold her hand at some points and I just had that contact”.

(L pg.11-12)

Both “K” and “L” seem to appreciate individual difference and, on the face of it, their motivation here in touching people is to offer some degree of emotional comfort.

Other non-verbal aspects of communication which have been identified as worthy of consideration by Egan (2011) and which were discussed by respondents as part of their narratives, included silence as part of an interaction and dress, in this instance uniform. Again it was “K” and “L” respectively who related a view.
4.5 Use of Silence

In regard to silence “K” was describing being with a family who had just been bereaved and we were discussing how difficult it must be to know what to say in such a circumstance. “K” advocates giving people time by leaving them on their own, either with the deceased, or in a separate but private space, to allow them to compose their thoughts and reflect on what’s happened.

She was telling me how hard she found it sometimes to judge how long to leave people alone for and identifying alternatives to this action. I wondered - “There might be a time then when you sit in there in silence, does that ever happen? “ the reply came quickly;

“Yes I think there is one, or two, yes two times I think it’s happened ....where you don’t know what to say...you sort of, how I get round it is, is there anything else you need to know? I say I can always get the doctor to come back and explain it a bit more.....”

(K pg.12)

“K” hadn’t raised the issue of silence and I didn’t feel on the basis of her answers she was comfortable talking about the notion. This may be reflective of the discomfort many nurses express in relation to having to contemplate being with someone at a very bad time and doing or saying nothing.

Egan (2011) offers the view that just being with someone at a very bad time for them can be an incredibly supportive action regardless of whether one knows what to say or not, but Back, Bauer Wu, Rushton and Halifax (2009) offer a slightly different view.
These authors (Back et al 2009) suggest there exists a typology of silences and that among these can be identified awkward silences, silence which they term invitational and compassionate silence.

Here is a problem for nurses argue Back et al (2009) in trying too hard sometimes to “use silence” consciously as an element of their communication, which results in the gaps in conversation becoming uncomfortable and awkward for both the nurse and the patient or relative. This deliberate attempt to use silence as part of an interaction is borne out of too great a focus on behavioural training in relation to communication, according to Back et al (2009) and can only be addressed by exhorting professionals to become more “contemplative” (aware) of how the interaction is progressing for the patient and themselves on a moment to moment basis and feeling more able to let silence “emerge” naturally in the conversation.

This doesn’t suggest that the silence that emerges won’t itself be awkward after a time, but the perspective on training is interesting here given Egan’s approach.

4.6 Uniform

With reference to uniform “L”, shortly after talking about the possible comfort which can be derived from a wink, went on to suggest that the most important issue was to acknowledge the patient’s presence, in whichever way was appropriate. She asserted that this was partly due to the patient’s vulnerability and partly due to the responsibility “L” felt came with being a healthcare professional;

“Yes, yes, they might like the uniform, I think, you know, we can make people feel safe”
This is in accord with the findings of a literature review into uniform conducted by Loveday, Wilson, Hoffman and Pratt (2007). These researchers were interested in the relationship between hospital acquired infection and uniform and reviewed literature relating to patients’ views about uniform which showed that it was linked (in the patients’ view) to professionalism and trustworthiness (Loveday et al 2007).

Egan mentions the need for the helper to be aware of their dress and general appearance, but from a nurse’s perspective this isn’t something which demands a lot of consideration. Each of the nurses I interviewed regularly wore a uniform to work (as do most general hospital nurses) so it’s perhaps fortuitous that patients generally seem to imbue the wearer with a number of positive qualities.

Attire as it relates to patients was also mentioned by “L”. We had been speaking about empathy and the ways in which “L” felt similarity with patients, either through reflecting on her own experiences of hospitalisation, or the experiences of people she knew well. I had asked “L” whether this empathy was important in her work and she told me

“But if you work in a hospital environment because they need, they’re vulnerable and they need some help, it’s not like you’re walking on the street and you see some teenagers, it’s different whether they’re in a gown or they’re in their own clothes, they’re all there for a reason and it’s because they need some help and support at that time”.

I enquired if her compassion and empathy was linked to the role of these people as patients and “L” replied with a grin;
“Yes, I suppose it is to a certain degree, because I wouldn’t you know, walk round town taking care of everybody”.

(L pg.12)

For me the last statement suggests “L” expected me to grasp what for her seems obvious. Part of the nurse’s role is to care and the people she cares for are patients, these patients may have a role themselves and this role is indicated by the wearing of a gown, in the same way that the nurse’s role and the expectations which come with it are underlined by the wearing of uniform.

The implications of wearing a hospital gown have also generated research interest, mainly from the perspective of patient dignity and the psychological impact of complying with this particular hospital norm (Walsh and Kawanko 2002, Gleeson and Timmins 2005, Woogara 2005, Baillie 2009), but in relation to “L’s” comment the view of the NMC (2008) is most apposite. “Make the care of people your first concern, treating them as individuals and respecting their dignity” (NMC 2008 pg.2).

The actual material evidence within the data to suggest awareness of conscious paralinguistic or non-verbal communication with patients on the part of my respondents is limited. This may reflect the lack of input on these topics in their original training or it may, and this seems more likely, be an artefact of the manner in which we conduct ourselves paralinguistically or non-verbally.

In the main we are less consciously aware of these elements of our communication than we are of the verbal component. This is borne out by the far more obvious presence of reference to verbal skills and the intentions behind the use of those skills in the narratives collected during this project.
In the next chapter I begin to illustrate the first of the verbal skills used most commonly by the nurses I spoke with.

This skill, information giving, is used for a number of purposes and I have highlighted the various reasons evident for giving information in order to show that it is more than the mechanistic skill Chant et al (2002) described it as being. Information giving can have real qualities.
CHAPTER FIVE
INFORMATION GIVING, RELATIONAL OR INSTRUMENTAL SKILLS?

Preamble

In all of these stories the most commonly used verbal “skill” can be described as information giving. This is seen as a vital element of contemporary healthcare and is linked to patient empowerment, informed choice, concordance and compliance with treatment and effective self-care (Timmins 2007). In the view of Heron (2005) giving information constitutes the basis of the informative interventions identified in his six category intervention analysis framework and is a normative aspect of the role of the healthcare professional. Ideally information should be given to facilitate self-directed learning, making full use of the person’s natural motivation to make sense of a situation (Heron 2005) and should result in change. This perspective sees information as being the basis for a catalytic intervention (Heron 2005) and offers a rationale for the empowerment argument.

5.1 Information giving as a preferred verbal skill

For Heron (2005) if too much information is given to a person too soon this can have a blunting effect on their motivation to explore a situation for themselves and this can serve to disempower the individual. On the other hand, if one isn’t given enough information one may not be in a position to follow up an interest and the real ‘task’ of the healthcare professional in terms of information giving, is to assess how much an individual needs in terms of quantity and quality.

The normative nature of information giving as part of the nurse’s role is reflected in the stories told to me. Each of the respondents spoke about either giving explanations, giving information in a number of formats or
clarifying issues with and for patients and relatives. There were a range of reasons offered for using this intervention and these incorporated the obvious, to inform the patient or relative, the altruistic, to promote patient choice, the facilitative, to encourage someone to challenge a view or belief, the authoritarian, to promote the views of the professionals involved and the ‘desperate’, to avoid having to deal with emotional issues or distress.

This latter represents the giving of information as an avoidance strategy, which is described here as being used to ‘protect’ the nurse.

5.2 Information giving to aid Understanding

The first of these, giving information to someone so they have a better understanding of something is not always straightforward, as evidenced by “H’s” attempts to explain to a male patient why he couldn’t have the eye drops which he normally administered to himself when he was at home, while he was in hospital. “H” described the situation thus;

“...this chap was wanting his eye drops giving at say four, four this morning, I say, I can’t give them because they haven’t been prescribed and I can’t find them....”

(H pg.3)

The patient would not settle for this explanation and asked repeatedly for the eye drops, in the process waking up a number of other patients who could not get back to sleep and who left their beds and went to the day room on the ward to sit down as a result. “H” made an attempt to get the eye drops prescribed in the early hours of the morning for the patient and explains how the patient was kept informed of this;
“...we went back and I said look we’re still waiting for the doctor coming, he said he understood why we just couldn’t give them there and then...”

(H pg.4)

Though he made no secret of his frustration with the patient’s demands and their effect on others in the ward “H” was able to understand his persistence;

“I think it’s because he’s just fretting because he’s a diabetic chap and he said his actual glaucoma, he missed the eye drops yesterday and he doesn’t want to miss them today....”

(H pg.4)

Most hospitals do not allow patients to retain any medicines they may have been taking at home when they enter a ward and the expectation is that any drug needed will be provided by the hospital during the patient’s stay. The patient had difficulty in understanding why the eye drops which he took for himself at home were not available to him in hospital and he didn’t become aware that this was the hospital’s policy until four in the morning. This left “H” in the fairly unenviable position of having to explain the situation and try to take action to reduce the patient’s anxieties. Information given in the spirit of facilitation under these circumstances is not likely to be received quite so magnanimously however and the patient’s response frustrated “H” to the extent where he became aware of the paralinguistic indicators of annoyance illustrated above. “H” did react to the patient however, he outlined how;

“...all I would say is we’re all human beings with our own frailties and fallibilities and at times you do know the odd one is being a bugger out of almost like spite and then at times, I will admit I do think at times “no
mate because of your attitude you can wait a few minutes because there are people over here that never complain” (H pg.5-6)

Perhaps “H” was naive in expecting the patient to synthesise the information he gave him about the lack of a prescription for the eye drops, or perhaps the intervention was expected to coerce the patient into acceptance that he was no longer in control of the way he looked after himself, but the end result seems to have been a degree of resentment in both parties.

Another example of giving information solely to ensure understanding comes from “K”. She had been involved in supporting family members after the unexpected death of a loved one following complications during a medical procedure and was the healthcare professional who had to break the news of the death. The family had been made aware that their relative was very unwell and had been called into the hospital; they were at the bedside as the lady involved died. “K” explains;

" ....from the time I went back in it wasn’t long then before the lady died, so they did ask me “ has she gone?” and all I could say was “well as far as I can see by looking at her I can say yes “ then we have to get the doctor to confirm”.

(K Pg.6)

Though there seems to be a degree of uncertainty in the way “K” phrases her answer here, legally a doctor has to confirm and certify death in a hospital so there wasn’t much else she could have done;

"I had to leave them, ring the doctor to say the lady had passed away, can you come and certify, I did tell them that I thought she had died, but I had to get him to come and certify it”.

(K pg.8)
“K” reinforces a desire to be direct and avoid misunderstandings later in her story. She had given the family time to be by themselves and had later gone back into the room where they were congregated. I’d suggested that it must be difficult to do this and reflected “at that moment you’re being asked is my mum dead?” she replied;

“Umm, and you must say “yes they have died” rather than sort of saying “they’ve passed away” because they may not take that as, in that sort of...” she went on; “You have to say that they have died because then they’ll take that on board...”.

(K pg.7)

Directness in breaking bad news is valued. Ptacek and Ellison (2000) surveyed a group of seventy three doctors who had to break bad news as a regular feature of their work and 100% of these reported that they used direct and simple language to ensure the message could not be misconstrued, while Rosenbaum, Ferguson and Lobas (2004) reviewed training in this area offered to American medical students and found that courses coached professionals to be direct in terms of the message being delivered.

Most of the policies on “Breaking bad news” which are utilised in English hospitals are based on work by Buckman (2005) who proposes a model based on the acronym SPIKES for carrying out this task. Buckman (2005) suggests a strategy which includes the professional considering the Setting within which the news will be broken, finding out what the Perception of the person being given the news is, many people know something is wrong before they are told, issuing an Invitation to the listener to indicate how much they want to know, because not everyone will wish to have full details, use this Knowledge to “frame” the news for
the receiver, show some Empathy for the receiver’s situation and Summarise what’s been said before giving a person time to think about things alone if that’s what they wish (Buckman 2005).

The SPIKES strategy reflects Heron’s (2005) views about professionals being informative and “K’s” actions in a difficult situation mirror the guidance toward best practice offered by the acronym.

The giving information purely to inform theme is further illustrated by “K’s” actions in relation to what relatives need to know about regarding practicalities following the death of a loved one in hospital. She talks to people about how to register the death, collect belongings and set about commencing funeral arrangements. These details are backed up for the relative through “K’s” use of written materials;

“...we have a booklet where it explains for the bereaved relative exactly what the next step would be, erm, if they would like to take the belongings, it is actually quite a useful book and we say roughly what’s in it and then I say well you can take it away and read it in your own time...”

(K pg.8)

Which again has some resonance with Heron’s (2005) argument that the professional should aim to empower the client to decide how to proceed for themselves and avoid burdening them with unnecessary information at inappropriate times?

Whereas “K” offers a fairly concrete example of information being used simply to inform as opposed to “H’s” genuine, but perhaps ill timed, attempts to do the same. “D’s” story suggests that this type of
intervention can sometimes result in relatives becoming confused about the options available in relation to the treatment their loved ones receive.

5.3 Information has the capacity to confuse

During our conversation “D” had told me about a gentleman who was very unwell and who had been admitted to the private ward she worked on through the accident and emergency department. She told me that this man’s family were informed about the “Liverpool Care Pathway” (LCP), a protocol for end of life care developed by the Marie Curie Institute (2010), which is used in hospitals nationwide to ensure best practice in palliative care.

The man’s family had taken it from this that his treatment was to be palliative. The gentleman had a number of long standing health problems including dementia and Parkinson’s disease and had developed a chest infection, he normally lived at a care home.

The doctor who took charge of this man’s care on the private ward had a different view and favoured more “active” treatment for his condition. “D” describes the man’s daughter’s perspective;

“...she just wants her dad to go in dignity and peace, the patient came from a nursing home and the family accepted what was going to happen to dad because he’s not young, what is he, ninety four, ninety five” which is at odds with that of the doctor...”

“ ....what Dr......doesn’t like about it (the LCP) is that you’re withdrawing everything, you’re withdrawing, you’re not withdrawing like mouth care and making them comfortable or anything like that, but you’re withdrawing giving them their medication, fluids, they go onto a morphine pump...” (D pg.5)
I clarified with “D” that the LCP meant no active treatment for the patient’s condition would be delivered and she confirmed this and I wondered what she felt about this approach to care;

"I agree with the Liverpool Care Pathway” she asserted and explained why “...that gives patients time to die with dignity and it also gives their family time to spend with them without nurses going trying to pump everything into them, because they’re not going to be prodded or poked or stabbed...”.

(D pg.5)

Thus “D” and the family favoured the LCP approach to care, while the doctor preferred a more active treatment approach. Medical staff have been found generally to favour the direction and evidence based approach to end of life care offered by the LCP (Ellershaw 2007), while nurses have been shown to benefit from the extra confidence engendered by its hospice movement origins and its use as a care tool for a difficult phase in treatment (Jack, Gambles, Murphy and Ellershaw 2003, O’Hara 2011); but satisfaction with its implementation is a little more questionable from the relatives’ perspective.

Van der heide, Van der rijt and Van zuylen (2010) surveyed the relatives of some 311 patients who had died of cancer and who had been prescribed end of life care according to the LCP (2010). They found that relatives were more likely to feel they had less to do with decision making when end of life care was provided in hospital, as compared to being provided in the patient’s home (76% compared to 96%) and that when they were involved in decision making 82% of those whose relative died in hospital felt they had been sufficiently involved, as compared to 100% of the people whose relative died at home (Van der heide et al.2010). The doctor who led the care of “D’s” patient had decided very soon after
“...Dr. did his ward round and decided” No, this patient’s not ready yet, I’m going to do this, this and this...”

(D pg.6)

and this was at variance with what the family had been expecting, but the message given by the doctor would have been hard to resist; “we can get something down him, we can bring your father back and then he can go back to the nursing home”.

(D pg.8)

and his rationale for choosing a more active treatment pathway was impossible to argue with;

“...they’ve asked about the Liverpool Care Pathway they’ve brought it up and Dr..... has basically told them that he’s not ready to go on it because he’s said it’s an infection; we can fight the infection with antibiotics....”

(D pg.8)

Such an opinion from an authoritative professional can leave relatives feeling unable to express their real views about the treatment they would prefer for their loved one. The consultant is seen as the leader of the care team in hospital, whereas when someone is dying at home much more “power” to take part in decision making might be felt by relatives.

5.4 Information can empower

The Liverpool Care Pathway featured in the story told by “C” as well, but in this instance knowledge of its existence seemed to have a more empowering effect for the patient involved. “C” had described meeting a
gentleman who was admitted to the ward she manages with advanced Motor Neurone Disease, the condition had not been diagnosed prior to his coming into hospital and the patient had to be told about the illness and its implications. “C” stated;

“\textit{The doctor explained to him roughly what it was, I then got a lot of information for him and the family printed it off, got it from various people and then talked it through with them}”.  
\textbf{(C pg.5)}

I asked whether “C” was cautious about the information she gave people, because Motor Neurone Disease is progressive and the symptoms can be very unpleasant and she took the view that if she didn’t give full details to people they would probably access these anyway;

“\textit{Yes, I think a lot of people do use the internet, they often say “I’ve read on the internet....” I don’t think I censored anything, no}”  
\textbf{(C pg.5)}

She rationalised her actions saying

"\textit{I suppose because he was already at that advanced stage he wanted to know what was going on and that’s his right to know really}“.  
\textbf{(C pg.5)}

“C” also illustrates here, almost in passing, that the doctor gave the initial news to the patient about his diagnosis and likely prognosis. This often leaves the nurse in a position where he or she will have to check the patient’s understanding of what’s been said, I asked “C” how she dealt with this aspect of information giving;

“\textit{I don’t know, I’m just myself I think, I don’t try and bombard them with loads of medical jargon or anything}”. “\textit{With the consultants and}
afterwards I always just tend to run through it with the patient as well, sometimes the consultants use all these fancy words and I just like to make sure that they know what’s - that they understand”.

“Putting it in simple terms and listening to the patient, if they’ve got any questions or anything that they, a lot of the elderly I find on the ward don’t like to challenge the doctors, or don’t like to ask them too much too many questions and as soon as the doctors have finished the ward round they’ll say what’s this and what’s this so I tend to stay just to see if they’ve got any other questions or anything”.

(C pg.4)

The other issue which confronted “C” was how to let this man’s relatives know what was going on;

“The daughters found it very hard; I think they needed a lot of reassurance of what was going to happen, what their dad wanted and whether we could get that done”.

“When they came in to visit their dad the mother had already explained to them what was happening, erm, then they came in and did still have questions that they wanted to ask, which was fair enough and I tried to answer as best I could. I think they just wanted a bit of reassurance as well”

“Yes, I think they were upset, we gave them a lot of information, we gave them leaflets about the Liverpool Care Pathway and explained that it’s not just about leaving their dad completely, it’s about making sure he was comfortable”

(C pg.7)
As a strategy for breaking bad news this seemingly worked well, the patient’s desire for information was honoured in an open and honest manner, but I wondered how he had accepted the news after he had taken some time to truly understand its implications “C” reassured me;

“I think he accepted it quite well, for the first few days, I think he was quite quiet, not as talkative as he normally was erm, but I think after it probably took a few days for it to sink in and then he was back to his normal self, good sense of humour ,yes.”

(C pg.5)

Once he knew what his situation was this gentleman was able to think about how he wanted to live out the final days of his life. One option was to die in hospital and this didn’t appeal to him, the other was to return to the care home where he had been living and this was his preference. “C” described the scenario where she had broken the news of the motor neurone disease as a “two way conversation” she said;

“...he’d stop me in between and ask things....”

(C pg.5)

I enquired what the patient had asked about that stuck in her mind;

“....probably about going home, whether he’d get home or whether he’d die in hospital”

(C pg.6)

and this was the impetus for the implementation of the LCP and getting the patient home. Unfortunately after the gentleman had been discharged home from the hospital he was re-admitted one night after, as “C” put it;
“The res... the nursing home had panicked, he’d had a bit of haemetemesis (vomiting blood) and they’d brought him back in to hospital”

(C pg.2)

and so “C” had needed to reorganise his discharge. However in what must have been a very difficult situation, information giving had enabled and empowered the patient to make a decision about his treatment and have that decision honoured. At times when dealing with bad news though, information giving can be used for purposes which could be described as less than altruistic.

5.5 Information can deceive

When we spoke “J” was the nurse in a situation where she met with people who were undergoing screening for bowel cancer, she had previously been a nurse in an endoscopy unit helping to carry out diagnostic tests for the same disease. She told me that in her previous role patients were not always given the information about a poor diagnosis in a timely fashion;

“some of them, we’d find a cancer, dependent on the doctor, do a biopsy and tell them they’d have to be confirmed by the lab. Tell them we’ll see you back in outpatients clinic in a couple of weeks and give you the results, so those ones we were more or less certain of what it was and we didn’t even have to address it.”

(J pg.11)

This “putting off” giving information is balanced in a rather unhealthy way at times through the use of information giving as a strategy to achieve the same aim of avoidance.
In the endoscopy unit “J” had little time to spend with patients, even after someone had received a terminal prognosis the nurses could spend no more than a few minutes with them and their relatives to offer any kind of comfort. I asked “J” how she managed these encounters she told me;

“Well....I probably stick to err........an informative format by discharging them, “I’m sorry it’s not good news today but this is going to happen, that’s going to happen, you’ll see the doctor da di da di da”.

(J pg.11)

While “J’s” answer here suggests a response to people which seems almost formulaic, she was able to offer a reflective view of how it felt to her to have to practice in this way;

“ I don’t know it was weird that it was different and it wasn’t ....Oh God do you know, now that I have done this job I probably didn’t really realise the impact of what I was doing before, sounds horrible doesn’t it?”

(J pg10)

This was the only example of a nurse avoiding talking about a difficult topic with a patient I came across and “ J” looked genuinely concerned that she may have failed through adopting the strategies identified above to offer some degree of comfort to the patients she had met in the endoscopy department.

She is now in a position to spend time with patients addressing any concern they raise and expends a lot of energy ensuring they receive the best care she is able to give them. Her actions previously could be considered to represent a perverse intervention in Heron’s (2005) terms though, as the person who really benefitted from the information giving was herself. In her current role “J” has a contractual duty to give
information to people visiting her clinic; I asked her if this was what she did;

“supposed to yes, unless I feel that the person’s just not going to benefit hearing it and a few times I’ve altered what I’ve had to say and decided not to say anything at all, because it’s just not appropriate in that situation”

“Other people are just so worried and anxious sometimes because they’ve had bad experiences and I just have to think about what I’m going to say to them and you can give summarised information and then find out what they want to know really”

(J pg.3)

Which suggests “J” now has a degree of autonomy to use her discretion about how she carries out this aspect of her role, something which I suspect suits her rather more than her previous role.

5.6 Informing to aid change

Whereas “J” may at one point have used informative interventions in a manner which was, at best, misguided or invalid (Heron 2005), the best example of information being used to therapeutic benefit for reasons Heron (2005) might describe as catalytic came from “R”. In the area where he works (intensive care) twenty percent of patients will die during their time in hospital. “R” suggests that this means he has to spend time with relatives either translating or reinforcing messages given by doctors about prognosis.

He states;

“...a lot of my job is relating what, although the consultants are very good at explaining it, there’s a lot of very technical stuff they have to go through in a very short time, so a lot of our work is reinforcing the family”
by which he meant relatives often need someone to repeat to them what the doctors have said and sometimes put this information into a format which they can more easily understand;

“Sometimes they won’t take it all in at once you know, and sometimes it’s “what are they saying? What do they mean? So you actually have to be able to assist them translate”

“I think there’s in my own view an importance around timing, you see, people may understand but they don’t accept”

In intensive care patients may look healthy enough because ventilators help them breathe and maintain chest movement, while other equipment keeps other vital functions such as temperature control and hydration in operation, this can make it difficult for relatives to accept their loved one is very ill or even clinically dead.

Part of “R’s” role is to help relatives take on board and accept this information and in so doing begin to grieve. “R” puts it thus;

“...you’ve got someone on the machine and they’re still breathing, but you know that they’re not going to survive........so that person although they’re still living to the family, is dead.....”

and it is a desire to help people come to terms with this changed reality which underpins the information he gives them. There is evidence that
“R” feels for the relatives he meets in his description of the intensive care environment at night;

“...the most privacy you can give is a curtain and you’ve got people on each side of you, it’s the size of a normal single bedroom, each space that you’ve got, you’ve got people on each side of you in this dark room, it’s two or three in the morning and someone you love is dying and there’s machines and bells and whistles all going on around you”.

(R pg.4)

this feeling for people was underpinned for me when I paraphrased “So you’re in the same space at two or three in the morning” to which he responded;

“sometimes you are, sometimes you aren’t’, you do get a feeling for what people want. Sometimes you say “look do you want to be alone” or “I’ll stop here”.

(R pg.5)

This empathy or understanding of what people might be going through is also evident in the argument “R” makes about relatives going through a process of change and this necessitating an awareness on his part of how things might be for the person at a later date;

“it’s not how they are then, it’s how they are six months down the line, because there’s a process when you’ve lost someone who’s dear…”

(R pg.5)

The concern to be deliberately catalytic in his dealings with these relatives is obvious and for “R” it’s fairly easy to relate this concern to an altruistic belief that he is in a position to help. I asked him if he was consciously
aware at three in the morning of the possible consequences for a relative of the change in their lives as the result of a loved one’s death;

“Yes....it’s something that’s part of my role, Nursing is a strange arena, but it’s my arena, these people have come into it like a stranger in a different social or cultural group and therefore I think there is a responsibility if you walk into that arena, there is a responsibility on you to do the best for them and I think a measure of that is how they are in the future”.

(R pg.5)

The combination of empathy and altruism seen here in “R’s” conversation is not unusual in nurses or nursing practice according to McCamant (2006). This author suggests that where both behaviours are seen together there is often some personal or psychological gain involved for the helper and terms this “the empathy-altruism hypothesis” (Batson 1990, McCamant 2006). For “R” evidence of such “gain” might lie in his desire to do his job as well as he can, which he himself suggests is part of his motivation.

However the fact is that “R” is very unlikely to meet any relative of a person who dies in his unit six months after the event, he will not be able to evaluate whether his actions helped or not and this, to me, suggests no hidden agenda or ulterior motive for his attitude. “R” is using information giving as a therapeutic intervention.

5.7 Altruistic nature of information giving

The final example of information giving as a communication intervention comes from “A”. The views expressed within what she has to say about her dealings with older people with dementia encompass all of the
concepts of altruism, concern, desire to empower and compassion outlined above;

“...the different stages of dementia, I don’t think you can go in saying right they don’t fully understand what’s going on, they probably do but they can’t make us understand how they’re feeling because we’re not in the mind of that person who’s in care, how can we say that they don’t understand what’s going on?”

“...I mean, they’re still an individual, they have individual rights it’s just that somebody’s said maybe because they’ve got this condition they’re not going to be able to make the right choice, but if they’re given the information in the right way that they could understand, maybe they would be able to”

“....I try to, you do try and engage with them, you know, and if you obviously pick the right moment and try and find, probably not the right thing to say, but when they are more lucid than other times, then I think you ought to yes”

“....with somebody with dementia, to try to help them, we try to have a routine of what we’re doing, we go at certain times to do certain things, and you know, you’re talking to them all the time instead of sort of talking down to them, as I say you’re treating them as any other person” (A pg.2)

and in her views about dealing with people recently diagnosed with serious health problems;
"if they were newly diagnosed it was really just to help support them through....the news that they’ve been given, making sure that they understood everything that they had been told, as a nurse advocate if you like, just making sure that they’ve all the available information to be able to make choices"

(A pg 4)

she repeats her position on patient choice. “A” understands she isn’t the only possible source of information for the people she is meeting;

“...over the past five or six years certainly there’s been a lot of patients that have come in that I would consider the expert patient and again this is people with those long standing diseases, they like to know and want to know what’s happening, is there a cure and that helps because that then challenges us to say-well, we are doing as much as we can”

“....people have expectations of what we should be able to do and about health services; I think again its checking their understanding. It’s all well and good accessing this service, but it’s what do they actually understand about what it’s saying and coming and talking them through it”

“(A pg 8)

“...the danger is with people using the internet, is they can get too much information and they expect too much when they come into hospital about what we’re doing and again that’s about us helping us, then put into perspective-what we can deliver”

but she also realises that the need for information given in the right spirit will be ongoing regardless of technological change even with its potential to empower people.
Information giving seems to be the basis for most of the verbal interventions these nurses described. It isn’t the case though that this is always used in an authoritative manner as one might expect if one were to take Heron’s (2005) propositions at face value.

The nurses identify a range of “drivers” in their use of this particular communication strategy with patients and carers and most of these “drivers” seem to arise from a desire to be facilitative in their interactions. Evidence of the use of the more mechanistic skills (Chant et al 2002) related to non-verbal communication is present in these stories, but each nurse who illustrated an awareness of these skills in their interactions was able to contextualise their use.

This suggests a degree of thoughtfulness and awareness one wouldn’t associate with an automatic acceptance of concepts such as skills of attending and this awareness is congruent with the same thoughtfulness which appears to underpin the use of information giving seen here. It appears that when nurses are confronted with a difficult or uncertain communication scenario that information giving is almost a “default” response to ease patients’ (and professionals’) anxieties.

The next chapter focuses on what I would assert is another such “default” response on the part of these nurses, I have identified this response, empathy, as a skill and offer a perspective as to its presence, to a greater or lesser degree in individual nurses interpersonal repertoires.
CHAPTER SIX
RELATIONAL SKILL
THE ROLE OF EMPATHIC UNDERSTANDING

Preamble

Giving information for a plethora of reasons is one of the default strategies used by the nurses in this study to get through situations which seem uncertain or difficult. It seems that this particular communication skill has anxiety reducing benefits both for the nurses themselves and for their patients.

A second default response apparent within these stories relates to what might be called empathic understanding. This helps to underpin the development of supportive relationships between nurses and patients and leads to the feeling of a shared experience. These relationships, while unable to “solve” any dilemma for the patient in themselves, (which most nurses by training are pre-disposed to try and do), would seem to have a large part to play in terms of “getting by” when one is faced with a life changing scenario which demands a commitment to a course of action, which, itself, may well have an uncertain outcome.

Empathy is evidenced by a number of the nurses I met with in the sense that they are able to accurately and sensitively infer what the patient they are interacting with is feeling and thinking and further, able to relate this understanding back to those patients so that they themselves will understand the nurse is “with them”, seeing things as they see them.
6.1 The Rogerian influence

This ability was described by Carl Rogers (1959) as being one of three “necessary and sufficient” conditions for helping in what he identified as non-directive person centred counselling. The other two “core” conditions identified by Rogers (1959) are genuineness (congruence) and respect (unconditional positive regard).

Rogers (1959) also identified the need for the two people interacting to be in “psychological contact”, one of them (the patient) to be in a state of incongruence in the situation (anxious or upset) and the helper (the nurse here) to be in a state of congruence or at least more comfortable in the situation.

Nurse training programmes include a brief overview of this Rogerian approach to counselling for a number of reasons. The “core” conditions are seen as pre-requisites for working in partnership with people generally, it’s difficult to see how respect, genuineness and a “bit of understanding” can do too much harm. Another reason is that the model forms the core curriculum of most of the training programmes which those teaching communication skills to trainee nurses will themselves have undertaken. While most practitioners of counselling, in my experience, would describe their approach to helping as “integrative” the presence of a person centred component is ubiquitous, every counselling course features a focus on the work of Rogers.

From a practical nursing point of view the approach also lends itself to “crisis management”. Nurses are often the first helpers someone experiencing illness will come across at a time of crisis and they need to be able to help the person with coping in the short term. Respectful listening, hearing and understanding on the part of the nurse can help
someone begin to come to terms with the situation they find confronting
them and would always in any case, be precursors to the problem solving
or problem management process (Corey 2009).

6.2 Other perspectives on understanding

The nurses I spoke with are not counsellors and they are not using
empathy as a “therapeutic tool” in the sense that Rogers (1961)
suggested it could be operationalised. One of the tasks of the counsellor,
according to the Rogerian approach, is to help someone recognise their
true feelings and thoughts about what confronts them, as opposed to
what their self concept wants them to show to the listener. This can only
occur where the “client” feels totally accepted and understood by the
therapist and is not the reason nurses are encouraged to think about
empathy during their training. Time to develop these deeper relationships
is not generally available and deep relationships may not be appropriate
anyway. Empathy in nursing is regarded as part of the process of caring
and empathy itself is seen as a skill in the nurse’s interpersonal
repertoire.

Showing the patient you care is one of the benefits which should accrue
from a genuine attempt to understand his or her situation (Elliott, Bohart,
Watson and Greenberg 2011). This view of empathy as a deep and
subjective understanding of the patient is what differentiates it from
sympathy (Corey 2009); empathy isn’t about feeling sorry for someone it
is about trying to share the patient’s view of an experience through
drawing on one’s own experience of similar phenomena.

This at least is the view of Clark (2010) who describes an “integral” model
of empathy which incorporates three different ways of “knowing”. Subjective empathy allows for the helper to experience what the client is
feeling, interpersonal empathy reflects the qualities I describe above,
being able to understand someone else’s view and being able to convey that understanding back to the person, while objective empathy is based on drawing on knowledge sources outside of what the client is describing or claims to be experiencing.

While Clark (2010) suggests a counsellor might utilise all three perspectives to develop a broader understanding of clients, nurses would be expected to be mindful of the need for the second type described here, interpersonal empathy.

Interpersonal empathy as described by Clark (2010) is similar to what De Waal (2008) has called “perspective taking”. This is one of three levels of empathy that author describes (De Waal 2008) which range in sophistication from “emotional contagion” which would entail adopting another’s emotional state (not a helpful stance from a nurse) through what De Waal (2008) calls “cognitive empathy”, where one recognises another’s situation through conducting a contextual appraisal to a level at which one can understand both what is facing the person and their view in regard to it. The latter according to De Waal (2008) demands both cognitive ability and imagination on behalf of the “helper”.

6.3 Shared experiences enhances empathic understanding

Though Clark’s (2010) interpersonal empathy and De Waal’s (2008) perspective taking are rather “technical” views of what empathy might be, to be present they share a need for understanding on the part of the nurse. Understanding is probably best achieved through similar or shared experience and speaking about empathy in a very theoretical manner tends to obscure its real worth in terms of helping, particularly when one considers empathy between a nurse who is an unqualified helper in the counselling context and the patient.
The ability to relate to what someone else is going through is enhanced if one has had the same or similar experiences oneself. The likelihood of the patient benefitting from perceiving this similarity is also itself high. Research from the field of mental health has shown that patients or clients are more likely to form helping relationships with those who they perceive to be the same as, or similar to, themselves in terms of life experience (Davidson, Chiunman, Kloos, Weingarten, Shayner and Tebes 1999).

The main benefit of having shared experiences from the patient’s point of view is the belief that the helper has a degree of experiential knowledge which seems to create a sense of camaraderie and a bond, because the client feels better understood according to Coatsworth-Puspoky, Forchuk and Ward-Griffin (2006). To give this argument more weight Paulson, Henrick, Demmier, Clarke, Cutter and Birecree (1999) found that where patients were offered help by what were termed “consumer providers” (ex-service users), rather than “non consumer providers” (more objective professionals), they felt better understood because they believed the people working with them had experienced similar crises in their own lives.

Factors such as cognitive ability, imagination, sensitivity and personal experience have featured as pre-requisites for empathic understanding in most theoretical models of the concept. The first three of these qualities are present in every human being anyway to one extent or another and over the course of a lifetime it is arguable that some degree of homogeneity of experience ensues.

Human beings are not uniform either in the way they show empathy or in the quality of the empathy they can share, what is it then that makes some people more empathic than others?
White (1997) put forward an argument that there is a difference between what she called basic empathy and trained empathy. Basic empathy consisting of a purely emotional “feeling” response, while trained empathy is based on a more cognitive understanding or analysis of why the person may be experiencing what they’re experiencing. The training being referred to here is based on active listening techniques, a position affirmed by the likes of Egan (2011). Hoffman (1987) posits a model of empathic development called the “cognitive-affective synthesis” which suggests that empathy is present in all human beings from a very early age, develops through a series of stages over time and is illustrated in a number of “modes”. He describes six such modes.

The first is the “primary circular reaction” which argues that infants are in tune with one another almost from birth. If a baby hears another baby crying it too will start to cry, in a sense the second baby is “feeling” the distress of the first, suggests Hoffman (1987). This fairly primitive (or primary) response to another human being is, over time, modified and refined by a process of classical conditioning so that the developing child becomes attuned to cues, non verbal usually, often initially from its mother, and responds to these.

The next stage in the development of empathic faculty is, according to Hoffman (1987), Direct Association. At this stage one is able to associate the emotional cues given off by another person, verbal or non verbal, with an experience they have had themselves. The past experiences of the “helper” or listener here are obviously crucial and in the narrative data I have gathered this “mode” of empathy is very obviously at work. The ability to recognise an association between behaviours and the feelings another may be experiencing is representative of Hoffman’s (1987) third stage in the development of
empathic ability and is something which has been exploited in the training of counsellors through processes such as mirroring.

The fourth mode of empathy Hoffman (1987) labelled “mimicry” and it has a physiological underpinning. The cues of one person (non-verbal behaviours) can be imitated or copied by another and in a short space of time this will lead to the imitator coming to feel the same way.

Language mediated association, the fifth mode, describes emotional reactions in a listener being fostered by words and their meaning to the listener. This isn’t dissimilar to the third mode where behavioural cues lead to direct association with what another is feeling, but words resonating emotionally, denotes a degree of cognitive sophistication on the part of the helper according to Hoffman (1987). He offers the example of the words not needing to be spoken to have this effect; the words in a book or in a letter for example can evoke an emotional response in an attuned reader.

Hoffman’s sixth mode (1987) “role taking” demands a degree of imagination on the part of the listener, in so far as they need to be able to put themselves in the place of the other in order to come to feel what the other is feeling.

This rather prosaic overview of the various types of empathy may bring with it an idea of a developmental model which shows why some people are better able to express empathy than others; it certainly asserts the argument that cognitive ability, imagination, shared experience and the facility to express one’s emotions are central to the concept of empathy, but more importantly it also offers an analytical framework against which “types” of empathy may be gauged. All of the nurses I spoke with illustrated empathy in their stories and Hoffman’s (1987) “modes” along
with the other models noted here may be useful in helping to offer some indication as to whether this ability stems from their training or from other experiences which they may have had.

6.4 Empathy’s moral component

Certainly for five of the nurses previous experiences are at play when their stories illustrate empathy. Four of these relate experience of death, three in terms of the death of a relative (a father in all three cases), while one nurse “R” talks about his own experience of serious illness and the possibility of death which it brought into focus, as being the catalyst for their ability to see things from the patient’s point of view.

“J” for example talks about the death of her father in the hospital where she now works;

“...I saw how my dad was treated as a patient and that’s always on my mind...that I want to treat people like they should be treated”

(J pg.14)

I paraphrased “there’s something personal there” and she went on;

“A little bit yes, I can’t get away from that really”

“....my dad was ill and from the age of about fifty eight until he died when he was seventy two so for all those years he was in and out of hospital”

“so I saw how he was treated, not that bad not all bad”

“...the last six weeks of his life when he was in hospital were, just wishing things were a bit different then so that’s all I’m saying, I want to do the best for people”

“.....he was dying in a four bedded bay and if it wasn’t for me and my mum going in and cleaning his teeth and washing his hands, cutting his
nails and feeding him, you know, I’m not sure it would have been done properly”
(J pg.14)

“..it makes me sad thinking about it”

“....I’m conscious of it most days...at work...it helps me to do my very best for these people, just let them talk and tell me what they need to say, for them to say to me before they leave my room. “finally someone that seems to care someone that listens”, that’s, that’s what we’re really here for”

“....I’d say daily I’ve got the desire to do the best for these people and make them feel satisfied with, with what they’ve received that day. I want them to feel like .heard...you know, not like “there are still gaps there and she didn’t address this or that” you know”.
(J pg.15)

This offers an insight into “J’s” sense of altruism and motivation and illustrates where these values originate. She wants to do the best she can for her patients and for her this means listening in order to both understand and just as importantly, show she understands how someone might be feeling.

“J” operationalises her empathy by giving people time, listening to them and trying to be understanding of their situation. She touches on most of these ideals when she describes a consultation with a patient.

“...let them talk yes, or cry. We’ve had a few or I’ve had a few who’ve had, they knew they had symptoms, they knew there was something not quite right they have tried to tell someone, but they haven’t been acted upon the symptoms) shall we say”
"...I listen, I don’t give them a diagnosis, I’m not a doctor but I listen to their problems and they say “oh finally someone who wants to listen to me, that, I’m a specialist nurse who has got an hour whereas the GP has got ten minutes, I think that’s why it’s not that I want to listen, but I do, I’ve got that extra time”

"...I think they think of me as much more caring, oh you really seem to care, you really want to listen, as if the others don’t, you know”.

(J pg.7)

She isn’t however in any way disparaging of colleagues who do not, cannot, or will not work in the same manner as herself with patients. “J” knows how she wishes to practice and has the autonomy to be able to manage this for herself. In the previous chapter I illustrated that she also understands what it feels like to be pressured by time and to have to work in a manner alien to one’s own instincts. The feedback she receives from some patients is obviously positive and that has reinforced her belief in developing empathic understanding with the folk she meets. She is a modest woman but “J” was rightly proud when she gave me an example of what one of her patients thought of her approach;

"....we talked about the town that she lived in, a lot of history about the place, I didn’t know that she was telling me all about that, luckily she got a positive result and she even wrote a thank you letter quoting my name to the Chief Executive”.

(J pg.9)

Evident in “J’s” story are elements of empathic thinking, empathic behaviour and imagination when dealing with patients.
While each of these is mentioned in the models outlined above there is also one feature which she illustrates that isn’t quite so obvious in the views posited by the likes of Hoffman (1987) or De Waal (2008). “J” seems to feel morally compelled to act in the way she acts, there is a moral component to her empathy. This is described by Mercer (2002) as “an internal altruistic force that motivates the practice of empathy” (Mercer 2002 pg.S10) and is obvious in the feeling with which “J” rationalises her desire to do the best she can for her patients. This moral component in “J’s” case stems from the treatment her father received when he was ill for the last time and the same component is present in the stories of other nurses I spoke with.

“C” offers a very similar argument to “J” as to why she wants to do the best she can for her patients. We had been speaking about her breaking bad news and I’d asked about what she felt “worked” when she was involved in this activity;

"I don’t know, I’m just myself I think. I don’t try and bombard them with loads of medical jargon or anything; I think, I don’t know whether it’s when my dad, my dad was diagnosed with a brain tumour and he died and the things that my mum had to go through during that stage, I think I’ve learned a lot from that erm and I try and think of how my mum and dad were during that period and try and make sure, you know that the relatives and the patient are given all the information and are given time to talk about it, yes”.

(C pg.8)

A little later in our conversation she told me;

“ and my dad died in hospital and erm ,it wasn’t very dignified either when I think back, that’s always stuck with me, so I try and make sure
that when I’m dealing with patients that erm, it would be something that my dad would be proud of and...Yes...I think that hit a nerve“.

(C pg.9)

Just as her reasons for wanting to do her best for her patients are almost identical to “J’s” the empathic behaviour “C” describes is also very similar.

I have illustrated how she ensures she spends time with patients, listens to their worries and desires and acts to facilitate these as in the case of her patient with Motor Neurone Disease and the Liverpool care pathway. “C” is also an advocate of giving patients all the facts about their situation so they are able to make informed choices about their care. This again resonates with what “J” expressed in regard to not telling people what to do, but helping them reach decisions which were best for them.

The third nurse who talked about the death of a relation impacting on her practice was “K”. Her story is more illustrative of a personal experience having an effect on her practice “in the moment” in a behavioural fashion, than the stories of “C” and “J” who seemed to have developed a philosophy of being empathic as a result of their respective bereavements. This doesn’t mean necessarily that “K” is any less empathic as a nurse than either “J” or “C”, it means simply that she expressed how she shows empathy and why differently.

6.5 Empathy’s impact on behaviour

“K” had been talking to me about how she had come on duty one day; to find a patient dying after a medical procedure had led to a poor reaction in a lady to a dye injected as part of a diagnostic test. The patients family were on the ward and “K” had to tell them what was happening and why;
“Well it happened on the early (shift) I came on and the patient was already...sort of...deteriorated, but I sort of took over in the afternoon. It all sort of happened in the morning but I was obviously, I was handed that over, what exactly had happened and I was speaking to the family regarding what had happened”.
(K pg.4)

she showed an insight into what the family may have been feeling;

“...I think they’d accepted it to the point, to a certain point, but it’s quite hard for anyone to sort of, accept that news I suppose, to start off with”.  
(K pg.5)

and acted to begin to help them through the “crisis” period;

“ I’d sort of moved the lady into a side room so it gives them a bit more time they can spend with, with their relative”
“ and also I had one of the other members of staff get them a cup of tea so it gave them time then, to spend time then and sort of reflect on what had been said....”.
(K pg.6)

“K” shares “C” and “J’s” views about being as honest as possible with people in difficult situations;

“It’s very hard because every situation is different erm, and this one I think was easier because the family were all brought in and they were told exactly what was going to happen ...”

which apparently worked well in this situation;
“...I don’t think they were angry, I just think they were upset but they weren’t, they definitely weren’t angry say towards me or any of the other staff. I think they were told the fact she was, perhaps in other cases they may have been angry, but in this case they didn’t show any anger toward the staff, me or the situation at all”.

(K pg.7)

and she values what she calls clarity when it comes to giving a message;

“....I think there’s, I think you do need to be clear with people I think it helps them then take the information in....”

“It’s not the nicest of jobs, but it has to be done for the patient really they have to know”

(K pg.10)

which was the only aspect of her behaviour that she credited to her training as a nurse.

Though practical in tone there is a moral component to what “K” is saying here, while her actions are undoubtedly altruistic they are also designed to help both the family and the staff deal with difficult issues at a difficult time, the moral element as described by Mercer (2002) is evident too though. The importance of having experienced what the other person is going through in order to understand it is made clear by “K”; after I ask her if one can be taught to deal with situations such as the one she described to me ;

“...erm, I don’t know if you can to be quite honest, I think you learn, I think you learn that, the books there’s textbooks saying that you should do this this and this, but I think every situation is different so I think you
just have to learn it and then if you do make mistakes you learn from them and feel a bit better next time”

which she followed up by telling me;

“ I think though the feeling with bereavement is if you’ve had bereavement in your own life I think you can then deal with it better with people”
“....I think you can relate to how they’re feeling at that particular time”
“....I think you know how they’re feeling at that particular point because you’ve gone through a sort of similar experience...”
“....my dad died three years ago and I think after he died I can then relate more to what the family we were talking about earlier were going through at that time and it made, it failed, it’s easier now I’ve gone through that.....”

(K pg.13)

Which illustrates the importance “K” places on her own experience in relation to this aspect of her work.

The insight she has gained into what bereavement feels like is the “building block” of her understanding of what people need from her at this time. She uses her own experience, cognitive ability to relate to the context of the situation and the ability to understand how someone else might be feeling to aid them in crisis.

Further evidence of how practical her approach is comes in her preference for giving people an information booklet about “what to do now” after a death, “K” talks through what’s in the booklet with the bereaved and believes that because this was helpful to her at the time of her father’s death, it will be helpful to those she is looking after. Her approach works
because she is very respectful of what people want and need and has the insight and awareness to alter her preferred manner of empathising should that become necessary.

6.6 Empathy as a practical response

“Pursuing the practical” is also the way that “R’s” empathy with his patients is expressed. He has experienced serious illness himself in the form of prostate cancer and says this gave him an interest in the way death is seen in our society;

“I think that comes out of my own personal experience when I realised I was facing my own death with my cancer, erm and therefore I needed to get a handle on that and in doing that I needed to separate the two, my personal life against my professional life and I think I learned from my personal studies there was a lack of, no lacks the wrong word, it was a direction in our culture that said “oh death will never happen” when in fact it’s like taxes it was Benjamin Franklin said death and taxes are the only certainty”.

(R pg.8)

Personal studies at the time he was ill led “R” to develop an interest in death which he followed up when he started work as a nurse, practising in intensive care after qualifying and studying the topic at Masters level, though he didn’t subsequently finish the course. I asked if the experience he’d had and the study it had motivated impacted on his practice;

"I think so, whether it’s used effectively is not for me to judge”.

(R pg.8)
and he gave me two examples of how this was the case. Both were rooted in his own experience and both are suggestive of very cognitively focussed empathic responses.

The first of these is illustrated by “R’s” philosophy of giving relatives of very sick patients, full information about issues around diagnosis and more particularly prognosis. He takes the view that when a loved one is dying relatives are so preoccupied “in the moment” with what’s happening that they don’t really take in either care “events” or the reasons and rationales offered for these. “R” wants to ensure that later, after the patient has died the relative will be able to look back on events knowing that everything that could be done for their loved one was done and not feel any anger or guilt in relation to the treatment the patient received, or their own part in this;

“.....The second thing is you should try to inform them so they’re making informed aware decisions, I think the third thing is you’re trying to give them, well you’re coming back to what I’m aware of in my work, so they can look back and say “well the best was done” because I try to reduce any subsequent guilt they may have. Now, that might be taking my role a bit far, but that’s how I see it. If I can act correctly now, in some human context, then in time, they can look back and say “well the best thing was done for hubby, son” and be content that they’ve done their bit.”.

(R pg.11)

This belief “R” has that people will “look back” and wonder if they could have done more is also what underpins the second practical empathic action he describes;

“I think to be as open as possible erm so that person can’t turn around and say “this didn’t happen, that didn’t happen” explain what’s
happening, emphasise to them that if they’ve got any questions please, please ask, keep a diary I always suggest to people, they may not want to”

“.......I sometimes say ”well, if you write down what your thoughts are at the moment then in a few weeks, few months time when you want to look back at least you can remember what happened”.

(R pg.6)

his actions are intended to help the bereaved relative avoid unnecessary pain when reflecting after the expected death and are based on altruism and compassion. “R” is illustrating what De Waal (2008) terms perspective taking, he is showing a degree of imagination in relation to the relatives’ experience and acting to “ease” proactively the grieving process they may go through.

The National Institute for Clinical Excellence (NICE 2004), CRUSE (2011) and Macmillan (2010) have all produced standards for bereavement care which incorporate a focus on the interventions professionals like nurses ought to offer to relatives prior to and after the death of a loved one, so as to reduce the likelihood of what these organisations identify as “complicated grief reactions. “K” with her practical advice for relatives at the point of a patient’s death and “R” in offering the suggestions he does to help the relative of someone very sick prepare for the future are working in line with these standards. Interestingly the CRUSE guidelines (2011) make the point that the two most important qualities helping professionals or volunteers need are empathy and compassion.
6.7 Empathy as a human response

Another nurse whose main motivation for showing empathy was contextual was “H”. In remembering that his elderly female patient who was being nursed in a side room had come from a care home where she had regular company and companionship, he shows concern that she might be lonely and so behaves in a manner designed to alleviate any problem this might cause for her;

“.....she did enjoy the company because she’d come in from a nursing home and, and I think that came from possibly like a lounge where she knew everybody to have a chat to like unfamiliar surroundings and for the time she was in a single room as well, you know, just lonely”

(H pg.2)

“H” describes making time to give this lady “tea and a chat” in the small hours of the morning and suggests that being able to perform this type of service for people gives him a degree of satisfaction;

“........and went to give her a drink of water, she said “can I have a cup of tea?” I said of course you can and that simple act of, sort of nursing in inverted commas gave me the most pleasure all night”

(H pg. 1)

a point which he underlines with;

“........it’s just these simple little, not chores, but little acts of kindness as it were that outweigh all the hassle at times, shall we say and restores your faith in the job”.

(H pg.2)

There is a school of thought which suggests altruistic acts, or doing things for others, brings with it its own rewards. Acts of kindness can be linked
to a feeling of subjective happiness in the person carrying them out (Otake, Shimai, Tanaka-Matsumi, Otsui and Frederickson 2006), but there is nothing in what “H” has to say which suggests his motivation in being kind is self gratification. Nor does he link his actions overtly to “caring”, his actions suggest that he does care for his patient, but “H” isn’t basing what he does on any theory of caring in the manner authors such as Warelow, Edward and Vinek (2008) argue all nurses ought to. He calls his act of kindness a nursing act, but talks about it needing to be framed in inverted commas as though he may believe that nursing is somehow more complex than caring for someone.

Of course the opposite may be true; “H” could perceive his simple act of kindness as “nursing” because he doesn’t know what else to call it. In any case “H” was the only nurse I spoke with who alluded to this concept in his conversation with me.

6.8 Training and its influence on empathy

There were only two nurses who commented on their training and its influence on how they related to their patients. Neither of these offered a positive view about the impact their original introduction to nursing had had on their preferred manner of helping, or on their view of empathy.

“A” spoke about the need to give patients respect and privacy and accept their point of view when treatment options are being decided. She works with people in partnership and because she spends a lot of time with people who have chronic health conditions and who have repeated admissions to hospital she gets to know her patients very well. At one point “A” described the phenomena of the “ward family” which can develop when staff-patient relationships are renewed and maintained on an ongoing basis. It was a surprise to me to hear “A” saying;
“Yes, I think there’s two ways of looking at it. Sometimes there’s not a lot of, not always the time, because obviously if you think being in a busy hospital ward when you need palliative care, end of life care, is probably not the ideal. There are specialist services available, but also nurses I don’t think, I may be wrong, but sometimes don’t deal very well with other people’s emotions. I think again that comes down to the way, it depends on how you were trained, but we were trained not to get too involved to that point where you become too emotionally involved, but I’ve always thought that you can’t do your job effectively if you don’t get a certain degree of emotional involvement with your patients, you can’t be as effective doing the job”.

(A pg.4)

which shows that she sees the value to patient nurse relationships and care if there is empathy between the two “partners”, but which also makes it clear that her training didn’t encourage the development of empathy with patient’s circumstances.

This view of the nurse maintaining a professional stance, not getting too involved and “keeping an emotional distance” between him/herself and the patient may seem old fashioned, but it is one of the tensions which makes the usefulness of counselling theory questionable in nurse training.

The NMC take the view that “The relationship between a nurse or midwife and the person in their care is a professional relationship based on trust, respect and the appropriate use of power. The focus of the relationship is based on meeting the health needs of the person in their care. A nurse or a midwife crosses a professional boundary when they behave in any way that oversteps their professional role with a person in their care, a family member or anyone else involved with the person’s care to create a personal relationship” (NMC guidance on maintaining boundaries 2012
This statement is intended to remind nurses not to become too socially involved with patients or their relatives, but if it were to be interpreted too literally it is possible that the experience in training “A” describes might not be that unusual.

“L” was the second nurse who mentioned training and its effect on the relationships she develops with her patients. She told me about the skills she felt she had been given the opportunity to identify and develop throughout her initial training and gave examples of how her understanding of and empathy with her patients had been enhanced by her own experience as a patient in hospital. “L” was very positive when reflecting on what she’d learned during her education as a nurse, but spoke more forcefully about the benefits of a different form of interpersonal skills training. “L” as a manager of a service conducts some of this training herself;

“….. radiographers come to me also with any problems they’ve got. So for training, there isn’t any specific training in place for mandatory, or appraisals, or cannulation what else, customer care, conflict resolution training because I was doing it for the nurses CIAs and OSWs then the radiographers came to me and I seem to have been , I seem to have taken on that role”.

(L pg.4)

her role allows for her to identify training which will benefit her service and “L” ensures that those working for her undertake her positive customer care course. Later in our conversation I enquired about what she thought this training did to benefit patient care;

“Communication is a massive thing though isn’t it, given that’s where you get most of the complaints. Most people know it already it’s just
reminding them....so they’ve got it from their life experiences that little bit of training it’s just reminding them making them think as well and maybe getting them to think of maybe going to the supermarket and buying something and not getting the customer care that you expect and how you feel so that you can put yourself then in the patient’s position , it’s just making you reflect I suppose, isn’t it on your own experiences because we’ve all got an experience where we’ve not been “treat” well as a customer“

(L pg.15)

The rationale underpinning positive customer care training is derived from “business”, where a customer centric culture is believed to inculcate loyalty in folk using particular products or services so that they might come back to the same provider again. In the National Health Service positive customer care training was introduced following a shift in ideas about how “quality” of care should be considered and measured after the introduction of the “National Health service and Community Care Bill” (DoH 1989) which followed the white paper “Working for Patients, Caring into the nineties” (DoH 1989). This was the bill which introduced the idea of hospital trusts as independent organisations providing care and treatment and which gave General Practitioners (GPs) the ability to offer their patients a choice as to where they wanted to be treated. The intention was to create a “market” within which trusts could compete for “business” from GPs and the belief was that this “market” effect would lead to trusts seeking to show that the services they provided were “better” than those offered by their competitors.

Systems for measuring the technical and professional quality of care evolved to include a focus on the “patient or customer perceived quality and satisfaction with the service experience” (Ferguson, Paulin and Leiriao 2006 pg.59) and this encouraged trust managements to consider how
their staff might be encouraged to consider improving interactions with customers (patients), resulting in the development of positive customer care courses. These were generally organised by trusts through their own “in house” training departments and often those attending were expected to “cascade” what they had learned on a course down to their colleagues on the ward.

“L” had been through this process and in passing on what she had gained from such a course to her own staff was seeking to improve the experience patients had of the X-ray service she manages. The desire to ensure staff patient interactions are good may relate to her own experience of hospitalisation which might make the training in itself an act based on empathy, it is certainly underpinned by a degree of altruism and a belief in its efficacy.

Rogers (1961) argued that central to the helping process was a desire on the part of the helper to understand how the client (patient here) feels about the situation within which he/she finds him or herself.

The ability to show this desire to understand how another feels, to that person, is also said to assist in the development of therapeutic relationships. The stories I gathered provide evidence in their content that these nurses were all minded to understand how their patients felt, wanted to share this understanding with those patients and believed that these actions, in and of themselves, could be helpful.

This desire to be empathic stems often from the personal experiences of the nurses concerned (though not exclusively so) and seems to have little to do with any training processes the nurses have been through. The information giving discussed in chapter five, allied to the desire and ability to be understanding illustrated here represent what these nurses resort
to, almost by default, when confronted with difficult and challenging demands on their interpersonal abilities.

The relationship of these findings to the literature reviewed above is considered in the next chapter. I also reflect on the implications of the findings for the training processes with which I have been associated as a teacher of nurses and discuss what the findings might imply for research into this area in the future.
CHAPTER SEVEN

DISCUSSION

Preamble

Endings as a theme has formed an integral part of every course in counselling I have undertaken. Good endings to helping relationships are planned in advance, worked towards and should be celebrated by those involved.

The celebration for me has always been a moot point, not because of any inborn predisposition to being miserable, but because I want to know I have done what I was meant to do and that there is actually something to celebrate.

If one applies the same principles of good endings to the research process, then this is the time for me to be wrapping things up, celebrating the end of what’s been a fairly arduous process all in all and thinking about what, if anything has actually been achieved.

I think I am in a position to answer my research question which was to do with whether nurses’ use of counselling skills is evident within the stories they tell about interactions with patients and carers. The answer is yes and I have identified the particular skills that are used and explained, to some extent, why this might be.

I am also in a position, thanks to those who were generous enough to offer me narratives and those who have guided my analysis of these to claim I have learned much more than this in relation to the context within which the skills are used, the reasons for their use and the relationship of these skills to the caring enterprise. This learning beyond what I
consciously sought is an “artefact” of the research process itself and one of the benefits of engaging in that activity. I have been surprised that in seeking to answer my original question I have actually discovered there are many others which are equally or perhaps more interesting which in the future I would like to be able to follow up.

I will attempt to reflect on what I have gained from my involvement in research and on the inspiration it has given me later on but for now……….

The chapter itself is concerned with reviewing the results of my investigation. This necessitates comparing the findings with what the literature originally reviewed had to say about counselling skills in nursing and my revisiting the literature in the light of those findings.

I outline the skills evident within the narratives and offer an argument that they are “linked”.

The skills I’ve identified within the narratives are “Empathy” and “Information giving”, and while development of the former always precedes delivery of the latter in any of the interactions, I have analysed the two skills together represent “caring” on the part of the nurse.

This places information giving as an empathic act in itself, or as what I describe here as the behavioural component of empathy. A rationale for my assertion is offered and I discuss the implications of what I have found before I comment on the limitations of the study.

I conclude by returning to the reflexive comment begun above.
7.1 What has been identified?

The two skills most evident in the narratives I analysed were “Empathy” and “Information giving”. Both of these skills have featured prominently in the findings of other investigations whether these were based on quantitative or qualitative approaches to gathering data.

While some surveys might suggest that nurses feel being “informative” is a more comfortable option for them than being, for instance, “cathartic” (Burnard and Morrison 2005) or that nurses need to feel expert in their field before undertaking patient counselling (Lipponen et al 2006), hearing a nurse’s explanation of why he/she offers information allows for a better insight to be gained into the thoughts and feelings which underpin the actions identified by the more “one dimensional” survey approach.

Equally the narratives contain examples of empathic thought and empathic behaviour, which I feel illustrate what the concept of information giving means to nurses in a manner which a score from a questionnaire could not.

I have found that the assertions I make about the narratives are influenced to a degree by the way in which they were told to me. Hearing the way the nurses tell their stories, being able to gauge tone, detect emphasis and sense nuance, allowed me to make similar assertions to those made by Soobhany (1999) on reading the work produced for him by the participants in his analysis of their reflective writing. My reason for including reference to Soobhany’s small study in the first place related to what I felt was a link between the thoughts of a person being expressed
on paper and hearing those thoughts spoken out loud as part of a narrative. Through medium, written or spoken, the narrator conveys more than just the meaning of the words he/she uses to deliver their message to the reader or listener. I have found that narratives represent a rich source of research data and have discovered the researcher is tempted to follow up ideas raised within the stories he/she hears which may not necessarily relate to the topic originally identified for investigation.

While my focus in this study has been on the skills used by my narrators within their embedded counselling role (McLeod 2008) a number of concepts, each of which would represent an interesting and worthwhile focus of research in their own right have become apparent.

7.1a Concern

For example, it is obvious that the nurses I met with care about their patients. “C” wanted the man who had motor neurone disease to have his wish to die at “home” facilitated; “H” understood the lady in the side room who had come from a nursing home might be lonely; “K” believed the family of the lady who had died unexpectedly deserved an explanation of what had occurred and “L” acted to relieve some of the anxiety her patients might feel having investigations for illness which could prove serious.

There is evidence of the nurses’ concern for their patients in these narratives as well as indicators of the nurses desire to create an environment within which people can express what might be bothering them, be listened to respectfully and have those worries addressed.

Creating an environment within which patients can express their worries demands that the nurse is willing to engage with the patient, spend time
listening and do what is needed to assuage any anxieties. These abilities, and priorities, are evident within each narrative and are the bedrock from which the skills of empathy and information giving emanate.

These were also the qualities Soobhany (1999) asserts were present in the writings he analysed and which he argues evidence the use of counselling skills in the practice of the nurses who wrote those pieces. I am not certain I would agree entirely with Soobhany’s (1999) description of the human qualities evident here being counselling skills, but those qualities need to be in place as a pre requisite to any more focussed attempt at helping and do in themselves represent a fairly close approximation to what Rogers (1959) might have recognised as underpinning the humanistic person centred approach.

7.1b. Caring

Both the concern for people and the desire to act on this to improve conditions for them which is evident in the stories I heard are indicative of what Gastmans (1999) described as caring. Each of the nurses I spoke with exhibited what Gastmans (1999) terms a moral attitude in the sense that they are willing to offer a “sensitive and comforting response to the circumstances of a vulnerable human being who is in need of help” (Gastmans 1999 pg.216).

Nurses such as “R” in the intensive care unit, “J” in her clinic seeing patients coming for investigations, “H” on the medical ward at night time and “K” dealing with relatives on the surgical unit all show a willingness to “do something” for their respective clients. This willingness is representative of what Gastman (1999) terms “morally virtuous behaviour” (Gastmans 1999 pg.126) a quality which itself is indicative of caring. Gastmans (1999) argument is that the nurse can choose to ignore
the patients emotional need for comfort, their main responsibility is after all to provide physical care and it can be difficult and time consuming to try to understand and empathise with a person’s feelings and then act to help improve the situation from the patients perspective. The caring nurse will opt to address the patients emotional need. The choice as to whether to act in a morally virtuous manner is, one assumes, only open to those nurses who are able to understand the patient has these emotional needs anyway and this understanding depends on an ability to be insightful and empathic, acting on this empathy is what makes the nurse caring.

Within the narratives there is evidence of such conscious consideration to provide comfort for the patient on the part of the nurse. The desire to help seemed to be intuitive but this doesn’t mean it was purely emotional. As Gastman (1999) points out a purely emotional response probably wouldn’t meet the patient’s practical needs anyway, there has to be an understanding of the patients need for comfort of some kind, a willingness to meet this need and an ability to decide what one can practically do to help.

The narratives show the nurses I spoke with are able to develop an understanding of what it is that is troubling a patient, have a willingness to act so as to make things feel better and recognise the limits of what they can practically do to assist the patient.

The case studies from the Health service ombudsman relating to the care received by older people within the NHS (2011) and the report from the Public Inquiry into Mid Staffordshire Foundation Trust (2013) might suggest that this ability to recognise needs beyond the physical and the willingness to act on this recognition is not universal to all healthcare professionals.
In its response to the recommendations which arose from the Mid Staffordshire inquiry the Department of Health (2013) has recognised the need to assess in some way the caring values of those who wish to enter nurse education. The Department of Health is suggesting that “values based assessment” as part of the selection process may help identify those prospective students most suited to a career in nursing (DOH 2013) and in so doing they are reflecting Watsons (1999) argument that nursing is caring, nurses have to have the sensitivity to identify and understand the patients’ needs and the willingness or motivation to act on this understanding.

In suggesting that prospective nursing students have to have caring values before they enter training the Department of Health (2013) are reinforcing an assertion Gastmans (1999) makes about the genesis of the caring nature.

Gastman (1999) argues that caring is a quality which a person develops as they gain life experience. If the culture within which one is raised and educated is caring then one will come to value the morally virtuous behaviour one is exposed to and internalise the desire to provide assistance and comfort if one can.

This perspective on caring suggests that the nurses may have had the motivation to behave in a morally virtuous manner prior to their entering nursing at all. It raises questions for me about whether all the elements of caring can be taught but simultaneously it reassures me that in focussing on the teaching of interpersonal skills from a counselling perspective nurse education may at least facilitate the more behavioural elements of caring described by Jerome (2009) and Watson (1999).
As a teacher the presence of these more behavioural components of caring in the narratives is reassuring as this suggests, at the very least, that some elements of interpersonal skills training are transferred into practice and may at the very best facilitate patients benefitting from the “naturally” caring nature of the nurse.

The perspective of caring as moral attitude demands that the nurse engages in caring behaviours initially in order to create the relationship within which he or she can begin to understand the patient’s needs. This relationship is underpinned by respect for the individual and the ability to listen to his or her perspective described by Jerome (2009) as caring behaviours and by the nurses adherence to and engagement in what Watson (1999) termed as carative factors.

The importance of the nurses interpersonal skills in regard to the development of a relationship within which caring can be demonstrated as morally virtuous behaviour is reflected in the interdependence of the behavioural and affective components of caring outlined here.

Nurses such as “R”, “J”, “H” and “K” are not in a position to “cure” the people they are working with, their role is to care, a concept complementary to curing and in the circumstances described within the context of the narratives arguably more important. The desire to help, the ability to form good interpersonal relationships with their patients and the insight to appreciate the limits of what they can offer are all illustrative of the caring qualities these nurses possess. It is these qualities and the interactions they underpin which, as Tuckett (2005) suggests, make the difference between nursing and caring.
7.1c Willingness to engage

There is a seeming openness about the interactions described within the narratives which offers a sharp contrast to the argument posited by Redley (2010) that nurses seek to engage in “interaction management” by controlling conversations. Though Redley’s (2010) work was focussed on interactions between nurses and folk who had “self harmed” and this could understandably lead to conversations which any nurse would find difficult, some of the nurses I spoke with offer insights into scenarios which could be just as challenging.

“A” in her dealings with patients who have debilitating and degenerative long term conditions; “J” meeting regularly with people who fear they might have cancer and “R” in his bedside interactions with relatives of patients in intensive care engage daily in difficult conversations.

Their stories are not suggestive of any desire to avoid topics which might be troubling for them, rather they are open to being guided by what the patient wants to talk about, willing to listen and able to deal with the anxiety which might be generated by not being able to provide an answer.

These nurses are not simply reacting in the interaction as did the nurses in the research by Movahedi et al (2011). There is nothing to suggest that only when the patient brings up a topic which is troubling him/her will the nurse address such an issue. “R” and “C” both speak about the responsibility; they feel they have to sit down with patients after a doctor’s round to make sure the patient has understood the message being given. “D” talks about the necessity of ensuring relatives understand the options open to them when a loved one is nearing the end of life and “K” emphasises the worth of clarity when it comes to the nurse having to break bad news.
Each of these nurses shows a willingness to engage in difficult interactions and to initiate those conversations in a sensitive manner. There isn’t any hesitance evident due to feelings of not knowing enough about conditions or other medical matters, as was the case with the nurses Lipponen et al (2006) surveyed, nor is there any overt evidence of fear at “getting it wrong” acting as a stumbling block to the nurses engaging in these difficult interactions. Witness “K’s” story about meeting the family of a woman dying after a medical procedure had caused a catastrophic reaction, or “L’s” tale of waiting to speak with the man who was rushing to hospital because his wife was dying but who, in the end, got there too late.

7.1d Motivations

While the desire to act in a caring manner could explain this willingness to engage with people, to do something to offer comfort, there is evidence within some of the narratives that prior experience and the original motivation to enter nursing is also important here.

“J”, “C” and “L” all offer insights in their stories of a desire to do their best to provide a standard of care which is better than they have experienced or witnessed themselves.

This motivation is the inverse of one of the intrinsic motivating factors described by Mooney et al (2007) Morris-Thompson (2011) and Eley et al (2012) in the sense that these authors argue that in their investigations nurses were motivated to enter nursing partly because they had witnessed loved ones receiving good quality care.
In the cases of “J” and “C” the poor care they felt their fathers had received is cited as one of their motivations for doing the best they can for their patients while in the case of “L” her own experience of feeling left alone on the ward while in hospital inspired her to want to ensure her patients were both acknowledged and comforted while under her care. All of the nurses I spoke with wanted to provide the best care they could for their patients which reflects the findings of the RCN (2013) survey and none suggested that staffing levels, patient numbers or long working hours were a problem.

None of these nurses expressed the desire to change the work they were doing or leave the profession which were factors illustrated in research by Gambino (2010) and within the RCN survey (2013) though one nurse “J” did tell me that her current position allowed her to interact with patients for longer than was the case in her previous position and accordingly gave her more job satisfaction.

Satisfaction with work is identified as a motivating factor for staying in nursing in research by Dockery and Barns (2005), Newton et al (2009) Morris-Thompson et al (2011) and Eley et al (2012). This satisfaction seems to derive from patient contact and the opportunity to help improve someone’s situation which this facilitates (Newton et al 2009, Eley et al 2012) and has been described as a privilege which brings fulfilment (Morris-Thompson 2012).

While the narratives evidence the ability on the part of the nurses I spoke with to use interpersonal skills to form relationships, empathise with the situations of their patients and act in a caring manner on this empathy there is no evidence of any desire to depict themselves individually as especially caring people.
Given that these nurses made no attempt to focus their conversation on the interpersonal and communication skills I was actually hoping to see illustrated within their narratives this is not too surprising.

Only “L” makes any reference to the public’s expectations of the nurse to be caring and then in a joking manner. This is perhaps surprising given the recent publicity accorded to caring, or the lack of it, within the nursing profession (YouGov 2012, Ipsos Mori 2012, DOH 2012, DOH 2013) and reinforces my view that these nurses are driven to do the best they can for their patients by intrinsic rather than extrinsic factors. Public perception of nurses as reflected in opinion polls (YouGov 2012) would suggest that nurses are less caring and less professional than they “used” to be. The criminal prosecutions of care staff after the Winterbourne view abuse case (DOH 2012) may have fuelled this perception and the Mid Staffordshire Foundation Trust Public Inquiry (DOH 2013) will have served to confirm it for many people.

The public are unaware of and probably wouldn’t care that nurses now have to look after more people with more complex needs than ever was the case before (Gambino 2010,CQC 2012) and they expect to be treated with kindness, courtesy, respect and compassion (Huffstutler et al 1998, Ipsos Mori 2012, YouGov 2012, CQC 2012, DOH 2013).

The narratives I’ve collected suggest that, at least in respect of these nurses, this is happening, not because of concerns that a nurse has to be seen to act in a caring manner but because caring is the reason they became nurses in the first place.
7.1e Ensuring understanding

Nurses being willing to sit down with patients and give explanations, almost acting as interpreters of what a doctor might have meant sometimes, is a phenomenon which has also been identified by other investigations.

Tejero (2012) suggests that patients, when asked, say they value very much explanations and information being given by a nurse. The opportunity to find out more about one’s condition, what has caused it and what can be done to relieve it, is seen as an element of good quality care by patients (Tejero 2012).

That a number of the nurses’ narratives suggest they are willing to discuss with patients the illness affecting them, its possible consequences and ensure that the patients understand the implications of these, is also in line with what Persson and Frieburg (2009) found when they interviewed nurses and patients about the content of their conversations.

In their accounts “R”, “C”, “K”, “J” and “D” all allude to being concerned with ensuring the patient understood what it was the doctor had said, or had meant, during a consultation. Their reason for this was often centred on a belief that doctors sometimes used quite complicated technical language which patients might not understand and the patient, being too embarrassed to admit to not understanding, would be left “in the dark” without the medical conversation being followed up.

Two of these nurses spoke about their willingness to provide written information for patients. “C” told how she would use the internet to search for relevant materials and “K” described the booklet she gives to patients which provided information on what to do after a death.
There are echoes within the narratives of what Collins (2005) found in his investigation of the ways in which doctors and nurses related to patients, in the sense that nurses generally spent more time with patients and were better able to negotiate conversations to maximise both understanding and collaboration.

7.1f **Time**

The points made above in relation to the nurses’ narratives suggesting a willingness to listen to patients, a desire to ensure patients understand what it is that is happening to them and have the opportunity to express any feelings they may have about their health, indicate that these nurses were willing to find time to spend with their patients to facilitate these things happening.

“J” told me that having the time to spend with patients while they discussed their worries about the results of the diagnostic tests they were having, gave her a great deal of satisfaction. Previously she had worked in an outpatients department where patients were receiving the results of diagnostic tests and had been upset on occasion at having to cut short her conversations with people who were worried.

She told me that at times patients had been told their results would be sent to them at home, rather than being given to them in the clinic, because staff were afraid they would not be able to deal adequately with the upset the result would cause for the patient.

“J” knew this felt wrong, but the pressure of time created by the number of people being seen in outpatients meant she had no control over the attention she could give these unfortunate people. In her new position she was more autonomous and could devote the time she felt necessary to each patient.
“L” also managed her own time and spoke about the opportunities she had to engage in more social conversation with patients who might be anxious at attending for diagnostic tests. She felt this interaction was important both for helping patients relax and “humanising” the clinical environment in which she worked. In a similar vein “H”, working nights in a medical ward found that he had time to spend with patients he felt might be lonely or in need of company. He described conversations with an elderly lady in a side room who had been admitted from a nursing home and whom he felt liked a chat and a cup of tea. When he had time he would join her.

The narratives of these nurses indicate they are able to spend time with patients to engage in clinically focussed and social conversation, which is at odds with what McCabe (2004) found in her interviews with patients about nurses communication skills.

McCabe (2004) discovered that the patients she interviewed wanted a more personal relationship with the nurses who looked after them. These nurses should be friendly, able and willing to listen and empathic. Patients also wanted nurses who had a sense of humour and who got to know them as people. The biggest problem in communicating with nurses found by McCabe (2004) was to do with time. Patients felt nurses didn’t have the time to spend with them in order to get to know them very well. They believed that nurses could communicate very well in the main, but that a lack of time impacted on the type of relationships which could develop as a result.

The two other nurses who regularly worked night shifts “D” and “R” also mentioned being able to spend time with patients and their relatives.
“D” works in a private unit within a district general hospital which provides accommodation for the relatives of very ill patients and “R” works in intensive care.

“D” told how she only has to tell her colleagues a patient, or his/her relatives, wish to talk and she can find the time to accommodate this. “R” described spending time conversing behind the curtains in his unit at two and three in the morning.

The other three nurses in my sample all regularly work day shifts. Even so “K”, “A” and “C” described interactions with patients without citing time as a particular problem. The nurses who described time as a specific asset in terms of being able to interact with patients were those who had the autonomy to be able to decide how to utilise their time or those who worked nights.

Patients when asked about what nursing behaviours are most indicative of caring have regularly cited the nurse giving them time and being accessible as very important priorities for them which tends to reinforce the assertion of McCabe (2004).

A number of studies utilising either the CARE Q instrument (Larsen 2002) or the CBI (Wolf et al 2003) have shown that patients in various hospital settings valued the nurse being “there for them”. Parsons, Key and Gray (1993) found that patients in surgical units were reassured by the regular presence of the nurse at their bedside, patients being treated in a trauma unit said that the nurse spending time with them made them feel as though he/she was “putting them first” (Hayes and Tyler-Ball 2007) and relatives of patients being treated within intensive care units saw those nurses who made themselves accessible, approachable and who spent time with them more caring (O’Connel and Landers 2008)
From the illustrations of concern, caring, willingness to engage with patients, willingness to listen to them and desire to ensure they understand what’s happening to them which are apparent within these narratives it would seem that these nurses were practicing as the NMC (2010) and NICE (2010) would wish.

Their descriptions of interactions with patients and their carers suggest the nurses are compassionate and caring in their approach and that they are willing to become involved in conversations which are challenging and which could be upsetting for themselves and for their patients. The narratives suggest nurses are motivated to be “present” for patients and supportive of them when health difficulties create uncertainty or fear.

The next section of the chapter discusses the skills nurses draw on to facilitate these difficult interactions.

7.2 Non Verbal Skills

Kruijver et al (2000) argued that the skills most often retained into practice were those deemed mechanistic; in making a similar point Chant et al (2002) used the term instrumental skills. These are skills which can be learned almost by “rote” and which students find easiest to practice. They are also the skills most students feel most confident in using. The most mechanistic of the skills the nurses who provided narratives would have learned would have been those which relate to “skills of attending” (Egan 2011). These are the non verbal skills encapsulated in the acronym SOLER.

Surprisingly in a subject area replete with acronyms (SOLER, SURETY and SEGUE are described above) none of the narratives refers to any. Only
three narratives refer to non verbal communication at all and the same number contain reference to paralinguistic communication.

“L”. Describes being aware of posture as a non verbal feature when she is interacting with people and links this conscious awareness to her training. She uses the term “Open Posture” as indicated in SOLER and rationalises her opinion about its importance with broad reference to having to appear open or approachable to her patients. This view probably reflects her belief that if patients are anxious they need to know they can broach this with a helper and “L” is sending out a signal that she is amenable to such an approach. This type of behaviour on the part of a helper impacts on a patient at an emotional or relational level according to counselling psychologists such as Sikorski (2012).

“L” also refers to eye contact in her narrative, but not in the expected sense. She talks about winking at patients to help them feel “less alone” in the clinical environment. One can’t be sure but one suspects this was not recommended as good practice during her session on skills of attending (Egan 2011), but it brings to mind improvisation in terms of communicating which mirrors Stickley and Freshwaters (2006) views about encouraging nursing students to utilise their innate emotional intelligence.

“L” was the only nurse who mentioned using touch as a non verbal skill describing how she saw it as her role sometimes to be there just to hold the patient’s hand. SURETY (Stickley 2011) includes a focus on this particular intervention and the implication is that touch should be explicitly advocated as a communication skill to student nurses. The survey by Kozslowska and Debszynska (2012) suggested that the majority of the nurses they asked said they used touch as a non verbal
communication skill, again holding hands was the example given, so perhaps finding reference to it in only one narrative should be surprising.

The other narrative which contained reference to one of the skills of attending came from “D” She spoke about the need to sit down when in conversation with patients or relatives for any length of time. The final mention of any non verbal skill came from “K” who described her conscious use of silence when involved in breaking bad news to patients or relatives. Silence is something with which nurses can struggle in interactions (Harris and McEwen 2010) and many will try to avoid its occurrence or try to “fill” it inappropriately when it does occur. “K” is using her own silence to allow people to assimilate the news she is helping to impart. In doing this she is helping to aid reflection and understanding, but in remaining present she is also showing support for the person receiving the news. This particular “skill” is one which many students I have met are anxious about having to use in practice; in her narrative “K” gives it an almost normative quality.

7.3 Para Linguistic Skills

Only three nurses, “H”, “L” and “D” described using these skills in their narratives. The specific features of this type of communication mentioned were tone and speed of speech.

“H” described how he became aware that his tone of voice was changing as he spoke with a patient who was beginning to annoy him. “L” spoke about how someone’s tone can convey an insight into what they might really be thinking or feeling and “D” talked about the need to be calm and clear when delivering a difficult message to patients or relatives. This demands an awareness of one’s tone and the speed of one’s speech.
Counselling theorists such as Sikorski (2010) argue that para linguistics, or para verbal language, can be a good indicator of the true emotional state of a patient and is something which a therapist should be mindful of during interactions. Looking for inconsistencies between the words being used and the emphasis put on them, or the congruence of words with other non verbal signals, should alert the therapist to issues worth following up. Nurses in training do not consider paralinguistic communication in the same manner one would expect students of counselling to, but the narratives from these three nurses show a bigger focus on “how something is said” could be a positive step toward improving the quality of care patients receive.

One of the reasons paralinguistic communication is important to the counsellor is its link to the emotional state of the patient. If a nurse were to become able to understand and interpret paralinguistic behaviours this would, arguably, put him or her in a position where they could begin to interact with the patient on a more emotional or relational level.

Awareness of his tone allowed “H” to moderate the way he was speaking and reflect on how he might be “coming across” to a patient annoying him. “L” and “D” also focus on the manner in which their paralinguistic behaviour may impact on patients, the one in an attempt to appear friendly and “safe”, the other in her desire not to upset patients any more than possible when delivering bad news.

In all three narrators there is ability to “put themselves in the place of the patient”; at least in terms of what the patient might be hearing and how he/she might be hearing it, which is suggestive of a relational rather than an instrumental phenomenon at work. The ability which is implicit here to understand how one can affect others and the desire to control the impact
of this is reflective of the qualities which underpin emotional intelligence (Mayor, Salovey and Caruso 2002). These are the qualities of self-awareness which training in communication would be aimed at developing through the use of experiential learning methods and the combination of interpersonal and intrapersonal sensitivity, engendered by such an approach, should help to increase a student’s capacity to be empathic.

The presence in the narratives of this more relational quality is discussed in the next section.

7.4 Empathy

All eight of the narratives contained descriptions of behaviour which is indicative of the use of empathy.

This is a very positive finding if one accepts the assertions of authors such as McCabe (2004), that patients see the understanding synonymous with empathy as a key communication skill on the part of nurses looking after them, or if we recognise the importance of this quality in developing any therapeutic relationship (Reynolds and Scott 2000).

Empathy is also valued as being integral to the provision of high quality care (Yu and Kirk 2008) and simply to be understood is described by Kunyk and Olson (2001) as a “basic human need” (Kunyk and Olson 2001 pg. 317).

The finding is also positive in the sense that the quality of empathy is not universally associated with nursing practice (Reynolds and Scott 2000), is not a quality all nurses have been found to possess anyway (Yu and Kirk 2008) and which cannot reliably be taught (Brunero et al 2009).
7.4a **Empathy in Nursing Practice**

While there is much literature focusing on empathy in nursing it is inconsistent in its tone and inconclusive in terms of results. Part of this may relate to the description of empathy as an “immature concept” (Kunyk and Olson 2001), which suggests it is not fully understood or that there is no real consensus about what it actually is in nursing terms. Part of the problem may lie in the approaches that have been used to measure “empathy levels” in nurses. Yu and Kirk (2008) describe twenty different “instruments” in their literature review, these have been used variously for self-reporting studies, patient – nurse dyad comparative studies and peer review studies. Attempts to measure whether empathy can be taught are also varied in their results. Brunero et al in their literature review of this topic of 2009 found nine different measurement tools had been used, while some authors (Ward et al 2012) found empathy levels actually reduced in student nurses over a one year period of practice placements.

Interestingly Gambino (2010) touched on this phenomenon when researching the concept of motivation among qualified nurses. She asserts that where a person has the ambition of entering nursing and this is based on a desire to care or to make a difference to the lives of those he/she will encounter that there is a danger of what she terms “reality shock” impacting on this idealism. Reality shock is related to the realisation that nursing is less than glamorous, hard physical work and carried out in an environment which is pressured and often poorly resourced (Gambino 2010) it is one of the factors likely to encourage nurses to want to leave bedside nursing.

Within the results of the RCN survey (2013) there is some evidence of this realisation that nursing is “not quite what I thought it was” if the
figure of 43% who would recommend nursing as a career to anyone else is to be believed (RCN 2013) and the findings by Brooke et al (2004) that second and third year student nurses had been shocked by the responsibilities they were expected to take on, the long hours, shortage of staff and academic demands placed upon them reflects what Gambinos respondents had to say.

Most of the attempts made to identify how empathic nurses are have been rooted in a quantitative approach. (Yu and Kirk 2008). Generally this has meant a survey method has been used and questionnaires administered either to nurses themselves, or to the patients they are looking after, or to nurses and another group of healthcare workers to arrive at a comparison.

Recent examples of such studies are represented by the work of Hojat et al (2003) who administered the “Jefferson scale of physician empathy” (originally designed for testing empathy in medical students) to 32 nurses, 33 doctors and 37 paediatricians in an American study. Paediatricians scored more highly than nurses and both scored more highly than doctors, most studies though show no real difference in their subjects.

In a study using the same instrument with 56 nurses and 62 doctors, again in America, Fields et al (2004) identified no differences and Ward et al (2012) used the same questionnaire on 214 students at the start and the end of the 2006-2007 academic year and found that their empathy scores decreased; the students who had had more practice placements during the year had the biggest decrease in scores!

There are two points worth noting here. The first is that where a number of different instruments are used to conduct research, there is likely to be
a fair degree of inconsistency in the results yielded by the research. The second is that even when the same research instrument is used for different projects, there may still be inconsistency in the results obtained. Empathy is undoubtedly a difficult quality to measure and in nursing it has proved a difficult concept to define.

A number of authors have suggested that empathy is a multidimensional concept which introduces the notion that there may be different types of empathy, or different components to the quality. Allgood (2005) talks about intrinsic and acquired empathy, Kunyk and Olson (2001) describe five different conceptualisations of empathy, these being empathy as a human trait, a professional state, a communication process, as caring and empathy as a special relationship. It has been described as comprising emotive, moral, cognitive and behavioural components (Morse et al 1992, Mercer and Reynolds 2002) and of course Rogers (1957 pg 99) defined it as an ability “to sense the client’s private world as if it were your own”. He stressed the “as if” element suggesting a need for some objectivity on the part of the helper.

Applying some of these ideas to the empathic content of the narratives allows for an analysis of the quality of the empathy illustrated. For example while each of the narrators show they are able to understand the difficulties confronting their patients and what these difficulties may mean for the patient, thus “sensing the clients world” each of them also shows the ability to maintain the boundary between what the patient is experiencing and what they are experiencing themselves. These nurses remain able to usefully work with their patients because they are not overtaken by sympathy for them or by sadness at their situations.

“J”, “R”, “K”, “L” and “C” all disclose in their narratives personal experiences which have a resonance in the context of the encounters with
patients which they describe. Three of the women here all cite personal experiences of bereavement as something they draw on in their dealings with the patients they speak about. Each of these women shows an awareness of how the death of their fathers is impacting on their desire to ensure the patients they are dealing with, in the present, receive the best care they can provide. In the cases of “J” and “C” this desire relates to a belief that their fathers could have received better care than the nurses felt they had actually received, while in “K’s” case, the memory of the shock and numbness she felt at the sudden death of her father seems to act as a “driver” to the same end.

“L” discusses her brief experience of hospitalization which, probably not as traumatic on the face of it as the experiences of bereavement described by her three colleagues, has obviously “left its mark” on her, while “R” talks in his narrative about his experience of cancer and how it raised issues about his own mortality for him which inspired him to go on and study the field of “care of the dying” at a high academic level. This “R” felt was having an influence on the manner in which he related to patients relatives within the intensive care unit.

These five nurses are recognising the impact of their own personal experience on the way they relate to patients, but their narratives suggest they are not acting toward the patients in a biased or overly directive way because of it.

They illustrate an ability in their narratives to recognise their own “frame of internal reference” and their ability to suspend acting on it in a way which would overly influence or direct the care they provide for their patients.

Williams and Stickley (2010) argue that this ability to recognise and then suspend the impact of personal experience is suggestive of the self-
awareness which underpins “professional empathy” (Kunyk and Olson 2001) and it is also indicative of the “as if” understanding Rogers (1957) felt enabled a helper to desist from taking over and directing a client’s choices and actions in the counselling context.

“J” is very clear that she will not tell somebody what they should do; “C” wants to ensure her patient has his wishes met; “K” seeks to clarify options for people after bereavement; “L” makes sure she is present for her patient and “R” works to help prepare relatives for what might come. Each of these narratives suggests an individual behavioural response to the individual nurse’s “internal frame of reference” which comes from their own individual experiences. Empathy may not necessarily be displayed in the same way by everybody and narratives offer an opportunity to illustrate how different people operationalise the quality in differing nursing contexts.

“H’s” feeling that his elderly patient may have been lonely; “A’s” view that patients need to be treated as individuals and their autonomy respected even if they have little mental capacity and “D’s” desire to ensure understanding and choice do not appear to have any grounding in personal experience.

These represent the affective and cognitive dimensions of empathy underpinning examples of empathic behaviours which are rooted in what Morse et al (1992) and Mercer and Reynolds (2002) described as the moral component of empathy. This is related to an internal altruistic drive which is evident in all of the narratives and which relates to the nurses wanting to do the best they can for their patients.

Kunyk and Olson (2001) argue that the end result of this altruistic phenomenon, the nurse acting to improve the patient’s situation, is
indicative of what they call “empathy as caring”. Each of the narratives suggests the nurses are driven by a desire to “improve the patient’s lot” and that they act in their various ways to achieve this. Again the quality present is the same; the indicators of that quality at work are different.

The altruistic desire to “make things better” stems from what is termed by some theorists as natural, intrinsic or trait empathy (Allgood 2005) or basic human empathy (Kunyk and Olson 2001). The argument made is that this is either part of the person’s personality or it isn’t and that it probably cannot be taught. Its presence within these narratives is reassuring, but one cannot assume it exists in every nurse. The ability of at least five of these nurses to recognise the importance of their own experiences and gauge the impact this could have on their practice while at the same time managing not to imbue their patients with their own thoughts and feelings, is also reassuring and indicative of the qualities valued by Rogers (1957).

Evidence of the moral, cognitive, affective and behavioural components of empathy identified by Morse et al (1992) and Mercer and Reynolds (2002) is also heartening as are the indicators of Professional empathy and empathy as caring conceptualizations posited by Kunyk and Olson (2001).

It is difficult from the narratives to present an argument about what impact training has had in helping the narrators develop the quality of empathy, if indeed it has had any impact at all. It is possible though to quantify the end result of this empathy, “the empathy as caring (Kunyk and Olson (2001) indicator” as it were.

In most of the narratives this behavioural component was reflected in “information giving”. The reasons for this behaviour stem from a relational perspective and while information giving has been termed an
instrumental (Kruijver et al 2000) or mechanistic (Chant et al 2002) communication behaviour in the next section I will attempt to show that it is actually an extension of the nurse’s empathic ability.

7.5 Information Giving

My assertion that information giving is an extension of the “empathic complex” is based on the evidence within the narratives that very often it is the behaviour nurses resort to once they have understood, cognitively and emotionally, what the patient is thinking and feeling.

Information giving may be the only “practical” thing the nurse can do for the patient and working nurses are predisposed to doing practical things. It may be that the nurse sees the opportunity to empower the patient in giving him or her information, empowering in the sense that information will increase knowledge and may promote choice.

Some theorists see information giving as the basis of what they actually term “Empowering Counselling” (Kettunen et al 2000) because of these factors.

Nurses, I have stated above are not counsellors, they use counselling skills as part of their role as nurse (McLeod 2008) and it is in this context that information giving is identifiable as a counselling skill. McLeod and McLeod (2011) include giving information (and giving advice where this is appropriate) as part of the nurses embedded counselling role and it is this perspective which seems to inform much of the thinking about information giving as an act of counselling.

Within or outside the hospital context it has been used to facilitate lifestyle modification (Woolard et al 2007) for people with a range of
health problems including Cancer (Mills et al 2001), epilepsy (Couldridge et al 2001). Coronary syndrome (Timmins 2005), Post partum depression (Glavin et al 2009) and for patients attending Accident and Emergency departments (Paavialianen et al 2008), as well as middle aged men attending GP surgeries (Naslindh- Ylisangar et al 2008).

Often where nurses are involved in work with patients in the community setting or where their focus is on assisting a client group with particular health needs the giving of information is a normative part of the nursing role. This would include for instance the activities of nurses such as those Towers and Diffley (2011) describe as providing a counselling service to people with cancer in London as well as the nurses operationalising an “ask-tell-ask” strategy with end of life patients described in the work of Peereboom and Coyle (2012). Patients with life threatening or life limiting conditions are very likely to want the nurses who care for them to be able to provide them with information which will help them to understand treatment options and likely outcomes (Azzizadeh et al 2010) and many nurses who work in this field of care are aware of their responsibilities in this regard (Towers and Diffley 2011, Johanson and Lindahl 2011).

The nurses who offered narratives about caring for patients with cancer to Johanson and Lindahl (2011) spoke of the privilege they felt at being able to facilitate choice for their patients through the giving of information, a factor which is illustrated in a number of the narratives I collected myself, Towers and Diffley (2011) point out though that in their use of information prescriptions they believe nurses need to be a little circumspect in terms of what they tell the patients with cancer with whom they were involved.

In other areas of care the need for information to be given to patients has long been established as part of the counselling process a nurse will offer.
This can most clearly be seen where the client group might benefit from making a “lifestyle change” as in attempting to lose weight for health reasons (Magnusson et al 2012), giving up smoking (Wilson et al 2006, Korz et al 2008) or reducing alcohol intake (Geirson et al 2005). Nurses working within hospital settings though are likely to have to make their decision as to whether to offer information at the same time as they are carrying out another clinical task. Often it is during such clinical activity that patients will raise issues that are concerning them (Fleischer et al 2009), the nurse will have to find or make time to listen and in so doing take on the embedded counselling role described by McLeod (2008) before making any decision about how best to help the patient (McLeod and McLeod 2011).

This, in the main, is the process described to me by the nurses I spoke with and the information giving they engaged in represents both a counselling skill in itself and the end result of their embedded counselling role.

Other theorists writing from a counselling perspective (Burnard 2005) and Bor et al 2008) see information giving as a legitimate action for the counsellor and one which is more relevant than many others in the healthcare context (Bor et al 2008).

Bor et al (2008) argue that giving information isn’t giving advice and suggest it may be particularly pertinent in areas, such as healthcare, where the person acting as helper has a degree of “expert” knowledge. It is placed by Bor et al (2008) at a basic point in the counselling skills continuum, though they acknowledge that in delivering information the helper may need to be aware of the need to follow this up by being prepared to offer more supportive counselling, or what is described as “implications counselling” to the patient. Egan (2011) takes a different
view in that he sees giving information, particularly when it brings with it the challenge to the patient of developing a new perspective on something, as a fairly high level skill.

Burnard’s (2005) view is that information giving demands specific skills from the “informer” in that he or she has to ensure the information is accurate, up to date, appropriate to the context, understandable to the patient, sufficient to meet the patients needs and delivered clearly. The person giving the information also needs to ensure they have sufficient time available to answer any questions the information might raise for the patient (Burnard 2005 pg.174)

All of my narrators met these conditions in their use of information giving as a skill.

Their motivations for using these skills derive from their understanding of, and feeling for, the situations their patients find themselves in.

“R” is seeking to clarify for relatives what is going on with their loved ones, what the likely outcome will be and giving them assistance in preparing for what is to come; “J” wants to clarify the situation for those worrying about bowel cancer and is conscious of having the time to ensure any questions can be answered fully; “K” wishes to clarify and to inform using written materials to reinforce the message sometimes and accepts the “discomfort” this may cause for her; “A” believes that however difficult it might be to give information to help those with dementia make a decision, the effort is worth making, “C” illustrates how information can facilitate choice for her patients and uses the internet as a source to draw materials from and “D” will sit down with families and explain how one of their number will be cared for until death.
On this basis the information giving behaviour can be seen as a continuation of the empathic process, or as the behavioural component of empathy described by Morse et al (1992) and Mercer and Reynolds (2002).

7.6 Limitations of the Study

In the methodology chapter I outlined some of the more obvious limitations to a study of this type. The sample size is very small and could not be considered indicative of all general hospital nurses, for these reasons the results cannot be generalised. Though all of the narrators had been through the same training programme, not all had received facilitation from the same lecturers or instructors. This may mean that there are variations in the subjects covered throughout the training programme and the pedagogical approaches used. It may be that while each narrator attended the same course, these possible variations in learning have impacted on the content of their narratives.

While each narrator had been in the health service for between seven and ten years, their experiences and job roles may have led to them encountering different “variables” which may have impacted on the manner in which they put counselling skills into practice.

Equally, different personal experiences as well as practice experiences have to be taken into account; again these are not variables a researcher can control.
7.7 Reflexive statement continued, Conclusion

The answer to my original research question is yes, there is evidence that contained within the stories they tell about their interactions with patients and carers they do use counselling skills as part of their practice.

There are two main skills evident, Empathy and Information giving. I have offered examples of both of these skills from the narratives collected and I have rationalised my arguments for their use with reference to relevant literature. I have also suggested that both of these skills are relational in their use by the narrators and that these skills can be seen as linked. Within these narratives the combination of empathic understanding and information giving represent a caring response by the nurse to a patient experiencing a difficult or uncertain healthcare situation.

There is some evidence in the narratives that empathy may be founded in personal experience, on the part of the nurse, of the phenomenon the patient is living through. Nurses seem able to recognise this and are able to separate the patient’s experience from their own internal frame of reference.

The empathy illustrated within the narratives reflects both the conceptualisations of empathy posited by Kunyk and Olson (2001) and the components of empathy described by Morse (1992) and Mercer and Reynolds (2002).

There seems to be almost a “staged” empathic response to patients from the nurses, which depends on their developing an understanding of how the patient might be thinking and feeling, experiencing a moral drive to do something to ease things for a fellow human being and acting to make things a bit better, in this case by giving information to the patient. This is
similar to the process described by Williams and Stickley (2010). This process also mirrors Gastmans (1999) analysis of caring in that the nurse having developed a relationship with the patient and identified an unmet emotional need will choose to act so as to meet or ease that need. In deciding to try to help the patient according to Gastmans (1999) the nurse is acting in a morally virtuous manner and going beyond what might be expected of a professional who sees their role as meeting purely physical need.

The choosing to act to help improve another’s situation is true caring behaviour according to Gastmans (1999) and the narratives suggest these nurses are motivated to care. This cannot be taught, but where it exists it can be developed and the ability to use it facilitated. It is my belief that in teaching student nurses the interpersonal skills which enable them to form helping relationships with their patients we enable and encourage them to identify needs for comfort and their own predisposition to act in a morally virtuous or caring manner directs them in terms of how they do this.

As is highlighted within these narratives the nurses I spoke with chose to use information giving as a strategy to help improve the situations of their patients.

There is little overt evidence within the narratives of the training the nurses received in this area of practice. One nurse “L” spoke positively of the insight she had gained from considering posture and eye contact during her training; another “K” was adamant that you could not learn how to deal with real nursing situations from a text book, while a third nurse “A” suggested she had been told in training to be wary of getting too close to patients emotionally anyway.
The paucity of reference to training in the narratives is surprising given that the narrators had responded to an advertisement which had made it clear what the purpose of the project was. That the investigator was someone who had facilitated the training in communication skills the narrators had received might have been expected to ensure reference to the training process in the narratives collected makes the absence of reference to training more surprising still.

As a nurse teacher I had hoped to gain some insight into how the training I help facilitate is taken into practice, from the analysis of these narratives I feel this has been possible, but not quite in the manner I envisaged. I had fairly “concrete” expectations that narrators would mention acronyms such as SOLER and talk about how they used skills of active listening to engage with their patients, that these expectations have not been met is one of the surprises I’ve experienced from the research process.

The counselling abilities the narrators seem to possess have not it appears been developed as a result of their initial training nor can I claim any credit for the manner in which they use these skills in practice.

Rather, it appears the skills the narrators have derive from more personal experience and predate their entry into nursing. The most I can claim is that perhaps the training they received in counselling skills from myself and the likes of me has enabled them to feel confident enough to be with people who are experiencing uncertainty and distress, which in itself provides them with the opportunity to use the abilities to empathise they possess and act on this to relieve that uncertainty and distress.

I feel it is not too much to stake a claim to have had some part to play in the development of the skills the narrators describe themselves as using.
Dwamena et al (2012) in their review of “person centred approaches in clinical consultations” concluded that patients valued very highly being given information about conditions and treatment options where that information was delivered by someone who showed a genuine interest in them and who was willing to treat them as a person rather than a disease. Interestingly Dwamena et al (2012) found no correlation between these abilities in nurses and the length of time they had spent learning interpersonal skills. Their review concludes that a short course of perhaps twenty one hours is as effective in helping these abilities transfer into practice as a course which was longer (Dwamena et al 2012). While this may be plausible, it seems to me that if ones students already possess the motivation to care anyway then the short training they receive in interpersonal skills may be transferred into practice to help facilitate the embedded counselling role (McLeod 2008) when and if the opportunity to assist someone in this way arises as part of the nurses normal routine (McLeod and McLeod 2011).

With this in mind I feel the Department of Health in their response (2013) to the Mid Staffordshire Foundation Trust Public Inquiry recommendations (2013) are quite right to attempt to find a means of assessing the prospective student nurses desire and ability to care.

Where this desire and ability exists the Department of health believe it can be nurtured in training and transferred into practice ensuring patients will be treated with compassion respect and consideration. (DOH 2013). Values based assessment strategies at point of application and a period of practice as a healthcare support worker have been mooted as means of identifying those most suited to undertaking nurse training.

My concern, and it is one shared by colleagues in nurse education, nursing practice and management is that there is a need to recruit
thousands of students every year and the proposed selection process is likely to take time and be labour intensive. Currently when students apply to enter nurse education they will probably not be interviewed in the traditional sense. It is more likely that just now they will be invited to a group interview and “marked” on their performance in a discussion with other students, asked to take a numeracy and a literacy test of one form or another and offered a place on the basis of success in these activities. This selection process facilitates the recruitment of large numbers of student nurses but it doesn’t focus at all on their motives for wanting to enter the profession or on whether they might have the “aptitude” for caring work or not. Any assessment of these qualities is made on the basis of what students might say in their application statements.

The expected change to this process might have been to one mirroring the process other university students go through, usually based on assessment of the application form without an interview at all necessarily but the Department of Health (2013) proposals will demand a complete review of how student nurses will be assessed for suitability in the future. It’s unclear just how the new recruitment proposals will be implemented, paid for or operationalised but if they can help identify a workforce with the qualities and motivations apparent within those whose narratives I have been fortunate enough to examine then the difficulties inherent in “picking the right people” are worth working through.
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APPENDIX ONE

SUMMARY OF FIELD NOTES/ INITIAL ANALYSIS.

Interviewing is easy. Reflecting, paraphrasing, clarifying and summarising all help a person begin to settle into the task of talking and as time goes by and a rapport develops the odd challenge to what’s said or a bit of self disclosure serve to move things along. Encouraging people to tell stories isn’t, I found, quite so straightforward. Asking someone to “tell me a story” felt a bit like saying to someone “tell me a joke”, it made peoples minds go blank, they felt (and sometimes looked) anxious and somehow pressured and invariably asked me to give them a more specific idea of what I wanted from them. This meant I had to be involved more in conversations than I expected, I can’t sit and watch someone squirm but at the same time I didn’t want to “lead” anyone in terms of what they told me. For that reason some of the stories I gathered were spread over several pages of transcript but for all that they are still recognisable as stories. Below I have reproduced snatches of the conversations I had with the nurses who were my respondents. Their stories represent the data I have based my analysis on for this thesis, each one is as different as the people themselves, influenced by the context they work within, their beliefs and values and their interactions with me as a listener. My task was to look for particular commonalities or themes. Using some of the data I have collected here at this stage of the finished work gives me the opportunity to invite the reader to begin, as I began, by thinking about what these snatches of conversation mean to you.

Julie works in an endoscopy suite where people are tested for Bowel cancer. Her job is to support a public health initiative which is aimed at reducing the death rates from this type of cancer in those aged over sixty years. Everyone over this age is sent a leaflet in the post outlining the problem and offering them the chance to be tested. Those who want a test are sent “sampling” equipment so they can conduct home testing for blood in their stools. If the test is positive the option of attending the clinic “Julie” works within for a follow up test is offered. At this stage the test consists of a colonoscopy, the insertion of a tube with a camera in it into the bowel to look for physical signs of bowel cancer.”Julie’s” role is to
conduct the initial assessment of the patient and complete the documentation necessary prior to the test being carried out, she is also training to become an endoscopy nurse and so is present at and conducts some of the actual colonoscopies on the patients who attend her clinic. “Julie” is a woman in her early thirties, she has been in nursing for less than ten years and the role she has is new, she is the first person to hold such a position in her hospital and tells me she had to go through a staged interview process to get it. She has a very welcoming air about her, smiles easily and has a warm comforting way of speaking, she does not wear a uniform for the assessment element of her role and has a degree of autonomy in terms of the length of time she can spend with the people she meets, the average patient assessment lasts for half an hour but can be “stretched” to an hour when necessary. She describes her role thus;

“**People are sent a home test kit and they have to do a stool sample at home they send it off and its checked for traces of blood and if its found to be positive for blood depending on how many some people end up with, ummm, an appointment to see me to discuss these test results and I offer them further investigations into why they might have blood from their large bowel**” (Julie pg.1)

I wondered if the people “Julie” met were worried;

“**To say the least, yes**”

“**Yes, most of them are worried when they come through my door yes**” (Julie pg.2)

which made me curious about the first meeting she had with a patient;

“**Erm, well it does vary but erm,..............................what my role is to explain why they’ve ended up in a room with me, what the results of the test mean ,what could have caused the bleeding from the large bowel and what investigations we can do but the patients are normally very, erm, anxious and keen to explain their own way out of the situation, why they think its positive and initially then they, some of them, I think try to just say well I know whats caused it and its not really necessary . But then on the other hand people often think the worst case scenario and are often quite keen to have a test and find out whats going on**” (Julie pg.2)
There is a clue here as to how “Julie” tries to act as an understanding and supportive presence within a context of uncertainty confusion and fear for her patients. She is recognising that some people will rationalise their situation while others want to know more about it, I wanted to know how she dealt with this dichotomy;

*(information) and others are not you know, and I say if you know, I don’t force t*“It depends on, it depends on the patient, some of them are quite receptive to it hem to listen to what I’ve got to say but you know I will explain, just give you a bit of information then you’ve got the whole picture and then you can make a decision when I’ve given you all the facts or you can go away and think about it, I don’t pressurize them into anything but I am quite keen to get my message across ,yes, I think it’ll help” *(Julie pg.3)*

“...some people aren’t going to benefit from hearing about that in much detail, some people want it which is fine, other people I don’t know if they want it or not so I give it to them anyway but other people are just so anxious and worried sometimes because they’ve had previous bad experiences and I just have to think about what I’m going to say to them and you can give them summarised information and then find out what they want to know really” *(Julie pg.5)*

“Julie” had to make decisions about how to carry out her role "in the moment" and sometimes this could be difficult. She told me about a patient she had met who illustrated this quite well;

“I’ve got a lady in my head now that you’ve said crying , she didn’t want to know, she didn’t , she even told me that she didn’t want to know but she wanted a test, I’ve got this lady in my head now”

“No she was, she’d almost convinced herself that it was going to be a bowel cancer”

“(she was upset) yes, hardly spoke at all, very hard to communicate with but that was a difficult one , that was very difficult now I’ve remembered her”

“I asked her, I said you don’t have to be here today, I said we can do this another day if its not right for you today, you can, theres 246
no rush to have this done you can go home we can have this chat, all I’m doing today is having a chat and it can take up to an hour but if you’re not happy to do it today then we can arrange it for another day but she was insistent “no, we’ll do it today” but then it was really difficult and she hardly spoke to me I was constantly thinking is this what she wants? I don’t know if she wants to be here, does she want to have any tests done? I checked with her and she was “yes, yes” but she was crying and very worried that she has cancer”

“I was (having doubts), physically I have to assess their physical state, whether they’re fit to have any tests, you have to have an empty bowel before you have any tests and you have to take a really strong laxative drink, you’ve got to be fit to do that and I mean that can not suit everybody so I’m assessing whether they’re fit for these tests medically, physically which she was but emotionally? Erm, but she was insistent this was what she wanted, didn’t want to know any details, didn’t want to know what was going to happen at the tests, told her very briefly”

“.....just giving her exactly what she needed, this is what you need to do, this is what you need today this is where you need to be, have this blood test”

“she could hardly speak for crying, like I say I asked her if she wanted to carry on she just nodded a lot really, I said “obviously you’re upset she didn’t want to speak, I tried to encourage her to open up and her husband says “shes just very anxious, she just worries a lot, about everything”

“He was with her, he talked more than she did”

“most people have a partner or husband (with them)”

“He did speak but he wasn’t answering questions for her, she was just very, very quiet and I’d try and encourage her to talk about why she was so upset but she just kept telling me she was very worried, she was that sort of person, she worries about health, shes got a sort of pessimistic attitude toward health”

“I remember exactly her face, the look of misery, she, obviously she must have been in bits the first time she came, I was there
when she had the test (during a follow up appointment) and she was a different person on the day”

“On the day she came for the test she wasn’t crying all the time, she spoke a lot more, we chatted during the test, she seemed much more relaxed on the day, I don’t know why that was”

“...we talked about the town that she lived in, a lot of history about the place, I didn’t know that, she was telling me all about that, luckily she got a positive outcome and she even wrote a thank you letter to the chief executive quoting my name” (Julie pgs.5-9)

The decision made by “Julie” to carry on during the first appointment even though the patient was upset and anxious turned out to be the correct one, both for the patient and for her care programme. Decisions about care can be very difficult to make and aren’t always that well understood by all members of a care team.

“Cheryl” is a sister on a medical ward, she has held this post for six months and has been qualified for five years. If one includes her training “Cheryl” has been in nursing for eight years. She is in her early forties and is married with two children, she meets me in her navy blue uniform towards the end of an eight hour shift, she looks tired but exudes calm and patience, she came to England from South Africa nine years ago but hasn’t lost her accent, she speaks in a low voice and gives the impression she remembers me and is pleased to see me. When I ask her if she could tell me about dealings with a patient or relative that stand out in her mind she gives me the answer that initially most of my respondents gave

“Yes, erm, I suppose theres lots of patients that stand out, erm, yes I can think of one. Theres , do you want me to talk about the patient?” (Cheryl pg.1)

“erm, had a patient in that came to us with motor neurone disease, quite an elderly gentleman, it was found that he had motor neurone disease that was quite advanced and that there wasn’t much that the doctors could do for him. He’d stopped eating and drinking, we got the Macmillan nurses involved to see if we could fast track him home because thats where he wanted to be. He ended up going to, he was fast tracked to a nursing home which was his choice and I got a phone call yesterday from A+E saying they had re-admitted him”
“..even though he was on the Liverpool care pathway on being discharged”

“the res...the nursing home had panicked, he’d had a bit of haematemesis and they’d brought him back in”

“So A+E were on the phone to me wondering what they should be doing because our umm, (nurses name) who does the fast tracking she wasn’t available yesterday and he was actually to go back home because he was on the Liverpool care pathway”

“It was his choice, he didn’t want to come back into hospital but for some reason they panicked and sent him back in”

“That was a bit of a shame really”

“Just because of what’s happened yesterday and him being re-admitted when they were told where he needs to be, in the nursing home, not to be re-admitted that’s not what he wanted to do and for some reason they re-admitted him so it was a shame for him really being pulled and prodded and, yes”

“The doctors have spoken, we’ve got a diagnosis and the doctors have spoken with him and his family, him and his wife were divorced but she was still his next of kin ,, they got on really well and it came to a point where he wasn’t able to swallow anymore and when they decided to put him on the Liverpool care pathway.....” (Cheryl pgs.2-3)

Whereas “Julies” thoughts and actions are probably transparent enough to a “lay person” Cheryls thinking may need some explanation. She has been looking after a man with a terminal illness, the patient has been told he is going to die and has accepted this prognosis, he has decided he doesn’t want to die in hospital and “Cheryl” has facilitated his discharge to a nursing home as a more normative environment than a hospital ward taking into account that managing his care at home would not be possible. The staff at the nursing home had sent the patient back to hospital after he had vomited blood (haematemesis) and Cheryl attributes this move to their panicking. She is saddened that the man’s desire to die outside of hospital has been compromised by a seeming lack of understanding of his situation on the part of those working in the nursing home. I describe the Liverpool care pathway below but it is essentially a care pathway implemented to ensure comfort at the end of life, the
pathway allows for treatment of symptoms but not active medical intervention, so called palliative care.

One of the two male nurses I spoke with “Hughie”, offers a vignette from nursing life which lacks the pathos of the two stories alluded to above but which illustrates the banality of much of everyday nursing work. We met early one morning just after he had finished a night shift on the stroke unit where he was a staff nurse. “Hughie” looked tired and fed up, he seemed pre-occupied and took a while to settle to the coffee and “Danish” I gave him. During our conversation it seemed apparent that “Hughie” had become less fond of nursing than he once was, I found out not long ago he had moved to Australia and was working outside of healthcare. He began by describing an incident that had occurred a few weeks before the previous night;

“............there was a lady of ninety four in”

“...........its about four in the morning and she says “can I have a drink?” and I said course you can and went to get her a drink of water she said “can I have a cup of tea?” I said of course you can and that simple act of, sort of nursing gave me the greatest pleasure all night”

“....its those simple little, not chores but little acts of kindness that outweigh all the hassle at times, shall we say, and restores your faith in the job”

I asked what happened when the lady got the tea, did they talk?

“I didn’t then, I must admit, I just had basically a there you go my dear, if you want any help just shout but I’m busy at the moment you see, I didn’t talk to her then no but on other occasions she was a chatter box bless her and she did enjoy company because she’d come from a nursing home and I think going from possibly like a lounge where she knew everybody to have a chat to like unfamiliar surroundings and for the time she was in a single room as well, you know, just lonely”

“ I think probably because physically she was frail however faculty wise she was with it totally and I think she was probably just lonely coming from the nursing home with all her friends into the single room and it was her trying to engage everybody every time in a chat with you”
“But its only with her being as sharp as she was and in a single room that I probably thought that no the cup of tea wasn’t a case of “can I have a drink?” it was a case of “can I have a drink and a bit of chat as well?” (Hughie pgs.1-2)

Talking about the possibility of a chat in a single room at four in the morning led “Hughie” to describe a situation which had happened the previous evening and which highlighted his reluctance, sometimes, to converse;

“..this chap was wanting his eye drops giving at say four, four this morning. I say I can’t give them because they haven’t been prescribed and I can’t find them and he’s chuntering on so much we could hear him at the desk and his bay was the furthest one away, two of the other three people came out and sat in the dayroom because they’d had enough of him going on, so at times a single room does have its…”

The patients sharing the four bedded bay with this man had been disturbed and I asked about what happened next;

“well they came up to the desk about fourish this morning and they said “can we have a cup of tea?” and they said “he’s doing my head in” we said right go into the actual dayroom and we’ll make you a cup of tea and hopefully after you’ve drunk it it’ll have settled down a bit, but they just wanted, as opposed to just wanting a chat, they just wanted at this time to get away from it because it was like a record that was going around and round and round”

“everything was just negative with him ,it was hard”

“ we went back and said look we’re still waiting for the doctor coming, he said he understood why we couldn’t just give them there and then he said you know and after a bit he nodded off back to sleep again you know because about an hour and a half later we did realise that the room had finally become quiet but I think no matter how many times when I was trying to explain why we couldn’t give, we couldn’t give because it wasn’t prescribed we couldn’t find it it was just going round and round he said “yes but I need them” I said yes, I know you need them mate I said but we can’t give them if they’re not prescribed or if we can’t find them “yes but I need”....so”. (Hughie pgs.3-5)
Another “picture of the everyday” was painted for me by “Lynne” who like “Julie” has a role which is new and which places her outside the nursing mainstream.” Lynne” manages an Xray suite where people have investigations of various sorts (X ray, ultrasound, MRI, barium enemas) and where she hopes soon patients needing radiotherapy will be treated. She meets me at lunchtime, she looks bright alert and well scrubbed in her sisters uniform and has spent the morning with a lady having some tests. She described for me the process she had gone through with this lady;

“Yes as soon as I saw her I introduced myself, said hi told her my name and asked her what she likes to be called, I explained to her exactly what was happening”

“I gave her information, it wasn’t just information at the beginning of the procedure there was information all the way through the procedure as well where I said tom her , you know, we have to put contrast into the bladder and what we’re trying to do is to fill the bladder and that could become uncomfortable”

“ I was probably with her twenty twenty five minutes something like that, it wasn’t too long a procedure but halfway through the procedure I said to her if you become uncomfortable let me know and then we can always switch it off. Halfway through the procedure she said ”Lynne I can feel, I can feel my bladder starting to fill up” so I went to her and pulled a screen round so she could see the screen properly Told her this is her bladder, this is the contrast and what we need, really reiterated what we needed to do again,we needed to fill the bladder up as much as we possibly could and put enough pressure on it so that if there was a leak we’d see the leak on the screen”

The test was called a fluoroscopy and it is done to check how well bladder surgery has gone I asked “Lynne” whether the patient was interested in what was going on;

“Yes she was, she was interested in it, not everybody is, not everybody wants to see you have to gauge it but I explained to her exactly what I needed and said to her now if it is really uncomfortable we can stop but if you can manage to keep going a little bit longer then that’d be more beneficial and she said to me” thats fine Lynne, as long as I know what I’m doing”
“we’d built up a rapport right from me introducing myself and asking what her preferred name is it made it initiating a conversation finding out a little bit about her while I was waiting for the consultant to come in instead of just standing there looking clinical” (Lynne pg.7)

While these tales represent the mundane and routine types of interaction that go on between nurses and patients a far more dramatic and much more rare scenario was described by “Karen” a staff nurse on a surgical ward. Curiously it also involved something “Lynne” had mentioned. “Karen” has been a qualified nurse for five years and has always worked in the surgical environment, the unit she works on is busy with a high patient turnover, most people having general surgery do not spend more than two or three nights in hospital. I asked if there were patients she’d met who “stood out” for her;

“I imagine there are several but I’ve just had one recently, she wasn’t surgical she was more of a medical patient”

“errm, she was sort of,erm, a nice lady really ...and we always thought she was going to go home but then all of a sudden she deteriorated”

“she came in with a leg oedema and there were other medical problems as well added to what she came in with and she had to go down for some procedure...and it was just, like, a CT angiogram”

“...and I don’t know if I’m allowed to say this but I’m going to say it anyway, she had the contrast and that affected her kidneys and stuff” (Karen pg.3)

I confirmed that the contrast was a type of dye

“ Yes it is and sometimes that can affect kidneys and that and she just sort of deteriorated, her condition deteriorated and thats something that sort of...well we brought the family in”

“ you can react bad, some patients do react quite badly and sort of and something happened to her kidneys thats one of the risks I believe that contrast does have in certain patients”
“that’s the first time I’ve seen that happen but talking to a more senior staff nurse it has happened”

“her condition worsened, that’s the way it happened, sort of to the point where we had to get medical...medics up quite quickly to see if they could deal with the problem but...” (Karen pgs.3-4)

It is rare that a medical investigation leads to so serious a situation and I wondered what part “Karen” had to play in dealing with it;

“It happened on the early (shift) I came on and the patient was already sort of..deteriorated..but I sort of took over in the afternoon...it all sort of happened in the morning but I was obviously, I was handed that over, what exactly had happened and I was speaking to the family regarding what had happened”

“The family had been explained everything in the morning so they were aware that..but its still difficult to sort of deal with that situation when its unexpected...”

“...when I asked them had everything been explained to them they said yes, so erm, in the end the lady did die...”

“...so it was that serious, the doctors had, I spoke to the doctors beforehand they said, looking at the bloods and that there’s nothing they could do they couldn’t do any more for this lady and this was explained to the family so that was the bit then you have to...deal with afterwards”

“I mean she had been in there for a few weeks but the point is she was all right one day and then the .. this dye” (Karen pgs.4-5)

The first task “Karen” had to undertake on starting her shift was to spend time with a family coming to terms with the sudden unexpected and Iatrogenic death of a relative. Other nurses I spoke with reminded me that death itself is part of nursings fabric, many people die in hospital and most deaths are “managed”. “Cheryl” touched on this concept mentioning the Liverpool care pathway, the second male nurse I interviewed “Ray” gave an illustration of how this idea could be applied to the period following a death. “Ray” is a staff nurse in an intensive care unit, he is in his sixties and came to nursing rather later than most people do , he has been qualified for three years so has some six years experience of nursing work. “Ray” had in a previous life been very successful in a forces career, he is over six feet tall but doesn’t look at all like the archetypal military
man, he has a gently distracted air enhanced by the rather bookish look conferred on him by spectacles and the cardigan he was wearing when we met. “Ray” described his work thus;

“The patients I’m meeting are very often unconscious but the people I meet especially if I exclude the staff are conscious, a lot of our work is about family”

I asked him why his work was more about families

“Obviously the one of communication, reassurance and there’s some very good work that’s described intensive care as a vortex of emotions and it has a cache. Twenty percent of people who come into intensive care die”

“One in five either in hospital or very shortly afterwards usually after withdrawal of treatment so... there are some very emotive, some...very..deep emotions going on there”

I asked why treatment might be withdrawn;

“It aint going to work is the main reason, its all to do, a lot of it with, with well I suppose its easing suffering. You can keep someone alive for a long time but you can’t get them better if they’re not repairing themselves, then there’s not very much that they can do. A lot of my job is relating what, although the consultants are very good at explaining it, there’s a lot of technical stuff they have to go through in a very short time so a lot of our work is reinforcing the family” (Ray pg.2)

This focus on family members was reinforced when “Ray” talked about the death of one of his patients;

“It was one of those times and its...well one of those times where you say well actually I got it right, which seems a silly thing to say but I remember some of the things to tell them, for example, if someone’s on a ventilator and they die you can’t turn the ventilator off, its a doctor. So that means that someone’s passed away but their chest is still moving”

“You say to them, heres the situation, our best knowledge is and I think what I said to this person was there’s just a couple of things to be gone through after the withdrawal of the ventilator has taken place, thats an interesting one withdrawal because its a
consultants and teams decision but if its my patient then I’m quite
I feel I have to be the one to say I turned the machine off
because its my patient I can’t give that responsibility but I
managed to remember to say to the partner he will have passed
away but the chest will keep moving and this is why, and she
accepted that and I actually managed to say if you want to say
goodbye, nows the time”

"what I did say to her was, what I do say to people is if you don’t
want theres no need for you to be with him, I won’t let him die
alone, and that’s the sort of thing we do…” (Ray pg.9)

He explained why it was important he took this active stance;

“I think it goes into three areas, One, you’re trying to, not
necessarily trying to reduce the burden but ease the burden, its
slightly different, you’re trying to extend it so they’ve got time to
come to terms, so its not, there is a soupson. The second thing is
you should actually try to inform them so that they are making
informed aware decisions. I think the third thing is you’re trying
to give them, well you’re coming back to what I’m aware of in my
work, so they can look back and say well the best was done
because I try to reduce any subsequent guilt they may have. Now
that might be taking my role a bit far but that’s how I see it, if I
can act correctly now in some human context then in time they
can look back and say well the best thing was done for hubby, son
and be content that they’ve done their bit” (Ray pg.11).

Just as philosophical and equally as concerned about the feelings of other
people was “Andrea”, a staff nurse on a medical unit which specialised in
the care of people with respiratory disease. She was talking about a
patient she had met when her focus switched to what she saw her work
as really being about;

“…within the last five years, a female patient yes, she was what
you call chronic obstructive airways erm disease, which is a
disease where they degeneratively become worse over a number
of years and it is quite distressing to that in the end they’re being
suffocated and to get to know somebody, get to know their family
and see them, witness them all going through that is very hard.
Again some, you try to get to know patients and family, some
allow you in some don’t and again thats part of the nurses skill I

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think is to respond and recognise when somebody puts up the barriers and know how far you can go”

“somebody who wants the support its little things they do like try and keep you talking you know when you’re in there they want you to be in there they keep talking they don’t want you to leave, theres always something to bring you back to them”

“little things that you do for them you know, they call you in if they want erm, help, they try and, its like they’re skirting round the problem almost, they come up with any sort of erm, way to get you to sit down and talk to them, does that make sense?”

“you get the feeling that, you know, they, they want to talk to you because they’ll come up to you or you’ll go to them to do something and they start talking about things, not necessarily to do with their condition or whats happening to them, but others I think are more stand offish more sort of erm, like stoic They’ve been for instance, they’ve been told bad news, they’re very stiff upper lipped about it and get on with it and...you know”

“I think its not necessarily about me its letting them talk I think fro our point of view our job is to listen and maybe...support...maybe advise erm, I as I say itn is really taking on that role and being included in the confidence of that person its very I think, oh whats the word I’m looking for, its a privilege I think. The fact that they would probably respect you enough , trust you enough to take you into their confidence to to talk about how they’re feeling emotionally. I mean from myself, I’m I don’t like being, I’m not an emotional person I try and hide my emotions quite a lot, so to be able to take on somebody elses emotion, it is, it is quite difficult sometimes erm, but with experience you’ve got other people that you can talk to for advice” (Andrea Pgs.6-7)

In popular fiction nurses are rarely featured in stories without their medical colleagues being central to the plot, only one of my respondents really introduced doctors into their narrative, “Denice” is a staff nurse on a private unit within an NHS hospital, she is a scot and spoke in the frank and confident manner for which that race is known;

“we’ve got, had, one patient who came to us six weeks ago, they came in , he was unconscious, unresponsive and he was to be put
on the Liverpool care pathway but our consultant Dr. doesn’t believe in the Liverpool care pathway”

“that way they get to die with dignity”

“they can get more resources like if the family want the patient to go home to die with them then the idea of the Liverpool care pathway is the fact that they’ve got twenty four hour care at home”

“Dr. wouldn’t put him on it”

“He fights, the good thing about Dr. is that he will never give up on the patient, at all. Even if he knows that the end is coming, he won’t”

I enquired how sick the patient was;

“He was septic- infection sepsis, yes”

“Yes, he got Parkinsons, has got MS, has got no quality of life, at all”

“He cannot talk, has got no swallowing assessment, we’ve feeding him through an NG tube which he’s pulled out about thirty of them, he’s pulled out at least thirty of them he doesn’t want them in but he’s too ill to go for a peg feed”

“He knows he’s got something there, I don’t think he’s aware of it, they’ve even been stitched in and he’s pulled them out”

“Hes not consciously aware, according to his family he’s not been consciously aware for months2

“really now, the daughter, she just wants her dad to go in dignity and peace, the patient came from a nursing home and the family accepted what was going to happen to dad because he’s not young, what is he, ninety four, ninety five”

“they cancelled his bed at the nursing home, and accepted it so they want to talk to Dr. to see the outcome of this because if the family say to Dr. about the Liverpool care pathway then he will put him on it, he will respect the family’s wishes”

“it’ll be mentioned to them in A+E (The Liverpool care pathway) when he came through, that the idea was for the patient to go on
this and the patients ask about the Liverpool care pathway and then we tell them, what Dr.....doesn’t like about it is that you’re withdrawing everything, you’re withdrawing, you’re not withdrawing like mouth care and making them comfortable or anything like that but you’re withdrawing giving them their medication, fluids, they go onto a diamorphine pump they get micelle to help them with their secretions”

“.......... I agree with the Liverpool care pathway”

“because that gives patients time to die with dignity and it also gives their family time to spend with them without nurses going in trying to pump everything into them because they’re not going to be prodded or poked or stabbed trying to take blood from the patient, we’re not going to be going in there trying to take bloods from them every single day” (Denice Pgs.3-5)

Denice is illustrating a difference in opinion she has with a consultant over the way a patient is being cared for, later on she explains her point of view;

“I argue with the doctors because I. Well Dr......calls me the Liverpool care pathway queen because I believe in it. If it was my relative I would say I want him on the Liverpool care pathway because the Liverpool care pathway its proven that the patient dies with dignity, I don’t, if there’s no chance for the patient, like even after resuscitation you don’t get the whole patient back, I, I was, all the staff on the ward know that if I was to drop down don’t resuscitate me I don’t agree with it, I don’t believe in it” (Denice pgs.9-10)

A perspective which throws a little light on where the roots of her belief in managed death might lie.

These stories represent my starting point, what follows is my explanation of why they are of interest to me, my explanation of what they mean
APPENDIX 2

TRANSCRIPT ONE. THURSDAY 17TH MARCH 2011

"JULIE"

Me........No, No, You’re welcome to the two but take one anyway.

J    I know I’m eating for two but I don’t think I could manage two (speaking about the Danish pastries I had brought to our meeting which was early in the morning)

Me........When are you actually due?

J    Not until the 21st August

Me So when will you go off then

J    End of July

Me Do you mind if I make some notes while we’re talking?

J    No, No its fine

Me That information sheet if I try to summarise it should say something like “what I’m interested in is the interactions that you end up getting involved in as part of your daily work and I know you’ve got a particular kind of daily work haven’t you? Do you mind telling me what that is?

J    Yes

Me Take your time

J    I’ve got a mouthful now. I work in bowel cancer screening, it’s an NHS screening programme open to people between the ages of 60 and 70, male and female.

Me   Right.

J    People are sent a home test kit and they have to do a stool sample at home they send it off and its checked for traces of blood and if it’s found to be positive for blood depending on how many some people end up with a umm, an appointment to see me to discuss these test results and I offer them erm further investigations into why they might have blood from their large bowel.

Me   Right so this is some sort of NHS initiative?

J    Yes

Me   For people who are worried for one reason or another

J    No just purely invited on the basis of being aged 60/70
Me  Right so is that done for everybody in the country then

J  Yes (nationally rolled out)

Me  The people you’re meeting then are 60 years old 70 years old

J  Between 60 and 70, we do get patients over the age of 70 who’ve chosen to request a home test kit they’re not actually sent one

Me  Right

J  People are initially sent an invitation letter before they’re sent this home test kit and they can decline the receipt of a test kit if they don’t want to participate

Me  They get the test kit and perform the test themselves

J  At home yes

Me  And, depending on the results they are asked to get in touch with you

J  Yes

Me  So the people you’re meeting are probably people who are worried

J  To say the least yes

Me  To say the least?

J  Yes most of them are worried when they come through my door yes.

Me  So what’s that first meeting like

J  Erm, well it does vary but erm,..................what my role is to explain why they’ve ended up in a room with me, what the results of the test mean what could have caused the bleeding from the large bowel and what investigations we can do but the patients are normally very erm anxious and..........keen to erm explain their own way out of the situation why they think it’s positive and initially they, they some of them I think try to just say well I know what’s caused it and it’s not really necessary. But then on the other hand people often think the worst case scenario and are often quite keen to have a test and find out what’s going on

Me  So you’ve got people who accept that there’s a problem and want the problem investigated

J  Yes

Me  And you’ve got at the other end of the scale people who don’t want there to be a problem to the extent where they’ll offer you explanations for why the bloods there

J  I do yes

Me  So you’re meeting people then who you probably have to give a message to

J  Yes

Me  What’s that like?
Er, it depends on the patient, some of them are quite receptive to it and others are not you know and I say if you know, I don’t force them to listen to what I’ve got to say you know, but, I will explain, just give you a bit of information then you’ve got the whole picture and then you can make a decision when I’ve given you all the facts or you can go away and think about it I don’t pressurise them into anything but I am quite keen to get my message across, yes, I think it’ll help.

There’s two very different things there. There’s the information giving, Do you have to give it to them, is that part of the deal?

Supposed to yes, unless I feel that this persons just not going to benefit from hearing it and a few times I’ve altered what I’ve had to say and decided not to say anything at all because it’s just not appropriate in that situation.

And what would tell you that somebody wasn’t going to benefit from hearing it?

Erm.................If ....If ohhh, if somebody’s had the tests that I’m offering them in the past then I won’t go through all the information in detail because they’ve been there and done that before or if somebody is particularly upset then and emotional then they’re not going to benefit from hearing all the details of what I have to say. I just summarise it.

Do it quickly?

Yes

So what’s the average sort of time you’d spend with somebody then?

Well I’m allocated 30-35 minute appointments but invariably I spend an hour I’m not very good at keeping to time targets

I’ still quite a long time though, in the scheme of things

Yes .....especially if you’ve got somebody who lives alone and thinks you’re a doctor who wants to ask you everything about everything. Trying to keep them on you know focussed on what we’re talking about can be very difficult.

Is that because (our bags?) giving the information or because they want to...

Yes both and because this screening programme is for 60/70 year olds a lot of people have heard their neighbours experience of it or relatives experiences of it and they come up with pre-conceived ideas which we have to address and correct if necessary.

So you’ve got the natural anxiety that some people have ,you’ve got people who accept there’s a problem and want to be here and then you’ve got people with all the baggage that might come from knowing folk who’ve been through the process before.

That’s it yes. I don’t only see patients in that , environment, I see them again if
they choose to come and have the test, see them at their test on that particular
day and then after the test on that day to give them the results of that test so

Me You might meet the same person more than once
J Yes
Me Does it get any easier? Meeting.
J Yes, definitely yes.
Me Cause they’ve settled down
J Yes they’re usually quite pleased to see you the second time around, they’ve
already met you...

Me If the news is good?
J Well no even before the tests you know because I go and speak with them even
before they go and have the tests and they’re a different person that time when I
walk in the room that time because I’ve spent an hour with them a few weeks ago
and by the end of that hour we’ve usually formed some sort of relationship.

Me So, are you doing investigations ,doing sort of physical stuff, you know...
J No the doctor does the investigations I assist him and my role during the
investigation is to document everything that happens for the national data base,
computer base, we want to know everything that’s happened

Me Right so you’re recording this
J Yes recording it but I’m also (knocking at door) talking to patients
Me Sorry
J That’s all right,
Me You say you record it
J Yes document it and later on put it on to a computer, national computer data base
but I try not to focus on that too much I try to, you know, talk to the patient
explain to them what’s happening and just engage in everyday conversation

Me Smalltalk
J Yes try and take their minds off what’s happening at the time, but because
they’re so well prepared because we’ve explained what’s going to happen they’re
actually quite relaxed. They know what to expect.

Me You’ll have people who. who are anxious, you want to give a message what tells
you they are not receptive to that

J Oh phew, some are just so wound up, I mean they’ve got themselves in such a state that me telling them details about what’s going to happen when they have their test that me telling them details about what’s going to happen step by step and me telling them details about polyps, I don’t know if you know about polyps, polyps are the most common thing that we find they can be pre-cancerous, some of them can be pre-cancerous so I try to give people information about that because that’s likely to be what we find and we can treat those. But some people aren’t going to benefit from hearing about that in that much detail some people want it which is fine, other people I don’t know if they want it or not so I give it to them anyway but other people are just so anxious and worried sometimes because they’ve had previous bad experiences and I just have to think about what I’m going to say to them and you can give them summarised information and then find out what they want to know really.

Me Can you think of somebody that’s been the case with somebody who you had to draw back from giving that information to?

J Ohh I’ve done it a few times, ....................................................

Me Someone who was crying or upset to the extent that you had to stop the information process

J Yes, I’ve got a lady in my head now actually that you said crying and she didn’t want to know, she didn’t, she even told me that I don’t want to know but she wanted a test she didn’t want the details but she wanted a test I’ve got this lady in my head now.

Me She wasn’t even at the stage where she found out there was a problem

J No she was, she’d almost convinced herself that, that it was going to be a bowel cancer

Me She was very upset about that

J Very, yes, hardly spoke at all, very hard to communicate with but that was a difficult one, that was very difficult now I’ve remembered her.

Me So what do you do in that kind of instance?

J I asked her, I said you don’t have to be here today I said we can do this another day if it’s not right for you today you can, there’s no rush to have this done you can go home we can have this chat, all I’m doing today is having a chat and it can take up to an hour but if you’re not happy to do it today then we can arrange it for another day but she was insistent “no, we’ll do it today” but then it was really difficult and she hardly spoke to me I was constantly thinking is this what she wants I don’t know if she wants to be here, does she want to have any tests done? I checked with her and she was “yes, yes” but she was crying and very worried that she had cancer
Me  You still had your doubts then

J  Yes

Me  Looking at this woman having doubts

J  I was (chuckling) Physically I have to assess their physical state whether they’re fit to have any tests you have to have an empty bowel before you have any tests and you have to take a really strong laxative drink you’ve got to be fit to do that and I mean that can, not suit everybody, so I’m assessing whether they’re fit for these tests medically, physically which she was, but emotionally? Erm but she was insistent this was what she wanted. Didn’t want to know any details, didn’t want to know what was going to happen at the tests, told her very briefly

Me  And then you’ve got to get on with what you’ve got to do

J  Yes, it’s just giving her exactly what she needed; this is what you need to do this Is what you need today this is where you need to be, have this blood test?

Me  You sound like you feel sorry for her

J  Yes (chuckling) I say to people actually a lot, “I don’t know it hasn’t happened to me but it must be difficult when an invitation letter drops through your door inviting you to partake in a cancer screening programme. Part of you must, I don’t know, part of you must think it’s the right thing to do but the other part of me wonders, I do feel sorry for them. I think a lot of people are torn,

Me  They wonder themselves?

J  Yes, and deep down they know it’s probably the right thing to do because in the end you could have peace of mind and forget all about it if you get a good outcome

Me  It’s a fairly rocky road to peace of mind though isn’t it

J  (chuckling) Yes, exactly yes. And I know most of them ask me “what do you think, what do you thinks caused it?” “in me from what I’ve told you”

Me  Do you have to give an answer

J  I can’t, I say I wish I could I wish I could tell you today,

Me  It’s more than feeling sorry for them then isn’t it? It sounds like it’s beyond offering a tissue

J  Yes, Yes its difficult because you can’t give them any definitive answer and that’s what they really want immediately, and the next ......that passes, they agree to a test and we’re so busy, we’re only a small department and we didn’t realise that we’d be having more sort of clients than we expected so people are having to wait for up to six weeks for a test
Me Right so they’re coming to you and they’ve had time to ruminate.

J Yes they’ve had a couple of weeks since they’ve had their home test results before they come to me, to.......(place name).....and then I’m making them wait, for some people, for up to six weeks which I feel really guilty about, I hate that.

Me You look it, I mean the tape can’t see but you look as though you don’t like that it’s not your fault though is it.

J Oh, no no. but I just think if it was me or my parents you’d just want it over with or tomorrow please, today preferably.

Me So, you’ve 45 minutes and they’re very upset, that takes time doesn’t it, being upset takes time.

J Yes,,,,,,,,, because of all the information that we have to give and the questions that we have to ask it doesn’t leave a lot of time to address the emotional part of it really.

Me But it sounds as though you’re giving time to them.

J I always try yes.

Me How does that work, do you just let people cry?

J Yes, let them talk yes or cry. We’ve had a few or I’ve had a few who’ve had, they know they had symptoms they knew there was something not quite right they have tried to tell someone but they haven’t been acted upon (the symptoms) shall we say.

Me Toward the medical profession.

J Yes, I listen, I don’t give them a diagnosis, I’m not a doctor but I listen to their problems and they say oh finally someone who wants to listen to me that ....I’m a specialist nurse who has got an hour whereas the GP has got ten minutes I think that’s why, I’s not that I want to listen, but I do, it’s just that I’ve got that extra time.

Me That dynamic is a bit different the time makes a difference.

J Yes, I think they think of me as much more caring, oh you really seem to care, you really want to listen as if the others don’t you know?

Me Because of the time?

J Yes, probably, I don’t know. But I do encourage them to tell me their stories and that’s it.
Me If they’re crying or if they’re upset and in the middle of that they’re asking for your view

J I say I can’t decide for you it has to be your decision I give them all the information and as a professional probably say I would advise you to investigate, you’ve passed some blood in your stool I think most health care professionals would advise you to have that investigated.

Me it’s quite a gentle way of being though isn’t it it’s not like telling folk what to do

J No, don’t do that.

Me You shook your head then as if it was

J Because I just think it’s up to them, that they’ve had an invitation letter drop through their door, they’ve chosen to do the test kit at home, they’ve chosen to come and see me, it’s up to them, they haven’t had a problem and gone to their doctor expecting something to be done so, and of course there is risk with the test they do, it’s really invasive so I personally couldn’t say to somebody “this is the test, these are the risks, you should have it done because I couldn’t cope with having made them do it, it has to be their decision

Me You steer clear completely of telling a client what to do?

J I try not to spell it out to them I probably sometimes say “you know it would be advisable from what you’ve told me I think that probably needs checking out“ but I wouldn’t be heavy handed about it

Me Right

Me You don’t sound heavy handed

J Good

Me If you go back to that lady you were thinking about before, I’m interfering with your eating that Danish...

J It’s all right, it’s all right

Me If you go back to that lady you were talking about before what happened with her, what was the process of....

J After that consultation we had

Me Yes, well she met you ,she was upset when she met you

J Umm...

Me It was difficult trying to get any interaction going it sounds like

J Umm ... she could hardly speak for crying....Umm...like I say I just asked her if she wanted to carry on she just nodded a lot really I said “obviously you’re upset “ she didn’t want to speak I tried to encourage her to open up and her husband said she’s just very anxious she just worries a lot about all sorts, everything”
Me  Was he with her?

J  He was with her yes, he talked more than she did

Me  So sometimes you've got more than one person

J  Oh most people have a partner or husband

Me  That must change the dynamic again mustn't it...

J  Oh yes, (chuckling)

Me  Go on

J  (chuckling) only because they tell you about themselves as well

Me  Had he had a test as well

J  I don't think I asked him sometimes I do ask that yes sometimes I do ask and they’ll say “yes mine was normal” but yes I do wonder if it helps if the other ones been through a similar anxiety waiting for test results, I can’t remember if I did...

Me  Was he talking for her

J  No, he did speak but he wasn't answering questions for her she was just very....very....very quiet and I’d try and encourage her to talk about why she was so upset but she just kept telling me she was very worried, she was that sort of person she worries about health, she's got a sort of (pessimistic) attitude toward health

Me  Some folk are more anxious than others

J  Yes ,even though I remember exactly her face,........ the look of misery, she ,obviously she must have been in bits the first time she came, I was there when she had the test and she was a different person on the day

Me  The second time you met

J  Yes on the day she came for the test she wasn't crying all the time she spoke a lot more we chatted during the test she seemed much more relaxed on the day I don't know why that was

Me  Just talking about normal stuff?

J  Yes, normal stuff, we talked about the town that she lived in a lot of history about the place I didn’t know that she was telling me all about that, luckily she got a positive outcome and she even wrote a thank you letter quoting my name to the

Me  So the news for her was good

J  It was

Me  And she was relieved about that, pleased about that...
J   Yes, yes.

Me   She was crediting you with that good result?

J   She mentioned some of the other staff as well not just me (sounding a bit irritated with me)

Me   No, no (trying to sound apologetic, I gave the wrong impression just now) I mean do you think in any way she thought you ....?

J   Oh I don’t know

Me   Do you know what I mean?

J   Yes was it down to me, I don’t know (chuckling) No she was just saying thank you for being kind and considerate and putting her at ease especially during her first appointment

Me   That’s nice

J   Yes

Me   To get that...

J   Yes, it doesn’t happen that often it’s nice

Me   You know the husband was there

J   Yes

Me   Was he there the second time

J   Yes, yes, oh yes

Me   Because that must be a strange thing to have to do ,even if the spouse is supportive, you know to be involved in the dynamics between two people

J   That’s right yes

Me   Who might have been together for a long while

J   That’s right yes .You know obviously you do give bad news on occasion and sometimes it’s the spouse that’s the one that needs the help really

Me   Do you have to do that, do you have to give that news?

J   Well, Doctors will say the words and then they leave the patient with us

Me   You’re left pretty much with the aftermath

J   Yes but because we’ve, because I know them the doctors only met them that day, not actually got a relationship with them whereas I have I’ve taken a little bit of time to be with this person so that’s OK to do as far as we’re concerned and the patients are happy with that
Me  Yes, that’s not something I would dream of commenting on. So you’ve got the second or third meeting and you’re giving this, his is really bad news isn’t it
J  Yes
Me  And you have to be around while they initially process that
J  Yes
Me  What’s that like?
J  Erm.........It’s not so bad now, now I’ve been doing it for over a year,
Me  You’re used to it
J  Yes I probably have got used to it now
Me  You look like that’s a negative thing
J  Yes well, that’s awful to say isn’t it, “I’ve got used to it now” I remember the first few times I had to do it obviously I ,in my previous job I’d done it but it wasn’t like this. In my previous job it was people I’d only met half an hour ago you know because this is someone who ,you know, I know quite well now so.....

Me  Do you think that time makes a difference?
J  Yes definitely
Me  So what was the deal when you didn’t know somebody so well?
J  I don’t know it was weird that it was different and it wasn’t.........Oh God, do you know, now that I have done this job I probably didn’t really realise the impact of what I was doing before, sounds horrible doesn’t it?

Me  No it doesn’t it sounds really interesting because you’ve time now to spend with them, not a lot of time, but some time and it sounds as though you value the time whereas before, were you working on a ward before?
J  Well sort of, yes, the endoscopy unit
Me  Same sort of work?
J  Yes people just came in and out we only had an hour
Me  Outpatients aren’t they
J  Exactly yes ,they were all outpatients clinics type place
Me  Fast turnover
J  Some of them, we’d find a cancer dependent on the doctor they wouldn’t tell them there and then they’d you know take samples, do a biopsy and tell them they’d have to be confirmed by the lab. Tell them “we’ll see you back in outpatients clinic in a couple of weeks and give you the results” so those ones we were more or less
certain of what it was and we didn’t even have to address it because the doctor hadn’t given them that diagnosis that day so they could go out the door. Other doctors would tell them there and then “This is, I’m almost certain this is what it is” and because it was a busy clinic department the nurse would discharge them and you had very little time with that person and yes it was very much different then. Didn’t quite say much to the time

Me No but I suppose you’re not looking to draw people out
J No that’s right yes, now I look back on it they’re just equally as shocked and upset and overwhelmed as the people that I see that I do spend a lot of time with

Me So are you doing different things because the job is different
J Yes
Me The demands of the job are different
J Yes the last job it was more coming up with answers
Me Similar process though
J Yes, you don’t want to keep people waiting though once the diagnostic tests have been conducted

Me What’s your strategy for dealing with those people, they’ve had the news, they’re on the way home
J Well I,.....I probably stuck to errr.............an informative format by discharging them “I’m sorry it’s not good news today but this is going to happen that’s going to happen” you’ll see the doctor dadidadida.

Me Lots of information
J Yes but I wasn’t giving them a phone number to ring, I wasn’t saying get in touch with us none of that I was just handing them out the door telling them you’ll see the doctor next week or the week after you know that’ll be the next thing whereas this time I’m encouraging them to write questions down giving them my phone number ring me anytime

Me There is a bit of encouragement to contact you
J No there wasn’t things might have changed
Me But just now there is from you, you use it..
J Oh yes
Me You use that strategy telling people they can contact you
J Oh yes I tell them I’m going to ring them the next day anyway and speak with them or one of my colleagues will ring next morning.

Me There’s a conscious effort to contact these people

J Yes we ring next morning then we ring a week later but in the meantime we say you can ring us anytime you like and people are stunned usually so they don’t...some people ask lots of questions but most don’t so we encourage them to write most questions down any question they want, give us a ring and we’ll.....

Me Has anybody ever come back with a list of questions?

J Yes, often the ones that we couldn’t, don’t know the answers for

Me What’s the set up do you have your own office?

J Yes

Me A quiet place

J Yes

Me And the time is guaranteed

J Yes

Me Tea, coffee?

J Yes if they want it, it’s offered, not many people want it

Me Its quite a formalised erm....supportive set up

J Yes, yes.

Me And that suits you, you like that?

J I do like it yes,

Me I want to ask why you like it, because its the bad news end of nursing isn’t it really?

J Yes it is, erm, So why do I like it, the people for whom it is bad news do you mean?

Me No why do you, I’m not making myself very clear, why do you like the arena of work that you’re in? Why have you gone into it.

J Oh that, I liked what I did before and it was similar, it appealed to me because you’re more autonomous and you have the extra time and you could follow the patient from, you know, beginning to not end, but,..... to the diagnosis whatever that may be and handing over to whoever just I like the fact you can really spend time with that patient instead of just seeing them come in the door, half an hour later out the door, that’s it you never see them again I like the fact that I can ring
them I can arrange things for them you know they can ring me that’s I, it’s just that extra responsibility I suppose I was ready to move on to that so

Me  What’s the autonomy about?

J  Erm, well just I’m part of a very supportive team but I work, my working days are spent, it’s usually just me apart from when there are tests but even then it’s just me and the patient

Me  It sounds like you want control over the way you operate, you know saying like you can do more.

J  Yes I do, a bit yes, obviously you’ve got to stick to......sort of....protocol, yes we all do things slightly differently. I like to have that erm control over what I do and the way I do it

Me  A bit more say in the way that you do things, it sounds as though you wanted to be more involved with the process of people getting through this stage of their life

J  Yes

Me  Whereas the outpatient ....

J  Yes, they just get written information posted to them and then they turn up and have a test, I wanted to be able to see this person tell them exactly what they needed to know or ask them what they want to know and, yes, tailor it to suit them

Me  A more personal process

J  Yes

Me  Are you into that, into that idea of ....

J  Yes

Me  So where’s that come from? Is that part of you or is that a reaction to what you’ve seen

J  A bit of both I think.....................................................I saw how my dad was treated as a patient and that’s always in my mind .....that,......I want to treat people like they should be treated

Me  There’s something personal there...

J  A little bit yes.......I can’t get away from that really

Me  And how do you feel speaking about that?
J  All right

Me  Because that’s probably the case for a lot of people really isn’t it? A lot of people in nursing will have had,......you said that..........a lot of people coming to you will know people who have been through the same process and now you’re saying that you’ve been through a similar process

Me  You’re sure you’re happy talking about this?

J  Yes, no problem. My dad was ill and erm, from the age of about 58 (?) until he died when he was 72 so for all those years he was in and out of hospital

Me  Right

J  So I saw how he was treated, not that bad, not all bad

Me  No you didn’t say it was bad there’s nothing in your face to indicate it was bad but now you’ve said “not all bad” I’ve got to ask you...

J  (laughing)

Me  What does that mean?

J  Ah, probably the last six weeks of his life when he was in hospital, were, just wishing things were a bit different then so that’s all I’m saying I want to do the best for people

Me  You didn’t think that six weeks was good

J  No

Me  Can I ask why?

J  Because he was on a busy medical ward and.....he.....was in a four bedded bay the ward was merging with another ward the staff had been thrown together because the other ward was closed so there was politics between the staff and you could just, things just weren’t right at that time on that ward and patients weren’t, I was a student nurse at the time and just by looking round I could see they weren’t getting the care and attention they needed. You know, he was dying in a four bedded bay and if it wasn’t for me and my mum going in and cleaning his teeth and washing his hands cutting his nails and feeding him , you know, I’m not sure it would have been done properly.

Me  It’s quite sad that......I had a similar deal with my mum, when my mother died, a similar deal.

J  Umm

Me  Different again to when my father died twenty years ago, a very different ...it’s sad. You seemed sad when you were talking about it
J Yes, it makes me sad thinking about it

Me So is there anything to you now that’s a reaction to that

J Yes definitely influenced my outlook. I was a student nurse at the time it happened. He died in March and I qualified in September of that year so it influenced the way I nurse people definitely

Me That was the last six months of your training, the last semester. You were doing exams at that stage as well weren’t you It’s making your life more difficult

J It did, but I wasn’t taking the time off school I decided to stick to...he died on the Friday I was back in lectures on the Monday That’s what I wanted to do it worked for me

Me Yes, and people have to do what they have to do but you’re saying at the same time you gained something from it

J Yes definitely

Me And as part of that....does part of that, what you do for people now represent what you’ve gained?

J Definitely, yes, I’m conscious of it most days, at work, it helps me do my very best for these people just let them talk and tell me what they need to say, for them to say to me before they leave my room. “Finally someone that seems to care, someone that listens that’s,.....that’s what we’re really here for

Me You say you think about it every day are you conscious of it,are you conscious of it or is it more “I want to do the best I can do”

J No, I wouldn’t say I’ve got an image of my dad when I’m sitting there..

Me No No....

J No...(chuckling)

Me And I’m not asking “are you on a crusade?” I’m asking......

J No but, but I’d say daily I’ve got the desire to do the best for these people and make them feel satisfied with what they’ve received that day. I want them to feel like...heard....you know not like “There are still gaps there and she didn’t address this or that” you know.

Me When I analyse this, this section of the tape is going to suggest you’re empathic

J No...
And this sounds trite to ask but do you think your experience has helped you to relate to peoples situations in a better way?

Yes,...people often tell me that their relative has died and coming to hospital isn’t a very good experience and I don’t say it but that obviously makes me think I understand exactly what you mean.

So what, I mean, you don’t say it you said quite firmly, why don’t you say it?

Because I represent the trust don’t I and I don’t want to be seen to be saying “yes its rubbish” you know...

Now I didn’t go that far I

(Chuckling)

It sounded as though you wouldn’t you know, you’ve had this experience but you’re not going to tell other people about it ...

No

Even if it matches their own?

I, I have on one or two occasions I’ve said “I know what you mean my dad had a similar experience” a couple of times I’ve said that people want to know more “Did he, did they do this to him?” and I feel like I’m almost confirming that the care here in the hospital is no good ... I know that it is but the good stuff doesn’t ge talked about

So it’s a desire on your part not to...

Yes I don’t want to be seen to be damaging the reputation of the hospital so, while I’m sitting here representing the hospital

Yes that’s perfectly fine, that...

Umm

I’m wondering if your history, your own experience is one of the things that gives you the desire to, to provide a better service for people, and you’re conscious of that

Yeah (nodding assent)

And.....is there any harm in telling people sometimes why you’re listening, you can understand their experience , what makes it a no-no? Do you know what I mean?

Yes, I don’t know I don’t think I’m not going to tell you my personal experience reflects that because it would make me upset because they would get upset in front of me, like I said the couple of times I have said it I’ve not had any shock horror negative reaction but they’ve actually seemed you know quite pleased that
I’ve told them but I think I probably, it’s just the fact that I probably don’t want to be seen to be bad mouthing the hospital.

Me  No, no not at all

J  (Chuckling) Although I have to bear my own little grudges you know, you can’t let it impact on what you do can you

Me  I’m looking at the clock because I’m aware I’m keeping you, erm, I want to finish by going back to that lady you were talking about...

J  OK yes

Me  You said that her result was positive ... she was told she didn’t have cancer

J  That’s right yes

Me  Did, was she pleased about daft question really,

J  Yes, oh yes

Me  Did you share in that pleasure?

J  Yes

Me  How do you share in it?

J  Yes , I say if its good news then the doctor doesn’t even come in to the room and I come in and say, I mean she knows during the test because we’re all commenting on what’s happening and if we find anything we usually tell them what we’re doing at the time so she had an idea that it was all OK but I go in and I say “It’s great News, we’ve looked at the whole of your large bowel it’s all completely normal and You’ve nothing to worry about at all” and that’s great news she’s going “thank you, Thank you” you know

Me  (Nodding assent) I’ve kept you talking for about forty minutes is there anything you want to say

J  Time flies don’t it?

Me  anything you want to say? You’ve not had your chance to...do you want some More coffee

J  No I’m fine

Me  I’ll turn that off and make you a drink, is there anything you want to say before I Switch it off?

J  No, happy with that
Me  OK, what’ll happen with it now is the thing will be first of all transcribed by myself
Which is a slow process because you have to type out what’s on the tape and then
I?
Have to analyse the tape itself and then it’s read by somebody else from this
Region.....

J  Yes

Me  ....And then it’s read by my supervisor who’s a chap at Manchester, a doctor of
Counselling, and if they agree with my analysis I can use it as part of...

J  Yes

Me  .....Do you know what I mean....?

J  Yes

Me  I’m going to meet eight or nine people altogether

J  Uh huh

Me  .....And the argument I would be making is that here are the stories that people
tell me I should be able to extrapolate from those stories arm the means by which
People get by in the situations they’re in, that make any sense?

J  Yes

Me  So essentially I’m looking for the skills of counselling but the tape could be analysed
for skills that are apparent, we talked about empathy or it can be analysed for
things like the tone ...

J  Right...

Me  the way you come across or the story itself so there’s a range of options

J  OK

Me  But you won’t hear anything as a result of this ,so you won’t feature for anybody
else in this

J  OK

(The intention at the end was to reassure J that the material would remain confidential.
She had already read the information leaflet for interviewees, asked me questions and
signed a consent form.)
“KAREN”

K What do I put down here for version? Is that one? (talking about completing the consent form)

Me No that’s OK I think it is one actually. It’s written on it somewhere, it’s usually me that writes that on.

K That’s done it. I don’t like the look of that right next to me (talking about the tape recorder) (chuckling)

Me you’ll forget it in a minute it won’t bother you that long my plan is to keep you for about forty, forty five minutes

K Umm

Me Is that all right?

K Fine yes

Me We won’t be disturbed I’ll put that on the door (a don’t disturb sign) you’ll be done by about tenish that’s all right

K Fine

Me What I want to do, what I plan to do is ask you to tell me a story, to tell me something about a patient you’ve dealt with...

K Right...

Me Who stands out for you do you know what I mean....

K Yes

Me It can be difficult to do that so I’m going to ask you one or two questions first about, you know your general situation. You work as a surgical nurse what does that mean?

K You’re looking after pre and post op patients..

Me So these are people....

K Waiting to go to surgery or who’ve had surgery

Me Right, what sort of surgery is it that people are having

K We do a lot of bowel surgery ‘it’s like other surgery, we have appendix but it’s mainly bowels

Me So appendix is, is that usually emergency stuff?

K Yes we have some on like when they have their gall bladder removed as well
Me Is that an emergency

K It can be, sometimes, they don’t always take the gall bladder out as an emergency because we have to wait for the inflammation to go back and settle down like but that’s usually a waiting list procedure.

Me What about the bowel surgery...

K That can be an emergency procedure if someone comes in with a blocked bowel

Me That’s very serious...

K Yes

Me So you’ve got a range of emergencies Are you meeting people who’ve waited for surgery for a while then?

K You can do we usually get some patients whose operations have been cancelled previously

Me Right bowel surgery sounds a big.....

K Like bowel cancer... sometimes they are, that’s due to other circumstances

Me Serious enough stuff

K Umm

Me How long have you been doing that

K Oh nearly five years

Me About five years doing it...

K Yes

Me And do you like it?

K Yes

Me You do days and nights don’t you?

K Yes,

Me You said you were coming up to doing some nights. Right that’s your context, your working context

K Uh huh

Me Is it male and female...

K It is yes, usually ranging from we have had a sixteen year old was the youngest up to a hundred

Me A hundred years old
K: Umm
Me: It’s a fair age that
K: It is isn’t it
Me: And what I’m really interested in is if any of those, over the five years and I’m sure it will be the case that they do, stand out?
K: Umm, yes.
Me: Are there people that you can think of now that you’ve dealt with that stand out for you?
K: I imagine there are several but I’ve just had one recently, she wasn’t surgical she was more of a medical patient..
Me: This is a woman
K: Yes, yes........
K: Erm....she was sort of erm...a nice lady really,.....and we always thought she was going to go home but then all of a sudden she sort of deteriorated
Me: What was wrong with her then?
K: She came in with leg oedema and there were other medical problems as well added to what she came in with and she had to go down for some procedure ....and..it was just like a CT angiogram
Me: That’s a scan type of thing
K: Yes and, I don’t know if I’m allowed to sort of say this, but I’m going to say it anyway she had the contrast and that effected her kidneys and stuff...
Me: Contrast is like a dye
K: Yes it is yes and sometimes that can effect kidneys and that and she just sort of deteriorated, her condition deteriorated and that’s something that sort of. Well we brought the family in.
Me: When you say deteriorated is that, some people react badly to
K: Yes you can react bad, some patients do react quite badly and sort of and something happened to her kidneys that’s one of the risks I believe that contrast does have in certain patients
Me: How many times has that happened
K: Erm. I , that’s the first time I’ve seen that happen but talking to a more senior staff nurse It has happened
Me: So the woman reacted to the dye, that was unexpected...
K: Yes
And deteriorated, what does that mean?

It means sort of, her condition worsened, that’s the way it happened sort of to the point where we had to get medical....... medics up quite quickly to see if they could deal with the problem but...

So she reacted to this stuff, you see that she’s not well

You have to get doctors to...

What do they do?

They, they obviously look at the bloods, blood gases sort of measures and see if they can re, sort of, how can I put it, solve the problem, that’s the way I can...

Yes that’s fine

Yes

So this is like, Im trying to, this is like an allergic reaction

Yes

But its happening inside your body after you’re injected with this stuff

Yes

Its quite serious, and you had to get the family in...

Well it happened on the early (shift) I came on and the patient was already sort of ...deteriorated...but I sort of took over in the afternoon . It all sort of happened in the morning but I was obviously I was handed that over, what exactly had happened and I was speaking to the family regarding what had happened

So you go into work thinking this woman is OK...

You get into work, find out she’s had this test ...

And has reacted badly to the stuff they buse in the test...

And then you’re left with picking up the pieces of that...

It’s not easy is it?
K  Its not not really no The family had been explained everything in the morning so they were aware that , but its still difficult to sort of deal with that situation when its unexpected that's how I...

Me  So you were waiting at some point for the family to come in ....

K  The family were actually just arrived they were actually there, I have, soon as I came on  I actually went to see the patient first I thought that was the most important priority to deal with them, and I was speaking to the family about the situation when I asked them had everything been explained to them they said yes, so erm.....in the end the lady did die from...

Me  As a result of this....

K  Yes erm, so it was that serious The doctors had, I spoke to the doctors beforehand they said, looking at the bloods and that there's nothing they could do, they couldn’t do any more for this lady and this was explained to the family so that was the bit then you have to ,.....deal with afterwards.

Me  That must come as a hell of a shock to them

K  Umm

Me  If they think she is in for investigations then she

K  Yes, I mean she had been in there for a few weeks but the point is she was all right one day and then the, this dye ..... 

Me  What were the family like ,you met the family as well

K  They were obviously distraught and distressed but I think they ,they'd been told about the likely outcome and I think they were preparing themselves , as best they can, for the outcome ,erm, that would happen

Me  They were told this woman was not very well at all?

K  Umm yes

Me  Which is like a euphemism for “she’s going to die”

K  Yes

Me  And they had accepted that, they understood that?

K  Well, I think they’d accepted it to the point ,to a certain point, but its quite hard for anyone to, sort of ,accept that news  I suppose, to start off with

Me  Its very bad news though isn’t it, and they were distraught?

K  Umm

Me  Upset and...
Yes, crying and,...you have to then try and sort of erm how can I put it erm its hard,...to comfort them In a way you sort of.....sort of..try and comfort them in a way that they might feel a little bit better given the circumstances

Not a lot you can do though is there

No there isn’t

So what do you do, what do you do to comfort them?

Well, I’d sort of moved the lady into a side room so it gives them a little bit more time that they can spend with, with their relative

You’re giving them that privacy

Yes ....and also I had one of the other members of staff get them a cup of tea so it gave them a bit of time then to spend time then and sort of reflect on what had been said and we came and gave them a cup of tea asked them if they needed, any more questions, that we were there to ......

So you create a bit of privacy for them

Yes

Give them a bit of time, a bit of space

Yes

Give them a drink..

Umm

Did you go back in?

I did yes, just to see if they were all right and spend a little bit of time with the relatives there and

Do you stay with them then at that point?

I didn’t in that circumstance because I felt it was , just, to give them more time really and when I did go back in , from the time I went back in it wasn’t long then before the lady actually died so, they did ask me “Has she gone?” and all I could say was “well as far as I can see by looking at her I can say yes, then we have to get the doctor to confirm......

You’re actually there at that point?

Yes umm, so it was hard on me obviously but you have to sort of erm you don’t actually get used to it , you can erm, you have to learn to deal with that kind of situation at that time I think

What does it mean to deal with that situation?
I don’t know, its how we can help them overcome their grief, I know its hard but, in time they will but its there, being there, not being sympathetic but I can’t think of the right word but being, trying to understand their situation just being there to be, sort of, there to, if they’ve got any questions we can listen to them and try and ....

Just being there must be hard though

Yes

At that moment you’re being asked “is my mum dead?”

Umm, and you must say “yes they have died” rather than sort of saying “they’ve passed away” because they may not take that as, in that sort of....

So your language has to be....

You have to say that they have died because then, they’ll take that on board then I think more....

Clarity is important?

I think so..

Its not easy is it? Have you had to do that sort of thing a few times?

Two or three times now, its not hard, it does, I feel it does get a little bit easier every time you do do it

Is it getting used to it or is it developing a skill or ...?

I do think You develop a skill in the way that you can reflect on what you say to them and you think how you can do it better next time that’s how I sort of look at it

What is it that struck you you’d have to do better next time?

Its very hard because every situation is different erm, this one I think was easier because the family were all brought in and they were told exactly what was going to happen its not like its .....

Were they not angry?

Not ,they weren’t angry at .......no they weren’t actually...no because this lady was an elderly lady and erm I suppose its, I suppose its at that age more expected than somebody younger...

Its more natural?

It is I don’t think they were angry I just think they were upset but they weren’t, they definitely weren’t angry say towards me or any of the other staff I think they were told the fact that she was, perhaps in other cases they may have been angry but in this case they didn’t show any anger toward the staff, me , or the situation at all.

I’m just wondering because if it comes out of the blue and it sounds like it did
Yes

And you’re not expecting it

Umm

Then there might be a number of ways that people react and it may be that they get upset and you describe these getting upset and it may be that they react by getting really annoyed

I didn’t feel they appeared to be that way

Well you were there you know

Yes umm

You’ve created a bit of space for them, give them a bit of privacy, looked after them in terms of a drink, gone back in they’ve asked you to “is my mother dead?” you’ve had to say yes, what happens after that?

Well we just, I had to leave them, ring the doctor to say the lady has passed away can you come and certify, I did tell them that I thought she had (died) but I had to get him to come and certify it. They understood that bit, that we’d have to get someone. When the doctor did come I did have to ask them just to leave the room for a short period of time so....

While he does an exam...

Yes he does an examination and then after that I said “you can spend more time if you want with your relative” and we have a booklet where it explains for the bereaved relative exactly what the next step would be, erm, if they would like to take the belongings,...it is actually quite a useful book and we say roughly what’s in it and then I say well you can take it away and then read it in your own time. Things like that, funeral directors and ....

Practical advice

Yes and there are helplines in the back if you need....

Things like support networks?

Yes

Phone numbers to ring and stuff like that?

Yes

There’s a lot of information giving isn’t there

Yes because a lot of relatives do say “what happens next?” then like I say that we’ll wash your relative and prepare to take her down to the morgue or him down to the morgue or mortuary, you have to say that because they I think it’s better to say that so then they’ll ....obviously...a bit more to take it in and give them time to accept it
Me  There’s a theme there isn’t there? About being clear with people?

K    Umm

Me    Is that something that you value, do you value that idea of being clear with people letting them know....

K    I think so, I think there’s, I think you do need to be clear with people I think it helps them then take the information in, better than just sort of not giving them a clear

Me    Nothing wishy washy about that

K    No that’s the best way of doing it I think you do need to tell them somebody might get the wrong idea if you say you’re going to ..... 

Me    You’ve got to know where you stand?

K    Yes

Me    Where’s that coming from?

K    Sorry

Me    Where’s it coming from, why would you be definite in that its more important to know where you stand than just...you know...letting them get on with it

K    I don’t know, I just think you should do, I just think you need to follow that so, they get an understanding or they can take it in better that he has died if you’re talking about that

Me    Is that because you’ve learnt that that works or because you were taught to do that or is it because you believe that’s how you...

K    No I think its a mixture of all three because we’ve been taught that from sort of training “be straight, with the person when they have died” courses Ive been on I’ve learnt bits out of there to tell them sort of to be clear in what you say to patients someone may not, if you’re not clear they might not sort of understand or ....take the full information in and get sort of confused with the information you’ve given them so I think its always better be clear

Me    Are there times when they just look too stunned to take information in?

K    At times I suppose yes, shock if that’s the....

Me    Good word, what do you do when you see somebody’s in that state?

K    Well its only happened once with me and sort of perhaps you need to sort of if the doctor comes with us I sometimes say “do you understand?” what we’ve just said?

Me    This is to do with giving bad news?

K    Yes
Me   Somebody gets bad news, do they always get it from the doctor, is that how it works?

K    Well we tend to, if there’s any sort of medical thing get the doctor involved as well because I feel that they can explain it in more detail than perhaps we can. He might have more understanding of the condition or problem.

Me   Is this when its very bad news?

K    Yes usually, when the doctors going in they usually ask us to go in with them so...

Me   So the persons waiting, the doctors going to give them, by very bad news they’re going to die...

K    Umm, or cancer or something like that its....

Me   Right.........and you’re going to go in with them?

K    That’s right, we usually do yes. Usually one of them goes in but I think in some cases the patient probably already knows there is something not quite right so.......

Me   Is that your experience?

K    Well I have in some cases, where they know there’s something wrong but they’re not exactly sure what it is.

Me   Does that mean that they can’t be surprised

K    Sometimes, sometimes I don’t know. Sometimes they don’t think its like cancer it might just be something else but usually when they say a thing like a mass that usually means it could be that.

Me   People pick up on that

K    Yes,

Me    So they’re going in giving the bad news, what’s your part in that?

K    Well, sometimes we have to we’re there just as a sort of support for the doctor as well the patient because I think sometimes doctors, they always ask nurses to come in with them or somebody to come in with them when they are telling them that.

Me    Can’t be a nice job can it

K    No, it’s not the nicest of jobs but it has to be done for the patient really they have to know.

Me    So they’re given the news, are you then left? Do they go away

K    In some cases they do. Sometimes they do but not always because sometimes they actually sit down, explain it to the patient so there sort of not, but sometimes, I can see why the nurses are brought in to.....
They do the job, tell the person you’re then left with this notion of support what does that mean, what have you had to do?

I just sort of say, you know, “If you’ve got any more questions to ask, just ask.... just ask... and if you need any more information we can always get the doctor back to explain it again if you .....sometimes they get upset we sit with them and talk to them a little bit

You’ll stay with them, that can’t be easy to stay with somebody at that time..

No, its not always, umm..

What do you say?

That’s hard! It is honestly, it is, if they cry then I do offer them a tissue ....

Are you a touchy person?

Umm I can be I can be I do hold their hands and stuff like that if they want it,I mean some people don’t want it

Do you know whether they want to or not?

Erm, I think you can tell so.....

I mean, you’re willing to be there

Yes ...

The touching, the tissues...

Yes, sometimes we close the curtains around them, so that, so it appears as though they’ve got their own little space

It appears as though they’ve got their own little space

I think so you close the curtains so they’re sat there enclosed rather than having everybody else, staff or patients, sort of look or stare

You’re creating that privacy but its curtained its not....

Its probably not the same as a single room on its own but I think it’s better than ..

Nothing..

Umm

You’ll stay in that space with them?

For as long as they want really , some patients don’t want me to be in there or want me to be in there for, we’ll say "If you need us for any more questions we’ll be a
little while” they can take it on board a little I think it varies depending on what patients you've got so...

Me  And what they want...

K  Yes,

Me  Is it easy to tell what they want?

K  Not really, sometimes, some people just need to be left on their own and ....

Me  Have you ever got it wrong?

K  Erm, I can’t remember, I don’t think so but, from where I sort of look I don’t think I have but...

Me  I ask because in that situation its incredibly difficult to ....

K  Yes....

Me  There’s no book that tells you ....

K  No..

Me  There might be a time then when you sit in there in silence, does that ever happen?

K  Yes I think there is one, or two, yes two times I think its happened ....where you don’t know what to say..you sort of,how I get round it is ”is there anything else you need to know?” , I say I can always get the doctor to come back and explain it a bit more ....if you need it....its a lot when you’re told something like that it must be hard to take that on board

Me  Shocking...

K  Umm ...

Me  And if they get upset....let them cry....would you stay there with them if they were crying?

K  .............That’s hard, because you don’t know whether to stay or go, I sometimes say “do you want me to stay?” you can say that, or you can say “if you want to be left alone then...” or “is there anybody you want me to call?” or anything like that to help them

Me  I wonder if there are strategies that you’ve learnt as you’ve said from having to deal with it The best way to deal with it.

K  Yes

Me  I wonder if there are strategies people can be taught, can you teach people how to be with people who’ve just been bereaved?
Erm.....I don’t know if you can to be quite honest I think you learn, I think you learn that. The books, there’s textbooks saying that you should do this, this and this but I think every situations different so I think you just have to learn it and then if you do make mistakes you learn from them and feel a bit better next time

Me You said, you reflect sometimes on.....have you made mistakes

K No I ....probably early on when you don’t know...

Me I’m not asking , just generally you know...

K Everyone makes mistakes because no ones perfect and I think, even sort of doctors sometimes don’t come across as the way they should do

Me Umm

K ....You can “wish I’d done that better”

Me I’m sure most of us...

K Umm

Me ....Go home sometimes wishing we hadn’t opened our mouths at all...

K Umm, I think though the feeling with bereavement is if you’ve had bereavement in your own life I think you can then deal with it better with people....

Me I’m not sure, does that mean that if you’ve experienced it you can relate to what somebody else is.....is that what you’re saying?

K Yes, you can, I think you can relate to how they’re feeling at that particular time , erm,...

Me Just in that moment?

K Yes, .....I do, that’s how I .....as you know.... I think you know how they’re feeling at that particular point because you’ve gone through a sort of similar experience and perhaps that does....in some cases..

Me I’ve got to ask, are you saying you’ve experienced...

K Yes, my dad died three years ago and I think after he died I can then relate more to what the family we were talking about earlier were going through at that time and it made, it failed ,its easier now I’ve gone through that sort of now that it had been before he died. So I think giving the book to the relative, talking through that I found it easier ..... 

Me Do you mind talking about this?

K No, not at all.

Me There’s a belief in you that having experienced something like that yourself, you can now appreciate more....
K Yes, I do, I feel its easier, I found it more difficult before it happened, what to say to the patients now, then I can sort of deal with it better now I don’t know its just how I feel ...

Me And its a perfectly valid view, but I’m wondering does that mean that if you think you feel better in that position now than you did four years ago does that mean that we should have people dealing with those who are going through bereavement and stuff who’ve experienced it?

K No, no I don’t think that because everyone’s different

Me Can you see why I’ve asked the question?

K Some people are better at dealing with that before, than others...

Me Naturally?

K Yes, naturally i THINK

Me So what would make you naturally better at dealing with people who are upset?

K I don’t know..I don’t know honestly I just think some people are better at perhaps talking? Than others maybe...

Me But there’s that view from you that your own experience...

K Has made me better because I probably understand people more in that situation than previous because I always found that it was a difficult subject to talk....

Me Umm

K .....To anybody who has experienced it previously but now I’ve had that I feel I can relate more if that’s.....

Me It makes perfect sense but its a crap way to learn and its ....

K It is, I’m not saying I was poor at doing it but I think I’m better doing it now.

Me What’s it given you, what’s it given you now that you didn’t have?

K Perhaps more and understanding and better to be able to talk about it more to relatives I don’t know its hard to explain I just feel its easier because I’ve actually gone through that situation and it can sort of help them

Me Your personal experience?

K Well that ,that was sort of a shock, it wasn’t expected at all I’d had my gran and my granddad but with my dad it was all a bit more, because I was there when it happened so it was a bit of a shock really but more than sort of ....my grandma and granddad were in their eighties and nineties you see so it was different....

Me You said that before, you said there was something natural about older people something expected....
K Yes, then again...I was upset when they died that was when , about fifteen, twelve thirteen years now, so I was still upset then though I don’t know, its different, I don’t know..

Me There’s something about the experience that changes the way you work?
K Yes

Me That you couldn’t get from a textbook?
K No, I don’t think you can get it from a textbook you have to experience it before you, personally that’s what I think, I , yes that’s it...

Me I think its a really interesting view .....but its got big implications you know really if you examine it
K Yes...

Me Because most people who come into nursing are still I know the average age of the student nurse has gone up but there are still lots of eighteen year olds
K Umm

Me .......Who will never have...
K Yes

Me You’re quite a young woman, you’re not an old woman....
K (laughing) I think I am

Me I don’t, so that experience is you would have had to have had that experience quite young to make you
K Umm

Me Good at dealing with
K Other people, some eighteen year olds probably had to deal with it I just feel, me personally, that’s better at being there

Me You think it’s given you the insight into how people might feel
K Umm

Me Its given you an idea that you would sooner be dealt with in that very practical way..
K Yes, yes

Me That’s your preference...
K Yes

Me Do you think other people have got that preference as well?
K    I think a lot of people have because they do say “what happens next?” because they want to know and I think they would rather be told sort of straight than go around the.....

Me    Do you think people ever say, focus on practical things because it takes their minds off what’s happened?

K    Possibly......I do think though ,yes possibly, I think its hard to sort of I think ,we’ve had several obviously ,several deaths and often people say “whats next?” because I think they want us to..guide them in that sort of direction

Me    You need to know

K    You do you have to sort of “I’m allowing you to go through the book, this is the number you need to ring tomorrow, this is for the death certificate” I have to say that because ,I think, just say for the bereaved relatives of a patient who has died ....

Me    There are things you’ve got to do...

K    There are and that’s one of the things you need to do

Me    It can’t be all doom and gloom your work can’t, there must be elements , surgery, most people who have their appendix out leave hospital don’t they?

K    Yes,

Me    That’s happier stuff, so you’re meeting those people as well does that balance up the hard stuff?

K    Yes, the majority of them go home it’s a fairly small....

Me    Percentage...of people?

K    Yes

Me    And does that experience with good things outweigh

K    Umm Yes, yes

Me    It does, I suppose if you’ve got too much bad stuff going on its going to get very bleak isn’t it

K    Umm that is the worst part, when they don’t go home, when they die and obviously it has to be done

Me    How.... you’re working with other people, other nurses, how do they get on after, say something like that lady who had the reaction ,how do they get on? Does everything carry on as normal?

K    I think in a way, yes, you have to, you have to be there for the other patients as well, obviously we need to deal with the, if the relatives are still there then you still need to deal with them as well. So that’s hard to balance that at that particular time I think

Me    Which gets priority?
K Erm, that’s a hard question because if you’ve got people who are,.....actually...still here they they’re there and the relatives are there ( illustrating with outstretched arms ) you have to try and juggle your time to spend with them and with the other patients, its hard.......Very hard

Me Umm and a lot of the time there’ll be lots of patients and not a lot of you

K Umm (smiling)

Me I know you’re smiling but that’s what people say isn’t it..

K Yes

Me But you enjoy it?

K I do yes Umm

Me We’ve been talking for about forty five minutes was there anything you want to ask me?

K No (chuckling)

Me Are you sure

K Yes I’m sure

Me Then I’m going to turn that tape recorder off and get you a coffee so you can actually finish that Danish

K (Chuckling) That’s all right

Me Thanks very much for speaking to me.
TRANSCRIPT THREE  22^{ND} MARCH 2011

"ANDREA"

A  ....Qualified there, worked for four years there and it was actually a relatively new ward and we dealt with everything from sort of pyrexia of unknown origin to HIV and AIDS so I followed that route for about two years and then did ...........and cardiac medicine and then came here and worked on ward two which is general medicine...

Me  Is that what you’ve been doing general medicine?

A  For my last stint yes

Me  What do you see in general medicine, what....?

A  I think its, because its, well its not so much of a slow turnover now but you get a good period of time, because some of them are complicated discharges you get to spend longer time with them , with the patient, to be able to develop a relationship whereas in surgery they’re in and out you know,you go in one day, go back next day and you could have a completely new set of patients to ......

Me  So its work where you see people over a period of time?

A  Yes, a long period of time

Me  Whats the average length of stay?

A  Oh probably, well I think the average we’re aiming at  is about five or seven days isn’t it generally but you know,you get patients that could be there for two or three months

Me  Because they’re older people?

A  Well complicated social discharges, complicated medical problems so it sort of gives you that time to get to know them a bit....

Me  What does complicated discharge mean?

A  It probably means that there might not be funding available for the services they need so I need to go through lots of assessments to find out what they can do ,sometimes because of their age they might need nursing homes and if they’re under sixty five that makes it a bit more difficult there isn’t the funding for the younger patients that require that kind of assistance generally its because we haven’t got the services that they need or we can’t put them in for the length of time that they need them or ......

Me  These sound like people who aren’t always in control of their own futures

A  I think if you look along the lines of the patients that we have with dementia, they may have no next of kin so they have no power of attorneys or people to speak for them , obviously a lot of it comes down to social services, they take that responsibility so they
have to be fully assessed and given the opportunities to look at their dependency levels to see what they can do for themselves but obviously I don’t think they want to put people in nursing homes unnecessarily you know it would confuse, particularly dementia patients even more ....

Me My understanding, when I hear the word dementia I think about people who aren’t really able to engage

A I think so, but obviously the different stages of dementia ...I don’t think you can go in saying “right they don’t fully understand what’s going on” they probably do but they can’t make us understand how they’re feeling because.....we’re not in the mind of that person whos in care how can we say that they don’t understand what’s going on?

Me How do you, why do you have the belief that they may have feelings they can’t....

A I think just generally because they’re individuals and I don’t think we should take that away from them just because we decide, you know they’ve been diagnosed as having a condition that means that they can’t make those decisions ,I don’t know if I’m making sense ....

Me You are yes, that sounds as if it’s a view you’ve got,you’ve got this view.....

A Yes, I mean they’re still an individual, they have individual rights, its just that somebody’s said that,maybe because they’ve got this condition they’re not going to be able to make the right choice but if they’re given the information in a way that they could understand maybe they would be able to

Me Right

A So I don’t think we should taken that choice away from them just because you know....

Me Have you tried to do that? Have yyou tried to give them that information in a way that they could understand it?

A Not on a regular basis no, I try, you do try and engage with them you know, and if you ,obviously pick the right moment and try and find ,probably not the right thing to say but,when they are more lucid than other times then I think you ought to yes

Me The right moment depends on that lucidity then?

A Yes

Me How do you pick up when they’re lucid? What are you looking for?

A What we looking for,I think they know , things like, they know what day it is, they know where they are they are probably making more sense than they probably would do on other occasions , and again, see, sometimes its the time of day as well or the fact that sometimes if they’re on certain medication it makes them less.....we’ve probably put them on medication to stabilise them and calm them if they’ve been agitated but it does affect their ability to make that decision so we shouldn’t just be going in, you know they’re affected by medication that we’re giving them for their condition then.....
Me Theres a lot there isn’t there? You’ve mentioned a lot of stuff ....just to get an idea of whether someones lucid

A Yes

Me Any gut feeling?

A I think so yes, to a certain degree but you only get that when you’ve, you’ve looked after that person for a certain period of time

Me You’ve got to get to know them?

A You’ve got to get to know them and they’ve got to get to know you as well importantly and they obviously, you know, sort of trust you in a way ....

Me How do you put your trust in someone whos....

A I think you just treat them with respect really, you go in, you erm you’re consistent with what you’re doing the responses you give and you’re consistent with the care that you give I don’t know if that makes sense at all but...

Me Makes perfect sense

A If you’re doing, working with them in a routine, getting them into a routine if you like I know in hospital we try and get away from routines but with somebody with dementia to help them we try to have a routine of what we’re doing we go at certain times to do certain things and you know, you’re talking to them all the time instead of sort of talking down to them , as I say you’re treating them as any other person and.....

Me So your approach wouldn’t be different with somebody who was dementing than to somebody who isn’t?

A My individual...no no. I wouldn’t treat them any differently, erm, .......

Me So wheres that come from, is that justv experience then?

A Erm, I’ve no personal, sort of history of dementia, I think its just,you know that my upbringing, I think we always, we had values and were taught to respect your elders and treat them....and the nursing training that we did used to teach you to treat everybody as individuals as though they were a member of your family

Me To look at that person as if they were somebody, make sure they got the same deal as what we got?

A Yes,

Me When you were dealing with people who weren’t dementing ,was it the case that most people you dealt with weren’t dementing?

A In a lot of cases yes, I mean we, for the situation we meet a lot of people diagnosed with terminal illnesses who need our support and, you know, everybody is an individual case and only really through getting to know them can you build up an individual picture so that you’re able to ,like, tailor the care that you give to support each
one and of course, everyone going to need a different, different input from you as a nurse.

Me: So those people with a terminal illness then what were your main priorities there? What were you.....

A: If they were newly diagnosed it was really just to help support them through....the news that they’d been given, making sure that they understood everything that they’d been told as a nurse advocate if you like, just making sure that they’ve had all the available information to be able to make choices.

Me: Right, they’re encouraged to make their own decisions.

A: Yes, I think in hospital what we don’t do very well is ....we do take away elements of choice for the patients, you know, if their dying wish is to be at home, you know we need to be able to make sure we do everything we can to get them home.

Me: I keep hearing that.

A: Umm....

Me: You know the government keep talking about that.

A: There has been a lot recently hasn’t there?

Me: And do you do it?

A: We try, we try, its within reason we have to say look at the bigger picture and see what is reasonable and impossible for us to be able to achieve that and that, you know again, its something we always discuss with families not just with the patient.

Me: So its carers and families...

A: Yes,

Me: So what if you can’t accommodate somebody?

A: Then we can’t, in hospital we just have to make them as comfortable as possible, make things as, as normal as possible, umm....

Me: There been, going back to the nineteen sixties there’s been a criticism about whether nurses work with people who are dying....

A: Umm

Me: Not in the way they look after them, physically, but in the way we give them time

A: Yes, I think there’s two ways of looking at it. Sometimes there’s not a lot of, not always the time, because obviously if you think being in a busy hospital ward when you need palliative care, end of life care, is probably not always the ideal. There are specialist services available, but also nurses, I don’t think, I may be wrong but sometimes don’t deal very well with other people’s emotions. I think again that comes down to the way it depends on how you were trained, but we were trained not to get
too involved, to that point where you become too emotionally involved but I’ve always thought that you can’t do your job effectively if you don’t get a certain degree of emotional involvement with your patients, you can’t be as effective doing the job.

Me  That must be quite draining though, if you’re working with people who are dying

A  It is, yes, but I think at the end of the day if you know that you’ve done everything you can, you’ve done it well and you’re comfortable that you’ve done the best job you can or that you’ve done everything you can for them and their relatives as well and I think too that we talk to each other, we don’t necessarily have the sort of one to one supervision, we talk amongst ourselves a bit more informally particularly if it’s a patient we’ve known for a long time, you know, some of us would reflect on what we did and what we could do better and erm its just more informal its nothing formal to that.

Me  As a means of supporting one another you mean?

A  One another yes......

Me  So if these folk are dying, they’re likely to be with you for a while you form a relationship with them, that relationships going to come to an end...

A  It is yes,......I think,......if you have looked after them for a long while the bereavement, that bereavement process a nurse would go through it but on a lesser extent than the families go through

Me  You’ve experienced this?

A  Yes to a certain degree but I think in the back of the mind is that well say that, you know, we’ve always got another patient then that would.....

Me  Take their place?

A  Take their place or, you know, somebody else that needs our care

Me  Suppose its like a conveyor belt isn’t it....

A  It is

Me  You never run short

A  No you don’t

Me  This is a fairly difficult question, can you think of an example where somebody who you looked after who was in the process of dying, there wasn’t anything else you could do, with whom you developed a relationship, that you remember just now?

A  Yes, oh yes, there were a number of patients that I’ve looked after that I always remember, I remember my first death when I was a student, a first year student nurse

Me  Why do you remember your first death?

A  Because it was the first and it was quite traumatic, a situation where the person I’d been looking after arrested and....
Me: That's a heart attack

A: Yes

Me: The likelihood is that my supervisors not a medical person

A: Right, yes (chuckling)

Me: That should amuse my supervisors

A: So their heart stopped and we had to resuscitate them and if somebody's not seen that before ...

Me: Even though they're dying

A: Yes even though, yes we would yes, but there's also the case recently I mean I left that practice a year ago now but we had regular, particularly respiratory patients with airways diseases that are sort of more chronic diseases that each time they come in they're a little bit worse, their condition becomes a little bit worse, gradually deteriorates and that's hard because you know they're going to die, they know they're not going to get any better and you, because they're coming in and out of hospital for treatment you're building up a relationship with them, they do become part of the family on the ward, our ward family, ...

Me: Do you remember somebody who fits this bill?

A: Yes, within the last five years, a female patient, yes, she was what you call chronic obstructive airways, erm disease, which is a disease where they degeneratively become worse over a number of years and it is quite distressing to see that in the end they're being suffocated and to get to know somebody, get to know their family and see them, witness them all going through that is very hard. Again some, you try to get to know patients and family, some allow you in some don't and again that's part of the nurses skill I think is to respond and recognise when somebody puts up the barriers and know how far you can go.

Me: What tells you then that somebody is interested in you supporting them and what tells you when they're not?

A: I think somebody who wants the support its little things they do, like try and keep you talking you know when you're in there they want you to be in there they keep talking they don't want you to leave, there's always something to bring you back to them.

Me: What sort of things do people talk about?

A: Little things that you do for them you know, they call you in if they want erm help, they try and, its like they're skirting round the problem almost, they come up with any sort of, erm, way to get you to sit down and talk to them, does that make sense?

Me: It does yes, this is something you feel

A: It is yes, you get the feeling that, you know, they, they want to talk to you because they'll come up to you or you'll go to them to do something and they start
talking about things, not necessarily to do with their condition or what's happening to them but others, I think, are more standoffish, more sort of, erm... like stoic. They've been, for instance, been told bad news, they're very stiff upper lipped about it and get on with it and ....... you know

Me So what do you do with those people?

A I think you just have to let them, I think it's just the way they're dealing with it, everybody is going to deal with the news, bad news, in a different way. It's their way of coping with it. Not necessarily a sense of denial but that's their personality that's the way you know they see it.

Me You see that, you know they've accepted whatever is going to happen to them, they just want to get on with it?

A Yes, get on with it, with the time they have left, where as I say, others want to, they do want to talk about it it helps them to talk about it, to verbalise that, to verbalise their fears, it's a way of, sort of, like an emotional release

Me So how do you feel talking about it?

A Erm... I think, I think it's not necessarily about me its letting them talk I think from our point of view our job is to listen and maybe... support... maybe advise erm, I as I say it is taking on that role and being included in the confidence of that person its very I think...... oh what's the word I'm looking for...... its a privilege I think. The fact that they would probably respect you enough, trust you enough to take you into their confidence, to talk about how they're feeling emotionally. I mean, from myself, I'm, I don't like being, I'm not an emotional person I try and hide my emotions quite a lot, so to be able to take on somebody else's emotion, it is, it is quite difficult sometimes. Erm, but with experience you've got other people that you can talk to for advice about how to

Me Do you think you get used to it?

A I don't think you ever get used to it, I think the day that you get used to it or it just becomes a part of your role you become very stone faced about it and that's probably the time to give the job up. I think being a nurse that is a big part of your job

Me Does that mean you feel sorry for people?

A Yes you wouldn't wish some of the conditions on your worst enemy because you know what's happening. I particularly feel sorry for the people who, you know, work, work hard all their life and then something like this can happen to them and you know, they don't have the support of their family members or they're not expecting the news that they've been given

Me You're talking about unfairness now, you sound like you're talking about unfairness

A Unfairness in?
Me Unfairness in the sense that you work hard all your life and then you get visited with some horrible disease

A (Chuckling) Yes I think thats it isn’t it yes, nobody deserves to be told that they’re dying of a horrible disease or

Me Do people say that?

A I think they do you know, “whys it happening to me?” you know, thats often a question that patients come to you with and say “whys this happening to me?” you know

Me Whats the answer?

A You can’t say, you can’t really tell them can you? I don’t think there is any answer again thats why I think thats just, to allow patients to talk about it and put it into perspective for themselves

Me Thats an interesting phrase “put it in perspective for themselves”

A Umm, and I don’t think its down to mus to tell them why its happened to them its help.....,its helping them understand why it might be happening and not our view of it

Me And do you do that by, do you give information to do that?

A You can give information yes, give them information so that they can make those choices and the choice thats best for them

Me Do people now, the internets there for everybody isn’t it?

A Umm

Me Do people come in with information?

A I think moreso, I mean over the last five or six years certainly therers a lot of patients that have come in that I would consider the expert patient and again this is people with these long standing diseases, they like to know and want to know whats happening , “is there a cure?” and that helps because that then challenges us to say “well are we doing as much as we can?”

Me Because if they’ve got the information and one of our normal strategies as nurses is to give information , it must change the dynamic, mustn’t it?

A It does, but I think thats about patients taking ownership of their condition anyway we can probably, yes, the danger is with people using the internet is they can get too much information and they expect too much when they come into hospital , about what we’re doing, and again thats about us,helping us then put that into perspective, what we can deliver ......

Me How do you have to moderate somebody’s views?

A Thats difficult because, you know, people have expectations of what we should be able to do and about health services it, I think,again,its looking at checking their understanding . Its all well and good accessing these services but its what do they
actually understand about what its saying and coming and talking them through it . I assume thats what sort of meaning.......... 

Me Yes, you’ve got to achieve a shared understanding 

A Exactly yes, but I think at the same time we have to respect that, yes I’m the nurse but I don’t know everything there is to know about particular diseases or conditions for me to be saying to “well no thats not right,you can’t have that and you can’t do that” and again it is about us , about patients taking more ownership and them directing what we should be doing , giving care or whatever. Its not for me to say “you’ve got that condition we’re going to treat it like that” 

Me Does it work like that? To me it sounds like a belting strategy,you know, giving people the chance to work things out for themselves, does it work? Do people in your experience work things out for themselves? 

A No, I think in general no, they,again that comes down to the expectation that patients have of the profession and that we will always be there to give them the advice they need 

Me If thats what people want most of the time is it not simpler just to give it to them? 

A Yes 

Me Tell them what to do,do you know what I mean? 

A Yes, sometimes you have to if they’re not necessarily looking at it in the right way again I think it about managing their expectations about what we can deliver as a service and at the same time they need to have that ownership when they come into hospital over their condition 

Me It sounds like for you theres got to be this....the person has to be in control 

A Yes 

Me And if they don’t want to be, if they want you to tell them what to do your view is that you don’t do that. As far as you can you encourage them to work it out in partnership 

A Exactly , as far as would be expected 

Me Thats a very cognitive strategy isn’t it? This thinking about what.... 

A Yes, at least then they know what they want. If they don’t want us to be involved they want to take more ownership, what we want is just to step back, sometimes it automatic for a nurse to make those decisions for patients 

Me To get involved? 

A Yes to get involved but when they come in the whole purpose of care planning is for the person to decide what their goals are going to be .. 

Me Right, “about me not without me” (slogan from the 2011 white paper)
A  Yes, thats a good term
Me  Its from that white paper..
A  Is it
Me  I can’t own that one its not mine its to do with working things out....
A  Between you,
Me  What if somebody comes in with an idea that you think is daft or dangerous? “I want this to happen, I want that to happen”
A  I think thats when you obviously have to start seriously thinking about whether or not we can achieve that or who can you refer that patient to to help them and what is, what would be achievable,what are their long term aims within the boundaries of what we can do
Me  Do you recognise that sort of blind spot that somebody might have though?
A  I think that through experience you do , I’m just trying to think of a situation where that happened
Me  Where somebody had a very obvious view of what was going on
A  I think yes, thats probably within the responsibility of the carers , to try and make that person understand you know “it won’t be possible because of this” and....but not dismiss them altogether it might be that you’ve had a ....you can come up with a different route for them to take
Me  I’m thinking that a lot of the folk you have to deal with have COAD right?
A  COPD we call it
Me  And my simplistic view is that probably a lot of that, things like that are caused by smoking
A  In a lot of cases yes, in a lot of cases its industrial , you know working with dyes and yes, working, occupationally...
Me  People who smoke are very reluctant to stop
A  Yes
Me  But stopping sometimes would be good for you
A  It would be good for them but probably not necessarily cure them , stopping smoking, and in something like Chronic Obstructive Airways disease it is a long term condition that people have to learn to live with and yes,fair enough,we can give them the advice to stop smoking but if they choose not to then thats their choice
Me  You wouldn’t push it?
A  No, they wouldn’t, well, I’m not a smoker so I don’t... I know enough about that disease to say that smoking, that it is a smoking related..thats caused it......and if you’ve got something like Chronic Obstructive Airways disease its a combination of other respiratory conditions like Bronchitis, Asthma, Emphysema...and .....who are we to say that you know, to somebody who has it for occupational reasons who smokes, it just so happens that they smoke would the smoking necessarily have made any difference to that condition or by stopping smoking will it improve that condition,you know we don’t know enough about it but I would certainly say something like “look you smoke, do you think that it would help if you stopped” you know you can’t go “right I think you should stop smoking”

Me  No your tone changed there to.......but would you put it to someone that it might be a good idea to stop

A  You could advise that,but if they choose not to take that advice then thats....

Me  Of course . Would it be advice or would it be one of a range opf options that you suggest to somebody?

A  With something like that it would probably be seen more as advice . I can’t erm......if they’ve smoked all their life and they know that they’re not going to get any better is telling them just to stop smoking the best advice to give? You know, as I say,probably smoking is only their pleasure in life, you know and I think psychologically if you tell somebody to stop doing something then they’re more likely to do it anyway so...

Me  Yes, well.....So,,have you met anyone you couldn’t deal with? For whatever reason

A  I think there have been....instances..I mean I can’t sort of recollect any but there , I’m sure there would be .....where there was a sort of, its more to do with the limits of what you can give ......as I say....if you’re giving advice you know, you can givev the advice but if they don’t want to take it they won’t take it thats mainly the situation that might arise , you know, give them advice and no they’re not going to take it and thats all, all you can do

Me  You sound fairly philosophical about that though, you don’t sound as though you would resent....the

A  No No, I think it is, as I say, its down to the individual you know, we do certain things because we know from experience what is likely to happen , you know, it probably isn’t going to happen every time but I don’t want to come in and tell a patient “you need to stop doing this and stop doing that” just because we think its going to make their life better and improve their condition, you know, patients need to be able to make their own choice about their problems and their health and ....as with everything else.

Me  You sound as, you say that consistently you’ve not changed your view...

A  Sorry (chuckling)

Me  No fine ,for me you’ve made that point . The lady you were talking about earlier on, you had a lady in mind ....
A Umm..

Me Who was involved in the system, came back in a few times and was gradually getting worse

A Yes

Me Did she ever raise the question of her getting worse, overtly?

A Yes, I think within the sort of last year of her life, she started to realise that you know, she wasn’t getting any better, when she came into hospital it was taking her longer to recover and she’d got to the point where she didn’t feel she was improving with anything that we were doing and I think what made it difficult was that she was quite a young lady, she was in her late fifties and now the quality of her life, I’m not saying....but if you know somebody whos older you know they’ve probably had a good life, good quality of life to a certain point. This lady being as young as she was probably shes lived with this two thirds of her life and shes gradually getting worse and I think you see the impact it has on her children and they’re probably, erm, I think they’re probably more shocked with it because they don’t see it happen, they don’t want to see it happen, there’s a certain amount of denial that theres somebody, I mean this lady was very open and honest anyway,she was aware of what was going to happen and she’d ask us if we’d seen this before and you know, could we tell her what would happen but you can’t because its different for everybody some do say, accept it, some don’t

Me Did she ever raise the fact that she knew her time was up?

A Not to me personally.I mean I wasn’t around at that time she died and I’d only seen her a couple of times while I was working on the placement and it was certainly not something she brought up with me I think, I mean she was quite a strong lady anyway and I think deep down she knew, I think, that ....she’d even try to protect her family,they were a very caring family and I think trying to hide it from them, not let on that something is, such as that ....because she knew it would upset her family . You know they were always very positive about her , her condition....

Me Its quite complex stuff that isn’t it?

A Very

Me Can you say that you can feel this going on, or you can see this going on

A You can certainly feel it and to some extent you do see it because its , you msee how they are when the family are not around, you see them with their family and they act differently. Its trying to protect them ..... 

Me My final question....and its going to seem off the wall but I’m interested in whether you’ve got some sort of religious background? When you say you grew up with certain values are you talking about growing up in a family, the same as most families, where values are passed on or is there a particular influence in your family

A No, not really. I mean I wouldn’t say I’m religious , I’m church of England, erm , I don’t ,I don’t look at faith in such a way as to lead my life by but ,I think its vreally not
so much to do with faith but to do with how we were disciplined and how we were taught
to say, respect your elders, you know, ....

Me Is there anything you want to ask me?

A I can’t think of anything. I don’t know if thats ......

Me Its excellent, I ’ll turn this off and I’ll tell you what.....I’ll offer you a view if you
like

A OK.
TRANSCRIPT FOUR  FRIDAY APRIL 15TH.

LYNNE

Me And it’ll run now for about forty minutes
Lynne Am I OK sitting here?
Me Absolutely yes, are you comfortable where you are?
Lynne Yes
Me We shouldn’t be disturbed but I’m not going to lock the door because then you’ll become really uncomfortable. Would you mind saying your name for the purposes of the tape?
Lynne Yes Lynne Stanton
Me You work as a nurse?
Lynne I do, I work as a radiology nurse specialist
Me Thats a branch of nursing I’ve never come across
Lynne Its rare, it is rare erm what we’re trying to do at the moment is encourage student nurses to come to the department, I’m in negotiation with Liz Cotrel-gibbons and the university to try and get more nurses down there to you know to help their understanding of radiology particularly because its a massive area and people aren’t aware of it
Me Radiology is to do with X rays isn’t it?
Lynne It is yes and interventional nursing CT ultrasound so you’ve got your biopsies and aspirations and pacemakers
Me So is it all stuff around investigations?
Lynne It is its diagnostic
Me The radio….radiography isn’t for treatment, its not like radiotherapy?
Lynne No its for diagnostic purposes
Me Right so your job is to do what with people?
Lynne My job, as is every nurses job is to be a patients advocate. Its to be there to support patients through the procedure whether its an X ray procedure just a simple procedure or a pacemaker or an angioplastythese can be really very scary for patients and also to scrub up and assist the surgeon or consultant cardiologist in doing the procedure so I could be a scrub nurse, I could be a circulating nurse or I could be there just to hold the patients hand
Me So its got elements of theatre work and elements of ordinary nursing

Lynne Yes and management

Me What does “hold the patients hand” mean? What are you saying when you say that?

Lynne Just to support them, emotionally not physically, I might have to hold their, somebodys hand physically if thats what the patient wants but its just to support them through a procedure that could be potentially frightening for them

Me Do they need support

L Yes, I think so I think that patients can deal with things a lot better if they’ve got somebody that is empathetic, somebody that’l talk to them somebody that’l communicate with them somebody just there for them

Me Right and you’ve been working this morning

L Yes

Me Have you had a patient in this morning?

L Yes it was for a cystogram ,its an investigation of the bladder, the lady had had an operation and we just wanted to make sure that she hadn’t a leak in the bladder before we trialled her without a catheter. Psychologically for the patient, its not an interventional procedure as such but for a patient its quite a big thing, she knows that her operation went OK and we can try her without a catheter and that frees her up from having a catheter and catheter bag

Me Right, so this is a woman, how old is she?

L She was in her forties

Me Thats young, a forty year old woman who was using a catheter regularly for a long time?

L No, I should say for about three months, so not, thats subjective isn’t it?

Me Shes using that because shes got some bladder problem?

L Uh Huh,

Me Shes had a bladder operation and the hospital need to know whether its worked?

L Exactly

Me She comes along to you, they do their cystoscopy, cystogram

L Cystogram yes

Me And they can tell the woman whether this has been successful or not

L Yes
Me Its quite a nervous time for her?

L Yes

Me And forty’s not old

L No, some of the procedures we do that I didn’t discuss with you earlier are Histosarceadagrams (?) where we actually put contrast into the uterus

Me This is a dye, the contrast

L Exactly yes, and thats scary for a patient as well to tell them that we’re going to put dye into their system and then ask them if they’ve got any allergies. Also we have to undertake a pregnancy test before we do that, although the ladies have come because they’ve had problems conceiving if there was a chance that they had actually conceived within, since, the last period obviously with Xray radiation thats actually over the uterus and also the contrast there could be a risk of abortion or miscarriage

Me Are these women who’ve had IVF?

L These could be twenty year old ladies or forty year old ladies who haven’t been able to conceive they’ve tried for like a year or so

Me So you’ve a range of people who are coming to you with all sorts of...

L Yes, Barium enemas, again it could be any age ,thats an awful procedure for anybody to go through , they have to have a catheter inserted into their back passage and again thats a bit of a shock if you haven’t got anybody to talk about it with and that can explain properly whats going to happen

Me Do you always only meet the people on the day or do you meet them before?

L No usually we meet the people on the day although I do have patients that come back time after time say for a nephrostomy tube, so we’d insert it initially and we change it every three months and if they have a problem they can ring me up and then they can come in and see me and I can assess if there is a problem and what we need to do

Me Some of these people you’ll get to know quite well?

L Yes, Yes

Me And some of them you’ll meet as a one off

L Yes

Me Sometimes when they’re being investigated for quite serious problems

L Yes

Me So its quite a wide remit?

L A massive remit, a massive remit some radiology areas don’t have nurses , I know we do in our trust but, especially within CT and Ultrasound I don’t think Lincoln have
nurses within CT and Ultrasound and that again, where you have liver biopsies or your lung aspirations also on a Thursday particularly we have a lot of clients from chemo...

Me Chemotherapy?

L Chemotherapy, from the chemo ward to see what their progress could be

Me Those people have cancers, do you know I’m meeting people now and I’m surprised by the range of jobs that people do because I had this view it would all be ward based, nursing, but a lot of nursing now isn’t ward based at all

L No I manage the radiology staff, as band six I’m the highest grade nurse and I have four nurses and twenty health care support workers and porters...

Me Thats your team

L Thats my team that I do the appraisals for the rotas for, that I manage and I lead, I’m the person they’d come to although since I’ve been there in the past few years radiographers come to me also with any problems that they’ve got. So for training, there isn’t any specific training in place for mandatory or appraisals or cannulation what else, customer care conflict resolution training because I was doing it for the nurses, CIAs and OSWs then the radiographers came to me and I seem to have been, I seem to have taken on that role

Me So thats grown

L Its grown, in the past three years my job has changed dramatically and I’m actually in the process of project managing the room, the room I used to work in was sixteen years old and the machinery kept breaking down so I was on the team that decided the room needed changing and how we’d lay it out for the patients benefit so we’ve knocked two rooms into one to make a more comfortable area and in the room itself I’ve made it quite light and bright and knocked a wall down. I’ve chosen the flooring, the colours on the walls I’ve also invested in and I think this is the first time actually in this trust in what we call “sky sidelights” so when a patient is lay on the table for two hours, three hours having a pacemaker as they actually look up into the ceiling they now see what looks like a window, a blue sky, with white clouds. Its not cheap, its seven hundred pounds a pane so its not cheap but I think when you’re laid there for two hours its just lovely to have that kind of brightness about it because X ray departments are historically very dark places

Me You commission the services

L Yes, Yes

Me Whats your thinking then to make the place sweet, you say you’ve chosen the colour on the walls

L Yes they’re a mixture between clinical and....they’re not white or very bright because I think thats intimidating, they’re a warmer colour but also its a clinical area so it does have to be, it can’t be too garish its got to have a balance but then like I say the colour comes from this panel in the ceiling. And also we’ve got this strip lighting around the outside, along the edges to settle the patients but I’ve also asked, we have a
recovery area because I don’t think patients should be consented in the room, because if they’re consented in the room its too late, they feel as though they can’t back out so I like them to be consented outside and I’m actually able to talk to them, find out what their preferred name is get them to know me before they come into the room into what could or had been quite an intimidating room where its too late to say anything. I think its nice to see that friendly face. So though I don’t always get chance to meet them beforehand I like to meet them before they come into, I could say theatre room. Also I’ve binvested in some music, so lights and music.

Me So what put that in mind. I’ve not met a nurse before who, I didn’t know such things as “sky light windows” existed, but I’ve not met a nurse in any specialism whos spent money on the surroundings and whos talked about music do you know what I mean? So whats the music about?

L I think its fairly important, its important for a patient to feel, just relaxed in the area

Me So what sort of music have you bought?

L Well they can have their own music or we have got a choice of music thats quite relaxing, background music, nothing thats too much, too loud because obviously you’ve got surgeons working and they need to be able to hear each other

Me You’ve got a sound system?

L Its brilliant and the thing is we’ve brought it in under budget so I think we’ve done fantastic, we’ve done really really well. I’ve spoken to the owners of “sky inside” and apparently some people, some other people at Lincoln have been looking into it I think its I really really like it.

Me Where did you get the idea from?

L I was looking through catalogues, because obviously I’ve got a budget as well for the department so I was looking through catalogues and I saw it in the catalogue. Its actually in the MRI area and we are developing for next year

Me Thats magnetic resonance imaging

L Yes

Me So you’ve put thought into the environment

L Yes

Me Because you had concerns about the way people were in the environment

L Yes

Me Where do those concerns come from then? Hpw do you learn you need to look at the environment?

L Experience. Obviously my nurse training had something to do with it but....

Me Your training wouldn’t consider the environment
L The environment? I'd say it had something to do with it but because of my experience of life, when I've been into a hospital, I've not been into hospital as a patient very much but I have had some experience and I can understand what it's like you know to be intimidated, to be scared to have that clinical, dark and cold environment and for people to walk past you and not look at you and not say hello. It doesn't take much, it doesn't take much to look at people and nod and smile and have a warm atmosphere.

Me The environment, is that part of this atmosphere?

L Yes, Yes

Me The physical environment?

L Yes Its not a home, its not a front room you know, but, it doesn't need to be intimidating and scary. So you've got to have a balance. If you come into the room, I'd love you to come and see it I'm so excited about it there are, there's, I've looked at infection control the scrub sinks you don't need to touch the taps you just wave your hands in front of the scrub sinks and water will come automatically the cabinets that I purchased haven't got flat tops, they've got sloped tops so you won't get dust actually laying on top of the cabinet. They're tiny little things that you probably wouldn't think of

Me Fairly clearly focussed though isn't it, the reason you have those taps is for infection control and at the same time as you've got going round in your head the place has to be OK it has to be comfortable the atmosphere has to be all right

L Yes there's got to be a balance hasn't there

Me It's just interesting you raise that issue of balance, I don't think anyone before you has raised that issue of balance

L Balance is my key to life (smiling) You can have a chocolate bar as long as you have an apple (chuckling)

Me The lights are the chocolate bar, and the music

L Yes

Me So you're thinking about the environment before people came into it. You said it was important as well that people don't feel you're going to walk past them

L Thats again my own experience where I've been a patient and I've been sat on my own all day worrying about myself and watching nurses walking back and forth and you feel its so nice if somebody just looks up at you gives you a bit of a wink or a smile just to know that, to know, well you know that people care

Me Winking

L (chuckling) Well its, it could be a wink, its just knowing its acknowledgement I think, I suppose

Me The fact that you're sitting there
L Yes, Yes they might like the uniform, I think you know, we can make people feel safe

Me How does that desire to want to make people feel safe translate into your practice now, with your woman this morning?

L Yes

Me Did you work with her, physically work with her?

L Yes as soon as I saw her I introduced myself said Hi told her my name and asked her what she likes to be called I explained to her exactly what was happening

Me You gave her information

L I gave her information, it wasn’t just information at the beginning of the procedure there was information all the way through the procedure as well where I said to her, you know, we have to put contrast into the bladder and what we're trying to do is to fill the bladder and that could become uncomfortable

Me How long are you with the woman?

L I was probably with her twenty, twenty five minutes something like that it wasn’t too long a procedure but halfway through the procedure I said to her “if you become uncomfortable let me know” and then we can always switch it off. Halfway through the procedure she said “Lynne I can feel, I can feel my bladder starting to fill up” so I went to her and pulled a screen round so she could see the screen properly. Told her this is her bladder, this is the contrast and what we need, really re-iterated what we needed to do again, we needed to fill the bladder up as much as we possibly could and put enough pressure on it so that if there was a leak we’d see the leak on the screen and erm ....

Me In real time?

L Yes, fluoroscopy is real time images and er....

Me Was she looking at this then?

L Yes she was, she was interested in it not everybody is not everybody wants to see you have to gauge it but I explained to her exactly what I needed and said to her “now if its really uncomfortable we can stop, but if you can manage to keep going a little bit longer then that’d be more beneficial” and she said to me “Thats fine Lynne, as long as I know what I’m doing”

Me The information worked for her

L It did work yes

Me And if she’d questions for you, you’d answer the questions

L Yes, we’d built up a rapport right from me introducing myself and asking what her preferred name is it made it, initiating a conversation, finding out a little bit about her while I was waiting for the consultant to come in instead of just standing there looking clinical....
Me Use the time for a bit of chat

L Exactly, If I’m stood there I’ll speak to the patient about their lives. One of my consultants says ,he says that I’m better than sedation (smiling ) I don’t know if thats a compliment or not (chuckling)

Me For calming people down, its a compliment isn’t it

L Yes I think so

Me Is that just the way you are,or have you learned to be like that?

L I should say that the reason I’m a nurse is because of the way I am, because of my experience in life we’re all different aren’t we?

Me Yes but whats your experience in life that brought you into nursing?

L I care about people. I want to help people that are vulnerable

Me Thats a very vocational type thing isn’t it

L Yes I think you’re not just a nurse in your uniform at work its something thats with you

Me What that desire to look after people? Do you think so?

L I do yes, I do. I can go on holiday or anywhere you know and people will come to me for help and advice and they won’t know that I’m a nurse

Me Why?

L Don’t know , maybe just because I’m open and honest so yes it has got a lot to do with ....I sound as though I’m blowing my own horn don’t I but I’m not

Me No I’m asking you , I’m encouraging you I suppose in that sense

L Yes

Me I’m just interested in why.Because it could be seen as nurses are caring, theres a stereotype around angels and you’re not saying that in any kind of shameful way, you’re just saying it

L Not all nurses, not all nurses, I think sometimes a nurse can become cold and cynical and then maybe its time then for them to change career.

Me You must get used to stuff, so it must lose its novelty

L Yes but then also in the back of your mind you’ve got to think that ,you know, this is the first time for that person how would you feel if that was you or one of your relatives? You might come from one cubicle and you’ve laid somebody to rest , a youmg mum with a family, and then you walk into the next cubicle and somebodys fallen down and grazed their knee and that, that could be a big thing and you’ve got to treat everybody, its the same as pain isn’t it, its individual and you’ve got to treat everybody exactly the same you can’t just say to somebody whos fallen down and hurt themselves
Me: Well that lady you saw this morning, how many times have you seen somebody going through a similar process?

L: Oh loads, on a weekly basis

Me: It's a regular occurrence

L: Yes

Me: So how do you stay.....fresh?

L: I don’t know, I just care and I look at people as though they’re individuals and they are individuals, they’re not just numbers they’re not just “the cystogram” it’s a person and that person could be, well could be a relative or a friend and I try to treat everybody with the same respect, whoever whatever the background they come from

Me: So the respect is for you important, to respect the family...

L: Yes

Me: If you’re doing it every week it must become like, I don’t know, a role, like in the team

L: Well like I said earlier I do have a balance to my role I do have management and I do have nursing so I don’t I don’t get that plus I have my holidays

Me: You’re not doing it all the time

L: No

Me: Is it easier to give....yourself if you’re not doing it all the time?

L: I think it could become difficult if you were doing it 24/7, there’s got to be a balance hasn’t there, you know so you’re an individual too it’s important to look after yourself isn’t it? Because otherwise you could become bogged down in anything

Me: What’s the longest length of time you would spend with someone?

L: With a patient on the table maybe erm that would be four or five hours

Me: Four or five hours and you’ve gone to some trouble to get the environment right or distracting, pleasantly distracting

L: Yes, Yes

Me: And you’re willing to give of yourself while you’re with this person

L: Yes

Me: And is that possible for four or five hours?
L   Oh yes, yes we could talk about coronation street if we start to run dry (chuckling) or the weather
Me   Anything?
L   Yes, some of the patients talk to me more than I talk to them and some of the patients don’t want to talk to me they don’t want to know, I’m there for them if they do I’ll try and encourage them I’ll try and ask them questions but if they’re giving me closed questions then they don’t want to talk
Me   So you’d know if someone wasn’t answering you, because they weren’t saying any more than yes or no?
L   Yes, and maybe just looking around, except its not just verbal is it? Its the facial body language you just pick up on those things
Me   You learn to do that over time? Have you made mistakes?
L   Yes, of course, everybody makes mistakes
Me   So you’ve learnt to some extent the hard way, what happens when you get it wrong?
L   Well it depends what extreme you know if I was really wrong I would apologise I’d admit the mistake, that I was wrong and I’d apologise
Me   In the sense that if you’re chatty and you’re talking to someone
L   If you’re too familiar with someone you’d re-address yourself wouldn’t you, you’d stop yourself from being friendly and you would talk to them at a level they’re talking to you, you’d bring yourself......
Me   How do you know if you’ve gone too far?
L   You can usually just tell by how they look at you and how they react to you
Me   Something changes?
L   Yes, the tone of voice
Me   You react to that, you change
L   Yes
Me   You’ve been doing the job for six years
L   Yes
Me   So in them six years if someone asked you to look back over the six years to the most memorable person you’ve met is it possible to do that? I don’t know whether it is or not
L   There’s been quite a few and so I’d need more, something a bit more specific
Me   A stand out case
A stand out case?

Something thats stuck in your head

That I’ve dealt with. There was a, three years ago three and a half years ago there was a young mum and it was difficult because I rang the husband to come in because it was nearing time and I had to communicate with him in a way that got him to the hospital urgently but not too urgently that he’d crash his car or

Shes a young woman ,you said nearing time what do you mean?

She was dying

The lady was dying

Yes

How old was she?

She was in her thirties and she had young children

That is young isn’t it

Yes Yes

Shes dying,are you looking after her at that time?

Yes

Did she know she was dying?

Yes, Yes she did it was a terminal illness that she’d had for a long while

The husband was working or something...

It would have been nicer if we could have got her into a better environment into a small room rather than a large cubicle and given some more privacy

So its not always possible to do that?

No No you have to adapt don’t you

Has that had any influence on your ndesire to improve the environment?

Maybe , then again its another balance isn’t it? Some people don’t want to be alone if they haven’t got family or anybody that can come and sit with them the last thing they want to be is in a room all on their own and left on their own,you know to hear people walking around just to keep checking in on them

Yes on the radio a while ago I heard Ranulph Fiennes ,hes an explorer this fellow he crosses the poles and ice caps, and he did one last year for Marie Curie and in the interview on the radio he said he did it because he was on a ward where there were old people on their own and he did it because he thought there was more dignity in being at home because then you’re not obviously alone . Thast lady who was dying,what was your level of contact with her?
L I was in and out, we might have built up a relationship but she doesn’t always want me there, like when she’s got other family members she just needs to know that I’m there if she needs me. I might, I did actually hold her hand at some points and I just had that contact.

Me It can’t be easy, you’re a young woman yourself.

L Yes.

Me It can’t be easy to be around somebody in a similar position who’s dying.

L That’s probably why it’s stuck with me really it’s.....you’ve got to have an empathy with people haven’t you, and I do......

Me Is that borne out of sameness, because you’re similar.

L I have an empathy, I can understand people, everybody I suppose, whether it’s a teenager because I’ve got a teenage daughter, whether it’s a retired person because I’ve got a grandma whether it’s somebody the same age as me I’ve got a sister and a brother, an auntie and an uncle.

Me There’s something in what you’re saying that suggests everybody has the same deal, that if you thought about it, everybody has, everybody should have that capacity you’re talking about.

L Yes.

Me But not everybody does.

L I suppose that’s hard for me to understand because I have it and I assume that other people do have it but I do come across people who haven’t its a shame.

Me Not everyone with a teenage kid is going to be understanding of teenage kids.

L Yes.

Me Anymore than everybody with a grandparent is going to be understanding of older people.

L But if you work in a hospital environment because they need, they’re vulnerable and they need some help its not like you’re walking on the street and you see some teenagers its different whether they’re in a gown or they’re in their own clothes they’re all their for a reason and its because they need some help and support at that time.

Me Is it linked to their role as patient?

L Yes I suppose it is to a certain degree because I wouldn’t walk you know round town taking care of everybody.

Me No I’m not suggesting you would if you’re saying that you can empathise with these people because of things in your own life there are lots of other nurses who have the same things in their lives who aren’t of the same mind Do you know what I’m saying?
L Yes Yes
Me And I don’t know why that is and you said you don’t know
L No
Me And I’m wondering if there’s something in the fact that these people may need to be looked after that means you do something to make sure you understand them that’s where I’m coming from
L Yes again it’s got to be experience then hasn’t it? It’s been my life experience
Me Does that mean it can be taught? Because if it’s about your life experience....
L No it’s got to be a combination I think no you can’t teach people to....otherwise I would have taught my daughter to be the same as I am and she’s not you know she’s not exactly the same as I am though I’ve always been the main parent in her life she’s not just a clone of me
Me You’ll have modelled the way to be for her though
L Yes but we haven’t had the same experiences also I really value my nurse training, I really value it, because whatever I had I think it makes me understand so maybe I’m a caring person and it’s probably my strength, I think probably are communication but it makes me understand what I do and how I do it just the open posture and the eye contact and that’s not the kind of thing that you grow up thinking well I’ve got to have an open posture you know or if I look at somebody too much that’s uncomfortable so that’s where my nurse training came in with regards to communication skills
Me Yes it sounds like you’ve reflected on it
L Yes
Me On whether it was worth it or not
L Yes
Me And that is more than most people do . I don’t know whether anyone needs to be told what’s appropriate, most sensitive people anyway
L But it’s knowing that you’re doing it
Me Where does that sensitivity come from
L I don’t know
Me And whether you can teach it or not
L No No you can’t teach people I don’t think if somebody’s not sensitive they’re not sensitive if somebody’s not empathetic they’re not empathetic you can, you can give them the tools but whether they use it or not is a different thing
Me So you’ve either got it or you’ve not got it?
L It seems that way (chuckling)

Me It’s a fair view, I’ve no problem with the view

L No speaking for myself, I think I am an empathic person and I am a caring person and that’s why I came into nursing but when I was doing my nurse training I, to me, for me that just crossed the Ts and dotted the Is for me personally

Me When you qualified did you go looking for the type of work that would allow you to do the sort of things you were interested in?

L When I first qualified I’d done a management placement on the clinical decisions unit I loved the variety of that it is really really busy and you do have to be careful in those kind of environments because of burn out

Me Too much going on and too fast?

L Yes Yes

Me I’m explaining for the tape because my supervisors...

L (chuckling)

Me So you manage...

L One hundred and seven

Me Of those you must be likely to meet one who is less than empathetic

L What can you do? You can only advise them really yes you can only advise them. I would liken to go on a managing poor performance course that I’ve not been able to go on

Me That sound like its giving people a bollocking

L Its not giving them,......maybe it could be, maybe it could be giving somebody a telling off you don’t go straight in to do that I’ll have a quiet word with people well actually what you do start with is acting a way yourself and encouraging them to work your way its easy to explain it in a physical way isn’t it rather than, say like moving and handling by me saying well you’re at the top so its your call or first time doing it myself I’m at the top so its your call or first time doing it myself I’m teaching them what to do so that next time I’ll say oh all right you’re at the top so its your call and assessing you know in doing that and then hopefully they’ll have learned from that

Me You have to walk it as you talk it

L Yes

Me You’ve got to do it yourself

L Yes learned behaviour it is I think
Me: You’ve got to be relating to the people you look after in the way that’s empathic in order to expect other people to be able to do it?

L: Yes.

Me: And you recognise when they’re not doing it?

L: Yes.

Me: So what do you see when they’re not being empathic?

L: It could be something as small as somebody making a comment that I don’t agree with... not get involved in that comment, reacting to the comment in front of the patient, so it could be... a comment about a patient which has been said over the patient or a conversation over a patient that shouldn’t be going on over the patient so they could be talking to me and trying to engage me in conversation but I wouldn’t acknowledge them....

Me: You’d ignore it.

L: I’d ignore them, yes for something like that, I wouldn’t want to embarrass the patient at all, I may have to just take them away or you have to give them a look, you know, to say that’s enough because they’ve had the training, they’ve had the customer care training and they know what to do and what not to do when you know, with a patient.

Me: That customer care you’ve mentioned that twice you’re involved in the training?

L: Ummm.

Me: The involvement I’ve had in positive customer care training was telling people about what you do to keep people satisfied and it was more like a deliberate attempt to stop people complaining.

L: Communication is a massive thing though isn’t it given that’s where you get most of the complaints. Most people know it already its just reminding them... so they’ve got it from their life experience but that little bit of training its just reminding them making them think as well and maybe getting them to think of maybe going to a supermarket and buying something and not getting the customer care that you expect and how you feel so that you can put yourself then in the patients position, its just making you reflect I suppose isn’t it on your own experiences because we’ve all got an experience where we’ve not been “tret” well as a customer.

Me: I agree with what you’re saying and I guess in that kind of scenario you always have the facility to say “listen that wasn’t very good”.

L: Yes.

Me: Your lady the thirty year old woman who was dying would not have had that facility would she? Her husband would, so how do you know that what you did for her was right?

L: Because I read her body language.
Me  I don’t know what goes through the head of somebody in that position
L  No you can’t........well....she must be  scared
Me  What does she want from you? The time for giving information has gone hasn’t it?
L  Yes , its not even reassurance is it?
Me  I don’t know
L  I think its probably......at that time, it wasn’t reassurance for her you
just......comfort  for somebody in that......and she did want me to stay around......
Me  She will do......................what about the husband?
L  Oh the husband was too late bless him
Me  The lady had died by the time he got there?
L  Mmm,
Me  What sort of state was he in
L  He was very upset, I took him in to see her, there were no doctors around so I led
on that. I took him into an office and er......
Me  You had to deal with that?
L  Yes ,again, I talked to him I was there for him if he needed anything, if he needed
any answers  or what answers I could give him ....erm....tissues, gave him a bit of time
gave him time to organise himself and his feelings and his emotions because he was
going then into the cubicle with the lady and the family .....and just talk
Me  Its that kind of time when things must be very difficult
L  Yes.....
Me  How confident are you with that, dealing with that kind of time?
L  .................Well.........the length of time can vary with patients and you’ve just
got to be patient and wait and wait for them but there does come a time when you think
“right you’ve got , you’ve got to move on to the next step” but then its all individual isn’t
it you’ve just got to cope with it as you’re going along
Me  I’m wondering what prepares you or what has prepared you for being there in
that moment which is probably the most miserable moment this persons going to
experience?
L  Yes, I can’t say that anybody that close to me has died so I can’t really draw on
that
Me  You can’t relate to it in that way?
L No, I’ve got aunties and uncles that have died and grandma erm.....but....erm...I don’t know .....its just there isn’t it. Its, just thinking how would I feel , I suppose How would I feel if it was me , what if it was a family member? Thats all I can....(tape has to be turned over).

L No because normally it would be a doctor who breaks the news , but I’ve been there when doctors have done it and I wouldn’t say no..... I wouldn’t even say a dozen times ....not even half a dozen times probably have I been involved in brealing that kind of news

Me Thats not so much a part of the deal for you as looking after people while they’re going through it ? Through these investigative processes?

L Yes

Me I know you’re working today and I’m very grateful that you’ve let me tape record this conversation . What’ll happen now is that we’ll analyse it, I’ll analyse it, I’ll transcribe it first in the next couple of days, I’ll send you the transcription , they usually run to about six thousand words, so it’ll be the longest email you have ever had,

L (laughing) I’ll look forward to that

Me You have the chance to look at it and say “ well I don’t want them to use that” do you know what I mean?

L Yes

Me Thanks very much for talking to me

L Its a pleasure

Me I’m going to turn that off now is there anything you want to say before I turn it off?

L No..... I’m sure you’ve got what you need.
DENISE

Me So is it a medical ward, surgical ward....
D Both
Me Mixed?
D Medical and surgical. We get a lot of NHS outliers
Me What does that mean, outliers?
D People that aren’t paying
Me Right so.....yours is a private ward then?
D Yes
Me In a general hospital?
D Yes
Me Most of the people who come to you then come under some form of insurance scheme or they’re paying for care?
D Yes they’re paying yes
Me And you’ve got a number of NHS outliers?
D Yes because the NHS are taking our beds like we also have what is called a “sleep clinic” running....
Me Within the ward?
D Yes on the ward. Dr..............runs it and he has patients come in and we have at least four sleep patients a night and thats worth two thousand pounds a day...
Me From the insurance company?
D No from the clinic and the government who mpays for, I don’t know who exactly pays for it because they’re NHS patients but they’re always, they’re coming in , they’re equipped, they’re set up with either a vitalab, whats called a vitalab which is a computer which watches them sleeping while they’ve got all kinds of probes attached to them ... 
Me Somebody’s having problems sleeping?
D Well they stop breathing or they can diagnose a lot of problems
Me So its more serious than they can’t sleep, I’m thinking insomnia but it sounds more serious
D No, sleep apnoea where they stop breathing so they do these tests overnight and if the beds are, if there’s a bed crisis they cancel our sleep patients. We’ve had some sleep patients cancelled three or four times.

Me How long would you have to be in hospital for if you were a sleep patient?

D You’d come in at seven o’clock at night and you go home at six o’clock in the morning but if you want to stay for breakfast you would go home after breakfast so it’s only coming in overnight.

Me And through that time people are being watched, they’re being observed sleeping.

D Yes but the nurses aren’t watching them it’s, there’s a computer in the room that’s watching them, you set it up to a computer.

Me This monitors them, are they on television as well?

D Yes there’s a screen and everything and it records them.

Me I didn’t know that went on, didn’t realise it happens.

D Yes we do a lot with different consultants, we do orthopaedics, we do gynaecology gynae, medical anything.

Me So it’s a big mix of people.

D It is.

Me How long have you done that kind of work for?

D Four years.

Me Do you like it?

D Yes it’s interesting I like the fact that on our ward because it’s a variety of patients and it’s an ideal ward for a newly qualified nurse because they’re learning to deal with all the different skills not just “oh, I’m a surgical nurse” or “I’m a medical nurse” they deal with it all.

Me So that variety of people that you get.

D Helps you improve yes, in nursing.

Me That’s interesting that you’ve got that kind of variety I didn’t know that, I suppose I should have done but I didn’t.

D That’s what the, see when we have students on the ward you know, that first year student what I’ve done with her is because of our private patients, they see the consultant, we’ve got outpatients there as well, they see the consultants they get their diagnosis they go for the tests and then if they’ve come in for surgery they get prepped and then they go for surgery and they come on our ward. The good thing is my student is going to see a total hip replacement so she’s been in with Mr.……….. while he has diagnosed the patient, she has been in the pre assessment where they’ve assessed.
everything the patient needs and then she went and watched the, no shes watching the operation on Saturday and then she'll look after that patient until they go home.

Me So its a total care thing

D Its a total care

Me Is that something that you see as well, do you see that?

D Yes

Me So you’re meeting these people then at every stage of their dealings with the hospital

D Yes

Me Because they’re private are they only going to be dealing with the hospital if its going to be good news?

D No, not always, we do have some patients put in complaints but a lot of that in fact,.....when I first started on the ward it was all totally private and they weren’t as demanding as they are now.

Me The patients?

D Yes, it was straightforward, they’d come in for surgery, they’d be in for five days they go home. It was that straightforward, but now you get a lot more complicated patients coming through the doors, because patients are living longer so they’ve got a lot more complications

Me These are people who might not now be working, they might be retired

D Oh we get a lot of retired,erm, it seems as if a ward is asked to outliers, the patient because they want to get an acute patient onto their ward, we get a lot of patients with......social admissions! That need a lot of input before they go home. They can be with us for a long time

Me The bed is effectively blocked?

D Yes, it is blocked we’ve got, had, one patient for example who came to us six weeks ago they came in, he was unconscious unresponsive and he was to be put on the Liverpool care pathway but our consultant Dr............. doesn’t believe in the Liverpool care pathway

Me The Liverpool care pathway is something that people go on if they’re dying?

D Yes and that way they get to die with dignity

Me Do you mean they get more resources?

D They do, they can get more resources like if the family want the patient to go home to die with them then the idea of the Liverpool care pathway is the fact that they’ve got twenty four hour care at home
Me    With support right. So, he came into you unconscious?
D    Correct
Me    You put this person on this Liverpool care pathway?
D    No, Dr............ wouldn’t put him on it
Me    The doctor wouldn’t put him on it
D    No
Me    What happened to the person
D    Hes still alive!
Me    Right, so the doctor was right not to put him on it?
D    He fights, the good thing about Dr............ is that he will never give up
Me    On the patient?
D    On the patient, at all Even if he knows that the end is coming , he won’t
Me    The person must have been quite sick
D    He was septic
Me    Poisoned
D    Infection, sepsis yes
Me    Because of that he was unconscious?
D    Yes, hes got Parkinsons , hes got .....MS , hes got no quality of life ,.....at all.
Me    They’re very severe conditions
D    He cannot talk, hes got no swallowing assessment we’re feeding him through an NG tube which hes pulled out about thirty of them , hes pulled out at least thirty of them he doesn’t want them in but hes too ill to go for a PEG feed
Me    Is he aware that hes got this thing in and he doesn’t like it?
D    He knows hes got something there, I don’t think hes aware of it , they’ve even been stitched in and hes pulled them out
Me    Is he someone you could talk to and tell him..
D    No . Sometimes his eyes open and he shouts but other times nothing
Me    You’re not convinced he is consciously aware of...
D    Hes not consciously aware , according to his family hes not been consciously aware for months
Me What are they like, the family?

D Really nice. The, their daughter, she just wants her dad to go in dignity and peace the patient came from a nursing home and the family accepted what was going to happen to dad because hes not young, what is he ninety four ninety five

Me Thats a fair age

D It is, so they cancelled the bed at his nursing home and accepted it so they want to talk to Dr........ to see the outcome of this because if the family say to Dr........ about the Liverpool care pathway then he will put him on it, he will respect the family’s wishes

Me Do they know about these things families ?

D Yes because we discuss them with them, the nurses

Me You’ll tell them about....

D It’ll be mentioned to them in A and E when he came through that the idea was for the patient to go on this and the patients ask about the Liverpool care pathway and then we tell them. What Dr......... doesn't like about it is that you're withdrawing everything, you’re withdrawing, you’re not withdrawing like mouth care and making them comfortable or anything like that but you’re withdrawing giving them their medication, fluids, they go onto a diamorphine pump they get HICELE to help them with their secretions

Me So anything that was considered aggressive or active treatment wouldn’t happen?

D No , it doesn’t happen at all.

Me What do you think about it?

D I agree with the Liverpool care pathway

Me You think there is a time when this is...

D Yes, because that gives patients time to die with dignity and it also gives their family time to spend with them without nurses going in trying to pump everything into them because they’re not going to be prodded or poked or stabbed, trying to take blood from the patient, we’re not going to be going in there trying to take bloods from them every single day

Me Do you have those conversations about the Liverpool care pathway with patients?

D With relatives

Me Did you have them with this fellows relatives?

D I did , but they want to discuss it with Dr....... because Dr......... wants him to have a PEG feed
Me  How does it work them tell me how, the fathers admitted ...

D  Yes, the father was admitted through A and E and he came to us at three o clock in the morning not expected to be alive at ten o clock in the morning

Me  Hes quite sick

D  Yes , and Dr............... did his ward round and decided “No this patients not ready yet, I’m going to do this, this and this” he put him on, he put an NG tube in started to feed him and give his medication because the main problem was that the patient keeps being poorly without his medication, it was stupid because he wasn’t getting his medication he couldn’t swallow it and he had to have Madopar (a drug for treating Parkinsons disease) six times a day

Me  Thats for the Parkinsons

D  The Parkinsons yes and he wasn’t getting that and he was starting to stiffen up so what we did was we had a word with the pharmacist and we found out that there was a patch that he can have once a day put on him which helps with the Parkinsons

Me  Right that takes the place...

D  Of the madopar....

Me  So between three when he came in and ten in the morning when he was seen by the doctor, were his family around at that time?

D  His family were all there yes. His family had been with him so they’d followed it. If a patient is dying any family can stay for as long as they want . We’ve had quite a few cases where the family have stayed there was another patient that was dying and he knew he was but he was dying slowly and his family were with him for about a week and a half, solid, on the ward all the time

Me  You made space for them

D  Yes they were taking up the garden room and at one time there were about eight or nine of them there at night

Me  Were you there when this family came in? Were you working the night?

D  Yes I was there when the patient died , and the sister reported back that the family couldn’t have been any more pleased with how myself and my other colleagues dealt with the situation they died with dignity

Me  When he came in at three o clock what were your dealings with the family?

D  We were getting the patient comfortable , we had to check out the patient because the patient came in with a huge pressure sore on his sacrum

Me  You’ve got your assessments to do

D  Yes you have to do your assessments and get the patient settled and give him his mouth care and then let the family go in and just keep checking on the patient
Me  You’re just making him comfortable for the night

D  Yes

Me  Making sure hes all right, do you have to have dealings with the family, do you have to say anything to them?

D  We just ask the family what they know we don’t exaggerate what they know because sometimes we’ve known quite serious issues, like the patients been given a diagnosis and the family’s said “what’s the diagnosis?” and we’ve known its not nice news but its not our job to tell them its the consultants job to tell the patient its not the nurses job to go up and say “we know the results, your husbands got cancer of the throat “ or anything like that thats not our job thats the doctors job, but we’re there then with the patient when the consultant goes in

Me  Theres going to be times though when, I mean this family would have been asking questions that you may have felt not able to answer

D  No, I’d have got the doctor back I’d have got a doctor down to speak to them or I’ have got site (site nursing manager)

Me  What do you do in the meantime? If their asking you questions before the doctor comes they’re not going to stop asking them are they?

D  Well I’ll be honest with them, if I don’t know something then I’ll tell them that I don’t know but I will get somebody that can answer their questions or I’ll say that I’m not legally obliged to  not legally allowed to tell them that , the questions that they’re asking me luckily with this family they were just asking “is he comfortable, can he hear us? Does he know that we’re here? “ and you always tell families , you always tell families that the patient knows that they’re there because the last thing, its proven, the last thing to go on a patient is hearing so even if they’re by them and totally unconscious they can still hear you in some way, some form or other

Me  So at some point this family were thinking it was the fathers time to die

D  Yes

Me  Did they tell you that during the night? Did they say ...

D  They said “do you know how long it will be?” and I said “I don’t know how long it could be” because the doctors and that are going “oh its only a few hours“ and they said “do you know when it will be?” I said “no, we never know” They’re prepared for it, even now they’re still prepared for it, six weeks down the line

Me  They’re prepared for this death, they know its coming they’re telling you, giving you that impression anyway you go off at whatever time, what time do you go off,seven?

D  Half seven

Me  And there’s a doctors round at ten and the doctor decides no its not time
Yes, and he started feeding him and everything. The family were pleased in a way because they thought “well, we’ve got a few extra days, weeks with him” even though the family accept it the longer they’ve got with their father the better because its not something you wish to happen.

Were you working the night after as well, were you back?

No I was on the day shift I’d done some night shifts with the family. They don’t stay they go home and they come in about ten o clock in the morning and they go home at six.

You were there when the fellow was admitted they see the doctor in the morning, when were you next back on duty?

The following day on a late.

This is the afternoon of the next day?

Right.

You come on duty, the fellow is obviously still alive the family are still there.

Yes, they just, they think the world of Dr.......... they tell me that they think the world of Dr.......... because they think hes a miracle worker because hes saying to them 2 we can get something down him, we can bring your father back and then he can go back to the nursing home” so maybe you’ll have a few more months with him” but at the minute the few more months they’re getting with him is on my, on our ward.

You said they were thinking he would go on the Liverpool care pathway?

Yes they’ve asked about the Liverpool care pathway they’ve brought it up and... Dr.......... has basically told them that hes not ready to go on it because hes said its an infection, we can fight the infection with antibiotics and then hopefully dad will come back round so it’d be pointless putting him straight onto the Liverpool care pathway if we’ve not tried getting rid of the infection, because its septic.

Right so they found out about the Liverpool care pathway from?

Nurses in A and E.

From the A and E doctors, then they talked about the Liverpool care pathway with yourselves and probably talked about the care pathway with the doctor.

Yes Dr.......... And he decided that no, its not time for that what we’re going to do is treat the infection.

Yes.

How were the family about that?

They accept it, I think if the family had been a younger family then they might have fought it because of the generation side of things but I’ve found that if we get a
patient whos eighty, seventy eighty ninetyn they’ll just agree with everything the doctor says but if we get a patient twenty, thirty, forty maybe even fifty they will argue the fact and say “ but why are you doing this?” whereas the older generation accept what the doctor says

Me Right, so you think that younger relatives...

D Will argue

Me And ask more than older relatives

D Yes because its just the way that they’ve been brought up they were, the older generation were brought up to “doctors always right” what the doctor says is correct but the younger generation has been taught well maybe the doctors not always right so they will argue , well they won’t argue about it they’ll ask questions and they’ll look it up especially now you’ve got the internet I have found that with a lot of patients younger patients they will say” but why are you doing this?” and the doctors need to know why they’re doing things

Me They’re going to ask you as well aren’t they? They’re going to say to you ...

D Why are you doing it? I tell them that I do everything that we do as nurses is research based so that if doctors ask us to do something that we don’t know anything about then we’re going to ask them to back it up , why they’re asking us to do something

Me Theres got to be a rationale

D Theres got to be a rationale for doing something. There has always got to be a rationale for why you do certain things Like we’re getting all new paperwork because of the CQC

Me Thats a recent thing isn’t it

D Yes since last Monday (chuckling)

Me So the people are in a position where they were expecting one thing and another thing was happening

D Yes

Me Did they ask you about that? Did they ask you to explain why that is or....

D We’ve been quite lucky that they’ve just accepted what Dr....... said , his family, and they, we just show our sympathy or our empathy towards them, we tell them that we’re there and if they want to talk to us then they can come and sit and talk to us I have sat the family down and told them their dads poorly and that we’re doing everything to getv rid of the infection because as nurses we don’t criticise the doctor to the patients. I might argue with the doctor behind the patients back but we back up the doctor to the patients so we’re saying “ we’re doing everything that we can, we’re fighting this infection hopefully you might be able to getvb your dad back to the nursing home you’ll get a few more months with your dad” and they seem to accept it
Has nobody ever said to you “Denise this is just wrong! Hes ninety four”

Not yet, I argue with the doctors because I, well, Dr.......... calls me the Liverpool pathway queen because I believe in it. If it was my relative I would say “I want him on the Liverpool care pathway” because the Liverpool care pathway its proven that the patient dies with dignity I don’t, if there’s no chance for the patient, like even after resuscitation you don’t get the whole patient back I was, all the staff on the ward know that if I was to drop down don’t resuscitate me I don’t agree with it I don’t believe in it

Thats your own personal view though isn’t it?

Yes but I would only....

Where have you got that view from

From what I’ve seen from doing resuscitation myself on patients.......... and you can see that if you go, there’s a centre that you can go to for patients that have come out of resuscitation and its proven that you don’t get your full quality of life back after resuscitation

Because you’re limited afterward you wouldn’t want that for yourself

No

Does that have any impact on your dealings with patients then, do you, your Liverpool care pathway then, you suggest that people should look at that?

I suggest it if I think they fit the criteria, there has to be a criteria that they fit and basically they have to be dying and close to death

How do you raise it though, how do you say to someone’s relative “there’s nothing....

I don’t really raise it with them I raise it with the doctors because its the doctors job to raise it with the family

So you wouldn’t actually be involved in saying to the family.....

I would go in with the doctor to discuss the Liverpool care pathway and I may say “yes, I think its a good idea” to the family but I would not raise the subject with the family without the consultant there

Chances are you’ll be there after the doctors gone out as well though won’t you?

Yes

People will then, presumable be asking questions

Yes, and thats when I’ll tell that the Liverpool care pathway is, we’ve actually got a booklet that tells everything about the Liverpool care pathway

So there’s information giving
Yes there's information that we can give them and a lot of people ask, for the fact that their relatives have been on the Liverpool care pathway have thanked us because they've seen that their relative has died with dignity.

Do they ever say to you “what do you think Denise?”

A couple of people have said it and I've tried to be honest I've said that I agree with the Liverpool care pathway.

It's a big decision isn't it?

It is the biggest decision but it's the same as the decision about when patients are in ICU their relatives are getting asked “there's nothing we can do, can we turn the machines off?” It's the same sort of decision that they've got to make because that patient is dying and our patient is dying they're just dying a different way because ICU I feel, gives a lot of false hope because people see patients going up and down and they're saying “they're still breathing, they're still alive” and they will fight for it whereas on our ward when we tell patients relatives that patients are dying they can see it, they can see that the patient is struggling to breathe, they're breathing really fast or then it gets really slow and this is the stage when they go onto the Liverpool care pathway its not just somebody that's going to come in and they've got to be showing signs that they're shutting down and they see their fingers are going blue, their lips are going blue.

You think that that helps?

It does help, because they know that it is their time and they get to spend their time with them they know to say their goodbyes.

The obviousness of the situation....

Is apparent to the relative anyway.

And that pushes them to accepting that this person is going to die.

Yes You don't just go in and say “your relatives dying, we're going to put them on the Liverpool care pathway” there are ways that you lead up to it.

How do you lead up to it?

I just, I tell patients, the relative, that the patient is being poorly and there is a chance that they're not going to make it that we're doing everything we can to help them and that's when we get the consultants to come in and say that they're not going to make it, we say that there's a chance we don't tell them that they're not going to make it even though we know.

Why are you telling them that? Why do you do it that particular way?

I think they seem to, I've found that if I do it that way they seem to be more accepting that their relatives not going to make it when they're told.

So its the beginnings of...
Its the beginnings of telling them, the patient, right say, “your father is really really poorly we’re doing everything we can but we may not be successful at what we’re doing but the doctor will be able to tell you more when he comes in “

How do you know that they’ve actually understood your real meaning?

I find its the way they react to you . If I was to tell a patient that they’ll say “what signs are we looking at for signs of improvement? Or signs of them deteriorating”

How do you know that they’ve understood your real meaning?

And I’ll say “ sometimes the breathing gets a little bit faster when they’re struggling” but you’ll obviously notice signs of improvement because ninety percent of the time a lot of them are quite unconscious if they’re on the Liverpool care pathway

OK

Its pretty obvious then

Its pretty obvious at the time if shes gone on the Liverpool care pathway because theres a criteria that they have to meet to go on this, you don’t, they don’t just come in unconscious theres certain criteria that they’ve got to meet, their blood results have got to show certain things as well

Does your giving people this information help them? Make them less anxious?

I’d say that it does, when I give the patients the information, you see a lot of relief actually on the relatives faces when they actually go on to the Liverpool care pathway because they seem so relaxed that they’re getting to spend that quality time with their relative and they get to say their goodbyes because, luckily,all our rooms on our ward are single, they’re all single rooms they can have all of their family in their, they’re not interrupting they’re not intruding on other patients whereas if they were upstairs on a four bedded bay you can only have two people in but they get the privacy because, theres toilets in there, we make sure they get plenty of drinks , this and that.

I’m thinking it sounds as though its quite subtle telling people, you’re leading people up to the point where you’ll tell them their relative won’t survive. How do you know when they’ve not accepted it? How do you know when somebodys missed the point?

Because we keep, we had one about six months ago who kept saying “ can’t we do this? Can’t we do that?” this is even after the doctor has told them “we can’t do any more, theres nothing more” and they’re saying “ please” and eventually the sister went in and spoke to them and said “look, there is nothing that we can do you need to accept it “ but we have, within the hospital, theres people that can come and talk to the family and you can get priests, is it priests? The church people come in and speak to them

What do they do? You’ve done what you can do in terms of letting them know this persons dying

I think they use the spiritual side of things , that they’re going to a better place and things like that.
Me: If they’re doing the spiritual side of things how would you describe what you are doing?

D: The holistic side of things.

Me: Holistic?

D: Yes, we have to look at everything, because you have to deal with the emotional side of things but as they say when you’re told about death there’s certain phases that the person has to go through, and before they get to the acceptance stage of it they’ve got the anger stage, the resentment stage before they even accept what’s happening.

Me: Has anyone ever got angry at you when you’ve been, when you first start out to tell them, to prepare them for ....

D: I’ve been quite lucky, no, they haven’t been angry at me a couple of my colleagues have had patients get angry at them, they’ve taken it calm. They’ve said “please sit down” and “we’re really sorry we accept that you’re angry” and they leave the room and then they go back when they’ve let them calm down, let them try and absorb the news themselves before they go back in. Most of the time they apologise for being angry and they say “we understand that you’re just doing your job” and they, a lot of patients and relatives as well can see that we genuinely care. To us it’s not just a job, we care about these patients.

Me: How do you convince them that you care.

D: It’s the way we show, the way we talk to them we talk nice and calm to them you don’t talk loudly you talk in a nice calm voice, try and keep your voice the same tempo and you always sit down, you don’t look over them when you talk to them, you sit down and talk to them. And they also watch the way we look after the patient as well.

Me: I suppose they will see how you deal with their relative. Do you have time to prepare for the conversation?

D: Sometimes yes, yes, because their consultant will say “right I need to see to this, this and this and then I’ll come back” the consultant makes time so that he can speak to the patient and he will tell the patient that he is there, he arranged that at three o’clock in the afternoon he was going to talk to the family and that’s when he broke the news that there was nothing more we could do for the family and he was there available.

Me: Do you make time though? In the same way, do you put time aside to give this message?

D: Yes I always make time. Like if I’m, if that patient is on my side that I’m working on I would say to the rest of my colleagues that I’m working on that side “I’m going in here, I don’t know how long I’m going to be” and this is what we’re going in here for then they’ll leave us alone and they’ll give us the time that I need.

Me: Do you always take the responsibility on for these people?

D: Sometimes, it depends who’s there that goes in.

Me: So do you think any nurse should be able to domit?
D: All my colleagues can I don’t know if its because we have meetings we discuss it if we have patients that are on there long term. We have weekly meetings on a Monday where we discuss these patients and say like what do we need to do for these patients, what needs doing? If we’ve got patients that are there long term so everybody else knows every patient on that ward. Luckily enough we’ve got eighteen patients, we only have eighteen patients on our ward.

Me: That’s less than some of the wards.

D: Yes they’re twenty nine bedded or thirty two bedded wards we have eighteen patients and we do get that time to spend with our patients. Like when we wash our patients they get their feet and legs washed, every single patient does.

Me: Does it make any difference, the care you get, whether you’re private or an NHS outlier? Is it the same?

D: It’s the exact same we don’t treat them any different if you come on our ward we’ve got a board the same as the rest of the wards have, where the patients are, none of it will say that’s a private patient, that’s an NHS patient, you cannot tell.

Me: So it’s not obvious.

D: It’s not obvious.

Me: And your attitude to....

D: The only difference you’d be able to tell is the private patients are only seen by the consultants.

Me: That’s the main difference? The rest are seen by....

D: Junior doctors so sometimes the NHS patients may not see the consultant. The private patients will, like if there’s a problem in the middle of the night I will phone the consultant at home I’ve all the consultants phone numbers and I phone them at home and ask them to come.

Me: Regardless of what the problem is...

D: Regardless of the problem, if you need a doctor it will be the consultant.

Me: And that’s part of the insurance deal?

D: That’s part of the deal, they’re paying four hundred and odd pounds a night and then they’ve got consultant fees on top and they pay for everything.

Me: Who’s likely to be given the sort of news you’ve been talking about. Private patient or an NHS outlier?

D: I would say most likely an NHS outlier but we have had a couple of private patients where they’ve come in from home because they don’t go through A and E they come straight to us. They’ve come in from home, like, one of the patients she came straight in from home she’d had a cold and then we found out she had end stage lung...
cancer and she didn’t know, she didn’t have a clue about it. She did stay, she chose to stay on the ward, her insurance company paid

Me It can’t be very nice finding that out if you’ve no idea, genuinely no idea

D She genuinely had no idea and the thing that made it worse was her daughter, daughter in law, was one of the staff nurses that works on the ward but we were there for her and

Me Its not an easy dynamic that

D No, but she’s fine. The daughter in laws, well the son is finding it hard to cope with but we treat them the same as we would any other patient. Whether you be private or you be NHS you still deserve to be treated the exact same.

Me I just wondered what the situation was because I’ve not had a lot to do with private healthcare and I know that this is a ward within the hospital that has...

D Private yes. That’s the only big difference. There was a bit of a difference when we had our own chefs

Me But you don’t have the chef anymore?

D No, the other difference is the private patients get their meals from the canteen.

Me Rather than.....

D On the trolley, the same as the other wards. We have the trolley that comes round for the patients on the NHS side of things, they get food from there so they’re having the same as the rest of the hospital but the private patients are having from the canteen.

Me You get more of a selection, maybe....

D Maybe, you’ve seen the canteen food

Me Its interesting. I’ve been talking to you now for about forty five minutes and I don’t want to keep you any longer than I need to is there anything you want to ask me?

D No

Me Sure? I’m going to transcribe this and I’ll send you a copy of the transcription and if you send it back to me with whatever view you’ve got, is that all right? Thanks very much.
TRANSCRIPT SIX 21st APRIL

RAY.

Me It took a long time to get through that process
R I didn’t like it
Me I don’t blame you I found it really really difficult
R Having got through the first lot at Nottingham then, very very nice people there, anyhow what do you want to do?
Me What I’ve invited you to speak to me about is your experience just, you’re working at the moment as a nurse
R Yes
Me You work in ICU in a general hospital and you’re the first man I’ve spoken to
R Its been a long life!
Me And my interest is in hearing from you a story about your practice and I’m really interested in the way you have to deal with people in your everyday work. Sounds very broad that doesn’t it?
R It certainly sweeps a wide......
Me What do you do, what’s your role within the ......
R Intensive care nurse with three years experience but I haven’t done the critical care course yet
Me Your training as well so you’re six years in nursing altogether?
R A year as a health care (support worker) makes seven
Me Seven?
R Yes
Me So what’s your current job? What do you actually do for a living?
R Intensive care nurse
Me You look after the unconscious?
R Well, ICU has been divided into level three which which tend to be sedated and unconscious which is intensive or level two which is high dependency and they tend to be awake
Me So there’s a scale for the level of dependence and you’re technically, is three the top end of the scale?
R Yes, but within that there are limitations, we can do for example, dialysis, ionotropic support (?) we can do ventilation what we can’t do is something like Echmann(?)

Me What’s that?

R It’s external....I knew you were going to ask that, its external corporeal...its where they take the blood out of the body totally and oxygenate it. Like an artificial lung and artificial heart

Me Right Is that done then? Somebody does do that?

R Leicester

Me I didn’t realise that went on. It sounds very serious stuff

R That can be, I’ve seen it, heard it been taught on it but I’ve never actually done it

Me So the people you’re meeting are very often unconscious?

R The patients I’m meeting are very often unconscious but the people I meet, especially if I exclude the staff are conscious. A lot of our work is about family

Me Right, the relatives of the people you’re looking after

R Yes

Me In what sense?

R Obviously the one of communication, reassurance, and there’s some very good work that described intensive care as, for families, as a vortex of emotions and it has a cache. Twenty percent of people who come into intensive care die

Me One in five?

R One in five, either in intensive care or very shortly afterwards. Usually after withdrawal of treatment, so....there are some very emotive, some very .....deep..emotions going on there.

Me Why would the treatment be withdrawn?

R Futility, erm

Me It’s not going to work?

R It aint going to work is the main reason. Its all to do, a lot of it with, with well I suppose its easing suffering. You can keep someone alive for a long time but you can’t get them better if they’re not repairing themselves then there’s not very much that they can do. A lot of my job is relating what, although the consultants are very good at explaining it, there’s a lot of very technical stuff they have to go through in a very short time so a lot of our work is reinforcing the family

Me Right, so you’re looking after people who may be dying, who may in fact be dead
R: Yes, that's an interesting thought.....yes so we're looking after palliative people, end of life care, in intensive care that's quite something, and you know it's my interest anyhow end of life care.

Me: Yes, palliative care to me as an outsider I think of people dying in the community in their own homes and stuff or in a hospice.

R: Yes, palliative in a sense is what anybody does which eases suffering it's a broad brush thing, end of life is quite specific.

Me: OK, and most of the work you’re doing is end of life work?

R: Yes.

Me: Because it's in the ICU.

R: Yes.

Me: You’re meeting people's relatives while someone they love is dying?

R: Yes.

Me: Not an easy job.

R: No......I think it's what................I think it's what nurses do as a unique.....a strong element of what we do during this social transition from, social transition from living to not living.

Me: Death? A social transition?

R: Howarth two thousand and......

Me: No I’m willing...it's just a term I’ve not heard before.

R: If you look at it, sometimes I look at it , you've got someone on the machine and they're still breathing but you know that they're not going to survive because that's the best decision that the consultant has come to that the team has looked at so that person actually although they're still living to the family is dead....not living so there's a social side to it and a biological side to it.

Me: How do you, how do you introduce the relatives of this person to the fact that they’re going through this transition? That they’re dying.

R: Usually that's done by a consultant with support.

Me: So usually the consultant will give the message to the relatives.

R: Yes and there's a very set procedure for that “The East Mids.....” it's got a complicated.....it's basically a methodology for imparting that news. One can understand the situation “well this is where we are now”.

Me: So this is like a protocol that's used?

R: Yes.
Me A policy?

R Yes I think it is policy and our job in essence, the way I perceive my job, is to support the family in that the best you can. Support is possibly a silly word to use, be there to explain sometimes, sometimes they won’t take it all in at once you know and sometimes it’s “what are they saying? What do they mean?” so you actually have to be able to assist them translate.

Me So they’re getting the initial message from the consultant according to a policy code, and then afterwards you, because you’re around presumably, are the person who’s going to be asked to clarify the message.

R If necessary yes

Me Do you have to repeat the message?

R Sometimes yes

Me Because people haven’t understood?

R I think it varies, it depends on what you mean by understand. I think there’s, in my own view an importance around timing, you see actually people may understand but they don’t accept and you go through the stages, almost like Kubler Ross’ stages of Denial, Grief, Anger

Me Have you met people who’ve been going through that process?

R Yes, I think the overriding thing, emotion, you get from them is shock and concern ....erm.....obviously your care is focussed toward the individual that’s lying in the bed, what’s the phrase I’m looking for? Actually I think you used the phrase a long time ago when you were teaching us something about nursing with this helicopter where you just rise above the big picture and then focus in and come down, I can’t remember was it you or someone? You sometimes stand back and say “where am I best used here?” with this kind of focus. For example, one patient I was thinking of they were comfortable, as far as we could tell. They had no pain, their heart was obviously failing because we’d taken them off the Eptropic support and there was very little I could do for them but to make sure there were no obvious signs of pain, the mouth was moist those things, no obvious signs of discomfort or anything like that. All the focus was on I think it was the wife and brother because of course intensive care is a very strange place to die and you’ve got the concept of “the good death” which I have problems with but if you can imagine our intensive care unit the most privacy you can give, because its a line of eight beds and a side room, the most privacy you can give is a curtain and you’ve got people on each side of you, its the size of a normal single bedroom, each space that you’ve got, you’ve got people on each side of you in this dark room, its two or three o clock in the morning and someone you love is dying and there’s machines and bells and whistles all going on around you its a very strange environment

Me And these people are in that environment going through that process?

R Yes

Me And you have to do something for them?
R  Have to, want to, need to I think it gets very much on how you sense the person is. Some people ..........I think it becomes just a very basic human emotion you know, theres someone there who might need some help you just want to make it, realistic but if they want some help or support its there but in some senses (telephone jingles) I’ve just turned my phone on! In some sense...

Me  Do you need to answer it?

R  No its just turned itself on. It becomes just very spontaneous, not following any theoretical basis that I’m aware of I don’t know you’re just basically there, erm, and I think its the idea...I suppose the best example I could give is empathy

Me  So you’re in the same space at two or three in the morning

R  Sometimes you are, sometimes you aren’t you do get a feeling for what people want. Somtimes you say “look do you want to be alone?” or “I’ll stop here”

Me  You ask them then?

R  Yes, sometimes . Theres no set, I think it depends on who you read and who you research but something like thirty billion people have lived and died and each death has been an individual process and I don’t think you go into it saying “ well I have a cookbook plan here for how that person may react or how that family may react” most of the time we get it right in the sense that although theres a huge amount of shock and tears people will come back later and say “thank you” and thats my measure of it, its not how they are then, its how they are six months down the line. Because theres a process when you’ve lost someone whos dear. Sometimes very rapidly in the intensive care environment because a lot of the time we don’t put people into intensive care thinking they’re not going to come out you go in there with the great hope of survival but sometimes it doesn’t work and sometimes therefore its a great shock to the individuals family

Me  Why are you mindful of how they might be in six months, why aren’t you just thinking in the moment? At two or three o clock.

R  I think its both, I think its both. You want to be active in the immediacy of it but you’re aware that there are consequences to what you do.

Me  Are you consciously aware of those possible consequences at two or three in the morning?

R  Yes...........its something thats part of my role . Nursing is a strange arena but I.....its our arena, these people have come into it like a strangre in a different social or cultural group and therefore I think there is a responsibility if you walk into that area, there is a responsibility on you to do the best for them and I think a measure of that is how they are in the future

Me  That makes you almost a host doesn’t it? In that environment.

R  Strange form of host. I was going to use the word .......(/) but I won’t. I’m not sure host describes it ....point of contact, guide host is maybe as good as any.
Me If you’re consciously aware that there might be problems, difficulties six months down the line what do you do, what’s your strategy for trying to prevent them?

R I think to be as open as possible erm so that people can’t turn around and say “this didn’t happen, that didn’t happen”, explain what’s happening emphasise to them that if they’ve got any questions “please, please ask” keep a diary I always suggest to people, they may not want to

Me Do you advise them to keep a diary?

R Theres a school of thought that says tell them to keep a diary. Sometimes when you’re talking to people about withdrawing treatment they go through a process of 2 why am I doing this, what’s happening here?” and I sometimes say “well, if you write down what your thoughts are at the moment then in a few weeks, few months time when you want to look back at least you can remember what happened”

Me You actually encourage them to get pen and paper and write down……

R No I’m saying to them, that’s not an option I’m not encouraging them its their decision

Me You’re offering that as a possibility

R I’m offering it as a possibility

Me Do many take it up?

R I don’t know, some have, in fact I always say that to people who….“you’re going to go through an intense period in your life “ apart from what’s going to happen to our patient. Our patients are looked after very well if you’ve been on a ventilator you’re invited to come back to clinic but there’s a very good study of six thousand patients from Canada I think it was from two thousand and six and once you go through that process of being on a ventilator and going through intensive care for any length of time it is a long process to get your physical and mental balance back. And in many cases we’re talking six months to a year

Me So it’s the patient you’re encouraging to keep the journal not the family?

R No, the family

Me You’re encouraging them to keep the diary

R I’m not encouraging I say that’s an option

Me Where’ve you got that idea from?

R I seem to remember some of the papers I’ve read. I do say to people “if you wake up in the night phone, or if you’ve got any question write it down “

Me Any time?

R Any time, people say “we don’t want to bother you” we say “actually looking after someone very important to you is not a bother” “we don’t close”
Me You encourage that contact

R Yes. You’ve got a very short period of time to do that. Part of, in fact the best training I had was running a market stall, you know, we used to have a business we did about twenty five farmers markets a month for about three years and you do actually learn a little bit about how to approach people.

Me Because you mean, there’s so many of them?

R Because you’re trying to sell something.

Me So what are you selling in intensive care?

R Hope, and when hope is gone some form of comfort which seems sort of reasonable.

Me You said there’s no cookbook, no recipe for a good death, I think that was the phrase that you used.

R Well, Robert Smith in his article in the British Medical Journal of two thousand thought about this notion of a good death. Thirteen items I think it was then were taken up from it and you do have something called the Liverpool care pathway which I’m sure you’ve heard of...

Me I’ve heard of it.

R We don’t use it at the moment because it hasn’t been given the general approval of the consultants and in one sense, although it’s a good document and a very good care path our care models most probably cover everything that it does.

Me I’m asking because you mentioned Kubler Ross then and a lot of people have interpreted what the likes of Kubler Ross as a cookbook for after death.

R Yes but she’s been criticised, you know its, it was a damn fine first step but but someone like Steve Levine has taken it a bit further, who’s died? Things like that, but I think that is a reflection of society where the onset of, depends who you’re with I suppose, but a lot of people they haven’t thought about death.

Me You’ve read a lot about it, I mean, in the time we’ve been speaking here you’ve named a few people.

R Well, I was doing a masters in it.

Me Death?

R Death in intensive care.

Me So as opposed to not thinking about it at all you’re certainly thinking about it.

R I think that comes out of my own personal experience when I realised I was facing my own death with my cancer, erm... and therefore I needed to get a handle on that and in doing that I needed to separate the two. My personal life against my professional life and I think I learned from my personal studies there was a lack of, no lacks the wrong word, it was a direction in our culture that said “oh death will never
happen” when in fact its like taxes it was Benjamin Franklin said “Death and taxes are the only certainty”

Me So your own experience has got some...

R Some bearing on my research, on where I went, on what I studied

Me Its given you a push into looking at what you’re interested in

R Yes

Me And that vinterest has given you a degree of knowledge you have used in practice

R I think so, whether its used effectively is not for me to judge

Me You said you had indicators of whether it is or not, people six miths down the line if they’re OK

R Yes, I don’t......we have indicators and we.......get a lot of thank you letters, things like that, sent to the ward, which is great but there’s no overall sort of assessment apparently done. We do have the monthly mortality meetings where we sort of say well how about this, how about that” so we do evaluate what we’ve done

Me Monthly mortality meetings? A case conference looking at...

R Yes a case conference, we lose, I think we have about a hundred and twenty pass away each year and we’re only a nine bedded unit but our survival rate is better than Lincoln

Me While the survival rate for an ICU is quite good thats a lot of people to see dying a year. Do you get used to it?

R No, the day I get used to it is the day I leave. You learn to cope with it and you learn to be there for the family but no you don’t get used to it. Each ones an individual experience I think it would be insulting to that patient if I got used to it.

Me So if we went back to the, you were talking about the wife of somebody and the brother of somebody

R Yes, it was one of those times and its........well one of those times where you say “ well actually, I got it right ” which seems a silly thing to say but I remember some of the things to tell them, for example, if someones on a ventilator and they die, you can’t turn the ventilator off its a doctor. So that means that someones passed away but their chest is still moving ...........

Me So how do you .....give that message......

R Well you say to them “ Heres the situation our best knowledge is...” and I think what I said to this person was, “there’s just a couple of things to be gone through after the withdrawal of the ventilator has taken place” thats an interesting one withdrawal because its a consultants and teams decision but if its my patient then I’m quite, I feel I have to be the one to say “I turned the machine off” because its my patient I can’t give that responsibility but I managed to remember to say to this partner “”He will have
passed away but the chest will keep moving and this is why” and she accepted that and I managed to actually say “ if you want to say goodbye nows the time ................

Me And is that clear?

R ........It was in this case ........its.......what I did say to her was , what I do say to people is “ If you don’t want , theres no need for you to be with him. I won’t let him die alone “ and thats the sort of thing we do. Thats what makes it a good team

Me Is that to give them some comfort or is that some form of protocol?

R I ,whether its protocol or not I don’t know . Its to give them an option. I’ve been in a similar sort of situation when my father in law died I think the only thing I do is think well what would I want , what would I need to do, different things, if one of mine was passing away but I do say to people “ they won’t die alone” unless its totally unexpected

Me So if they’re not there or can’t be there or don’t want to be there you will tell them that somebody will be there

R Yes . I mean if a thing like a cardiac arrest or unexpected then thats completely different . In events we do have “do not resuscitate” orders very clearly marked, very clearly handed over

Me Where do they come from? That means you’re not going to resuscitate someone

R You’re not going to attempt a resuscitation and that usually is based on the consultants, the doctors and the teams thinking it would be wrong for that person, to try and bring them around . Most probably usually because the chances of survival are such or that the effects of that survival will be limited

Me Does that decision involve the relatives? Are they involved in that decision?

R They’re involved to the extent that are informed and asked their opinion but obviously it depends on what , if theres a living will or something like that, that also comes into it

Me Are there people who make living wills?

R I haven’t met one yet,

Me Its something I’ve heard of but....

R No I’ve, we haven’t had one I don’t ..........

Me Because its something that you hear about. Its something I hear being discussed on the radio ..... 

R No its a good question, its not something I’ve come across in practice erm no so, the decisions tend to be very rapid but it did happen. A lady that came in, she walked into A and E but she was dead two days later after a sudden arrest and we tried very hard to get her back .....but it didn’t work

Me What happens if the relatives don’t understand or aren’t in agreement?
Well that then gets into the stage of, in what sense? Withdrawal or...

Say you know, you’ve a doctor and the team working with the doctor who believe that somebody if they’ve had a heart attack or if they’ve had an accident, then the relatives might think that thats not what hospitals do.

That depends very much on what the doctor thinks is futile.

The doctors a major player.

The consultants are. Mainly because they have the knowledge I think it was the Berlin lecture on positive and negative autonomy where we can.....in our culture you’re perfectly at liberty to say I’m not going to have that but you mustn’t be free to say I will have that Its like “Champ and Childers” you know, medical ethics.

No, not ringing a bell for me Ray

(laughing)

So all that stuff informs what goes on, the ethics of what goes on.

Yes, do you watch House?

No, I’m not a Hugh Lawrie fan.

I always say our consultants make him look like a paramedic with a hangover. They do actually think, they go into things and so, you get an order, we have to be far more into that area and be willing to be judged,

Its not the case that they’re saying “this is within my gift, I will tell you what’s happening”?

No, no they think, I don’t know of an instance where its gone wrong though I suppose I’ve never seen a legal challenge because normally they will explain extremely well and the family will say “well, do whatever you think is best its up to you” or you know, and part of my job is to explain it to them, support them to think it’s part of a decision for them to think they’ve made.

Are you supporting them with a view to getting that decision made? Without leaving them feeling guilty about having contributed to it?

Unconsciously, I hadn’t thought about it in that way. I think you sort of, it comes back to the basic nursing premise that if someone ever needs a hand........ I think, I can’t think of a time where I’ve questioned any of our, there was once, very early on, where I said to a ward sister “why has he made that decision?” and it was explained to me. Its very open in that sense, if you think there’s something that needs explaining so we live with it erm I don’t think there’s any sort of “shut up and do it”

I’m not hearing that, it sounds like giving information is part of the deal. It sounds like something that you do.

For the family and the patient, yes.
And it sounds like being supportive of people in the position they find themselves in is also part of the deal.

R  Yes

Me  It doesn’t sound as though you’re telling people what to do.

R  Well it’s interesting you see......this thing about medicine the medical profession, the nursing and the healthcare professions. We don’t tell people what to do, however they can be very persuasive. I’m just trying to work out in my mind The one that came into my mind immediately is about consent forms. Where the doctor stands up, I think, what I’m very well, I try and do is sort out, as best I can, is things happen very rapidly at times and I try and make sure that the family is aware of what’s happening so that if I think the doctor hasn’t explained it to the family, then I’ll say “I’ll ask him questions which I hope will clarify” and when I ask the question a couple of times you know “But how does that effect such and such?” so that the doctors not omnipotent. Sometimes you can ask a question which they hadn’t thought of and the family might have thought of

Me  It sounds as though there’s a conscious attempt to take the burden off the family, the relatives. So they’re not going to be left with this notion that “well I killed him”

R  I think it goes into three areas. One, you’re trying to, not necessarily trying to reduce the burden but ease the burden. It’s slightly different, you’re trying to extend it so they’ve got time to come to terms, so it’s not, there is a soupson. The second thing is you should try to actually inform them so that they are making informed aware decisions I think the third thing is you’re trying to give them, well you’re coming back to what I’m aware of in my work, so they can look back and say “well the best was done” because I try to reduce any subsequent guilt they may have. Now, that might be taking my role a bit far but that’s how I see it. If I can act correctly now, in some human context, then in time, they can look back and say “well the best thing was done for hubby, son “ and be content that they’ve done their bit

Me  Where’s that come from? Where’s your concern for the future come from?

R  I don’t know It just seems to me to be a very natural part of nursing supporting someone. If you can’t support you know, its a bit like saying “OK we’ll prop the side of this building up and then taking the prop away and having nothing to replace it

Me  Yes, I think.......you only operate in the moment you operate in that moment at three or four o clock in the morning

R  Yes

Me  You’re talking about somebody six months down the line

R  Yes

Me  That’s what’s interesting, that’s what I find interesting
R I think if you try and think, obviously a lot of the time you have to act very immediately, but sometimes when you just sit there and you’re waiting for someone to pass away and you’re thinking “am I in the right place? Am I doing the right thing?”

Me Does that mean you’re quite considered? In that moment?

R Reflective

Me Reflective? You don’t like the word considered?

R Sorry considered? I think one of the remarkable things I’ve seen nurses do, and I don’t know if I sound like a nerd, but you are, you become fairly Hail fellow well met or whatever depending on the context you’re in but, its like the duck or the swan gliding across the water. Gliding across but working furiously underneath

Me You have to deal with whatevers going on but you have to look a certain way while you do it?

R I think so. Thats how my practice has developed

Me Wheres that desire to look a certain way come from? Is that something you’ve learnt is necessary, do people want that from you?

R In a lot of ways what I think I’ve learnt to do is to reflect the individual I’m talking to

Me Again, thats very considered that sounds liken you’re trying to give somebody what they want, give somebody what you think they want

R Give somebody what I think they need

Me Right

R As I say I think you’ve got to be very careful with that because of course you may get it, I haven’t got it wrong, I’m not aware of getting it wrong yet and I’m getting more relaxed as time goes by which I suppose is dangerous but no I think you do, as a nurse, just try and be there for someone if you, sounds daft but if you’ve got a uniform on which says nurse, and therefore people ascribe certain values certain features to what you are and to what you can offer them. One of those I think is a friendly shoulder or almost a physical shoulder

Me They have that expectation of you

R I think some do, I think some don’t I’m not trying to force anybody in any particular direction I’m trying to say “this is an option, thats an option” and then see where we go

Me And it works well enough?

R I haven’t had negative feedback, I’ve had positive feedback But you see the thing is, this is the very difficult thing, this is why people get................................(?) as far as I know I don’t think I’ve caused any pain I may have eased some pain I don’t think I
need to ask any more than that, It may become too intrusive to the family . Youn don't get a piece of paper back from Saint Peter, End of life care, marks out of ten

Me  Probably not

R  Hugh Penny's notorious book on near death experiences in ICU.

Me  I’ve never thought about that, I just accept theres somewhere else you go . I don’t know whether other people think there is . Do people have concerns about that?

R  I,I think once someone asked for a priest and thats about it. It may well be that its a reflection of our society in that death becomes so unexpected that there isn’t any sort of provision there . Theres no, oh you know, uncle Freds going to die , we need to get this, we need to get that we’re equipped with all sorts of things you can bring to any situation, most of them, whatever

Me  Nobody asks for them

R  Nobody asks for them I think there were, I think a couple of years back we had a Muslim die they were with us twenty four hours and there was a set up to deal with that

Me  Ignorantly I’m thinking that that religion or religions, the presence of some sort of religion suggests a, a respect for spirituality Probably not a good view really

R  Sorry?

Me  Its probably not a good view really I’m wondering whether intensive care is place where there is not any real spirituality

R  Spirituality yes, I’m not sure about religion

Me  I’m thinking the one represents the other, what are you thinking? You don’t think religion is about spirituality

R  We’re hazing definitions here but I think religion to me has a logical underpinning while spirituality , yes spirituality is more a higher thought process , the mind is separate from the body or something like that whereas religion is an explanation of that I have not, I must admit , I must declare my interest I’m a sort of weak agnostic going atheist I suppose I have not seen religion manifest itself, Ive seen what I’d define as the spiritual , human spirituality

Me  Strange isn’t it,in a place where lots of people die

R  Well its a very technological secular space although we try our best to help someone as soon as we know somethings happening all the extraneous equipment goes the silly cuffs and stuff like that and we get rid of all the pumps and the machines . We do the best we can but its not a......its not a good place to die

Me  There wouldn’t be somebody suggesting to the relatives that it might be a good time to get the priest that wouldn’t happen?

R  Well we do actually say "are there any needs?“ and certainly on one occasion
Me Thats a side issue for me but its interesting isn’t it

R I think its fascinating ,I think part of it is this this tendency for things to happen very rapidly in ICU , this vortex effect. Theres no sort of structure to it or there is a structure but its very much a structure which is dictated.

Me If its a very clinical, different type of space , albeit a secular space, I’m wondering whether people want or need either support or a guide in that space?

R Thats what we’re there as

Me You’re the guide?

R Well I’m part of a team, the teams the guide

Me But you’re a guide through this experience, you will guide somebody through bthis experience

R Yes, its what we do . Guide to me its a bit sort of, its a heavy laden word

Me Its not the best analogy but my next question was going to be where do you get your map from. If you’re guiding where do you get your map from?

R Thats, I’m wondering, whats the route I think the map comes from best understanding of the individual patient and the family . A knowledge of what has happened and what is likely to happen and also what is available in terms of help so for example if someones going to go for autopsy thats something we need to talk a little bit about , autopsy thats American, so that would be something that would come out I try to do just a little bit more than hand them a leaflet saying “ Bereavement office is open on Monday” The standard .........................(?) Its interesting . The reports are that the UK is a very good place to die

Me The UK is?

R Yes, not sure what it means

Me A better place than other places to die

R I’m not sure how they measured it Its a very human thing What we as nurses do is try and, the doctors do obviously but because we’re with the patient and family that bit longer we try and make the human side of it, yes we support them but I think it would be arrogant to say we take the pain away we don’t.

Me We’ve been talking for about forty five minutes is there anything you want to say before AI switch this thing off?

R No I mean its interesting to review (tape is turned over)

R I don’t write it everyday like I did when I first started but…..sometimes I sit down....

Me So you’re keeping that journal yourself?

R Ummm, when I give up nursing it will all be dumped
Me You won’t write a book or....
R I thought of like “a year in Provence” a “year in ICU”
Me People do, people do write books about stuff
R Funny, because I think there is a need for it because there is this mystique about intensive care which I think is down to, not ignorance because ignorance implies a lack of ability but a lack of knowledge about what goes on there.
Me I think its one of the places people are scared of as well though
R Oh yes, very scary places
Me I’m going to turn this off, I wanted to catch the view on reflection
R Right.
Me This should run for about forty five minutes
H There’s always more pressure finishing the shift than at the start
Me You’ve just come from work haven’t you?
H Yes, Yes.
Me Do you always work nights?
H No but because I’m flexible I get all the, shall we say, ...
Me ( Laughing) No you can say it
H That’s it.....s...e!
Me So you’re doing nights and you’re working in a general hospital and you said you were on the stroke unit
H Yes
Me What’s that like, the stroke unit?
H Well, its probably like every ward its hard to actually generalise things like that because some nights, like last night, lovely nights, we had time to meet, to spend time with people. There’s a lady there and I’d had a chat with her one day and she said “why are you nursing?” just I thought come in, spend time with people, and that was it you know, can I help you, what do you need today? Was what my naive view of nursing was but overnight she was awake and I took her across to the loo a couple of times and you know that, that was nice. And about a couple of weeks before that there was a lady of ninety four in ....
Me Are they all old?
H No No there’s some in their early fifties, give or take, as well the youngest one we’ve ever had which I remember was twenty one
Me Really?
H Yes, and she’d had two strokes as well
Me For one reason or another I don’t associate it with very young people
H No I don’t , I don’t either still now, no. But its about four in the morning and she says “can I have a drink?” and I said “course you can” and went to get her a drink of water she said “can I have a cup of tea?” I said “of course you can” and that simple act of, sort of nursing in inverted commas gave me the most pleasure all night
Me Was that just this last night?

H No, about a couple of weeks ago but its just those simple little, not chores but little acts of kindness as it were that outweigh all the hassle at times, shall we say and restores your faith in the job.

Me That lady that asked you for a drink, you made her a cup of tea, you go back with the tea, do you talk to her? Are you there...

H I didn’t then I must admit I just had basically a “There you go my dear, if you want any help just shout but I’m busy at the moment” you see, I didn’t talk to her then no but on other occasions she was a chatter box bless her and she did enjoy the company because she’d come in from a nursing home and I think going from possibly like a lounge where she knew everybody to have a chat to like unfamiliar surroundings and for the time she was in a single room as well, you know, just lonely.

Me Are you conscious of that? That she’s coming from this place with the lounge to....

H I don’t think I was initially conscious but possibly later on I think no she has come from a nursing home and she’s probably just lonely in there maybe, form that having all her friends to like a room on her own, just the buzzer for company because every time you went in she did have a good old chat

Me Is it the fact that she was willing, she was a chatter box you say, is that what’s telling you she’s lonely? Is that what’s telling you she might be missing the people from home or........how do you know?

H Oh there’s a question yes, I think probably because physically she was frail however faculty wise she was with it totally and I think she was probably just lonely coming from the nursing home with all her friends into the single room and it was her trying to engage everybody every time in a chat with you

Me Why is that in your head, why is it in your head that she’s come from a nursing home where her friends are?

H I knew she’d come from a nursing home, yes that all, am I missing the point here?

Me No, I’ve not met anyone yet who said to me that they thought about the person coming from any background particularly

H Oh yes, got you

Me I meet people who say they do this, this and this but I’ve not met someone who’s said they seem to have in mind a background for them

H No I admit it was purely that I’d known that she had come from a nursing home because we’re getting ready to discharge her back to it you see

Me Right
But its only with her like, being as sharp as she was and in a single room that I probably thought that no the cup of tea wasn’t a case of “can I have a drink?” it was a case of “can I have a drink and a bit of chat as well?” yes

Are you up for a bit of chat?

I didn’t initially, when I gave her the cup of tea I just left the cup of tea because I was halfway with another job but when I went back in later on she was awake still and we did have a bit of, a bit of chat and I’d met her previously in a different room and we’d had a chat about this and that and she’d mentioned having pets and I said “I’ve got a cat” and two days later, three days later I think it was I think it was she said to me “you’re the one with the cats aren’t you?” and I said “I am my dear yes” so I think that’s why she just likes to chat because her faculties were...

Thats just everyday chat isn’t it? That having a pet is about commonality I suppose

Yes possibly that yes but also can I say she may be used to at the nursing home having the telly on in the lounge for nothing whereas like she wasn’t up to going into the actual day room on one of the chairs during the day and of course having to pay at night she maybe actually just missed background noise almost

By your bed now you have this machine (television) you have to pay for and its quite expensive

Yes it is expensive

And the dayroom is a common area

Common area yes...

I’m just saying that for my supervisor

Yes of course

Are they all in single rooms then the people you’re looking after?

No there’s four single rooms and four four bedded bays unfortunately both times I’ve met her she was in a single room and then she was moved to another different single room but I’m not aware of the reason why she was moved from single room to single room

It must be easier to chat in a single room

Yes oh yes

If you want to talk it must be easier to talk

Yes oh absolutely yes

Especially early in the morning

Yes because, again about that, this chap was wanting his eye drops giving at say four, four this morning, I say “I can’t give them because they haven’t been prescribed
and I can’t find them” and he’s chuntering on so much we could hear him at the desk
and his bay was the furthest one away two of the other three people came out and sat in
the dayroom because they’d had enough of him going on, so at times a single room does
have its …..

Me He was moaning?

H Very much so

Me Moaning loudly, the people around him move, so what did you do?

H Well they came up to the desk about flourish this morning and they said “can
we have a cup of tea?” and they said “he’s doing my head in” we said “right, go into the
actual dayroom and we’ll make you a cup of tea and hopefully after you’ve drunk it it’ll
have settled down a bit” but they just wanted, as opposed to just wanting a chat, they
just wanted at this time to get away from it because it was like a record that was going
around and round and round

Me Because he kept on moaning

H And everything was just negative with him, it was hard

Me Did you have to go back to him?

H What the actual eye drop chap, we went back and said “look, we’re still waiting
for the doctor coming” he said he understood why we just couldn’t give them there and
then he said, you know, and after a bit he nodded off back to sleep again you know
because about an hour or so later we did realise that the room had finally become quiet.
But I think no matter how many times, when I was trying to explain why we couldn’t
give, we couldn’t give because it wasn’t prescribed, we couldn’t find it, it was just going
round and round he said “yes but I need them” I said “yes I know you need them mate”
I said but “we can’t give them if they’re not prescribed or if we can’t find them”, “yes but
I need…..” so…..

Me So you give the same message again and again

H Yes

Me Does it work that, giving the same message?

H No, not with him no, trust me no

Me (laughing) How many times would you give it

H I must have told him last night about six times in ten minutes

Me Always the same message

H Yes, cannot give because…cannot find because…

Me Is it because he’s old? Or because he’s just…

H I think its because he’s just fretting because he’s a diabetic chap and he said his
actual glaucoma, he missed the eye drops yesterday and he doesn’t want to miss them
today I said “its in the doctors book to be prescribed and if your friend doesn’t bring them in again we’ll order them from pharmacy” I think he was just worried to be truthful about his eyes as opposed to not actually the ......

Me  Serious stuff though isn’t it when your eyes...

H  Oh aye, yes, I’d rather be deaf than blind

Me  Yes but how do you, if somebody, I mean I’ve got a picture on the one hand of this fellow who’s asking you the same thing

H  Yes

Me  And on the other hand an acceptance that this is serious stuff, how do you keep the balance?

H  Well, again, I just sort of explained to him that the doctor was coming down on the ward for other jobs, when they appear we will ask them to prescribe, and I’m trying to say that without making it sound horrible what I’m trying to say is your eye drops could not be the doctors priority I can understand your eye drops are your priority to you but there could be a medical emergency elsewhere in the hospital and I just said without being rude you’ve just got to be patient and we will endeavour to get them prescribed in time for your night time ones tonight

Me  How do people hear that message then?

H  It depends on the person

Me  Does it?

H  Oh god yes

Me  You sound like you give it in a fairly calm way

H  I admit probably last night I was, I thought for goodness sake , how many more times and you could tell the people around were peed off with it

Me  Do you get peed off with it?

H  Well yes, we’re human beings shall we say, although you do try and not , not come across as getting peed off with it but, it was a case of I’ve just explained why I can’t give it the reason I’m giving you hasn’t changed from half a minute ago so sort of thing, so I’m just, what I’m saying is I just cannot give it because it isn’t prescribed ,period. What you do at home is what you do at home unfortunately now you’re in hospital we can’t give it because there are policies but how people take it some people maybe on their nature can be accepting they’ll say it doesn’t matter mate you can only do what you can do and other people maybe think he who shouts loudest gets

Me  Which is the way a lot of things work if you keep at it long enough, wear someone down

H  Yes but then again it could be a case of they’re winding me up I’ll let them wait

Me  Would you do that?
H    Well.....

Me    Whatever you say doesn't go anywhere else

H    I know John, you’re fine mate, all I would say is that we’re all human beings with our own frailties and fallabilities and at times you do know the odd one is being a complete and utter bugger out of almost like spite and then at times, I’ll admit I do think at times no mate because of your attitude you can wait a few minutes because there are people over here that never complain and they get left alone because of you complaining all the time, I’ll go and see the ones who don't complain all the time first and you can wait in the queue shall we say.

Me    No I suppose that you can’t help but do that

H    No there’s nights, working on the trucks as well people say to me “how do you clean up peoples bums?” as it were

Me    Trucks, you do some lorry driving

H    Yes, Yes, and they say “Oh I couldn’t do it” I say, “ you probably could mate” they say “oh no you lot are whatever, wonderful,” and I’m like that, “we’re all human beings, we’ve all got our own prejudices, fallibilities, insecurities, I am no different to you” shall we say, but at the end of the day we’re human beings who get equally fed up with certain things but maybe we hide it better

Me    You sound like you get fed up in a fairly patient way Do you know what I mean?

H    Yes, Yes.

Me    You’re not ranting

H    Oh God no (chuckling)

Me    Maybe that’s because you’re tired but you’re not ranting

H    Actually I always thing its when I’m tired I rant more but its, I think like you said before ex marines, now I have come across more and more ex marines...

Me    You were in the forces

H    Yes, who now nurse I thought I was the actual only one but there’s a couple of them who I’ve found out since they were the biggest bruisers you could wish to meet, you wouldn’t want to cross them

Me    You associate marines with hardness

H    Yes,

Me    With paratroopers these are people who are sent in first to wars

H    Yes, in many ways we were sort of physically tough also though we had a sort of mental training of teamwork, collaborating, you all had to sort of work together in order to get the actual job done so the teamwork bit of my brain overcomes the wanting to say “oh go away, you’re annoying me”
Me Does that mean that the individuality is stifled?

H In the forces?

Me Well, generally

H I think the individuality is broken down in the forces to mould you all together because, this is one thing that annoys me in the NHS because I hear “it’s not my job” or whatever when in the forces it just wasn’t allowed to happen you see, like they did say that they used to break everybody to bring them up again as a team and if one person needed help you would all help, shall we say as opposed to being a bit

Me The NHS rightly or wrongly tend to stress the individuality of the people you’re working with

H Yes

Me So that the people you’re providing a service for they stress their individuality

H Yes, oh yes, that’s it, they’re they would be like me, their own prejudices, their own qualms about, however I would not have a problem about going to clean up anybody, shall we say, no matter what I thought about their political or religious beliefs

Me Does that mean that you accept them for what they are?

H Hopefully yes, I would maybe disagree with their beliefs or thoughts or whatever however I would, hopefully to goodness not let it impinge on my attitude towards them.

Me Is that just you? Is that how you’ve always been or have you learnt that that’s the best way to be?

H I think I’ve been like that since whenever because my mum and dad always brought me up to be fairly tolerant

Me Tolerant is an interesting word isn’t it? Is that what it is, an acceptance of people as they are?

H Everyone is different aren’t they, for goodness sake, I’m quite sure on the wards I annoy lots of people, staff wise, but yet they have to work with me and likewise I have to work with them.

Me Your backgrounds just an ordinary background

H Yes nothing special about it

Me Tolerant

Me Well that’s it, because again my mum was a teacher and her and my dad taught me discipline, shall we say, things like that, but I certainly, I’m certain I’ve never been able to judge people on say colour or whatever, things like that. Or beliefs

Me It’s something in your background that’s contributed to the way you deal with people then

H Oh yes, definitely. Yes, yes.

Me I’ll make you another drink
H  No you’re all right John

Me  Sure

H  Yes thank you, I haven’t finished this one, you’re all right. It’s a case of is it
nature or nurture which gives you your values almost isn’t it?

Me  Are you saying its nature or nurture which gives you the ability to be with
people

H  Nurture for me

Me  You think its the way you’re brought up

H  Your parents yes,

Me  I’ll ask you directly, do you think we have any contribution to make in that
regard?

H  To learning?

Me  Do we do anything in the time you’re training to help with the people you’re
working with ?

H  Oh God yes, things like, again, you see, you would maybe put the odd self
doubt or thought in your mind and you would start thinking yes maybe they are right
and I’m wrong, you can’t jus, just go on your own beliefs can you.

Me  That sounds like you might be told stuff but you sound like you’re saying you’ve
got to reflect on it

H  Yes, yes because nobody is perfect, shall we say, that once again even now I
have no qualms about people telling me that you’ve done that or you should
have done it slightly differently its all in the manner in which its done, shall we
say, I don’t mind being told by a student on day one that you never washed
your hands or whatever it’s just the manner in which its done so

Me  The way somebody says it?

H  Yes, that to me is far more important at times than what’s being said.

Me  Does that mean you’re sensitive to the way that people say what they say?

H  Yes, yes and I do at times find it difficult you know working in a predominantly
female environment

Me  Why?

H  Why? Because a few of them seem to think they can speak to you how they
wish but if I were to speak to them the way they speak to me I’d be in the office quicker
than anything

Me  Do you think that’s not the case with the men though, is it different with the
men?

H  Possibly but like I say even nursing friends they have said to me they would
rather work with a ward full of men than women because like hopefully with the men
you’d have a laugh and a joke you get the actual work done and that’s it.

Me  Your background sounds like it’s a very male background

H  Oh it is yes, yes very male
Me Marines are all male

H It is yes

Me Do you think that influences the way you consider the women?

H Yes, because again I just, there's a couple of them on the ward and they're sort of, they'll say something which is fairly OK you know fairly supportive an at the last minute they'll add one little comment and I'll think thank you very much for that but whether or not it is just because I am normally used to working with blokes I don't know but one of them, one of the male staff, he'd been wound up so much by a female all day he just told her to eff off and I'll admit I said “well the only thing you did wrong was tell her to eff off in public, hit her in the bay”

Me Most of your patients are going to be women aren't they? The patients you've described to me, two of them were women

H Yes

Me It sounded to me like they were older women

H Yes

Me So you've got to make an accommodation for working with them

H Oh yes, no the patients are fine, at times its the attitudes of the staff

Me For you there's difference

H Yes

Me The way you deal with one has to be different to the way you deal with the other

H Yes

Me You've got to be more cautious when you're dealing with patients

H Well, like I say, how should I put it without being too crude as it were, wiping a females bottom and wiping a males bottom has got no difference to me whatever on that score I don't have, I think possibly because I've never worked on the ward as a student and all the staff had been there for X years I wanted to say to them “ I won't be as good as whoever because I've never worked here before I won't be as quick as whoever because I don't have twenty odd years experience “

Me You've got to fit into this group that's been there for a while

H Ermmm

Me And that's a strange dynamic sometimes

H Yes

Me Whereas with the patients its not the same

H No
Me  You have a job to do, you’ve got to do that job in a particular way
H   Yes
Me  And you’re going to be calm and pleasant
H   Yes, yes
Me  You’ve said that, there’s one thing that intrigues me about the way that you talk about your dealing with people and that’s the language that you use. When you speak to these two ladies the ninety four year old and the
H   Yes
Me  You address them as “my dear”
H   Yes yes
Me  That’s a fairly old fashioned way of speaking isn’t it?
H   I think possibly because my mum and dad are in their eighties now so I think that I’m possibly older than the average nurse
Me  You’re not that old, you’re younger than I am
H   Yes but I think that therefore maybe because my mum and dad are in their eighties maybe I get it off them. With the ages it would be either Mister or missus or my dear to one of them I wouldn’t go up and say “morning Muriel” and then she said please call me...
Me  Why not?
H   Disrespect.
Me  Somebody’s first name isn’t the name you would automatically use, you wouldn’t call her Muriel
H   If they were my ageish, give or take I probably would but I think, say ladies of, shall we say a certain generation will be more used to being called Mrs Smith rather than say, as opposed to Christian names until they say “oh please call me.....”
Me  Age is a factor for you
H   On the name yes
Me  Is age something which might dictate the amount of respect you give somebody?
H   Apart from the names my respect hope fully would be the same if they were like ninety five or twenty five
Me  I might not have phrased that well. Would you be more cautious around the ninety five year old than you would around the twenty year pld?
H   In what manner cautious?
Me  In the way that you dealt with them, would you be more courteous?
H   Yes, I would be more courteous and I would definitely , I’d be watching me Ps
and Qs a little bit more because maybe somebody of our age if you let a word
slip they wouldn’t mind but I wouldn’t want to swear in front of a lady. One time
I had a , I was chastised for saying bugger
Me Right, I’s not the worst word you can use
H No I know
Me There are worse words
H Yes, that’s right you see I was in the doctor’s office and unfortunately brought
the phone in and I thought it was on mute and I said oh Blah, blah blah once
I’d been asked about the early shifts and I said “I’m buggered if I know” I got a
warning for it and like you say it’s not the worst word I could have used either
Me Well you regularly hear worse words on telly
H Yes that’s it yes, but I think again possibly is it the PC culture almost in the
NHS where you can’t sort of do this
Me What is that PC culture, you’re talking about the culture you’ve got to operate
within aren’t you?
H Yes
Me Is it female culture?
H Yes however though if you’re in the staff room, my word, some of the things
that they come out with and out of earshot, my word I blush.
Me Yes women can be a bit risqué but it is a woman’s world isn’t it
H Oh God yes
Me And you’ve probably got to live with that, but the PC element what were you
thinking of? In the culture that effects the way you’ve got to....
H With my upbringing I never swore at home, however if I was to be out with the
lads it’d be eff you and things like that but
Me It sounds like there’s an awareness of when you should or
H And that’s it because to me in a liberal environment you do have to draw the
lines you can’t say eff this and eff that in front of the patients
Me Do you see the NHS as liberal?
H No
Me You don’t?
H No , Well not, I think the PC ness has gone a bit over the top right, shall we say,
another chap he had to go for a scan and he was a large obese chap . On the
bed, the porters refused to take him because of his size and I thought to myself
“I’ll push him then” “Oh you can’t”
Me They wouldn’t actually move the trolley because he was a big fellow?
H Yes,
Me They thought he might be heavy?
H Yes, so I said “I’ll push him then”, “Oh you can’t”. Little things like that, if you
could just get the blinking job done! As opposed to Health and Safety PC ness
Me Get the job done, you’ve said that a few times. Get the job done, and there is a collaborative element to what you’re saying as well, people should work as a team and that kind of thing.

H With the forces we all accepted we’d come out deaf, bad backs, bad knees on my medical records it does have deaf, likely to have arthritis in the knees and tendency for a bad back. At the moment like my back isn’t bad but because we didn’t have the Health and Safety culture almost we all just mucked in and accepted something if we got hurt doing it, I just cannot, even now I cannot see why the porters would not push him along a flat floor by bed for a scan. I cannot work it out even now John.

Me I agree with you, I think there are examples of behaviour I don’t understand and I can’t see what the problem might be. But if you’ve got a culture that’s different to work within, you’re aware enough to work within it and you know what you’ve got to be sensitive to.

H Yes.

Me You sound like you understand how things have to be. It certainly sounds from the way you’re describing the people you meet at work the patients you meet at work as though you’ve got the skills to do it.

H Yes.

Me So where did those skills come from then? You were in the marines.

H Yes.

Me Where did you develop the skills to enable you to talk to a ninety four year old woman at four in the morning?

H I would, I would say probably from the parents, to be respectful, then the marines to have the confidence to start talking to complete and utter strangers you know and then, then with the nursing and the sort of skills stroke attitudes built up over your nursing to sort of know what is (not) more appropriate to say to a lady of ninety four at four in the morning.

Me How do you know what’s appropriate and what’s not, I know that sounds like a stupid question...

H No, No.

Me I know its something you would never be asked ordinarily 9but nor would you be talking to a tape recorder at seven in the morning) Why is there skill involved in talking to a ninety four year old lady at four in the morning?

H Right, I don’t know about skill, but awareness almost shall we say, you know, because again I’ve never done nursing before, generally knowing what is and isn’t appropriate to say is maybe built into you from maybe the first day here is that, you know talking to somebody of ninety four and talking to somebody of twenty four totally totally different shall we say and I can only probably put that again down to, is it nature more than nurture things like that.

Me What do you mean?

H Well is it, is it nature or nurture, one is your upbringing and the other is who you are or something like that.
Me: There is no, I’m not hearing you criticise these people even though you said that your man with his eye drops was complaining and complaining and driving people up the wall. It sounds like you may well have thought he was a mitherer but you responded to him in the same way that...

H: Yes, that’s, at one stage my tone of voice must have changed because he said “I’m not wanting to argue with you” and I said “I’m not arguing with you, I’m just trying to tell you that I cannot give it without the actual prescription”

Me: That’s a skill isn’t it, recognising tone is a skill

H: Yes

Me: It’s not the same as being aware and its not the same as having respect and it’s not the same as accepting just that people are what they are

H: But even, how should I put it, being a human being, the fact that it’s like a record almost, tenth time around I was not getting fed up but I could feel it welling up and the other people they were fed up with it and he must have realised that I was getting a bit edgy shall we say for him to say to me “I’m not wanting to argue about it” so I thought well why don’t you just accept what I’m saying then mate?

Me: Have you ever got it wrong? Have you ever read somebody the wrong way?

H: Oh I must have done

Me: What does that mean, does that mean you might have done but you don’t know or?

H: No No, being human I must have got it wrong.

Me: Usually in nursing if you get it wrong somebody will tell you won’t they?

H: Staff wise or the patients?

Me: I mean patients particularly but either

H: Yes

Me: You don’t deliberately get it wrong, nobody gets out of bed to...

H: No, the staff would, I’m quite sure, tell you there and then however the patient maybe would not want to moan or criticise you in case they, they’d be worried in case it affected their relationship with you in the future so maybe the patient would bite their tongue just in case like next time I’m in he might “here’s that miserable so and so”

Me: Be waiting for me

H: Yes, shall we say.

Me: So is your recognition like “I wish I hadn’t said that” straight away?

H: Yes

Me: Have you ever had that?
H What as in bad vibes do you mean
Me Yes, what do you mean by bad vibes?
H Oh, when you meet somebody and you know you’re not going to get on well
Me What’s telling you, how do you define bad vibes?
H (laughing, tired)
Me I know, I’m really sorry I’m aware that you’ve been working all night and it’s not the time of the morning to be asked these types of questions
H (still laughing) No its all right. How do you describe bad vibes, my god!
Me How do you know, what tells you the vibes are bad?
H Apart from personal instinct I don’t know but I can’t describe it any further than you just know there’s something not going to click or not quite right you just feel it
Me You just feel it
H But I can’t describe how you know but there’s a feeling there, you just know at times that you and whoever aren’t going to bond
Me Have you had that feeling about patients?
H Yes
Me How do you deal with it, you’ve no choice with a patient
H You’ve just got to, again using the phrase, do the job, get on, get it done, because you know like being a human being you sometimes go into the staff room and say well that patient in five bee blah,blah ,blah and then the other member of staff would say “I’m glad it’s not only me who feels like that about “ you know whoever it is. Quite often it’s not you as an individual it can be you almost as a group that have the same feeling about any certain patient see
Me Would you feel better if other people had those same feelings?
H God yes,
Me If it wasn’t just you you would feel the vibe validated?
H Absolutely yes.
Me What about when it is just you?
H I’m not, without being evasive I don’t know if that’s ever happened it probably has happened of course but I, if it has happened I don’t know
Me When you’ve had bad vibes about somebody others have had the same view
H Yes, generally yes
Me and I’s not the case that when you’ve had bad vibes about somebody and other people didn’t you wouldn’t trust your own instincts
H I think for me that I would still trust them yes, because everybody is different
but you know nobody is perfect, no two people are the same I’m quite sure that if I’ve , if I’ve gone for ” I cannot warm to you” and other people have said “He’s lovely” I would still think we I’m sorry but you can and I can’t . Off the top of my head though I can’t think of any , it must have happened but I can’t think of any time

Me That’s OK . Some very interesting stuff that you say and I’m aware now that I’m beginning to keep you up so is there anything you want to ask me?

H No I’m fine John thanks

Me I should have given you that . I’m going to turn that off now and let you get off, thanks very much for talking to me . When this is transcribed I’ll send you a copy of the transcription to read and if there’s anything you want changing you only have to tell me . This won’t be read by anyone who knows you and when it is read your name won’t be on it

H No

Me It’ll be anonymised, possibly with a number, number seven.

H I could actually come in again if that would help

Me I’ll transcribe it , send it to you, analyse it and then come back to you, is that all right?

H Yes, Yes. I hope it helped

Me It’s very useful
Me Would you mind saying your name for the tape?
C Cheryl Broderyk
Me And what sort of work do you do Cheryl?
C I’m junior sister on ward 9A, elderly medical
Me That’s a medical ward looking after older people
C It is
Me And how long have you been doing that
C Since May 2011
Me So how long have you been in the health service altogether?
C Since 2007, I’ve been qualified
Me And you’ve always been a nurse?
C I have yes
Me Always had patient contact, always worked with patients
C Yes
Me Because what I’m interested in is whether you would be able to think of something that involved a patient a relative or someone you’ve been looking after that for one reason or another stands out for you that you remember, does that make sense?
C Yes erm, I suppose there’s lots of patients that stand out erm, yes, I can think of one. There’s, do you want me to talk about the patient?
Me If it’s OK, if you can give me an idea of who the patient was
C OK
Me What they were in for and the sort of contact you had with them
C Erm, had a patient in that came to us with motor neurone disease quite an elderly gentleman, it was found that he had motor neurone disease which was quite advanced and that there wasn’t much that the doctors could do for him. He’d stopped eating and drinking. We got the Macmillan nurses involved to see if we could fast track him home because that’s where he wanted to be. He ended up going to, he was fast tracked to a nursing home which was his choice and I got a phone call yesterday from A+E saying they had re-admitted him ...
Me Back to the hospital?
C Yes, even though he was on the Liverpool care pathway on being discharged...

Me Right

C The res...the nursing home had panicked, he’d had a bit of haematemesis and they’d brought him back in

Me Vomiting blood?

C Yes, So A+E were on the phone to me wondering what they should be doing because our erm....Debbie Petley who does the fast tracking she wasn’t available yesterday and he was actually to go back home because he was on the Liverpool care pathway

Me This is a pathway that people go on at the end of life

C Yes it is yes, and it was his choice , he didn’t want to come back into hospital but for some reason they panicked and sent him back in

Me Right

C That was a bit of a shame really

Me So has he gone back now to...

C He has yes

Me Gone home or...

C Gone back to the nursing home

Me Right. Why does he stand out for you ?

C I don’t know.....I don’t know

Me Was he diagnosed with the motor neurone disease while he was with you?

C He was yes and it was quite advanced , erm, I suppose because he was on the ward for quite a long time and we got to know him and the family

Me Right yes

C And then, just because of whats happened yesterday and him being re-admitted when they were told that is where he needs to be , in the nursing home, not to be re-admitted thats not what he wanted to do and for some reason they re-admitted him so it was a shame for him really being pulled and prodded and, yes

Me Its not a nice condition

C No

Me The MND, motor neurone disease

C No, no it isn’t
Me So he’s diagnosed while he’s with you, did he not know before that?

C Not that I’m aware of no

Me So somebody’s got to tell him

C Yes the doctors have spoken, we’ve got a diagnosis and the doctors have spoken with him and the family, the ....him and his wife were divorced but she was still his next of kin they got on really well and it came to a point where he wasn’t able to swallow any more and when they decided to put him on the Liverpool care pathway he was dying to have some chocolate and we decided to do a swallowing assessment on him, managed to give him custard thick fluid and this one particular day he kept asking for sweets, he really wanted something chocolatey so I made him a hot chocolate and thickened it up a bit so it was like a mousse type thing and he absolutely loved it

Me Right

C So, yes, I don’t know, probably because he was here for so long

Me How long was he with you?

C Could have been about two months

Me And did he have a big family, I mean the wife...

C He did yes, yes, family from away and one of his daughters was pregnant at the time erm and his wife, she came to visit everyday

Me Even though they were divorced?

C Yes

Me How long had they been divorced?

C I don’t know,

Me But she was still offering him support?

C Yes,

Me Could you tell her what she wanted to know about his condition?

C After speaking to the patient yes, he wanted her to be part of everything that was going on and he wanted the doctors to speak to her as well, she was involved...

Me So he’d no problem sharing

C No

Me When he came to you first of all did he know what was wrong with him?

C No, No

Me He’s got these symptoms, difficulty swallowing could he walk all right?
He was struggling to walk in the last few, obviously in the last month or so he’d been bed bound, can’t walk at all and really deteriorated quite quickly.

Right and no previous indication that this was what was wrong with him.

No.

Who tells him then, that he’s got motor neurone disease?

The consultant told him.

You do your tests, your diagnostic tests,

Yes.

...work out that this is the problem..

uh huh.

And the consultant gives him the news.

Yes.

Are you with him when he...

Yes, yes.

You’re with the consultant...

With the consultant and then afterwards I always just tend to run through it with the patient as well, sometimes the consultants use all these fancy words and I just like to make sure that they know what’s that, they understand.

You’re likely to stay behind, you did stay behind after the consultant had gone.

Yes, yes.

Just to clarify.

Yes.

What does that mean when you’re clarifying stuff what do you do?

Putting it in simple terms, and listening to the patient, if they’ve got any questions or anything that they, a lot of the elderly I find on the ward don’t like to challenge the doctors or don’t like to ask them too much too many questions, and as soon as the doctors have finished the ward rounds they’ll then say, erm, what’s this and what’s that, so I tend to stay just to see if they’ve got any other questions or anything.

Right, Don’t younger people do that? Don’t younger people listen to the doctor as well or are they more likely to question the doctor?

I think the younger generation are more likely to question.

What about his relatives? Has he got kids or...
C He has, one of them lives away so he wasn’t always available he did ring up everyday to find out how he was erm, but I don’t think I ever saw them here while the doctors were around.

Me Right, so he gets the message “you’ve got motor neurone disease” did he know what that was before...

C No

Me He’d no idea?

C No

Me You’ve got to explain to him not just what it is but...

C The doctor explained to him roughly what it was I then got a lot of information for him and the family printed it off, got it from various people and then talked it through with them.

Me Do you have to censor what you’re giving them? Do you give them what you get? I suppose people can go to the internet....

C Yes, I think a lot of people do use the internet, they often say “I’ve read on the internet...” (chuckling) I don’t think I censored anything no.

Me I’m just wondering because there are some groups aren’t there that say “don’t read....” because it’ll depress you and I’m thinking motor neurone disease...the term depresses me.

C I suppose because he was already at that advanced stage he wanted to know what was going on and that’s his right to know really.

Me Was he asking questions, “can you tell me what this is”?

C Yes,

Me And how did he accept the news that this is not a good condition?

C I think he accepted it quite well, for the first few days I think he was quite quiet not as talkative as he normally was erm, but I think after it, probably took a few days for it to sink in and then he was back to his normal self, good sense of humour, yes.

Me So it takes a while to accommodate that

C Uhmm, yes

Me When you were with him, you’re giving him information?

C Uhmm

Me Does he ask you stuff or do you just tell him stuff or how does that work?

C I think it’s a two way conversation, I’d tell him things and he would just listen and then ask questions at the end sometimes he’d stop me in between and ask things...
Me  What stands out that he asked you about? What did he have an interest in?

C  ...............Probably about going home. Whether he’d get home or whether he’d
die in hospital I think that was a big thing for him

Me  He’d accepted that?

C  Ummh

Me  He’d made the accommodation that he was going to die?

C  Yes, the doctors ahd told him it was quite advanced and that they didn’t expect
him to live much longer

Me  That must be quite a difficult conversation to have

C  Ummh,

Me  You know if you’re following that, not easy to follow

C  No, it never is, I think in any circumstances its not very easy

Me  What’s your preparation for going into that scenario?

C  Its funny you say that because I was looking on the internet this morning and
there’s a breaking bad news course that’s coming up in Grantham that, and I’ve been
trying to go on one for quite a while because I feel that I can talk OK with patients and
relatives and I’ve got no problem with that but I’ve not had any formal training on how
to break bad news or anything erm and I think sometimes you can go to courses like
that and see things that you’ve maybe not thought of before.

Me  So it’s something you’re considering doing?

C  Yes

Me  What do you want to get from it?

C  I don’t know probably just that knowing that what I’m doing is all right. I
suppose, erm, I suppose I’ve been doing it for so long and I’ve dealt with loads of
patients and relatives that are dying and we’ve had to put on the Liverpool care pathway
I’ve not had any complaints yet, touch wood! Over how I’ve approached them and how
we’ve discussed it, probably just knowing that what I am doing is right

Me  Does that mean you’ve a doubt?

C  Sometimes, I wonder

Me  Because no complaints would be good enough for me, I would live with that

C  Yes, it is,erm, but I suppose because I haven’t had, nobody’s said to me “this is
what you should be doing when you’re breaking bad news I don’t know maybe I’m
missing something or....

Me  Its all right, I’m just wondering do you see it as a grey area do you
Yes, it is a bit of a grey area

So you’re giving the man the message, hes taking it well, hes asking questions about the process that hes going through hes accepted that hes likely to die fairly soon what about his family?

Daughters found it very hard, I think they needed a lot of reassurance of what was going to happen what their dad wanted and whether we could get that done as to where he wanted to be for his last days of life. The wife, I think she ,she knew. I think she had inklings before he came in that there was something seriously wrong and I think she accepted it. It was still hard for her, I think it would be for anybody but I think she accepted it better than what the daughters did

You believe the wife had a...in her heart she knew something was wrong

Yes ,

But you think it was a surprise to the daughters

Yes, yes

How do you break that to somebody whos going to be surprised by it?

I think when the daughters came in, because as I said they were away, when they came in to visit their dad the mother had already explained to them what was happening erm, they then came inn and they did still have questions that they wanted to ask which was fair enough and I tried to answer as ,as best I could, I think they just wanted a bit of reassurance as well. I don't think its easy for any family

Its very bad news. So the wifes told and then there is some degree of the wife sharing that information

Ummh

They come in and they’re not totally....

Oblivious to it

They know somethings going on and they can clarify any concerns they’ve got

Yes, yes.

Did they get upset?

Yes, they were upset understandably so but I think once I’ve explained to them the process because I think by the time they came up we had then decided to put him on the Liverpool care pathway . The wife was in agreement with that, he wasn’t able to take his medications so they automatically stop them on the Liverpool care pathway and make sure the patients comfortable and I think .......yes,I think they were upset . We gave them a lot of information, we gave them leaflets about the Liverpool care pathway and explained to them that its not just leaving their dad completely, its about making sure that he was comfortable and pain free and able to breathe properly
Me You’re giving information, in a form, to let people know what’s going on and you’re giving information to reassure

C Yes

Me And you’re saying people can get their own information

C They can yes. A lot of patients relatives come in with things they’ve printed off google and (chuckling) yes.

Me Good things?

C Not always (chuckling)

Me How do you deal with that. They come in with “look at what they’ve found in California”

C (chuckling) Oh I don’t know, how would I deal with that?......

Me Is it something you’ve had to deal with?

C No, not really I know people do say that they’ve looked on internets, this is what they read up on the internet maybe not actually physically brought me something in but when we’ve discussed it further a lot of it is similar to what I would have said to them anyway and I think, sometimes I’ve heard that google is not always the best place to get information

Me You can get three million hits in five seconds

C Yes (chuckling)

Me So there’s no surprises

C No

Me You sound quite in control of it, you sound quite

C I try to be, it’s not always easy

Me You’ve done this a number of times, this chap is one of a number you’ve had to be around

C Yes

Me Who’s had the bad news, you’ve had to be around the relatives as well and you’ve not done any course that prepares you for that so what have you learnt works?

C ......I don’t know, I’m just myself I think I don’t try and bombard them with loads of medical jargon or anything. I think, I don’t know whether it’s when my dad, my dad was diagnosed with a brain tumour and he died and the things that my mum had to go through during that stage I think I’ve learned a lot from that erm and I try and think of how my mum and dad were during that period and try and make sure, you know, that the relatives and the patient are given all the information and are given time to talk about it, yes.
Me Is that, was that before you started nursing
C Yes before I started nursing
Me Did it have anything to do with your starting nursing?
C ........Yes I think it might have
Me Do you mind taking about it?
C I’d always wanted to, when I was in school I always said I wanted to be a nurse and never did anything about it and then, my dad did go through a difficult time because we were in South Africa at the time and he was diagnosed with a brain tumour, they didn’t have all the resources like we’ve got here nowadays Macmillan nurses and fast tracking home and what have you...
Me Right
C And my dad died in hospital and erm, it wasn’t very dignified either when I think back thats always stuck with me so I try and make sure that, when I’m dealing with patients that erm, it would be something that my dad would be proud of and.....yes...I think that hit a nerve.
Me Theres something personal that makes you want to give as good a deal as you can give
C Yes
Me At the same time you know you’re not dealing with black and white there is a grey area
C Yes
Me You do the best you can
C Yes definitely
Me There is some degree of uncertainty in doing the best you can because you want someone to say its OK
C Yes (chuckling)
Me Or do a course that says thats how you should be doing it. Its a strange business nursing isn’t it?
C It is, very
Me Because there isn’t a guarantee
C Not one patient, not one day is the same erm....its nice, I’m enjoying being a nurse and we do have really good times with patients and their relatives, you have the odd one where its quite difficult but I think you just learn from it and move on
Me Thats pretty philosophical

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C (chuckling)

Me  I think you’re right, you will have bad times, you’re working with people at very bad times and if you can be philosophical and learn from it tats grand

C  Yes

Me  It must be upsetting?

C  It is, I often go home, it takes me forever to switch off at home thinking about patients. Yes, we’ve had we’ve had quite a few that I think have hit a nerve and we’ve had a lot of good thats come out just lately , yes its......

Me  Are the patients you’re looking after with you for a while?

C  ON here they tend to be,on my previous ward they were sort of in and out quite quickly here we’ve got quite a few people on the ward who mhave been with us for ten weeks now so you get to know about them, you get to know about their family . Theres one patient whos actually written a book and I was talking to him and his wife and she brought me a copy in and I’ve read that and its about being born into poverty erm the patient was left on the doorstep of a workhouse

Me   Really?

C  Yes, him and his sister, really interesting and reading that I can understand why sometimes he acts the way he does but yes you do get to know them quite well.

Me   That sounds like extra insight though into somebodys past doesn’t it

C  Umm

Me   Sounds really interesting, the idea that they’re with you for a while and you get to know them. Do you miss them more then when they go?

C  I do some of them, I do, yes I do we’ve got one gentleman on the ward at the moment that loves to sing and he loves to sit and have a chat with you , on other wards you don’t always get that because they’re in and out and erm .....We were talking the other day and some of, my colleagues were saying that on this ward you tend to be able to chat a bit more with them and get to know them more, whether its because they’re elderly I don’t know....

Me   I think its interesting because the perception at the minute is that the elderly get a hard time

C  Umm...

Me   In the health service, that wasn’t ever my experience

C  No

Me   The experience I had was people were dealt with respectfully and dealt with as anybody else

C  Yes
Me You’re meeting them for a while, getting to know them, getting to know their families. I suppose that’s a counterbalance isn’t it for the ones where, like this gentleman is getting bad news very quickly, you know.

C Yes.

Me There is a mix there and your own experience probably does impact.

C Yes.

Me If you were thinking about this chap having to come in again and you said it was because the nursing home weren’t sure of what to….do you think they panicked?

C Yes they did, yes.

Me Because they don’t have the experience of dealing with these things or….

C I don’t know if that was the reason, they definitely panicked in bringing him in, they knew he was on the Liverpool care Pathway, they knew that he didn’t want any interventions or anything.

Me Had he said that? Do people say that?

C We have a lot of patients that will say “I don’t want anything more done” erm, they refuse to have cannulaes in they just don’t want anything more done and especially for somebody that’s on the Liverpool care Pathway, it’s about dying with dignity and if that’s their wish then you have to try and …..I know it’s hard.

Me That must be some conversation, dying with dignity and this idea of a pathway.

C Yes.

Me “We can do this for you in the last couple of weeks” is it a couple of weeks of a programme?

C Yes, it tends to be, it gets reviewed every three days if the patient starts picking up, we have had on occasion where the doctor has taken the LCP away and erm the patient has gone home.

Me Does it bring special funding with it or something? Is it…

C No, when they’re being fast tracked home they get special funding if they’re going home, to their own home, they’ll get all the equipment in they’ll get the nurses in throughout the day, they’ll get night sitters in so it’s a lot of funding that gets put into place.

Me Right so there are resources around if this pathway gets put into place and it helps people to get home?

C Yes.

M It must reinforce for them though the idea that they’re soon going to be dead.

C Umm.
Me: Do they express that, do people say “is that at the back of their minds somewhere?”

C: I’ve not heard it from this particular gentleman but I have heard it on previous occasions where patients say “I’m not going to be here much longer”

Me: What’s your answer to that?

C: It’s difficult, we always, I think, if you speak to other nurses we always tend to say, oh you know, I don’t know,

Me: It is the darker side of nursing isn’t it?

C: It is, I don’t think we deal with that very well

Me: I don’t know that you can, you do the best you can, there isn’t a guidebook telling you what to do

C: No, I don’t think there is

Me: So people, bad times, they’re getting bad news, you’re dealing with them in a supportive way you’re giving them information anything else?

C: No not that I can think of, I’ll probably think of something when you’ve gone

Me: Do you sit down and have normal conversations

C: Yes, yes

Me: Just a chat, and the focus doesn’t have to be on work

C: No, we talk about family, I often get asked if I’ve got any children and yes we talk about loads of other things

Me: So people express an interest in your life as well

C: Yes, yes

Me: Do you tell them stuff?

C: I do yes, I don’t tell them all the intimate stuff (chuckling) but I tell them I’ve got a son and yes

Me: That’s helpful in developing a relationship?

C: I think it is, it’s a bit of give and take I think erm I think especially in the elderly they like to, I think they like to know about your family whether you’ve got any children and grandchildren and I don’t see any harm in telling them that

Me: Oh no, it’s just human stuff, the things you would do anyway in a conversation

C: Yes

Me: When they go, if it’s been traumatic, is there any kind of support for you? What do you do with that, or is it just a matter of on to the next one?
C I think it is on to the next patient. I don’t think you have erm a lot of time, you don’t have time to stand and think about it. I get the bus home and I sometimes get the bus into work but when I’m on the early shift I get the bus home and I tend to use that time just to sit and think about, do a bit of reflection on to patients, on how the day has gone, we do occasionally talk between ourselves as colleagues do about different patients and what we feel is done and....

Me In a colleagues chatting kind of way, its not a formal....

C Yes, No no

Me Sort of informal

C Yes

Me The bus ride home gives you a bit of time and distance....

C To reflect yes

Me Would it be useful to have a morer formal kind of support?

C I think in some circumstances yes , yes it would

Me There is some research around isn’t there on supervision but it doesn’t seem to be very prevalent to me

C No erm, if I think back to days when I worked on 7B and with it being cardiac and respiratory we would often have quite a few “arrests” (heart attacks) and I’ve been through quite a few traumatic ones and we, after the arrest, the staff that been dealing with it we’d tend to just speak with each other and sometimes it would be nice to have somebody else come and talk to you and discuss what you had done, what you could have done,

Me Not blamne you though

C No, no

Me With the health service I would wonder whether....

C (chuckling) Yes , I did have Jan from Resus come up once we’d had a chap that did “arrest” and I was quite upset about it because he was quite a young chap and he did come up and have a chat with me and I did find that that was good

Me I’ve met people who have spent time in A+E , students, and they’ve had problems and they said he was very good they spoke very well about the support they got

C Yes

Me So it does seem to be that it isn’t punitive , it would be useful that kind of support on a regular basis

C Yes
Me: So, all in all it's a matter of dealing with it, learning from the experience and moving on to the next one?

C: Yes

Me: There is always a next one

C: Yes, yes

Me: I don't suppose you can afford to let people stay in your mind can you?

C: I think you always have the few that do I think you'll find with a lot of the staff in the NHS that there's always the few that stick in your mind and at some point you might, whether you see them admitted into hospital again or, you see them in the newspaper, you often hear staff saying "Oh, have you seen so and so is dead" so there is people that stick in your mind yes I don't think that you ever completely forget them

Me: I'm thinking just now of somebody that I knew twenty seven years ago so I think you're right, there is that element

C: Yes

Me: for one reason or another of people staying in mind

C: Yes

Me: Is there anything you want to ask me I'm aware I'm keeping you?

C: No you're all right, erm, tell me a bit about your thing that you're doing

Me: What I'm doing is research for a doctorate its with Manchester and the stuff that you've signed (consent forms) is linked to that what I'm interested in and its going to sound queer this is whether you use, or what communication skills you use in your dealings with people and what I'm beginning to find is that most people never mention communication skills you've not mentioned communication skills in our conversation and that about half the people I've met relate their desire to do well by people to experiences they've had themselves

C: Yes

Me: So when you mentioned your dad that isn't ast all uncommon, and the idwea that you deal with things as well as you can but still wonder whether they could be done better is common as well and I don't know whether that's because nurses are self critical or because they worry

C: Yes

Me: About....

C: Whether they've done something wrong! (chuckling)

Me: Yes, I don't ask about those things they come out in the conversation. So, what I should be able to do in the end is identify the things that are present in the stories
people tell me that relate to what underpins the communication between yourselves and patients, does that make sense?

C Yes

Me Thats what I'm doing

C Yes

Me It shouldn't be too intrusive, it does mean people can remember things that are sad but I ask people if they mind talking about it

C You'll have to let me know when you've done it

Me What I'll do now is transcribe this and send it to you, a copy of the transcript

C Right OK

Me And you have the chance then to say it's accurate or no it's not accurate and you have the chance to take anything out you don't like

C Right

Me In any case it won't be analysed until you say the transcript is all right and the analysis will come back to you as well, I'll send it by email

C Right

Me There won't be any mention of yourself, not that there's anything you've said which is problematic but, you're completely divorced from.....

C Yes

Me You won't be able to be identified within the process. This stuff gets shared now with two other people one is my supervisor and the other one is one of colleagues and they're looking at it to make sure my analysis is OK

C Yes

Me Thats it, thats as far as it goes

C Very good

Me Thank you very much

C No trouble

Me I'll switch this off and get out of your way.