CRITICAL CARE NURSES' PERCEPTIONS OF CARING: A PHENOMENOLOGICAL STUDY

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BY

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To the Provost of the Graduate School:

I am submitting herewith a dissertation written by Wendy J. Barr entitled "Critical Care Nurses' Perceptions of Caring: A Phenomenological Study." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

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ABSTRACT

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The present study investigated critical care nurses' perceptions of caring and the factors which influence caring. Fifteen registered nurses who were actively employed in the critical care setting were interviewed. Two open-ended questions and appropriate cue questions were asked during the interviews. The interviews were tape recorded and then transcribed by the researcher. The data from the transcription were analyzed according to the steps outlined in the Colaizzi (1978) method.

Analysis of the data yielded findings which included (a) the description of a model for caring in the critical care setting and (b) identification of factors which positively and negatively influence caring in the critical care setting. Critical care nurses described eight major concepts which comprise the model for caring: (a) totality of care, (b) priority of care, (c) nature of caring, (d) the blending of attitude with action, (e) recognition

of patient's individuality, (f) family involvement, (g) teaching and communication, and (h) patient perception of outcomes.

Positive factors which influence caring in the critical care setting included patient progress, positive patient and family interaction, nurse's knowledge and experience, nurse receiving support of colleagues, nurse's personal attraction to some patients, expanded visiting hours, and adequate staff and work environment. Examples of negative factors which influence caring in the critical care setting were difficult or confused or noncommunicating patients, absent or hostile or uncooperative families, lack of continuity in patient care, nonsupport from colleagues, nurse's fear of some disease conditions, economic conditions, bureaucratic forces, and inadequate patient assessment data.

The findings of the study suggested several avenues which could be explored to improve caring in the critical care setting such as increased family involvement, adequate orientation and continuing education for nurses, provision of support systems, better planning of the physical plant of critical care units, increased usage of step-down units in the critical care setting, and revision of patient assessment forms.

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CHAPTER 1

INTRODUCTION

The study of the phenomenon of caring is of vital concern to nursing and provides many avenues for research during this time of rapid technological advances and escalating health care costs. According to Leininger (1981c), "caring is the central and unifying domain for the body of knowledge and practices in nursing" (p. 3). Despite statements such as this and the fact that the term "caring" has been in the nursing literature since the time of Nightingale, caring has not been well-defined or operationalized, and the factors which influence caring have not been clearly delineated. It has only been recently that a small cadre of nurses has begun to attempt to define caring and to look at the scientific and humanistic implications of this concept.

A great deal of work is needed in the area of caring if nursing is to maintain its hold on an element which truly distinguishes nursing from other health professions. Leininger (1984a) claimed that other disciplines recognize nurses as "exquisite caregivers." Nursing must preserve

this position, or there may no longer be a need for the profession. Nurses must clearly describe and define caring and investigate factors which serve to promote or inhibit caring.

Problem of Study

The problem of this study was given in two parts: How is caring described by critical care nurses? What are the factors which critical care nurses believe positively and negatively influence caring?

Justification of Problem

In an age when health care costs are escalating and the public demands its "money's worth," nursing must strive to demonstrate that caring makes a difference in client outcomes. In order to accomplish this goal, nursing must be able to clearly describe caring and be cognizant of factors which enhance or inhibit caring in the hospital setting. If nursing cannot justify the value of caring, it can be hypothesized that the future of nursing may be in serious jeopardy.

Leininger (1981c) elaborated on several reasons caring needs to be intensively investigated by nursing. With the rapid advances of technology, curing has been rewarded to the detriment of caring. Leininger stated:

> nursing curricula still contain far more content on medical diseases, conditions, and curative treatment regimes than nursing care or caring behaviors. Searching for the essence, nature, expressions and function of caring and its relationship to nursing care remains a major area of investigation. (p. 6)

Depersonalization of human beings has become common in the hospital setting, while hospitals have been plagued by economic, legal and political constraints. By increasing the study of caring and the factors which affect caring, the nursing profession could instill renewed interest in human caring in the hospital setting. A final point cited by Leininger was that nursing has never systematically studied caring since its inception. The time has come to study the attribute which is believed to form the basis of the profession.

Gustafson (1984) discussed several factors that may have a negative influence on caring in nursing including a possible inappropriate perception of caring in today's society; lack of energy on the part of nursing to achieve "ideal" caring; economic and political devaluation of caring; historic traditions passed down through hospitals and schools of nursing; "notions that caring requires exceptional motivation and does not command commensurate reward; and notions regarding the secondary importance of

women and caring attitudes and behaviors in our society" (p. 71). If Gustafson is correct in her evaluation of these factors, nursing has a difficult task to accomplish before caring can be viewed as a valuable concept for the profession.

Watson (1979) faulted nursing education and practice for concentrating on the technical aspects of nursing rather than on an understanding of the relationship between health, illness, and human behavior. Watson stated that

> the educational and practice situations in nursing often prevent or at best discourage the nurse from being too sensitive to or getting too involved with another's feelings. As a result, the nurse often forms impersonal, detached professional relationships, in which she or he hides behind a so-called professional character armor. (p. 17)

In her more recent work, Watson (1985) stressed that nursing is being profoundly affected by technological, bureaucratic, and economic changes within the health care system. Diagnostic Related Groups (DRG's) have particularly begun to impinge on nursing practice. All of these factors have made it extremely difficult to maintain caring ideologies and caring behaviors in today's health care systems. Watson declared that "preservation and advancement of human care is a critical issue for nursing

today in our increasingly depersonalized society" (p. 29).

Statements such as those made by Watson (1979), Leininger (1981c), and Gustafson (1984) suggest that there are many factors which can negatively influence caring. There is a need to investigate these factors and to ultimately search for methods which will diminish the effects of factors which inhibit caring in the hospital setting.

Theoretical Framework

Leininger is the primary nurse theorist in the area of caring. She has written extensively on caring from a nursing/anthropological view and has established the importance of caring for the profession of nursing, and for mankind in general.

According to Leininger's (1981c) framework, caring is cross-cultural and is essential for human development and survival. Leininger maintained that caring is a "generic construct" of human services and forms the basis of "health care services" (p. 4). Leininger's world view approach to caring held that both scientific and humanistic aspects of caring are essential if holistic caring is to be provided for mankind.

Leininger (1981c) proposed a conceptual and theory-generating model for the study of caring. According to this model, cultural values, social structures, and health-illness beliefs have a profound influence on caring. Fifty-six caring constructs were outlined including comfort, support, empathy, involvement, health instruction acts, sharing, stress alleviation, touching, trust, succorance, and love.

Assumptions of Leininger's (1981c) theory include the following statements:

1. Caring acts and processes are essential for human development, growth and survival.
2. Caring should be considered the essence and unifying intellectual and practice dimension of professional nursing.
3. To provide therapeutic nursing care, the nurse should have knowledge of caring values, beliefs, and practices of the client(s).
4. Caring behaviors and functions vary with social structure features of any designed culture.
5. There can be no curing without caring, but there may be caring without curing. (p. 11)

Leininger (1981c) offered several hypotheses or theoretical statements as avenues for research on caring processes and behaviors. One of Leininger's hypotheses--"the greater the signs of technological caregiving, the less signs of interpersonal care manifestations"

(p. 12)--was of particular interest in this study. Since the critical care unit provides the highest level of technology in the hospital setting, Leininger's hypothesis led to the inference that critical care nurses would be more interested in technological caregiving than in the interpersonal aspects of nursing care. This study sought to support or refute Leininger's hypothesis regarding the relationship between technological caregiving and interpersonal care manifestations.

Assumptions

The assumptions of the study were the following:

1. Caring is central to nursing practice (Leininger, 1981c).

2. Caring is an interpersonal activity (Leininger, 1981c).

3. "Caring has biophysical, psychological, cultural, social, and environmental dimensions which can be studied" (Leininger, 1981c, p. 11).

4. Caring is an important component in the practice of critical care nursing.

5. There are common, consistent factors which impact caring in the critical care setting.

6. Critical care nurses are able to describe caring from a personal perspective and to identify factors which influence caring in their practice.

Definition of Terms

The following terms were defined for this study.

1. Caring--"Those assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (Leininger, 1981c, p. 9).

2. Perception--insight, intuition, knowledge, and comprehension pertaining to the concept of caring.

3. Registered nurse--a licensed individual with a diploma, Associate Degree, or Bachelor of Science degree in nursing, who is currently employed full- or parttime in a critical care setting.

Limitations

The following limitations of the study were identified.

1. Generalizability of the findings of this study are limited to populations with characteristics similar to those of the sample described in the study.

2. The participants in the study were selected on a nonrandom basis.

3. The possibility exists that participants who were interviewed in this study responded in a particular manner because they were aware that they were part of a study.

4. There is a possibility that subjective bias was introduced during interview sessions due to unconscious facial expressions/voice tones of the interviewer.

5. Phenomenological analysis of data requires a certain amount of subjective interpretation on the part of the researcher. Unconscious bias may have entered into the interpretation, despite the researcher's efforts of bracketing.

Summary

The nursing profession acknowledges that caring is central to the practice of nursing. However, caring remains an abstract concept which has not been clearly described or operationalized for the clinical practice of nursing. Nursing researchers are recognizing the need to explore the phenomenon of caring and expand the theory and knowledge base of this vital concept. This study sought to contribute to the knowledge of caring by describing caring and identifying factors which influence caring in the critical care setting. Chapter 1 presented a theoretical framework and assumptions for the study. Specific study terms were defined and limitations were stated.

CHAPTER 2

REVIEW OF LITERATURE

The terms caring and nursing care have been discussed directly and indirectly in the nursing literature for more than 100 years. Despite this fact, the phenomenon of caring has not been extensively studied until recently. While the majority of the work on caring has been accomplished by nursing, caring has also been described and defined by members of other disciplines including philosophy and psychology. The literature presented is divided into sections: writings by non-nurses, articles by nurses, research studies by nurses, and a review of two articles by lay persons.

Writings by Non-Nurses

Gaylin (1976), a psychologist, stated that humans are caring people and respond to the helplessness in others. According to Gaylin,

> man cares because it is his nature to care. Man survives because he cares and is cared for. . . . But the goodness in men is no theory. It cannot be a product of culture because no species constructed as peculiarly as man could have survived to a point of culture without possessing at its core a supremely loving nature. Rather, we must see our culture and institutions themselves as being derived from the caring aspects

> of our species' nature. Civilization is, at least in part, a form of crystallized love. (p. 13)

Mayeroff (1971), a philosopher and author of On Caring, described caring as a process which allows another to grow and self-actualize. Mayeroff submitted,

> Caring is the antithesis of simply using the other person to satisfy one's own needs. The meaning of caring I want to suggest is not to be confused with such meanings as wishing well, liking, comforting and maintaining, or simply having an interest in what happens to another. Also, it is not an isolated feeling or a momentary relationship, nor is it simply a matter of wanting to care for some person. Caring, as helping another grow and actualize himself, is a process, a way of relating to someone that involves development, in the same way that friendship can only emerge in time through mutual trust and a deepening and qualitative transformation of the relationship. (p. 1)

C. Rogers (Meador & Rogers, 1979) included the concept of caring in his theory entitled "person-centered therapy." The central hypothesis of Rogers' theory is that "the growthful potential of any individual will tend to be released in a relationship in which the helping person is experiencing and communicating realness, caring, and a deeply sensitive non-judgmental understanding" (p. 131). In other words, a genuine, caring, and understanding therapist can be effective in the positive growth of another individual. Rogers espoused the view that caring has both direct and indirect components. The

direct component of caring is related to therapeutic actions while the indirect component is related to the attitude of the therapist.

Articles by Nurses

Long (1972) discussed caring for and caring about gerontological patients. According to Long, an individual requires more "caring for" when he is in a dependent state. "Caring about" an individual is also extremely important, "for only as an individual feels wanted and needed and feels he is contributing something worthwhile will he find meaning in his life" (p. 4).

Orem (1980) described nursing as a helping profession. Orem stated that nurses choose caring actions in order "to help individuals or groups under their care to maintain or change conditions in themselves or their environments" (p. 5).

Carper (1979) addressed the ethical implications of caring. Carper asserted that nurses have an ethical obligation to provide caring for their patients. However, Carper pointed out that the levels of specialization and technology which are present in today's hospitals have resulted in depersonalization and fragmentation of the care patients receive. According to Carper, patients

frequently describe that they do not feel cared for in the hospital setting.

Bevis (1981) described caring as an essential ingredient of life. According to Bevis, caring requires three elements: "commitment to caring as an important aspect of life, lifelong study of the theory and philosophy of caring, and continual practice of caring for and about people, events, and the progress of society" (pp. 49-50). Bevis discussed several factors which affect caring behaviors including cultural values, social expectations, cost in terms of energy and renumeration, maturational level of the individual, stress levels, and time. When time is short, two types of behavior can occur. Persons either attempt to reveal themselves more quickly and more intensively, or persons use the lack of time as an excuse not to get involved.

Hyde (1975) wrote a series of articles on caring in which she stressed the need for extensive research pertaining to caring. Hyde proposed that nurse researchers interested in caring should investigate the definition of caring, theoretical implications, evaluation and measurement of caring, the relationship between caring and curing, caring outcomes, the expectations of the provider and user, settings for caring, and support systems for

those involved in caring. Hyde's suggestions provided many challenges for nursing researchers.

Parse (1981) submitted that phenomenology is an appropriate method to study caring. She discussed caring in relation to three essential elements: "risking, being-with, and moment of joy" (p. 129). Parse suggested that in caring, nurses must be willing to take risks and to endure possible suffering. Parse pointed out that there must be increased focus on caring at both the undergraduate and graduate levels of nursing education.

Research Studies by Nurses

Leininger (1981a, 1981c) expressed the view that the term caring has been employed in nursing for more than a century with no real knowledge base for this term. Leininger proposed that nursing must focus on caring in the areas of research, teaching, and practice so that caring can be more clearly explicated and forces which influence caring can be identified. Leininger viewed caring as cross-cultural and stated that caring patterns follow the social structure features of a culture. Westernized nurses seem to rely on technological and psychophysiological actions in order to assist their clients. Leininger (1981c) believed that "caring behaviors appear more important than curing in recovery of

clients, but receive less economic and social reward than curing by physicians" (p. 14).

There were many factors which Leininger (1981b) discussed as influences on caring in today's hospitals. Included in these factors were increased usage of electronic monitoring equipment, poor working conditions, "paper work, meetings, salaries, diverse role expectations, shortage of nursing staff" (p. 139) and nursing administrators who are not committed to nursing care. Leininger also stated that several older nurses believed that nursing care was more technical and less personal than in the past. She further asserted that "much of nursing dissatisfaction and burnout today is directly related to nurses not being able to give care in the fullest way desired and to receive positive rewards or recognition for their caring activities and efforts" (p. 140).

Leininger (1984b, 1984c) elaborated on factors which continue to influence caring such as social, political, economic, and religious values of a culture; increased dependency on technology; lack of caring content in nursing curricula; value placed on caring by individual nurses; lack of time to provide caring with increased time focused on medical regimens; dehumanizing practices of

hospitals; lack of a budget item for caring; influence of education such as liberal arts, philosophy, and anthropology; and the view that caring is too feminine. Leininger suggested that it might be possible to shock nursing into caring by highlighting some of the noncaring behaviors of nurses.

Watson (1979) viewed nursing as the science of caring in which there is a balance of scientific and humanistic aspects of care. According to Watson, one must know oneself before effective caring is possible. Caring involves true concern for another individual and the desire to assist the other individual to achieve mental, physical, sociocultural, and spiritual well-being. Watson stated that role modeling can influence caring, particularly the role modeling which occurs between nursing student and nursing educator. Watson claimed that a person's philosophy and values exert an influence on caring behaviors. Watson called for consciousness raising as a means of developing one's philosophy and values.

Watson (1979) developed and described 10 primary carative factors which form the basis for understanding nursing as a science of caring. The carative factors are:

1. The formation of a humanistic-altruistic system of values
2. The instillation of faith-hope
3. The cultivation of sensitivity to one's self and to others
4. The development of a helping-trust relationship
5. The promotion and acceptance of the expression of positive and negative feelings
6. The systematic use of the scientific problem-solving method for decision making
7. The promotion of interpersonal teaching-learning
8. The provision for a supportive, protective, and (or) corrective mental, physical, sociocultural, and spiritual environment
9. Assistance with the gratification of human needs
10. The allowance for existential-phenomenological forces. (pp. 9-10)

Statements and assumptions of Watson's (1979) science of caring framework include the following:

1. Caring (and nursing) has existed in every society.
2. A caring attitude is transmitted by the culture of the profession as a unique way of coping with its environment.
3. Caring consists of carative factors that result in the satisfaction of certain human needs.
4. Effective caring promotes health and individual or family growth.
5. Caring is more "healthogenic" than is curing. The practice of caring integrates biophysical knowledge with knowledge of human behavior to generate or promote health and to provide ministrations to those who are ill. A science of caring is therefore complimentary to a science of curing.
6. The practice of caring is central to nursing. (pp. 8-9)

The statements and views generated from Watson's science of caring parallel and compliment Leininger's (1981c) theoretical framework.

Gaut (1984) generated a theoretic description of caring through use of philosophical analysis. Five conditions are needed for caring to exist: (a) awareness, (b) knowledge, (c) intention, (d) change, and (e) criterion welfare of X.

The action descriptions for caring were summarized by Gaut (1984) in the following manner:

1. The nurse identifies goals based on patient needs with an overall goal being a positive change in the patient.

2. The nurse selects techniques to implement the attainment of goals.

3. The nurse acts and accomplishes the goals.

Gaut (1984) emphasized that caring is a "mediated action, accomplished through many other activites" (p. 41).

Griffin (1983) conducted a philosophical analysis of caring and proposed the belief, parallel to C. Rogers, (Meador & Rogers, 1979) that caring has two complementary components, an activities component and an attitude component. The activities component arises from the direct nurse-patient relationship and encompasses helping

or assisting a patient, as necessary. The attitude component involves three aspects--moral, cognitive, and emotional. According to Griffin (1983), the moral and cognitive aspects are not optional in nursing, while the emotional aspect is not a strict obligation and often depends on the nurse's personal development and the constraints of the work situation.

Griffin (1983) submitted that when caring is present in the nurse-patient relationship, there is "a clinical assessment of what is required, the cognitive and moral recognition of importance of the patient as a person, and significantly, the emotional element, motivating and energizing the act, and licensing us to call it caring" (p. 292). In Griffin's view, there are several benefits which the nurse receives from caring: enhancement of life, expanded knowledge, and an increased sense of personal worth. Griffin held that a sustained nurse-patient relationship is necessary for true caring to evolve and called on nursing education to recognize this expanded concept of caring, as beneficial to the giver as well as the receiver of caring.

Gardner and Wheeler (1981a) conducted a study to determine (a) supportive nursing behaviors perceived as important by nurses and patients, and (b) congruence

between nurses' and patients' perceptions of supportive nursing behaviors. Gardner and Wheeler formulated a questionnaire in which patients and nurses were asked to rate the importance of supportive nursing behaviors on a 7-point Likert scale. Behaviors included activities directed toward physical, social, emotional, and cognitive needs of patients.

Gardner and Wheeler (1981a) reported that patients and nurses disagreed to a significant extent on the importance of 35% of the items.

> Nurses tended to perceive listening and discussing patients' feelings as relatively more important than patients did; and patients tended to perceive receiving physical care administered adequately and on time, and the nurse being friendly as relatively more important than the nurses did. (p. 112)

Gardner and Wheeler's study suggested that caring can be affected by an incongruence of expectations between the nurse and the patient.

Gardner and Wheeler (1981b) stated that the following variables may also influence the nurse's ability to give support: "the emotional and personal concerns of the nurse, the amount of time the nurse usually gives to patients, her knowledge and skills, and the receptiveness of the patient" (p. 70).

Larson's (1984) investigation of caring compliments the studies conducted by Gardner and Wheeler (1981a, 1981b). Larson (1984) employed a Q-sort to determine which caring behaviors were perceived as most important by patients with cancer. In Larson's study, patients reported that clinical competency behaviors of nurses were more important than psychosocial skills, such as listening and talking, which were perceived by nurses to be the most important caring behaviors. Larson proposed that "perceptions of caring appear to be somewhat influenced by the setting in which the nurse-patient interactions occur and whether one is the enactor or the recipient of care" (p. 47).

Ray (1984) conducted a study in order to (a) determine caring values of hospital employees and (b) develop caring patterns and trends. Ray's was an extensive study which utilized participant observation, interviews, and questionnaires. There were 192 participants. The study led to the development of a classification system of institutional caring which included psychologic, practical, interactional, and philosophic behaviors.

There were several important findings in the study by Ray (1984). Licensed practical nurses listed slightly more caring responses than registered nurses. In

addition, "although the 'humanistic' dimensions of caring were declared by nurses and others to be the highest-ranking category, participant-observation research strategies revealed that the technological, political, economic, and legal systems were dominating the hospital caring culture" (p. 109). Ray hypothesized that nurses may not exhibit caring behaviors because they are not rewarded for caring. Furthermore, humanistic caring was not viewed by nurses to be the most rewarding or fulfilling role. Many nurses reported an interest in leaving nursing for professions with fewer stresses and better benefits. Other nurses reported a conflict between personal caring ideologies and the economic bureaucracy of the hospital. Additional factors believed to affect caring included a "shift from 'other-oriented' service to more 'self-centered' interests" (p. 107), the incongruence between amount of responsibility and the reward system, and lack of communication.

Ray (1984) emphasized that although there is evidence of a structure of institutional caring, this structure has not brought optimism or growth for the nursing profession within the hospital setting. According to Ray, nursing must expand its humanistic caring component in order for the profession to survive. She concluded that "the

tension that exists between the ideal elements of humanism and the material structure of bureaucracy offers the greatest challenge to nursing" (p. 111).

Weiss (1984) conducted a study to determine which verbal and nonverbal caring behaviors and technical competency and incompetency behaviors were perceived as caring by male and female subjects. In general, Weiss discovered that females responded more readily to verbal and nonverbal behaviors, while males were more attuned to the nurse's technical competency. This finding suggested gender of the client is a factor which can influence caring in the nurse-client relationship. Some of the conclusions which Weiss reached included the suggestions that schools of nursing need to be more careful in choosing instructors to teach verbal and nonverbal skills, and hospitals need to place an economic value on verbal and nonverbal caring behaviors. Weiss also proposed that "additional studies could be carried out in relation to nursing evaluation tools to include or increase the amount of verbal and nonverbal nurse behavior" (p. 180).

Riemen (1983) conducted a phenomenological investigation of the "essential structure of a caring nurse-client interaction" (p. 3) from the perspective of the client. Riemen described a caring interaction as one which may

very often be voluntary and unsolicited by the patient, during which time the nurse sits down with the patient and really listens to his concerns and responds to him as a unique individual. Riemen's subjects appreciated "being recognized by the nurse as a unique, thinking, feeling human being" (p. 74) and experienced physical and mental "relaxation, comfort, and security" (p. 70) as a result of having their needs recognized and responded to by the nurse.

Hospital administrators have also recognized the need for studying and improving caring in the hospital setting. In an article by Rubin (1985), one administrator was quoted as stating, "'I think hospitals have just become too institutionalized. I think we've lost that caring attitude in health care'" (p. 19a). Hospital administrators have increasingly recognized the value of caring, particularly with the decreased hospital censuses and the competition facing the health care industry (Barr, 1985).

Articles by Lay Persons

The lay public has also voiced both positive and negative views of the caring prevalent in health care settings. Jaret (1984) wrote of the valuable caring which home-health care nurses provided when his mother was dying

of cancer. "Their care and compassion was one of the few blessings we could count on during those last terrible months" (p. 16). According to Jaret, the caring of the nurses served to support the family through the crisis and helped everyone involved to assist his mother in dying with dignity.

Switzer (1985), a lay person, described the uncaring treatment received by patients in the American hospital setting. Switzer's mother died in a top university-affiliated hospital, and Switzer described her mother's hospital treatment as "not only inadequate but humiliating and uncaring enough to break her spirit and deprive her of the will to live" (p. 47).

Switzer (1985) submitted that there is a lack of courtesy, humanity, and concern in today's hospital setting. Switzer attributed the problems of the health care system to the quality of today's medical education, medical economics, overuse of technology and laboratory tests, ambiguous role of nurses, overwhelming amount of paperwork, and the uncaring manner with which demanding or cantankerous patients are treated. Switzer recognized the fact that there is an abundance of physicians and hospital beds in many areas of the United States. This fact has led to competition among hospitals and, hopefully, will

serve to return the feelings of warmth and caring to today's technologically advanced health care institutions.

Summary

Review of the literature pertinent to caring demonstrated that caring has been described in a variety of ways. Mayeroff (1971), Gaylin (1976), and C. Rogers (Meador & Rogers, 1979) provided nursing with powerful justification for the importance of caring in professional nursing practice.

Nurse authors have written that caring has been influenced by changes in the health care system. Rapid advances in specialization and technology have resulted in depersonalization and fragmentation of care. Despite this fact, nurses have an ethical obligation to provide caring for their patients. Caring is essential to personal health and development and can be expressed through helping behaviors and the presence of the nurse.

Nurse researchers have investigated the meaning and components of the phenomenon of caring, the factors which influence caring in various cultural and technological settings, and the congruence of patients' and nurses' views of essential caring behaviors. Lay persons have addressed the quality of caring which is offered in

today's health care settings. There were conflicting views expressed in the lay literature. One view was that caring nurses were the main support for a dying patient and her family. Another view was that patients are receiving uncaring, inadequate, and humiliating treatment in the American hospital setting.

The literature indicated agreement regarding the general description of caring. Caring was considered to be essential for growth and survival and was of great import for nursing. There was a concensus, however, that a multitude of factors impinge on nursing's ability to provide optimal caring in the modern health care setting.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The phenomenological research method was utilized in this study. Phenomenology is a philosophy as well as a research method and has developed as a result of the failure of traditional scientific methods to understand the human being as a whole. Omery (1983) described the phenomenological method as "an inductive, descriptive research method . . . which attempts to study the human experience as it is lived" (p. 50). The researcher utilizing the phenomenological method must approach the study with no preconceived categories, expectations, or operational definitions. Bracketing is employed by the researcher. Bracketing was defined by Davis (1978) as "suspending assumptions or the 'reduction' of concepts to a point where the observer can obtain a pure apprehension of experience" (p. 189). The purpose of bracketing is to prevent the researcher from imposing preconceptions on the meaning of an experience as <u>lived</u> by another individual.

The phenomenological researcher attempts to understand the data obtained in the study from the

participant's perspective of the experience. The researcher strives to understand the subjective perceptions of the participant as well as the effect of these perceptions on the participant's lived experience. The goal of the phenomenological method, as outlined by Omery (1983), is to "describe the total systematic structure of lived experience, including the meanings that these experiences had for the individuals who participated in them" (p. 50).

This study utilized the phenomenological method to investigate (a) the meaning of caring for critical care nurses and (b) the factors which critical care nurses believe positively and negatively influence caring in the hospital setting. Prior to the study, registered nurses had not been asked to delineate factors which they personally believe influence caring. Gustafson (1984) pointed out that there has been limited self-reporting by nurses regarding caring and motivation for caring. Since registered nurses are the individuals directly responsible for providing caring and care for hospitalized patients, they have the greatest potential to impact caring in the hospital setting. Consequently, their views on caring and the factors which enhance or inhibit caring were considered to be an essential source of data for this study.

Setting

The participants in this study were interviewed in their homes or another mutually agreeable setting. The pheomenological interview methodology required settings which were quiet and free from interruptions. All of the participants, except one, were interviewed outside the hospital setting so that time and environment were not constraining factors during the interviews.

Population and Sample

The sample for the study was drawn from the population of critical care nurses currently employed in general hospitals located in a metropolitan area of the southwestern United States. Of that group, a sample of 15 nurses was obtained. To be eligible for inclusion in the study, an individual had to meet the following criteria:

1. Licensed registered nurse in the state of Texas.
2. Currently employed full- or part-time on a critical care unit.
3. Willing to participate in an interview of 30 minutes to 1 hour.

A nonrandom sampling technique was employed in the study. When using this technique, available persons or persons who self-select themselves are used as study

participants (Polit & Hungler, 1983). Nonrandom sampling is justified in phenomenological research since phenomenology is a qualitative methodology which does not require statistical analysis nor bias-free selection. Furthermore, the scope of the study was limited to a sample of critical care nurses so that some reasonable conclusions could be drawn about caring in the critical care setting. According to Waltz and Bausell (1981), limiting the scope of a study to a much smaller unit "affords the possibility of drawing some reasonable conclusions regarding that unit with the attendant possibility of tenuously generalizing to other, similar units" (p. 38).

Protection of Human Subjects

In order to comply with the rules and regulations of the Human Subjects' Review Committee at Texas Woman's University, the following steps were taken.

1. Permission was requested and given by the Human Subjects' Review Committee and the Texas Woman's University Graduate School (Appendix A).

2. Prior to the interview, each participant was given a cover letter (Appendix B) which explained the purpose of the study and any potential risks involved in participation.

3. Participants were requested to sign Form B (Appendix C) as written consent to participate in the study and Form C (Appendix D) giving permission for tape recording of the interviews.

4. Participants were assured that confidentiality and anonymity would be maintained as their names would not be included in the written report of the study and tape recordings would be erased immediately after transcription of the interviews.

Instruments

Instruments developed by the researcher were utilized in this study. Demographic data (Appendix E) were obtained prior to the interviews in order to assist participants in feeling more at ease with the interviewer. Two open-ended questions (Appendix F) were asked of each participant. As needed, cue questions (Appendix G) were employed during the interviews. Interview questions were derived from the review of the literature, discussions with colleagues, and the researcher's personal experience with caring.

Validity and Reliability

Leininger (1985) discussed validity and reliability criteria for qualitative research. Leininger contended

that validity in qualitative research refers to gaining "knowledge and understanding of the true nature, essence, meanings, attributes and characteristics of a particular phenomenon" (p. 68). Leininger stated that the goal of qualitative research validity is to know and understand a phenomenon, whereas the goal of quanitative research validity is accurate measurement of a phenomenon. Leininger asserted that criterion-related qualitative validity focuses on establishing the existence and meaning of a phenomenon while qualitative construct validity emphasizes the identification and explanation of the underlying nature of the phenomenon under study.

Leininger (1985) submitted that reliability in qualitative research focuses on the identification and documentation of recurrent, accurate, and consistent features, patterns, values, meanings, or themes pertaining to the phenomenon of interest. Stern (1985), in her discussion of qualitative research, stated that qualitative reliability can be established by asking the participants to evaluate the findings since the participants are the most reliable judges of the situation under study. According to Stern, a test-retest procedure can be carried out by asking participants if they agree or disagree with statements or interpretations of previous participants.

In order to establish validity in this study, one transcription from the pilot study and the researcher's analysis of the data were sent to two validators who have doctorate degrees in nursing and have previously conducted phenomenological research. The validators concurred with the researcher's analysis of the data. An additional measure of validity was obtained by asking 4 participants to evaluate the findings during follow-up telephone interviews. All 4 participants concurred with the researcher's interpretation of the findings. Reliablity was obtained in the study by observing for recurrent patterns and themes in the data.

Data Collection

Pilot Study

A sample of five registered nurses currently employed in the critical care setting was obtained for the pilot study. This was a nonrandom sample. The sample was obtained through personal contacts and networking through friends and colleagues. Potential participants were contacted by phone at which time the purpose of the study was explained and appointments for interviews were established. All five nurses originally contacted by the researcher agreed to participate in the study. Two

participants were interviewed in their own homes, and three requested to be interviewed at the researcher's home. The interviews lasted from 45 to 90 minutes. All interviews were conducted during February, 1985.

Permission to conduct the study was approved by the Human Subjects' Review Committee of Texas Woman's University (Appendix A), and steps were taken to protect the participants' rights, as outlined in section Protection of Human Subjects. All participants consented to the tape-recording of the interview sessions. During the interviews, two open-ended questions (Appendix F) and selected cue questions (Appendix G) were asked of the participants.

All responses of the participants were recorded. At appropriate times during the interviews, questions were asked by the interviewer in order to clarify information related by the participants. After the participant had responded to the researcher's questions and ambiguities had been clarified, the interview was terminated and the participant was thanked for her participation. All tape recordings were transcribed by the researcher, and data were subsequently analyzed phenomenologically according to the Colaizzi (1978) technique. The analysis of the data from the pilot study is included in chapter 4 because of

the similarity in data from the pilot study and the major study.

Major Study

Permission to conduct the study was obtained from the Human Subjects' Review Committee and the Graduate School of Texas Woman's University (Appendix A). Following this, the same procedure for data collection which was outlined in the report of the pilot study was utilized for the major study.

Treatment of Data

Data from the study were analyzed phenomenologically according to the Colaizzi (1978) method. Colaizzi outlined a seven-step method of analysis. Colaizzi stated that his method is by no means definitive and can be modified by an individual researcher, as necessary. A description of Colaizzi's seven steps follows.

1. Read all of the data, termed "protocols," to begin to make sense out of the information.

2. "Return to each protocol and extract . . . phrases or sentences that directly pertain to the investigated phenomenon; this is known as 'extracting significant statements'" (p. 59). Repetitions or near repetitions of significant statements may be eliminated.

3. Formulate meanings by using creative insight in attempts "to spell out the meaning of each significant statement" (p. 59). As this is obviously subjective in nature, the researcher must guard against formulating meanings which have no relation to the data.

4. Repeat the first three steps "for each protocol and organize the aggregate formulated meanings into clusters of themes" (p. 59).

(a) Refer back to the original protocols to validate the clusters of themes by ascertaining that the data does indeed contain that which is accounted for in the clusters of themes.

(b) If discrepancies are noted between and/or among clusters, do not be too hasty in eliminating data or formulating a theory.

5. The results of the previous steps are incorporated into an exhaustive description of the phenomenon under investigation.

6. "An effort is made to formulate the exhaustive description of the investigated phenomenon in as unequivocal a statement of identification of its fundamental structure as possible" (p. 61).

7. A final step that the researcher may utilize is to return to participants and validate the results of the study during a follow-up interview (Colaizzi, 1978).

In the present study, four participants were requested to participate in follow-up telephone interviews in order to validate the interpretation of the data.

CHAPTER 4

ANALYSIS OF DATA

In this chapter, the findings of the study and the data analysis are presented. A description of the sample is followed by presentation of the data which are relevant to the research question. Data were analyzed according to Colaizzi's (1978) method for analyzing phenomenological protocols. The chapter concludes with a summary of the findings of the study.

Description of the Sample

The sample of the study consisted of 15 female registered nurses over 18 years of age who were currently employed in the critical care setting of hospitals located in a large metropolitan area of the southwestern United States and who were willing to verbally communicate their feelings and perceptions pertaining to caring. Five of the participants were obtained during the pilot study and 10 were obtained during the major study. Responses of all participants were combined because of the similarity of the data. The participants in this nonrandom sample were obtained through personal contact and networking through

friends and colleagues. Fifteen of the first 16 individuals contacted by the researcher met the criteria and agreed to be interviewed for the study. Demographic data of the sample are presented in Table 1.

Findings

The phenomenon investigated in this study was stated in two parts: How is caring described by critical care nurses? What are the factors which critical care nurses believe positively and negatively influence caring? Taped interviews with the 15 participants were transcribed (a sample transcription may be found in Appendix G). The transcriptions, termed protocols by Colaizzi (1978), were read several times in order to gain a beginning understanding of the participants' perceptions and feelings pertaining to caring. Significant statements were then extracted from the protocols, and repetitions and near repetitions were eliminated. The significant statements provided the raw data for analysis. Table 2 presents a sample of significant statements. (Refer to Appendix H for a complete listing of the statements.)

Meanings were formulated from the significant statements. These meanings were derived following numerous readings of the data and by reflecting on the original

Table 1

Demographic Data of Participants

Participant	Age	Level of Education Achieved	Type of Unit	Nursing Modality	Type of Position	Number Years in Position	Number Years in Nursing	Number Years in Critical Care
1	26	BSN	ICU	Case	Staff/Charge	0.8	3.5	0.8
2	28	BSN	ICU	Primary	Staff/Charge	5.5	6.0	5.5
3	26	BSN	CCU	Primary	Staff/Charge	1.0	2.0	1.0
4	26	BSN	ICU	Primary	Staff/Charge	3.5	3.5	3.5
5	30	BSN	ICU	Primary	Staff/Charge	4.0	9.0	9.0
6	25	BSN	ICU	Case	Staff/Charge	2.5	2.5	2.5
7	33	BSN	ICU	Primary	Staff/Charge	5.0	11.0	5.0
8	50	ADN	ICCU	Primary	Staff	3.0	14.0	8.0
9	24	ADN	ICU	Case	Staff/Charge	1.0	2.5	1.0
10	35	Diploma	CCU	Primary	Staff/Supervisor	7.0	13.0	8.0
11	26	Diploma	ICCU	Case	Charge	1.0	5.0	4.0
12	28	BSN	ICCU/PCU	Case	Charge	4.0	6.5	4.5
13	40	BSN	ICU/ICCU	Case/ Primary	Staff/Charge	8.0	16.0	16.0
14	28	MSN	ICU	Primary	Supervisor	0.5	6.0	4.0
15	32	BSN	ICU	Primary	Staff/Charge	6.0	10.0	8.0

Table 2

Samples of Significant Statements: Caring

	Statement
1.	Do whatever it takes for them to live--you take care of all their needs, physical or psychological.
2.	Kind manner, supportive, being there.
3.	Express a caring attitude to family members, spend some time with them and deal with how they're feeling.
4.	Being sensitive to other people's needs and trying to meet those needs as best you can.
5.	Explanation and teaching because the equipment and noises are so foreign to alot of people.
6.	Eye contact, touching would be a big part of caring.
7.	Sitting down in a chair at the bed and listening to him, and hearing what he had to say.
8.	Prioritize as to what needs attention first, as to whether it's emotional or physical.
9.	The little things--realizing they're uncomfortable, offering some juice, or rubbing their back.
10.	Knowing that the patient is alot more comfortable than he would have been otherwise.

protocols and the significant statements. The formulated meanings are presented in Table 3.

The aggregate of formulated meanings was organized into clusters of themes. These clusters of themes were derived from and were common to all of the participants'

Table 3

Formulated Meanings of Significant Statements: Caring

Statements
1. Caring involves meeting all of the patient's needs--physical, psychosocial, cognitive, and spiritual.
2. Caring for the family is as important as caring for the patient.
3. Contact with the family helps the nurse learn more about the patient as a person, and this facilitates caring.
4. It is important to take the time to sit down with the patient and discuss his needs and his care, and allow him to express his feelings.
5. Caring involves a caring action and also an attitude which indicates to the patient that someone really cares about him.
6. A caring attitude can be expressed through kindness, concern, empathy, touch, eye contact, and a gentle tone of voice.
7. Explanation of every aspect of care to critical care patients and their families is a manifestation of caring.
8. Caring helps the patient to feel more comfortable and improve his condition.
9. Caring means that each patient is recognized as an individual with unique needs.
10. Caring in the critical care setting demands that nurses accurately assess patients and address the need which is a priority at the time of the assessment.

table continues

Statements
11. Validation of needs with the patient and/or family is an essential aspect of caring.
12. A caring nurse makes an effort to communicate with patients whether they are conscious or unconscious.
13. Nurses who step aside from their routine and give of themselves are demonstrating caring.
14. Caring involves empathy or putting oneself in the patient's position to try to ascertain how he is feeling and how he wants to be cared for.
15. Just the physical presence and availability of the nurse indicates caring.
16. Nurses must be attuned to the need to allay patients' fears, since the critical care setting is so foreign to patients.
17. Nurses must assist patients to accept and adapt to situations which are disruptive to their lives.
18. A caring nurse is able to function within a bureaucracy and adapt rules and regulations in order to effectively meet patients' needs.
19. Caring is an inherent part of the nursing which many nurses practice.
20. A caring nurse does not have to perform in an extraordinary manner; caring can be demonstrated through "little things" like a conversation about the weather or brushing the patient's hair.
21. Caring can mean guiding a patient to a peaceful death, as well as to rehabilitation and recovery.
22. A caring nurse may need to act as the patient's advocate with the physician or the family, so that the patient's needs are apparent to all concerned.

table continues

Statements
23. Caring includes involving the family in the patient's care to the extent that the family wishes.
24. Caring requires that the nurse is knowledgeable regarding the patient's condition and care and that this knowledge is communicated through a written plan of care.
25. A caring charge nurse has the responsibility of assigning the appropriate nurse to a patient, so that the patient will receive optimal care.
26. A caring nurse is often perceived by peers as knowledgeable and efficient, yet empathetic, kind, and gentle.

descriptions of caring. The clusters of themes are presented in Table 4. Validation of the clusters of themes was accomplished by referring back to the original protocols to determine if there were data not accounted for in the themes or if the themes proposed ideas which could not be accounted for in the original data.

The results of the previous steps of the analysis were incorporated into an exhaustive description of the phenomenon of caring. As described by Colaizzi (1978), the exhaustive description is a statement of the fundamental structure of the investigated phenomenon. The exhaustive description of caring is presented in Table 5. A final step utilized in the study was returning to four

Table 4

Clusters of Common Themes: Caring

Theme	Statement
Totality of care	Caring requires that nursing attempts to address all of the patient's needs--physical, psychosocial, spiritual, and cognitive.
Priority of care: anticipation and validation of needs	Caring in the critical care setting demands that nurses accurately assess and validate the priority in which a patient's needs must be addressed; e.g., a patient must be kept alive before addressing cognitive needs.
The nature of caring	Caring should be a natural part of nursing care and can be expressed by simple actions, such as a smile, holding a patient's hand, or brushing a patient's hair.
Blending of attitude with action	Caring means that a caring attitude is displayed whenever a task is performed by a caring nurse.
Recognition of the patient's individuality	Caring requires that patients be treated as unique individuals with unique needs.
Family involvement	Concern for the family's needs is a priority of a caring critical care nurse.
	Communication with the family provides a vital source of patient information, particularly when caring for a patient who is unable to communicate.
	Contact with a caring family facilitates a caring nurse/patient relationship.

table continues

Theme	Statement
Teaching and communication	One of the most important aspects of caring in the critical care setting is patient and family teaching, which requires open communication and careful explanation of every aspect of care.
Patient perception of outcomes	When the patient perceives that he has been well cared for, he will feel comfortable and satisfied with his care.

Table 5

Exhaustive Description of Caring in the Critical Care Setting

Caring in the critical care setting is all-encompassing and recognizes that patients have needs which may be physical, psychosocial, cognitive, or spiritual. Before addressing these needs, a caring nurse must assess and validate which of these needs has priority and respond accordingly.

Caring does not require extraordinary actions on the part of the nurse. Rather, caring should be viewed as an inherent part of nursing care which can be accomplished by simple person-to-person interactions, such as a smile or holding a patient's hand.

A caring nurse displays a caring attitude whenever performing a nursing task. A caring attitude can be displayed through kindness, concern, touch, eye contact, and a gentle tone of voice. A caring nurse treats each patient as an individual and makes an effort to address the unique needs of that individual.

table continues

One of the priorities of caring in the critical care setting is family involvement and concern for family needs. Contact and communication with a caring family assist the nurse in learning about the patient from a personal perspective and facilitates a caring nurse/ patient relationship.

Caring in the critical care setting necessitates open communication and patient and family teaching. Since the equipment and general atmosphere are so foreign and often frightening to patients and their families, a caring nurse endeavors to answer questions and provide careful explanation of the patient's care.

The expression of caring by nurses in the critical care setting produces positive consequences. A caring nurse can assist patients through rehabilitation and recovery or guide a patient to a peaceful death.

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of the participants and requesting them to validate the clusters of themes and exhaustive description of the phenomenon of caring.

Additional data were gathered in the study pertaining to the following areas of interest: uncaring behaviors of nurses, factors perceived by nurses to promote or inhibit caring in the critical care setting, and rewards nurses perceive they receive for caring. Uncaring behaviors described by the participants are presented in Table 6. Tables 7 and 8 list factors which promote or inhibit caring, respectively. A list of the rewards which the participants stated they receive is presented in Table 9.

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These areas of data were gathered because they were identified throughout the literature (Bevis, 1981; Gustafson, 1984; Leininger,1981b, 1984b, 1984b; Ray, 1984; Watson, 1979) as directly influencing the quality of caring in nursing practice.

Table 6

Uncaring Behaviors of Nurses

Statements
1. Ignoring patients' requests or questions
2. Not spending time with patients or families
3. No consideration for a patient's individual needs
4. Talking "down" to a patient
5. Speaking to patients in an abrupt manner
6. Labeling patients
7. Yelling at patients
8. Handling patients in a rough manner
9. Not stopping to really listen to a patient
10. Taking away the patient's call light
11. Not acting as an advocate with physicians
12. Performing only routine functions
13. Talking over a patient or about in patient while in the patient's room
14. Dealing only with the equipment in the room rather than the patient himself

Table 7

Factors Which Promote Caring

Statements
Factors related to the client/family
1. Patient progresses and recovers
2. Patient provides positive feedback for the nurse
3. Positive rapport with the family
4. Family provides the nurse with personal information about the patient when he was in a well state
5. Patient is cooperative and appreciative
6. Family is appreciative
7. Family does not abuse visiting hours
8. Patient/family receptiveness to caring and suggestions from the nurse
9. Family brings pictures of the patient prior to his illness
Factors related to the nurse
1. Seeing patients recover and leave the ICU
2. Feeling that caring makes a difference in the patient's condition
3. Quality of basic nursing education
4. Knowledgeable regarding patient's condition
5. Self-confidence in ability to do the work
6. Individual personality

table continues

Statements
7. Support of peers, clinical specialist, chaplain
8. Nurse's personal example--caring begets caring
9. Preference in a work setting, i.e., surgical versus medical ICU
10. Personal attraction to some patients more than others, e.g., if a patient reminds nurse of her grandfather
11. Experience and familiarity with the work setting
12. Continuing education programs
13. If the nurse enjoys working with peers
Factors related to the environment
1. Less restricted visiting hours
2. Positive patient/family orientation on the unit
3. Adequate staffing and adequate time to spend with patients
4. Ability to really get to know patients since the nurse/patient ratio is usually 1:2
5. Primary nursing
6. Unit dose
7. Proximity of supplies; proximity of patients
8. Supportive attitude of physicians
9. A flexible supervisor
10. A well-structured work environment with clear expectations

table continues

Statements
11. Patient assessment forms which provide data on the patient's psychosocial needs
12. Increased involvement in the patient's care through patient-family-nurse-physician conferences
13. Cohesiveness of critical care nursing staffs
14. Group discussion sessions with a chaplain

Table 8

Factors Which Inhibit Caring

Statements
Factors related to the client/family
1. Absence of patient feedback related to level of illness of the patient
2. Communication barriers, particularly with confused patients
3. Chronicity and length of hospital stay
4. Patients who are hostile, nasty, or obnoxious
5. Manipulative patients
6. Patients who refuse caring from the nurse
7. Labeling of patients
8. Patients who have no visitors
9. Over-protective, irrational families

table continues

Statements
10. Families which are difficult and demanding
11. Families that are hostile and threaten nursing staff with legal action
12. Patients who are continuously calling for the nurse
13. Families who treat nurses as servants
14. Families who abuse visiting hours
15. Lack of continuity in patient care
Factors related to the nurse
1. A tense, nervous, or stern personality
2. Burnout, anger at the institution
3. Personal problems
4. Feelings of hopelessness related to the inability to help gravely-ill patients
5. Problems with peers
6. Lack of knowledge/clinical expertise
7. Feelings of powerlessness as a staff nurse
8. Feelings of frustration and the feeling that the nurse is a contributor to suffering when caring for a patient she believes should be allowed to die
9. Fear of caring for some patients, e.g., AIDS patients
10. Personal preference/attraction to some patients more than others
11. Personality conflicts with patients

table continues

Statements
12. Becoming too involved and too subjective when caring for patients
13. Loss of idealistic goals when faced with the reality of the situation
14. The belief that nurses are handmaidens who must conform to keep their jobs
Factors related to the environment
1. Inadequate and sometimes unsafe staffing
2. Lack of time to do too many tasks
3. Restricted visiting hours, leading to insufficient contact with the family
4. Amount of paperwork and constant demands for documentation
5. Anti-caring, anti-teaching, nonsupportive attitude of supervisors
6. Noise level
7. DRGs and the economic situation facing hospitals--constant reminders of cost-containment
8. Nonsupportive attitude of physicians
9. Out-of-date equipment and procedures
10. Legal and ethical issues which arise when caring for gravely-ill and "no-code" patients in a critical care setting
11. Nursing performance appraisal process which does not provide positive reinforcement or reward for caring but does reward for compliance with bureaucratic standards

table continues

Statements
12. Problems with staffing at institutions which have eliminated overtime pay
13. Lack of structure, which makes it difficult to meet routine demands
14. Inadequate supplies
15. Poorly functioning ancillary services
16. Reassignment of nursing staff to other hospital areas without consulting staff
17. Amount of equipment involved in the care of critical care patients
18. Patient assessment forms which do not address psychosocial needs of patients so that this information must be communicated orally
19. Assignment to patients who are not close in proximity
20. Number of decisions which must be made by nurses

Table 9

Rewards Nurses Receive for Caring

Rewards
1. Appreciation from patients and families
2. Gifts, cards, and thank-you letters from patients and families
3. A smile or a hand squeeze from a patient.
4. A relieved look in a patient's eyes

table continues

Rewards
5. Personal feeling of accomplishment for helping someone and seeing people get well
6. A happy patient
7. Feeling that a patient died graciously
8. Knowing the patient and family understands what has happened
9. Words of praise or encouragement from peers or supervisor that the nurse did the right thing in a difficult situation
10. Return visits from former patients
11. Recognition from physicians that the nurse is doing a good job and contributing to the patient's recovery
12. Notes of appreciation from hospital administrators who have heard something positive from patients or families
13. Belief in a reward from God for caring
14. Education and intellectual stimulation
15. Colleague relationships
16. Money
17. None, few and far between

Summary of Findings

A summary list of findings is shown hereafter.

1. Eight major concepts describe caring by critical care nurses.

a. totality of care

b. priority of care: anticipation and validation of needs

c. nature of caring

d. blending attitude with action

e. recognition of patient's individuality

f. involvement of family

g. teaching and communication

h. patient perception of outcomes

2. Eight elements portray the positive factors which influence caring in the critical care setting.

a. patient progress

b. positive patient and family interaction

c. nurse's knowledge

d. nurse receiving support of colleagues

e. nurse's own modeling of caring

f. nurse's personal attraction to some patients

g. expanded visiting hours

h. adequate staff and work environment

3. Ten components represent the negative factors which influence caring in the critical care setting.

a. difficult or confused or noncommunicating patients

b. absent or hostile or uncooperative families

c. lack of continuity in patient care

d. lack of knowledge on part of nurse

e. nurse's feelings of anger, hopelessness, powerlessness, frustration, and the condition of burnout

f. nonsupport from colleagues

g. nurse's fear of some disease conditions

h. economic conditions

i. bureaucratic forces

j. incomplete assessment data

CHAPTER 5

SUMMARY OF THE STUDY

A phenomenological approach was used to investigate critical care nurses' perceptions of caring. Chapter 5 presents a summary of the research with a discussion of the findings. Conclusions, implications, and recommendations for future study are presented.

Summary

The present study investigated critical care nurses' perceptions of caring and the factors which influence caring. Fifteen registered nurses who were actively employed in the critical care setting were interviewed. Two open-ended questions and appropriate cue questions were asked during the interviews. The interviews were tape recorded and then transcribed by the researcher. The data from the transcriptions were analyzed according to the steps outlined in the Colaizzi (1978) method.

A summary list of findings is shown hereafter.

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a. totality of care

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g. nurse's fear of some disease conditions

h. economic conditions

i. bureaucratic forces

j. incomplete assessment data

Discussion of Findings

Description of Caring

Contrary to some of the views expressed in the literature (Gaut, 1981; Leininger, 1984a), participants interviewed for the study were able to describe what caring meant to them. Furthermore, caring did not appear to be an elusive concept but rather an automatic part of the nursing care they provided for their patients.

All participants described caring in the critical care setting as a multi-faceted phenomenon which addresses patients' physical, psychosocial, cognitive, and spiritual needs. This finding coincides with the multi-faceted picture of caring described in the literature (Ray, 1984;

Watson, 1979). All participants mentioned the importance of assessing patients and establishing priorities in meeting needs. Watson (1979), Gaut (1981), and Griffin (1983) also stressed the importance of assessing a patient's needs prior to caring for the patient.

Physical needs were described as a priority by 10 of the participants. Since the participants were critical care nurses, it was not surprising that they stressed the physical needs of patients. The purpose of critical care units is to monitor and care for individuals with grave physical illnesses. As one participant stated, "the bottom line is keeping them alive." This finding suggests that critical care nurses have their priorities well in order. Nurses cannot meet the psychosocial or cognitive needs of a patient who does not survive. This finding parallels results obtained by Gardner and Wheeler (1981a) and Larson (1984). Their studies indicated that patients were more concerned with having their physical care administered adequately by a clinically competent nurse, and they were less concerned with the psychosocial behaviors of nurses, such as listening and talking. Larson (1984) proposed that perceptions of caring are influenced by the setting in which caring takes place.

Thus, it would be logical for physical caring to be perceived as a priority in the critical care setting.

Despite the emphasis on the priority of physical needs, all participants stressed that nurses must consider the emotional needs of the patient in the critical care setting. Ten participants mentioned the importance of empathy as a facet of caring. Empathy was listed by Leininger (1981c) as an essential construct of caring. The participants also stressed the importance of displaying a caring attitude so that patients would truly feel that someone cared about them. The importance of a caring attitude was mentioned in the literature (Griffin, 1983; Mayeroff, 1971; Riemen, 1983; Meador & Rogers, 1979).

Caring was further described as a process through which nurses strive to assess and treat the unique needs of individuals, so that patient needs can be adequately met and there will be an improvement in the patient's condition. Griffin (1983) and Riemen (1983) stressed the necessity of recognizing each patient as an individual with unique needs. Orem (1980) emphasized that nurses choose caring actions to help individuals change or maintain personal or environmental conditions. Gaylin (1976) wrote that one of the goals of caring for human beings is to respond to the helplessness in others.

All participants underscored the importance of family involvement, concern for the needs of the family, and family as well as patient teaching in the critical care setting. Participants expressed sensitivity to the stresses which families experience when they have a loved one in an intensive care unit. Jaret (1984) and Switzer (1985) are lay people who wrote of the influence caring can have on families. Leininger (1981a) and Parse (1981) addressed caring and families, but their orientation was from a cultural, anthropolgical stance. The impact of caring on the family who is involved in the critical care setting needs to be addressed in the nursing literature.

To summarize, the participants in the study described caring in the critical care setting as a multi-faceted action/attitude process in which patients' and families' unique needs are assessed and addressed according to priority, with the goal of improvement of a less than optimal condition.

Factors Related to Caring

Participants identified many factors which they believed influence caring in the critical care setting. Factors listed by the participants were found to be clustered into three major areas of concern: factors

related to the client and family, factors related to the nurse, and factors related to the environment. These factors are discussed in terms of positive and negative effects on caring.

Factors which promote caring. Participants expressed the view that it was easier to manifest caring to patients who provided the nurse with positive feedback regarding their conditions. Family involvement also helped to promote caring, according to all participants. Family involvement was stressed as particularly helpful when caring for comatose or obtunded patients, since the family could provide the nurse with information or pictures of the patient when he was in a well state. This finding indicated that caring is facilitated when nurses take a personal interest in the patient. This finding was supported in the literature by Griffin (1983) and Riemen (1983). An additional factor related to caring was the patient's level and type of illness. Nurses reported that they enjoyed caring for patients who showed progress and were able to be discharged in a relatively healthy state. This finding supported Gaylin's (1976) and Orem's (1980) statements that caring is important for those who need help from other human beings.

There were several factors directly related to the nurse which participants felt influenced caring in a positive manner including a caring personality, self-confidence in the work situation, adequate level of clinical knowledge and expertise, personal attraction to certain patients, role models, and support systems. Support systems which were mentioned by the participants were chaplains, clinical specialists, and peers. As one participant said, "caring begets caring." These factors indicate that caring would be facilitated if hospitals (a) require that nurses have a minimum of 1 year's nursing experience prior to working in critical care, (b) provide adequate orientation for new nurses, (c) provide support systems for nurses, and (d) utilize discretion in appointing head nurses and supervisors to critical care units, as these individuals should serve as role models for staff.

Factors related to the environment also had positive effects on the caring nurses were able to exhibit in the critical care setting. All of the participants mentioned that they have more time for caring when they are adequately staffed and do not have to rush from one task to another. The physical plant of the unit also was a positive influence if it was designed for efficiency and if patients and supplies were in close proximity. Another

factor which nurses cited was the general atmosphere on the unit--one that was less restricted in terms of visiting hours and also more patient and family oriented promoted caring. Eight of the participants additionally stated that a positive attitude on the part of a patient's physician encouraged a caring attitude toward that patient. Five of the participants discussed the fact that they believe critical care nurses have a greater opportunity to exhibit caring to patients since the nursing staffs are generally more cohesive than floor staffs and the nurse/patient ratio is usually 1:2. Five of the participants perceived that the economic crunch in hospitals would make the ratio on the general floors much worse while the ratio on critical care would remain stable.

The responses from the participants suggested that hospitals need to be cognizant of patients' and nurses' needs when planning critical care units. Units which are well-designed afford the nurse greater time and ease to exhibit caring for her patients. Physicians also need to be cognizant of the fact that when they display a positive attitude to nurses and patients, nurses are motivated to be more caring to those physicians' patients.

Factors which inhibit caring. Participants mentioned several factors related to the patient and family which had negative influences on caring. One of the main factors discussed by 11 of the participants was the lack of communication and absence of positive feedback related to the level of illness in patients. These participants emphasized that it was extremely difficult to provide caring for patients who were obtunded, comatose, confused, or on ventilators. Eight of the participants also stated that it was difficult to be caring to patients who were hostile, nasty, obnoxious, or refused the nurse's help. One nurse described a patient who had been in her intensive care unit on and off for 3 years. This patient would take himself off the ventilator and chase nurses down the hall with a butter knife. The nurse stated she had great difficulty in being caring to this patient. Families were also described as being possible negative influences on caring. Participants mentioned that they reacted negatively when families were hostile, demanding, or threatened legal action. One nurse described a patient's daughter who announced on her first visit to the coronary care unit that her boyfriend was an assistant to a lawyer. According to the nurse, the staff held back from the patient because of the daughter's implied threat.

The negative factors related to the patient and family suggest that nurses need support when caring for nonresponsive patients or when interacting with patients and families who are hostile or demanding. Nurses should be able to recognize that patients and families are acting as they are because of physical or emotional strain. At the same time, nurses are human and need to be assisted during difficult experiences.

There were several factors directly related to the nurse which tended to have negative influences on caring. A few of the factors cited were the personality of the nurse, personal problems, burnout, and feelings of frustration and hopelessness related to the inability to help gravely-ill patients. One nurse stated that she felt like a contributor to suffering instead of a helper when she knew a patient should be allowed to die. These factors further indicate the important function that adequate support systems can provide for nurses working in the critical care setting.

The participants listed a total of 20 negative factors related to the environment, which are believed to influence caring. Some of these factors included inadequate staffing, lack of time, restricted visiting hours, nonsupportive supervisors, economic situation facing

hospitals, ethical and legal issues constantly present in the critical care setting, nursing performance appraisal process which does not reward for caring but does reward for compliance with bureaucratic standards, and patient assessment forms which do not consider the patient's psychosocial needs. These factors were mentioned throughout the literature (Bevis, 1981; Gardner & Wheeler, 1981b; Leininger, 1981b, 1984b, 1984c; Mayeroff, 1971; Ray, 1984; Switzer, 1985).

Although there are many factors which cannot be altered in the critical care environment, there are several fctors which could be modified in order to facilitate caring in the critical care setting. Perhaps critical care units need to examine their stringent visiting hours as well as the retention of noncaring, nonsupportive supervisors. Hospitals need to look at the performance appraisal process afforded their nursing personnel. If hospitals are in the business of caring, why are nurses not rewarded for caring? Patient assessment forms need to be updated to include consideration for patients' psychosocial needs. The 15 participants interviewed in the study represented six different institutions. Three of those institutions had patient assessment forms which included consideration of the patient's psychosocial

needs, and three did not. As one supervisor stated, "The JCAH will force all hospitals to include it (psychosocial needs) within the next year." Hospitals should not have to be told to include something which is so basic to patient care.

In summary, there were multiple factors identified which can negatively influence caring in the critical care setting. Although it would be impossible to alter all of these factors, many could be modified so that caring could be facilitated.

Uncaring Behaviors of Nurses

All participants were able to identify uncaring behaviors of critical care nurses without difficulty. Some of the uncaring behaviors included ignoring patient requests, rushing, being abrupt with patients, handling a patient roughly, or performing only routine functions. These findings coincide with Riemen's (1983) description of a noncaring nurse/client interaction. Of importance is the fact that participants emphasized they did not feel the nurses meant to be uncaring. According to the participants, "uncaring" behaviors occurred when time was short, assignments were unevenly balanced, or patients were exceedingly confused or demanding. In discussing

confused patients, one participant stated, "there is a point at which you just snap." Switzer (1985) wrote that she had witnessed uncaring attitudes displayed toward demanding or cantankerous patients. The reality is that nurses are also human beings who may react to difficult situations in a manner which is perceived as uncaring when it was not meant to be. One participant pointed out, "we're not cloned Mary Poppins."

Five of the participants discussed the fact that uncaring behaviors may be perceived to occur when a nurse is assigned one patient who is well on the road to recovery and one patient who is bleeding and has no blood pressure. At times like this, a nurse has to be more concerned with maintaining a patient's blood pressure than with fluffing a patient's pillow. This pattern of patient assignment is unfair to both patients and nursing staff and should be examined by those in charge.

Rewards Nurses Receive for Caring

The participants were asked what they view as their rewards for caring in the critical care setting. This question was included because the literature (Ray, 1984) suggested that nurses may not care because they are not rewarded for caring.

The results of the data analysis were interesting in that only one nurse mentioned money as a reward and only one nurse said there were no rewards. Both of those nurses then went on to say that they were rewarded by the personal feeling of accomplishment gained by helping people and seeing them get well. This finding was reiterated by the other 13 participants. This finding indicated that nurses experience intrinsic rewards for caring.

Extrinsic rewards, such as appreciation from patients and families, return visits from patients, and words of praise from peers, supervisors, and physicians, were also mentioned. This finding should be noted by individuals associated with the critical care setting. It takes very little effort to give a person a smile or a word of encouragement, and these simple actions can serve to be motivating factors for caring critical care nurses.

The participants discussed the fact that they are not directly rewarded for caring by hospital administration in terms of salary increases or promotions. Nursing performance appraisals tend to focus on leadership skills, technical skills, and adherence to bureaucratic standards. This finding suggests that hospitals need to examine the performance appraisal process. Since caring is central to

nursing practice, caring must be considered in the evaluation of the professional nurse.

Conclusions and Implications

The conclusions and implications for nursing are denoted below:

1. Major areas of Leininger's (1981c) model for the study of caring were supported. The present study supported two assumptions of Leininger: (a) caring is an interpersonal activity and (b) caring has biophysical, psychosocial, cultural, social, and environmental dimensions. Leininger's definition of caring was very clearly validated: "those assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (p. 9).

2. Leininger hypothesized that "the greater the signs of technological caregiving, the less signs of interpersonal care manifestations" (p. 12). The hypothesis was not supported in the present sample of critical care nurses. The analysis of the data indicated that participants did not dwell on the technology of the critical care setting as a factor which influences caring. Only five nurses mentioned technology and equipment as a

factor which influences caring. Four of these nurses went on to state that level of technology mainly influences new nurses who are being oriented to the critical care setting. Once a nurse becomes comfortable with the critical care environment, the influence of technology becomes less important. One participant stated that once nurses become familiar with equipment, they should be able "to regroup and re-prioritize to meet the patient's need for caring."

3. The instruments used in this study encompassed questions which needed to be asked. Asking nurses to share feelings about caring in their work produced important answers for nurses and the discipline of nursing. Cue questions, some of which were derived from the framework model and some from other sources in literature, were relevant. The phenomenological approach was elegantly appropriate to the study question. The instruments employed in the study were valid indicators of the phenomenon of caring. The findings coincided with the theoretical framework. Reliability was obtained through the similarity and repetition of responses. Although the participants represented six different hospitals, their responses were very similar and frequently repetitive, indicating instrument reliability.

4. Regarding the limitations of the study, the fact that participants' responses were so similar negates the possibility that participants were influenced by being included in the research process. Additionally, the limitation that possible researcher bias may have played a part is negated by the consistency of the findings.

5. The description of caring as perceived by critical care nurses in the present sample constitutes a new model of caring for the nursing practice setting. The eight major concepts need further research to test for inclusiveness and also the nature of each. An example of such research is a systematic comparison of the new model with Gaut's (1984) description of caring, which was comprised of awareness, knowledge, intention, positive change, and criterion welfare of X.

Recommendations for Further Study

Several recommendations for future research can be made.

1. Continued testing of Leininger's (1981c) model should include an investigation of families' perceptions of caring, including the families' reactions to increased involvement in the critical care setting.

2. The description of caring which has been generated in this study should be tested. Studies should be conducted using a variety of research methods and techniques with samples of nurses in primary, secondary, and tertiary settings. An example is participant-observation and/or video-taping of nurse/patient interactions in the critical care setting as a validation of the present findings.

3. A sample of male nurses should be examined to check for differences in their perceptions of caring. The new model of caring, as defined by critical care nurses, should be compared to existing models for congruence.

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APPENDICES

APPENDIX A

Permission from Human Subjects' Review Committee and Texas Woman's University Graduate School

TEXAS WOMAN'S UNIVERSITY
Box 23717, TWU Station
Denton, Texas 76204

1810 Inwood Road
Dallas Inwood Campus

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Wendy J. Barr Center: Dallas

Address: 1412 Dreda Cr. Date: 2/28/85

Desoto, Texas 75115

Dear Ms. Barr:

Your study entitled Nurses' Perceptions of Caring and Factors Which Influence Caring: A Phenomenological Study.

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

_____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

__X__ Other: To the cover letter add provision for the following rights of human subjects.

1. Contact person(s) for questions
2. Effects of participation or nonparticipation on care
3. Freedom to withdraw from study with what consequences
4. Availability of results

_____ No special provisions apply.

Sincerely,

Lois Hough

Chairman, Human Subjects Review Committee

at Dallas

PK/smu/3/7/80

TWU Texas Woman's University
P.O. Box 22479, Denton, Texas 76204 (817) 383-2302, Metro 434-1757, Tex-An 834-2133

THE GRADUATE SCHOOL

September 26, 1985

Ms. Wendy Barr
1412 Dreda Circle
DeSoto, TX 75115

Dear Ms. Barr:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Leslie M Thompson

Leslie M. Thompson
Provost

tb

cc Dr. Helen Bush
Dr. Anne Gudmundsen

APPENDIX B

Cover Letter to Participants

LETTER TO PARTICIPANTS

Dear

I am a graduate student in the nursing doctoral program at Texas Woman's University, and I am conducting a research project entitled "Critical Care Nurses' Perceptions of Caring: A Phenomenological Study." The purpose of this study is to identify the meaning of caring as well as factors which influence caring in the critical care setting.

This study will benefit patients and nurses by providing a description of caring and identifying factors which enhance or inhibit caring in the critical care setting. There are no known risks to you as a participant associated with this study. Please be assured that all responses will remain confidential and participants will not be identified by name or institution in the reporting of this study.

If you agree to participate in the study, an interview of approximately 30 minutes to 1 hour will be required of your time. A sample question would be the following: Can you give me some of your feelings about caring in the critical care setting? During the interview, if you should wish to withdraw from the project or terminate the interview session, you may feel free to do so with no negative consequences. If you have any concerns or questions about the study, please call me at 233-1094.

I would greatly appreciate your participation in the study and will be pleased to share the results of the project with you. I will contact you by phone within a few days to set up an interview appointment should you agree to participate.

Thank you for your consideration of this research project.

Sincerely,

Wendy J. Barr, R.N., M.S.
Doctoral Student
College of Nursing
Texas Woman's University

APPENDIX C

Consent Form B from Participant

TEXAS WOMAN'S UNIVERSITY

HUMAN SUBJECTS' REVIEW COMMITTEE

CONSENT FORM B

Title of Project: "Critical Care Nurses' Perceptions of Caring: A Phenomenological Study"

Consent to Act as a Subject for Research and Investigation:

I have received an oral description of this study, including a fair explanation of the procedures and their purpose, any associated discomforts or risks, and a description of the possible benefits. An offer has been made to me to answer all questions about the study. I understand that my name will not be used in any release of the data and that I am free to withdraw at any time. I further understand that no medical service or compensation is provided to subjects by the university as a result of injury from participation in research.

_____ _____

Signature Date

_____ _____

Witness Date

Certification by Person Explaining the Study:

This is to certify that I have fully informed and explained to the above named person a description of the listed elements of informed consent.

_____ _____

Signature Date

_____

Position

_____ _____

Witness Date

APPENDIX D

Form C for Permission to Tape Record Interview

TEXAS WOMAN'S UNIVERSITY

HUMAN SUBJECTS' REVIEW COMMITTEE

CONSENT FORM C

We, the undersigned, do hereby consent to the recording of our voices and/or images by Wendy J. Barr, R.N., M.S., acting on this date under the authority of the Texas Woman's University. We understand that the material recorded today may be made available for educational, informational, and/or research purposes; and we do hereby consent to such use.

We hereby release the Texas Woman's University and the undersigned part acting under the authority of Texas Woman's University from any and all claims arising out of such taking, recording, reproducing, publishing, transmitting, or exhibiting as is authorized by the Texas Woman's University.

SIGNATURES OF PARTICIPANTS

_____
Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge and understanding of its contents.

_____ _____
Authorized representative of Texas Woman's University — Date

APPENDIX E

Demographic Data Schedule

DEMOGRAPHIC DATA SCHEDULE

1. Participant's number: _____

2. Age: _____

3. Gender:

   _____Female
   _____Male

4. Highest level of education achieved:

   _____Associate degree of nursing
   _____Diploma
   _____Bachelor's degree in nursing
   _____Master's degree in nursing
   _____Doctorate degree

5. Type of nursing unit:

   _____Intensive care unit
   _____Coronary care unit

6. Nursing care modality:

   _____Primary
   _____Team
   _____Other

7. Type of position:

   _____Staff nurse
   _____Charge nurse
   _____Other
   _____Fulltime
   _____Parttime

8. Length of time in current position: _____

9. Number of years active in nursing: _____

10. Number of years in critical care setting: _____

11. Would like copy of results?

    _____Yes
    _____No

    Address:

APPENDIX F

Open-Ended Questions

OPEN-ENDED QUESTIONS

1. What does the term "caring" mean to you?

2. Can you give me some of your feelings about caring in the critical care setting?

APPENDIX G

Cue Questions

CUE QUESTIONS

1. Can you describe a situation in which you utilized caring behaviors with a client?

2. Can you describe a situation in which you witnessed uncaring behaviors being used with a client?

3. What factors promote or enhance (positively influence) caring in your practice?

4. What factors prevent or inhibit (negatively influence) caring in your practice?

5. Do you have a role model for caring?

6. What do you view as rewards for you as a registered nurse in the critical care setting?

7. Are you rewarded for caring?

8. Was caring an important component of your nursing education?

9. Can you recall having a particularly caring/uncaring nursing instructor? If so, what behaviors distinguished this instructor as caring/uncaring?

10. Do you feel that caring is feasible in today's critical care setting?

11. If you are dissatisfied with caring in nursing practice, what do you think could be done to change the situation?

APPENDIX H

Sample Transcription of Interviews

SAMPLE INTERVIEW TRANSCRIPTION

Participant 1

Q. Can you tell me what the term caring means to you?

A. I think caring means being sensitive to other people's needs and trying to meet those needs as best you can.

Q. Do you have any feelings about caring in the critical care setting in particular?

A. I think there are alot of factors that affect caring in ICU as far as--just the fact that the patient is so critical--sometimes you can't always communicate with them as well as you'd like. Sometimes they're intubated or they're comatose--just their condition makes communication limited, and that, I know personally, that affects me because it's hard to know that person personally, and alot of times the personal factor of your relationship affects how much you really care about that person. So if you get somebody in from surgery or into your ICU that you've never really communicated with on much of a personal level--it's more of a distant--you care about them as far as you know they're a human being, and you know that they're in a position where they're limited or they're sick, and you want to do the best you can, and yet you don't have that personal involvement; whereas if you're on a floor, you might know them personally before they went to surgery and got sicker--you had met them, you've kind of established a relationship with them. In ICU, you don't have that established relationship, alot of times, with that person. I think that might be one big thing that affects my caring attitude, because I don't know them personally, so it's easier for me to be a little more distant.

Q. So you don't get the feedback, is that what you're saying?

A. Right, and I guess I need that. I need the feedback.

Q. Can you describe a situation in which you utilized caring behavior with a client?

A. I don't know if I can think of a specific patient. . . .

Q. Or just in general?

A. In general? I think when I'm really caring the most for a patient is when I go above and beyond just the routine. Of course, as a nurse, you're required to do certain things each hour--you're going to take their vital signs, you're going to do their meds, you're going to carry out the doctor's orders, and if you're doing that in a caring manner, if your affect--the way you're touching them, the way you're communicating, carrying out those responsibilities, is caring. And when I really feel like I'm caring, is when I go above and beyond that--like I might really give them good oral care because I can just tell they're really uncomfortable, or they've expressed that to me, and of course you can do that each--it's kind of do oral and trach care q. shift, but there's just little extra things you can do--turning them more frequently, or saying "Are you hurting?" and really being attuned to their needs more so than you might be on just a routine basis--just doing that extra little stuff that to me communicates caring to the patient.

Q. Can you describe a situation in which you might have witnessed somebody utilizing uncaring behaviors?

A. Yes, I think it can happen alot in ICU. Probably when I see it the most--it's either a chronic patient that we've had a long time, they can be a real frustrating patient to take care of as far as they're not really improving, they're not getting any worse, they're still on the ventilator, they may be very elderly, you feel like they're really a nursing home patient, but because they're still on a ventilator, they're an ICU patient--(blank) doesn't have a step-down unit. So if they're a chronic patient, we may have them for months and months, and I think that tends to get nurses frustrated, they feel like they're not doing anything for the patient, and I think the care gets lax. And maybe the caring attitude, as a result, isn't what it should be. And then I've seen caring when it's a patient that--it's just a "problem" patient--a patient that's yelling, screaming, very uncooperative, a "difficult" patient--I've seen it where nurses automatically get a bad attitude--they reflect it to the

patient and they reflect it to the other staff-- they're just like "oh, he's a bad patient, you're going to have so much trouble with him"--you give that in report, so the negative attitude just keeps continuing, and I think all of that is going to result in a little less caring attitude toward that patient, because you've already started out negatively.

Q. What factors do you think make it easier to care?

A. I think alot of things for me personally. One is if I feel--it's almost like that transference theory--you can't really say what attracts you to a patient more than to another person, but it happens--it might be because it reminds you of your grandfather or a friend of yours, but it's something about that person that appeals to you, and so you tend to want to do more for that person--it brings out more caring in you. I think how cooperative they are affects me, if they're real nice and appreciative, if their manner is one that generates more caring in me, and I feel like I'm being positively reinforced for my caring feelings toward them, I tend to be more caring. And I think family, I've noticed just recently, the way family treats you--you may not have a personal relationship with the patient--didn't really know them--didn't talk to them, maybe they've been in a condition where you never knew them on a personal basis, but the family comes in--they can really affect how you feel toward the patient, because they can be real demanding and real difficult to work with, and it tends to reflect on how you feel about the patient, but if they're real nice and don't abuse the visiting privileges, and are appreciative of what you do for the patient, then that can affect how you feel about the patient, because you can think "Oh, this daughter is so sweet, and I hope he does well, because I know it will really upset her if he doesn't." That might tend to make me want to be real sweet to him, because I know she is so nice, and she'd do everything she could if she were in there, so you kind of take on her role almost.

Q. I never thought of assimilating the role of the family.

A. When you really care about them, it does affect me.

Q. In terms of negative factors, you've already mentioned the comatose patient and the negative family--is there anything else that you think makes it harder to care?

A. I think that just recently, I had a patient that was a gun shot wound to the head, and we did two EEG's on him, and he was brain dead, and it was a homicide case, so we had to do everything that we could to take care of him because legally, we could not not do things; whereas, if it had just been a routine, maybe if it was self-inflicted, or something, the family would have been able to say "we don't want anything more done," and we could have stepped back on our care. Whereas, this man, we couldn't, and I get real frustrated, if I feel what I'm doing is just pointless, because in that case, definitely, he was already legally dead, so I felt I was taking care of a dead person, and that was hard. I felt frustrated in that situation and probably not as caring. I felt I was caring toward the family--I didn't mistreat him as a person or a body, but I thought "Why are we doing this? This is so ridiculous." I feel this way also when there's elderly patients that are in their 90s and their prognosis is very poor, I feel as though I am inflicting suffering on that person, and I think if they were me, I just know I wouldn't want all these things done--the one's they continue to tube feed. They have to really--where do you draw the line? Where do you stop the care? But those situations get frustrating, because instead of feeling you are a helper, you feel almost as though you are a contributor to suffering to that person, and it makes me feel kind of bad about myself or at least about my job. Am I really helping--am I really doing nursing by taking care of these patients? Or am I just prolonging suffering? It's happened in younger patients too who were just critical and were irreparably brain damaged. Where do you stop the care? Where do you draw the line? Technology, the way it is today, I think we're more and more going to see that problem, and especially in the real critical settings, because we're going to be able to do so much, but at what cost to the quality of life, so you start questioning what you're doing? Are you really helping? Are you really being a nurse? Are you really caring about these people? Or are you just doing it because the hospital needs more money?

Because ICU is so expensive--it has to be a money maker for the hospital, and before DRGs, these routine cholecystectomies were in and out, and you just felt these people did not need to be in ICU, and you just questioned the motivation.

Q. Have DRGs affected your practice?

A. Yes, we're getting alot more sicker patients, which makes you feel like you're having to work alot harder. The days of the nice little patient coming in ICU for one or two days postop are over.

Q. Do you have a role model for caring?

A. I can't think of one specific person. Probably some peers I've worked with--people that always seem to go beyond, they always seem to do the little extra, and the patient always looks clean and cared for, and they just have a real good attitude about work, and they have a real good attitude about their patient, they're real kind to the patient, and real empathetic with their needs, and think of things--like if they're going to get a patient up, to get him a pain shot. They don't get so caught up in the busy frustrating aspects of the job--they are affected by that, but they are still able to generate a real caring attitude, and those are the type of people that inspire me--I think that can be my goal to generate caring and not to generate my frustrations of the job or some situation that occurs. In a business, if you're expecting an order that day, and it doesn't come in, you can kick the dog or yell at your secretary, but in the hospital, the same thing can happen, only you're yelling at your patient, or you're handling him roughly--the same thing happens, but in this situation, you say, "Oh, I can't believe I did that--this is a person." But that's your job--you're caring for people, you're not caring for a business order, but the same things can happen, so when you see a peer who doesn't allow the frustrations to carry over into the caring attitude for the patient, that's an inspiration for me, because it's difficult to do sometimes, especially if you've doubled back the night before--so many things can affect your performance and your attitude.

Q. What do you feel are your rewards in the critical care setting?

A. I think family--you see the family is so relieved and they're going to be transferred, and we do get cards and candy and little physical things of appreciation, as well as words, and sometimes patients come back, and I think that is the biggest reward--when you see someone you cared for a month or so that was in a car wreck or had been in ICU for weeks, and you just wondered if they were going to make it and they do, and they come back in a wheelchair or just walk in and say "I just wanted to see where I was, because I don't really remember much about ICU." And they say "Thanks for taking care of me--I don't remember much of you all, but I know I almost died, and I know that you all did so much for me." That is such a neat feeling, because then you're seeing the person better, because alot of times our patients get better, and you transfer them to the floor, and you never see what happens, you never see them go home in a really well state, so that's a really big reward. And family's appreciation. And for me, I think I have a really good unit as far as peer groups and supervisor, so my rewards are alot of times that they recognize that you've had a bad day. They see when you've had a bad time, but they say, "Oh, you've done a good job." Just little notes of praise and encouragement from your peers or your supervisor that you handled that fine--"It was a difficult situation, but you did the right thing." And that is a reward, because you think--"I was frustrated, or I did have some problems, but it was recognized that I handled that OK."

Q. You're fortunate to be in a situation like that.

A. Yes, our supervisor is real flexible, and that helps. We're just a real easy going, kind of laid back ICU, but there is structure there, and I feel like we get the important things done, but there's not mass chaos--it's just a more flexible environment, and for me, I need that.

Q. Do you remember if caring was an important part of your nursing education?

A. I remember they stressed the difference between empathy and sympathy. They said be emphathetic--be able to put yourself in that person's shoes and treat them with empathy, rather than feeling sorry for the patient.

Q. Do you remember any caring or uncaring instructors and what they were like?

A. One was very uncaring toward students.

Q. What made her uncaring?

A. She was very manipulative and negative toward students' self-esteem. And I think you can do that to your patients--you can instill negative self-esteem, "you're a bad person, because you're not cooperating, you're a bad patient because you're asking me for these pain medications every three hours--you're bothering me." As far as instructors, I don't remember alot of role models for caring, because I didn't see them with patients--they stressed alot of independence (for students).

Q. Several nurses have said it is difficult to care for comatose or intubated patients. Is there anything you can think of that would make that a better situation?

A. I think families make a difference. We have comatose patients that we never see the family, and that makes them less of a person to you, and that seems real cold. But you don't see any personal evidence--you don't know what they were like before, you just don't have that person in mind--you never heard him talk. But when a family comes in and you see they have a son or a wife, and they'll mention things--they'll say "Would you mind putting a blanket on him? He always complained about being cold in his other room." You start seeing little things that they mention--make them more personal to you--that helps me probably more than anything.

Q. Are your visiting hours flexible enough to allow for family contact?

A. Yes, there are at least two visiting times on each shift, so if the family is there, you're going to see them. And if they're real critical, we're real flexible about letting the family come in--if they say "we know it may be the last day or so, could we come in more? We'd really like to stay with him"-- we're open to that. And then when some patients are there for months, the family may not come as often-- after all, they have to go on with their lives. But when the family gives up, it kind of affects you because you think "Gosh...."

APPENDIX I

Complete Listing of Statements

COMPLETE LISTING OF SIGNIFICANT STATEMENTS: CARING

Interview 1

1. Do whatever it takes for them to live--you take care of all their needs, physical or psychological.

2. Involves the family because they need alot of caring.

3. Doted over him; we would hang stuff in his room around Christmas.

4. Made sure he looked real nice and was comfortable.

5. We took out a Swan-Ganz and showed them (family), just so they knew what was happening.

6. If they're turned and the room looks nice, if they're on the vent and on Pavulon, what more can you do for them?

7. Spend extra time with your patient, spending those full 15 minutes with the family.

8. Family teaching, patient teaching, made sure the patient understood what was going to happen to him.

9. Sit down with the patient at the beginning and ask what would help him feel more comfortable during his hospital stay.

Interview 2

1. Caring is a feeling you have inside and hopefully can be displayed to the patient to show you understand what they're feeling.

2. It carries into the actual physical caring for the patient, doing things to make the patient feel better or improve his condition.

3. Alot of times caring is felt by the families, you're treating families and showing them you care.

4. Patients can understand and sense caring even on a ventilator, and they're even more frightened, they need it more, and you have to be extra careful, extra-explanatory, you have to be more caring.

5. You can't just go in there and do your job, you have to have a certain amount of caring or the patient is even more nervous, and that stops getting well.

6. Moral support.

7. You have to explain where they are, what they're doing, and what we're doing for them.

8. Help them come to grips with the feelings because it's totally new and it's disruptive to their whole life.

9. If the patient is benefitting from extra visiting time, we always bend the rules.

10. I sat there and had him up in the chair and was feeding him.

11. I constantly had to praise him, constantly encourage him--give him extra support, extra pushing, extra loving care.

12. Empathy--I think that goes hand in hand with caring.

13. Kind manner, supportive, being there.

14. Talk to your patient, especially giving baths and doing dressing changes--you have time.

Interview 3

1. General concern for someone that you would put yourself out for them, to do something for them.

2. Give that patient the little bit extra.

3. Express a caring attitude to family members, spend some time with them, and deal with how they're feeling.

4. Ventilator patients--alot of them have various drips and frequent monitoring of their vital signs.

5. . . . if they're feeling the way you think they're feeling.

6. A family member arrived after visiting hours and the patient was really scared and restless that night, and I thought it would probably be best if the patient was able to see this person and talk to them, so I let the family member in.

7. I think it helped him to relax a little.

8. Be concerned about some of their psychosocial needs.

9. Identify some of the patient's needs just by talking with the family members.

10. Relate the clinical aspects of care to how this would affect the patient emotionally.

11. Every patient was just as important as the next and do not downplay any little emotional need that the patient might have.

Interview 4

1. You really feel and use your feelings.

2. You care about what the patient's going through--you kind of put yourself in their position and how you'd want to be taken care of yourself instead of just mechnical (care).

3. In critical care, the patients are more dependent on you for even the basics.

4. They need alot more explanation because the equipment and noises are so foreign to alot of people.

5. With someone who's intubated, just standing there and taking the amount of time it takes to go over everything and finally figuring out what they wanted and giving them some relief.

6. Being there, being available.

Interview 5

1. Showing a genuine interest in a person, a genuine feeling for the situation they're in and for their problems.

2. Sympathy, empathy.

3. Taking time to indicate to a person that you understand what he's going through.

4. Touching would be a big part of caring.

5. Eye contact.

6. Explaining things to him and answering his questions would be a big component of caring.

7. Be pleasant.

8. It's just an automatic part of the nursing that I try to practice.

9. Care about his whole family situation because that can really have big ramifications.

10. Sit and spend some time with a patient, to really talk with him and explain, or just to talk generally with him, just about the weather or their hobbies, or something like this. Personal conversation.

11. . . . to delve or help them express the things that they are feeling, so we can exhibit caring for them.

12. Their tone of voice, their gentleness in dealing with a patient, their ability to do their work without getting ruffled, without getting tense or nervous, it's a quiet . . . (serenity) . . . . An attitude like that goes a long way in conveying to a patient that you do care about his welfare.

Interview 6

1. Being sensitive to other peoples' needs and trying to meet those needs as best you can.

2. Personal involvement.

3. When I'm really caring the most for the patient is when I go above and beyond the routine.

4. Doing vital signs, giving meds, carrying out the doctor's orders in a caring manner--the way you're touching them, the way you're communicating, carrying out those responsibilities, is caring.

5. Really give them good oral care because I can tell they're uncomfortable.

6. Doing little extra things--turning them more frequently, or asking if they are hurting, and really being attuned to their needs.

7. Take on the role of the patients' daughter.

8. Feeling you are a helper for a person.

9. Patient always looks clean and cared for.

10. Real kind to the patient and real empathetic with their needs.

11. If they're going to get a patient up, they get him a pain shot (first).

12. Generate a caring attitude without generating the frustrations of the job.

Interview 7

1. Empathy for the patient you are with--it's similar to loving.

2. Caring is physical and emotional.

3. Anticipate their needs.

4. Allay a patient's fears--fears about the environment, fears about the people she comes in contact with.

5. The nurses went out and got the patient a beer when the doctor said he could have one and the hospital didn't have any.

6. The unit secretary would pick up his wife and take her home because $20 one way for a cab is alot, so everyone in the hospital really cares for them.

7. Talking sometimes really helps.

Interview 8

1. Total patient care with the end goal of getting that patient out of that unit onto a progressive unit.

2. It involves everything--medical, nursing, social, spiritual.

3. In critical care, we are more concerned with that patient's acute illness.

4. More personalized attention.

5. Sitting down in a chair at the bed and listening to him and hearing what he had to say.

6. Eye-to-eye contact, physical contact.

7. Realizing we could make decisions so we could get things done a little faster for the patients--pushing the doctors.

8. Be concerned about the patient's individualism, confidentiality.

Interview 9

1. Empathizing with a patient, trying to think of it as one of my loved ones and see how I would feel.

2. The more you care about someone, your actions will change too, as well as your feelings--if you really cared about the patient, you'd try a little harder and really do a good job.

3. The nurse knows what to do for the patient.

4. I called the doctor and told him we had to do something for this little girl, she was in so much pain, so we got her narcotics increased--that would be an example of caring.

5. Do what I can to help them, even if it might be trivial.

6. Consider the family and the expense (of the hospitalization).

7. Talking to the patient, real calm, trying to do everything you can for them.

8. Focus on the family and the psychosocial problems.

9. When you talk with the family and learn about the patient and what happened and about their life before, you think twice about what you're doing and realize this patient was fine before, and you should try to care about him even though his prognosis is bad.

Interview 10

1. Caring means showing concern for a patient and doing everything to make them comfortable, to make them at ease and make them feel they are wanted in a hospital.

2. Caring in critical care is more intense than in a floor situation because you have more time to spend with the patient and, of course, patients in the critical setting would be alot sicker, so they need more attention and more TLC.

3. Critical care patients need not only physical but emotional caring, including the families.

4. Pay more attention to the family's needs emotionally to help them get over their stress.

5. For the families, we explain the procedures, the patient's condition, and the rules and regulations of the unit, so they won't be separated totally from the patient.

6. Prioritize as to what needs attention first, as to whether it's emotional or physical.

7. (Nurses) go beyond their duties to show caring behavior to the patient and to the family.

8. Help patients and families go through rehabilitation as quickly as possible.

9. Being in the critical care unit, the main thing is to keep them alive.

10. Give support when needed.

11. Talking to patients and telling them what I am going to do whether they're conscious or not.

12. When I'm caring for an obtuned or unconscious patient, I always talk to them because you can never tell whether they've lost their sense of hearing or not.

13. When a patient is very critical, a nurse may be more concerned with the machines, but she should be able to re-prioritize and re-group after a day or two and consider the total patient.

Interview 11

1. An emotional feeling that brings about actions--it precipitates how you treat someone.

2. Empathizing.

3. In critical care, there are patients who aren't able to communicate in all ways and to realize that and to put yourself in their place.

4. It also involves alot of caring for the family, providing emotional support.

5. The little things--realizing they're uncomfortable, offering some juice, or rubbing their back.

6. Allowing the family extra minutes to visit if they're lonely or scared.

7. Holding their hand.

8. Helping to get across to the doctor some of their feelings, things they're afraid to approach them on, kind of being their advocate.

9. Sometimes, they're so upset, just knowing to leave them alone and give them some space, treating them with respect.

10. Companionship.

11. Knowing the patient died with dignity and that the family was able to make alot of touch and talking contact with them.

12. Patient teaching, family teaching, and letting them know what's going on; knowing they're well-informed and that they understand what has happened.

13. Special attention.

14. Developing careplans and following through.

15. If the patient is very, very sick and they want to be left alone, and their family is just clamoring over the door, then sometimes I help them by keeping them out.

16. (When taking care of comatose patients), realizing hearing is the last sense to go, I can chatter away to these patients and do little things like give them ointment so their sclera does not dry out, and doing oral care . . . .

17. Touching a comatose patient's hand and letting him know you are there.

18. If you carry on a general conversation with these (comatose) people, you really look on them more as a person.

Interview 12

1. To do things for people that they cannot do for themselves or they do not have the knowledge to do for themselves.

2. Talking to a person can be caring, if they need to talk about something.

3. You know your patients better, you have more contact with them.

4. It's something you do every day.

5. It's what they (patients) need done, not what you (nurse) need done.

6. Do basic care for them.

7. Get to know the patients better.

8. Shouldn't put them down . . . not to look down on these people (nonpaying patients).

9. Find out what their problems are going to be . . . are they going to need someone to check on them at home?

10. They need your help to sit there and help them think about what they need done.

Interview 13

1. A focused attention on patients' needs.

2. It's more than physical, it's the whole gamut, you are doing total personal type nursing.

3. In the intensive unit, you are more focused in on physical things.

4. Caring occurred when I stopped doing my routine and listened to them and heard what they really felt they needed.

5. Answer those extra patient needs or modify my routine for the patient needs.

6. I may have helped them along to die.

7. My being there made a difference--I didn't just shove a needle at them, I didn't just shove pills at them, I made it a little more human, and digested some of that machinery away, so I could get to a people-to-people basis.

8. Knowing that the patient is alot more comfortable than they would have been otherwise.

9. Meet the psychological needs of the patient.

10. When I'm taking care of an obtunded patient, I always have this inner feeling that there's something there, and I'm just taking care of this body that they've used all the time.

Interview 14

1. Being able to empathize with someone in whatever situation they're in, and hopefully offering something to them to make their situation improve.

2. Need to make a special effort to care in the critical care area because you can get so involved with the technical aspects.

3. Take the time out to be there when they need you, and just do the little things to let them know you're there.

4. Dealing with the patient and family both go together.

5. Treat each patient as a person and take care of their individual needs.

6. Emphasis on emotional needs.

Interview 15

1. Caring would encompass the total patient, it would be both dealing with physical cares, as far as giving medications, turning a patient, bathing a patient, dealing with the emotional problems, caring about the way they were accepting their illness, the way their families were accepting it, it encompasses everything.

2. A personal relationship.

3. Know the interactions between patient and family.

4. I let her (wife) rinse his (patient's) dentures, and it made her feel like she was a part of what was going on.

5. Gave her extra time in there.

6. Something small--feeding a patient or brushing their hair, shaving them.

7. You have to be attuned to letting them (family) be as involved in the care as they want to be, or as they think they can take.

8. Pick up if there are problems within a family, alot of time what the family is bringing into the room is not what the patient needs, and picking up on that, and being the heavy, as far as keeping the family out or cutting down on the number of visitors . . . you're protecting the patient.

9. Acting as a mediator with the physician--if we can grab a doctor and tell them a family needs to talk to them.

10. To be an advocate, if feelings are made known to us, to step forward, and to share this with the appropriate people.

11. There comes a point in time when I think you have to accept that the quality of life that they would be left with is not what you would want for yourself or your loved one.

12. You want to go over the line, you want to go farther.

13. Giving that extra.

14. There are some nurses who won't or can't take care of AIDS patients, so we don't assign them to those patients, because you know they wouldn't get the best care that they could.

15. Have time to talk with them (patients) when you got them up in the chair.

16. What it boils down to is the minimum is just keeping them alive.

17. You do the best you can with the time you've got.

18. You can determine how fast a patient's recovery is--you hold people's lives in your hands--like a stroke patient who needs range of motion, PT comes up twice a day, if we don't do it . . . .

19. You're dealing with a human life, if someone is in distress or needs help, I personally feel it's your responsibility to deal with that.

20. You can have a machine take the blood pressure, and you can have a machine take the heart rate and flash up on the screen what drug you need to give, and you can drain the urine into a bag and have it measured and computed, but you still need someone to care for the patient as a person, and that's why I think there is something beside skills in nursing.

21. Maybe part of it is that I know how I would want to be cared for and how I'd want my loved ones cared for, and it's a hope that if I take care of others well, when it's my time or my family's time, that someone will care enough to do the same for them.